Appendix 1

Health and Public Services Committee

17 March 2011

Transcript of Item 4: London Ambulance Service

James Cleverly (Chair): Good morning everyone and thank you for coming. Today's meeting is split into two parts: the main part of the meeting will focus on the role of funding, governance and pressures on the London Ambulance Service (LAS). The second part of the meeting will focus on commissioning, the opportunities and risks. Richard [Webber], would you mind setting the scene and giving us a brief overview on the current structure and functions of the LAS?

Richard Webber (Director of Operations, London Ambulance Service): Thank you for inviting me today. I would like to say I am very grateful for the opportunity you have given me to give a brief overview of the London Ambulance Service.

The LAS does strive, as we know, to provide excellent patient care to the users of the service. We are particularly proud of significant, recent, achievements across several areas. In terms of trauma care for patients in London, we now take all critically injured patients directly to one of four specialist centres in London: that has been live since last April. It relates to about ten patients a week, and we have found that the average journey time for that is about 14 minutes. We can evidence, working together with other partners that 37 more patients have survived as a direct result of the implementation of the changes.

In terms of heart attacks, we have changed the way patient care is delivered in London for heart attack patients. For the last five years we have not taken patients to the local casualty department; we have taken them to one of eight specialist heart attack centres providing specialist care: we are the only area in the UK to do this across the entire area. This, again, has led to significant improvements in survivability, a reduction in the length of stay for patients, and improved health for patients.

Stroke care has, again, been an area of notable success and the changes were only implemented last June. The changes have meant that, all patients who suffer a stroke are now conveyed directly to a specialist stroke centre. Again, we are seeing significant improvement and patients are now being discharged with very limited loss of function compared to previously.

Cardiac arrest is probably one of the biggest success rates that we can talk about: in the last four years the survival rate for cardiac arrest out of hospital has doubled in London, which is quite a sizeable achievement! Our success rate now sits at just over 21.5% on an internationally recognised benchmarking system, and that is one of the highest in England.

In terms of performance and financial targets last year, the LAS received 1.5 million 999 calls and we answered them in an average time of four seconds. Those calls are all taken in one control centre based at our headquarters, which is the largest control centre in Europe, and has efficiencies by size and scale.

In terms of quality, the control centre was awarded the Cabinet Office Customer Excellence Award last year and was also nominated for the European Control Centre of the Year Award last November.

Of those 1.5 million calls that we took last year, we responded to just over one million of those with an ambulance, car, motorcycle or cycle. Our calls are categorised in terms of Category A, B and C - Category A being those suffering from a potentially life threatening condition. We are obliged to arrive on the scene of those calls within eight minutes of answering the telephone. We are very proud to say, we have achieved the national standards for the last eight years and, despite probably the worst winter in decades, we are on target to achieve that again this year.

As a result of increased investment in the LAS which has been a point made by our commissioners - and we are very grateful for the additional investment - last year we responded to 68,000 more Londoners within the national contract times than we did the year before.

In terms of financial management, we have achieved a financial balance for the last six years and we have been rated as excellent on our financial management for the last two years by the Audit Commission - again, another external body: that is the highest rating of any ambulance service in the country.

In terms of value for money - and value for money is particularly pertinent at the moment - in and healthcare costs in London, the average cost per head of population is £1,500. Out of that £1,500 the LAS receives £30 per head of population. When you compare those figures to the Fire Service, which run at a cost of £50 per head of population and then the Metropolitan Police Service at £400 per head of population, by comparison that does represent value for money.

In terms of value for money, we have 3,000 operational staff and we take 1.5 million calls a year. If you work that out at £30 a head that is one in seven of the London population, on average, using us per year.

There has been much talk about Foundation Trust and Foundation Trust status: we are very keen to progress with that; we believe it has many benefits.

In terms of additional scrutiny, perhaps one of the key points I can bring to your attention is about the Council of Governors. There will be 16 elected public and staff governors and there will be eight partnership governors. Their role will be to hold the Board of Directors to account for the organisation's performance.

In terms of moving forward from here, clearly there are financial challenges and we accept that we need to become more efficient and further improve patient care as well as better manage the ever increasing demand. We firmly believe this is best achieved by the LAS remaining within the National Health Service, and being the mobile arm of health care in the capital. We think it is important that, in order to better manage demand, we need to ensure that patients receive the right care, at the right place, at the right time, and this is most likely to be successfully achieved by working together with other health care providers in London: such health care providers might be, the small number of specialist centres in London, accident and emergency departments or enhanced and improved community based services.

James Cleverly (Chair): Thank you. That has been very, very useful in putting the rest of the conversations we are going to have this morning into context, both in terms of the scale of the financial

challenge and also highlighting the successes. It is very easy at meetings like this sometimes to focus on the difficulties and the challenges rather than the things that are self-evidently going well. If it comes across that sometimes we do not recognise the good work that is done, I apologise in advance and I am glad that you set that record straight.

Andrew Boff (AM): Regarding the performance of the LAS, we are aware that the Category B target is being abolished from next year. Could you explain to us why the Service has failed to meet the Category B response target in recent years?

Richard Webber (Director of Operations, London Ambulance Service): We recognise that Category B is a significant challenge: we focused on the most life threatening patients. We are strongly working towards the changes planned for the future which see Category B replaced by clinical indicators. Those clinical indicators are things like cardiac arrest survival and stroke survival. It would be fair to say, we have put a lot of focus and attention there.

We have seen year on year improvements, but we have also seen year on year increases in demand. This last year has seen an increase in demand, again, above what we had forecast. While we have seen continued improvement, we do accept it is not where it should be.

Andrew Boff (AM): I was one of the prime movers for us doing this piece of scrutiny work. What moved me to really want to see this scrutiny was an impression gained from people within the LAS that, somehow, the determination of what is a Category B and what is a Category A was perhaps not what it could be. If you can, please would you summarise the discretion that takes place at the point of receiving a call and how it is then determined what kind of response the LAS will then make?

Richard Webber (Director of Operations, London Ambulance Service): We use an internationally recognised system called Medical Priority Dispatch System. As soon as the call comes in to the ambulance service control centre a series of standardised questions are asked and we work through quite a detailed process to assess what is wrong with the patient. From the moment we can validate the address the dispatcher, who works in a separate area of the control centre, is able to decide if we have a near resource and what type of call it is (as the call is taken), so we can dispatch very quickly on the most serious calls. It can take two to three minutes on average to completely assess what is wrong with the patient. The system that we use then categorises the call across one of 1,700 different outcome determinants, which then map across to Category A, B and C. It is on that basis that we then determine what resource we send.

Broadly speaking we send a fast response unit - be that a motorcycle or a cycle, which is a good example of what we are doing to improve on carbon reduction. We have 40 or 50 cycles available across London: we use a motorcycle, cycles and fast response cars to provide a very fast response, backed up by an ambulance, for Category A calls. For Category B calls, central London areas may receive a motorcycle or a cycle, but again, broadly speaking, they will receive an ambulance. For Category C calls - we need to determine the timeframe to respond to that, so some of those Category C calls could be a doctor's call for a booked admission to hospital and therefore do not require a blue light ambulance, and then there are various other conditions that fall within that. We do look to sieve the calls quite effectively as early on as possible, and then dispatch according to the end result that we believe is wrong with the patient.

One thing we have done in trying to manage the demand down: is provide increasing amounts of telephone advice. There are some patients who we believe do not need to go to hospital so we put a trained clinician on the line who then speaks to the patient, assesses what is wrong, and then refers the patient to an appropriate care pathway: that could be a referral to their General Practitioner the next day; a couple of days later it could be for the patient to make their own way to a walk in centre; a referral to a minor injuries unit, or it could be the dispatch of an ambulance.

Andrew Boff (AM): You talk about that moment when the decision is taken and the internationally recognised automated system that you use: to what extent does human discretion come into that, because you cannot automate everything can you?

Richard Webber (Director of Operations, London Ambulance Service): We operate London across about 12 different sectors; we have a controller in charge of that sector who ultimately makes the decision, whilst there is still an automated process. If a person, for example, says, they have had a heart attack or they are not breathing that is picked up on the initial call, we recognise that as a serious call and the system, through assessing what is said by the patient, then determines to send the nearest response automatically. We can see a dispatch time of about 20 seconds from when the call is received. Clearly if those key trigger words are not used, we do not automatically send a vehicle and it waits later on: it is down to the dispatcher ultimately to make the decision. If they believe it is an incorrect dispatch decision, they cancel the resource down and wait until further information is available.

Andrew Boff (AM): Reminding ourselves of what the Chair said - because it sounds like we are being terribly critical - why are the response times varied so much between boroughs? Broadly, I can see between the best and worst performing there is a tendency there that the outer London boroughs will be worse performing, and the inner London boroughs will be better performing. I am assuming it has got something to do with distance to travel. Are there any other reasons for the quite substantial variation in response times?

Richard Webber (Director of Operations, London Ambulance Service): We need to put into context the geographical areas. In London our obligation and our funding, and the national standard is to achieve 75% across London as a region. We have never been specifically funded to cover by geographical area. What we do is, review very closely the times; we have a floor which says, we should have no area falling below a certain level. In fact, we have the tightest geographical spread of performance across any region in the UK.

There is a slight performance differential, but if you actually review - and I reviewed it this morning - one of the boroughs that has been picked out previously in south east London, where there have been some performance issues, we do arrive there within nine minutes, not without eight minutes. If you live somewhere like Biggin Hill and look at the reality of it, you might say, is there a big difference between eight minutes and nine minutes and what is reasonable and realistic for us to have the level of availability to be able to respond to those calls? The difference may be 3% or 4% but, in terms of time, instead of responding in eight minutes, it means we respond in nine minutes.

If you look at December 2010, it was probably our most challenging month. You remember the winter, and the fact that it was difficult to get round on the roads. We did not achieve 75% in December 2010. What we did do is, we got to Londoners within ten minutes - in fact it was less than ten minutes - rather than eight minutes. When you consider what the driving conditions were like, that is actually quite an

achievement. That needs to be borne in mind. Whereas, in central London, the density of work and the geography means that you can get through the streets relatively quickly when it compares to the more rural areas where you could have to drive three or four miles.

Andrew Boff (AM): Finally in this section, what do you think the ambulance services can do to improve patient outcomes, rather than just getting to the incident? You have touched on a few of those.

Richard Webber (Director of Operations, London Ambulance Service): There are, broadly, two cohorts of patient: the very seriously ill who need the specialist assessment and treatment, and the less ill who need the appropriate care in the community. I have talked already about cardiac care and stroke care, and how we have made significant inroads there.

What we are doing is we are working very closely through the commissioners and other partners, and we are looking to the future with the GP consortia, to work on how we can improve community services. For example, somebody who falls at home, taking them into hospital is probably not the best outcome for that patient: what they need are good community services. We have agreed through the commissioners in the last year a service for fall patients: we have worked towards having a falls pathway across every borough in London so that falls patient can then be referred to their GP and appropriate community based services to initiate that. It is looking at the two patient groups slightly differently and providing the right care for the right condition.

Navin Shah (Deputy Chair): I generally want to explore whether attendance time performance is poor in outer London boroughs? Is that generally true for the reasons you have stated more or less?

