Written submissions received for the London Assembly's investigation into the future of the London Ambulance Service

London Ambulance Service – Evidence Log

Number	Organisation	Contact/Title
Sub-001	Department of Health	Simon Burns – *MP Minister of State for Health*
Sub-002	London Borough of Haringey	Fiona Hare - *Assistant Director, Adult Services and Commissioning*
Sub-003	London Ambulance Service	Angie Patton - *Head of Communications*
Sub-004	South London healthcare NHS Trust	Jane Harryman - *Director of Operations*
Sub-005	Ealing Hospital NHS Trust	David James - *Board Secretary*
Sub-006	Chelsea and Westminster Hospital NHS Foundation Trust	Axel Heitmueller - *Director of Strategy and Business Development*
Sub-007	-	Julian Green
Sub-008	City of Westminster	Cllr Colin Barrow – *Leader of the Council*
Sub-009	Medical Services	Mr Joe Sheehan – *Managing Director*
Sub-010	British Medical Association	Madeleine Knight - *Policy Analyst*
Sub-011	North Middlesex University Hospital	Clare Pannlker - *Chief Executive*
Sub-012	Ambulance Service Network NHS Confederation	Creina Lilburne - *London Relations Manager*
Sub-013	London's Air Ambulance	Dr Gareth Davies- *Medical Director and Chair of the trustee Board*
Sub-014	British Consulate-General New York	
Sub-015	Berlin Fire Brigade	

Sub-001

From the Rt Hon Simon Burns MP Minister of State for Health

Department of Health

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Mr James Cleverly
Chair, Health and Public Services Committee
London Assembly
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18 FEB 2011

Dear Mr Cleverly

Thank you for your recent communication requesting views and information relating to the London Ambulance Service NHS Trust.

The following provides the Department position on each question posed as part of the London Assembly review.

- *How is the London Ambulance Service currently performing, and how can performance be improved?*

The Department of Health collects and publishes weekly activity statistics for ambulance trusts which includes performance for responding to Category A immediately life-threatening calls within 8 minutes, and Category B serious but not immediately life-threatening calls within 19 minutes. Data for the week ending 13th February 2011 shows that London Ambulance Service NHS Trust responded to 80% of Cat A calls within 8 minutes against the 75% standard, and 80.1% of Cat B calls within 19 minutes compared to the 95% standard. Data for the last four weeks show an average performance of 80.1% for Cat A and 84.5% for Cat B. London Ambulance Service, as with all ambulance trusts, are also required to respond to all Category A calls that require transport within19 minutes, 95% of the time. This information is not collected as part of the weekly activity statistics, but as part of the Information Centre's annual data collection. The most recent information against the 'A19' response time standard shows that London Ambulance Service responded to 98.7% of Cat A calls within 19 minutes compared to the 95% standard (2009-10). Data for 2010-11 will be published by the Information Centre later this summer.

In response to how performance can be improved, it is for primary care trusts as commissioners and strategic health authorities to work with NHS organisations to ensure they are providing an appropriate level of high quality care for patients. We expect the local NHS to plan and provide appropriate resources to meet local demand, in line with national response time requirements.

- *How can the increasing demand for the services of the London Ambulance Service be managed?*

Understanding increases in the demand for ambulance services is integral to the frontline management of ambulance resources and improved commissioning by Primary Care Trusts across all urgent and emergency care services, and we expect the local NHS to plan and provide appropriate resources to manage local demand effectively. To support the NHS on this matter, using good quality, real-life ambulance data, a small team, comprised of Department of Health analysts, ambulance providers and PCT commissioners, have worked together to develop a practical tool to assess a wide range of factors that are influencing the steep rise in demand, in order to help facilitate better whole system commissioning. This toolkit was launched in October 2009, and can be accessed via the Department website.

We also recognise that many 999 calls made to ambulance services are not serious or life-threatening. Locally ambulance services need to work to offer public education as well as alternative services as ambulance trusts will need to refer patients to other services where appropriate.

