



House of Commons  
Committee of Public Accounts

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**NHS ambulance services**

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**Sixty-second Report of Session 2016–17**

*Report, together with formal minutes relating  
to the report*

*Ordered by the House of Commons  
to be printed 24 April 2017*

## The Committee of Public Accounts

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Committee reports are published on the [Committee’s website](#) and in print by Order of the House.

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### Committee staff

The current staff of the Committee are Dr Stephen McGinness (Clerk), Dr Mark Ewbank (Second Clerk), Hannah Wentworth (Chair Support), Dominic Stockbridge (Senior Committee Assistant), Sue Alexander and Ruby Radley (Committee Assistants), and Tim Bowden (Media Officer).

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## Summary

Ambulance services provide a valuable, life-saving service that is held in high regard and plays a vital role in the entire urgent and emergency care system. Since this Committee last examined ambulance services in 2011: funding increases for the urgent and emergency services provided by ambulance trusts have not kept up with increasing demand; ambulance trusts increasingly struggle to meet response-time targets, despite focussing on these targets to the detriment of wider performance; and significant variations between trusts, in both operational and financial performance, persist or have got worse as insufficient work has been done to understand and reduce variation. Action is being taken by NHS England, NHS Improvement and ambulance trusts to address the performance and long-term sustainability of the ambulance services but it has taken too long to begin addressing the issues identified by this Committee in 2011. We recognise ambulance services and national bodies are inherently reliant on the rest of the health system to deliver new care models and services outside of hospital in order to support a more sustainable ambulance service.

## Introduction

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In England, 10 regionally-based ambulance trusts provide urgent and emergency healthcare, with separate arrangements for the Isle of Wight. In 2015–16, these services cost £1.78 billion. Ambulance services received 9.4 million urgent or emergency care calls and 1.3 million transfers from NHS 111, which together resulted in 6.6 million face-to-face attendances in 2015–16.

Since July 2012, ambulance responses have been split into Red and Green calls. Red calls are calls where the patient's condition is considered to be life-threatening. Red 1 calls are the most time-critical, and cover patients suffering cardiac arrest, who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls are serious but less immediately time-critical, and cover conditions such as stroke and heart attack. For Red 1 and Red 2 calls, the ambulance service has a target requiring an emergency response arriving at the scene within 8 minutes in 75% of cases. If onward transport is required, a vehicle capable of conveying the patient should arrive at the scene within 19 minutes in 95% of cases. Green calls are calls where the patient's condition is considered not to be life-threatening. Locally agreed targets are in place for these calls.

The ambulance service has a pivotal role to play in the performance of the entire urgent and emergency care system, as a conduit to other services and helping patients access the facilities they need close to home. For ambulances, this means applying new models of care rather than taking all patients to hospital. The new models of care include: resolving calls over the phone by providing advice to callers; treating patients at the scene; and taking patients to non-hospital destinations.

## Conclusions and recommendations

1. **Ambulance trusts have organised themselves to meet response-time targets, at the expense of providing the most appropriate response for patients.** The ambulance service believes current response categories and practices mean too many patients are being coded as Red 2, when they should be Green. Despite this, ambulance services have adopted a number of operational behaviours that undermine the efficiency of the service in order to meet the Red 2 target of arriving at the scene within 8 minutes in 75% of cases. For example, dispatching vehicles before they have fully determined the nature of the patient complaint; and dispatching multiple ambulance vehicles to the same patient and then standing down the vehicles least likely to arrive first. This has the knock-on effect that other patients wait longer for an ambulance, potentially including patients who are clinically a higher priority. It also means patients who are less seriously ill, but who nonetheless may need an ambulance ('Green' calls), can wait a very long time before an ambulance arrives. NHS England has established the Ambulance Response Programme to address some of these issues, and told us that the changes recommended from the programme can be implemented quickly once ministerial approval is received.

**Recommendation:** *The Department, NHS England, NHS Improvement and ambulance trusts should implement the recommendations of the Ambulance Response Programme at pace. Any changes to the response-time target system should address 'tail breaches' (very long delays) and the lack of focus on Green calls.*

2. **Despite this Committee identifying significant variations in ambulance service performance and efficiency in 2011, the causes of these variations are still not well understood.** Substantial variations persist between ambulance trusts across a range of performance and efficiency measures. For example, in 2015–16, the proportion of Red 1 calls responded to within 8 minutes varied from 68.1% to 78.5%; the proportion of incidents where one or more vehicles were stood down after mobilisation varied from 4% to 46%; and income per head of population varied from £26.7 to £36.6. Many of the factors contributing to these variations are within the control of ambulance trusts or the wider health system, though some factors, such as rurality and population demographics, are outside of their control. Each ambulance trust has developed its own operating framework which contributes to the variations and inefficiencies in performance. Key operating framework variables include workforce mix, the types of vehicle used, and number and type of ambulance stations. In addition, ambulance services are not commissioned consistently across England, with differences in how they are funded and what they are funded for.

**Recommendation:** *NHS Improvement should determine the underlying causes of variations in performance, identify an optimal operating framework for ambulance services and work with NHS England to incorporate this framework into commissioning arrangements for 2018–19. The new framework and commissioning arrangements should establish commonality but allow flexibility where appropriate.*

3. **Various ambulance service improvement programmes are now underway, but this has taken too long to happen.** Many of the key issues discussed at our evidence session, and in the accompanying report by the National Audit Office, were identified as issues in 2011, when we last reported on ambulance services. For example, too great a focus on response times, delayed patient transfer at hospital, a lack of consistency in key data sets, and integration with the wider health system, were all identified as areas of concern. Since 2011, NHS England has initiated the Urgent and Emergency Care Review and the Ambulance Response Programme, and last year NHS Improvement launched the Ambulance Trust Sustainability Review. We had expected to see greater progress over the past six years, and will be looking to see real improvements being delivered over the next two years.

**Recommendation:** *The Department of Health, NHS England and NHS Improvement should set out a trajectory with clear milestones for all its modernisation programmes that focus on ambulance services, by October 2017. As part of these programmes, they should ensure consistent and reliable data sets for key performance measures are available, including clinical outcomes, new models of care, efficiency metrics, and patient-transfer times at hospital.*

4. **To deliver new ways of working, ambulance services will need a different mix of skills and vehicles. They will also need to work with their commissioners to fund a paramedic pay increase from 2018–19. It is not clear how the costs associated with these changes will be funded.** The Urgent and Emergency Care Review and likely changes from the Ambulance Response Programme will require ambulance services to continue to adopt new ways of working rather than taking all patients to hospital. This requires significant changes to the vehicle fleet and workforce. There will need to be changes to the vehicle fleet, with a move from lower-cost rapid response vehicles to more expensive double-crewed ambulances. To address the shortfall in paramedic staff, the number of trainee paramedics has doubled in recent years, and these trainees began joining the workforce in 2016, alongside an increasing number of ambulance technicians. In addition, paramedics have recently received a pay increase, in recognition of the increased skill set they have developed. There is no additional funding planned for staff cost and capital investment in vehicles. Ambulance trusts and commissioners will therefore need to find efficiencies across the urgent and emergency care system to fund vehicle fleet changes and the paramedic pay-uplift from 2018–19 (NHS England and the Department are funding the increase for 2017–18).

**Recommendation:** *NHS England and NHS Improvement should assess whether sufficient resources are available to ambulance trusts to support new ways of working including capital expenditure. They should also provide additional assurances to the Department regarding how increased paramedic costs will be met from 2018–19 onwards if the provision of central funding to cover these costs does not continue after 2017–18.*

5. **Ambulance services have struggled to recruit and retain staff, and staff shortages are exacerbated by many trusts having high sickness absence rates.** Ambulance trusts face resourcing challenges that are limiting their ability to meet demand. Most ambulance trusts struggle to recruit the staff they need, while paramedics are increasingly being recruited by organisations outside the ambulance service. Staff



shortages are made worse by high sickness absence rates, up to 6.7%, in some trusts. To help improve staff retention, NHS England and NHS Improvement are planning initiatives to better support ambulance staff, such as mentoring schemes for new staff and more support from senior staff when they attend a patient. However, currently there is no programme in place for the career development of staff below the paramedic grade.

**Recommendation:** *NHS England and NHS Improvement should set out their plans for tackling ambulance workforce issues and report back to the Committee on progress by April 2018; including progress against recruiting additional staff, reducing staff turnover rates, and reducing staff sickness absence rates.*

6. **Many patients are waiting too long to be transferred from an ambulance to hospital care, and this situation has got worse since we last reported.** Transferring patients from an ambulance to an emergency department should take no longer than 15 minutes. Each failure to meet this standard results in a poor experience for the patient and a delay in an ambulance crew being available for a new emergency call. Just 58% of patient transfers were completed within 15 minutes in 2015–16, compared to 80% in 2010–11. NHS England told us that ambulances not being able to offload patients is one of the most serious concerns in the urgent and emergency care system currently and to address this issue much firmer performance management of the system is happening. After the transfer is complete, ambulance crews are expected to make their vehicle ready for the next call within another 15 minutes. Ambulance crews are failing to achieve their own 15-minute standard, adding to the delay. In 2015–16, this was achieved in just 65% of cases. Despite this Committee recommending in 2011 that a quality indicator should be developed for hospital performance in meeting the transfer-time target, this has not happened.

**Recommendation:** *NHS Improvement should publish a set of improvement trajectories for hospital turnaround times and introduce transparent reporting on progress by October 2017.*

7. **Ambulance services are pivotal to the wider health system but it is not clear how they will be incorporated into local Sustainability and Transformation Plans or become fully integrated into the wider health system.** Effective collaboration is key to ensuring that all urgent and emergency care services are connected and integrated. However, the complexity of the healthcare system creates challenges for ambulance trusts in terms of engaging with all the relevant local stakeholders. NHS England has introduced 44 Sustainability and Transformation Plan areas, in which health and care leaders in each area are required to set out how local services will change and improve over the next five years, to meet rising demand within the resources available. However, it remains unclear how locally driven plans will fit with the national aim of connecting and integrating all urgent and emergency care services and getting a consistent service offer across regions. The ambulance service has to fit in with plans made elsewhere in the NHS; this has an impact on its ability to respond to emergency calls.

**Recommendation:** *As part of their planned commissioning guidance for 2018–19, NHS England should provide greater clarity on how ambulance services will have a seat at the table in local Sustainability and Transformation Plans, and how they will become fully integrated into the wider health system.*

# 1 Performance

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1. On the basis of a report by the Comptroller and Auditor General, we took evidence on NHS ambulance services from the Department of Health (the Department), NHS England, NHS Improvement, and the Chief Executive of Yorkshire Ambulance Service NHS Trust.<sup>1</sup>

2. The ambulance service provides urgent and emergency healthcare, including life-saving care for some patients, and is held in high regard both by the public and this Committee.<sup>2</sup> In England, 10 regionally based ambulance services provide urgent and emergency care (with separate arrangements for the Isle of Wight). The provision of urgent and emergency ambulance services cost £1.78 billion in 2015–16. In the same year the ambulance service received 9.4 million telephone calls from the public or other health professionals, and an additional 1.3 million electronic transfers from the NHS 111 service requiring an ambulance response, which between them led to 6.6 million face-to-face attendances from the ambulance service.<sup>3</sup>

3. The ambulance service has a pivotal role to play in the performance of the entire urgent and emergency care system, as a conduit to other services and helping patients access the facilities they need close to home. For ambulances, this means applying new models of care rather than taking all patients to hospital. The new models of care include: resolving calls over the phone by providing advice to callers; treating patients at the scene; and taking patients to non-hospital destinations.<sup>4</sup> The Committee of Public Accounts last reported on ambulance services in 2011.<sup>5</sup>

## Response time targets

4. Since July 2012, ambulance responses have been split into Red and Green calls. Red calls are calls where the patient's condition is considered to be life-threatening. Red 1 calls are the most time-critical and cover patients suffering cardiac arrest, who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls are serious but less immediately time-critical, and cover conditions such as stroke and heart attack. For Red 1 and Red 2 calls, the ambulance service has a target requiring an emergency response to arrive at the scene within 8 minutes in 75% of cases. If onward transport is required, a vehicle capable of conveying the patient should arrive at the scene within 19 minutes in 95% of cases. Green calls are calls where the patient's condition is considered not to be life-threatening. Locally agreed targets are in place for Green calls.<sup>6</sup>

5. The ambulance service believes current response categories and practices mean many patients are being coded as Red 2 unnecessarily as they do not clinically require an 8-minute response.<sup>7</sup> In order to meet the Red 2 target, the ambulance service has adopted a number of operational behaviours that undermines its efficiency. For example, dispatching

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1 C&AG's Report, [NHS ambulance services](#), Session 2016–17, HC 972

2 Q222; [C&AG's Report](#), para 1.2

3 Q1; [C&AG's Report](#), para 1, 1.2, 1.9

4 Qq124, 126; [C&AG's Report](#), para 1.6–1.7;

5 Committee of Public Accounts, Forty-sixth Report of Session 2011–12, [Transforming NHS ambulance services](#), HC 1353

6 Qq5, 14, 104; [C&AG's Report](#), para 1.3–1.4

7 Qq3–7, 14; [C&AG's Report](#), para 2

resources before they have fully determined the nature of the patient complaint, and dispatching multiple ambulance vehicles to the same patient and then standing down the vehicles least likely to arrive first.<sup>8</sup> This diverts ambulance resources away from other patients, potentially including those who are clinically a higher priority. It also means patients who are less seriously ill, but who nonetheless may need an ambulance ('Green' calls), can wait a very long time before an ambulance arrives (which is known as a 'tail breach').<sup>9</sup>

6. NHS England has established the Ambulance Response Programme, to address some of these issues. The Ambulance Response Programme has three parts. The first part, the 'dispatch on disposition' trial, allows ambulance trusts to spend more time assessing the patient over the phone before deciding what type of response is needed. This is paired with a new set of questions used before the assessment to better identify the highest risk patients more quickly. It is expected that the Programme will recommend increasing the time allowed on the telephone to deal with Red 2 calls from 60 to 240 seconds. The second part, involves updating patient categories and codes, so that they specify the patient complaint and the response (covers type of clinician and vehicle) required. The third part involves developing a new set of performance measures that cover safety, clinical outcomes and efficiency.<sup>10</sup> NHS England told us that once it receives ministerial approval, the Programme could be rolled out across all ambulance trusts by autumn 2017, and that benefits should be seen by 2018. NHS England noted that these gains may be negated if the wider health system is not also updated.<sup>11</sup>

## Variation in performance

7. In 2011, the previous Committee identified significant variations in the performance and efficiency of ambulance services, and made recommendations intended to help improve performance and reduce variation.<sup>12</sup> Despite this, significant variations remain in the performance and efficiency of ambulance trusts across a range of performance and efficiency indicators. For example, in 2015–16, the proportion of Red 1 calls responded to within 8 minutes varied between trusts from 68.1% to 78.5%; the proportion of incidents where one or more vehicles were stood down after mobilisation varied from 4% to 46%; and income per head of population varied from £26.7 to £36.6. Much of this variation is caused by factors within the control of ambulance services or the wider health system (though some factors, such as the rurality of the location and population demographics, are not).<sup>13</sup>

8. Each ambulance trust has developed its own operating framework, which has contributed to these variations. Key variables in the operating frameworks include: the workforce mix, such as the proportion of paramedics, advanced paramedics and technicians; the type of vehicle used, such as the proportion of rapid-response vehicles

8 Qq16–21; [C&AG's Report](#), para 3.4

9 Qq7, 105–107

10 Qq21, 40, 57, 108; [C&AG's Report](#), para 3.5

11 Qq177–180

12 Qq176–177; Committee of Public Accounts, Forty-sixth Report of Session 2011–12, [Transforming NHS ambulance services](#), HC 1353, summary; paras 4–7

13 Qq136, 151; [C&AG's Report](#), paras, 3.3, 3.6, 3.8, Figure 4, Figure 13,

and double-crewed ambulances; and number and type of ambulance stations, such as whether a hub and spoke model is employed with fewer ambulance stations and more standby points.<sup>14</sup>

9. In addition, ambulance services are not commissioned consistently across England, with differences in how trusts are funded and which services they are funded to provide. NHS Improvement told us there were a number of reasons for these variations in commissioning; some were historical and came about because of factors such as the merging of smaller, county ambulance services into larger regional services, while others factors related to geography or population demographics. NHS Improvement noted that by April 2018 ambulance services would be commissioned on a consistent basis.<sup>15</sup>

10. In moving to standard operating and commissioning framework, there is a risk of imposing a 'one size fits all' approach across the ambulance service that will not suit all parts of the system. NHS England confirmed that the new arrangements are seeking 'commonality not uniformity', and should not restrict local initiatives such as locally-agreed co-responding schemes with the fire service.<sup>16</sup>

## Improvement programmes since the previous Committee's report in 2011

11. Many of the key issues discussed at our evidence session, and in the accompanying National Audit Office report, were identified as issues in 2011, when the previous Committee reported on ambulance services. For example, too great a focus on response times, delayed patient transfer at hospital, a lack of consistency in key data sets, and integration with the wider health system, were all identified as areas of concern, and remain so.<sup>17</sup> NHS England launched the Urgent and Emergency Care Review in 2013 that sets out its ambition to integrate urgent and emergency care systems, and the Ambulance Response Programme in 2015, whilst NHS Improvement launched a review of ambulance trust sustainability in 2016.<sup>18</sup>

14 Qq65–66, 70; [C&AG's Report](#), para 3.4, 3.6

15 Qq70–71, 81, 136; [C&AG's Report](#), paras 1.15

16 Qq158–165

17 Qq3–7, 86–89, 108, 126–130, 176–177, 182, 217; Committee of Public Accounts, Forty-sixth Report of Session 2011–12, [Transforming NHS ambulance services](#), HC 1353, paras 4–7; C&AG's Report, [Transforming NHS ambulance services](#), Session 2010–12, HC 1086, para 17

18 Qq13, 39, 66, 134, 143, 167, [C&AG's Report](#) (2017), paras 1.6, 1.14, 3.5

## 2 New ways of working

### Adopting new ways of working

12. The Urgent and Emergency Care Review and likely changes from the Ambulance Response Programme will require the ambulance service to adopt new ways of working rather than taking all patients to hospital. This will involve significant changes to the types of vehicle used and the workforce. The three ambulance trusts participating in the Ambulance Response Programme's trial of new clinical codes have found that they require fewer rapid-response vehicles and more double-crewed ambulances. It is not yet clear how many more double-crewed ambulances will be needed across the 10 English ambulance trusts, but the Chief Executive of Yorkshire Ambulance Service estimated that his trust would need another 20 to 30.<sup>19</sup> The cost of double-crewed ambulance (around £120,000) is a lot more expensive than the cost of a rapid-response vehicle (around £50,000). This suggests that the changing vehicle fleet-mix will represent significant capital expenditure nationally.<sup>20</sup>