Richard Webber (Director of Operations, London Ambulance Service): No, not in all London outer boroughs. It is not an outer London/inner London split. It depends on geography and other issues out in those boroughs on occasion.

Richard Barnbrook (AM): I would like to come in with an optimistic note on this! It is not directly related to the functions of the ambulance but I have had a bee in my bonnet for some time about the air ambulance in London. I know it is primarily used for trauma but do you see any scope for extending the air ambulance - I know it is a charity at the moment, still associated with the National Health Service - to assist in situations like the poor weather we had during the winter? I know it is not easy to get a helicopter in a snow blizzard but, to assist you, can an air ambulances help in any other way?

Richard Webber (Director of Operations, London Ambulance Service): There are benefits to an air ambulance but we need to look at the geography of London and the ability for us to convey patients to the right centre. We now have four trauma centres in London, whereas we previously took the majority of trauma patients to the Royal London. They are now being spread across other areas.

Perhaps Professor Woollard could add some depth on here. We have to bear in mind that the training paramedics receive is far, far advanced to what it was 10 or 15 years ago and the vast majority of interventions that you might ask a doctor to do at a roadside a paramedic would now routinely do. For example, for a patient who is not breathing, a paramedic would insert a tube into the throat to assist the breathing. If they had an obstructed airway they can, again, insert an airway directly into the trachea of the patient.

The range of drugs given by paramedics now is far more advanced than it was previously. For example, for patients who are diabetics or asthmatics, we have been routinely treating them, for quite some time now, with drugs to reverse those conditions. A patient with an allergic reaction, again, we will treat. The range and types of conditions that we treat out of hospital now with a paramedic is far advanced to what it was 10 or 15 years ago. That is, really what belies the increased survival rates. We have seen that taking the patient to the right place with the right facilities is the benefit. For example, if a patient requires emergency surgery they need that in an operating theatre.

Yes, there are benefits in the air ambulance and, yes, it does assist with saving Londoners' lives but there are other ways that that can be achieved, and it is about us taking the patient to the right place. Professor Woollard can probably add to that.

Richard Barnbrook (AM): Would anybody else like to make comment on the value of the air ambulance?

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): We have got too many air ambulances in the UK, without a doubt. Certainly across the UK there is a danger they will be fitted with air to air missiles, because charities seem to be competing with each other for patients. Again, across the UK - without referring to London specifically - some of the research we have been involved in suggests that patients with very low injury severity scores are being brought into accident and emergency departments - that is to say patients with not very severe injuries and even patients who walk out of the A&E department an hour later. This does suggest they are being over used.

There is a risk in flying in helicopters: I live in Wales and in Wales in one year all five of our police helicopters crashed in one year, one of them twice. You must be very cautious about being glamorised by helicopter air ambulances: they do come with a risk. Further use needs to be very carefully considered. It does have an impact on things like traffic flow and that has an impact on London ambulances dealing with other patients. As I say, be cautious.

I would say all of the issues which were raised you could apply to any other ambulance service in the UK or, indeed, in any developed country in the world: we are seeing very similar issues in most developed countries now.

There is a big problem with the medical priority dispatch system that is being used. Again, across all ambulance services in the UK - this is not a criticism of the LAS. It is not being used for what it was meant to be used for. The medical priority dispatch system that is used for triaging 999 calls, for sorting them into priorities was designed to detect patients by high priority condition, not by low priority condition. The system is quite good at identifying with severe conditions; it is however, very bad at successfully identifying patients with low priority conditions. What that means is that lots of patients who have got relatively minor conditions get triaged as having a high priority condition and when the ambulance crew arrive they say, the patient has been over prioritised.

That is being addressed with the development of a new system called NHS Pathways. We do not know how successful that is going to be yet. It is being piloted in a number of areas: without a doubt, it is going to need to be tweaked as it goes on.

A few years ago Peter Bradley, the Chief Executive of the LAS, wrote a report called *Taking Healthcare to the Patient*. That emphasised the importance of training ambulance staff to be better able to cope with the majority of the patients they saw through the 999 system who actually were the sort of patients you would expect to see in the GP's surgery. The majority of people who dial 999 are the sort of patients you would expect to see in primary care: because either they are not familiar with the primary care services or because they are not familiar with the healthcare system in this country. This could be because: they are immigrants who do not speak the language; because they have not registered with a GP; perhaps they do not feel they can contact their out of hours services; they are worried about waiting for their out of hours service; or just do not want to wait. We live in a society which wants health services now, so they call an ambulance instead. That is by far the majority of the calls that we respond to. 50% of the patients we take to A&E departments are discharged with no significant treatment and no onward referral; that reflects how low acuity our patients are.

Peter Bradley's report recommended that our paramedics receive more training to deal with those types of patients. It made 70 recommendations, and about 65½ of the recommendations were geared in that direction. Unfortunately, one of the recommendations also suggested that the time at which the clock started for responding to 999 calls for recording the response time started a bit earlier, and that was called Call Connect. Up until that point the clock started at the point we had identified the patient's chief complaint, and then we had eight minutes to get to those Category A top priority patients. Peter Bradley's recommendation was that the time should actually start at the point that the phone rang in the 999 ambulance control room.

The reason that he made that recommendation was for fairness. That was already the approach taken by London, but there were a couple of other ambulance services which, to be quite frank, were cheating, and he was trying to eliminate that: it seemed a very appropriate recommendation.

Unfortunately, it turned out to be a perverse incentive. Without realising it, it became such an exacting standard. It cost a minute and a half, and to hit that extra minute and a half was very, very difficult indeed. What it meant was that all ambulance services had to move to something called a front loaded model; so most ambulance services had to put more and more resources into single manned response vehicles. Richard will be able to explain better than I can, if this is what happened in London. I cannot comment on this on a local basis, but it certainly happened across the UK. So more and more resources were taken off of double manned ambulances and put into motorbikes and single manned cars, to get them out so they could stop the clock and meet that target. That meant, they then had to wait for an ambulance to respond and that meant there were less double manned ambulances available to meet the Category B response time target. That is why ambulance services across the country struggled to meet the Category B targets; there was a perverse incentive in meeting that Category B response time target. That happened across the UK.

Andrew Boff (AM): Can I take from what you have just said that, the effect of dispatching to a patient who has been over prioritised - I am trying to get an impression of whether or not that is an impact on the resources of the service to the point where that might affect the Category A?

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): It is, but what I want to emphasise is, it is safe. It is safe. Would you

rather that we accidentally respond too quickly to people who are actually not that sick, rather than respond too slowly to some people who are very sick?

Andrew Boff (AM): I absolutely agree. We would always rather err on the side of the caution. What I am trying to understand is, whether or not by doing so we affect the rest of the service's ability to respond? If that becomes too much, you will have your ambulances addressing over prioritised patients when they should possibly be addressing Category A. That is the impression that I got and I want to be sure.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): No. Let me tell you something extremely radical. There is no evidence whatsoever to support an eight minute or a 19 minute response standard: there is no evidence for either; there is no evidence in the literature whatsoever. The only evidence for any response standard is for a five minute standard and that is for cardiac arrest: we do not have a five minute response time standard.

James Cleverly (Chair): Neil [Kennett-Brown], I would like to tease out your views on this from the commissioners' point of view.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): I want to clarify a point on the air ambulance service: the paramedic input to that is funded; it is funded by the NHS in London, so all the Primary Care Trusts (PCTs) in London do fund that service.

To build on Professor Woollard's point. One of the most important things with the ambulance service is, as the call comes in, we put the resident of London at the centre of this process and we work out what is their need. The current prioritisation system is geared around how quickly we can get there. That is appropriate for the most life threatened calls. Then you have also got NHS Pathways that has been developed. The good news is, it is endorsed by the Royal College of GPs, it has got all the different Royal Colleges involved and it is a changed way of doing the triage process.

To say it is a pilot is probably not quite correct because it has been working in the North East Ambulance Service for the last five years. It is currently being rolled out in North West, South West and South East Ambulance Services in the country. As a commissioner, I am looking for the LAS to move to that system. Not every part of the process is going to go live this year but by the end of 2011/12, the plan is for the core handling part of the process - where you want clinical telephone advice - to use NHS Pathways.

The advantage of that is not just the clinical tool; it is the fact that when you are asking the questions, it then links to a directory of services so you know this is someone who has got a urinary tract infection and they need community support. Then the people in the control room are able to say, "OK. What do we now do? Here is a service. We are in Kensington. That is Dr Stevens' patch." They know what the services are that are available and they can make the appropriate link through to there.

The other advantage is the out-of-hours services and NHS Direct will also be looking to move towards the same system, so everyone will be using the same telephone triage system. It means that, if the public do not understand where to call and they end up calling the out-of-hours service or NHS Direct, but have a life threatening call, they can get the same kind of priority response as if they rang 999. Also, if you have the non urgent calls then they can get dealt with most appropriately.

It is really important overall, as a direction of travel that we, as commissioners in London, are looking to lead on, but also it is work that is happening across the country. There are three national pilots under this banner called 111 which is a new number to try to bring together the non urgent numbers. London is looking to be a pilot for that as well so, during 2011/12 there will be three or four pilots in London that will be going live with that system. Overall, that will really help because it is about using the resources most appropriately.

One of the other approaches that we are looking at in terms of dispatch model is, there are times when you want to send a single responder in a car who has got the advance skills and who can do what they call see and treat. Part of Peter Bradley's report, as Department of Health Ambulance Adviser back in 2005, set out that, quite a lot of things can be resolved through see and treat. You do not have to take the person somewhere else or you can refer on to other services.

The work that Richard [Webber] referred to earlier, about falls patients is an example of that. There are quite a lot of fallers in London who are not injured and they do not need to go to hospital. Part of the process that we put in place this year is a GP referral process: an onward referral to the GP so that the GP knows that their patient, the resident of London, has had a fall; the GP knows about it and they can follow up to make sure the appropriate care is put in place.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): Dealing with a few of these issues. Andrew Boff, you mentioned the issue of outcomes. Outcomes are an area which the Patients' Forum has been very concerned with for a long time. In relation to heart, stroke and trauma, the data about outcomes is improving, but I would say it is very hard to get good data in relation to what the outcomes of emergency care are.

One of the discontinuities which we have often been concerned about is the relationship between the paramedic on the front line and the A&E department. We have often asked for joint clinical meetings between the paramedics and the people in the A&E departments.

One of the issues that we have been concerned about, for example, is that paramedics, generally speaking, do not know the outcome of the care they have provided. We think this is a great weakness in the service and it means that often very little is known about what is happening in relation to the care provided; that is a very important issue.

Another issue which is of great importance is the point you made about before Category 8 and Category 19[1] is interesting. We have always wondered why it is that in the most important cases, the A8 cases, the target is 75% within eight minutes. You would think, if somebody is most critically ill, the target would be 100%. We have never really understood why the target sits at 75%. It seems somewhat irrational to us.

One other thing I want to say at this point is that there often is a big issue that we are concerned about: communications. In the very best case, when somebody communicates with the ambulance service, if they can express themselves or somebody else can express themselves very well and the information is very good, then you get the very best service. We are concerned about, for example, if people do not speak English, if they have learning difficulties or if they have hearing disabilities. There could be all

[1] The aim is to respond to Category A calls within eight minutes and Category B calls within 19 minutes.

sorts of reasons why their communication skills may be hampered in some way, and we wonder whether people who have communication difficulties - perhaps because of illness or the other issues I have outlined - get the same level of service as other people. We have suggested that the emergency operations centre should have much more sophisticated skills to communicate with people who do not speak English or for whom English is not their first language.

