Appendix 1

Health and Public Services Committee

6 April 2011

Transcript of Item 4: London Ambulance Service

James Cleverly (Chair): Good morning everyone. Let us move on to the main agenda item of the day which is to take evidence from our guests from the London Ambulance Service (LAS). Before we start one of the things I would like to pass on are comments that we had from Members with regard to the first half of this scrutiny which was our last meeting. The feedback I have had from Members is that the information that came out and some of the questions that we were asking about the challenges and the response to those challenges from the London Ambulance Service generated one of the most interesting Committee meetings that we have had. Thank you for your contribution thus far.

I would also like to take this opportunity to thank you for the various times that the London Ambulance Service has engaged with us in other areas of our scrutiny work - things like teenage drinking and emergency service response to the Olympics. I would like to put that on record right from the word go.

I was wondering if you could give us an overview of the London Ambulance Service's performance, particularly the differential performance between Category A and Category B performance targets over the last few years, if you could?

Peter Bradley (Chief Executive, London Ambulance Service): Good morning. As far as performance is concerned the London Ambulance Service's key response time target, as you are aware from the earlier session, was 75% - life threatening calls in eight minutes. That is the Category A target. The LAS has achieved that target for the past seven years in a row, including the year that has just finished. The Category B target is probably the biggest group of patients that we attend to, approximately 500,000 calls. That is a 19 minute response required for those calls on 95% of occasions: the LAS has struggled to achieve that target over the years. This has also been the case with other ambulance trusts around England so we are not alone in that. In the year that has just finished, we had our best ever year and responded to around 87.5% of those patients in 19 minutes. Then there is a third internal target that we have for the remaining patients that we attended to, we had our best year in that regard this year, as well.

James Cleverly (Chair): I apologise if we seem to be over-focusing on the negatives, but we will address the positives as well. With regard to your progression towards hitting that target - as you say this past year you got closer than you have done in previous years - what have you done differently or what circumstances have changed to enable you to get close, even though you have not quite hit that threshold?

Peter Bradley (Chief Executive, London Ambulance Service): We have had a lot of extra staff and money given to us by the Primary Care Trusts (PCTs), so we have been able to recruit a record number of student paramedics into our Trust, so we have large numbers of extra staff. We have used our technology more effectively and efficiently and, crucially, our staff have managed to turn around the bit at the hospital that is in our control: we visit many hospitals across London. Our staff have become more

productive, and turn around in hospitals have become a lot quicker enabling them to move on to the next call more quickly It is also about freeing up resource, having more resource and using technology better. That has resulted in us getting to more patients, so more resources are welcome.

Richard Hunt (Chair, London Ambulance Service): We perhaps ought to mention that we have had the opportunity - and, again, it is an investment - to renew the older elements of our fleet, so we have had an active programme of new ambulances coming into the fleet.

James Cleverly (Chair): One of the things that we discussed, to a degree, at our last Committee was the shift from a purely by the clock based metrics approach to a more outcome based performance metrics approach. How is that going to impact what you do, and your ability to meet those targets? How do you envisage that affecting you in forthcoming years?

Peter Bradley (Chief Executive, London Ambulance Service): I think it is a good move: we have had little control over the need. We have had to respond to 65% of our calls - and send an ambulance without any discretion or ability to find a more appropriate care pathway for our patients until 1 April 2011. It has now changed, and I think - our staff are pleased about this as well by the way because they believe - and we believe too - there is an over-focus on time, rather than the care we provide, certainly for big groups of our patients - it will provide us with a much better opportunity to target our care, and to focus more on outcomes of patients and compare ourselves with other ambulance trusts against a range of measures linked to patient care. It is not just about time; it is about what we do when we get there.

Our staff welcome it and we welcome it because it will really mean two things. One, we can see how we compare against the rest of England in the ambulance service world and, two, it means we have got more ability to provide better care for our patients by finding more alternatives for them. It is not always about going to Accident and Emergency (A&E) which has been our traditional approach.

Richard Hunt (Chair, London Ambulance Service): Time remains a component of those new measures: that is one thing that should not be overlooked. The temptation is just to see this as Category B has gone. No, Category B has been effectively reconstructed with these outcome measures. One of the things we are keen to remain aware of inside the organisation is that this does not necessarily mean that we have our foot off the pressure to achieve things. These outcome measures, as Peter has said, are supported but they will also be challenging in their own right as well, and that is right because they are patient focused.

Richard Barnes (AM): There was a period when there were stories in the newspapers and certainly in the media – when every news broadcast was - of ambulances queuing up outside A&E to deliver patients. The impression given was that patients were not the hospital's responsibility until such time as they had left the ambulance, and if a patient was left on the ambulance you could achieve your four hour target, or whatever. Has that now ended, and helped you to achieve your turnaround for your targets, or is that still a feature of your work?

Peter Bradley (Chief Executive, London Ambulance Service): It is still a feature in terms of we still struggle. We still have difficulties at times of high demand in some parts of London, during busy periods, in terms of handing our patients over to A&E. The change in focus in the targets for A&E and for the ambulance will help. Richard Webber, our Operations Director, who attended your last meeting, may have mentioned it. A&E are also more aware now, in real time, of the patients that are coming in, so

we have now got a system of the A&E department being able to see on the screen our patients, so they can better plan.. The problem is not fully resolved and still exists in pockets of London, and at certain times of the year.

Richard Barnes (AM): Are they almost predictable, where they are and in what weather conditions it will occur --

Peter Bradley (Chief Executive, London Ambulance Service): Yes they are, absolutely.

Richard Hunt (Chair, London Ambulance Service): Can I give a perspective on that because when you are in the sort of world that I am, coming from the outside, you are struck --

Richard Barnes (AM): I read your background.

Richard Hunt (Chair, London Ambulance Service): I read yours! I thought I had better as we share a name.

The thing that surprised me when I first became involved is just how informal the arrangement for handovers are - that is my word. In the sense that I come from a world of supply chain where you hand over from one part of the chain to the other, it is rather more structured, it is slick and ownership is clear. I was surprised to find that on the critical interface when you arrive at A&E that it was rather more informal.

Richard Barnes (AM): Not like "Holby City" [Television hospital drama] then!

Richard Hunt (Chair, London Ambulance Service): I am surprised you have time to watch that, Richard.

Richard Barnes (AM): I only get to watch the repeats!

Richard Hunt (Chair, London Ambulance Service): I can see the advantage of some of that informality, but I describe it as something like cats in the garden; you have to attract somebody's attention to get that handover and obviously that works better in some places than others. On a system-wide basis - I know our Commissioner is not here - that is something that needs to be looked at. That informality, it seems to me, in an emergency operation, is a surprising thing to find within the chain. I think it is time to raise those issues when you see them.

Richard Barnes (AM): You cannot stop the stopwatch. Is it really worth measuring it?

Richard Hunt (Chair, London Ambulance Service): Stopwatch?

Richard Barnes (AM): You know what I mean.

Richard Hunt (Chair, London Ambulance Service): Yes, I do know what you mean. That is not the issue. The issue should be a relatively immediate handover, insofar as it can be arranged. As Peter has said, now we are trying to pre-advise. It is an element that in a joined up, working together way we have got to seek to improve. We have seen this year, during some of the highest demand periods of difficult

weather conditions, far too many delays on the handover side of things: that has been a feature of the performance.

Andrew Boff (AM): You may be right. Throughout the country, obviously, there are other ambulance services. There is an ambulance service that covers, basically, the West Country.

Peter Bradley (Chief Executive, London Ambulance Service): The South West Ambulance Service.

Andrew Boff (AM): The South West Ambulance Service concentrated on handovers and achieved a remarkable improvement in its overall performance as a result of just that interface between the ambulance and the hospital. I am pleased that you have identified that that will be something to look at in the future.

Richard Hunt (Chair, London Ambulance Service): We have a different scale issue of course: They are dealing with far fewer Accident and Emergency departments than we are.

Andrew Boff (AM): It does not matter where you are in the country, when the ambulance drops off at the hospital, it does not matter where the hospital is, that handover time is critical to the outcomes.

Richard Hunt (Chair, London Ambulance Service): I am giving you an impression as an outsider coming in and that I had no idea that that was the way it was done. You say to yourself, "I know we have targets and we are working together to reduce our part of that turnaround time but, equally, we are part of the hospitals' turnaround time". I attended a Board meeting of another Trust and it was interesting to hear it say that it was a common problem. What it referred to was, that it was not on the key performance indicators or the score card of that particular acute Trust, the monitoring of that level of performance. If it does not get measured it will not get improved.

Andrew Boff (AM): I see your point. We are talking here about the targets that you have met. Obviously you do not set those targets: those targets are established for you. What is the thinking behind eight minutes?