- *What services should be provided by the London Ambulance Service?*

It is the responsibility of commissioners within the local NHS to agree with the London Ambulance Service what services it will provide. The requirement to deliver against the nationally set response time targets will form a fundamental part of those discussions.

- *What would be the implications of the London Ambulance Service becoming a Foundation Trust?*

London Ambulance Service NHS Trust is working towards achievement of Foundation Trust (FT) status along with all the remaining NHS Trusts. The commitment is for all NHS Trusts to achieve FT status by April 2014.

The implications of any NHS Trust achieving FT status is the organisation being able to be autonomous in it's operation by being self-governed and directly accountable for the services it provides and the decisions it takes. That is, not having the safety net of a regional or national body to ensure an organisation is running itself well, as is the current governance arrangements for NHS Trusts with Strategic Health Authorities and the Department of Health.

Another key implication of achieving FT status is the local accountability to patients through memberships and governors. FT governors, as representatives of public, patient and staff memberships, have a formal role to ensure the organisations operate in a way that best meets the needs of the populations they serve.

To achieve FT status an NHS Trust will have needed to demonstrate it's capacity and capability to deliver sustainable high quality services. Underpinning this there will need to be a robust business model and a strong governance culture supporting this. This assessment will be undertaken by Monitor, currently the independent regulator of FTs, who will take on a wider economic regulatory function in the new system being established by the Health Bill.

The implications for London Ambulance Service NHS Trust achieving FT status will be therefore to establish itself as a well-governed and sustainable provider of quality services. This will be crucial for their continuing effectiveness in the new system where other organisations look to develop more effective and efficient ways to provide high quality healthcare services i.e. it will be in a strong position when market forces take effect.

- *What would be the implications of the move from Primary Care Trust to GP commissioning of ambulance services?*

GP consortia will be responsible for commissioning urgent and emergency care, including ambulance services. It will be for consortia to determine how they organise themselves to commission these services. The Health and Social Care Bill includes provisions for consortia to pool budgets and enter into 'lead commissioner' arrangements to facilitate commissioning across consortia.

- *To what extent should ambulance services in London be subject to greater competition?*

Centrally, we are not in a position to judge whether more competition is required for ambulance services in London. This would require a market analysis to be undertaken by the commissioners, taking into account current performance, the potential for alternative providers and the need for the strategic co-ordination of emergency services.

- *What should be the relationship between the Mayor and the London Ambulance Service?*

We recognise the importance of close, effective working relationships across the London region, and would continue to encourage that this continues between the Mayor and the London Ambulance Service.

I hope this reply is helpful.

SIMON BURNS MP

Sub-002

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Mr J Cleverly AM
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Dear Mr Cleverly

Re: **Review of the London Ambulance Service**

Thank you for your letter dated 7th February 2011 addressed to Mr Kevin Crompton, Chief Executive, Haringey Council, and for inviting us to comment. This has been passed to me for my attention and I would respond to the key questions you ask as follows:

Q1. **How is the London Ambulance Service currently performing, and how can performance be improved?**

A. Performing well for category A patients however some of the pathways for example around falls has never really progressed. This has remained patchy across London, although there was some work led on clinical decision making in the context of not taking patients to hospital.

Q2. **How can the increasing demand for the services of the London Ambulance Service be managed?**

A. Communicating (greater awareness) with primary care and via local networks on the inappropriate use of an ambulance. Greater use of local paramedics as in other PCTs, perhaps aligned with community/primary care providers. Divert to community services however, this would need a sector approach given the multiple access points to services (*There was some work in the Black Country 2008 on pathway diversion via Ambulance services).*

Q3. **What services should be provided by the London Ambulance Service?**

A. Suggestions as follows: recatherisation, more patients transferred to hospital for same procedure and in particular out of hours where provider service not 24/7. Also, simple wound care – leg bandaging.