Those are some of the issues that have concerned us for some time.

Richard Barnes (AM): Do I get the impression then that you all agree that the change away from a Category B target is welcome?

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): I know you are the expert but let me make a comment! What we are concerned about is that there has been no public exercise - people across London do not know this is happening. It is a technical process as far as the service is concerned, but the public do not know anything about it: it is completely hidden from them.

Richard Barnes (AM): Does that matter?

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): It does because people have a certain expectation of the service.

Richard Barnes (AM): They expect you to be there as soon as they put the phone down.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): Historically, they have understood how the service works and it works very differently. Instead of getting the service they expect they are speaking to somebody on the telephone and it can be very distressing for people because the system does not always work as it should and the pathways which are supposed to be available locally are often not available. For example, when I speak to people in local PCTs or local GPs and say to them, "What about these developing pathways that are going to replace Category B" they say, "Not much happening" --

Richard Barnes (AM): There are 31 PCTs in London. Would you like to indicate one of those which is --

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): The one I work most closely with is Hackney and my conversations in Hackney suggest that the development is very slow. They say, "It's up to the LAS to develop these services".

I think there is confusion, locally, about how to replace Category B effectively. For example, the paramedic is in a situation of thinking, "I've got to get back on the road so shall I take this person to the A&E department and get back on the road or should I try to locate the local pathway where the treatment might be more effective but it's going to take very much longer".

There is a tension there. It is both about whether the alternative pathway is available, how quickly it is available and about the priority to get back and deal with the next person who may have had a heart attack.

Richard Barnes (AM): I understand that roughly 50% of Category B calls are aborted before the response reaches the patient. Is that so?

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): I do not know.

Richard Webber (Director of Operations, London Ambulance Service): To answer that question that refers to the point made before about automated dispatch; we automatically send a vehicle and then review what is wrong with the patient. Whilst often another vehicle may be assigned, that was an initial vehicle assigned and the vehicle was sent on. We do respond to the Category B calls and probably about 70% plus of those patients then get conveyed to hospital.

Richard Barnes (AM): Roughly 30% get aborted then?

Richard Webber (Director of Operations, London Ambulance Service): No, no, the patient may not be there or they may not need to go to hospital.

Richard Barnes (AM): There will be instances where people ring you up to call for an ambulance and then five minutes later, before you have arrived, he has cleared off. They have recognised that there is no need for an ambulance to be there. Does this happen?

Richard Webber (Director of Operations, London Ambulance Service): Yes, it does happen. People are driving down the road, they are not quite sure where they are on some occasions, they see an accident on the other carriageway, they call for an ambulance and then we later on get a call saying there is no accident there.

Richard Barnes (AM): I understand also that at some stage the previous Government fined you £5 million for not reaching your targets. Is that so?

Richard Webber (Director of Operations, London Ambulance Service): That is a question the commissioners could answer.[2]

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): To clarify …?

Richard Barnes (AM): The punishment for not reaching your target was £5 million.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): There is a nationally mandated target in the current 2010/11 contract which is national for both Category A8 achievement in 75 minutes and the Category B19 achievement in 95 minutes. Both of those are set out nationally as a 2% of contract value. The ambulance service contract is roughly £250 million, so that means that the potential penalty is worth £5 million for that.

Richard Barnes (AM): Has the ambulance service in London ever suffered that penalty?

---

[2] Following the meeting, London Ambulance Service confirmed that in 2009/10 it received a net penalty from commissioners of £1.6 million, and for 2010/11 £2.2 million for failing to meet the category B target.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): It has never had to for Category A because it has always achieved Category A performance, and it will again this year. For Category B there has been this year quite a lot of discussion about that penalty and the mitigation against it. We are still in negotiation between the ambulance service and commissioners about that. It is looking like the net impact - because there has been activity growth in year - will be that that penalty will not be applied. We are still in discussions --

Richard Barnes (AM): In negotiation or under the threat. Isn't that a perverse incentive because one assumes that budgets are set accurately in the first place?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): It is interesting. We have reflected on that and we are taking a different approach for our 2011/12 contracts. We have got heads of terms signed for the next financial year which set out a different approach for that.

What as commissioners you have got, and the national direction of travel, is to use the contracts and the performance levers that are available, to ensure that providers deliver the performance that commissioners and Londoners would want. All we are doing is following that national process.

There can be what might be perceived as a perverse process that gets put in place when you apply a penalty at the time that the ambulance service might perceive that they need that funding to deliver the improvement in performance.

Richard Barnes (AM): Do we assume they are at the moment? Just because a lever is there does not make it the right lever or, indeed, justify it.

James Cleverly (Chair): Professor Woollard, I will invite you to speak, then we will have started moving into some of the areas around commissioning which is quite a natural flow: I would like to explore some more things about commissioning.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): If I could briefly go back to our discussion on outcomes so I can reassure you, on this change in Category B performance measures. What we have got now is wrong. It is not in the interests of patients. Getting an ambulance to most people quickly is not in their best interests if that is all we do. For example, stroke patients. Getting an ambulance to them quickly and doing nothing else does not serve them well. We need to make sure we then take them to a stroke unit within the appropriate timeframe, and if we do not measure our performance in doing that then we may well not bother to do that adequately. Getting to a patient with a heart attack on its own is not enough; we need to make sure we take them to a heart attack centre quickly enough.

As I said to you, an eight minute target or a 19 minute target on their own - there is no evidence to support either for any condition. For cardiac arrest victims we should be getting there within five minutes.

In the original questions that were sent to me, the question was asked, "Should the London Fire Brigade have a role in the provision of ambulance services"? The hairs on the back of my neck bristled when I

saw this because, although I am a Professor of Pre-hospital Care, I have been a paramedic for 27 years, and if you cut me through the middle that is what it says; it says paramedic.

I also believe the ambulance service firmly belongs in the NHS, but I am going to be radical now and make a radical suggestion. I read with interest that the London Fire Brigade has 5,600 staff at 112 stations all of whom have been trained to use automated external defibrillators and are equipped with them - all of which have been paid for by the public purse. The London Ambulance Service does at least five times the volume of 999 calls that the London Fire Brigade does and I am absolutely sure that the London Fire Brigade has spare capacity - it spends a large amount of its time in wait mode or in doing non-emergency work such as fire prevention - so if the LAS had access to the London Fire Brigade's resources, its spare capacity, to dispatch to cardiac arrest where it believed the London Fire Brigade was able to reach those patients more quickly than it could until it could back them up with paramedics, I am absolutely sure it could increase the proportion of cardiac arrest victims that could be successfully resuscitated.

I am not suggesting that the LAS should take over the running of the London Fire Brigade and I am not suggesting the London Fire Brigade should take over the running of the LAS, but this is a model which has worked very successfully in parts of the United States when it has been done using this model - not using other models - it has worked very well in Melbourne and Victoria in Australia and it is something which I recommend that you consider. If the London Assembly really wants to apply leverage in supporting the LAS this is something you should consider doing. These are resources you could bring to bear.

Richard Barnes (AM): Professor Woollard, would you be surprised at the ten years I have been trying to get the ambulance service and the fire service operating out of the same base, where the fire service has a proper unit and bays, where you can maintain the ambulance service, but the two services will not agree because of different levels of reward, response, shift patterns - the whole lot? It is a unionised thing that sets its face against it.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): You do not need to do this; I sympathise; I share your frustration. I am a former Deputy Chief Ambulance Officer and in south Wales I finally managed to persuade a local fire station to allow us to site an ambulance in a conveniently located fire station and within two weeks they chucked us out because the ambulance crew kept waking the fire fighters up at night when they went out on emergency calls. There is your problem; we do not need to go that far!

It is morally unacceptable that the public purse has paid for these automated external defibrillators to be on fire appliances and to train fire fighters to use them, and the excuse that they are there just in case firefighters happen to come across a patient in a cardiac arrest in a fire - patients do not have ventricular fibrillation as a result of being burnt in a fire. They do not have ventricular fibrillation as a result of being injured in a road traffic accident - the excuse that it may happen to one of their colleagues - well if their colleagues are having ventricular fibrillation then they need to check their occupational health procedures --

If they are being dispatched by the LAS at the LAS's discretion then they could make a real difference. I suspect they could probably increase the survival from out of hospital cardiac arrest by 50%. The

figures, the LAS is achieving, already, are to be congratulated. They are much better than anywhere else in the UK but that is not an excuse not to improve them further.

James Cleverly (Chair): That is genuinely a fascinating intervention. The words cat and pigeon spring to mind with that. The role of this Committee is sometimes to ask some more challenging questions stimulated by our guests.

We do need to move on. We started to move into some of the implications of commissioning. One of the big high profile changes that is currently being proposed by the Government is the move towards GP commissioning, and I would like to explore the opportunities and risks which a move towards GP commissioning of the ambulance service in London is going to bring about. I would very much like to ask, perhaps as a starting off point, our guests who have, as yet, not had a chance to speak.

Dr Junaid Bajwa (General Practitioner at Conway Medical Centre, Plumstead and Clinical Commissioning Champion, Royal College of GPs): My name is Junaid Bajwa and I am a GP in Greenwich, a resident in Harrow, a Member of the Royal College of GPs (RCGP) London Faculty and I am here representing the Centre for Commissioning.

The RCGP really sees itself as an educationalist, setting standards and, potentially, supporting commissioning in London. Having used the ambulance service as a patient I think it is fantastic; using it as a GP, second to none! My patients' experiences of the LAS have been fantastic as well and I would hope that we would, with our patients, continue to commission excellently in the future.

Whether GP consortia at a local level should be commissioning LAS at a regional level is something of a discussion. There are two ways to think about it. Perhaps it is something that the National Commissioning Board will take on in the future or - which I think Andrew [Steeden] is going to be talking about in a moment - perhaps a leading consortia or a leading commissioning arrangement may exist in the future.

Dr Andrew Steeden (Clinical Director, NHS North West London): My name is Andrew Steeden. I am a GP in Kensington and I am working with Neil [Kennett-Brown] as a clinical director for the lead commissioning sector for London in north west London.

In preparation for GP commissioning, what we are in the process of setting up is something that is going to be a GP led clinical quality group which is going to be working with the LAS, which will have representation from each of the six sectors in London, and each of the GP path finding groups beginning to develop inside the NHS. This will be the first time that we have a forum where GPs will be meeting with the medical directors and medical professionals inside the LAS to scrutinise performance, to develop new care pathways both inside the LAS and in the community as well and, also, where we can do some peer review where maybe the community services need to have particular practices addressed so that they can support the LAS, and where the LAS might fit in in the jigsaw which is developing in the NHS as well.

One of the risks, potentially, that could happen in that transition phase is that GPs are spending a lot of their time at the moment preparing for GP commissioning, which may mean that they do not quite have the focus or the expertise that the PCTs have had up until this stage. That is why in London - and as

regional commissioners - we are hoping to develop this over the next 18 months before GP commissioning starts.

Neil and I are already talking about the possibility of extending this London model to a national model and, as the National Ambulance Commissioning Group is scaled down, we can have a similar GP forum that takes its place nationally.