13. NHS England and NHS improvement told us that Health Education England had set up a programme to train more paramedics, with about 1,750 learners this year. This programme aims to help rectify existing shortfalls and ensure that trusts can implement the new ways of working required. However, there is no additional funding planned for additional ambulance staff or capital investment in vehicles.<sup>21</sup>

14. In addition to increased number of paramedics, from 31 December 2016, in recognition of the increased responsibilities and skill set of paramedics, their pay was uplifted within the 'agenda for change' pay bands, from band 5 to band 6. This represents an increase from around £32,000 a year (including a £7,500 enhancement for unsocial hours) to around £39,000 a year (including a £9,000 enhancement for unsocial hours).<sup>22</sup> Until 2018–19, funding to cover these costs will be provided by NHS England (one-third) and the Department (two-thirds).<sup>23</sup> The Chief Executive of Yorkshire Ambulance Service told us that after 2018–19, the expectation is that funding will come through efficiencies achieved by having a workforce with enhanced clinical skills. The Department cited the example of West Midlands Ambulance Service who already pay their paramedics at band 6, and fund this from their existing resources.<sup>24</sup>

### Workforce challenges

15. Most ambulance trusts are struggling to recruit the staff they need and then retain them. For example, the paramedic vacancy rate was 9.3% in 2016 and paramedics remain on the immigration shortage occupation list.<sup>25</sup> One of the contributing factors to recruitment and retention issues is the demanding nature of working within the ambulance service. NHS England the Chief Executive of Yorkshire Ambulance Service noted that ambulance staff: frequently work in isolation and make decisions on their own with limited support

19 Qq39–40, 60–65, 167; [C&AG's Report](#), paras 1.6–1.7

20 Qq49–54, 67–68

21 Qq60, 67–68, 89–90, 97–100, 127, 130; [C&AG's Report](#), para 1.19–1.20

22 Qq97, 100–103, 186; [C&AG's Report](#), para 1.13

23 Qq97

24 Qq97–103; [C&AG's Report](#), para 1.13

25 Qq89–96; [C&AG's Report](#), para 1.17–1.18; Department of Health (ASS 05)

from senior colleagues; face high rates of violence and assault; and can struggle with stress and work-life balance. We also received written evidence identifying poor relationships between front-line staff and management, and confusion caused by organisational change as contributing factors. NHS England and the Chief Executive of Yorkshire Ambulance Service told us that workforce morale was one of their main concerns.<sup>26</sup> Another contributing factor that NHS England told us about was that paramedics are increasingly being recruited by organisations outside the ambulance service, including acute hospitals, general practice, private ambulance services and by insurance companies (as injury assessors). NHS England told us that they have identified this trend as a risk, and a potential threat to the future workforce that needs to be monitored.<sup>27</sup>

16. Staff shortages are made worse by high sickness absence rates in some trusts. In 2015–16, the ambulance service had a sickness absence rate of 5.5%, compared to 4.2% for all NHS clinical staff. While some of this may be explained by the demanding nature of the work, it is a much greater problem in some trusts, with sickness absence rates ranging from 3.7% to 6.7%.<sup>28</sup>

17. NHS England, NHS Improvement and the Chief Executive of Yorkshire Ambulance Service told us that a number of initiatives were planned, or in train, to improve workforce morale, and thereby improve the retention of staff. These included providing: a new career framework for paramedics; greater support for newly qualified paramedics when they attend a patient; greater support for staff suffering from issues like post-traumatic stress disorder; and nationally consistent learning programmes.<sup>29</sup> However, at present there is no programme to support the development of ambulance workers below the level of paramedic. NHS England told us that they believed Health Education England were planning to develop such a programme, but that it was dependent on funding.<sup>30</sup>

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26 Qq155, 159, 217–219; University of Manchester (ASS 03)

27 Qq185, 209–211; [C&AG's Report](#), para 1.18

28 Qq137, 140, 152; [C&AG's Report](#), para 1.21, Figure 6

29 Qq108–109, 154–156, 158–159

30 Qq156–157



## 3 The ambulance service within the wider sector

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### Transfer of ambulance patients to hospital care

18. When an ambulance conveys a patient to hospital, transferring the care of that patient from the ambulance to the hospital emergency department should take no longer than 15 minutes. Each failure to meet the 15-minute standard results in a poor experience for the patient waiting in the ambulance, and a delay in an ambulance crew being available for a new emergency call. However, just 58% of patient transfers were completed within 15 minutes in 2015–16, compared to 80% in 2010–11.<sup>31</sup>

19. NHS England told us that ambulances not being able to transfer patients to hospital care quickly enough is one of their most serious concerns across the urgent and emergency care system, because, unlike patients already in a hospital or in an ambulance, patients in the community waiting for an ambulance are at greater risk as they are not being cared for by medical staff. NHS England and NHS Improvement told us that, to address this issue, much firmer performance management of the system was taking place. This requires hospital trust executives, such as the medical director, to engage with the ambulance service during periods when the hospital is missing the patient transfer-time target. Another key approach in preventing delayed patient transfers is to ensure that patients can be moved from the hospital emergency department onto wards, and then out of the hospital and into appropriate social care in a timely fashion. NHS England told us local Sustainability and Transformation Plans will bring together local authorities and the healthcare system, to avoid blockages of patient movement in the system.<sup>32</sup>

20. After the patient has been handed over, ambulance crews are expected to make their vehicle ready for the next call within another 15 minutes. In 2015–16, this was achieved in just 65% of cases, with wide variation in the performance of individual ambulance trusts. Collectively, hospital delays in accepting care of the patient, and ambulance delays in preparing their vehicle, meant almost half a million ambulance hours were lost in 2015–16, NHS Improvement told us they are focussing their efforts on patient transfers as this is where most of the time is lost.<sup>33</sup>

21. In 2011, the previous Committee recommended that a quality indicator should be developed for hospital performance in meeting the transfer-time target; this has not happened. The Department and NHS Improvement told us that data was being used operationally, but that NHS Improvement was working through the detail of how this data could be incorporated into official statistics.<sup>34</sup>

### Integrating ambulance services into the wider health system

22. The Urgent and Emergency Care Review sets out NHS England's ambition to integrate urgent and emergency care systems and provide care as close to home as possible. To help deliver this ambition, NHS England established 23 urgent and emergency care networks,

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31 [C&AG's Report](#), para 1.22–1.23

32 Qq86, 113–116, 121–122, 217

33 Qq117–119; [C&AG's Report](#), para 1.23–1.24, Figure 7

34 Qq87–88, 123; [C&AG's Report](#), para 1.26

to provide strategic oversight at a regional level. These networks are expected to include at least one ambulance trust and are supported at an operational level by Accident and Emergency Care Delivery Boards.<sup>35</sup> NHS England has also introduced 44 Sustainability and Transformation Plan ‘footprints’, each of these has produced a plan setting out how local services will change and improve over the next five years, to meet rising demand within the resources available.<sup>36</sup> NHS England has produced guidance to support the development of these Sustainability and Transformation Plans, and has asked urgent and emergency care networks to provide expert advice to them on urgent and emergency care.<sup>37</sup>

23. Effective collaboration is key to ensuring that all urgent and emergency services are connected and integrated. Ambulance services find it challenging to engage effectively with all their stakeholders. The Chief Executive of Yorkshire Ambulance Service told us that his trust deals with 20 clinical commissioning groups, about 15 accident and emergency delivery boards and four Sustainability and Transformation Plans systems. It is not always there for the day-to-day planning discussions with all its stakeholders, which means it is “playing catch-up”.<sup>38</sup>

24. It remains unclear how locally driven Sustainability and Transformation Plans will fit with the national aim of connecting and integrating all urgent and emergency care services and getting a more consistent service offer across regions. Moreover, plans are being taken forward in different ways across the country, and ambulance services have been insufficiently involved with local planning, meaning it is not clear how the ambulance service will be integrated into the wider health system.<sup>39</sup>

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35 [C&AG’s Report](#), para 1.6, 3.12, 3.14

36 Qq116, 138; [C&AG’s Report](#), para 3.12, 3.14

37 Q137; [C&AG’s Report](#), para 3.14

38 Q126; [C&AG’s Report](#), para 3.13–3.15

39 Qq126–130, 167–173; [C&AG’s Report](#), para 3.14



# Formal Minutes

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**Monday 24 April 2017**

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon	Anne Marie Morris
Charlie Elphicke	Bridget Phillipson
Kwasi Kwarteng	Karin Smyth
Nigel Mills	

Draft Report (*NHS ambulance services*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 24 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

*Resolved*, That the Report be the Sixty-second of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[The Committee adjourned.]

## Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

**Monday 20 March 2017**

*Question number*

**Chris Wormald**, Permanent Secretary, Department of Health, **Professor Keith Willett**, Medical Director for Acute Care, NHS England, **Rod Barnes**, Chief Executive, Yorkshire Ambulance Service NHS Trust, and **Miles Scott**, Improvement Director, NHS Improvement

[Q1-221](#)

## Published written evidence

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The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

ASS numbers are generated by the evidence processing system and so may not be complete.

- 1 Dr Roger Cooke ([ASS0002](#))
- 2 Department of Health ([ASS0005](#))
- 3 NHS Providers ([ASS0004](#))
- 4 University of Manchester ([ASS0003](#))

## List of Reports from the Committee during the current session

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All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2016–17

First Report	Efficiency in the criminal justice system	HC 72 (Cm 9351)
Second Report	Personal budgets in social care	HC 74 (Cm 9351)
Third Report	Training new teachers	HC 73 (Cm 9351)
Fourth Report	Entitlement to free early education and childcare	HC 224 (Cm 9351)
Fifth Report	Capital investment in science projects	HC 126 (Cm 9351)
Sixth Report	Cities and local growth	HC 296 (Cm 9351)
Seventh Report	Confiscations orders: progress review	HC 124 (Cm 9351)
Eighth Report	BBC critical projects	HC 75 (Cm 9351)
Ninth Report	Service Family Accommodation	HC 77 (Cm 9351)
Tenth Report	NHS specialised services	HC 387 (Cm 9351)
Eleventh Report	Household energy efficiency measures	HC 125 (Cm 9351)
Twelfth Report	Discharging older people from acute hospitals	HC 76 (Cm 9351)
Thirteenth Report	Quality of service to personal taxpayers and replacing the Aspire contract	HC 78 (Cm 9351)
Fourteenth Report	Progress with preparations for High Speed 2	HC 486 (Cm 9389)
Fifteenth Report	BBC World Service	HC 298 (Cm 9389)
Sixteenth Report	Improving access to mental health services	HC 80 (Cm 9389)
Seventeenth Report	Transforming rehabilitation	HC 484 (Cm 9389)
Eighteenth Report	Better Regulation	HC 487 (Cm 9389)

Nineteenth Report	The Government Balance Sheet	HC 485 (Cm 9389)
Twentieth Report	Shared service centres	HC 297 (Cm 9389)
Twenty-first Report	Departments' oversight of arm's-length bodies	HC 488 (Cm 9389)
Twenty-second Report	Progress with the disposal of public land for new homes	HC 634 (Cm 9413)
Twenty-third Report	Universal Credit and fraud and error: progress review	HC 489 (Cm 9413)
Twenty-fourth Report	The sale of former Northern Rock assets	HC 632 (Cm 9413)
Twenty-fifth Report	UnitingCare Partnership contract	HC 633 (Cm 9413)
Twenty-sixth Report	Financial sustainability of local authorities	HC 708 (Cm 9429)
Twenty-seventh Report	Managing government spending and performance	HC 710 (Cm 9429)
Twenty-eighth Report	The apprenticeships programme	HC 709 (Cm 9413)
Twenty-ninth Report	HM Revenue & Customs performance in 2015–16	HC 712 (Cm 9429)
Thirtieth Report	St Helena Airport	HC 767 (Cm 9429)
Thirty-first Report	Child protection	HC 713 (Cm 9429)
Thirty-second Report	Devolution in England: governance, financial accountability and following the taxpayer pound	HC 866 (Cm 9429)
Thirty-third Report	Troubled families: progress review	HC 711 (Cm 9429)
Thirty-fourth Report	The Syrian Vulnerable Persons Resettlement programme	HC 768 (Cm 9429)
Thirty-fifth Report	Upgrading emergency service communications	HC 770 (Cm 9433)
Thirty-sixth Report	Collecting tax from high net worth individuals	HC 774 (Cm 9433)
Thirty-seventh Report	NHS treatment for overseas patients	HC 771 (Cm 9433)
Thirty-eighth Report	Protecting information across government	HC 769 (Cm 9433)
Thirty-ninth Report	Consumer-funded energy policies	HC 773 (Cm 9433)
Fortieth Report	Progress on the Common Agricultural Policy Delivery Programme	HC 766 (Cm 9433)

Forty-first Report	Excess Votes 2015–16	HC 954 (Cm 9433)
Forty-second Report	Benefit sanctions	HC 775
Forty-third Report	Financial sustainability of the NHS	HC 887
Forty-fourth Report	Modernising the Great Western Railway	HC 776
Forty-fifth Report	Delivering Restoration and Renewal	HC 1005
Forty-sixth Report	National Citizen Service	HC 955
Forty-seventh Report	Delivering the defence estate	HC 888
Forty-eighth Report	The Crown Commercial Service	HC 889
Forty-ninth Report	Financial Sustainability of Schools	HC 890
Fiftieth Report	UKTI and the contract with PA Consulting	HC 772
Fifty-first Report	HMRC's contract with Concentrix	HC 998
Fifty-second Report	Upgrading emergency service communications	HC 997
Fifty-third Report	The HMRC Estate	HC 891
Fifty-fourth Report	Department for International Development: investing through CDC	HC 956
Fifty-fifth Report	Tackling overseas expenditure	HC 1034
Fifty-sixth Report	The Defence Equipment Plan	HC 957
Fifty-seventh Report	Capital funding for schools	HC 961
Fifty-eighth Report	Local support for people with a learning disability	HC 1038
Fifty-ninth Report	BBC licence fee	HC 1037
Sixtieth Report	Integrating health and social care	HC 959
Sixty-first Report	Access to General Practice: progress review	HC 892
First Special Report	Protecting the Public's Money: First Annual Report from Chair of Committee of Public Accounts	HC 835

# Public Accounts Committee

## Oral evidence: Ambulance Services Study, HC 1035

Monday 20 March 2017

Ordered by the House of Commons to be published on 20 March 2017.

[Watch the meeting](#)

Members present: Meg Hillier (Chair); Mr Richard Bacon; Philip Boswell; Charlie Elphicke; Chris Evans; Kevin Foster; Kwasi Kwarteng; Nigel Mills; Anne Marie Morris; Bridget Phillipson; John Pugh; Mrs Anne-Marie Trevelyan.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Robert White, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-221

### Witnesses

**I:** Chris Wormald, Permanent Secretary, Department of Health, Professor Keith Willett, Medical Director for Acute Care, NHS England, Rod Barnes, Chief Executive, Yorkshire Ambulance Service NHS Trust, and Miles Scott, Improvement Director, NHS Improvement.

Report by the Comptroller and Auditor General  
NHS Ambulance Services (HC 972)

Examination of witnesses

Witnesses: Chris Wormald, Professor Keith Willett, Rod Barnes and Miles Scott.

**Chair:** Good afternoon. Welcome to the Public Accounts Committee on Monday 20 March 2017. We are here to look at ambulance services, on the back of a study by the National Audit Office that followed up from a Public Accounts Committee Report in 2011 when we last looked at this. It is of particular interest to Mr Richard Bacon, who is the deputy Chair of the Committee, because he has had such challenges in his area. We encouraged the NAO to do the Report without, I have to say, any resistance from them.

Our witnesses today are, from my left to right, Professor Keith Willett, who is the medical director for acute care at NHS England. Welcome, Professor Willett. I think this is the first time you have appeared before the Committee.

**Professor Willett:** No, there was a time before.

Q1 **Chair:** Forgive me; I should have remembered that. Chris Wormald, who is a regular visitor to the Committee, is permanent secretary at the Department of Health. Rod Barnes is the chief executive of the Yorkshire Ambulance Service NHS Trust, but I think he also speaks for the chief executives of the other nine English ambulance services, other than the Isle of Wight. I should say that the Report covers 10 ambulance services in England but not the Isle of Wight, which has a slightly different arrangement, so we are not covering it today; apologies to residents of the Isle of Wight. Miles Scott is the improvement director at NHS Improvement. Our hashtag today is #ambulances. I will hand straight to the deputy Chair, Richard Bacon, to kick off.

Q2 **Mr Bacon:** Professor Willett, perhaps I can start by asking you, and then I might come to one or two others to answer the same question. Do targets help, or do they make things worse?

**Professor Willett:** I think targets can be very beneficial. As David Nicholson indicated last time the Committee looked at ambulances in 2011, when you are a long way from something, a target helps to move the service towards it. However, they can be rather blunt instruments and tend to be quite narrow. As a result of that, as you get closer to them, and as the performance gets in that park, they can start to distort. There is a plus and a minus to targets.



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From my perspective as a clinician, targets need to be clinically credible and they need to be sensitive. They need to be doing what you want for—in the ambulances' case—the sickest patients, but not at the expense of those patients who clearly have a need, but which may not be of the same priority.

Q3 **Mr Bacon:** Mr Barnes, do targets help or do they make things worse?

**Rod Barnes:** I think they generally help. There has been a view in the ambulance sector for a number of years now that the current Red 1/Red 2 category response times put too high a proportion of patients in the highest category of call. That, in itself, can lead—

Q4 **Mr Bacon:** In other words, in Red 1?

**Rod Barnes:** Particularly in Red 2.

**Chair:** Perhaps it would be helpful to be clear what Red 1 and Red 2 are. We have read the Report and know this, but for those who might not.

Q5 **Mr Bacon:** Can you just say for the record what Red 1 and Red 2 are?

**Rod Barnes:** Red 1 is the highest clinical urgency of call, such as for patients having cardiac arrest. The Red 2 category can include patients having strokes or heart attacks, but there are also an awful lot of other categories of patients that fall into Red 2. In terms of a typical ambulance patient workload, for want of a better term, close to 50% of calls coming in to 999 would fall into the Red 1 or Red 2 categorisations.

Q6 **Mr Bacon:** Your statement a moment ago was that there is a widespread view in the ambulance service, which has been growing for some years, that—I think you used the phrase—“too high a proportion” of the totality ends up in the highest category. I thought that is what you said, which is why I asked whether you meant Red 1.

**Rod Barnes:** Apologies. I would classify Red 1 and Red 2 together as the—

Q7 **Mr Bacon:** I see. So “too high a proportion” of the totality of calls ends up being triaged into Red 1 or Red 2?

**Rod Barnes:** That's correct. That view is certainly shared by clinicians in the service. Clinicians are responding under blue light conditions for patients who ultimately, on clinical grounds, do not need a response in eight minutes. That is actually diverting resources away from perhaps higher priority patients, based on their condition.

Q8 **Mr Bacon:** Mr Scott, do targets help or do they make things worse?