Peter Bradley (Chief Executive, London Ambulance Service): That is a good question. If you go back to the 1970s there was some evidence from America that if you were able to get to a patient within eight minutes and 59 seconds they had a better chance of surviving cardiac arrest - non breathing, no pulse - so eight minutes and 59 seconds was the time that was used and seen as a benchmark time to try to get to patients and bring them in for those small numbers of conditions. That was the thinking behind what then came into force in England. Then it was seen that eight minutes was better than eight minutes and 59 seconds.

In fact, it is really three or four minutes really. In fact, to be fair, up until we had the national targets properly introduced, in my view, in the 1990s, we used to have some ambulances that did respond and the target was eight minutes and 59 seconds because the interpretation of eight minutes varied across the 31 ambulance trusts in England. It is only in the past five years that we have had absolute clarity on the eight minutes. What is eight minutes? We started measuring it in seconds actually so there was no ambiguity at one stage.

It was primarily aimed at, in our case, 30 calls a day. Those top 30, of about 3,000 responses, where those patients are in cardiac arrest and they require defibrillation and immediate life support. We need to get there in four minutes really for those.

Andrew Boff (AM): This is the evidence that was received at our previous session; there was some question about what on earth is eight minutes? Eight minutes is a target to achieve something but there does not appear to be, nowadays, much basis in evidence for that being the right target.

Peter Bradley (Chief Executive, London Ambulance Service): No there does not seem to be. It is perhaps not completely the right target but it is the best we have got and it is the best response time standard in the world for ambulance services. Perhaps the triage system could be better. At the moment our life threatening calls are 10%, yet our triage system gives us 35%. We are responding to too many eight minutes responses, in theory, and our staff know that.

Having said that, the 30 a day, which require an ambulance service in three, four or five minutes get the fastest response. We discriminate positively against that particular group of calls: every ambulance service in England will be introducing that in the next few weeks[1], where we all respond more quickly even to that group.

We have seen - and Richard Webber [Operations Director, LAS] mentioned it when he came - an improvement in our cardiac arrest survival for discharge - or, as the Americans say, returning to full tax paying status! From that standard, because our response times in London have improved dramatically in the past ten years, so have the number of people discharged alive. Last year 97 people in London - it does not sound a lot - who were dead were resuscitated and walked out of hospital alive: that is two people a week. In 2000 it was 27. We can do better and I think the change to the Category B target will mean we can focus more of our resources at those, coupled with all the work on the defibrillators in public places.

James Cleverly (Chair): Andrew brought up the differences between London and the south west and the handover procedure. You made the point that London is different. One of the things that came out from our desk research was that London has a higher number of ambulance calls per head of population than any other trust in the country. Obviously London is a big city, we understand its totality. Have you got any indicators as to why there are the more calls per head as well as just the more calls in total?

Peter Bradley (Chief Executive, London Ambulance Service): There are two or three reasons I suppose. The first may be a sweeping statement. I worked in New Zealand for a long time, in a lot of rural areas over there, and I also worked in Australia. It tends to be that people in rural areas are more self-reliant, and are more reluctant to call for an ambulance. That is one issue. The second reason is relates to urban areas. The North West Ambulance Service is as big as London but it has got four big counties in it. If you look at Manchester, its calls per population are about the same as London: so big urban areas have more calls. The North West Ambulance Service made it one big service. Certainly deprivation is higher in urban areas and there is a strong link between deprivation and calling the health and ambulance service out: so deprivation, lower levels of car ownership account for reasons why there is a higher number of calls. There are a whole range of things.

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[1] Following the meeting, the Chief Executive for the London Ambulance Service confirmed that the sentence - 'every ambulance service in England will be introducing that in the next few weeks' should read – 'every ambulance service in England will be introducing that in the next few **months**'

The Department of Health produced a tool kit last year which looked at why the ambulance service was used so much: it is quite useful; it looked at a range of things. We also know that there is an issue around demographics, around age. Our biggest increase in call volume is the 20 to 30 years olds. The 70, 80 and 90 year olds call the ambulance less proportionally than the 20 to 30 year olds: that is a new phenomenon for us: in rural areas it is older people that make more calls and in urban areas it is younger people. We have a worrying trend in London of there being a disproportionate number of 20 to 30 year olds calling the ambulance. You may ask why? And the reason we would be that we have had campaigns in the past about not using the ambulance service wisely. You may now ask who stops ringing? The answer is, it is probably the older people, because they do not want to bother those busy ambulance people: the younger people are not bothered. There is that tendency, in the society we are in.

Richard Barnes (AM): Is there a cultural factor there, as well; with those who are not necessarily used to having a general practitioner (GP) from where they come from?

Peter Bradley (Chief Executive, London Ambulance Service): Yes there is that too.

Richard Barnes (AM): With the 20 to 30 year olds being told, "Give us a ring next Thursday and we'll see if we can fit you in", the default position is call an ambulance.

Richard Hunt (Chair, London Ambulance Service): There is one thing I would mention: I was going to mention demographics as well. The better your service the more demand it is likely to create in a service environment. An element of what we do by reaching more people in Category A within eight minutes, reaching more people in Category B within 19 minutes - and you can see it in some of our statistics - that the call growth rate has been slower than the response rate, because fewer people have to call back and say, "Where's the ambulance?" That better and improved performance will, of itself, generate demand because it becomes a more certain bet, it provides a more certain chance of a response, which will be an interesting strategic challenge for the next 5, 10, 15 and 20 years.

Murad Qureshi (AM): It has just occurred to me that maybe those young people do not necessarily know where their A&Es are. Is that a factor?

Peter Bradley (Chief Executive, London Ambulance Service): Some would say there is one on every street corner in London almost comparatively at the moment. Possibly that is the case. I think it is easy isn't it, to dial for the service? It is an easy number; it is 999. Alcohol is also often involved.

As you have mentioned, Richard, we were talking to some ambulance staff three or four weeks ago that work predominantly with the Turkish community in London. As we try to find more alternatives for our patients rather than going to A&E, the Turkish community want to go to hospital: they are quite insistent. Their expectations are, "I will go to hospital and will be seen in hospital". Our staff have a job to work through there in terms of education and trying to remain targeted.

Richard Barnes (AM): There is not a GP tradition in Turkey.

Peter Bradley (Chief Executive, London Ambulance Service): There is less of a GP tradition. I am sure you are right.

Richard Barnbrook (AM): This pretty much leads on to the question I have. There is a strong consensus now of more community based urgent care services regarding GPs. As we have discussed in this conversation there is an element of communication problems between parts of the community who may not have a very good relationship with their GP and who automatically think 999 and go straight to hospital. How can the LAS work around the idea of enhancing this out of service working?

Richard Hunt (Chair, London Ambulance Service): As you say there is a consensus that the right thing to do is to convey less patients to A&E as the default option. Those that should go must go and, indeed, you will have seen from your first session not only A&E but, depending on their condition, the right A&E, and that is having a dramatic effect. It is the group where you should have a choice as to what the right treatment for them is, which is to more community based services, and there is a list of walk in centres etc. That is the direction of travel that we are on. That is part of our strategy for the next few years; to ensure that we are playing our part in taking people to the right place for treatment and non-A&E options will feature more and more in that.

It is only a part we can play. We need the supply side to be in place, up to speed and relatively consistent. If you are an ambulance crew and you know what you are doing in north London or Tottenham because there is an option but you do not know whether that option exists in the south west, that is a barrier to making that progress. Again, the whole direction of travel with the directory of services and the availability of those options in cab through our new in cab systems is all part of us playing the role of taking people to the right place, and not always to A&E.

From our point of view of course it is still a response. It is still the same level of demand. Even when we convey them to a walk in centre - which I challenge my colleagues on, by saying, "Surely, there is a clue in the title here? Why are we taking somebody to a walk in centre?"

Richard Barnbrook (AM): What are the potential benefits of the 111 number as a way of relieving calling the 999 service? Working in parallel with 111 and the GPs to enhance GPs awareness of alternative numbers, and alternative approaches. Rather like your suggestion, hospital, that is where it ends. Nothing else.

Peter Bradley (Chief Executive, London Ambulance Service): Potentially very big but as, we saw when NHS Direct was introduced in 2000 or 2001, demand for the ambulance service went up when that came in because we got a lot of additional referral calls. Things have improved. 111 is a memorable number and it is free. As our Chairman said, if we have the directory of service behind that so that the people who take the calls can refer people and have got real time information about the GPs' availability, mental health crisis teams, it could be very powerful, but, in London, it is very complex with a number of referral pathways and clinical options.

We are supportive of 111; We want to be involved in it. We need to be involved in it when it is rolled out because it can, if managed correctly, relieve demand on the ambulance service.