James Cleverly (Chair): It strikes me that with the GP consortia, their focus falls somewhere between what we in London government would call the local and the sub regional. That is the geographic range that a consortia would realistically look at. Obviously, currently the LAS is geared up to be a regional provider, if you look at London as a governmental region. Currently we are talking about what the implications would be of having a sub regional commissioning model commissioning a regional delivery model. Again, we are drifting into the sacrilegious territory here, but you started it! Do you think there may be an opportunity to move away from the LAS as being a single regional body? What would be the implications of that? If not that, what would be the implications of a commissioning model based around a different sized footprint to the delivery model?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): As Lead Commissioner in London, my team and I are funded by all of the PCTs in London. It is important to note that all PCTs already have professional executive committees that are made up of GPs. To say that we have not had GP involvement in commissioning to date would be incorrect because, actually, all the PCTs have got professional executive committee as part of that. In fact, Andrew Steeden was the Professional Executive Committee Chair for Kensington and Chelsea. It is not like GP input has not been around.

There is a real opportunity with the new arrangements to say where does commissioning sit? A lot of people do not really understand commissioning. I am going to try to do a lecture in commissioning but some people, when they perceive commissioning, they think contract management. A service really can only have one contract in terms of a contract for delivering the ambulance provision for London in the case of the LAS but, within that, there is a lot more to commissioning: the needs assessment for example. What are the needs? In order to do that you need to engage people about saying, what are the needs? In order to do that you need to talk to your local GPs to understand.

There are different needs in different parts of London. There are different demographics, different populations and particular issues that happen in different parts of London. We know that, for example, in the Mayor's Health Inequalities Strategy, there is a lot of work going on around alcohol and things like that. There are some specific issues that you need to say, "What are the needs that the ambulance service needs to respond to?" then you develop your strategy and what your service developments are.

Malcolm was talking about care pathways and, what are the care pathways that are needed? In some parts of London there are specialist knowledge areas that need to be put into place. Some areas in London have much higher incidences of diabetes than others, but it is a common issue. There is a dynamic about understanding what the needs are and then you build that through to your contract, and then you evaluate it. That is my mini what is commissioning.

Then the question is, where do you do commissioning? At what level? You can to it at all levels. There is an element of the ambulance service that needs to be done nationally and there is an emergency

resilience role that the ambulance service provides in terms of the 999 infrastructure that you want to have nationally, and in terms of emergency preparedness. We have got things like hazardous air response teams. The specification for that is set by the Department of Health. It is a national infrastructure requirement to make sure we can have mutual aid support.

Regionally, if we talk on a London level, things like a 111 service, you need to have working across London. You cannot have a different approach in Harrow to Ealing; you want the same approach to be there.

Then you get smaller than that. If you are trying to develop your local pathways and you have got particular chronic conditions that you are looking to develop services for, then you need to make sure that those local pathways will be local; that they will be at a borough level or even smaller than that. Then you can get down to patient specifics; when you get down to patient specific plans people have particular issues and particular care management plans that need to be followed.

When you commission, you need to commission at all those levels. Then the question is where do you want to put your infrastructure around that, to make sure that you have got a body to take it forward. Simon Burns, who is the Health Minister, set out to say that there should be a lead commissioning arrangement for every ambulance service. It is really acknowledged that to have 31 separate contracts for the ambulance service would fragment it. I have had discussions with the British Medical Association, as part of my role within the National Ambulance Commissioners Group, to say, it also does not want to see fragmentation.

What we do want to see is that we can embrace the new policy direction so that we have got a much stronger clinical engagement. Both Andrew [Steeden] and Dr Bajwa helped set out some of those opportunities that we have got.

Dr Andrew Steeden (Clinical Director, NHS North West London): It is the expectation and the hope that although we may have a regional commissioning plan for the LAS as we stand at the moment, we will maintain that sensitivity down to patient level so that the LAS can respond to individual patients' care plans. Certainly in my part of the world in north west London we are piloting that for end of life services, so we are developing the opportunity for patients to have advance care plans which the LAS can have access to, and then can respond appropriately, and not necessarily take people straight to hospital if that is not their wish.

James Cleverly (Chair): We have discussed a lot about patients. I think it is only right to bring Malcolm [Alexander] in at this point.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): First of all I think it is very important that commissioning is done in a way which is unified. There is a profound danger of chaos if it is not done in a very highly organised way. Historically, if you speak to many people locally, the knowledge of the skills of a paramedic, for example, are not very well understood. In fact, I do not think, locally, people often understand very much about how the LAS works.

There is a critical part to commissioning which is often forgotten and that is the role of patients and groups of patients in commissioning. James, you were at a meeting the other night when a group of people from the Sickle Cell Society - and people suffering from Sickle Cell - came along to our meeting

with many experiences of using ambulances over a long period of time. Many issues were brought up about how effectively the ambulance service meets their needs. This is a model which is missing, very often, from commissioning which we have really got to develop. Patient groups understand a great deal about the sort of services they need and trying to communicate that to the commissioners is something which we have really got to build up in the future. It is an essential component of effective commissioning.

Dr Junaid Bajwa (General Practitioner at Conway Medical Centre, Plumstead and Clinical Commissioning Champion, Royal College of GPs): I have to completely agree. Commissioning, historically, has put patients at the end, as a, "Do you agree with this or do you not?'' It is not patient led. Certainly in GP practice we do a lot on patient centred communication and patient centred approaches to developing care pathways. The RCGP, with the Centre for Commissioning, has a patient group representative sitting on it to make sure that, if you are developing a curriculum trying to teach GPs how to commission, you have to have patients at the core of that, and I would have to agree with everything that Malcolm has said on that.

Richard Barnbrook (AM): To what extent do you think GPs should have financial incentives to reduce the number of 999 calls?

Dr Andrew Steeden (Clinical Director, NHS North West London): The anticipation is that where there are inefficiencies in the NHS system, GPs or clinicians involved in commissioning should look at how systems currently work, and try to get as much value for money for Londoners and for taxpayers generally as they can.

I do not think there is any plan that GPs receive direct financial incentives for changing the way that services are going to be working, but there will be services to the whole system as a whole if people use the service better and if the services are more patient centred, so that things are not repeated messages are not lost or inefficiencies where patients transfer from one place of care to another. That is a piece of work that we are doing in preparation for GP commissioning.

You will be aware in the submission that Neil [Kennett-Brown] gave about the quality, innovation, productivity and prevention process which the whole NHS is going through. That is an attempt to try to use the money that is currently being spent in the NHS as efficiently as possible. There are efficiencies that the LAS can make but it can only make it in combination with other services. An integrated urgent care system is something that we are looking at providing.

Richard Barnbrook (AM): You mentioned the 111 number to run parallel with 999. Could you explain further? What would be the purpose of the 111 call number? Is that for the ambulance or for a less emergency case?

Dr Andrew Steeden (Clinical Director, NHS North West London): One of the unforeseen things that happened when we increased access in the NHS is, that the system has become incredibly complex. It is very difficult for people to know where they go with any particular condition. We cannot criticise people for using 999 if it is their default system for their safest port of call. The hope with the 111 number is that if patients or carers have any questions about how to use the NHS system that that will be the place to call, and then they will be directed. It might well be that it is to an LAS service or it might well be to another service that is being developed.

The Directory of Services which will back up 111 will be constantly evolving so the range of services, the care pathways and the units that are delivering care will be changing in different parts of London at different times. The Directory of Services will be a local Directory of Services that the call handlers will have access to.

Richard Barnbrook (AM): I presume there will be massive advertising boards throughout the whole city or nation and on television, "Call 111 if you need advice and it is not a direct emergency". Is that the sort of advertising for this 111 number?

Dr Andrew Steeden (Clinical Director, NHS North West London): I think so.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): Yes! At the moment there are three national pilots that are already live: one in the north east, one in the east midlands and one in the east of England. They have quite a targeted approach because it is not across the country at the moment. The plan with the pilot in London is that it will be targeted communications initially in order to make sure it can be focused, as we are testing the system out. The ambition is that the system is live across London by the end of March 2013. Then there will be some very clear indications about that.

The idea is it is a single non-urgent phone number. You do not have to remember your out of hours GP number. You do not have to remember the NHS Direct number. The idea is to say, "If it's not life threatening, this is the number you can call". I know the single point of access that has been developed in inner north west London, where Andrew works, has already got a system where in hours you can ring the single point of access there and, if you are struggling to get a GP appointment, they can organise a GP appointment for you or suggest which walk in centre would be the most appropriate place for you to go to. It helps prevent and tackles some of the demand issues that happen.

Richard Barnbrook (AM): Thank you for clarifying that. I seem to have drifted off from the initial question relating to commissioning. It asks whether individual consortia should meet the cost of ambulance call outs amongst their patients? I imagine this refers to the fact that each consortium - if it goes in that direction - should cover the cost for the ambulance call out for their patients, thereby trying to educate their patients that if it is not a direct 999 call, "Please listen to my advice during this particular stage. Don't use this unless you really have to". Therefore the burden comes back to the consortium to take responsibility for the costs of the ambulance. Your thoughts on that?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): At the moment there are 31 PCTs in London who will have an allocation for their overall envelope. We take the total £250 million contract and we split it by that PCT's share of the ambulance activity over a three year basis. In London at the moment, it looks like there will be between 40 and 45 GP consortia, so the same principle would be the activity that is generated by that geographic area would be the share of costs that would be borne by that particular consortia.

There is a national move towards what they call payment by results for ambulance services. We are looking at doing some shadowing work for that over the next year to two years just to test it out because, there are potential disincentives and perverse incentives in the way that the system could work,

where additional activity for an ambulance service can mean there is more money. Therefore, potentially, demand management might be mitigated because it might be an incentive to have more activity.

We want to make sure that it is in everyone's interest to manage the demand most appropriately so that the ambulance service is kept for those who absolutely need that service. There is a potential that, in the future, there will be a much more direct relationship between every individual journey and cost. At the moment it is based on an annual allocation.

Richard Barnes (AM): I need two bits of clarification: we have drifted into the 111 system - I presume that is the general telephone number for non-emergency calls within the medical profession - the Mayor has got £6 million and a bit in his budget for a 101 number which is for the police service; how many non emergency numbers do we damn well need?!

Secondly, I want to ask, what you are actually commissioning? I have got some confusion. As a general Londoner I understand you dial 999 to get an emergency response from the ambulance service. You give me the impression that you have not only got this emergency response, whichever category it is, but there is also a pre-booked ambulance taxi service with expensively trained and highly qualified paramedics in them. Am I getting confused here?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): I think there might be an element of confusion. We commission an ambulance service that is very much focused on providing the most appropriate response for the patients' needs. As a commissioner we do not say there will be this proportion of Category A calls or this proportion of Category B calls. What we commission is a service that is appropriate for the needs of the population in London. That involves the call centre staff, the handling and dispatching process and the crews. As you have heard there are over 3,000 of those and we have invested significantly over the last few years in expanding that workforce to meet the growing demands in London.

There is not a taxi service that is put in place. What we have got as part of the --

Richard Barnes (AM): You call it patient transport don't you? A posh name!