**Miles Scott:** I think, with the caveats that were particularly pointed out by Professor Willett, I would say they help. They help to concentrate the mind. I am sure we will talk a lot this afternoon about the impact of targets on ambulance services themselves. The comment I would make is that they help to concentrate not just the minds of people like Rod, to my right, but those of the wider service. I think services like ambulance





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services easily disappear from view if one is not careful because of the public emphasis on hospitals and acute care. So long as the targets are clinically relevant, well-constructed and so on, as Professor Willett said, I think it is a very helpful way of having a public dialogue around important services such as the ambulance service.

**Q9 Mr Bacon:** Mr Wormald, I wouldn't say you are itching to get in, but you should have an opportunity to answer the question as well.

**Chris Wormald:** Thank you. I think the devil is in the detail. A target is a proxy for a set of behaviours that we are trying to incentivise a set of people to undertake. I suspect the point of your question is whether the ambulance targets do that and incentivise the behaviours we want to see, rather than the ones we don't.

**Q10 Mr Bacon:** Quite. Do they incentivise behaviours that we don't want to see? My own trust, the East of England trust, is quite big and covers a very large area of the counties of the east of England. We had 15 paramedics from East of England together with the Minister in a room along this corridor—it may well have been this one—explaining to the Minister what was wrong. One of the things they said was that the targets incentivised the wrong behaviour, so that a crew could be out in either an ambulance or a rapid response vehicle and move from one location where they had been told to go to another, and before they got there, being reinstructed to go to a third and then a fourth, so that they sometimes spent half the day going from pillar to post and not actually reaching a patient. They were doing seven sides of an octagon without ever actually doing anything. Any system that could create those sorts of behaviours has plainly got something wrong with it, has it not?

**Chris Wormald:** The kinds of issues you are pointing to is why Professor Willett has been leading a very large programme on what we might do with the ambulance response performance framework, which I am sure he will describe. We discussed with the Committee before the need for some balance to be struck between consistency of targets and the public understanding of targets—we don't want to change the framework all the time—and needing to update them for the reasons that you say. As I have said, this is a live debate at the moment, and Professor Willett has been leading a large programme to look at whether there is a better way of doing this.

**Q11 Mr Bacon:** Professor Willett, you look like you want to come in, so I will keep this short. It seems to me that, several years after it seemed quite fragile, it still seems quite fragile. I remember Mr Anthony Marsh, who is the chief executive of the West Midlands service, coming into East of England as an interim, temporary chief executive. It got so bad that we had a debate in Westminster Hall, and Anthony Marsh wrote a report questioning whether the board knew what they were doing and why they were there. I saw him give evidence in a House of Lords Committee Room down the corridor, in which he sat next to the Minister and said, "If it is a choice between meeting these targets"—he meant the existing ones that we have now; the eight minutes and the 19 minutes—"and



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providing an effective service, I am going to provide an effective service". He said this with the Minister sitting next to him. That was some time ago. I do not feel that we have got to a new point yet, where we can say, "Aha. Things are better because", and then complete that sentence.

**Chris Wormald:** We have been trialling for over a year. Actually, Anthony both hits the target and provides quality.

Q12 **Mr Bacon:** I know, and one of the interesting bits of data on this is how consistently West Midlands is better than most of the others. We might get into why.

**Chris Wormald:** Of course, as well as the targets, one of the very big things that has been added to the mix since this Committee last discussed it is the CQC regime around ambulances, which, from 2013, has been looking at a much wider basket of things concerning whether a trust is well run or not. That is the other thing we have to say about targets: they are but one part of the picture here. The story that the CQC tells across the ambulance service is at least as important as the targets and they, of course, look at the actual quality of care delivered as well as the things that the target regime covers. But we do not fundamentally disagree with you that all this needs looking at, which is why we have—

**Professor Willett:** On the ambulance response programme, we are confident, I think, in saying that it is the largest prospective trial of a system change in any ambulance service in the world.

Q13 **Mr Bacon:** How long has it been running so far?

**Professor Willett:** We are now into about 18 months and we have looked at and followed through to outcome 10 million ambulance calls.

Q14 **Mr Bacon:** So you have big data.

**Professor Willett:** So 10 million ambulance calls, and we have looked at them with more than 30 measures. This is looking not just at the target—the crude performance level—it is looking at 30 measures that include things like the performance of the ambulance service, efficiency of utilisation of the assets of the ambulance service, clinical outcomes for patients and the experience of staff working in the different systems. The ambulance response programme we will discuss, I am sure, at whatever point the Committee chooses this afternoon, but in essence it takes the issues. Perhaps I could just explain, because it is not quite as straightforward as, "You have a target and therefore it either doesn't work or does work". The issue in the system is that currently the ambulance services have a 75% target for eight-minute response to those calls in categories Red 1 and Red 2. For those patients in category Red 2, the ambulance service has 60 seconds from the point at which the call is connected to them to come to a decision about the right thing to send.

Q15 **Mr Bacon:** And then the clock starts.

**Professor Willett:** The call handler is taking the information from the patient—perhaps an old lady downstairs and a poorly husband upstairs—



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and in 60 seconds you have to get an awful lot of information across to come up with something that says, "This is what we think is wrong with the patient and this is what they need". At the end of 60 seconds, while the call handler is still taking that call, the dispatch desk has no choice but to discharge an ambulance on blue lights and sirens. Many of you will have experienced driving along the road and pulling over to allow an ambulance to pass you with blue lights on, only to find 400 yards down the road that it has pulled over and stopped and you think, "What was all that about?"

Q16 **Mr Bacon:** Back to my point about effectiveness—

**Professor Willett:** One in four ambulances that are currently dispatched on blue lights and sirens does not get to the scene because it is stood down beforehand. That is immensely frustrating and highly efficient and many ambulances—

Q17 **Mr Bacon:** Sorry, did you say highly inefficient?

**Professor Willett:** Inefficient, yes, and frustrating for the crews. That ambulance may well have been going to treat a lady who had been on the floor for a couple of hours, who did not have the same priority as perhaps what was possible in that 60 seconds that had not been determined. So that creates enormous inefficiency—

Q18 **Mr Bacon:** Yes, back to my original question: are targets helping, or are they making things worse? Your own description, just then—

**Professor Willett:** When you have headroom in the system, and the system is not under immense pressure, you can afford targets to be blunt and still respond without detriment to patients who have a lower priority, but, as the Report clearly shows, demand has increased in terms of callers by 30%—

Q19 **Mr Bacon:** Hang on, can I just stop you there? Let's imagine that you have headroom in the system—I realise that you don't. What you are saying is that if you have headroom you can afford to have one in four of your ambulances set off and then stood down.

Q20 **Professor Willett:** Yes—

Q21 **Mr Bacon:** Right, well most taxpayers would say, "No, you can't". What you ought to have is an efficient and effective response regarding each ambulance that starts off, or each vehicle that starts off—it doesn't have to be an ambulance; it could be a rapid response vehicle, and it might be a RRV that was differently configured so that it was capable of putting somebody on a stretcher if required, but we don't have that at the moment. Why would you accept a model in which it was okay to have one in four journeys started and then stood down? To the lay person, that sounds extraordinarily inefficient, even if you have got headroom.

**Professor Willett:** Because at that point, when it is dispatched, the clinical knowledge about the patient puts them into a life-threatening or serious category, and therefore the ambulance service's clinicians and dispatchers have an absolute priority to get something to that patient as soon as possible. In an urban area, with traffic difficulties and ambulances



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at different distances, you do not know who is going to get there first. If it is in that category, the ambulance service has always tried to get something there quickly, and they will therefore often put out multiple vehicles to try to do that.

- Q22 **Mr Bacon:** Back to your 60 seconds, what you are saying is that in the ambulance response programme, you are measuring or finessing that 60 seconds and seeing what a better time is, whether it is 180 seconds or—

**Professor Willett:** It would be much more than that, I suggest. There are three parts to the ambulance response programme that we have now piloted and tried right up to the complete set of three being in ambulance services over the past 18 months, with the Secretary of State's permission.

The first thing is something called "dispatch on disposition". It is a silly term, but what it means is that rather than just giving them 60 seconds—we know from looking at this that the length of time it takes to make the right decision is often more than 60 seconds—we have trialled longer periods in order for them to come to the right decision. That is part of this big study that is independently being scrutinised by the University of Sheffield through its centre for urgent and emergency care.

- Q23 **Mr Bacon:** I am sorry to move you on, but we have a lot of ground to cover. After 18 months and 10 million data points, do you have enough information?

**Professor Willett:** We do. Their report will be coming to us very shortly, and we would hope for it to be published in the next month.

- Q24 **Mr Bacon:** But are you expecting that it will probably be 180 seconds?

**Professor Willett:** We are expecting them to indicate that additional time is appropriate. It looks like an additional 180 seconds is what is appropriate. That is the first thing.

- Q25 **Chair:** Can we just be clear? This report will be published, you think, in a month.

**Professor Willett:** In the next month, we expect.

- Q26 **Chair:** When will you make decisions and how long will it take to get those decisions into the system?

**Professor Willett:** We will need to look at that report and fully evaluate it—

- Q27 **Chair:** How long?

**Professor Willett:** Then we will need to take that to the Government.

- Q28 **Mr Bacon:** The report will be published during April 2017, and then you will need to think about it internally.

**Professor Willett:** No, we will have done the thinking by that time, because we have been working with this—



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Q29 **Chair:** We do not need very long answers. In April, it will be published and will go to Ministers with advice. It does not need any primary legislation, does it, Mr Wormald?

**Chris Wormald:** There were some changes in this that will require secondary legislation, because it is set out in regulation.

**Chair:** Secondary, okay. That is quite easy when the Government have a majority.

**Chris Wormald:** What we are expecting is that the Secretary of State will need to receive formal advice from NHS England.

Q30 **Chair:** Roughly, what is the timetable, Mr Wormald?

**Chris Wormald:** We are expecting that advice in the next six weeks and a decision soon after that.

Q31 **Chair:** By the end of the year?

**Chris Wormald:** Certainly, yes.

Q32 **Chair:** Just to be clear, Professor Willett, if one of us called an ambulance in an emergency now, how long—is the 180 seconds in addition to the 60?

**Professor Willett:** Yes, it is in addition.

Q33 **Chair:** So it is up to four minutes.

**Professor Willett:** The average length of time for them to reach what we call the correct disposition is only 60 seconds more than the 60 they already had.

Q34 **Chair:** So two minutes.

**Professor Willett:** Yes. The evidence to date is that that does not change the actual response, interestingly. It means that fewer ambulances are riding out on blues and twos, as we call it—with sirens—so ambulance crews are much more likely to know, at the end of that blue-light request they have been given, that they are going to find something that really—

Q35 **Mr Bacon:** To what extent—this may seem unfair, because I know you have your data points and you have been looking at this very hard—are you just moving the goalposts because you are not achieving the targets?

**Professor Willett:** That doesn't interest me; I am a clinician. The whole concept of the ambulance response programme has come from the ambulance clinicians. It did not come from us. It came from Anthony Marsh, who is the chief executive of the Association of Ambulance Chief Executives, who came from the medical directors of the ambulance services. Those are the people who gave us the advice that we initially took, and we then took that advice to the Secretary of State.

Q36 **Mr Bacon:** What is causing the increase in demand for ambulance services?



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**Professor Willett:** We have the same demands as there are in the rest of the healthcare system. We have an ageing population. The average age of patients is much older and they have multiple co-morbidities. We have more patients in general in society in that age group who are more frail, and relatively small events cause quite significant changes in dependency. Ambulance service demand has increased at about twice the rate of A&E attendances or hospital admissions—

**Mr Bacon:** Which themselves have gone up quite steeply.

**Professor Willett:** Hospitals are going up 2% or 3% and ambulances in the region of 5% or 6% year on year—

Q37 **Mr Bacon:** To what extent is it due to the increase in the population of the country? We are 5.3 million people more than we were in 2004.

**Professor Willett:** No, it is independent of that. This is a healthcare need. We also have a society that behaves differently. We have a bit of a “right now” society, with people expecting immediacy and seeking help.

**Mr Bacon:** I can see Mr Kwarteng coming in. I think he is interested in the fact that you do not think the population increase has anything to do with it.

Q38 **Kwasi Kwarteng:** The airy way in which he said that an increase in the population of 5 million people, which is almost 10%, in 12 years has nothing to do with it—

**Professor Willett:** No, it doesn't have nothing to do with it. I'm sorry. I didn't mean that it had nothing to do with it. Clearly there is proportional increase with that, but the demand that we see increasing in healthcare is over and above just a population number. It is the fact that we have an ageing population. I will give you some idea, 10 years ago, in the last few years of life people would go into hospital on average once or twice and now they will be in hospital three or four times. People are surviving illnesses and events that they would not previously have survived. Medicine has moved on. There is a distinct improvement in that. That is great, but the consequence is that the demand, particularly in the older population, has increased—

Q39 **Kwasi Kwarteng:** I hear civil servants dismiss this all the time, and constituents are acutely aware of it and talk about it all the time—

**Chris Wormald:** Very clearly, one element of the increased demand on health is demographic. I think that what Professor Willett is saying, which we would agree with, is that the bigger proportion of that demographic is the ageing of the population as opposed to the total size. An extra young, fit person does not add much to our demand, whereas the ageing population adds a lot. Clearly, any demographic change will add to our challenge, but it is more in the ageing population.

Q40 **Mr Bacon:** What can be done to manage this increasing demand before it reaches the ambulance service?





**Professor Willett:** Well that is part of what the urgent and emergency care review is doing, which I am leading on for Sir Bruce Keogh, the medical director of the NHS. We know that in terms of addressing the demand in the system we have to do something with every single element. We have to do something around self-care. We have to do something about members of the public seeking medical advice that does not require them to end up going to hospital. The 111 service is being transformed from what it is currently, which is a service that was very much about giving advice and directing people, to one that is going to have much more clinical involvement, with clinical advice behind it. That is the transition over the next two or three years. Patients phoning 111 will be put through and be able to speak a clinician, if that is appropriate, so they can get more accurate advice, do not need to be referred to A&E, do not need to have an ambulance called by the 111 service in many cases, and can get the closure of the consultation, if you like, on the phone, or in some way other than by transfer to hospital—in the community.

Q41 **Mrs Trevelyan:** On that, you have not mentioned the algorithm that is used by staff when triaging people, and how that has continually increased a drive towards calling out the ambulance, along with—

**Professor Willett:** Do you mean in the ambulance service or in 111?

**Mrs Trevelyan:** In the ambulance service, so that you are seeing this increased “hit the blue button” phenomenon.

**Professor Willett:** There are two computer-aided dispatch softwares used in the ambulance service. Five services use something called AMPDS and five use NHS Pathways. They are both well-established systems in the ambulance service, and the second part of the ambulance response programme, in addition to the dispatch on disposition extra time, is that we have built in at the front of them questions that increase the sensitivity to identify the highest risk patients first. The three objectives, if you like, of the ambulance response programme are that we need to focus on the sickest to make sure they are getting what they need, we need to provide the best—not just necessarily the fastest—thing for the rest, and we need to make sure that there are not very long delays and bring in that tail that has been talked about, particularly in rural areas.

Q42 **Mrs Trevelyan:** In order to assess that, are you driving an increase in the qualifications of staff? That went the other way for several years, leading to a reliance on the computer decision-making rather than applying—

**Professor Willett:** Are you talking about 111 again here or the ambulance service?

**Mrs Trevelyan:** Within both.

**Professor Willett:** The programme for call handlers is there. The algorithm is written by clinicians. It is a clinically based algorithm. The colleges wrote the algorithm. What we need to do is where—

Q43 **Mrs Trevelyan:** There is a very strong protection—



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**Professor Willett:** Yes, because when it was designed it was not expected to have clinical input. What we are now doing is putting in a clinical advisory service that sits behind that, so that at a much earlier point in the conversation with the call handler if it is clearly a complex case, or a sick young child, or something like that, they will step out of the algorithm and pass that case to a clinician for management. That is where we are going with the system and that will apply to the 111 service.

Q44 **Bridget Phillipson:** On 111 and its predecessors, what has been the history of direct clinician involvement in call responses? How have the changes taken effect?

**Professor Willett:** Do you want to go back to NHS Direct?

Q45 **Bridget Phillipson:** Yes.

**Professor Willett:** NHS Direct was a service that was not an urgent call-line service; it was a general helpline service. So it got everybody phoning up about everything. It peaked at about four million or five million calls. It did put about three quarters—

Q46 **Chair:** Is that per annum?

**Professor Willett:** Yes. It put more calls through to a clinical adviser—nurses—but the problem there was that the system became overloaded and although it only got four million or five million callers at its peak, the callback times became so long that people were just going off and doing other things, such as going to A&E or calling an ambulance. That's why the 111 system was designed.

The 111 system has become very popular, despite what might be reported in the media. We now have over 14 million people calling 111 each year: 11% of them are issued an ambulance; 8% are sent to A&E; and the rest are managed in alternative ways. It is acting as a significant buffer, but again it is an indication of the increase in demand in society for health care, particularly of the "We want to know now, we want a response now" sort. We know that if people can't access primary care or care in the community, many of them will seek care elsewhere.

Q47 **Bridget Phillipson:** This may be for Mr Wormald. Was it a mistake to have reduced clinician involvement in some of this decision making? Could we have foreseen that some of the problems that have arisen under 111 could have been prevented?

**Chris Wormald:** I'm not sure I can answer that question, because I wasn't there at the time, but certainly NHS 111 has always had a bigger clinical involvement, and that was clearly a conscious decision of Government to do that. I couldn't tell you about the decision making previously—

**Chair:** Ms Phillipson's point is an important one that this Committee raises about cost shunting; you make a decision somewhere else and it causes pressure on the system. On that point, I will bring back Richard Bacon.





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Q48 **Mr Bacon:** Given this rising demand that we've been talking about, Professor Willett, to what extent do you think the ambulance service has enough funding to deliver the required level of service?

**Professor Willett:** We have to live within the funding envelope we've been given. What the ambulance response programme is doing is making sure that we have the highest level of system efficiency. The third part of the ambulance response programme is very much addressing that.

At the moment, if I can just complete the ARP description, at the end of the call you reach a code, based on the symptoms or the story given by the patient, which indicates what they think is likely to be wrong with the patient. In AMPDS, that is about 2,000-plus codes—

Q49 **Mr Bacon:** Can you just tell us what that is?

**Professor Willett:** It's the advanced medical priority dispatch system. It's just a system of prioritising calls. It's the same as Pathways, but an alternative version.

At the end of that call, a patient could get one of more than 2,000 codes in AMPDS; there are over 4,000 codes in Pathways. What you have in terms of a Red 1, Red 2 or Green response currently was a best guess by clinicians, looking at the case and saying, "This patient's got this amount of bleeding", and so on. "Therefore, I think it could be this or it could be that, and we probably should put it in that category".