One of the criteria for 111, interestingly, in its national specification, is that the 111 call taker has got to be able to send a call automatically to the ambulance despatch desk. We are concerned about that because it could mean that we get additional calls without any additional triage service. In London, when 111 rolls out, we will start, as appropriate, receiving 111 calls directly to our despatch desk which has to have an ambulance sent. It is very important to us that we are involved right at the beginning of this process, so we have got some control over any involvement that we will have.

Richard Barnbrook (AM): There is one last question on GPs. I am getting on now. 50 has reached me, and I continue to get older. I remember 20 or 30 years ago there were, even in small communities where I came from, in the north east, back of London, GPs did have out of hour surgeries and they said, "If there is a problem. Call me at night. I'll pop out and see you". This does not seem to be apparent much these days. What effort or response could you apply to GPs - especially going through this restructuring now - to try to get them to be more proactive with their patients to say, "You are getting old. You have a little heart problem. We know about this. It is not a major concern but you may get a little twinge here or there. Please call me first before you start calling 999"? What sort of pressure activity are you working on to try to get this resolved?

Peter Bradley (Chief Executive, London Ambulance Service): I think there are 11 out of hours providers in London at the moment and we are keen to - in fact we are meeting with NHS Direct, GP out of hours groups and NHS London to look at how it would roll out 111 and how we can have an integrated approach to that. That is crucial. Otherwise we will end up with silos, with each doing their own bits. We think by working together we can do the right thing and avoid duplication. At the moment we tend to work a little bit separately - if I am being honest. 111 gives us an opportunity to make sure that we can work together and that we can get the right referral pathways. If someone rings a GP out of hours, 111, 999 or the GP in hours with a blocked catheter they should, by and large, get the same referral treatment advice: that is not necessarily the case right now.

Richard Barnbrook (AM): Are you seeing any particular development on this at the moment?

Peter Bradley (Chief Executive, London Ambulance Service): We have had some productive meetings with a couple of GPs out of hours in London. NHS Direct is very keen to work with us and we are keen to work with them. NHS London is looking at some pilots for London and we want to be involved.

Richard Hunt (Chair, London Ambulance Service): It is all part of what I would call a joined up supply chain. The health supply chain is not integrated or joined up; it is in a silo.

Richard Barnes (AM): Will the 111 operator have the same training as a 999 operator?

Peter Bradley (Chief Executive, London Ambulance Service): The training will be different.

Richard Barnes (AM): If you can go straight to despatching an ambulance then there must have been some significant triage process before that?

Peter Bradley (Chief Executive, London Ambulance Service): That is correct.

Richard Barnes (AM): So is the 111 operator being trained to the same standard as 999?

Peter Bradley (Chief Executive, London Ambulance Service): Trained to a different standard primarily because the triage package they are using is different to the one that we use for 999 calls. Early indications in the north east, where it is live, Durham and Darlington, are that it has slightly increased the number of ambulance despatches, not too bad. What we would want to see with London is it working in an urban area before it gets rolled out in London, to get a sense of what the impact might be.

Richard Barnes (AM): The object is to decrease not increase.

Peter Bradley (Chief Executive, London Ambulance Service): That is exactly right. Helpfully, in the north east, they have got the 111 call takers sitting alongside the 999 call takers, and that has been quite helpful in terms of transferring calls. Some of the 999 calls have been able to be transferred to 111. It is work in progress but we need to get it right: we have got a good chance. There were some issues when we rolled out NHS Direct initially: we need to make sure we get this absolutely right because it could be a good thing.

Richard Barnes (AM): Its default position was, "Call an ambulance".

Richard Hunt (Chair, London Ambulance Service): It is interesting if you sit in and listen in to NHS Direct calls exactly what they are all about. They maybe are not about what you think they are. There are a lot of information requests made such as, 'what is the number of my local X, Y and Z service?'

What has got to change here is behaviour. Behaviour that is, "I'm happy to have my problem fixed with a conversation on the telephone". Otherwise we have only got influence to try to make it work better but, at the root, we have got to get into - through whatever communication methods we can jointly come up with - changing behaviour that says 999 means this - and I am sure it did when we were all growing up - 999. 111 can mean a whole range of other things.

As Peter said a little while ago there could be a cultural issue about expectations and an individual's requirement. They may want to be taken to a hospital, so that is an element of behaviour that we have got to work on.

Richard Barnbrook (AM): You did mention before the idea of a programme for 5, 10, 15, 20 years. Are you in the process of going into education and schools to inform the youngest generation who will be growing up, and also the parents of this generation to try to highlight to them, "This is 111 and this is 999. If we say to you, as the medical system, that you do not need to go to hospital, you need to go there". Educating the public to get a better understanding of what they need and do not need.

Richard Hunt (Chair, London Ambulance Service): What is required is something along the lines of "Clunk Clink Every Trip" [slogan from public information films from the 1970s], which ran for how many years?

Peter Bradley (Chief Executive, London Ambulance Service): I was not born then!

Richard Hunt (Chair, London Ambulance Service): To come back to your specific point, do we engage with the community in schools - you and I were talking about it just coming here Peter, weren't we?

Peter Bradley (Chief Executive, London Ambulance Service): Yes, we were.

Richard Hunt (Chair, London Ambulance Service): We do participate extensively - in terms of public education programmes and, frankly, I would like to see us make more of it because it is a real shaper, potentially, of exactly what I have talked about in terms of behaviour for the future. I do not know whether you can recall some of the statistics we have got, Peter, on it?

Peter Bradley (Chief Executive, London Ambulance Service): The Fire Brigade has done a great job with the smoke alarms in schools and communities. There is no smoke alarm equivalent in the ambulance service; unfortunately, because, if there was, then it would be simple The Fire Brigade has done a good job; we need to replicate some of that. We are starting but we have got a lot more to do. You are right; let's target the people that are going to be ringing 999.

Richard Hunt (Chair, London Ambulance Service): Certainly we are in schools and the general community opportunities with the message about resuscitation and the use of defibrillators and that sort of thing. But I was on a bus the other day and I was looking at an NHS London advert to say, "Call 999". It was related to the chest pains exercise but, of course, if you did not see that end of the advert, it just said, "A&E call 999". We need to think about how we put some of these things across and the language we use.

If I was to reflect on just our early conversation here it is all full of internal language which again, coming from the outside, it takes you a while to learn, otherwise you do not know what anybody is talking about, words such as Pathways and others. We are talking about 111 as though it is here: 111 is still, actually, in trial with pilots yet to start.

Richard Barnes (AM): When we were growing up there was a primary care service in which the doctor held a certain status within society, and we all knew who our own local GP was and he had probably treated a couple of generations within the family as well: we have moved away from that now. I do not know whether it is a loss of confidence in the primary care service or a lack of access to GPs, but surely that change in the environment around illness must have an impact on you.

Richard Hunt (Chair, London Ambulance Service): It does, absolutely. I tell you what we do have which we did not have when we were growing up, and that is the capability of the modern ambulance service. The ability to do much more in terms of clinical input and treatment.

Andrew Boff (AM): They just moved you, in the past, didn't they? Took you from one place to the other.

Richard Hunt (Chair, London Ambulance Service): I remember being taken in a red blanket to a hospital: being transported. Now, we want to be more capable at the front end in terms of being a mobile healthcare service, we want to be more effective at taking patients to the right place for the right treatment and we want to do less in terms of using vehicles in responding to issues and patients' needs that could be handled by telephone, or even the internet. You talk to NHS Direct and it is talking about not just telephone response, but the capability to deal with peoples' queries using all the modern systems.

Richard Barnes (AM): I recognise that but we have not got exclusive insight and no doubt this is not the only meeting where you have articulated what you have articulated this morning. Are other people listening to what you are saying, and is there receptiveness to change?

Peter Bradley (Chief Executive, London Ambulance Service): It is a complicated area isn't it? We have got some of our communications team here with us today. It is a complicated area; how you influence the public and things. We had the campaign for the heart attack chest pain. We had big posters on the Underground and buses and a picture of a leather belt round someone's chest. As a result

of that campaign we got an extra 50 calls a day. Some of them were indigestion but one patient had put the actual belt round their chest! We have seen in previous campaigns demand go up because people do not use the ambulance service wisely. They think "That is a good idea; I never thought of the ambulance they're pretty quick. I'll give them a call".

We have lacked resource. We have not had enough resource to put in, like the fire service has. It has got people in every borough working on community fire safety. They have done a fantastic job. It has got people there full time in the community. We have got three. The police also have got people in the community. We have got three people doing that. We have got all our people in ambulances, more or less. We are looking to try to get more out there in the schools and in the communities but it is a very big job.