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): For clarity, patient transport services are not commissioned as part of my responsibility as Lead Commissioner for the LAS. Currently the LAS has about 15% of the private transport services (PTS) market in London; it is a very competitive market. There are well over ten main providers of PTS services in London. At the moment each acute hospital tends to be the Lead Commissioner for their PTS services and that is for taking in patients for outpatient appointments --

Richard Barnes (AM): Yes, a taxi service.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): Yes, but that service is not part of the £250 million contract that I provide.

Richard Barnes (AM): Would your people be providing it? The 15%?

Richard Webber (Director of Operations, London Ambulance Service): We have a patient transport section in the LAS and we do competitively tender with other trusts. We are only prepared to enter where there is a reasonable quality element so we price our services accordingly; we currently have 15% of that market. It does not have paramedics within it; it has ambulance persons who have a lower level of training, they provide that service. It is not done by the A&E service and it is not part of core contract; it is done by direct contract.

Richard Barnes (AM): It would not have blue lights on the top of the vehicle?

Richard Webber (Director of Operations, London Ambulance Service): Some of the vehicles do, but a very small proportion. The vast majority, as you have described, are patients taken to outpatients' appointments. It is done on a cost per head basis. In many cases, the level of service provided is little more than a taxi service but we look to provide a quality service and, where we have the contracts, that is what we do.

Richard Barnes (AM): Do you regard that as an income stream or a service?

Richard Webber (Director of Operations, London Ambulance Service): In reality it is a service because the income we take from it is very, very small compared to the overall contract. It is probably less than 2% of the LAS income so it is relatively small from our perspective, but it is an important part of the service we provide. Particularly in cases like major incidents, for example, we do use PTS to assist in those cases.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): In terms of penalising the GPs the wicked side of me would say, yes, we should because when I joined the ambulance service as a paramedic in 1983 and the ratio between 999 calls and calls from GPs to take patients into hospital was 50/50. That ratio is now 80/20 in favour of 999 calls. Guess where all the GP calls have gone? They have gone into the 999 service. That is because of the change in GPs' out of hours contracts.

I wish I had you negotiating on behalf of my trade union for my pay rise! That really was an amazing sleight of hand that you pulled off there - and good for you - but it really has changed the face of out of hours care. We have picked up a lot of that workload. It would be quite tempting to punish you for that but, clearly, that would not be fair. Perhaps the solution to that problem is to get a blue police telephone box, jump into it and go back in time and stop that happening.

This rise in demand is also an international phenomenon. It is very much about changing culture and it is about this, "I want care now". The way we use alcohol has also pushed up demand. Clearly we cannot blame GPs for that! Poverty pushes up demand. The care in the community policy has pushed up demand enormously and we have not been able to reverse that policy. Those are all things which have pushed up demand on the ambulance service, enormously.

One of the things we must be very, very careful about is not advertising that people should not use the 999 service; if we do that we will push up demand. If we have big banners up anywhere saying, "Do not dial 999, dial this number instead" people will dial 999 in ever greater numbers. They have tried this in the USA and they very successfully pushed up demand by 10% overnight.

We have successfully done this in the UK as well. A couple of years ago the British Heart Foundation had its chest pain campaign, "If you develop chest pain or if you develop a tight constricting band-like pain around your chest, dial 999". 10% more people dialled 999 for chest pain. Not one iota of them had any more significant cardiac disease. They all had non-significant causes of their chest pain. Let's not do that again!

I have to say I am very concerned about the 111 service. We used to have another service under a different name, just like 111, called NHS Direct. In the ambulance service we call it NHS Redirect because that is what it does. If you ring NHS Direct you get redirected to the ambulance service or the A&E service. 111, to be frank, I do not hold out a lot of hope for, is it going to be very different? It was quite successful at directing people away from general practice but reasonably successful at directing them back towards the ambulance service and emergency departments - not in huge numbers but enough to make a difference. I am a bit concerned.

James Cleverly (Chair): The only reason I am pulling you up is, because I do want to explore in a bit more detail a bit about demand management and that kind of stuff. If I could ask you to hold that thought. I am going to bring Malcolm [Alexander] in quickly and then we are going to quickly nail down a little bit about structure. I want to talk about autonomy and that kind of stuff. I want to finish off all the structural stuff and then move a little bit more into demand management. There are a whole load of things that we could draw out from that.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): Two brief points. One is about the PTS service Which is a service that carries people who are very vulnerable; people who are elderly, frail, people with cancer, strokes and post hospital care: it is a very, very important service. Having trained staff in that service it is very important –

Richard Barnes (AM): I am not knocking it.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): The way you presented it, it was like it was just a taxi service.

Richard Barnes (AM): It was the use of the ambulance vehicles I was implying.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): Fine.
The other point I want to make which is part of this infrastructure problem is about the out of hours services. I sit with a group in east London - it actually covers five boroughs. What is very clear about this out-of-hours service is that, one, the support from medical directors across the five boroughs is very poor - they often do not turn up. Secondly, the default position is, if the out-of-hours service is not working well, send the patient to the A&E department. Getting out of hours services working properly in London is really important to make sure that people do not just say, "We aren't able to cover these shifts so send people off to the A&E department". It is quite a critical piece of the jigsaw.

Navin Shah (Deputy Chair): I have a couple of questions on governance and autonomy. The first one is, given that we have the abolition of NHS London and given that situation, who should be responsible for developing London-wise health strategies on urgent emergency care?

Richard Webber (Director of Operations, London Ambulance Service): That is a good question. One of our concerns is that we are currently the only pan-London provider. We have taken on quite a large role over the last year in coordinating activity across London, such that every hospital now reports into us three times a day on their hospital capacity, the bed capacity and A&E capacity, then we control where patients move. We have brought a system in that allows us to know which ambulance they are coming in.

That is one of our areas of concern because, at the moment, there is the coordination that allows that to happen. That is probably best answered by Neil [Kennett-Brown] on the commissioning side, because clearly that coordination will pick them up. That is probably one of our biggest concerns going into next winter; how does the system get held together more effectively than it has done previously and how do we ensure that these community services do not get withdrawn?

I know we are going to move on to demand management in a minute. We are relying on increasing community services and the risk with the reduced funding is those community services go and what happens is more and more people call us. Perhaps, that is a question for commissioning to answer.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): It is important to note that NHS London has not yet been disestablished --

Navin Shah (Deputy Chair): In the process of, yes.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): -- and the National Commissioning Board is working very closely with NHS London to look at transitional arrangements and to make sure we do not lose some of the benefits we have had with existing structures.

There is something called the GP Commissioning Council which has been set up; it is already running and it has been running for well over six months in London. It is a group of GP leaders representing different GP consortia taking that work forward. It was that group that recently formally endorsed Dr Andrew Steeden's role as Clinical Director in NHS North West London to say, he is the clinical lead for the work with the LAS. It has endorsed the approach of getting other representatives into this new clinical quality group. There are already some structures there in terms of the GP leaders.

The 111 programme is under something called the Improving Unscheduled Care Board programme and there is already a structure to ensure that that work is kept together. Each of the six clusters in London - and London is divided into six - have set out their plans for the next one year as well as the next five years about where they see services going. Those plans have been brought together to create one overall integrated plan. There are some very clear plans and I know some of those plans have been shared with the GLA as well as that.

There is an opportunity to work with the GLA on health improvement and my understanding is there are some discussions underway around a possibility of a Health Improvement Board. There is recognition that the GLA has a remit and role. You already have the role around health inequalities and there may be an opportunity to work closely with the GLA. In our clinical quality group we have a slot where we talk about a public health representative. I would be very keen to explore whether the GLA's public health

lead joins our clinical quality group for the LAS to make sure that there is a way of bringing in the public health input that the GLA has into that.

The other side of things that is important in terms of the NHS London role is currently that it is where emergency planning sits for health. I know there are conversations underway at the moment. I was at a meeting recently with the Department for Health talking about that. Over the next couple of months there will be some clarity about what would be the structure for emergency planning across London. I know there is a very good working relationship already between the ambulance service and others: that needs to be absolutely maintained.

I would say I do not think there would be a risk that everything will disappear. There is an opportunity to bring things together. For the ambulance service there is a challenge that the different GP consortia, as they have a stronger voice than they may believe they have had in the past, may want slightly different services. One of the challenges for the ambulance service is, whilst it may want a lot of things to be pan-London, as a pan-London trust, it may need to adapt slightly differently.

The advantage of the Directory of Services means, if you have a slightly different diabetic pathway in different parts of London, providing it is clear and there is a system that joins the system together, we can make sure that we put the patient at the centre of that.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): I really cannot add anything to that. These are the experts on structure. The thing to avoid is fragmentation, always. My big concern is always change; change is very unsettling. We have too much of it in the NHS.

Richard Barnes (AM): Chair, our health inequalities teeth are pretty limited and pretty dull. If we are going to have a Health Improvement Board which includes the GLA are you suggesting, that also is given teeth so it can make proposals which are seen through, rather than lead by exemplar?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): I might have a personal view that would seem to make sense --

Richard Barnes (AM): I will pretend you are not a politician and then you can tell me!

James Cleverly (Chair): I think that was a complement!

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): There is an opportunity. Whatever we do, we need to remember that there are real people in London who are vulnerable and who have health needs and we need to get those needs better met. If we can get where we have got the lead clinicians who do most of the care - GPs do 80% of the care.

I will just pick up Professor Woollard's point. He mentioned NHS Direct called NHS Redirect. The ambulance service and A&E departments might often think it is that but if you look at the statistics about 80% or 90% of the work is resolved locally by telephone advice. It is important to realise that, we have got to put our residents at the centre of this approach. Whatever we do, whatever structures we

have got in place, it has got to have teeth and it has got to make a difference, otherwise what is the point of it?

Richard Barnes (AM): You would be accountable to it then? You would be prepared to be accountable to this Health Improvement Board?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): It is important to have a relationship with it.

Richard Barnes (AM): That is not quite the same thing. I have heard patient centred care for 20 years I think.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): It is important to note that the NHS policy - which I fully support - is around integrated urgent emergency care, where you join the whole system up. GPs do the majority of all patient care. As we have heard already, over 60% of the ambulance work is not life threatened work; it is actually care that potentially could be delivered by primary care. It is really important that the ambulance service sees its role within the NHS so, whatever the links are with the Health Improvement Board, I would be quite cautious, when we talk about accountability, the ambulance service needs to remain part of the NHS.

Richard Barnes (AM): The last thing the NHS needs is another talking shop.

Richard Barnbrook (AM): Malcolm Alexander, I would like to come back to one of the comments you made earlier. You used the word 'tried'. When talking about excellence and accountability you said you tried to create a communication between the paramedics and the A&E. Could you elaborate a bit further?

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): I did not say we tried. We have been recommending for a number of years. What I described was what we would regard as a discontinuity in terms of this NHS team. One would think that the LAS - which critically and essentially is part of the NHS - must be in there together with the rest of the NHS. You would think that there would be much more joining up between the paramedic and the A&E department.

The evidence is that there is very little at the level of the front line worker. At the level of the paramedic and technician and the A&E team, there is very little joint work going on. The paramedics on the road are moving around. If you have been with paramedics they move around pretty rapidly and it is a fast moving world out there.

The time to reflect, together with colleagues in A&E, about the outcome of their care is something which is really missing. Very often when I speak to paramedics they say they would love to know what happened. Their skill level is extremely high and for a clinician not to know what happens as a result of their care is extremely poor. We have made this point many, many times. The answer comes back to us there just is not time.