What we did at the start of the ambulance response programme was to take a million calls. We did not look to say, "What did we give them?", but, "When we got there, what did it turn out to be? What was the outcome of that call?", so we knew if that response was appropriate.

Now we have an evidence base behind what we send to a patient. So, rather than someone saying, "This is what we think you might need", it is a case of saying, "That code normally requires", and we send that.

Both that and the dispatch on disposition, on the evidence that we have collected so far—we anticipate that evidence being set out in the Report—free up literally thousands of occasions when ambulances could be released into the system that otherwise would be directed elsewhere.

Q50 **Mr Bacon:** Can you just remind us what a fully kitted-out box ambulance costs?

**Professor Willett:** I'll have to go to my chief executive colleague, because I'm afraid that I don't buy them.

Q51 **Mr Bacon:** Mr Barnes?

**Rod Barnes:** It depends on whether you go for a van conversion or a box body.



Q52 **Mr Bacon:** I understand that there are two benchmarks.

**Rod Barnes:** If you use a figure of about £120,000, including the equipment in it—

Q53 **Mr Bacon:** Mr White, didn't you say £99,000 and £135,000, depending?

**Robert White:** The box conversion is about £135,000, and the smaller, narrower vehicle is somewhere around £90,000 to £95,000.

Q54 **Mr Bacon:** And how much does a rapid-response vehicle cost? Those are these little Land Rover Freelanders, aren't they? Small four-wheel drives.

**Rod Barnes:** Yes. Skoda Scouts are probably the most common ones—it is an estate car. Off the top of my head, probably about £50,000.

Q55 **Mr Bacon:** £50,000?

**Rod Barnes:** Maybe slightly less than that.

Q56 **Mr Bacon:** But they are not long enough to have a stretcher in, are they?

**Rod Barnes:** No.

Q57 **Mr Bacon:** So you can't actually take a patient to hospital in them.

**Rod Barnes:** They are not normally used for conveyance. On occasion, if you have got a less critically ill patient who is walking, a paramedic will use them to convey people to hospital.

Q58 **Mr Bacon:** We occasionally have police cars used to convey people to hospital because there is no ambulance available. That's probably not ideal either, but it happens. What I am curious about is why we don't have a vehicle that has a long enough wheel base and is significantly cheaper than the ambulances that Mr White and you were talking about. Short of a motorbike, surely every vehicle that attends ought to be capable of conveying somebody to hospital. Wouldn't that be a better use of the available resources? You would have more vehicles in use for conveying.

**Professor Willett:** Part of the ambulance response programme is about looking at the codes and categories. There are patients who require conveyance, and that means it has got to be two people to move the patient on a stretcher and a vehicle big enough. You can't do that in most cars, and very few countries have even tried that, apart from some developing countries.

In the new categories, it is important that we send to the patient both the right clinician and the right vehicle. For instance, if you have had an epileptic fit and are known to be epileptic, what you want is somebody who can get to you quickly, can be with you and can get you out of that fit medically if they need to. The chances of you needing to be conveyed to hospital as an epileptic who has fits regularly is very low. You want a rapid response vehicle with an experienced clinician.



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If you have had a stroke, there is no point in a very experienced clinician turning up on a motorbike. What you need is two lesser paramedics who can do the basics but can get there promptly with a double-crewed ambulance that can convey you to a stroke centre very promptly. It is about matching—

- Q59 **Mr Bacon:** I have been present when somebody had an epileptic fit. A rapid response vehicle attended, and they were dealt with on the spot and were given oxygen and all the rest of it. My point is that in those circumstances, where it turns out that somebody needs conveying to hospital, if they are being conveyed in police vehicles because there is nothing else available, as happens, wouldn't it be better to configure and have available a vehicle that doesn't exist at the moment, which would be significantly cheaper than a full-box ambulance at £135,000 but would enable you to be more flexible?

**Professor Willett:** That is not a model that is being used internationally. I imagine it is because the vehicles are just not big enough, but I would defer to other colleagues.

**Miles Scott:** If a patient needs to be transferred to hospital, they need to be transferred in a proper ambulance. We need to make sure we can send a proper ambulance to those patients, as opposed to—

- Q60 **Mr Bacon:** As opposed to a police car, which is what is happening at the moment.
- Miles Scott:** Exactly. Inventing a third vehicle is not going to address the core issue. The core issue is exactly the one you point to, which is the lack of availability of an appropriate ambulance.

- Q61 **Mr Bacon:** In the east of England, part of the problem was physically not having enough vehicles. In fact, when Mr Marsh was in charge, he commissioned some extra vehicles, but whatever the optimal number of vehicles was, they didn't even have that. To what extent, across the ambulance estate—Mr Barnes, this is probably for you, as you represent all the services—do all the services across the country have what they say is the number of vehicles they need? Whether there are enough crews at any one time is of course a separate question, but this is about the actual vehicles. I know the services are configured differently—some have more ambulances, and some have more rapid-response vehicles—but to what extent do they say they have the right number of vehicles, or is there a shortage?

**Rod Barnes:** The services that are going through the ambulance response pilot are currently modifying their fleet of vehicles to fit with the ambulance response programme. The outcome for us—I am speaking for Yorkshire—is that we have seen, as a response to the changing dispatch model, a requirement for more double-crewed ambulances and fewer rapid-response vehicles. We are in the process—I understand that the other two organisations are going through a similar process—of reducing the number of rapid response vehicles and increasing the number of



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double-crewed ambulances. We are broadly there in terms of having the right number of ambulances—

Q62 **Mr Bacon:** Broadly there, but not quite there yet?

**Rod Barnes:** I would say that there will probably be a requirement to increase the fleet slightly.

Q63 **Mr Bacon:** By how much?

**Rod Barnes:** At a rough estimate, I would probably say about 20 to 30 vehicles.

Q64 **Mr Bacon:** Across the country?

**Rod Barnes:** Across our trust—across Yorkshire.

Q65 **Mr Bacon:** Twenty to 30 vehicles across Yorkshire? What about the rest of the country? How many vehicles short are we across the country, Professor Willett?

**Professor Willett:** We don't know if we are short. At the moment, what has happened, because the focus has been on the eight minutes 75% target, is that we have seen quite a lot of ambulance services, particularly those in rural areas, moving a lot of their fleet towards rapid response vehicles—and in urban areas, motorcycles. That is because they are trying to stop the clock to meet the target, but they are actually missing the point, which is that the patient might need a double-crewed ambulance. With the ambulance response programme, the sites that have got the full work-up, which includes Yorkshire at the moment, are seeing that they need fewer rapid response vehicles and more double-crewed ambulances. The question, as we go through this transition and if the recommendations are accepted, is whether the ambulance fleets will shift to having the right mix. At the moment the mix is distorted by the target. Once we have done that, we will be able to have an estimate as to what the total number of—

Q66 **Mr Bacon:** I am aware of all of what you say—that there has been a shift towards rapid response vehicles, driven to some extent by the need to meet the targets—so back to my first question, are targets helping or making things worse? I am still persuaded that targets are making things worse, but that is only my opinion—what do I know? But I am slightly surprised that you still do not know what the optimum number of ambulances is somewhere between three and five years after this first became a quite obvious crisis—I dislike using the word “crisis”, but certainly in the east of England it became a crisis. We are now told by Mr Barnes that you are 20 to 30 ambulances short in Yorkshire, and you cannot tell us how many ambulances you are short across the whole of England.

**Professor Willett:** I can't, and I would say that what has happened over the last few years has not just been that the fleets have changed, in terms of their proportion, but ambulance services have different uprating models. They have been trying to do things differently depending on their rurality, their deprivation or the calls on them—



**Mr Bacon:** Did you say “rurality” or “morality”?

**Professor Willett:** Rurality, I hope—I would certainly correct the minute if it was “morality”. They have developed not only different fleet proportions, but different proportions of paramedics, advanced paramedics and technicians, so there is a whole variety. We have got different operating models and different proportions of personnel so it is not as simple—

Q67 **Mr Bacon:** No. I realise that, but I and many of us find it puzzling. I understand that there are different staffing models, different vehicle configurations and different operating models used, but why is there so little consistency in the way ambulance services are commissioned across the country? Plainly you have rural, urban and suburban—there are different mixes that might mean different needs to some extent—but it is not that complicated. There ought to be a model or a variation of one or two on a model that would work in most cases. You do not yet seem to be anywhere near reaching that, do you?

**Professor Willett:** We are just about to go to that, and I will pass to Miles at this point. Having now got all the information and really understood to a level that we have never understood before, Miles has been leading the work on the ambulance transformation work, which is about the workstreams and looking at getting the right skill mix, the right financial sustainability, the right commissioning model and the right operating models. Because we have brought all the ambulance services together under the ARP, we now have all the ambulance services talking in a way that has perhaps never happened before.

**Miles Scott:** I can just tie up one slight loose end on the number of vehicles. We can be quite confident in saying that none of the reviews that has been undertaken into ambulance services, whether through the CQC, our own work or Professor Willett’s work, has identified the number of vehicles as a bottleneck or a rate-limiting step. The number of vehicles is appropriate to the model of service that people are operating currently. The issue is whether that model of service is correct. Then, as Keith says, should we shift to—

Q68 **Chair:** This is expensive capital expenditure, then you have the crews to put in them, so there is an importance, as Mr Bacon is trying to highlight, to having a sense of how many we will need.

**Miles Scott:** Exactly, so we need to have the right number. I am saying that none of the reviews we have done has identified that there are paramedics sitting around waiting for a job because they can’t get into an ambulance. I just wanted to reassure you on that point. In terms of the commissioning point—

Q69 **Chair:** I’m sorry, but I don’t think that was quite the point Mr Bacon was making. He was not suggesting there were paramedics wondering whether they would get a job. We know there is an issue about workforce, which we will come on to. You have an expensive bit of kit—the ambulance. If you need 20 or 30 in Yorkshire, there is an impact on



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your budget, Mr Barnes. How are you going to fund 20 or 30 ambulances and get the people to crew them up? Some of them would come from rapid response, from what you are saying, but would you have an additional recruitment problem?

**Rod Barnes:** At the moment, each ambulance service carries spare capacity of vehicles, in terms of day-to-day planned maintenance. We are managing the situation with that spare capacity over time, from where we are at the moment in the pilot, and after we would need to make a slight increase to the size of the fleet.

Q70 **Chair:** So there is no budget crisis because of the need for new ambulances?

**Rod Barnes:** We will be reducing the number of rapid response vehicles, which will free up—

Q71 **Mr Bacon:** —more money to spend on ambulances. Mr Scott, my real point was this: given that it hopefully should not be rocket science to figure out what a good operating model looks like, why is there so much inconsistency across the country in the way in which ambulance services are commissioned?

**Miles Scott:** I agree with you that we need to get to a more consistent position across the country. There is a mixture of reasons why the commissioning and operating models are so different. Some of those reasons are happenstance, and some are good reasons to do with geography, demography and so on. We have never had a national ambulance service. The ambulance services that we have currently have come up from county ambulance services and so on, so there has been a coming together of ambulance services, rather than a fracturing. It is important for the Committee to understand that.

Q72 **Chair:** We do know that. Can you get to the point?

**Miles Scott:** Yes, absolutely. We will be recommending a consistent framework for commissioning of ambulance services that will be consistent across the country.

Q73 **Mr Bacon:** That is something you are going to be recommending in the report coming out in April 2017?

**Miles Scott:** This is not part of Professor Willett's report. This is—

Q74 **Mr Bacon:** Another piece of work?

**Miles Scott:** Yes, exactly.

Q75 **Mr Bacon:** In what report is that recommendation coming and when?

**Miles Scott:** We will be signing off the scope for that piece of work next month.

Q76 **Mr Bacon:** It hasn't been done yet?

**Miles Scott:** No. We will be signing off the scope for that piece of work next month and would expect to put—





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Q77 **Mr Bacon:** In April 2017 you will be signing off the scope?

**Miles Scott:** Yes, and we would expect—

Q78 **Mr Bacon:** How long will the work take?

**Miles Scott:** Within six months we would put recommendations to—

Q79 **Mr Bacon:** Right, so in October 2017 you expect to put recommendations to whom?

**Miles Scott:** To NHS England primarily, but also to NHS Improvement.

Q80 **Mr Bacon:** Who will then agree with them or not. If they agree, will they then recommend them to Ministers?

**Miles Scott:** Exactly. That will be the basis for commissioning ambulance services going forward.

Q81 **Mr Bacon:** How long will it take from the time NHS England has made the recommendation to Ministers for that to become the standard reference point and operating model that people use?

**Miles Scott:** From that point, the commissioning would be on a consistent basis. Essentially, you would work into the beginning of the following financial year.

Q82 **Mr Bacon:** In other words, from 1 April 2018, you would expect to have a consistent commissioning model for ambulance services across England?

**Miles Scott:** Yes.

**Chris Wormald:** Can I add something?

**Mr Bacon:** Caveat, Mr Wormald.

**Chris Wormald:** No, it wasn't going to be a caveat.

**Mr Bacon:** You can back-pedal now if you want.

**Chris Wormald:** I might not speak at all. What we are aiming for is a national framework that allows for local variability. It is not a single framework we are aiming for, for the reasons you say. The other thing I wanted to clarify is that thing you said it then comes to Ministers. I don't think there is a ministerial decision in that bit. That is entirely the operational commissioning process.

Q83 **Mr Bacon:** Perhaps this is for you, Professor Willett. What impact has stopping fines against hospitals that delayed the transfer of patients had on performance?

**Professor Willett:** Within the NHS standard contract, which ambulance service lead commissioners use for the ambulance services, there are sanctions or penalties for—

Q84 **Chair:** We know that. What has the impact been on performance?



**Professor Willett:** The sanctions were suspended under specific conditions only—it was not blanket. It was for those ambulance services that were accepting control totals. The reason is that, as part of the STP and the control totals, if you are accepting the control total, you already have built in there a financial control, but if you had the sanctions as well, it would essentially be double jeopardy for the ambulance services, so you would not have both. Obviously, with the drive, as we have discussed, around the ambulance service, the demand is across the whole system, and in many ways it is inappropriate to penalise just one part of the system for a system-wide problem. In addition, we know that, in fact, for most—

Q85 **Chair:** Sorry. We do know the history of this. Forgive me for interrupting you, but Mr Bacon asked what the impact of that is.

**Professor Willett:** Perhaps NHS Improvement would like to clarify their operational view of it, but I do not think there has been an impact, for the reason that most CCGs were either not invoking the fines or they were disappearing at year-end settlements anyway because they were relatively small. They were a useful discussion tool.

Q86 **Chair:** So there has been no impact? That's fine. That has answered the question. Mr Scott?

**Miles Scott:** I wanted simply to say that handover delay is a very important issue that we have to address—the rise in handover delays happened when fining was in place. We do not believe that the fact of the fines actually—

Q87 **Mr Bacon:** Fair enough. What incentives need to be put in place to reduce turnaround times?

**Miles Scott:** It is largely about good practice within hospitals and across the whole system. The incidence of delays is very closely connected to the pressure on the hospitals and the flow within the hospitals—their ability to offload the patients into the department. With Professor Willett's input, we have provided new clinical advice to hospitals to help them to make the decision to take the patients more promptly, and we are beginning to see some improvement in the incidence of delays. But this is a major priority for us, with both the hospital trusts and the ambulance trusts. We have two national champions helping to take that forward.

Q88 **Mr Bacon:** Mr Wormald, we on this Committee recommended five years ago that a quality indicator be developed for hospital transfer times. Why has that recommendation not been implemented?

**Chris Wormald:** To be perfectly honest, we haven't been in the right place on this. A number of things were done and—this is quoted in the National Audit Office Report—a lot of management and operational data were created, so NHS trusts can now monitor their own performance, but we did not go for a published indicator. We are looking at that again—that is one of the things that Miles Scott is looking at—but as I say, I do not think we have been in the right place on this.





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Q89 **Mr Bacon:** Mr Scott, is that part of your report, or is that yet another report?

**Miles Scott:** No, we are using the data operationally. We have to agree the basis on which they are incorporated into official and published statistics. It is as simple as that.

Q90 **Mr Bacon:** What is the shortage of paramedics now? A shortage of paramedics has developed. What is the gap between what you have and what you need?

**Miles Scott:** Currently, vacancies are running at about 5%, so the big workforce challenge is less the current vacancies and more the number of paramedics that we are going to need going forward to accommodate the kinds of new models of care that Professor Willett talked about earlier in the session.

Q91 **Mr Bacon:** What are you doing to overcome that shortfall?

**Miles Scott:** Over the period since the last NAO Report, Health Education England have more than doubled the number of paramedic trainees. I know in your own patch there has been some bumpiness about the introduction of that with the local universities, but that is now in train and the number of trained ambulance personnel—both paramedics and technicians—actually increased significantly during the course of 2016. Over the last three years, the number of trained ambulance personnel was pretty flat for a couple of years and then significantly increased over the last 12 months.

Q92 **Chair:** So you have been growing our own. What about immigration? Is it on the shortage occupation list?

**Miles Scott:** It is on the shortage occupation list, but there are not many other countries that have training for paramedics that has equivalence in the UK—not many other European countries in particular.

Q93 **Chair:** Which countries do?

**Miles Scott:** Primarily Australia and New Zealand. The London Ambulance Service in particular has very successfully recruited nearly 200 paramedics from Australia and New Zealand.

Q94 **Chair:** How long does it take to train to be a paramedic?

**Miles Scott:** Three years.

**Chris Wormald:** Can I just clarify—

**Chair:** Another caveat.

**Chris Wormald:** No. I think the vacancy rate is 5% over the natural rate, so the total vacancy rate is 10%. You would expect a level of 5% in any organisation, and we have an excess 5%, so I think the number quoted in the NAO Report is nearer 10%.

**Chair:** Well caught, Mr Wormald.



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**Chris Wormald:** See, that wasn't a caveat.

Q95 **Mr Bacon:** No, you were making it worse. It is good to know we have clarity and honesty from the Permanent Secretary.

**Miles Scott:** It might be helpful if we could confirm with the Committee afterwards the latest workforce statistics.

**Mr Bacon:** Yes, it would be good if you could to write to us with that.

Q96 **Chair:** It would be helpful to have the vacancy rate for each trust as well, because it may be attractive for New Zealanders and Australians to come and work in London, but they may not want to go and work in—

**Miles Scott:** Yes, we will provide you with that.

Q97 **Mr Bacon:** And the total expenditure on agencies by each trust in the last two years as well, if you wouldn't mind.

**Miles Scott:** We can absolutely get you that figure.

Q98 **Mr Bacon:** This is probably for you, Professor Willett. Given the extra costs of the pay uplift, are those ambulance trusts going to be able to afford to recruit all these extra paramedics?

**Professor Willett:** The paramedic shift is obviously wider than that, because we are bringing a graduate paramedic programme into the country. We are training about 1,750 learners in the system this year. That will be the same—Health Education England will be bringing those into the system over the next three years to address the shortfall in paramedics.