Q4. **What would be the implications of the London Ambulance Service becoming a Foundation Trust?**

A. Greater freedom and flexibility in shaping the service to respond to the changing needs of London.

Q5. **What would be the implications of the move from Primary Care Trust to GP commissioning of Ambulance Services?**

A. Difficult to say at this stage as still a lot of unknowns, however as GPs are at the frontline they should be in a better position to know what type of service is required. This may be the impetus to really shape integrated (with LAS) pathway to divert people for secondary care.

Q6. **What extend should ambulance services in London be subject to greater competition?**

A. Any willing provider ideally should apply to the London Ambulance Service as with other provider organisations.

Q7. **What should be the relationship between the Mayor and the London Ambulance Service?**

A. As the lead for health care for London – a supportive as opposed to command and control relationship.

Please do not hesitate to contact me if I can be of any further assistance or if you require any additional information.

Yours sincerely

LISA REDFERN

Lisa Redfern
Assistant Director, Adult Services and Commissioning

cc: Mr Richard Berry, Scrutiny Manager, London Assembly

Sub-003

London Ambulance Service NHS Trust

London Assembly review of the London Ambulance Service

London Ambulance Service response

Background

The London Ambulance Service is the busiest emergency ambulance service in the UK to provide healthcare that is free to patients at the point of delivery. We are also the only London-wide NHS trust.

As the mobile arm of the health service in the capital, we are an integral part of the NHS and play a key role in the provision of urgent and emergency healthcare to patients across London.

1. How is the London Ambulance Service currently performing, and how can performance be improved?

Our response to this is answered under the following headings: patient experience, clinical outcomes, clinical quality and safety, and governance. In addition, we outline how performance can be further improved.

Patient experience

We recognise that our speed of response is important to patients, and we have three national response time targets. These are to reach:

- 75 per cent of Category A (life-threatening) calls in eight minutes
- 95 per cent of Category A calls within 19 minutes
- 95 per cent of Category B (serious but not life-threatening) calls within 19 minutes.

We are on track to hit both the Category A eight-minute and 19-minute targets for the year ending 31 March 2011. This will be the seventh successive year we have achieved both these targets.

In terms of the Category B target, we will not achieve the 95% target this year. However, we will have responded to over 25,000 patients more quickly in 2010/2011 than in the previous year. The Category B target is being replaced in 2011/2012 with a set of clinical indicators – these are explained later in this statement.

Our patients also expect their 999 call to be answered quickly. We have the largest ambulance control centre in Europe and this year we will receive over 1.4 million 999 calls and answer each of these calls on average in four seconds. This provides some of the fastest and most consistent 999 call answering in the UK.

In the last 12 months our control room has been awarded the European control centre of the year award and was the first ambulance control room in the UK to be awarded the Cabinet Office Customer Excellence Award for outstanding customer service.

Clinical outcomes

Our aim is to provide our patients with the highest quality of care that will contribute towards Londoners having health outcomes that are amongst the best in the world.

London's cardiac arrest survival rate has doubled in the last four years, and the ambulance service has had a key role in this achievement. We have monitored survival rates for out-of-hospital cardiac arrest (when a patient's heart stops) since 1998, and have seen a steady improvement year on year. For the last year where we have complete data (2009/2010), we had a survival rate of 21.5% as measured on the internationally recognised Utstein template[1].

We now assess and take trauma, heart attack and stroke patients to specialist centres in the capital where they receive immediate treatment from expert clinicians.

London's trauma system went live in April 2010, and critically injured patients are now taken to one of four major trauma centres. In the first six months after the network of centres opened, we took an average of 10 patients a day to a major trauma centre, with the average travel time from scene of the incident to one of the centres being under 14 minutes. Since centralising trauma care there have been an additional 37 survivors across London compared to the expected number of survivors using national data.