You referred to the helicopter service before. If you look at the helicopter service it has these really good team meetings regularly where everybody gets together and says what is the outcome? That is

high level trauma work so it is a bit different. However, for the paramedic to be involved in a process of reflective practice on their work, to see whether what they have done is effective, it is really critically important for their development.

Richard Barnbrook (AM): Paramedics are all professionals and all work to the best of their ability but, when they have done one particular case scenario, maybe slightly different to another one, without feedback coming back they do not know if they are applying the best medication to get the best result at the A&E.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): There is work that goes on within the LAS but what I am talking about is jointly with other NHS clinical staff. That is the critical part which is missing.

Dr Andrew Steeden (Clinical Director, NHS North West London): Who could disagree with that? We are on a pathway across the NHS about integrating services and working less in silos, whether that is community with general practice or paramedics and the LAS or A&E consultants in acute trusts. This idea that we have always worked to increase our performance in these silos is one that is out of date now. Neil has already mentioned the idea that we are developing integrated urgent care services across London which will give us an opportunity to peer review and performance manage each other and capacity manage the whole care pathway to see how we can improve it.

Dr Junaid Bajwa (General Practitioner at Conway Medical Centre, Plumstead and Clinical Commissioning Champion, Royal College of GPs): Outcomes are difficult. Having done A&E as Senior House Officer (SHO) and a Registrar the story for the patient does not end in A&E. Sometimes they are admitted; sometimes they go back to primary care. That dialogue between primary care does not always feed back to LAS as well. Outcomes in health are quite challenging to quantify. Say a patient came in with an MI [Myocardial infarction]. We might get a report, "Patient admitted for a MI into ward ended up being gastroesophageal reflux". That coding system is not completely robust.

I agree that there should be some dialogue and nurturing, but the outcomes bit is difficult from a grass roots level and experiential data.

Navin Shah (Deputy Chair): Richard, in your introduction you mentioned how keen you were to develop a foundation trust. Can you go a bit further and explore the risks and opportunities that will be posed by becoming a foundation trust?

Richard Webber (Director of Operations, London Ambulance Service): There are many benefits of becoming a foundation trust, one of which is financial freedom. We talked before about the financial position. For example, at the moment, we have a one year contract which we negotiate; we are still discussing what we are going to do next year, we still have not quite finalised it. This allows us to have more long term planning and it allows us to borrow money over a long term period.

The other thing is it allows us to better reinvest in our services. At the moment every year we are obliged to report a surplus and that can be of the order of £500,000 or £1 million. Whether there is or there is not a penalty applied at the end of the year, we then hand back any surplus. It is quite difficult to bring it exactly on budget but we do hand that money back.

What it means as a Foundation Trust is, you maintain any surplus - and we have had a minor surplus for the last five years - and that then goes back into patient care for the next year and is reinvested to improve the service: it gives a much greater stability.

We also move performance to public accountability where we have this Board of Governors. We end up with - and I think I quoted the figures before - a total of 24 Governors, six of them elected from public and staff. That gives them on the Board of Governors and they hold the Board Directors to account. There are eight Partnership Governors from other agencies we work with. We certainly see PCT, GP commissioning and one of the GLA being on that Board of Governors, which will give increasing public scrutiny.

Navin Shah (Deputy Chair): Any dangers or challenges that this might give you? Do you see any drawbacks?

Richard Webber (Director of Operations, London Ambulance Service): I do not see any specific drawbacks; it gives us more control over things. It has allowed us to much better plan for the future. One of the difficulties we currently face is, the financial position going forward. One of the points made before about involvement in integrated and urgent care was that there are some assumptions around what will happen in the future, around funding. That is a risk but I do not think that is directly a risk as a result of foundation trust.

Navin Shah (Deputy Chair): Is there any danger of some kind of disconnect with the rest of the National Health Service?

Richard Webber (Director of Operations, London Ambulance Service): No, I do not think there is.

Navin Shah (Deputy Chair): What about competition which is being promoted? Would that also hamper in any way what you are providing, or might it revitalise?

Richard Webber (Director of Operations, London Ambulance Service): Competition is exactly the right thing, and it is healthy. We need to be careful that we do not have competition for competition's sake but there are many benefits from that. Neil [Kennett-Brown] talked earlier on about payment by results. Clearly I would welcome payment by results because I talked before about getting £30 per head of population. That is less than all the Trusts around London get paid. Our neighbours earn more per head than we do despite the fact we are in London, with all the issues that London brings. We have the Royal Wedding coming up, for example. All those things we have to pick up within our common baseline; we do not have the ability for additional funding. I think, under payment by results we would have an ability to go to various groups to seek out that funding.

From where we are now, I do believe we provide a very cost efficient service. We need to open ourselves up to more scrutiny,- we compared the figures to other emergency services and I think we are quite lean and quite good value for money- If anything, I would welcome that.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): Overall the national policy direction is very much for all providers to become foundation trusts. I have been working with the LAS over the last 18 months since I

have been in post. One of the main projects has been the foundation trust process, and the LAS is hoping to become a foundation trust by the end of this calendar year.

From what I have observed the process of becoming a foundation trust is extremely helpful, because it requires the organisation to demonstrate its financial robustness and making sure that the strategy is aligned. For myself, as a commissioner, the commissioning intentions that have been developed - and we have had feedback from GPs into that, and the Patients' Forum - the strategy that the commissioners want is reflected in the strategy that the ambulance service has developed. The opportunity for things to be broken away should not happen, because you become a foundation trust. It is really beneficial in terms of the points that have already been raised. There is a real strength in going through this robust process to get there.

It is important to remember that once you become a foundation trust you are still a commissioned service. Our role as commissioners - if we choose to tender services and to bring in further competition - that can happen - being part of a foundation trust does not limit that; it just means that the governance process is slightly different for the organisation.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): Could I just add a few comments? In many foundation trusts the governors do not seem to have very much influence on the organisation. The issues that we have been raising with the LAS about it becoming a foundation trust is that the governors should have some real influence on strategy and service delivery: we have made it very clear. We find it very difficult to see what the benefits would be for the patients but, if it is going to happen, then it needs to happen in a way which is real in terms of public involvement so the governors are not going to sit there rubber stamping whatever happens with the organisation, and have a real role in change in the way the service works and reflecting public need.

The other thing is about competition. I cannot see any benefits for the LAS from competition. It would be extremely dangerous and could probably undermine the service considerably. We have seen with the patient transport service how we have many, many branded patient transport services across the capital with many different standards of care and very little public involvement in the quality of those services. There are real risks in competition for the LAS

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): I have to say I agree. Focus should be on delivery of a high quality service, not on competition. Also, there is a risk as well that, with a change in the management, there could be a temptation to focus on expanding or adding to the core business and I, for one, do not feel that that is appropriate. An ambulance service should be an ambulance service in my view. I may be a frumpy old traditionalist but hopefully what you heard from me earlier on suggests that may not be the case!

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): I was going to say in terms of the integrated business plans, just to reassure people, one of the things it says in the LAS plan is very much that it is doing the role of an ambulance service and looking to modernise and transform the service in the way the commissioners want. Potentially as a foundation trust you could come up with, as an independent organisation, some

very different approaches for different services you want to offer. The services and the developments that the LAS has laid out in that plan are very much in line with what we want to achieve.

Richard Barnbrook (AM): I have one very short little concern. I had several conversations with the air ambulance and how it was structured and working. I asked them, "Why is it that you stand in some respects alone as a charity and not fully involved with the NHS?" A director there - not mentioning names - had a joke with me and said, "The point is, if the helicopter is not being used for a trauma case at one particular moment, we could be flying politicians from one location in a town to another location in town". That is why he did not want to get fully involved with the NHS. With the aspect of competition is there an element of new heads and new management coming in and collecting nice bonuses and simply saying, "We've got to restructure this"? Is it all down to individuals' opinions on what is best practice and what is the best return to the public? My concern, with this competition, is the fact that we could go for cheaper and cheaper services and the eye coming off the ball so we do not realise we are giving a poorer service and we are saving money on a cheaper service. I am not a great person of change for change's sake; only if change needs to happen. I understood Professor Woollard to be saying, "Where are the safeguards that what we have achieved so far will remain and get better?"

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): I would say the safeguards are in the service that we commission. The service is the same so we are not asking it to produce a different service. The new quality outcome indicators will really, really help. It is not going to be so much how quickly do we get there; it is going to be what is going to be the outcome and what is going to be the patient's experience when we get there?

We have heard about the Category A8 target. Professor Woollard said, "Is that clinically proven?" In reference to cardiac arrest survival, the advantage is the new indicators are measuring cardiac arrest survival rather than a proxy, which is, "How quickly do we get there?" That national framework will really help.

I work in part with the National Ambulance Commissions Group. We are really keen to make sure we are as consistent as possible to make sure the ambulance service that gets provided is consistent across the country as well as being able to be tailored to meet the needs of the local GP consortia as well.

Dr Andrew Steeden (Clinical Director, NHS North West London): Potentially with GP commissioning in the future we are going to be commissioning for the whole health service. If you make savings on a poor quality ambulance service you will pick up the cost somewhere else and usually that is more expensive care as well. Hopefully, with GP commissioning, you will be paying for the quality of the service and not just trying to save money.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): To build on that, it is often said that 1.5% of NHS spend is on ambulance services but it has an impact on up to 20%. Nationally £1.5 billion worth is spent on ambulance service provision. That is, £20 billion worth of NHS resources are impacted because it depends on what you do with the individual when you have the phone contact or the physical contact with them. That is why it is such a critical role to get right and make sure that you have got the joining up of primary and secondary care and make sure we put the patient at the centre of all of this.

Richard Barnes (AM): How can that be controlled? I understand that 20% of your calls come from the police. You can break it down however.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): One of the things I would say about telephone systems, whether they are NHS Direct or not - it may be that 80% to 90% of cases are completed but, just the same, NHS Direct still resulted in increasing calls passed to the ambulance service and emergency departments.

There is evidence from studies, both in the UK and the USA, from telephone triage systems of patients making up their mind before they even call for advice what they feel their disposition should be. Before they dial any number they decide where they should end up in the system. If they decide they should end up at the emergency department they ring a number and they ask for advice, and if they are not told they should go to the emergency department they put the phone down, they think about it a bit and then they ring somebody else up. Perhaps they ring their GP out of hours service. If their GP out of hours service does not tell them to go to the emergency department they put the phone down and then they dial 999. The ambulance comes to take them to the emergency department and they realise they were right all along. There is evidence of people hunting to get affirmation of the answer they thought they should have. Of course not everybody does that.

Really what you should take from everything I have said is that people are voting with their fingers and they dial 999. We know that lots of people dial 999. In fact it is not just 60% of people that dial 999 that do not have a real emergency; it is probably about 80% of people that use the emergency ambulance service that do not have a real life threatening emergency or a time critical emergency once we get to them and are able to assess them.

There is not a lot we can actually do to stop them calling us in the first place. We can triage some of them out at the point of the 999 call but it is probably not much more than about 15%. What we really need to be able to do is go to those patients and make a thorough assessment because you have to be astonishingly brave to be able to talk to somebody on the phone and make a decision not to see them and, at that point, decide they do not need further assessment - whether you are a doctor or a nurse or a paramedic. You need to go and assess them, you need to have appropriate skills to do that and you need to be very talented indeed. In fact, the people who are best at doing that are general practitioners. They are very, very good at it indeed. They are the best and the safest risk takers in the NHS.