Individual PCTs do listen to us, but it is a case of have we not got the resource to put into working with them down on the ground.

Richard Barnbrook (AM): You mentioned clunk click which was quite a hard hitting television advert and put shock through. Is there a possibility of doing a parallel; by using this ambulance - unnecessarily so - you are taking this granny's life away from her. You have this parallel video of somebody with a bit of a pain who has had too much to drink and you have got a granny about to drop dead. How would that affect calls coming in?

Peter Bradley (Chief Executive, London Ambulance Service): Our staff would love that. What is one of the biggest impacts on staff morale in our service? What are the top three things for the ambulance staff in London that affect their morale? One of them at the top is inappropriate use of the ambulance service.

Finally, on that point of morale: we have done a really good job on knife crime. Our staff explain what happens if you start using knives. We have got the 'Stay alive' one where we have got people out in the community. We talk to teenage kids about what happens if you have a crash and are found to have been drinking; about the court system and some of the calls that we receive. We have got some fairly high impact campaigns like that, but we have not got the money for big campaigns.

Richard Hunt (Chair, London Ambulance Service): I did choose my example carefully. Clunk Click was not an advertising campaign that lasted for three months for a particular purpose: it lasted over years. I mentioned behaviour and you mentioned schools. All these are components that need to be addressed on a long term basis. That is what I meant by 5, 10, 15 years. You know, we do not have a choice. If we carry on down the path that we are on at the moment with demand escalating by - choose your number, 4, 5 percent or that sort of order of magnitude, you can do the compound arithmetic yourself!

It does have to be grassroots - is anybody listening- get everybody involved - and I was only semi-joking about politicians - all of us involved need to start to grasp what is the right message to give, how do we campaign about it, and how committed are we over a long period of time to do something about it?

Richard Barnbrook (AM): Let's hope Mr Clegg [Deputy Prime Minister] and Mr Cameron's [Prime Minister] meeting today with the NHS will work something out --

Richard Hunt (Chair, London Ambulance Service): I am very hopeful.

James Cleverly (Chair): We have started doing a little bit of a comparison between the other blue light services. One of the things that came out was integration.

Andrew Boff (AM): You mentioned the 111 service. I am enormously worried about the 111 service and worried about other agencies being given a very important person (VIP) pass to your service and how we control that. What we did hear at the last scrutiny meeting was that 10% of the calls to your service come through the police, and they do not have the benefit of any kind of triage, and it advances straight through to despatch. What work are you doing with the police service to better manage that?

Peter Bradley (Chief Executive, London Ambulance Service): We are doing quite a lot of work: we have not had a huge success yet. That is not a criticism of the police by the way; that is just where we are at. We receive 400 calls a day from the police in London. Two years ago when I joined, when the police rang for an ambulance, you used to speak to an operator on the 999 system so we could get a better sense of what was wrong with the patient. Because that was quite labour intensive we moved to a bit like the 111 system where they can automatically get it sent to our despatch desk, which has been good because it speeds up the ambulance, but what it does mean is, as you said, there is a less thorough triage process. I think it is about 16%, the number of patients that get transported by ambulance from a police call, so there is evidence that there is a high level of inappropriate attendance.

We are doing some work and we meet with the police regularly. We have got more work to do with them to say, "What can we do together to make sure that we can triage these calls better to reduce the inappropriate use?" It is fair to say, on occasions, we do get sent to have a look and we would rather say, "Police. Do you mind having a look and tell us if you need us?" A lot of calls we do attend with the police and we work very well together. There is no easy fix and there is no quick fix. They have got limited powers. It stops them going through a third party. When you have got 35,000 police officers it is very hard to get detailed information about each call. Often the police calls are quite fraught calls and there is a lot of confusion around what is actually going on at the scene.

Andrew Boff (AM): What work is being done at the moment?

Peter Bradley (Chief Executive, London Ambulance Service): We are doing a lot of work on analysing the types of calls; where, when, how and what we are going to do better.

Andrew Boff (AM): Why was the system changed? If you are saying, I was not aware that it used to be that a police officer on the scene would have to call 999.

Peter Bradley (Chief Executive, London Ambulance Service): It has changed because, when I joined in 1996, we used to have an answer phone in the control room and people used to wait for a long time to get 999. After two minutes the answer phone came on. "Is your call important? We will get back to you soon". We used to have horrendous delays in answering 999 calls and a lot of those led to the police. To improve our 999 call answering we automated the process and brought more call takers in. It was primarily around resourcing. It is much better now.

Andrew Boff (AM): Bearing in mind that the reason for the police having a direct link to despatch has now gone, wouldn't it now be wise if they returned to the principle of ringing 999 rather than straight through to despatch?

Peter Bradley (Chief Executive, London Ambulance Service): It is something we are looking at. We have now changed our response to calls from custody suites. Where we were just responding, we have now got a 999 call for those. We are doing it for the custody suites where they ring 999 and speak to the operator so we get a better sense of what is going on. It is work in progress: I am not sure we want to return to that. We need to understand the benefits of going back to the 999 call answering and we are doing a review of that now to understand what is the best way forward.

Andrew Boff (AM): If I were to ask the Metropolitan Police Service it would be aware of this work that was going on?

Peter Bradley (Chief Executive, London Ambulance Service): Absolutely. Definitely. Yes.

Richard Barnes (AM): If I can add some information? As soon as a police officer attends an individual they are effectively, I believe in law, in police custody. If they die under police custody in an ambulance or while someone is waiting there they can be immediately suspended, there is a police complaints review and there is a whole rigmarole which may well be part of those barriers and the police may well be operating on the principle, "Thank Christ I'm covered" because of their own and other internal processes.

Richard Hunt (Chair, London Ambulance Service): They rely heavily on us.

Richard Barnes (AM): Exactly. You provide them with cover.

Andrew Boff (AM): Do you see a role for further training of police officers to respond themselves to incidents as they are often the first people to be on the scene?

Peter Bradley (Chief Executive, London Ambulance Service): We have done work with the police in the past. Yes, we would convey our thanks to the City Police who respond to calls for us as first responders with defibrillators. There are a lot of police in London as you know. We would love to have the opportunity and the resource and for them as well to have all 33,000 police officers off the road for a day, working with us, telling them how to use the ambulance service wisely and basic life support. They do have their own training, basic life support and first aid, but we would love the opportunity to have more time with them and the resource to do it.

Andrew Boff (AM): We have on the record now that what you are saying is that, in many circumstances, the police officers are using your service when they do not really need to do it.

Peter Bradley (Chief Executive, London Ambulance Service): On some occasions, yes. We have shared that with the police.

Richard Barnbrook (AM): Should Hendon [Police College] be teaching young officers to deal with paramedics and, if not, why not have a paramedic based at the police station to go on calls that come through that maybe are, initially, bad health?

Peter Bradley (Chief Executive, London Ambulance Service): We have done that in Camden and one other parts of London. We have had a paramedic out on police patrol, with good results actually. They get to a call where someone has fallen over, say a drunk, or a bit of aggravation, a paramedic can do an assessment and say to the police, "You don't need an ambulance for this call. The patient can do X or Y". That has been quite successful. It is all work in progress, it is fair to say. One of our senior

managers in our control room is an ex-superintendent in the Metropolitan Police Service and came from the police straight to us. His name is Lee Brooks. He has done a good job and he has got some good relationships working with Richard Webber, our Operations Director, and other team members. I think we are going to see some positive moves in the next six to nine months on this area.

Murad Qureshi (AM): Can I extend this debate about convergence with the emergency services to the fire service? I was not privy to the last meeting but I think it was suggested at the last meeting that there was scope to combine the services provided, particularly around cardiac arrests. I wonder what your views are on that?

Richard Hunt (Chair, London Ambulance Service): Can I come in here? Reading what took place in the discussion in the first part of this meeting I do not think there was a suggestion of combining ambulance and fire; indeed it was quite clear to suggest that we would argue very strongly that the place of the ambulance service is within the National Health Service (NHS) because we are at the front of that demand chain.

What I do think was referred to was, can we use the skills, potential resource and training of colleagues in the fire service as being able to operate as first responders etc, as happens in other parts of the country. I think that that is an open question. A lot of response and discussion took place about the practicality of two workforces etc. That does remain - unless Peter is going to contradict or have a different view - an opportunity.

Peter Bradley (Chief Executive, London Ambulance Service): No, I think it is fair to say, being frank about it, in urban parts of England, including London, there is a reluctance - certainly from union colleagues from the Fire Brigades Union and from ambulance unions - for fire service colleagues to respond to ambulance calls because their view is that that risks jobs. If you have got the Fire Brigade doing all your work then why do you need an ambulance service, and, likewise, a fire service union would say the same, "We are not paid to do ambulance jobs". There is a big issue there.