Our crews now take patients diagnosed with recent onset of stroke to one of the eight hyper-acute stroke units in the capital where they have rapid access to life-saving treatment. This increases their chances of survival and also cuts the risk of long-term disability. Data collected for the three month-period between August and October 2010 shows that 92% of FAST positive stroke patients were transported directly to a hyper-acute stroke unit.

And patients who have suffered a heart attack are taken to one of the eight heart attack centres for specialist treatment. Patients benefit immediately from primary angioplasty – a procedure whereby a catheter is passed into the arteries in the heart and a balloon is inserted and inflated to release the blockage in the artery. In the last annual audit (for the year ending 31 March 2009) almost 90% of (ST elevation) heart attack patients were transported directly to a heart attack centre.

Currently we are exceeding the targets agreed with our commissioners in each of these areas.

Clinical quality and safety

We monitor our role in infection prevention and control. We have an extensive audit process that examines the cleanliness of ambulance stations and ambulances, and also the clinical activity of staff. This forms a key factor in being able to register with the Care Quality Commission. We have been able to register without any conditions, and

[1] The survival rate is based on patients whose cardiac arrest was witnessed and whose heart responded to an electric shock from a defibrillator.

compliance with hygiene legislation is audited through unannounced visits by the Commission. We are continuing to build on the infection control audit cycle in order to make continuous improvements.

There are a range of measures already in place to monitor the quality of clinical care offered to patients. Some are statutory such as safeguarding and complaints monitoring whilst other are Trust-specific such as meeting a category C (non-serious injury or illness) time target.

For safeguarding we were recently inspected by NHS London and the visit resulted in a number of recommendations but also highlighted a number of exemplar practices for sharing with other ambulance trusts.

A number of specific projects have also been identified for further development in 2011, and these include improving the care at the end stages of life and also improving the care given to mental health patients. Each project will have measures to monitor the impact of the improvement.

Finally, a suite of quality measures will be introduced during 2011. These will commence in April with a number of new quality indicators from the Department of Health which can be used by the public to compare the quality of ambulance services at a national level. These will be supported by an additional set of indicators that will measure aspects such as maintaining body temperature and pain relief. These will be used to support and drive continuous improvements.

Summary of performance measures

The indicators that the ambulance service will use for monitoring performance and quality from April 2011 will include:

- Outcome from cardiac arrest – return of spontaneous circulation (how many patients in cardiac arrest have a pulse/heartbeat on arrival at hospital following resuscitation)
- Outcome from cardiac arrest to discharge from hospital
- Outcome from ST elevated myocardial infarction (a common type of heart attack)
- Outcome from stroke
- Service experience
- Time to answer call (999)
- Time to treatment
- Calls closed with telephone advice
- Call abandonment rate
- Re-contact rate following discharge of care
- Category A eight-minute response time to life-threatening calls
- Category A 19-minute response time to serious but not life-threatening calls)

Governance

We manage our finances well and have achieved our key financial targets for the last six years. In addition, for the last two years we have received an “Excellent” rating from the Audit Commission for how we manage our resources. We are the only ambulance service in England to have received such a rating.

We also achieved unconditional registration with the Care Quality Commission and were re-assessed at level 1 of the NHA Litigation Authority's risk management standards, having shown a considerable improvement on previous performance against these standards.

Improvements

We are replacing the system that we use for handling 999 emergency calls and sending ambulance staff and vehicles to patients. The existing computer-aided dispatch system was built in-house and has served us well over the past 15 years. However, it has reached its 'end of life' and is to be replaced with a commercially available industry product, CommandPoint. The new system is provided by USA defence contractor Northrop Grumman and is currently in use by emergency service agencies in several US cities. It will provide us with a modern, reliable call handling system that will be the core of future developments for enhanced call handling. The new system will go live in June 2011.