There has also recently been the band 5 to band 6 change for paramedics, as part of NHS Employers' and Department's settlement for paramedics. That encompasses the recognition of the paramedics' significant skillset that has changed over the years. They have now been rebanded within "Agenda for Change". That is being funded one third by NHS England and two thirds by the Department.

**Rod Barnes:** Certainly within our own service, we have had to find savings in other parts of the organisation to reinvest in frontline staff.

Q99 **Chair:** Such as?

**Rod Barnes:** We are looking at doing things more efficiently in back office functions like fleet, IT, estate and rationalising some of the legacy estate that the organisation has.

Q100 **Chair:** Was that done in time? Obviously, the uplift came. Were you planning for those efficiencies? It takes a while to change backroom, IT systems and other things like that.

**Rod Barnes:** Yes, and like most provider organisations, we have a three-to-five-year cost improvement programme that looks out ahead at various degrees of fitness to go live with.



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Q101 **Chair:** Sorry, just to be clear: did you have three to five years to plan for the uplift in salaries? That was not quite clear.

**Chris Wormald:** This is why DH and the NHSE provided separate money for the first few years of the uplift. We are funding until 2018-19.

Q102 **Chair:** And you are funding the actual costs of every member of staff who has gone up from 5 to 6?

**Chris Wormald:** Of the rebanding? At that point, it goes into the general commissioning system, which gives people time to have made the transition.

Q103 **Chair:** Mr Barnes, is that enough of a cushion for you and your colleagues around the country to cover the cost?

**Rod Barnes:** It is.

Q104 **Chair:** So you don't have any worries in that respect?

**Rod Barnes:** Clearly, once we get past '17-'18 and the responsibility to fund the increase goes back to local commissioning organisations, the expectation is that the funding will come from efficiencies in the sector that are driven out by having enhanced clinical skills.

**Chris Wormald:** It should be said that there is one trust—West Midlands—that is our outstanding trust and has done this rebanding already within its existing resources, so we know that it is—

**Mr Bacon:** I'm sorry; say that again.

**Chris Wormald:** It has done the rebanding already within its existing resources. That is our outstanding trust, so we know that this is a possible model, but we have given people some—

**Mr Bacon:** You just need to clone Mr Marsh. I was about to put in a plug for the Genome Analysis Centre but I don't think I will—it is in my constituency.

Green calls represent half of all the calls, so why isn't there a target for them? Would it be a good idea to have a target? I have my own views. You can see why people might ask why there isn't a target for Green calls.

**Professor Willett:** That is a real issue. As we have understood more and more with the ambulance response programme, there is clearly a disadvantage to the patients in that Green call category. Standards are set, but they are set locally by the lead CCGs as part of the commissioning arrangement. They are not nationally reported but they are locally reported. It is usually 30 minutes or 40 minutes—something of that order is the target set for those.

Q105 **Mr Bacon:** Will there be a new set of clinical codes and performance standards for Green calls?



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**Professor Willett:** What we have to do is to make sure that Green calls are not forgotten and, most importantly, that we pull that in, as we call it, the long tail in the Green calls—patients who, in times of surge and real busyness, are disadvantaged.

Q106 **Mr Bacon:** The tail breaches, you mean?

**Professor Willett:** The tail breaches. We will be looking very much for that to be one of the products of the ambulance response programme.

Q107 **Mr Bacon:** Oh, right; good. So that is one of the outcomes you are expecting from it?

**Professor Willett:** That is what we would anticipate, yes.

Q108 **Mr Bacon:** Given that the data are not collected consistently, how useful are national indicators anyway?

**Professor Willett:** If they are national, I think they need to be nationally reported. As part of the fourth part of the ambulance response programme, now you have nicely walked me to it, is to actually look at all of the quality indicators. Now we understand the optimal configurations—we are working towards a very different way of operating and using our staff and our vehicles, and adjusting the calls—we need to look at the right measures that actually indicate whether the services are working properly in terms of safety, in terms of efficiency within the system, in terms of clinical outcomes. Also, very importantly, we have learned this from the ambulance response programme—what the staff think of it. Throughout the NHS—it doesn't matter where we go—the staff are the people who know whether the system is working well or not, and we have learned a lot from them.

On the ambulance response programme, the surveys we have done of staff to date—we will see what the final report says, but frontline staff in vehicles are recording far fewer unnecessary blue-light calls. Obviously they are driving at risk to themselves and the public. The call handlers and the dispatchers are having a lot less stress. I was in the Yorkshire Ambulance Service operating room not long ago, and the common comment on the services that are now working the new system is that the whole control rooms are just quieter. There is not the same level of chaotic intensity, if you like, that was being driven by everybody trying to get something that they had not got.

Q109 **Mr Bacon:** I thought you were going to say, for a moment, "being driven by the target", which goes back to my first question.

**Professor Willett:** No, not to you, Mr Bacon. Also, they are reporting there are fewer times when they miss meal breaks. Shift finishes are better. The unions have been involved. The staff have been involved very much with the ambulance response programme. We have taken a strong steer from that.

Q110 **Mr Bacon:** Should there be national indicators for things like trauma?



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**Professor Willett:** I do not think we should have them for trauma—I am a trauma surgeon, so I can say that. We have a set of measures in trauma. I will come back to trauma, but for things like stroke and heart attack we already have them. You are right that we should consider those at the national level, but there are other things that we could include.

The trouble with trauma is that it is very heterogeneous. Someone can have a head injury, someone else can have a chest injury, someone else can have a crushed pelvis or an amputated leg, or someone can have all of those, so actually setting an individual target for that is quite difficult. We have a very good system in place already for major trauma.

Q111 **Bridget Phillipson:** The North East Ambulance Service Trust tells me that, just in terms of Green calls, they have a system whereby with a Green 3 case, if the patient waits more than an hour their case is upgraded to a Green 2 emergency response—for a within-30-minutes response. Is that kind of protocol in operation in other trusts around the country? Is that a standard protocol?

**Professor Willett:** For the Green calls, the commonest effective intervention that has been introduced across the ambulance services is actually putting clinical advice into that call, because many of those calls perhaps do not need to be conveyed to hospital. When the ambulance eventually gets there, it may be something that can be managed in the community like urgent care support arrival, or it can be something done there. So clinical advice is the commonest new model, which we are strongly supporting. Obviously the graduate paramedic programme supports that. The idea of raising patients up categories makes sense in principle—the difficulty is if you haven't got assets to send it does not change anything. Usually the reason for the long delay in Green is because everyone is running trying to get to Red.

Q112 **Bridget Phillipson:** That is certainly the response that I have had from the trust, with a number of cases, but that has also gone hand in hand with regular clinical updates. Patients who are waiting for an ambulance will have been given regular updates. However, despite that, they are still having to wait longer, and they have had to introduce a new protocol to try and deal with it.

**Professor Willett:** From the ambulance response programme, the solution is to free up those vehicles that are currently running around all together not getting to scenes. If we can free up those ambulances—and we anticipate literally freeing up thousands of ambulance occasions each week, both as a result of giving them more time and the code set—that combination will be the best solution for those patients.

Q113 **Bridget Phillipson:** The biggest factor that we hear locally is around waits at hospitals—particularly at two or three major hospital centres. I appreciate this is not necessarily an easy response to give, but how do we sort that?

**Professor Willett:** From a clinical point of view I would agree. Ambulances not being able to offload patients is one of my most serious



concerns in the system currently. I do not think the patients in the ambulances are at particular risk, because they often have two paramedics with them. They are probably better staffed than intensive care, at a 2:1 ratio, but that vehicle and that crew is locked, and actually we know where the demand in the system is out there. That is a very serious one. Myself and others have written out to the system. We saw this building. It happens every winter to some extent, but we saw it building in the autumn and particularly into December and wrote out to the system at that point and made it clear that this needed to be looked at. We started to get some behaviours going on as well that we were not very happy with, so part of that programme has been taken over by Miles. Having put out the recommendations about what we should do about turnaround in hospitals, there is now a programme of escalation going on and much firmer performance management of the system.

**Q114 Bridget Phillipson:** Could you just clarify for me what the organisational response is when an ambulance identifies a particular problem in the system with a given hospital or hospitals within an area that causes significant delays to the handing over of patients, therefore putting pressure on the ambulance service in deploying resources? What is the organisational response to managing that and improving it?

**Professor Willett:** In the current structure, both the ambulance service and the acute trust will be represented on what is called the A&E delivery board, which used to be the system resilience groups. That would be the forum for those system-wide pressures to be discussed and for the acute trust to understand. More recently we have escalated that. Now, if the ambulance service is aware of delays building up at a hospital, there will be direct contact with the executive of the hospital to make them aware. We will task the medical director of the hospital—the executive of the hospital—to work with the ambulance service, and then on a real-time basis to resolve that issue, rather than it being something that is done perhaps in the cold light of day a few days after the issue.

**Q115 Bridget Phillipson:** But hospitals will already know they have a problem and will want to deal with it. They presumably say, “We know it’s a problem, but there are other factors here that we have no control over.”

**Professor Willett:** That’s right. That is why it has to be a system-wide problem at the end of the day, which is why it is the A&E delivery board where you have representatives there, and, for the STPs of the future, you will have local authority representatives, the ambulance service and the community sector. You will have everybody represented. It is this problem that the hospitals are congested currently with all the issues in the media that I am sure we have all discussed.

**Mr Bacon:** Yes, we have.

**Professor Willett:** And it backs right through. The last point of back-up appears to be ambulances that cannot hand patients over to the care of the A&E department, because the department has nowhere to put them. They cannot move patients out, so the hospital cannot move patients in.





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**Bridget Phillipson:** It just feels like we are talking about the problems within the system. We seem to be able to identify where the problems are. Doing something about it seems a lot more difficult.

**Chair:** You have just described a lot of people meeting.

Q116 **Mr Bacon:** We have had exactly this discussion on delayed discharges, which the Committee has looked at a number of times. Northumbria NHS Trust, which runs and organises adult social services in Northumbria, has zero delayed discharges. They have had 51 visitors from different parts of the country. It was Mr Stevens or Mr Rouse from DCLG who said you have to have a situation where the whole system owns the whole problem. You have said something very similar. Why is that understanding not more widespread?

**Professor Willett:** That is one of the main reasons behind the sustainability and transformation plans being generated. In some places that is the first time you have had local authorities working with the health providers and commissioners all coming together to take a local population view about the pressures in the system and helping each other out. That is what the STPs are all about. It is a joint management structure where you bring executives together to drive that.

Q117 **Mr Bacon:** I have one more question for Mr Barnes. Once the handing over is done and once any delay in the hospital has been dealt with, ambulance crews are supposed to have 15 minutes to make ready for the next call, but many ambulance trusts are not meeting that separate requirement. Why is that?

**Rod Barnes:** It can depend on peaks in demand.

Q118 **Mr Bacon:** In terms of what demand?

**Rod Barnes:** Let us consider an average 12-hour ambulance shift. If it is a particularly busy day and the crew have treated one patient after another, there can be times where in that 15-minute slot the crew might either take a break for a cup of coffee, depending on the nature of what is wrong with the patient, or they might take additional time to discuss the case and what happened during the incident. It is an area where I would say there has been quite an improvement over the last few years. There has been an increased focus on the amount of time that crews take to wrap up, which is what we call it, the 15-minute slot with patients. There is a bit more that we can do. A lot of trusts have implemented welfare calls with crews. If they have not come clear within 15 minutes, the control room will call the crews directly to check whether anything can be done to help.

**Miles Scott:** I was going to make the point that, although the absolute instance of it taking more than 15 minutes for the ambulance crew to turn their vehicle around is significant, the number of minutes over 15 minutes is usually much less. That is why, when the NAO looked at the two components of this—15 minutes for the hospital to accept the patient and 15 minutes for the ambulance crew to turn the ambulance around—they



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focused on the hospital bit, because that is where the time is being eaten up. Those delays can run into an hour, or several hours even, whereas the delays against the 15-minute stand for the ambulance crews tend to be a number of minutes.

**Chair:** It sounds like a bit of a meaningless target.

**Robert White:** I wanted to point out the variation in turnaround times on page 22 of the Report. While I think some of the responses for why there might be a delay were reasonable, what is not explained is why some trusts seem to be able to turn them around in 15 minutes and others are not.

Q119 **Mr Bacon:** There is a big variation, isn't there? Is that due to cultural behaviours?

**Miles Scott:** I accept that there is a big variation. I would simply say that, when looking at our operational response to this, we absolutely chose to focus on the hospital handover element of it, because our understanding of the data is that the significant delays are very much in the hospital end of it. I think we have resolved that. We can get into why it is there is this apparent variation, but our understanding of the issue that is having an impact on the system is that it is highly focused on the hospital handover bit.

Q120 **Chair:** Is it that clinicians and others in hospitals do not appreciate the need to get that ambulance out again quickly?

**Miles Scott:** No, not at all. As Professor Willett said, we are talking about hospitals that this winter have been typically over 95% occupied. Those are historically incredibly high levels of occupancy.

Q121 **Chair:** Is it primarily shortage of beds, then?

**Miles Scott:** Yes, it is the ability to get patients into the hospital. If you put yourselves in the shoes of a medical director who is responsible for safety in a hospital on a given day, the safety they can see is the safety of patients in the hospital. So they can see how full their hospital is. What they cannot see is—

Q122 **Chair:** The queue of ambulances outside.

**Miles Scott:** Well, they can see that, too, but in the queue of ambulances they can see you have got trained clinical staff—almost like an intensive care bed, as Professor Willett said. What they cannot see is the patients in the community waiting for an ambulance to arrive. That is why I think the key intervention was Professor Willett and Kathy McLean communicating with medical directors to say, "Look, our concern across the whole of the system is that the biggest clinical risk is lying outside of hospital. That is why we want you to accept the increased pressure in the short term of taking these patients straight into the hospital, even though you are at these very high levels of bed occupancy."





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**Chris Wormald:** The important thing in dealing with this is exactly the same set of measures as in dealing with A&E more generally. So when Simon Stevens and Jim Mackey wrote to the system on 9 March, they were talking about how we free up large numbers of beds and how we free up A&E. That should also be the set of measures that allows us to deal with this challenge. As I say, it is that system response.

Q123 **Philip Boswell:** This is probably directed at Mr Scott. It is in relation to metrics, KPIs and so on: the expected performance targets that colleagues have covered. In terms of the queues of ambulances outside, who is measuring or reporting the impact on the service from a countrywide perspective? Is it the delivery boards? Who collates that? How can we get this data?

**Miles Scott:** I think we covered this just before you were able to arrive, Mr Boswell. We are collecting those data and using that information operationally at the moment. We are just working through the detail of how we can incorporate that into official statistics.

**Chair:** It is partly to do with national statistics rules, isn't it? But next time you are in front of us, we will have that data—that is the key point.

Q124 **Anne Marie Morris:** You are painting a picture that on one level is encouraging, because you are clearly addressing many of the problems that the NAO and others have identified. That is the good news. But I am concerned about the deliverability of it, at the end of the day. Professor Willett, do you agree that in terms of the jigsaw puzzle that is health and social care, the ambulance piece is pretty mission-critical, because it determines so much of the entry into A&E, which is one of the most expensive bits of the system? Looking at the figures for 2015-16, it seemed to me as if the ambulance service was responsible for something like 20% of the entries into the A&E system, and therefore it was kind of pivotal.

**Professor Willett:** Yes, I agree, and actually I would take things one step further by saying that there is no better vantage point of the whole urgent health and social care system than the ambulance service. That service touches just about every part of the NHS. They know the general practices, the care homes, the community providers and the hospitals; they touch all parts of the system. So they are in a very good place.

From my time in urgent emergency care—that has been my career—I think there is still a significant under-appreciation by the health system leaders and by the commissioners, not only of the pivotal role of the ambulance services but of their pivotal position to lead transformation.

They are a relatively small player in terms of activity, finance and workforce, but actually they are in an absolutely pivotal position. That is—

Q125 **Anne Marie Morris:** So you agree with me?

**Professor Willett:** I agree with you.



**Q126 Anne Marie Morris:** Right. Mr Barnes, given how pivotal the ambulance system is, why is it that it is so little engaged in the overall change programme and the STPs? I appreciate that you have a challenge of 10 ambulance trusts and an awful lot of other organisations, never mind the total number of STPs and clinical commissioning groups. However, given the importance of the service, isn't there some learning to be had, or something that needs to be addressed in this new, future way forward, if we are to make sure that we are actually spending the right amount in the right place and getting value for money across the whole of health and social care? What is your perception of the engagement and involvement of the ambulance service in this huge change programme that is going on, and what more could be done to ensure that the service is properly engaged and consulted?

**Rod Barnes:** You are right to flag up the challenges for ambulance services. Within Yorkshire, and I think we are fairly typical, we deal with 20 different CCGs, probably about 15 A&E delivery boards and four STP systems. It is a huge challenge for groups of organisations meeting at a local level, whether or not that is in a CCG footprint, and meeting day in and day out. While we can and do send representatives to meetings periodically, we are not there always for the day-to-day discussions, which means that quite often we don't come to the forefront of all the planning discussions and we are playing catch-up.

Also, I think some of that is history. Again, going back in time, ambulance commissioning was probably seen as less glamorous and as second-tier, and it didn't necessarily get the key individuals within commissioning organisations to the table in the way that the core large acute organisations did.

**Q127 Anne Marie Morris:** How are we going to change that in the future? You are right about the history. I think there was an earlier question from one of my colleagues and you talked about this new world, and it was all going to be all right, and my concern is that I am not sure that by 2018 we will be in a shape to have this model. You talked about developing a standard operating framework. Well, if the ambulance service is not as engaged as it should be, how will you develop one?

My concern is that you will try to do what's been done to the STPs. You say that you've got to do it, but it's got to be within the same amount of money that you are spending already, and actually there is very little room for manoeuvre. Your challenge is that, with the ambulances, you have got so many different configurations and frameworks that I would have thought it's almost impossible to come up with one ideal framework.

**Rod Barnes:** I will possibly hand over to Miles in a second. I have been quite encouraged. About two years ago, I was quite depressed at just the fragmentation within the health service from an ambulance perspective, and I have been quite encouraged by the coherence of what's come together through the urgent and emergency care review, and the way that's led through to the work on the ambulance response programme. Also—



**Q128 Anne Marie Morris:** How are they interconnected? There is a lot of talking, as my colleagues said, but nobody is saying, "This piece of work is linked to that piece of work, and this is the overarching piece." We have got so many ways of looking at the NHS care world, but the average punter and even colleagues around the table remain confused about what the priority is. You almost want to see some sort of pyramid structure—some structure where something dominates, whether or not it is the STPs, and everything else falls into line. At the moment, it is a bit like wobbly jelly that hasn't set.

**Rod Barnes:** Certainly, from the groups that I am involved in, I think that clarity is starting to emerge. The work that Miles is leading on through the sustainability review and the review of the commissioning framework is very much a key element of that.

**Q129 Anne Marie Morris:** So Mr Scott, how are we going to get to a position where there is some structure that people who are working in the NHS and the care world understand, that we understand, and that the average man in the street understands?