Murad Qureshi (AM): I understand what you have raised. The Professor who made the suggestion did suggest that there was space capacity, and that is the issue. If firemen are there and are equipped to respond to those kinds of things first, I think there is a role clearly –

Peter Bradley (Chief Executive, London Ambulance Service): They have got defibrillators now on a number of the fire engines --

James Cleverly (Chair): One of the points that came out was the under utilisation of defibrillator kits currently held by the fire service, and whether there is something that could be done on that. The other one, from memory, is to do with the real estate and co-location and potential benefits from that. Perhaps one of you could explore those two issues?

Peter Bradley (Chief Executive, London Ambulance Service): We now share at least two sites with the fire service across London, and we meet regularly with its estates team to look at opportunities. We are looking to have, in time, probably fewer sites, and bigger sites, because our estate is not fit for purpose. We have got very close links with the Fire Brigade on how we can work together on that joint estate, as appropriate.

A lot of times we have got a fire station and an ambulance station next to each other. Twickenham is a case in point. We do share. We share resources in Barnet. We also had discussions about the control room and their new control centre and the prospect of sharing some of that estate with them, but we have not progressed that yet. There are a range of areas.

As far as the defibrillators on the fire engines are concerned they are relatively new and they have been placed there primarily to protect fire fighters in case one of them gets into difficulties. We trained their trainers for that, which is good, and we do and will encourage them, if they get a call where someone is in cardiac arrest, as they often are, to provide life support to those patients: they have done it many times before.

Murad Qureshi (AM): On the back of that, Chair, it would be quite useful to plot where ambulance stations are in relation to fire stations. Some of us will have the local knowledge in our particular neighbourhoods. It would be helpful to have a picture.

Richard Hunt (Chair, London Ambulance Service): Sorry, underpinning that, I hope what has come across is a preparedness on our part to engage with both the police and the fire service.

Peter Bradley (Chief Executive, London Ambulance Service): We do meet.

Richard Hunt (Chair, London Ambulance Service): That was the point I was going to make, Peter. We have in the last 12 months reintroduced regular meetings. In fact we hosted the last one ourselves in Waterloo. We have been round to the police and we have been round to the Fire Brigade. Kit Malthouse AM [Chairman, Metropolitan Police Authority] and one of the Assistant Commissioners come along from the police and obviously the Fire Brigade Chair and Chief Fire Officer come along as well. We get together. That is an agenda we want to develop. Chair, you will recognise this is something that we have talked about before when we have been in touch with you. There is an open preparedness to say, "How do we, as the three emergency services, provide the best response as needs arise?" That is an agenda we need to keep very active in developing.

Richard Barnes (AM): You see no impediment, in principle then, for joint bases; fire service and --

Richard Hunt (Chair, London Ambulance Service): I am not sure I would use those words myself. But I am sure they will arise. Do we have a fit for purpose estate that we want to hang on to? We do not have a fit for purpose estate. In fact one of our challenges is about how we remodel that over the next few years, because it is a legacy estate. My first visit to an ambulance station was to Heathrow, with the fire station on the north side of Heathrow. So, no, I do not --

Richard Barnes (AM): The fire service was separately funded though.

Richard Hunt (Chair, London Ambulance Service): I did not know so at that stage, Richard!

Richard Barnes (AM): In Ruislip we have got a fire service in one place and an ambulance service somewhere else. For 20 years we have been trying to get them to get married.

Richard Hunt (Chair, London Ambulance Service): In Hillingdon?

Richard Barnes (AM): In Ruislip.

Richard Hunt (Chair, London Ambulance Service): Oh, Ruislip. Yes. Ruislip is a whole discussion in itself!

Richard Barnes (AM): For 20 years you have been trying this.

Richard Hunt (Chair, London Ambulance Service): Our staff do not have an ambulance station anymore. I do not exaggerate. They are not there. If we go round for a visit they are at the hospitals; they are not on our stations. It is not a secret. We said it. We will have fewer larger sites because our staff are not sitting on the stations anymore. The issue with the Fire Brigade is not quite as clear cut now. We have got a mobile staff; they are out. On stations it takes two or three minutes extra to get the vehicle off the premises, so we need them sitting on street corners basically. We need them out and about. They get job after job after job and they are out.

Murad Qureshi (AM): Another aspect of convergence is the door to door service, the LAS patient transport. The Mayor and the boroughs have got a shared vision there. I want to know why it has not really happened yet?

Peter Bradley (Chief Executive, London Ambulance Service): Is this like a joint social transport service? We were not sure. Richard inquired. Door to door as in the door to door company or door to door as in providing a door to door service for people with social needs who require transport?

Murad Qureshi (AM): It is the latter.

Peter Bradley (Chief Executive, London Ambulance Service): I think it is fair to say - the Chair might say something different, although he should not do!

Richard Hunt (Chair, London Ambulance Service): I reserve the right to!

Richard Barnes (AM): Shouldn't that be the other way round!

Peter Bradley (Chief Executive, London Ambulance Service): When I joined we used to have a massive patient transport service. We moved around 1.5 million patients around. We were big into it. We had lots of mini buses. Over the years we have lost lots of contracts. London has got a very competitive patient transport system. We cannot compete on price. We lose contract after contract because our terms and conditions are more expensive. We provide a high quality service, we would say, and we do, but, at the end of the day, there are a lot of private providers out there who undercut us on price. Year after year after year we do less and less. Our patient transport; we have only got 10% of the business now in London. As the NHS looks to provide more medical need transport, rather than social transport, which it used to do, it is fair to say, we do not see it in our long term strategy as getting involved in the normal moving people around London transport business.

Murad Qureshi (AM): I understand that and we are aware of the historical context. I was struck by your earlier comment when the Chair asked you why do Londoners call the ambulance service more per head than anyone else, and you mentioned car ownership. Are more people in certain areas, like the outer London boroughs, more likely to get in to a car and get to hospital and people in central London less likely?

Peter Bradley (Chief Executive, London Ambulance Service): I cannot answer that. What I can say is that we get 1,000[2] maternity calls a year. It is a bit of an aside but I will say it in passing if you do not mind. When we arrive the patient has had nine months of pregnancy to prepare for the birth and we get an ambulance round to 1,000[3] of these and the partner follows in the car. Why doesn't the patient go in the car? That is not answering the question. I think car ownership should be less in central London than outer London, personally.

Richard Barnes (AM): There are statistics which I can give you that show car ownership per head of population per borough.

Murad Qureshi (AM): I have seen those figures and I do know in central London there are places where it is coming down. I am wondering whether, as a result, the drive to the hospital --

Peter Bradley (Chief Executive, London Ambulance Service): Cost of parking at hospital. They may have mentioned last time there is still a belief that you go in an ambulance and you get seen much quicker in A&E: that is a huge one. As was mentioned earlier, the Holby City example. On television patients are rushed straight in. Increasingly what is happening is they get triaged and they get put in the - there is an expectation. They get triaged by the nurse and they get put in a waiting room. When that happens patient say, "Hang on a minute. I just arrived by ambulance. I'm going with everyone else in a waiting room. That's not right. I'm an ambulance patient. There is a big issue there about people ringing 999 – in Holby City, Casualty [Television hospital drama] - "I'm whizzed through. I've got a VIP card. Business class. Ambulance class". It is good.

Murad Qureshi (AM): Business class on an ambulance service. That will increase take up!

Richard Hunt (Chair, London Ambulance Service): We had a number of questions about the issue of the underlying drive in demand. Firstly I know a lot of work is done on this and work needs to continue on it. I think you will find every reason there. This is part of the problem. When you are handling 1.5 million calls a year in a population of 7.5 million/8 million, have you made your call yet? One in seven people are calling the London Ambulance Service, which is amazing.

You asked about patient transport services (PTS) - sorry I am going native and using acronyms! As we have looked at our strategy going forward we have looked at whether we should be in it or whether we should not be in it? Our conclusion, even though it is a relatively minor part of our business, is that we believe we do do an excellent service job with a clinical focus for the patients that use our service and we resist the temptation of becoming just cost effective and not quality effective. So we have decided that, because it links to the rest of what we do - and you need to think about things in an organisation like bringing people in and moving them through the organisation and giving them a career type of structure - that we will stay in it. We are realistic to say that we will not always be able to compete on price - which I think is your question - with the other providers.

Andrew Boff (AM): Presumably it helps your revenue though if you are winning contracts?

Richard Barnes (AM): Only if you are making money out of it.

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[2] Following the meeting, the Chief Executive of the London Ambulance Service confirmed that '1,000 maternity calls' should read '**10,000** maternity calls'

[3] As above

Richard Hunt (Chair, London Ambulance Service): There is a critical mass issue here.