We are currently replacing the existing mobile data terminals in our ambulances and fast response cars with a new model of hardware. The terminals allow information about incidents to be transferred electronically from our control room to vehicles. The majority of the fleet refit should be completed ahead of the new computer-aided dispatch system going live. As well as improved reliability, the new terminals will provide additional functionality such as details of alternative places of care (other than hospital), and 'talk', which will reduce the risk to single-crewed vehicles in which paramedics may have been tempted to read screens while driving.

2. How can the increasing demand for the services of the London Ambulance Service be managed?

Demand for emergency ambulance services continues to increase year on year and so far this year demand is up five per cent on 2009/10.

We recognise that, given this demand increase and the current economic climate, we are going to have to adopt a different approach if we and the wider NHS are to sustain the current high quality service we provide.

Two key strategies have been developed as critical for the future.

Firstly, we will have to use the new found freedoms created by the change in response time targets to offer new and more appropriate care pathways for patients who ring 999. This will involve offering far more telephone advice to callers who have needs that can be dealt with over the telephone. In those cases where it is necessary to send an ambulance, we will be looking to find more appropriate care pathways rather than taking patients to A&E departments for treatment. We have already had some success with this including referring patients to falls teams and transporting patients to urgent care centres. However, we recognise that much more use of other more appropriate NHS services will be necessary in the future.

Secondly, we recognise that much more needs to be done to improve public health and general education about what to do in an emergency. We are keen to develop a health prevention and public education strategy with the Mayor's office and the new health and well-being boards.

Finally, we wish to emphasise that a London-wide NHS urgent and emergency care strategy involving acute trusts, GP services, out-of-hours services and NHS Direct, linked to the roll out of the new 111 number will ensure a fully integrated approach to this increasing demand.

3. What services should be provided by the London Ambulance Service?

We have identified six service areas that we should be providing. These are identified in our five year Integrated Business Plan:

- Emergency and urgent healthcare access, including call-taking and triage.
- Emergency and urgent healthcare response, including incident response and clinical telephone advice.
- Specialist operational response, including major incidents, Hazardous Area Response (HART) and Chemical, Biological, Radiological and Nuclear (CBRN).
- Health professionals' information provision and case management.
  Our emergency bed service 24-hour referral team provides services for:
    - neonatal transport
    - clinical transfers
    - GP referrals
    - capacity monitoring - collecting and sharing information about hospital capacity across London
    - 24/7 point of referral for safeguarding children and vulnerable adults
    - out of hours services for several district nursing services

  Also, our clinical co-ordination desk provides support and advice on specialist medical resources, major trauma and stroke.
- Patient transport and clinical transfers.

- Event management – including the London 2012 Olympic and Paralympic Games, Notting Hill Carnival, London Marathon, football matches, political summits and many other events that are hosted within London which is unique in the UK for the large number hosted throughout the year. Such activities include emergency planning and preparedness to ensure that as a service we have the resilience to support such events, whilst providing the day to day 999 responses outlined in the first two bullet points above.

In addition to these services we provide public health education, working with the public, local communities and other public and statutory agencies across London, to promote health outcomes. In 2010 we held or participated in over 600 public education sessions and have already had 80 contacts in January 2011. These positive impact activities include anti-knife and gun crime events; 'Safe Drive, Stay Alive'; child safety weeks; running community defibrillation, resuscitation training and community responder programmes; monthly basic life support sessions in Tower Hamlets aimed at teaching Bengali women with young children what to do in an emergency; school visits and junior citizens' schemes.

4. What would be the implications of the London Ambulance Service becoming a foundation trust?

We are proceeding with our application to become a foundation trust and we expect to be authorised within the next 12 months.

Becoming the only London-wide NHS foundation trust is important to achieving our vision and strategic goals. We will have increased accountability to our patients and the communities across London through stronger governance arrangements; greater freedom to invest and innovate in our services for the benefit of our patients and staff; and more opportunities to lead and work in partnership across London and in particular with the emergent GP consortia.