**Miles Scott:** That is a very important question. As Professor Willett said, right at the outset the ambulance response programme has been inspired by and has engaged with all 10 ambulance services in England. The ambulance services have all worked together with Professor Willett and his team on the ambulance response programme. If you look at the changes that are required across the whole of the urgent and emergency care system, to a large extent the ambulance service component is going to be plugged through the ambulance response programme. It is going to be about the changes that we talked about—a greater use of "see and treat" and "hear and treat" models, and so on. For that to be sufficient, it will also require the other elements of the urgent emergency care review, in terms of flow through hospitals, discharge and alternative primary care.

**Q130 Anne Marie Morris:** Forgive me, Mr Scott—that is a lovely story about what good might look like, but it is not telling me how you are going to deliver it. Mr Barnes, do you understand why there are such differences in financial and operational performance in the different trusts, so you are therefore able to say, "This, going forward, is the right model, and this is how we will commission going forward"?

**Rod Barnes:** I certainly think there are opportunities to improve on some of the historical positions. If you look at the different funding into different organisations, some of that is due to the historical funding of services. Certainly in my area, there hasn't been a rebasing of funding by CCG, based on the cost of delivering a service in that particular area. The allocations we get are based on historical funding for the CCGs and the primary care trusts.

**Q131 Anne Marie Morris:** What will be the driver going forward? Will you try to determine what the need is, or will you look at historic models? What will you do to try to look again at how you do this differently?

**Rod Barnes:** I can't speak in terms of the funding allocations that go into commissioning for ambulance services. There is a huge opportunity to establish some clear areas of best practice. Where we have seen diversity across the services in levels of clinical advice, which is picked out as one of the areas in the NAO Report, I think the commissioning framework potentially provides opportunities to say—

Q132 **John Pugh:** On that specifically, you have got commissioning frameworks, you have got aspirations and you have got talk of improvements and so on. I think you are very good in the ambulance service at analysing what the problem is. My ambulance service is taking ever more frail people to hospital, but the A&E can't discharge because they haven't got enough beds, and so on. Can you give us some examples? You indicated that things are going to improve or have improved a little bit. Can you give us some really good examples of best practice you have seen in the last couple of years, which has moved things on, apart from more discussions, more analysis and more frameworks?

**Miles Scott:** To give you an example of how something has actually changed—

**John Pugh:** A concrete example.

**Miles Scott:** A concrete example is what has happened with the introduction of the band 6 paramedic role. Hitherto, we had a long-standing debate about what paramedics should be paid. People all over the country did their own thing, and that led to more and more industrial strife. We have had a coming together of the ambulance services with NHS England and NHS Improvement, and we have got to the position where we have got agreement around a common job description. We brought all that together, we are implementing that together now, and we are moving that forward.

**John Pugh:** Could you specify an area where better systems management has occurred thanks to your intervention and analysis?

**Miles Scott:** If you look at the NAO Report, it picks out eight clinical indicators, and in five of those eight it shows an improving pattern. That is not one person's success; that is because the whole system has worked together to identify clinical priorities and change the way in which care is delivered, particularly to patients who have had a cardiac arrest, a heart attack or a stroke.

Q133 **John Pugh:** What is the best exemplar you can give of that, the best area that embodies that?

**Miles Scott:** I would give those examples of cardiac arrest, heart attack and stroke, because in those areas you can see actual—

**John Pugh:** Geographical areas.



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**Chris Wormald:** If you look at figure 17 in the NAO Report, which basically gives the CQC ratings, it gives some very clear patterns geographically. On the other things picked out in the NAO Report, things like “hear and treat” and “see it and treat”, we have seen numbers go up, and I think it is true that something like half a million fewer people have ended up in A&E as a result of those two programmes, all of which flows exactly from the kind of work that Mr Scott has been doing. So we do have some very specific examples.

I think the question that comes behind a number of your questions is: is there a variability issue here? Yes, clearly there is, and that is what figure 17 of the NAO Report shows. It should be said that the CQC, when I discussed it with them last week, said that they do not think the variability in ambulance trusts is any greater than in any other part of the system. Nevertheless, from the various things that my colleagues have described, we want to see that variability come down.

Q134 **Nigel Mills:** Can I just take you back a couple of minutes, Mr Barnes? I think that in one sentence you said you were worried about how fragmented the NHS was in comparison with the ambulance trusts and that you had to deal with lots of different STPs and other things, and in the next sentence I think you were depressed at the fragmented nature of the ambulance system. What do you think is the right size for an ambulance trust?

**Rod Barnes:** You need to balance off economies of scale and resilience issues within the organisation with local engagement. Within the sector there have been a number of long-standing discussions about what the right size of a service is. I would say that the broad consensus view at the moment is that the services are about the right size to get the right governance resilience in place. In terms of models that we are looking to take forward, within Yorkshire we have formed an alliance with North East Ambulance Service and North West Ambulance Service, which is to look at where there are opportunities to collaborate at a regional level. That might be in areas like back-office functions, procurement and sharing best practice in terms of operating models, driving out further efficiencies and quality improvements based on sharing best practice in economies of scale.

Also, there is an increased appetite to look at what we can do nationally, not just through the work of the NHSI sustainability review. Within the 10 services generally, we have always collaborated; there have always been very strong networks for the 10 services to share best practices in the clinical operational agenda and the financial agenda. There is more appetite to look at the variation within the service and say, “Is that really justified? Do we need as many different types of ambulance as we have in the system?” The Report highlights usefully some areas around things like sickness management. What can we do to learn from best practice and share that quickly across the other organisations in the system?

Q135 **Nigel Mills:** If one of your neighbouring trusts was really struggling and was perhaps inadequate on safety or overall, you don’t think that having



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one take over another is a particularly sensible solution?

**Rod Barnes:** I wouldn't rule it out altogether, but generally speaking, given the challenges that we have, I don't know whether organisational change would just be more of a distraction. Having previously seen some of the organisational mergers that have gone on in the acute sector, they can be quite long drawn-out affairs, so from that point of view I am not sure it is going to sort issues out for the ambulance sector in the here and now.

Q136 **Bridget Phillipson:** In figure 4 of the NAO Report we see the considerable variation there is in the funding per head of population across England. The north-east has the lowest in the country and £10 less than the highest. What is the reason for the wide variation in funding? Is any work being done to understand how serious the impact of that is and whether anything needs to change?

**Miles Scott:** It is largely a function of history, to be honest. We have never had a national ambulance service and we have not had national commissioning. Each ambulance service is commissioned on a slightly different basis, to slightly different specification—I am not defending this, I am just saying that this is the position that people like Mr Barnes have inherited, although there has been consolidation to 10 ambulance services. That is the principal reason. There are then some other issues about geography, demography and so on. Of course, the commissioning of other community-based assets is also different in different parts of the country, so some places have lots of community hospitals and other hubs, and others do not, but the big reason is history.

Q137 **Bridget Phillipson:** When you look at the difficulties that the North East Ambulance Service has experienced in responding to Red calls and sickness levels—although I have a considerable degree of sympathy with the challenge that all ambulance trusts are facing—and then you consider that North East also has the lowest per-head funding in the whole of the country, you have to question whether that is a system that needs to be reviewed. Is the Department doing any work on looking at the way in which the funding for ambulance trusts is delivered?

**Chris Wormald:** The amount that individual ambulance trusts get is the result of the local commissioning system, so it is the decision of local commissioners. We are not doing anything nationally to deliver that, are we, Keith?

**Professor Willett:** No, but what I would say is that obviously each CCG is responsible for commissioning locally. They have come together, they have chosen to act collectively and they have put together 10 lead commissioners. That is something they can do under the standing orders under the Act. But the ability of the lead commissioner to instruct, drive or implement a collective arrangement on a substantial level of funding bias is at the moment quite difficult. Most of the contractual discussions occur around things like patient transport services and other things, rather than around that.





Where there are historical elements, persuading agreement involves an average ambulance service that has 20 CCGs to work with and one lead commissioner from those. We have the ambulance response programme, the role of STPs and the fact that we will be giving commissioning guidance from NHS England to CCGs about how we move forward, which will be based on a lot of the work that Miles and I have done in this area. That guidance will be going out, and we expect the STPs, as that joint management executive structure, to be the vehicle for change to get us into a much better place.

**Q138 Bridget Phillipson:** What are these historical factors? Can you just explain to me what these factors are?

**Professor Willett:** They were just funded differently. They had different levels of priority. Just in terms of what they were given to do—there were 53 county ambulance services at the start. It has gradually gone down and down, but a lot of those things have been carried over.

In the complexity of healthcare commissioning—this is not an excuse, but is just where it is—ambulance services have not had the priority. With what we have done now with the ambulance response programme, the work we have talked about here and how we are taking it forward, I think this will go up the priority list. We have done some work that I think will focus commissioners and sustainability and transformation plans, in that we have done an extensive piece of work looking at what we call channel shift.

Channel shift is about the demand coming into urgent and emergency care, where, but for the want of something better being available, the patient could have been treated more conveniently, in a better way for the patient and at lower cost to the system. It is the idea that, for instance, a patient on a Green ambulance queue actually did not need to go to hospital if they could only have found a careworker who could have come in and been with them that evening, rather than using the hospital bed to provide that. We have done some work on that. We have produced a tool that is now out to STPs and CCGs, into which they can put their local system information and predict the levels of investment they need to make. We know that investing in the ambulance services has one of the bigger yields downstream in the system for getting patients the right care close to home at lower cost to the health service, which has to be where we aim.

**Q139 Bridget Phillipson:** I am loth to suggest looking too heavily at some of the historical anomalies, given the mess you end up in when you look at what is happening around schools. That said, it seems difficult to separate funding from the wider problems in the system.

**Chris Wormald:** The only thing I would add is that if you look at figure 4 in comparison with figure 17, there is not a lot of relationship between funding levels and quality, as measured by the CQC. The north-east comes out very well in the CQC inspection. There clearly are some funding issues





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in there, but the operational questions that Keith and Miles have been describing are bigger issues than the level of funding. That is what the evidence says to me.

Q140 **Bridget Phillipson:** I am not suggesting there is necessarily a causal relationship, but you equally in the north-east have one of the highest levels of Red calls that fail to meet the target and very high sickness levels. I am not suggesting there is a causal effect, but I would be reassured to know that the impact of funding on that range of other factors and on the operation of ambulance trusts was being considered as part of this wider look.

**Chris Wormald:** To the extent that we are looking at standardised commissioning. We are not going to set budgets centrally. This ought to be part of local commissioning, and people will need to make their own choices about whether they are prioritising ambulances or some other service; given the money, it is a zero-sum game within an area. But—I heard this come out in the hearing—standardising the commissioning process and therefore the operating model of ambulances is something we want to see. As I have said, the light of inspection on this, and the process of looking at where is good and who needs to learn from who is very important.

The other thing the CQC was keen to emphasise to me is that they have seen from ambulance trusts a very positive reaction to inspection results. It has painted quite a challenging picture for some places, but the CQC reports back that ambulance trusts have come to that with a “How do we get better?” approach, as opposed to a—

Q141 **Chair:** So the question may not be whether the north-east gets more, but whether some of the other areas spend less.

**Chris Wormald:** I am saying that it is clear from the CQC inspections that the things ambulance trusts should be looking at first is how they run themselves, as opposed to their funding.

**Chair:** Yes. That comes through quite strongly in the Report.

Q142 **Anne Marie Morris:** Mr Wormald, if I add up the different chunks of money that go into commissioning ambulance services—there is not a central budget—I get to £1.78 billion. Are you expecting the changes that we are looking at putting in place to be cost-neutral?

**Chris Wormald:** Sorry?

Q143 **Anne Marie Morris:** Are you expecting the changes to be cost-neutral? You are looking at a different way of commissioning. As the Chair said, if there is a new model, a new way or a new standard, some will get more and some will get less. Do you assume it will be cost-neutral?

**Chris Wormald:** What the sum is, going forward, will be a result of the local commissioning process, but most of the changes that Keith has described are cost savings, in that they free up ambulances to do more. With the exception of the rebanding, which we have discussed, and the



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increased number of paramedics we have—those are obvious additional costs to the system—the other changes we have been describing ought to allow greater efficiency, as opposed to greater cost.

**Professor Willett:** What we can say in terms of the efficiency gain is that the ambulance services will be put into a more sustainable position from where they are now, which is paramount. The advantage we get from the ambulance response programme and changing the way the whole system runs is those other system gains—the benefit in terms of patients not being conveyed to hospital and being managed locally, and doing more things in that way. That is where the overall financial gain will come in terms of the NHS.

Clearly we have to provide ambulance services across the country and work within the spending review allocation we have. To my mind, this is about the ambulance response programme creating sustainability in the short term—we have seen that with the ambulance services that have gone to the full model—but also giving us the headroom to make those changes. However, they will be dependent on the rest of the system changing around them—the whole urgent and emergency care review. What I mean by that is that if we have ambulance services that are capable of doing a lot more, with graduate paramedics, but they cannot access services in the community because they are not there, the gain that we have created at the moment will disappear within two, three or four years, I suspect.

Q144 **Anne Marie Morris:** So we land up in a big circle.

**Professor Willett:** We would do, but that is why this is one part of it. I have said when I have been in front of this Committee and the Health Committee before that the urgent and emergency care review has to be from one end of the pathway to the other. We have to make the changes in all of it. If we do something really clever in one patch, it doesn't take long for that effect to be negated by the rest of the system.

Q145 **Anne Marie Morris:** Do you believe that, between you, you have that joined-up, connected approach to implementation?

**Professor Willett:** I think we have now—recently. The ambulance response programme has driven that, because it has brought the ambulance services together, the commissioners together, the staff side together and the arm's length bodies together.

Q146 **Anne Marie Morris:** Tell me this, Mr Wormald, given that part of what this Committee looks at is value for money. If we move to this new way of commissioning and this new guide, if you like, to best practice and that is how you do this, how are we going to measure whether we are getting value for the money spent?

**Chris Wormald:** Again, I think what we get out of CQC inspection is absolutely key to this. If we deliver what we have set out here, we will clearly be making quite big value-for-money improvements, but I—

Q147 **Anne Marie Morris:** But how will you measure it?



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**Chris Wormald:** In all the ways set out in the NAO Report. We would expect to see—

Q148 **Anne Marie Morris:** Hold on. In the NAO Report, you are looking at targets; you are not measuring the value for the money you are putting into the ambulance service. I don't think that's where the NAO was.

**Chris Wormald:** No, but the set of metrics we use is exactly the set that the NAO has set out. It is at the moment the current target structure and then it's the CQC metrics.

Q149 **Anne Marie Morris:** Hold on. You are talking about two different things. One is targets for whether you get your timing right—whether you get someone to the patient in time and, if we are looking at A&E, the time that they then transfer to care. They are all measurements of time, not of the amount of money that the taxpayer is putting in and whether they are getting value for money out of it.

**Chris Wormald:** No, I'm sorry, but they are not all on time; at least half of them are clinical outcomes. What we look at when we judge the ambulance service—

Q150 **Chair:** Yes, time or clinical outcomes, but you could get a brilliant clinical outcome if you had an ambulance sitting outside everyone's front door, waiting for them to have a heart attack. Clearly, that's not cost-effective, at one radical extreme. This is about the money for the outcome and for the time target achieved.

**Chris Wormald:** I am not quite sure what else to say, because it is the measures here and the CQC outcomes by which we measure the service and therefore by which we measure whether we are getting value for money.

Q151 **Chair:** But we have also seen the regional variations in funding. On the north-east, you were saying quite positive things. Sometimes areas are doing better for less money, so if you could just pick up Anne Marie Morris's point, please.

**Chris Wormald:** Yes, this is exactly the point of my previous comment. We look at the resource used—CQC inspections will in future include the use-of-resource measure—against the quality as measured by the CQC and these targets, and what we ought to see is value for money improving as the outcomes improve for the same input.

Q152 **Anne Marie Morris:** So there are lots of "oughts" and not a lot about what is actually going to happen and how you are going to measure it. May I ask Mr Scott, as he is clearly eager to come in? One of the key pieces of this is the people part. You have a huge culture-change challenge if you are going to try to impose a new one-size-fits-all, "This is how you commission" and you are going to say, "You have to save money." How are you going to deal with the culture change within NHS Improvement? How are you going to deal with the fact that at the moment we have a real challenge with sickness in the ambulance service? There are a lot of individuals who are completely demotivated.



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Those who are below paramedic level are particularly demotivated; there is no career structure for them. If, as I think we have all agreed, this piece, the ambulance service, is such a key part of the jigsaw, the HR—human resources—piece is crucial, and I have yet to understand how you are going to deal with the culture change and the recruitment and motivation piece.

**Miles Scott:** In terms of the productivity point, we have weighted average unit costs, and through the work that we are doing, we are applying the model hospital approach that has been developed by Lord Carter and his team and two ambulance services, so we will have metrics of the kind I think you were after in terms of productivity.

**Anne Marie Morris:** Thank you for the answer.

**Miles Scott:** In terms of human resources—

Q153 **Chair:** What is the timetable for getting those metrics? Sorry, I may have missed it.

**Miles Scott:** Over the course of the next year. We have just appointed—

Q154 **Chair:** There is lots of stuff happening in the next year.

**Miles Scott:** Well, okay, but we've got the operational productivity team, as they are called, to bring forward their investment in ambulance services. They weren't going to start work on ambulance services until the summer. We got them to bring forward their investment and made the appointments required. That work is now getting up and running, building on the experience of the model hospital in other areas.

In terms of your workforce point, it is absolutely critical. We have described previously that we have a series of workstreams. For the workforce one, which we set up in January, we deliberately said that, for the first three months, they would focus solely on the implementation of the new band 6 role, because there are so many component parts to that and it was so important to get that right and to get all the paramedics who qualify to transition across to that. To be honest, that is what they have been solely focusing on. Once we have completed the assimilation to band 6 and got the new training role up and running, which we are pretty much there on, we will build out to other areas, which will include issues of recruitment, retention, supply and demand, but will also cover the kind of issues that have been raised in the CQC visits around leadership, staff morale, engagement and so on. There will be a wider workforce agenda that covers training.

Q155 **Anne Marie Morris:** When will that start? That is a bit late in the day, isn't it?

**Miles Scott:** It is bringing together some work that already exists. As I mentioned earlier, Health Education England have more than doubled the number of commissions for new ambulance personnel. They are investing some £5 million this year in additional development for our current staff. That is building on work that already exists. We want to take this very



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seriously and put more time and energy into the range of workforce issues that you have raised.

**Professor Willett:** I feel very strongly about this point, because the staff side, clinically, is absolutely critical to the conversion of any of this. We have to recognise that paramedics and ambulance technicians work in isolation a lot of the time. They face high violence and assault rates and work in very difficult environments. They make decisions on their own; they haven't got somebody senior to turn around to or pick up the phone to.