About five years ago we started to train a small number of paramedics and a small number of nurses to do this work in the ambulance service. We called them emergency care practitioners. We ran a pilot which started at Coventry University and then spread out to about 15 centres across the UK: we instantly lost control of it. We had 15 different training courses, none of which were the same as each other; all of different durations and all of which had different content. We allowed staff to see patients and to treat and discharge them or treat and refer them to general practitioners. We assessed how well they were doing by asking patients about whether or not they liked these people. Of course they were very nice to them and so they thought these schemes were very good. We did not do very well at assessing whether or not they were reliable and safe. They did things like stitch wounds and give patients antibiotics; some of the things GPs did. Remember we only trained them for about 15 weeks and gave them the --

Richard Barnes (AM): Drifting from demand control but it is very interesting.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): Not demand control, but it is about demand management because we did not take these people to hospital. We trained about 900 of these people. After this we introduced this call connect and we put these people on the back burner. Five years later we only have 700 of these people left and we have not trained very many more of them. What we need to do is get back to where we were.

It is not about demand control but it is about demand management. It is about accepting that these people do dial 999 and accepting that there is not a lot we can do to stop them dialling 999 because, remember, if we put up big notice boards saying, "Don't dial 999" 10% more people a year will. It is about accepting these people dial 999 and training your staff to better cope with them. We need lots of these people because we need them on every ambulance because the majority of people have these non emergency primary care needs.

Richard Barnes (AM): That begins to change the nature of the ambulance service. You become a mobile A&E unit.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): It actually does not, because the patients have always been there. What it means is we just recognise the need and meet the need of the patients instead of ignoring it and taking patients to the A&E, which is what we have done in the past.

Richard Barnes (AM): Do you think there is a cultural change in the demands on the ambulance service and, through them, the A&E? People living in the country who are not used to a doctor, primary care processes, the absence of primary care after certain times or not being able to get an appointment with the GP?

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): There has been a shift. There have always been a fair proportion of those types of patients. Certainly since the early 1980s when I joined the service there are more of those patients now, again, because of the change in the out of hours service provision. I guess there is a shift of about 20% but there have always been a high proportion of those patients.

Richard Barnes (AM): It is not just the out of hours service is it? I know if I ring my GP he will say in hours can you come back next Thursday, and I am ill now.

Professor Malcolm Woollard (Director of Pre-hospital and Emergency Care Applied Research Group, Coventry University): It is true. We have this see me now culture.

Richard Barnes (AM): Does anybody else want to comment on demand management?

Dr Andrew Steeden (Clinical Director, NHS North West London): If I may comment on the Professor's points? When you look at urgent care, urgent care is often a failure of planned care. One of the things that we are looking at across London is how we can better manage planned care. People who have a long term condition that becomes exacerbated or something happens out of hours which the patient or the carer does not know how to manage end up calling 999. There has generally been a

failing in how well we have managed planned care in the community and there are various pieces of work that are happening across London about how we can improve that.

The QIPP programme that Neil talked about early on recognises there are many millions of pounds of savings that we can make by improving the quality of planned care that we offer patients with a long term condition or who are in the end of life stage. Giving them care plans that make it very clear what they do if there is an exacerbation of if there is an emergency, what their alternatives are to calling 999, and maybe sharing that with the 999 services as well so that everybody is very clear about how that particular patient should be managed. That is one of the opportunities that the work we are going to do over the next couple of years will offer and help to reduce demand management.

One of the problems you can develop when you try to talk about demand management is that aspect of blaming the patient for their use of the service, and that is not a particularly useful path to go down. I do not think patients call 999 for any particular reason other than that they just do not know what to do. I am very hopeful that the 111 service, which offers a directory of service and a very clear signposting service, will have an advocacy service for the patient in London that will help to direct them to the most appropriate service that is available to them. That may well mean increased access to GP services, whether that is in hours or out of hours, and recognising that the contract did seem to reduce the ability to access a GP out of hours.

Nicky Gavron (AM): It is mainly for the two GPs on the Panel to develop what you were saying. What services do you think need to be developed locally for people who need urgent care so they do not rely on 999 and the ambulance service? You have talked about the individual patient and the patient plan. Can you develop that?

Dr Andrew Steeden (Clinical Director, NHS North West London): Without investing in and creating new services you make better use of what you have right now anyway. Within certain patches you have urgent care centres and in other places you do not. You need to make sure that you better utilise the urgent care facilities that you have. Out of hours you probably need to better utilise your local out of hours providers in a better way before you start trying to reallocate resources into investing in new specialities or new common pathways.

Once you have exhausted what you have currently then you could probably do a programme budgeting and marginal analysis exercise and you look at what needs to happen next, and then you look at reallocation and a different way of managing efficiencies.

At the moment everything is in such a flux of transition. We do not have expanding pockets of cash and we probably have to think about how we better utilise what we have now.

Dr Andrew Steeden (Clinical Director, NHS North West London): There are some very good examples about how we are doing that very piece of work and looking at how we are spending money and how we can spend it in a more efficient way in the future.

End of life services, where people are at the end of their stage of life, but there is not an active medical intervention that will prolong their life, these people often end up in A&E because there is a problem that could have been anticipated, that happens when they cannot access their GP and so they end up

defaulting to A&E, which is a very busy depersonalised service that they get. A bit of advance planning and communication would have avoided that from happening.

People who are frail and elderly who have long term conditions; people who could have a care pathway that we could plan in advance, about what to do if something was to happen and signpost them to services that are available. In north west London - and in various parts of London - we are working with academic health and science centres to see how we can develop into it care organisations or integrated care. In north west London we have got a pilot which is going to be starting in the spring which will look to see how we can join up community, GP and acute services to work across a whole care pathway to help make care very efficient so that people are not ping ponging across the whole economy.

The other area which often misses out on here but we are already discussing with the LAS is about how we can address mental health. Having somebody like a community psychiatric nurse (CPN) in the call handing service so if people call up looking for some intervention for a mental health condition, they can have an appropriate response then, rather than necessarily going to --

Nicky Gavron (AM): That is really going to increase isn't it? I have just been looking at what is happening to mental health in London. That is really going to increase.

Dr Andrew Steeden (Clinical Director, NHS North West London): I think it is a Cinderella service across the whole NHS. We are including it as a CQUIN (Commissioning for Quality and Innovation) as part of its contract for this year, Neil, aren't we?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): Yes.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): I want to reinforce that point. Where we have really good mental health teams, for example, around Southwark I know some of the teams very well and they keep people stable, they keep them at home and they are very well supported. The real disaster is when those teams break down and people end up in an A&E department with a severe mental health problem. That is something we really need to avoid.

The LAS is not really excellent at dealing with mental health issues and it is an area for real development. We have also got to watch the situation at the moment with the voluntary sector that does a lot of support work for people with mental health problems. A lot of the voluntary sector organisations are now in a very vulnerable state because of the local cuts in budgets. Trying to make sure that does not fall to pieces is critical in making sure that people get appropriate care, and there is not excessive pressure on the individuals and their families and on A&E departments.

Nicky Gavron (AM): What about walk in centres and falls clinics and so on as being local services which people could be referred to, rather than going through the ambulance route? I am not sure how many walk in centres and falls clinics exist. I am quite interested to know that there are some falls clinics.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): One of the whole points about the development of the 111 process and what will underpin that is, what they call the Directory of Services, so you know what

services there are available. There are a number of walk in centres in London and there are a number of falls clinics.

One of the main things we have put in place this year that will be rolled out next year is around falls and making sure we refer people back to the GP. They do not need an A&E service for their fall, but at the moment there is no formal relationship on a routine basis between the ambulance service and primary care. A GP does not know that the ambulance service has been in to see their patient. They only find out when they have been into hospital and the hospital has discharged them, and then they know they probably went there by ambulance. They do not have a direct relationship. That is going to change and that is going to be supported through --

Nicky Gavron (AM): That is good.

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): -- what is called a CQUIN, which is a quality improvement incentive payment. Just to say, on contracts, it is not just about penalties; there is an incentive process. We have got a specific initiative this year around something called Close the Loop which is about the whole wider system of learning. We have got one around mental health; we have got one around falls and one around end of life care. This is all about putting the patient at the centre, and I am delighted that it has had both GP support and the Patients' Forum have supported that. We have got a real opportunity to work our way forward and say, "How do we get better care for people?"

I would quite like to come back on the point about demand because there are a couple of things that the GLA has got particular opportunities with and I would welcome the London Assembly's view on this. The Metropolitan Police Service is the highest referrer to the ambulance service in London: on average they refer 333 calls a day. That is 9.7% of LAS activity. That is a significant amount! For me, as a commissioner, we have been talking with the LAS about what are the opportunities to do that. Essentially it is a two way referral process - three way with the fire as well - and they support each other. That is really important. There may be some opportunities to reduce some of the demand that gets put on from the Metropolitan Police Service to the LAS and to take that forward. Obviously the GLA has a direct remit over the Metropolitan Police Service and the Fire Service so we would welcome that.

Andrew Boff (AM): Can I just ask, are you saying that, of that 9.7%, there is a significant number that should not be referred to the LAS?

James Cleverly (Chair): Having identified the issue what is your proposed solution?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): Some of those calls are there because the policy says, and the protocol says, you need to be backed up by an ambulance. I would like to look at some of those protocols and policies and whether there is a slight over protection. That might be about the development of the skills of the Metropolitan Police Service and it may be about looking at that.

The other thing is that, at the moment, there is no automatic triage process so when the police need an ambulance there it is an automatic dispatch. It does not go through the normal processes of, "What's the issue?" Potentially, you might be resourcing an issue more than is required for that particular case.

Navin Shah (Deputy Chair): Does that apply to fire services?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): I am not exactly sure. Richard [Webber] would probably be able to clarify.

Richard Webber (Director of Operations, London Ambulance Service): The amount of calls we get from them are fairly minimal.

Nicky Gavron (AM): I want to ask a question about the 111 service. The 111 service is a very good idea but would, potentially, be a much better idea if there were more of the kinds of services it could direct people to. You have talked very eloquently about how there are all sorts of efforts to improve the links between falls clinics, the ambulance service, the GPs, walk in centres and so on. What about there being more of those services? More than is currently being introduced locally. Could we have a view? Is this now all absolutely not thinkable in the current climate?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): There are some significant opportunities to develop services. With the GP consortia quite often there are opportunities to do things that are better for patient care. If I take an example of a patient at home who has got a urinary tract infection, who has gone off their legs - as the phrase has often been. They might have had a fall but are not injured. What they actually need is someone to go in, probably need oral antibiotics and they need a comprehensive assessment maybe of their home and their condition, because there might be wider support systems, and be supported there. The total intervention of that might be two people involved in that.

At the moment you could well have a carer calls 999 because the person is on the floor, the LAS come in, the LAS takes the person to A&E, there is an A&E attendance, they run a suite of tests on this individual, they have not connected back to the GP to know that there was already a care plan for the individual, the individual might be admitted - that might cost £2,000 - and that person then gets discharged home. What is the difference? Actually, the patient care would have been much better to provide the oral antibiotics at home with a comprehensive assessment. If we can do that more effectively - this is an opportunity to really have a win/win/win situation - you could save money and improve the patient experience and quality of care.