Alongside our Board of Directors we will have a Council of Governors comprising 16 elected public and staff governors and eight appointed partnership governors from voluntary agencies, local authorities, PCTs (moving towards GP consortia) and staff unions. The Council of Governors will represent the interests of our foundation trust members and the partner organisations in the London community, holding the Board of Directors to account for the organisation's performance.

We will build on the London Ambulance Service name and reputation which is very strong locally, nationally and internationally, by continuing to focus on improved health outcomes and the quality of services we provide, as well as continuing to shape and influence changes and improvements in other parts of London's healthcare system. As outlined above, we have a strong public health education role and we work collaboratively within communities.

5. What would be the implications of the move from primary care trust to GP commissioning of ambulance services?

The exact implications of GP commissioning are yet to be fully understood. However, we are working with commissioning colleagues and a number of pathfinder consortia to better understand the future implications for London's urgent care strategy.

We see our role as one of influencing and shaping the development of local services in partnership with GP consortia to ensure consistency in the quality and safety of emergency and urgent healthcare.

In terms of how we should be commissioned, we believe we should be commissioned at a pan-London level rather than through large numbers of GP consortia.

6. To what extent should ambulance services in London be subject to greater competition?

We deliver two core services - emergency ambulance services and patient transport services. Our patient transport services, which involve transporting patients to and from clinical appointments, are already subject to competition and we compete in the open market place for this business. We currently have approximately 15 per cent of the patient transport service business in London.

In terms of the emergency 999 ambulance service, we are listed as a Category 1 responder in the Civil Contingencies Act and we believe that the Service should remain part of the core NHS services provided to the people of London and should not be open to competition. We work closely with the other two core blue-light emergency services and provide a vital public service, not only for 999 callers but also for major events including the Olympics and Paralympic Games, Notting Hill Carnival, New Year's Eve

celebrations and the London Marathon. Furthermore, we house the national ambulance coordination centre for any major incident or event, that impacts on more than one ambulance service area; this includes the swine flu outbreak.

7. What should be the relationship between the Mayor and the London Ambulance Service?

We are keen to develop our working relationship with the Mayor and believe there are a number of opportunities to do so.

We believe that we have a responsibility to contribute to the delivery of the Mayor's Health Inequalities strategy. We are in the unique position of having direct contact with 7,500 patients and public across London every day, and this presents some opportunities for us to encourage Londoners to improve their health and well-being.

We have contributed to the Health and Public Services Committee investigation into the drinking habits of young Londoners. Alcohol-related calls continue to put extra pressure on the ambulance service (six per cent of total workload) and on the wider NHS. Tackling these issues requires a society-wide response, and we are keen to work with the Mayor and other partners to find solutions and make people more aware of the costly effects of alcohol, both in terms of people's health and to society.

We are fundamental to the provision of emergency and urgent healthcare for London. We have demonstrated our ability to influence the delivery of specialist care through partnership working in cardiac care, stroke and major trauma; we are now working towards influencing the delivery of unscheduled care through increased partnership working with primary care and those involved in chronic disease management.

In terms of emergency planning and resilience, we already have strong working relationships with the police and fire services in London. However, we recognise that more can be done to ensure we are prepared so that we can provide an effective joint response at times of large-scale incidents and emergencies.

We also work closely with our emergency service colleagues to plan and manage large events in the capital. As the number of events increases we are going to seek additional funding sources to ensure we provide much needed cover for these while at the same time protect our core 999 service.

As an NHS foundation trust, we will be required to have an appointed governor representing local authorities in London. We would be keen for a member of the GLA to take on this role, and believe it will provide an ideal opportunity to further develop working relationships between our Service and the Mayor.

We are aware that in its response to the NHS White Paper, Equity and Excellence: Liberating the NHS, the London Assembly suggested that the GLA could have a role in the leadership of the London Ambulance Service. We strongly believe that it would not be in the best interests of patients in the capital for the governance of our Service to move to the GLA. This would be a significant shift in policy direction, and since our core role is to provide clinical care to patients, we need to remain integrated within the NHS so that we can contribute fully to the development of urgent and emergency care in London.

