NHS Providers 2022 – Written evidence (AES0027)

House of Lords Public Services Committee's inquiry into access to emergency services

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Overview

1. **Demand for NHS urgent and emergency care (UEC) services has increased considerably over the last decade**. On average there has been a 2%[1] annual growth for A&E services but demand for ambulance services has risen sharply, by over a third, since before the pandemic, including a 25% jump in the most severe, emergency 999 call outs[2] and growth in demand for a broader range of urgent care. Recent documented pressure across UEC pathways, particularly long handover delays, overcrowding in A&E and long waits to be seen are a result of system-wide pressures. The Care Quality Commission recently (CQC) published its annual assessment of health and care services[3], pointing to a 'gridlocked' system with pressures building in emergency departments as hospitals struggle to discharge people back into the community. Covid-19 surges also continue to impact services with increasing hospital activity following spikes in community prevalence.

2. **It is important to recognise that ambulance services are embedded in the NHS as an 'integrator', a mobile healthcare**

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

[2] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/

[3] https://www.cqc.org.uk/publication/state-care-202122

provider, and a highly respected emergency response service. Call centres already include multi disciplinary teams including midwives, community specialists, mental health specialists, consultants, and sometimes colleagues from other blue light services such as the police to offer supervision and advice and ensure patients are referred to the most appropriate service to meet their needs. Only 52.1% of ambulance calls involve conveyance to hospital, with 32.1% patients cared for via 'see and treat' at the scene and 10.9% 'hear and treat'. Given the growth in a range of demand for urgent care, which could include patients in mental health crisis, cohorts of patients such as older people (in some circumstances) and people who have fallen, we expect to see integration with 111 services (and out of hours primary care), the growth of mental health pathways (including dispatch cars including a mental health specialist) and urgent community response teams hosted by community providers, working in close partnership with ambulance trust colleagues.

3. **Boosting staff numbers, and improving workforce planning nationally, is key if the NHS is to reduce A&E and ambulance waiting times, and treatment backlogs.** Since last year, the total number of full-time equivalent vacancies across the NHS has risen by 34%, reaching an all-time high of 132,139. That means that nearly one in ten posts are vacant in England, and one in eight posts are vacant in London. Considerable variation in vacancy rates exists across the ten ambulance trusts in England, ranging from a low of 0.3% to 12%.

4. This situation has developed in large part due to the lack of a funded, nationally led, workforce plan to ensure a pipeline of newly trained doctors, paramedics, nurses and other health and care professionals. To address these challenges, we believe the government should commission a fully funded long term workforce plan that sets out the necessary future shape and size of the health and care workforce, as well as addressing the fundamental issues of appropriate pay, terms and conditions.

5. **More capital investment is critically important to improve capacity and resilience across UEC pathways**. Ensuring that all sectors, including ambulance trusts and those that deliver

emergency care have access to the capital they need is vital. Expanding the acute and mental health bed base is crucial to ensuring there is enough UEC capacity, particularly across winter. In the ambulance sector, capital funding is vital to improving fleet stocks and ensuring the provision of the right type of ambulance vehicles to support those in mental health crisis.

6. Capital investment, and staffing numbers, are also critical in maintaining the bed base. The NHS operates with fewer beds per head of population, and higher occupancy rates than comparable OECD countries. The Health Foundation estimate that an additional 23,000 to 39,000 beds would be needed in 2030/31 to deliver 2018/19 rates of care.[4]
7. **Putting social care on a sustainable footing would give the NHS the best possible chance of clearing the care backlog, and improving handover delays, by ensuring people can return home or to community settings in a timely way after a stay in hospital** – and therefore improving patient 'flow' from the front door of A&E right through to well managed discharge. UEC services have been facing significant pressures due to a number of issues which include the knock-on impact of pressured primary and social care services. The ambulance sector plays a crucial role in working with system partners, including social care, to avoid patients being sent to hospital when it is not the best care setting for their needs, but without social care reform and sustainable funding in place, the health and care system will continue to face extreme pressure.

The situation – challenges and demand for emergency services

8. The pressures currently facing the NHS can be traced back over the last decade as the result of five long-term fault lines, all of which have been exacerbated by the pandemic: the longest and deepest financial squeeze in NHS history[5]; a growing mismatch in capacity and demand resulting in pressure on national, performance standards; staff vacancies and the need for better workforce planning; an underfunded social care system in need of reform; and

[4] https://www.health.org.uk/publications/reports/how-many-beds-will-the-nhs-need-over-the-coming-decade

[5] https://www.health.org.uk/publications/long-reads/health-and-social-care-funding

a health system which is designed around treatment of patients, rather than prevention and early intervention.