Andrew Boff (AM): If you are not making money out of it, for the service, then why are you doing it?

Richard Hunt (Chair, London Ambulance Service): Let's leave making money out of it because it is all about which costs you allocate to it. Providing our analysis says that it is not causing us a drain on income - and our analysis at the moment is that it is not - we have decided to stay in it.

Richard Barnes (AM): As a social service?

Richard Hunt (Chair, London Ambulance Service): As one of the services we offer.

Peter Bradley (Chief Executive, London Ambulance Service): It makes a small surplus each year. As you said, Chair, as long as that continues. It is fair to say we worry slightly that there is some evidence to suggest that when we lose a patient transport service contract we pick up some additional calls after losing the contract. I am not supposed to do sweeping statements am I!--

Andrew Boff (AM): Sorry, how does that work?

Peter Bradley (Chief Executive, London Ambulance Service): What can happen is that some private providers undercut us by a huge margin and, once they have won the contract, they find out there is a lot more volume there than they appreciated. What happens is that they say, "We're not doing that. We're not doing this. Not doing that." As a consequence we get the call. The default setting is the LAS. We end up getting some of our old calls to do and we have to be quite careful with that.

James Cleverly (Chair): A proportion of the previously funded patient transport non-emergency gets redefined and you get those old customers back as patients?

Peter Bradley (Chief Executive, London Ambulance Service): It is possible. The margins are cut so tight with some private providers when they won the contract that the volume exceeds their ability to make a profit. We have been fairly - rightly so - liberal about accepting patients on our PTS at times. The private providers are very, very careful about what they will and will not accept. Hospitals ring us sometimes and say, "Can you help us out?", and we usually say, yes.

Richard Barnes (AM): To what level are your escorts and drivers trained to? They are not paramedics --

Peter Bradley (Chief Executive, London Ambulance Service): On the patient transport service? They do a basic training course over three or four weeks.

Richard Barnes (AM): As with local government escorts and --

Peter Bradley (Chief Executive, London Ambulance Service): They do have clinical training. They are able to defibrillate, they are able to provide basic life support and look after patients properly. That is part of our package of selling. We have got good training: they are trained by our people.

Richard Hunt (Chair, London Ambulance Service): One of the things that I think, again, is confusing if you are not on the inside is whether you understand that it is an independent organisation

that is providing you with the transport or not, because the vehicles look the same and the crews are dressed the same. I am surprised at that; that private operators are able to paint their vehicles and represent themselves in the same way that we are as the London Ambulance Service.

Richard Barnbrook (AM): You were suggesting ambulances are an executive way into hospital where the private car is simply the secondary --

Peter Bradley (Chief Executive, London Ambulance Service): Are you sure I said that!

Richard Barnes (AM): I will change my behaviour!

Richard Barnbrook (AM): Is there a possibility that somebody in the past thought, "Right. I'm going to drive my wife, myself or whomever it may be to hospital, sit there and wait for X amount of time"? I know from one hospital - without throwing sticks and stones - Queens in Havering the nurses pay to park. If you go in there for A&E I am not sure if you pay for there. If you go in there for a drop in you have to pay. People may say, "I've paid enough. I'm not going to pay to go to drive to hospital even though I'm not that ill that I can't do it. I'm just going to go for the executive entry, the ambulance". People in the past may have done this. "I'm not sitting in the waiting room for three hours". Maybe they are ill. They use the ambulance to get in quickly to procedures. Is that an element you could look into to try to resolve something and re-educate people? You could say, "You may need the ambulance and you don't like waiting but, please, try to make your own way there if you can"?

Peter Bradley (Chief Executive, London Ambulance Service): Absolutely. At Christmas time we had more calls than we had ambulances in the winter, so we had calls stacking and some non-urgent calls. If you rang 999 our medical team were ringing back to the patient and saying, "Listen. We're really busy at the moment. [I'm paraphrasing slightly] Do you mind finding your own way? We've got a bit of a queue here who are waiting". Invariably they say, "All right. We'll make our own way then. Thanks". The NHS is free at the point of delivery. We do not usually say no.

The question we have been asking ourselves is we have done that for Christmas, should we now do it routinely? There are some issues with that; moral issues and clinical issues. As part of the new target change we want to be a bit more robust. Also, we have to expect more complaints. That is not an easy message to think about because people expect, "I dial 999. I get an ambulance". We have been asked to do some education.

As we found when we started referring patients to NHS Direct, because we refer some of our callers to NHS Direct every day, initially there was tension, "I want to talk to the people in the green uniform and a yellow hat. I don't want to speak to a nurse on the end of a phone, thanks". What we try to do now is say, on the 999 call, "We think your condition is not serious. We think you could quite helpfully speak to a nurse and get some advice about this". That has worked quite well. It is a slow process but we have got to do it differently.

Richard Hunt (Chair, London Ambulance Service): It has shown some relief on the call out for an ambulance.

Peter Bradley (Chief Executive, London Ambulance Service): On the AA one just quickly. AA's performance is the best it has ever been. People wait the shortest time - and as the Chair was saying - sometimes the better you get the more work you get. On BT's national 999 figures for use of the

emergency services in England the Fire Brigade is getting less calls, the police are getting less calls and the ambulance service is getting more calls. In fact, for the first time in its history, in December 2010, the ambulance service in England got more 999 calls than the police in England. That has never happened. We were miles and miles and miles behind. We are now more or less the same.

Richard Barnes (AM): I should hate you to be in competition!

Richard Hunt (Chair, London Ambulance Service): There is an issue here that the more the NHS in the round is on our news every day the more it is in peoples' minds. There is a whole host of demand drivers that we need to think about.

One thing I would just like to add to what Peter was saying is, of course, we are very much a target driven operation. We have talked about the eight minutes and the 19 minutes. If you are trying to meet 75% in eight minutes you do not have a lot of time for the sort of additional discussion and analysis that you have got to have. That is one of the things that we are mindful of and are trying to improve upon over the next months, if not years.

We did not mention it earlier but I know you covered it well in the first part of the meeting, of course, that eight minutes used to be eight minutes once certain information had been obtained. 2004 and 2005 am I right, Peter, it was timed as eight minutes from the phone being lifted. When you are in that sort of environment you do not have a lot of time, hence our automatic despatch systems and everything else.

Richard Barnbrook (AM): What are the risks and opportunities of the planned move to GP commissioning on the ambulance service?

Richard Hunt (Chair, London Ambulance Service): There are plenty!

Peter Bradley (Chief Executive, London Ambulance Service): If we end up with 37 or 40 GP consortia in London then, potentially in terms of numbers, that is not a lot difference to the 31 PCTs and, therefore, on face value, it could be a small change, where you end up with a lead consortia commissioning our service on behalf of the other 30 odd commissioning groups/consortia. Of course it could be more than 40. People could want their own variation locally on the service provision, which is a worry. That is a risk. The risk is that we struggle to get a London-wide contract for service and, therefore, we end up having to try to tailor our service by borough, which is just not possible the way we work. We work as a pan-London organisation.

Another positive is potential more clinical input into our service. More interest in clinical care. As you were saying earlier about GPs and out of hours, if they are involved in the commissioning, then maybe they have got more of an interest in making sure the system works right.

We cannot be victims about this. The Department of Health made it very clear that even though we have lobbied as an ambulance service in England against GP commissioning - we would prefer to be regionally or nationally commissioned as a service - that has not been accepted, so we are going to be GP commissioned - rightly or wrongly. Let's get on with it and make it work.

Richard Hunt (Chair, London Ambulance Service): We wait to see what the detail of that is clearly, and we do not know. I do think it is worth re-emphasising the point that of course it brings GPs into the

commissioning environment directly, which means that the use of the ambulance service is now more directly linked to them, rather than at arm's length. I think that is a big opportunity of creating that joining up, providing we do not get the things moving in the opposite direction and the risk is fragmentation. Fragmentation, when you are the only pan-London provider of a service, obviously has clear risks associated with it.

Richard Barnbrook (AM): Going back to one of Murad's questions on the PCTs. We pretty much lost that and you are saying we do not really need it. What I did see this morning on television put a shock through my system. By chance I watched BBC Breakfast - and I mentioned earlier that David Cameron and Nick Clegg are meeting up. One of the things that the GPs were making an issue of, in the short period of time I had to watch this - and also the public - is what happens if the private sector starts sneaking its way in? My concern is this could be a brilliant situation of helping out London with the GPs working as closely as possible. What happens if the private sector starts coming in with the same uniforms, the same clothes, ambulances there, and it starts cutting corners? We could then, possibly, find an issue there where you find your own service slightly under threat by a cheaper alternative.