The challenge is how do you make that happen? The 111 system --

Richard Barnes (AM): Aren't they called GP home visits?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): That is also potentially an opportunity for developing the mobile workforce which is part of the role that the ambulance service can provide going forward. Things like the emergency care practitioner programme that has been talked about previously is where you can develop skills that are there.

There was some particular work done in Darlington where they were able to look at the calls that came in, and they identified that there was an opportunity to have intravenous (IV) antibiotics in some postcodes, but the services were not there in other places. Through using the 111 system where you

have got the data they were able to demonstrate that in one post code you could get the IV antibiotics and therefore you do not need to go to hospital, and in another area you did not.

Once you have got the data on it, you could say there is a business case to support enhancing that night nursing service. When they looked at a particular night nursing service and asked, "Why can't you do it?" they said, "We all could. We just need to go on a course". "How long is the course?" "It is one day." They sent five people on a one day course and they were able to prevent ten A&E attendances a week.

There are opportunities to enhance services by looking at what the real issues are on the ground.

Nicky Gavron (AM): That is very good and it is very skilful of you to talk about enhancing what is there. I was also talking about introducing a bit more of what we need. I wondered what you thought, in the current climate, were the opportunities for that?

Dr Andrew Steeden (Clinical Director, NHS North West London): If anything, the current climate is an incentive in itself to try to develop these community services. It is much cheaper financially, and politically it is more advantageous, to treat people nearer to their home than to have an expensive admission to hospital. If I have a frail elderly patient who is admitted to hospital their chances of being discharged home as an independent, - being independent reduces every time they are admitted and they are more likely to end up in expensive social care as well – is reduced. It is much more cost effective for people to be looked after at home and treated in community services, than it is to rely on an LAS service to transfer people to hospital.

Nicky Gavron (AM): Can you give an example anywhere of where there is very good provision that we can use as an exemplar? Where there is good provision in a locality where some of this is working in a quite optimal way?

Dr Andrew Steeden (Clinical Director, NHS North West London): We are developing examples across London. We do not have a lot of evidence across London at the moment. If you look at some of the integrated work that is happening across Britain there are good examples down in Torbay where they have been able to reduce admissions to hospital by producing community services that are better. There are some good examples in Surrey as well. I can forward those details to you if you wanted the details of those.

Nicky Gavron (AM): Do you think the Mayor of London should have any role at all in the 111 service?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): The Mayor and the GLA; we welcome the role around health inequalities, the whole engagement and the input Richard talked about as a governor, potentially in the foundation trust process. The Mayor and the team could support the commissioning intention and the direction of travel.

There is a Member of London Councils that is currently part of the 111 programme Board that I sit on and there is a Member of London Councils who links in with the 101 programme, so makes sure there is a helpful dialogue between the two of those.

There is an opportunity to work together effectively to share learning and best practice. The Mayor can be an advocate and is a high profile public figure. There is an opportunity to utilise that to communicate messages to the public. We are not at a stage where 111 is a programme that is live in London. We would not want to be overly publicising that.

Nicky Gavron (AM): When will it be live?

Neil Kennett-Brown (Director of LAS Commissioning and Whole Systems Transformation Programme, NHS North West London): The aim is to have a pilot in London this year and to be fully live by March 2013; that is the ambition.

Richard Webber (Director of Operations, London Ambulance Service): I want to make the point that demand management is a risk. We know we have more and more elderly and vulnerable people in the community. What happens is, when it goes wrong, they rely on a good and robust ambulance service; they dial 999 and we turn up.

Professor Woollard made a point earlier about increasing demand being an international issue. We see a 4% to 5% increase in activity year on year. My big concern is there is lots of reliance on enhanced community services and, if the funding is not available, how much will be there. We need to ensure the LAS continues to deliver a robust service. My concern is the real term funding envelope for next year for us means probably a reduction in front line services of about 100 ambulance staff. My concern is, we see an increase in demand, a reliance on services that are still being developed and a reduction in the amount of staff I have to respond. We do have to get on and deliver demand management, but there are lots of risks there and perhaps pulling some of the funding out before that is all there, can give me a future risk.

Richard Webber (Director of Operations, London Ambulance Service): There is a risk. We are talking about lots of enhancement and involvement in community services. We need to make sure we do not disinvest in the services that are there currently to allow us to continue to respond. If we still get 4,000 calls a day from increasing elderly and vulnerable Londoners, they expect us to be able to respond. We need to be able to ensure we are in a position to do that.

Nicky Gavron (AM): That is very well said in the current climate.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): May I just add something to that? There is something also here about public assurance because, as the system changes, what we have got to be absolutely certain of is that the public not only know what services are available, but are assured that those services will be available when they expect them to be there.

What we are really worried about is that, yes, there is going to be a Directory of Services which will be specific to each part of London, but what assurance does the public have that those services are really there when they are needed? That is quite fundamental to the success of this transformation.

Nicky Gavron (AM): I think a lot of people use the ambulance service on the basis of better safe than sorry: they just do not know what else to do. When more uncertainty is created demand will increase. We have really got to work hard now on making sure exactly what you said is the case; that there is proper information about what does exist.

Malcolm Alexander (Vice Chair, London Ambulance Service Patients' Forum): Yes. When people know that falls services and mental health services and other community services exist and they can trust them and they build up relationships with the members of those teams, then they are more likely to go in that direction than dial 999. It is about building up peoples' confidence.

Richard Barnbrook (AM): It is not on this agenda. Next year, 2012, for two weeks, maybe four weeks we have got the Olympic Games. You mentioned the possibility of a shortfall that could put pressure on you. How do you feel the Olympic Games may impact upon London and the ambulance service?

Richard Webber (Director of Operations, London Ambulance Service): We are currently discussing with the Department of Health and the commissioners about the funding envelope for the Olympics: we are planning effectively for it. My concern is that it is building on the current services we have and the service in London, particularly, which is stretched at times. It is about making sure we have sufficient service. We are currently working through the financial bid and we have already been to the GLA and discussed that with you. We are finalising those discussion with the Department of Health.

We need to absolutely ensure that the Games do not impact on the healthcare for Londoners and that we do provide a robust service. We estimate that we will receive up to a 10% increase in activity in London as a result of more people coming here to enjoy the Games - not necessarily on the site but around London and seeing the Cultural Olympiad that the Mayor has spoken so eloquently about. We absolutely need to make sure we do have the funding to allow us to increase our services. That is part of our current bid that we get to hear back on.

Richard Barnbrook (AM): It may also impact upon the GPs as well. People may be coming to GPs care of a friend, "You are ill, you have just come from X, Y, Z. Go and see my GP." Do you see an impact on yourselves?

Dr Junaid Bajwa (General Practitioner at Conway Medical Centre, Plumstead and Clinical Commissioning Champion, Royal College of GPs): Plans are afoot to make sure that there is increased access to GP surgeries too.

Richard Webber (Director of Operations, London Ambulance Service): If I can come back on that? In reality patients will tend to present to ambulance services and A&E departments more than a GP if they are a patient from a different country. We need to make sure that the investment goes into the places where the patients will present in reality.

Andrew Boff (AM): Mr Webber, are you saying there is going to be a reduction of 100 front line staff? Is that what you said?

Richard Webber (Director of Operations, London Ambulance Service): Yes, for next year.

Andrew Boff (AM): That is on the basis of what? That is a planned reduction?

Richard Webber (Director of Operations, London Ambulance Service): That is on the basis of the funding envelope we have for next year, taking into account inflationary pressures and other costs we have.

Andrew Boff (AM): Right. The funding you have received is being cut or staying the same or it is the demand that is resulting?

Richard Webber (Director of Operations, London Ambulance Service): It is broadly staying flat with where we are this year, but obviously inflation and other costs have increased that we need to absorb. We are estimating around 100 staff. It will not be in the form of redundancy; it will be in the form of not replacing staff as they leave.

Andrew Boff (AM): A wastage programme?

Richard Webber (Director of Operations, London Ambulance Service): Yes. There will still be a reduction in the current staffing we have now.

Richard Barnes (AM): The success of any service - emergency service or whatever - depends upon the confidence that the people of London have within it. If that fails and that assurance disappears then we all have major problems. The ambulance service and its response on 7 July 2005 was heavily criticised recently in the inquest. We can talk about it now because it is no longer *sub judice*. We are just waiting for the report. I am aware that since 7 July 2005, today the ambulance service has invested a lot of money. I wondered if you would like to briefly indicate where those changes have come, because you were not given the opportunity to defend yourselves at the inquest?

Richard Webber (Director of Operations, London Ambulance Service): Thank you for the opportunity to comment on that. It clearly was a very difficult day and the inquest has concluded. However, we await the final verdict of the inquest so it is difficult to comment on some of the potential outcomes until they have been announced.

What I would say is there has been significant investment in areas that were identified at the time. For example, command and control was an issue on the day and so we have opened a new special command control centre at our headquarters that would deal specifically with an incident. We have also invested in a thing called the Hazardous Area Response Team. We now have two of those teams for London. They have the ability to work in completely different environments to what we had five or six years ago. For example, we have staff now who are trained to work in urban search and rescue so they can work with ropes, they can work with breathing apparatus and they can go and work directly alongside other people like the fire service. We can operate in completely different environments to what we were previously. There has been significant investment in that and I believe the service is much more prepared for an incident, were it to happen, in the future.

That was a tragic incident. Bear in mind there were four separate major incidents in one day - something nobody had ever encountered before. We have accepted there were lessons to learn, we have learned those lessons and there have been significant improvements since. We wait to see any other outcomes that come from the inquest.

Richard Barnes (AM): There were two particular criticisms which were over highlighted by the inquest: one was the over high white board, the lady who could not reach to the top; I presume that has been lowered. The other one was, about ambulances turning up without supplies on board. Has that been addressed across London?

Richard Webber (Director of Operations, London Ambulance Service): Firstly there are a number of equipment dumps already across London in Underground stations. That was already rectified some time ago. We now have a number of mobile vehicles. We have, as part of a national scheme, a thing called a pod vehicle and a national vehicle that has a large amount of kit. We now have nine of those vehicles strategically placed across London so if an incident were declared, we can immediately deploy that kit to the scene, both with minor bandages etc on and also with advanced things such as fluids etc.

Yes, we are in a much better position to do that and we will be discussing further after the inquest.

Richard Barnes (AM): Over the last five years that resilience business continuity element of your service has been transformed?

Richard Webber (Director of Operations, London Ambulance Service): Yes, it has. I sit on the London Resilience Forum which you chair, Richard [Barnes], and we have invited you to come and have a look again at the facilities. I genuinely believe that we are in a much, much stronger position than we were previously.

James Cleverly (Chair): As I say, slightly off the core agenda but I thought it was really important that, as this is a particularly topical issue, and as, with everything, confidence in the professionalism of our emergency services and health services is really important should be discussed. One of the things that struck me from the conversation today is that we are going through a challenging time both in terms of the demand, financial pressures and the changes within the NHS. What really came across is how much confidence there is in the core ability of the service to provide for Londoners; that should be registered as well as some of the challenges and opportunities moving forward.

Thank you very much.