9. In the 2010s the NHS went through the most prolonged financial squeeze in its history. The average annual increase in funding for healthcare between 1949/50 and 2019/20 was 3.7%. However, between 2009/10 and 2019/20, the average real-terms growth in the UK government's health spending was 1.6%. Coupled with a lack of future planning nationally, this has led to workforce shortages, under-investment in a deteriorating NHS estate and a growing mismatch between capacity and patient needs. This meant that the NHS entered the pandemic with limited resilience.

10. Demand is increasing across all services, with an elective waiting list of over 7m[6], mental health services in contact with record breaking numbers of service users this year[7], and a backlog of care in the community sector of around 1m people including children[8]. Primary care services are also under pressure, with fewer GPs seeing more patients than pre-pandemic[9]. Local authority budgets have been badly squeezed and the pressures on social care are also biting. In this context it is all the more likely that individuals may reach crisis and need emergency attention, perhaps because alternative pathways are not available or perhaps exacerbated by the experience of the pandemic if they could not, or chose not, to access more preventative support and treatment at an earlier stage.

11. Demand for urgent and emergency care services has increased over the last decade. Between 2012 and 2020 annual A&E attendances increased by 15% - on average 2% per year[10]. However the demand for ambulance services has increased very significantly by around a third since before the pandemic and handover delays have increased to levels never seen before. This includes a leap up in demand for category one calls. Since the pandemic, handovers of

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[6] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2022-23/

[7] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-july-provisional-august-2022

[8] https://digital.nhs.uk/data-and-information/publications/statistical/community-services-statistics-for-children-young-people-and-adults/july-2022

[9] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-august-2022

[10] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

more than 60 minutes have risen dramatically – from 6,000 in August 2019 to 42,000 in August this year. The Association of Ambulance Chief Executives (AACE) estimate that the number of patients experiencing potential harm as a result of long handover delays remains high at around 35,000; with just under 4,000 patients potentially experienced severe harm. No trust leaders find this acceptable.

12. Ambulance services have historically been under-funded[11], with financial settlements failing to keep up with ever-increasing activity. The mismatch between demand and capacity throughout the UEC system, reflects system wide pressures, and has an impact on patient flow, patient experience and safety across systems where we are seeing long handover delays.

13. One of the solutions to these system wide pressures is greater investment to place the social care sector on a more sustainable footing. Inadequate provision of at home and social care services often results in medically fit patients finding themselves unable to be discharged from hospital due to the absence of care packages[12], therefore disrupting flow through the system and contributing to some of the challenges we are seeing with regard to ambulance handover delays. At the same time as responding to higher than average urgent and emergency demand, trusts are also working hard to prioritise care backlogs across all sectors, striving to meet the targets set out in the elective recovery plan to reduce long waits for planned care such as diagnostics, operations and outpatient appointments and to tackle long waits for mental health and community services.

Governance and leadership

14. Trust boards are legally accountable for the care they deliver and have the autonomy to make decisions about the way services are run and patients are cared for. However, there are a number of important factors which lie outside of the full control of any individual trust but have an impact on patient care. These include

[11] https://nhsproviders.org/media/690526/securing-the-right-support-for-ambulance-services-november-2020.pdf

[12] https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-discharge-data/

workforce planning, the rising cost of living (including inflationary pressures), access to capital funding and reform of social care. We would urge the government to work with leaders in the health sector to address these challenges.

15. Frontline staff in the ambulance sector, in particular paramedics, work autonomously to make clinical decisions and are responsible for patients in their care at all times. Due to the nature of the role (working in small teams, carrying out their shifts over a number of hours in many different locations) this level of autonomy is necessary and vital to ensure the best care for patients. Within agreed clinical guidelines, call handlers also carry considerable responsibility in discharging their duties, for very modest pay.

16. National bodies have a key role to play in establishing a national policy framework and setting regulation as well as national standards, targets and response times for the emergency services. The recent Health and Care Act put integrated care systems (ICSs) on a statutory footing, strengthening the foundations for integrated working. Ambulance trusts are already engaged in system working to varying degrees, and all are keen to realise the full value of their contribution in integrated UEC provision and population health management. It should be acknowledged, however, that this statutory change also presents challenges for ambulance services due to the fact that they operate on a large geographical footprint and will span multiple ICSs.

17. Both the Care Quality Commission (CQC) and NHS England (NHSE) have recently updated their regulatory frameworks to signal a shift in approach in line with the move to system working. In a recent survey we found that trusts expressed strong support for the policy direction being taken by regulators. An overwhelming majority supported CQC's planned shift towards a more risk-based approach, data monitoring, and its intention to update ratings more frequently. Similarly, a large majority of trusts were supportive of the collaboration and system focus seen in NHSE's new system oversight framework (SOF) and its oversight metrics.[13] The majority of ambulance trust leaders thought NHSE had a good understanding

[13] https://nhsproviders.org/regulation-reform-and-services-under-pressure

of the pressures they are facing and that regulators were mindful of Covid-19 pressures.