As part of the transition, a variety of things have come in. The new paramedic band 6 started on 31 December last year. From the work with the ambulance services led by NHS Improvement, as part of the condition for their funding they will need to put in place a new preceptorship role for paramedics coming out of graduate programmes for two years before they become band 6, so that they will have a proper, structured, supported role. For all the newly qualified paramedics, there will be a mentorship and a personal development plan. The ambulance services will be signing up to that.

The learning programmes that exist across the ambulance services already will be consolidated, so that we end up with a nationally consistent one, as paramedics might move around the country. As I indicated about putting more clinical support behind 111, we are also putting more clinical support in the ambulance services with the senior paramedics, so that newly qualified paramedics are supported at the scene. They will not be in isolation when making what are quite often very difficult clinical decisions around patients.

Q156 **Anne Marie Morris:** What about the more junior part?

**Professor Willett:** For those in the ambulance service who are at technician grade, or who might want to migrate through, there will be a programme in place for that. That has yet to be developed.

Q157 **Anne Marie Morris:** Is that something on your radar?

**Professor Willett:** I believe it is on Health Education England's radar. It is important that we take the stress and the risk out of the system and support the paramedics, because at the moment, some of that is untenable. None of that will happen if we don't, first, retain paramedics, and secondly, make it an attractive profession. I think what is in place—it is conditional on the funding—will be put in the ambulance service. It is going to be tough to do it, but that will be critical; I strongly agree with you.

Q158 **Anne Marie Morris:** Mr Barnes, we still haven't really addressed culture change. I guess you are going to be the one on the frontline. This is a lot of change. Given that you have a national hat on, not just for your part of the country, how do you see that happening for your service? Are you beginning to look with your colleagues at how you are going to enable that change process? Change is one of the most difficult things to effect.



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**Rod Barnes:** Yes, that's correct. Within our particular organisation, we have quite a big leadership and development programme under way at the moment. I would say that some of that culture change has already happened. Sorry to go back to the ambulance response programme, but it is that shift away from performance culture into more of a clinically-led culture. The ambulance response programme is a key element of that, and it is something that, through individual organisations and the ambulance chief execs' network, there has been quite a drive on for two or three years, which is the foundation. Miles mentioned earlier—

Q159 **Anne Marie Morris:** That is all well and good, but these changes are going to be not just about what you focus on but your working conditions, because of the way this one-size-fits-all system is developed. Is this going to affect what people get paid? Presumably, with the different amount, which at the moment is commissioned for the same thing, are people going to find that their wages change? What is going to happen to try to get this "one size fits all"?

**Rod Barnes:** There are a number of different things, some of which have happened and some of which are coming together. If we go back to the information in the Report around the turnover of staff and the shortage of paramedics, there was a lot of work done at the time to focus in. It is not just long-term training numbers. One of the key issues at the time was the attrition rate of qualified paramedics; as people were dealing with stress issues of work-life balance, new opportunities were opening up in primary care and other sectors for staff to move into. The sector has looked closely at how to address some of the housekeeping issues, focusing on issues around staff welfare—how we support staff suffering from issues like post-traumatic stress disorder—and there is a lot of joined-up work to try to get best practice in place. Other housekeeping issues are around staff engagement, getting staff involved in equipment-type decisions, about things like uniform—staff involvement in the new national uniform. Things like that can be demotivating factors.

The College of Paramedics and Health Education England are tied into this. They have published a career framework. Organisations have looked at their own structures: how we make working within the ambulance service an attractive career, both for people who are qualified paramedics—looking at the roles they can go into, whether in management or clinical leadership—and also from the grassroots, looking at how we can attract more staff at a local level. We have done things in terms of innovative recruitment events around black and ethnic minorities and other diverse groups that maybe we would not have had that reach into: how do we put forward the ambulance service as an attractive career? We have done a lot more work around things like apprentice roles and those junior roles to bring people into the service.

Q160 **Anne Marie Morris:** This new "one size fits all" worries me because I am concerned about its ability to reflect the different needs of geography, rurality, sparsity, deprivation and all those things. At the moment, although a lot of lip service is paid to the difference in rural communities, I have yet to see the flexibility written into any new "one size fits all" for





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those differences to be properly factored in, both in terms of what they cost and of a different approach to the model of care.

**Professor Willett:** Rurality is an important issue. What we are looking for is a degree of commonality but not uniformity. With the ambulance response programme, what we have done and the results as they appear to be coming out, would suggest that if we get this right it would appear that all the disadvantages, or the majority of the disadvantages, of rural populations that tend to struggle with that long tail will be addressed by responding in the way we have suggested, because you can then get the right resource to the right patient. That will be a really big gain in the system. It has been one of the objectives from the outset that we do not constrain the system, either by commissioning or by the way we ask it to operate, to a level that you cannot do what you need to do in the middle of Birmingham or London compared with what you need to do in the north-east or the south-west peninsula.

Q161 **Anne Marie Morris:** But isn't it going to be quite a different model of care? My constituency is in the south-west and we use a lot of individual first responders—the fire, the police—so in a sense we have a very different model of care. If we tried to rely purely on the ambulance you would not stand a hope of meeting the eight-minute target. That is fundamentally different.

**Professor Willett:** That would not be blocked in any way in any commissioning operating framework that we came forward with.

Q162 **Anne Marie Morris:** But would it be properly rewarded? One of the concerns—

**Professor Willett:** Well, they are rewarded if they count. For instance, in London the fire service will attend. Of those 2,000 codes that I talked about, the fire service are now trained by the ambulance service and capable of responding to about 30. That means that if the fire service's utilisation time for vehicles and crews is much lower than it is for ambulance services and they can get there, that scores. The patient is the focus, not the target or service, so that will count for that. The ambulance service will train and provide the equipment and the defibrillators, and the fire service may enact the response.

**Chris Wormald:** Just to be clear, we are not trying to create a single contract; we are trying to create a contract framework that can then be localised, for exactly the reasons you say. It is not one size fits all.

Q163 **Anne Marie Morris:** That is good, but my concern is the ring-fencing of the money. One of the concerns I have heard expressed by police and firemen is that, in effect, they are doing the work of the ambulance service; it is not that they do not want to do that—they absolutely put the patient first—but there is no recognition or reward, financially or otherwise. It will impact your budget. If you have other people outside the ambulance service doing some of the work that the ambulance service could do, how is that going to square up? How are you going to make that work? Mr Wormald, I think that might be one for you.





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*[Interruption.]* Mr Scott, you have got the short straw.

**Miles Scott:** Only to say that I do not think any of the analysis we have done suggests that we would get better value by taking money away from people like Rod and giving it to other services. We are looking at how we can make sure that the best-practice examples of ambulance and fire and rescue services co-operating are encouraged to develop across the whole country.

Q164 **Anne Marie Morris:** How are you going to motivate that?

**Miles Scott:** We motivate that, from the NHS point of view, by showing ambulance services the benefit to them of collaborating in that way. Where people share stations and have joint response arrangements it is often very popular, as you say, with the fire and rescue personnel themselves. There are benefits to them in terms of shared estate, and there are financial benefits from sharing back-office functions. We want to encourage those things that are of benefit. What we are not proposing is taking money from ambulance services and saying, "We'll denude that budget and give it to somebody else."

Q165 **Anne Marie Morris:** All right, but that somebody else is also saying, "I am doing more work than I was doing. If I wasn't working with the ambulance service, I would be having a cup of coffee."

**Miles Scott:** We are asking all the services to do more, aren't we? If we go back to the basic figures in the NAO Report, we see that between the two Reports the ambulance service has had to absorb 30% more work for a real-terms increase in funding of under 9%. *[Interruption.]* In real-terms it is less than 9%. That is a huge productivity gain—

Q166 **Chair:** Can I just say something on that point? We always get nervous if a figure is slightly different from what is in the Report. Perhaps Robert White could just confirm the figure for the increase; Mr Scott talked about the real-terms increase of 9%, but the Report talks about 16%.

**Robert White:** What we measured was a funding increase of 16%.

Q167 **Anne Marie Morris:** Can I move on to the model of care beyond the people and look at the methodology? At the moment the place most ambulance services would take someone to is the hospital. You described earlier that there are some clinical hubs that some ambulance services are looking at. Is that going to be recommended and used, and we are going to look at other parts of the health and care system to look at different drop-off points? It seems to me that you cannot really look at one piece—the ambulance service—without looking at the other piece, which is in social care and therefore local government. Is that being looked at?

**Professor Willett:** That is part of the wider emergency care review, so absolutely. There are opportunities for conveyance to somewhere other than a type 1 A&E department. Locally agreeing that urgent care centres or minor injuries units can take certain categories of patients clearly depends on the ambulance service making accurate assessments.



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Perhaps more important is the way in which we want to move ambulance services generally—this is strongly supported by them—away from what has been a traditional resuscitate and convey service, to one that is a mobile community treatment service. In other words, when the paramedic arrives it is not the default that they are going to pick the person up and take them off to hospital. For many patients—this is why we have the new categories coming forward in the ambulance response programme—it may well be that they can treat them at the scene. That would work with social care. Let's say an old lady falls over and collapses, which makes up, I think, 20% of Yorkshire Ambulance's calls. An experienced paramedic is very able to make an assessment that she hasn't broken anything, but a very brave/heartless paramedic would leave her there rather than picking her up, putting her in the ambulance and taking her off to hospital. A lot of patients get conveyed and once they are in hospital, they are in the hospital system.

This is what we are looking at with the urgent and emergency care review: rather than that patient being conveyed, the ambulance service will be able to talk to a clinical hub back at ambulance base, get clinical advice and arrange for a carer to come in at short notice to support the patient. You may even have a voluntary sector friend that comes in initially just to be with the patient until somebody else arrives. It can arrange for the GP to review that patient, perhaps the following day, and for an assessment by the falls team to occur. That is where we need to get to, so that the offer to the patient is far better than taking them to a crowded A&E department.

**Q168 Anne Marie Morris:** You are absolutely spot on, but my question is about social care. At the moment one of the problems is that come 5 o'clock, you cannot get somebody at the end of a line, and at weekends, forget it. Unless you can get this working—not just a seven-day NHS, but seven-days social care as well—what you are talking about is not achievable. Mr Wormald, have you had discussions with your colleagues in local government to look at the common review to ensure that we get them working together seven days a week? You can't have one without the other.

**Professor Willett:** Can I just finish that point? In social care, the model that has worked really well is having rapid response teams. Interestingly, the same things that you want to wrap around the patient who has just fallen over at home are almost the same things that you need to wrap around the patient to transfer them back into the community to be cared for. So the idea that you can have responsive social care will be one of the very common models that comes forward in the new care models that are being tried out and are working through the vanguards in NHS England. Those are the sorts of models. I suggest that if you give local authority and health joint decisions about how to spend money, that is where they would put it.

**Q169 Chair:** Mr Wormald, this will be wonderful if it all works, but we know the challenges. There were reports over the weekend of contracts being handed back to local authorities because the care providers can no longer



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afford to pay for them, for reasons that we know about that we do not need to explain in this hearing. Is what Professor Willett is describing desirable, given that it is pie in the sky because of the challenges? What are you doing about it at the Department of Health?

**Chris Wormald:** Obviously, the Government have just made a considerable new investment in social care.

Q170 **Chair:** We know those figures. We are not going to go into the £2 billion that was announced in the Budget. That is a standstill amount anyway, just to be clear, so to do what Professor Willett is describing, which sounds perfect—

**Chris Wormald:** There are two aspects to that: the local discussion aspect through STPs, which we have already discussed, and the questions that we said we would come back to later in the year in the Green Paper about the sustainable model for social care. That cannot just be about the social care bit of the equation; it has to be about how social care works with other services.

Q171 **Chair:** Professor Willett talked about local authorities and health combining their budgets on social care, which is what my borough is trying to do as a pathfinder in its devolution in Hackney. Is what he described something that you strongly support in the Department?

**Chris Wormald:** We certainly want to see that integration in all its forms. We have discussed it previously between hospitals and social care but also in this aspect. I should say that the position that Ms Morris described, in terms of social care knocking off at 5, is not the position across quite a lot of local authorities, and your area is one of them.

**Chair:** Sorry, I didn't hear that.

**Chris Wormald:** It is not correct that across the country social services knock off at 5. I have to dispute that.

Q172 **Chair:** Lots of places do, though. It is not universal that there is provision of care outside of hours—

**Chris Wormald:** There is a large variation in local government, and I would not want that to be the characterisation of all of it.

**Chair:** I do not think Ms Morris was casting aspersions on local government; I think she was talking about the wider system.

Q173 **Anne Marie Morris:** Certainly, my understanding from what I hear from my constituents and health professionals is that in social care, although there is a line and a telephone number, when they ring they get no answer. In theory you are right, and I am sure you are also right that in parts of the country it works well.

**Chris Wormald:** Yes, I wasn't disputing that.

**Anne Marie Morris:** But there are other places where it doesn't. At the moment, there may be a phone number and technical access, but there isn't real access seven days a week to be able to deliver what Professor



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Willett is talking about.

**Chris Wormald:** No, and we have discussed the big variability in social care and what we need to do about it with this Committee before, so I would not dispute that at all.

Q174 **Anne Marie Morris:** Are you conversing with your opposite number in local government to try to make this work together?

**Chris Wormald:** We discuss these issues with DCLG all the time, as you know. At one of the hearings earlier this month we were here together discussing these issues.

Q175 **Chair:** How's it going, getting integration between health and social care? Have we got Manchester coming, or Liverpool or Hackney?

**Chris Wormald:** I don't think a huge amount has happened in the two weeks since that hearing, so I will give you the same answers as then.

Q176 **Chair:** It is always good to get them on the record again, seeing as Professor Willett has laid out nirvana in emergency care.

**Chris Wormald:** As I have said, we have committed to a Green Paper later in the year about the longer term in social care, and clearly variability and integration are key questions that need addressing.

**Chair:** It is interesting that when local government took over public health, they found that because of the challenges of local government, there were a lot of extra costs that they would not have been carrying. It will be quite interesting to see what happens when integration takes place.

**Mr Bacon:** I do not think anybody would be distressed that not a lot has happened in the past two weeks. I am looking at the National Audit Office Report from June 2011, and my concern is that not nearly enough appears to have happened in the past six years. If you look at that report—

**Chair:** Can you give the title of the Report?

Q177 **Mr Bacon:** It is called "Transforming NHS ambulance services", and it was published 10 June 2011, almost six years ago. Among the conclusions, it says: "Performance over the last decade has been driven by response time targets and not outcomes." It says: "There is scope for improved efficiency as evidenced by variations between ambulance services in costs per call, the way resources are deployed to meet demand, the take-up of different approaches to responding to calls and reliance on overtime." It says: "Ambulance services need to take more opportunities to learn from each other." It says: "A lack of alignment of objectives between urgent and emergency care providers, including ambulance services, means that work remains to achieve cost-effective integrated emergency care."

Now, on this Committee I sometimes find that it is quite good to measure things in terms of second world wars—groups of six years. You have had one second world war so far in terms of time since that Report. Although I hear a lot of good stuff going on—it sounds like things are beginning to move and there is this data collection that started 18 months ago—and it



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sounds like you will be in a different position at some point in the future, you are not there yet, and I would like to know when you are going to be there. When can we assume that things will be significantly better? What point in the calendar should be put our finger on? Will it be sometime next year or the year after where we will be able to say, "Basically, we have a good ambulance service across the country"?

**Professor Willett:** What I can say is that with the ambulance response programme, at this stage we have had no safety incidents whatever across the ambulance services piloting it, so we have no reason not to leave it running while we make the decision. The length of time it takes us to put the changes into an ambulance service—the software changes in the computer decision tool and the staff training take about six weeks. If we were to receive the report from Sheffield and the recommendations were accepted and Ministers approved, we would be in a position to be able to roll it out in sequence in ambulance services through before the autumn. We would have the new way of working in before next winter. We cannot do more than one ambulance service at a time, because for resilience in the system we need to ensure that two cannot go down at the same time if there was a problem. We will do that in a staged way.

Q178 **Mr Bacon:** How long does it take to do all 10?

**Professor Willett:** Three are already there and the other seven have got the dispatch and disposition and nature of call elements already in, so for them it is only the code change to move them to the full change. We will have them all done by the early autumn.

**Mr Bacon:** I see.

**Professor Willett:** So we would have all 10 ambulance services there by that stage. That would be our expectation.

**Mr Bacon:** Then it has to bed in.

**Professor Willett:** Well, it's got to bed in, but if there are fleet changes to occur to create the better way of working and skill mix changes to occur, those will clearly take longer, because some of those ambulance services are quite a long way from what is probably the preferred position.

Q179 **Mr Bacon:** Right, so back to my question: when are we going to be able to point our finger to a date in the calendar and say, "By then, we should have a good ambulance service"? That is not a good report that has sort of been implemented but still has to bed in, but a good ambulance service.

**Professor Willett:** Going on the experience we have had with the three ambulance services that had the programme in place through this winter, they have shown better system stability than the others. They were not hit as hard when the surges happened; they rode that better and they held their performance better. If that is what happens in the rest, we would hope to see some of that coming through for next winter.

Q180 **Mr Bacon:** Say we were looking at this in autumn next year. By 2018—to



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give time for the changes to be made and to bed in, maybe it should be in 18 months' time, towards the end of next year—should we expect significant changes?

**Professor Willett:** I would expect the ambulance services to have benefited in terms of efficiency and sustainability, but unless we see the changes in the rest of the services, which they would then have to work with, that will be a limited recovery period. It could be two, three, four years, I don't know, but there will be a period. This is why the ambulance care review is so important now. We have to change the whole system; we cannot just change bits of it, because the rest of the system will negate it.

**Chris Wormald:** I would add only that it is not the case that nothing happened between 2011 and 2015. We have five of the eight clinical outcomes going in the right direction, we have 17.8—

Q181 **Mr Bacon:** No, I don't think you did, but my point was that this sounds horribly familiar and it is six years old.

**Chris Wormald:** I was going to come on to say that it seems to me that 18 months to two years ago, a very significant body of work, which is what has been described today, was begun, which ought to lead to these kind of improvements. I can say this because it was nothing to do with me, I wasn't here.

Q182 **Mr Bacon:** What is slightly surprising is that six years after this Report and four years after what was effectively an emergency debate on 23 June 2013, which happened to relate to the east of England, it took another two years—so four years from this Report—before that significant body of work started. That is what is slightly surprising.

**Chris Wormald:** I am not going to dispute the timeline with you. As I say, an awful lot has happened since then. Was it enough? Well—

Q183 **Chair:** When we make the recommendations after this hearing, we will be looking at those Treasury minutes that you respond to us in with particular interest, so that we can make sure we call you back at the appropriate moment.