Richard Hunt (Chair, London Ambulance Service): I was interested to read the text of Andrew Lansley's [Secretary of State for Health] statement to the House of Commons just a couple of days ago. In it - I have not brought it with me - there is a line that says the commissioning of emergency and A&E type services - whether he mentioned mental health or not, I cannot remember. He did not see that - and I need to find the text to give me reassurance on your point – as necessarily being a part that could go out to any qualified provider.

We do have to be careful of what I would call loose bricks in the wall which is a well known strategy of how you enter a market. What might they be? Treble one providers; patient transport services. On patient transport services we are already experienced at living in a competitive environment. On call taking I do not think we are unless you use the out of hours providers. Those are certain things that I think we need to be careful of.

What is absolutely clear is that there is a heritage and an ethos about the emergency service as represented by the LAS that must not be compromised or lost. We have got to be prepared to put our head above the parapet and make that very clear. When the phone rings there will be somebody to answer it. When there is an incident or an emergency then there will be people who respond readily and quickly and do what is needed. That is more than just a process, it is more than just an organisation's objectives; it is the very core of what I have found drives people to work for the LAS. You lose it once, you will not get it back very easily. Therefore, we must argue for being the provider of emergency and urgent response right across London for all Londoners.

Richard Barnes (AM): And when they answer that phone they do not say, "What is your national insurance number"!

Richard Hunt (Chair, London Ambulance Service): Too true.

Richard Barnes (AM): Is there an argument for the GLA and the Mayoralty to be the Lead Commissioner on a strategic basis for London?

Richard Hunt (Chair, London Ambulance Service): What we would be arguing for is not who owns it but the need for it to be done on a consolidated basis.

Richard Barnes (AM): And by somebody who knows what they are doing.

Richard Hunt (Chair, London Ambulance Service): That would be useful!

Murad Qureshi (AM): It is interesting. I have GPs in my family so I am not prejudiced against them but are GPs the best people to deal with emergencies of the type that the ambulance service deals with? The image that is conjuring up in my mind with GP commissioning is that you are phoning the GP first before you get to the ambulance service. GP services are structured, I would suggest, predominantly to the convenience of the doctors and how they run the show, more so than the patients. We still have a long way to go on that front.

Peter Bradley (Chief Executive, London Ambulance Service): It is a wider question, as has been in the media and in the NHS, are GPs the right people to commission these services? Some of them are and it is about getting the right people doing the right job. I think that a lot of what we do has got a synergy with GPs. A lot of our calls are primary care and indeed part of our work. Only a small amount of it actually is really emergency work. A lot of it is elderly, frail and chronic conditions: it is primary care. There is a lot of synergy between what GPs do and what we do. We could make it work well but we need the right people commissioning our service with the right skills, knowledge and interest.

Richard Hunt (Chair, London Ambulance Service): On a consolidated basis. We are going to take the opportunity to say this every time we are asked the question. If you have 40 people commissioning an ambulance service it does not look terribly logical so let's start with one doing it on behalf of whomever the stakeholders within that community are. Ultimately we are all stakeholders as residents of London.

Murad Qureshi (AM): You do not want to deal with the bureaucracy of 40 odd clients.

Richard Hunt (Chair, London Ambulance Service): Let's cut to the chase. It would not work. 40 of anything! I suppose the question is that the challenge for GPs - and I do not know much about it - is they are required to be professional service organisations going forward. I know something about that, and that is obviously a challenge. We wait to see. We will make our case and we will respond to whatever is put in place.

Andrew Boff (AM): I absolutely understand what you are saying about the importance of the LAS responding within a short space of time and the quality of the service that the patient is receiving is important. What is the issue with it being somebody else turning up to deliver that service as long as the response is the same? You have a controlled 999 service and you do the despatching. What is the problem with it being somebody else actually getting to the patient, rather than it being a London ambulance?

Richard Hunt (Chair, London Ambulance Service): If I have implied that somebody qualified and able to give the patient the right service is an issue then that is not correct. My challenge back to you would be, how do you make that work? Not would the treatment be appropriate, but how do you make that work?

Peter Bradley (Chief Executive, London Ambulance Service): Someone mentioned this the other day. It is not like nursing where you have got a big bank of nurses in England. There are no other

paramedics. The paramedics that work in the LAS are the paramedics: there are no others in London. There might be ten or 20 but that is it. Unless they took our staff to work for them there is no other service that has got –

Andrew Boff (AM): Just as an aside, of course that does happen. You have got Hatzola in Stoke Newington and parts of Barnet serving the Orthodox Jewish community. The relationship with London Ambulance Service was very close.

Peter Bradley (Chief Executive, London Ambulance Service): The point made is right. We do use Hatzola. We use them. We use St John. We use Red Cross. We do use them but it is for pockets of small amounts of work that we have pre-triaged. The concept of a private provider providing an emergency ambulance service --

Andrew Boff (AM): I am not disputing the fact that you are doing the triage. I would not want anybody else doing that!

Richard Hunt (Chair, London Ambulance Service): I thought you were implying that it was separate to -

Andrew Boff (AM): No. I would not want anybody else doing that. Is it relevant the badge that is on the front of a vehicle that turns up to deliver that ambulance service?

Peter Bradley (Chief Executive, London Ambulance Service): I think it is. I would say so I have been in the ambulance service a long time and a paramedic for years and years. I do find myself comparing, even though we are not, with the police and fire service. If Mr Bloggs' police service turned up to your burglary or Mrs Bloggs' firefighters turned up at a fire. It seems that the ambulance service is - like you said before, you see all these vehicles driving round London with blue lights on and they could be LAS ambulances. They are not. It is wrong. You do not see fire engines running round the streets, or the police. That is my own personal view. I, personally, am dead against a private provider of the emergency ambulance service. I could not agree with it and I do not support it.

Richard Hunt (Chair, London Ambulance Service): I spent my life in the private sector and in commercial practice. I am now finding myself a strong advocate for the fact that this should be a central publicly provided emergency service. Drive us on quality standards. Drive us on performance. Every good organisation should have that.

Andrew Boff (AM): That gives us an indication of your adaptability!

Richard Hunt (Chair, London Ambulance Service): You want a response!

Richard Barnes (AM): It has been heavily argued that it should remain a part of the NHS and governance arrangements have been discussed on a number of occasions. Is there any strong argument for you becoming a functional body of the GLA and the Mayor appointing the Governor or whatever else, or is the imperative to be part of the NHS?

Richard Hunt (Chair, London Ambulance Service): If you want my personal view, because I am a newcomer to the NHS, unlike --

Richard Barnes (AM): I want the benefit of your experience.

Richard Hunt (Chair, London Ambulance Service): Thank you, Richard. I am glad to give it. I would see it more effective, more adaptable and giving us more options to be integrated with the NHS structure. Why, because we are at the origination of demand. We are part of what I would call how you manage the demand chain. One of my criticisms would be that we are not yet joined up enough. To change ownership moves us, potentially, in the wrong direction.

Can I conceive of that being different? Of course I can. You asked me my view. My view, very strongly, is we should sit at the front of demand, along with GPs who are also at the front of demand, and make the whole chain work better. You do that from inside, not from outside, an organisation most effectively.

Richard Barnes (AM): Is that confidence in the service because you are bringing a medical service, because that is how it is viewed, which is part of that chain, also important?

Richard Hunt (Chair, London Ambulance Service): I think that is one of the reasons we are getting the increase in demand; we are seen as part of the start of looking after people, not just transporting them. It strikes you very strongly when you go out on an ambulance that, once the crew take the patient within what I call their orbit of care which is starting to do observations on them, talking to them, the attitude of the patient - of course not in major trauma cases but in the majority of cases - changes because they feel they are being looked after. I think that is something to build on. We want to do more at the front end in terms of the skill level and capability of our paramedic and other staff. The people who need the service would recognise the benefit of that being done.

Richard Barnes (AM): Should there be a Mayoral representative on your Board?

Richard Hunt (Chair, London Ambulance Service): I am Chairman of the Board under the governance arrangements as we move towards foundation trust. Then I think there is every opportunity for there being a Governor member from the GLA. The Chair and I have spoken previously about saying I do not have any reluctance to have regular contact, discussions and collaborations. This is something we need to do together under a foundation trust. I have recently recruited two non-Executive Directors in the last year. Did anybody from your neck of the woods apply?

James Cleverly (Chair): Richard, one of the things I would like to do - indulge me if you would. I take the point you are saying about being part of the NHS and being right at the sharp end of demand. I want to look at this relationship and play devil's advocate with that. If you look upon the police, for example. They have a much more intimate relationship with this building in terms of the governance arrangements, scrutiny arrangements and that kind of thing. There is a compelling argument to say that, they are the front end of demand for the criminal justice system and so things which start with the police flow through other elements which are detached from and separate to the work of this building going into the court system, the prison system and into the probation system. All those things are absolutely interwoven, but they are detached.