18. However, despite being supportive of the direction of travel, trusts do not yet report experiencing the benefits of this shift in practice. Overall, our survey showed that trust leaders reported an increase in the regulatory burden and the number of ad-hoc requests from regulators over the past year.

19. Furthermore, during a time of extreme operational pressure, the regulatory framework drives certain behaviours that seem at odds with managing risk across systems and not at a service level. For example, an acute trust may be criticised for overcrowding of patients or unsafe staffing levels in an emergency department, and ambulance trusts doubtless feel under pressure to help resolve handover delays, when the solutions to these challenges lie in system working and are not entirely within the gift of any one partner to resolve.

20. Finally there is a need for professional regulation to 'keep pace' with the development of new and blended roles – for example across community and social care settings, or to facilitate the development of multi disciplinary teams within an ambulance trust setting.

Innovation to secure better outcomes for patients

21. Improving outcomes for service users and working to share best practice across the system is vital. Ambulance services have a unique role to play in improving patient experience and transforming services and are well placed to identify people who would not otherwise be engaged with the wider health system. For example, ambulance staff are able to speak to people in their own environment when they are most in need of help and can signpost people to parts of the health system where patients will get the right help for their individual needs.

22. A recent case study[14] published by NHS Providers explains how one ambulance trust worked to reduce the number of alcohol related

[14] https://nhsproviders.org/providers-deliver-new-roles-in-prevention/yorkshire-ambulance-service-nhs-trust

falls and injuries. By intervening at an early stage and asking patients if they would like to seek help for their alcohol dependence, staff have been able to signpost people to the right services. In another ambulance trust, a team of community specialist paramedics was developed to work alongside senior clinicians to manage community pathways. The trust also developed social prescribing referral pathways in partnership with primary care networks and voluntary, community and social enterprise providers. By referring patients to these pathways, clinicians are able to support those patients who, following assessment, have been identified as having low acuity health needs or long-term conditions that need further management by primary care.

23. Access to capital investment for ambulance trusts and those that provide emergency care to deliver innovative ways of working is key. One example[15] of where strategic capital investment has helped in reducing admissions to accident and emergency is demonstrated through the use of a mental health response car. This allows trained mental health professionals to treat patients with specific mental health needs from the outset, reducing demand on the system, and preventing unnecessary visits to A&E. This initiative not only helps to improve care for patients but also helps reduce flow through the system and frees up time for paramedics.

24. These case studies underline the findings of the 2018 Carter review of operational productivity and performance in ambulance trusts[16], which highlighted the instrumental role played by ambulance services in delivering care closer to home and reducing unnecessary pressures on hospitals.

25. The introduction of ICSs presents a real opportunity for ambulance services to drive forward collaboration and to improve cross sector working with partners. Ambulance trusts are well-placed to participate in, and lead, provider collaboratives at system level where it makes sense to do so. Trusts have highlighted the benefits

[15] https://nhsproviders.org/news-blogs/blogs/the-introduction-of-a-mental-health-car-helped-us-reduce-ae-admissions

[16] https://www.england.nhs.uk/wp-content/uploads/2019/09/Operational_productivity_and_performance_NHS_Ambulance_Trusts_final.pdf

of provider collaboration and partnership working as particularly relevant for the ambulance sector, where demand can be so significantly impacted by wider system issues. Ambulance trusts are already engaged in system working to varying degrees, and all are keen to realise the full value of their contribution in UEC provision and population health management.

26. Ambulance trusts are also using "hear and treat" (dealing with cases on the phone when possible) and "see and treat" (care delivered at the scene) response models, which are key to keeping people out of hospital wherever possible – this was particularly relevant during the height of the pandemic. Figures show that 10.9% of patients are managed through "hear and treat", 32.1% are managed on scene and referred or discharged and only 52.1% are conveyed to hospital. These response models are playing a vital role in reducing unnecessary hospital admissions and attendances.

Conclusion

27. Ambulance services are uniquely placed to play a key role in the integration of services and their innovative work is vital to help address rising demand across the system. However, ambulance and UEC services are facing unprecedented challenges including financial pressures, a mismatch in capacity and demand, growing staff vacancies, government's failure to truly address the issues facing social care and, a lack of attention on prevention and early intervention. It is key for the future of ambulance and emergency services that these issues are addressed in order to ensure patients receive the care they deserve.

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