**Chris Wormald:** I am sure you will. I too read the 2011 report and it did seem quite familiar.

**Chair:** Sir Amyas Morse.

**Sir Amyas Morse:** No.

**Chair:** No, it's alright. You have obviously satisfied the Comptroller and Auditor General today.

**Sir Amyas Morse:** I would say no more than two years from now, certainly, before looking at it again.

Q184 **Nigel Mills:** One final question. One issue that gets raised by my trust is how it manages staffing and the issue of its staff working overtime for a different trust at a much higher rate and then it having to pay staff from





another trust a much higher rate via locum agencies. Is there any progress on trying to have pooled staffing agencies, so you can try to manage your staff more cost effectively? That way, first, they get a better HR experience, because you know how many hours they are working and what stress they are being exposed to, but secondly, it costs you less.

**Miles Scott:** Rod might comment on particular operational examples of that, but the critical thing is having a consistent approach to paramedic banding. In the last few years we have seen paramedics leapfrogging around looking for the band 6 opportunity. Having a consistent approach to that rolled out in the same way across the country, would be the critical intervention. In terms of a shared bank—Rod?

**Rod Barnes:** I would agree, the banding issue and organisations getting up to full establishment are key. The situation you are describing is a reflection of the shortage of staff in some areas, where organisations are paying a rate that is enough for staff to move quite significant geographies at times to go and work for other trusts. Ambulance trusts cover quite a wide geographic boundary, so perhaps there is not the same opportunity for things such as staff banks as in the acute, where you might have several acute organisations working within a 10 or 20-mile radius. So it is one of the things being looked at. If there is an opportunity, certainly. I described the work of the Northern Alliance earlier. Is there an opportunity to establish a bank? The geography of ambulance services does preclude some of the benefits of that.

Q185 **Chair:** There are some examples in the media of sign-on bonuses of up to £10,000. Do you recognise having to do that in Yorkshire, Mr Barnes?

**Rod Barnes:** It is not something we have done in Yorkshire, but I am aware that services have done it.

**Chair:** South Western Ambulance Trust had 25 unfilled vacancies in January this year, offering up to £10,000 for a qualified paramedic as well as a £2,000 golden hello for relocating and what they described as “a stunning relocation package of up to £8,000”. Mr Scott, is that something that concerns you? It’s just poaching the same staff, as Mr Mills said.

**Miles Scott:** It does not concern me that people are taking recruitment incredibly seriously and looking at what they can do, including recruiting from overseas. By having this much more consistent approach to what we are paying paramedics around the country, we will see movement that is of no benefit to the taxpayer or the patient eliminated.

**Professor Willett:** This is because the paramedic is a very skilled professional now. They are attractive, not just in ambulance services, but in the community—in general practice, and in injury assessments in the insurance market. There are a lot of paramedics, so I think this will remain a risk in the system and we will need to monitor it, because it could represent a threat.





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Q186 **Chair:** Can anyone tell us what a paramedic's starting salary is? Mr Barnes, you are probably the best person to know. I am sorry, I did not mean to put you on the spot—I mean, relative to, say, a nurse or another healthcare practitioner.

**Rod Barnes:** For a band 5 paramedic, mid-point of scale, you would be looking at about £24,000 or £25,000, plus an enhancement for unsocial hours of about £7,500. A band 6 paramedic, again at mid-point, would be earning about £30,000, with an enhancement of about £9,000 for unsocial hours.

Q187 **Chair:** So they are paid more than nurses?

**Professor Willett:** It is on the Agenda for Change. All NHS staff are on the banding structure; it depends where they are on the nursing scale.

Q188 **Chair:** Exactly, and it depends what type of nurse or midwife.

**Miles Scott:** They are now paid at the same level as a staff nurse. After two years of experience, they will move up a band and will then be paid at this new band 6, which is more like a ward sister's salary.

Q189 **Chair:** I am thinking about competition from general practice and so on. I wanted to rattle off a few quick questions before we finish. Can anyone tell us what percentage of time is spent by paramedics, when they are working, on active calls? I think it is quite a high percentage.

**Rod Barnes:** I can quote from my trust. If you averaged it out over seven days a week, 24 hours a day, in an urban area you would be looking at 70% utilisation plus. If you looked at times such as Friday evening, Saturday and Sunday, it would be close to, if not fully, 100% utilisation. It gets lower if you go out into very rural areas. You can sometimes see rates of utilisation at less than 50%. Again, that just reflects the—

**Chair:** Sparsity.

**Rod Barnes:** Yes.

**Chair:** That brings me to an issue raised by Victoria Prentis, the MP for North Oxfordshire. Her local maternity unit is being downgraded. In order to deal with maternity emergencies, they have a static ambulance outside the maternity unit to whisk mothers in great need to the John Radcliffe hospital in Oxford. That means a static ambulance is sat there for, she says, single-figure numbers of women who will need to rush to the hospital, which by car is 90 minutes' travel away—quite a long way away. The static ambulance is a cost, because it cannot apparently be sent off to a road traffic accident or any other emergency in the area. It has to wait there because, obviously, if there is a maternity emergency, it is very urgent that it be dealt with at the time.

Mr Barnes, how would that affect your utilisation figures and your overall budget if you are having to assign an ambulance? Do the other health care providers discuss that properly with an ambulance service if they are making that sort of decision? Is it outside the ambulance service's hands?



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**Rod Barnes:** I can't comment on that particular instance.

Q190 **Chair:** On the general point?

**Rod Barnes:** There are some similar models. A similar situation has been created at one of the hospitals in Yorkshire. The paramedics who are attached to that ambulance support the A&E department when they are not transferring the patients.

Q191 **Chair:** And they are part of the ambulance service?

**Rod Barnes:** They are part of the ambulance service. The ambulance is there, available to move the patient at immediate or very short notice, but the staff are available for use in A&E, and to support the A&E department.

Q192 **Chair:** From your experience, with your national hat on—Ms Morris touched on the connection between all the other health bodies and the ambulance service, and you gave full answers earlier—is that the sort of thing that the rest of the system would discuss when they are downgrading the service or need an ambulance on stand-by?

**Rod Barnes:** Usually at that level, detailed discussions go on with the ambulance service. I would say that the situation is improving through the STP footprint planning. It has been a bit patchy in the past. Sometimes those changes have happened and the ambulance service has been notified fairly late on in the process. One of the areas of improvement that I will be looking for through the STP process is that we are engaged in acute reconfiguration work at a far earlier stage and the implications for the ambulance service are taken into account in developing future plans.

Q193 **Chair:** Where do pregnant women who are in an emergency fit into the banding, Professor Willett?

**Professor Willett:** They are dealt with separately, so they do not come in the same way through that call categorisation; they would be inter-hospital transfers. As for the idea of ambulances being there, many paediatric intensive care units, for example, will have retrieval vehicles that are sat there, just waiting to do the paediatric retrieval.

Q194 **Chair:** So it is not uncommon?

**Professor Willett:** It is not a model that is outwith what is currently part of providing the right service, because critical to these patients is getting them to the right place.

Q195 **Chair:** But in some areas—there is a lot of reconfiguration going on; we have talked a bit about the STPs, and we have done that before—you could have a lot of services where you require static ambulances, because of the downgrading of the emergency services in those facilities. Surely there is a hidden cost to the ambulance service part of the system.

**Professor Willett:** There will be very few instances where you would need to have that; I don't think it is going to be a common problem, where it is part of the provision of service. People seem to think of



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ambulances as something to travel in. Ambulances are actually working environments, so we need to look at them very differently; I spoke about mobile community treatment services. The idea that the ambulance is just a conveyance vehicle is a model that we have to move away from.

Q196 **Chair:** Ultimately, it would be the CCG making the call on something like that.

**Professor Willett:** It would be around the local commissioning that they put around that service. With maternity services, you gave the example of the Horton hospital in Banbury, and there is an example from Yorkshire. It will be part of that commissioning arrangement.

Q197 **Chair:** I do not want to overload this example, but it is a useful example for the general system. If it is 90 minutes—okay, that is by car, not with blues and twos—to the John Radcliffe hospital—

**Professor Willett:** 19 minutes.

**Chair:** 90 minutes.

**Professor Willett:** No. I live in Oxford, and it is 30 minutes for me to drive, and that is not breaking the speed limit.

Q198 **Chair:** Apparently, a test run was done this morning, by car, in normal traffic—not with blues and twos. With blues and twos, you're saying half an hour.

**Professor Willett:** Yes. That is an estimate, but from local knowledge.

Q199 **Chair:** That is quite helpful to know, but is there a point at which the ambulance service can call out and say, "No, that unit"—whether it is a paediatric unit or a maternity unit—"is too far away from the next available facility for it to be safe for us, as an ambulance service"? Who makes the call? Professor Willett, you have very clearly talked about this being clinically led. If it is not clinically safe, would the ambulance service have the power to say to the system—we have talked a lot about this amorphous system today—"It's not going to work"?

**Professor Willett:** I think the arrangements you are talking about are specific individual arrangements where that is there always. It is not about calling an ambulance in, as it would be perhaps when an air ambulance arrives at an hospital. The helicopter arrives, and they have to provide a vehicle to transfer the patient.

Q200 **Chair:** Nevertheless, that is a bit of the system calling on a permanent ambulance, so it is a bit of the ambulance service in that area.

**Professor Willett:** I would expect that to be a separate part of the commissioning; I don't know the details of that.

Q201 **Chair:** But who makes the clinical call? That is really my question.

**Professor Willett:** On whether you need a permanent ambulance?

**Chair:** No, not on whether you need it, but if you have an ambulance



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stationed there, and the ambulance crew regularly find in a situation—whether it is a paediatric service, or whatever it is—that they can't get to the next facility in what they would consider a safe time, because they will have their safe targets, who would make the call? How would you resolve that clash?

**Professor Willett:** That would be between medical directors, through the normal clinical routes that we work in, and the A&E delivery board locally. At the end of the day, patient safety is going to trump everything else.

**Chair:** That is heartening to know. Thank you for clarifying that. Mr Elphicke, briefly, if you can.

Q202 **Charlie Elphicke:** I want to follow up on the example that Victoria Prentis, who is an extremely diligent MP and very hard-working, has been raising in the House of Commons. A woman is in this maternity unit; complications arise, and it is a 30-minute journey to a full crash facilities hospital. How is that safe?

**Professor Willett:** When you say “full crash facilities”—

**Charlie Elphicke:** Well, they'd have to go to John Radcliffe hospital if there are complications—a 30-minute journey. How exactly is that safe?

**Professor Willett:** For major trauma? The ambulance service now moves major trauma patients, who are seriously injured—

Q203 **Charlie Elphicke:** I am talking about a maternity case. I am saying there is a woman who has complications and it is 30 minutes to the John Radcliffe hospital. How is that safe?

**Professor Willett:** It depends what the event is. In terms of managing patients at clinical risk, the initial resuscitation assessment will be undertaken in the hospital, with paramedic support. You would make a critical care transfer, which we do all the time; 30 minutes is not a long journey by ambulance standards—

Q204 **Charlie Elphicke:** In maternity cases? Do you think that's safe?

**Professor Willett:** Yes. Many people travel more than 30 minutes from—

Q205 **Charlie Elphicke:** To be clear, you are saying that in a maternity transfer case, 30 minutes in an ambulance to a hospital with suitable facilities would be clinically safe, in your opinion.

**Professor Willett:** I am not an obstetrician, and I am not going to give a clinical opinion without a lot more detail, but it is all about managing clinical risk. I am assuming that, in this situation, for whatever reason, you may not be able to provide a certain service, as is the case for many small hospitals. The ambulance services and the urgent emergency care services are all about moving patients in critical circumstances to the place most likely to be able to give them the right outcome. If it is maternity, it is the right outcome for mother and child. That is what the services are designed to do, that is what we practice, and that is what the ambulance services are all about.

Q206 **Charlie Elphicke:** And if you came across a situation like this that you and NHS England considered to be unsafe, what supervisory powers do you have to intervene?

**Professor Willett:** NHS Improvement would be involved in looking at it, as would the Care Quality Commission, in terms of safety issues. The whole of urgent emergency care is about managing risk. What is important is that you assess and understand the risk, and put in place appropriate provision to deal with the risk. If that is an ambulance that is static, that can move the patient very rapidly to a high-tech obstetric unit, then that is the right mitigation. Many people live more 30 minutes' drive from healthcare facilities, so this is all about managing risk; that is what ambulance services and ambulance service control do all the time, and that is what clinicians do. As a trauma surgeon, every day in A&E, I will be assessing patient risk and doing the right thing for the patients.

Q207 **Chair:** Thank you. Ms Prentis will be able to take that up beyond this Committee, but it was a useful example.

I wanted to touch on the use of private ambulances. Obviously, this is one option to fill the gap, if you can't recruit and you are looking to reconfigure the system. I don't know who takes responsibility for overseeing whether this is working, and whether the private ambulances are of good enough quality. Presumably, Mr Barnes, it is largely down to you as an individual trust, if you commission private ambulances, to be sure that they are good enough to do the job.

**Rod Barnes:** That is correct. There is a stringent governance process that, again, is clinically led. Services are assessed before they come on to a contract framework within the organisation, and need to pass quality standards that are aligned to the quality standards that we would go through as an organisation.

Going forward—I won't go into this in too much detail—the CQC intends to expand the inspection regime to cover private ambulance services as well. That will help, but you are right to say that no service really wants to be in the situation of relying heavily on private sector provision. They prefer to have the right establishments.

Q208 **Chair:** Does the private sector employ NHS-trained paramedics?

**Rod Barnes:** Yes. They certainly employ a number of paramedics who have worked in the NHS.

Q209 **Chair:** Do they pay what they want? Presumably, they are not tied to the banding that you are tied to.

**Rod Barnes:** No.

Q210 **Chair:** Do they outbid the NHS?

**Rod Barnes:** In terms of level of pay, I don't know in detail. I have heard a mixed picture.



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**Chris Wormald:** To clarify, I think the CQC has already carried out a number of inspections on private ambulances and is planning to publish a number shortly. It is an ongoing thing.

Q211 **Chair:** One example, as you mention it, was the private ambulance service in Basildon, Essex, which the BBC reported on in January this year. The CQC inspected it in August last year, and concluded that many concerns raised by staff were unsubstantiated, but it did find poor standards in infection control, which is pretty serious, and staff not being given enough time off between shifts. It is quite right that it is being inspected by the CQC. Mr Barnes, presumably your preference would be that you manage your ambulances and your staff, and that you have an overall picture.

**Rod Barnes:** That is correct.

Q212 **Chair:** Another thing that came up in one of our previous hearings was about Airwave, the emergency services network. Mr Wormald, this is obviously going to affect all ambulance staff as well. Who is liaising with the Home Office to make sure that all the ambulance trusts are happy? Is that you, Mr Barnes? I am not sure who is leading on this.

**Chris Wormald:** For the Department, it is David Williams, who I think came to the Airwave hearing with Mark Sedwill.

Q213 **Chair:** Yes. So Mr Williams is the lead for the Department of Health?

**Chris Wormald:** He is the lead from the Department.

Q214 **Chair:** My question to Mr Barnes, as the operation lead on the panel, is this: are you happy that the emergency services network roll-out is going well, and are you content that you and your colleagues will be signing up to it on the timetable outlined by the Home Office?

**Rod Barnes:** I am aware that there are some delays and we are fairly late, and we are at the end of the programme of implementation. I understand that it is progressing reasonably well, yes.

Q215 **Chair:** Do you worry about it at all, or are you confident that it is all going to deliver on time?

**Rod Barnes:** I wouldn't say that it is in my top three.

Q216 **Chair:** Not your top three worries. I guess when you have a list of worries, that is not saying a great deal. This brings me to my final question to Professor Willett: what two or three things keep you awake at night in these major changes that are going through, and in the day-to-day running of the system?

**Professor Willett:** Workforce morale. The NHS is entirely dependent on it.

**Chair:** Quick-fire.

**Professor Willett:** Workforce morale and, in terms of urgent emergency care and ambulances, the hospital turnaround.





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**Chris Wormald:** I worry about whatever my clinical friends tell me to worry about, so I will go with Mr Willett.

Q217 **Chair:** So we are not worried about money at all?

**Chris Wormald:** I always worry about money. On ambulances specifically, it does seem to be the workforce questions that are at the heart of everything—workforce and leadership questions. That is what comes out when you read through these things.

Q218 **Chair:** It is back to workforce planning, one of our regular issues.

**Rod Barnes:** There is certainly more that we need to do for staff welfare and for the most severe cases of stress and post-traumatic stress. I still worry about the response times, particularly for lower priority patients, and the amount of time being taken, particularly at times of peak demand. That ties into some of the overall capacity challenges for issues such as hospital turnarounds and where there are unplanned acute reconfigurations. That can sometimes leave shortages of ambulances in particular areas, which, again, sometimes poses risks for patients.

**Miles Scott:** So as not to repeat my colleagues, the other thing I would add is the emphasis on the improvements in both primary care and in community and out-of-hospital care. We have seen the ambulance services rise really well to the challenges they face. There is a lot of change to come for them. Their ability to perform will be overwhelmed if we don't also manage to see the improvements in the rest of the urgent and emergency care system.

Q219 **Chair:** We talked about the wider emergency care system and first responders. Mr Wormald, please deflect this elsewhere if it is not for you, but we have already seen fire services move to the Home Office, which obviously also deals with the police. In other countries, you have a combined emergency services response. Is combining the emergency services in any combination something that has been thought about at all, even in relation to back-room operations, for the ambulance services?

**Chris Wormald:** For all the reasons that have been discussed in this hearing, the integration of the ambulance service with the rest of the health service, which is where most of the key issues arise—

**Chair:** Particularly blue-light services.

**Chris Wormald:** Clearly, they do have to work with the other blue light services, and we need good co-operation between them. What has come out in this hearing is the integration of primary care with ambulances and with hospitals. That is the key set of issues.

Q220 **Chair:** Mr Barnes, what do your colleagues think about it? Is the idea of joining forces with the fire services, as they do in Denmark and other countries, something that crops up in conversation?





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**Rod Barnes:** Less so recently. Our joint working with the police and the fire services is less than 10% of the total number of patients that we see, versus the partnership working with other parts of the health system.

Q221 **Chair:** So you are keen to get the health partnership up.

**Rod Barnes:** Yes. I think we have a very strong track record of working with the emergency services through first responder schemes and in other areas. Having seen tri-service centres in operation, the benefits of those are pretty marginal. Those general efficiencies can be gained through closer working, rather than structural changing.

**Chair:** Thank you both for reiterating that point. Thank you all for your time. I am sorry this went on for longer than we expected; that is because we have such passionate interest from colleagues around the House, not just in this Committee Room. I have had a lot of contact from colleagues, and I could have given you examples from around the country, but you have been spared that. They are serious points, and we all know that this is a vital first response for so many people in critical ill-health.

The difference made by the staff who work for you, Mr Barnes, and those around the country, is very much appreciated. I am heartened, but also slightly dismayed, that you are talking about staff morale, because it is a sign of the stresses on the system. It is good that management recognise that and have said that so publicly. On behalf of the Committee, could I thank all those ambulance crew who work 24 hours a day, 7 days a week, to keep us safe? Thank you very much indeed.