There could be an argument to say there is a similar vein; that the London Ambulance Service is at the front end of a larger health system in the same way that the police are at the front end of a larger criminal justice system. Could parallels be drawn across in terms of perhaps the Mayor or this Assembly's ability to be a financial champion etc? I am very conscious that in the reasonably tight central

government settlement fire and policing had a very vocal and high profile advocate, where the LAS did not have quite the same degree of profile? What would your comments be around that?

Richard Hunt (Chair, London Ambulance Service): I would make one brief sentence. Advocacy does not require ownership.

Richard Barnes (AM): We saw that with the student riots.

Peter Bradley (Chief Executive, London Ambulance Service): It is a tough one. We are a schizophrenic organisation. We are an emergency command and control, major trauma, big incidents on the one hand: a small part of our work. Then we are primary care, holding peoples' hands and looking after them as well. If we were just the high end emergency ambulance service, the 200,000 of our 1.5 million jobs, then it would make sense to be part of the Assembly or part of the three services because we would be a true emergency service in that sense. But we are not. We are much more embedded with other parts of the NHS now, with our primary care work.

As a corporate NHS employee , less so for the Chairman I would say, we cannot say too much about the things that we want to talk about, if that makes sense.

Richard Hunt (Chair, London Ambulance Service): Can I respond directly to the Chairman then and relieve you of that difficulty? Of course you can make your argument. I am not in any way saying you cannot. I just do not happen to agree with it and I do not agree with it because I do not think it is the best solution.

Peter Bradley (Chief Executive, London Ambulance Service): You can agree with the advocacy!

Richard Hunt (Chair, London Ambulance Service): I certainly welcome your involvement. Why not become a non-Executive Director? Why not become a Governor? We would certainly, collaboratively, welcome the arguments that are required to improve and provide improving health care for all of London, whether it is financial resources, whether it is communication campaigns or whatever.

James Cleverly (Chair): The mood that I am picking up is there is definitely an appetite for closer working and greater transparency to us as a body. As I said right at the beginning, we have never had any push factor. I just want to put that on record. This is not being driven by any prior concern that you have not been open with us because certainly in my personal experience there has always been complete openness.

Andrew Boff (AM): You very kindly came along today voluntarily.

Richard Hunt (Chair, London Ambulance Service): It did not feel like it! We are very happy to be here.

Andrew Boff (AM): Is the LAS summonsable? The point I am making is thank you very much for turning up. I have been on the London Assembly for three years. The last session - I am not putting down on this session - was probably the most interesting scrutiny that we have done, covering the range of ambulance services, in the time that I have been on this Commitee, and threw out so many issues. Would you object if all of a sudden you found that you were summonsable - we summons people and we are very pleased to see you - by the London Assembly?

Peter Bradley (Chief Executive, London Ambulance Service): I would not object. There has to be an implied accountability. With the capital's ambulance service we have got a big responsibility. We cannot just sit in isolation with the NHS alone; absolutely not. I think it is right that 1) you take an interest in us and 2) it is quite right; if you have got issues on behalf of Londoners that we hear them and respond to them. I, personally, have no issue whatsoever with that.

Richard Hunt (Chair, London Ambulance Service): Neither have I. Whether we are here voluntarily, by invitation, or as it were a quasi summons does not matter. It is the right thing to do and we are very happy to be here.

Peter Bradley (Chief Executive, London Ambulance Service): I absolutely agree.

Andrew Boff (AM): I have got one little question more to ask. From time to time one hears criticisms from London ambulance drivers themselves about the quality of the kit that they have: it is a perennial thing. I have seen, in the past - I am not talking about currently - criticisms of defibrillators and criticisms of certain pieces of equipment. I realise you have got a lot to pack on to those ambulances and you have to make compromises but what kind of liaison do you have with your paramedics on what is best to put on the ambulances?

Peter Bradley (Chief Executive, London Ambulance Service): We have huge liaison. It is fair to say, being frank about it, we have got no issues whatsoever with the quality of the kit. What we do have is issues with the availability and quantity because it goes missing a lot. Our staff do not look after the kit well enough. We have told them that, and I am happy to tell you that. We get emails every day from staff - yesterday in fact I received one saying, "Where's this and where's that?"

We have got plenty of kit, it just goes missing! We have got logistics issues in the organisation that we are still working through. It is however better than it was. In terms of the specific question around involvement, we have huge involvement. We have vehicle equipment working groups: we consult them. Our consultation arrangements with our staff is very good, they are heavily involved in the design of the ambulances and the equipment inside it.

Andrew Boff (AM): If I were to ask your members of staff the same question would they come back with the same reply; that they were heavily involved?

Peter Bradley (Chief Executive, London Ambulance Service): Not all of them, because they would say, there is a group that they do not get access to. Their biggest concern would be, "Where's the kit?" not "I wasn't involved with the design of it". That is the fundamental issue they have got. This has improved but is still an issue.

Richard Barnes (AM): When they leave the vehicle they often leave the back door open and go into somebody's house for however long.

Peter Bradley (Chief Executive, London Ambulance Service): It is a long story. We have got a flexible fleet. We have got 420 ambulances. They are all around London. We are trying to get them equipped in the right place at the right time, seven days, 24 hours a day. We used to have individual station based ambulances. When we were quiet we used to sit outside on a Sunday morning and polish the ambulance and look after our own ambulance. We are now so busy that we have got to move our

fleet around. Sometimes the lack of personal ownership of the vehicles and the equipment means that it does not get the same attention as it used to do. We have got more staff so it is a bigger issue. Our Chair, obviously a logistics expert from the past, has been helping us, with other people, and we have been trying to improve it. It is a little bit better but there is a lot more to do.

Richard Hunt (Chair, London Ambulance Service): It was one of the things that I felt strongly we needed to focus on, and improve, and we are continuing to do that. It is one of these things that looks relatively simple - A 24/7 operation. Mobile fleet all over the place – when actually it is more complicated. Does it need improving? The answer is yes it does. Are we working on it? The answer is also, yes we are.

Peter Bradley (Chief Executive, London Ambulance Service): A favourite topic, Richard, from years gone by, is radios! Police colleagues have got individual issue radios. I am told that if they lose it they pay a fine to replace it. We could not afford to give everyone an individual radio – for each staff member that would mean 3,500 of them. We have got hand held radios in the ambulances and they do not always stay with the ambulances. Sometimes we have got one radio for two. I got an email yesterday about the shortage of some of those missing on the round - where are they? Preferentially, we say it is personally issued, your responsibility, if yours is missing you are accountable. Our staff need to be more accountable, but it is a big issue.

Richard Barnes (AM): The one area we have not touched on is the morale of the people that work for you. One thing that can impact upon them is the way in which they are received - I am trying to be delicate, rather than politically correct - in the areas of London which they visit. There used to be a time when attacks on ambulances, on ambulance staff or threats to ambulance staff were rarely reported. There seems to be a quiet time at the moment, a plateau. How are your staff being treated once they arrive at a scene?

Peter Bradley (Chief Executive, London Ambulance Service): Considering we have hundreds of staff driving round alone they do pretty well. It would have been inconceivable ten years ago in the capital city; driving around 24 hours a day, going to estates and some difficult places. Currently, we get around 300 assaults a year, we receive a lot of verbal abuse and we get a lot of spitting: it has been quite quiet. One of our ambulance staff got his leg broken only a week ago at Lewisham Hospital. He was assaulted in the back of the ambulance. He was attacked quite seriously: he got bitten. It does happen!

We do the best to protect our staff and our staff are cautious. We get a lot of coverage in the media about health and safety. We work closely with the police. We have got agreed designated points. What tends to happen is that the cases that you do not expect to be a problem at are where the problems actually occur. If you get told there is a fight in a pub. Our staff on their way there are already aware of that and they wait for the police and they will do the right thing. You go to an ordinary job perhaps a collapse in a house, and something happens. That is where it is hard; our staff cannot do a risk assessment in advance.

It has been less of an issue; we have done training. We have also issued our staff with stab vests. We have got better at risk awareness. We have got better information going to our staff, by and large, but it still happens too frequently.

Andrew Boff (AM): When your staff are in need of police assistance do they skip the 999 service and get an automatic response--

Peter Bradley (Chief Executive, London Ambulance Service): Yes we do now. The new Airwave radio system is fantastic. It has got a priority button on it and our staff are able to get police assistance as soon as is possible. The police are very, very good at coming to our assistance.

James Cleverly (Chair): Peter and Richard, it has been genuinely fascinating listening to you this morning. I do appreciate the candour in your answers to the questions we have put forward today. Thank you.