The Secretary of State and the NHS are responsible for meeting the public's healthcare needs and deciding the most effective way of doing this within the overall resources voted by Parliament for the NHS. Under the changes proposed in the White Paper, it will be the responsibility of GP consortia to ensure these healthcare needs continue to be met. The Secretary of State will have a concurrent duty to ensure a comprehensive system of healthcare for England, and it would be inadvisable to take out an element of healthcare and separate it from the systems of accountability, budget setting etc for NHS services.

8. Any other issues we want to take the opportunity to highlight

We are currently preparing for the London 2012 Olympic and Paralympic Games and we have a vital pre-hospital care role to play in the biggest ever planned event in the capital. We have already given evidence to the Assembly's Health and Public Services Committee about our preparations and continue to work on meeting the milestones set out in the committee's report 'Business as usual?'.

23 February 2011

Sub-004

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Mr. James Cleverly
Chair – Health and Public Services Committee
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The Queen's Walk
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10 March 2011

Dear Mr. Cleverly

Review of London Ambulance Service

Thank you for giving us the opportunity to submit our views on the London Ambulance Service as part of the Health and Public Services Committee's review. I have shared your letter and public call for views with clinical and managerial staff working across our emergency care division and asked for their opinions and feedback

In general, our staff feel that the London Ambulance Service performs well given the pressures it faces in terms of increasing demand. We work closely with the LAS to improve the care we jointly provide, ensure they are aware and able to benefit from service changes and to support appropriate use of their service. We feel that we have a good working relationship on both an operational and strategic level and an increase in competition in the provision of ambulance services may complicate this.

In terms of the specific feedback received, much of this has been concerned with reducing the number of 'inappropriate' patients that are conveyed to emergency departments by ambulance which would have a positive impact on the ambulance service and our own services and these views are summarised below:

- Applying a more rigorous screening to emergency calls and sending out different LAS provision or other services (e.g. arranging a GP or District Nurse visit for that day) would reduce the need for emergency blue light ambulances to attend every cali.

- The public can inappropriately use the 999 number as the first point of contact with health services and there needs to be ways in which non-emergency calls can be diverted to a more appropriate service.

- There needs to be more emphasis on the ability of the ambulance service to provide alternatives other than conveyance to the nearest emergency department. The options available are wide ranging, e.g. treating and

Contd ...../

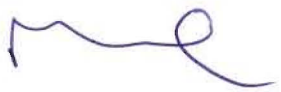
- stabilising patients in their homes, liaising with out of hours GPs to arrange home visits or conveying patients to services such as Urgent Care Centres or Mental Health crisis services. Improved partnership working with other providers and more effective monitoring of which patients are conveyed to EDs would support this working.

- Expanding the range of treatments Paramedics are able to provide in patients homes would reduce the number of unnecessary attendances at A&E and reduce the demand on the Ambulance Service.

- A high proportion of repeat attenders at our Accident and Emergency departments come in by ambulance. These patients use a disproportionate amount of both hospital and ambulance service resources and their needs are not best served by repeatedly being brought to A&E. A proactive approach to case managing these patients in conjunction with community services could prevent them coming to hospital and hopefully from repeatedly calling an ambulance. This type of service does exist in pockets, but needs to be more robustly implemented across the patch.

I hope these views are helpful to your review, if you would like any further information then please do not hesitate to contact me.

Yours sincerely,



Mark Cubbon
Director of Operations
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MC/HJH/6/837

cc. Dr. C. Streather, Chief Executive

Sub-005

Ealing Hospital NHS Trust

Sir,

In response the letter sent by James Cleverly 7th February 2011 to Julie Lowe CEO of Ealing Hospital NHS Trust I have gathered the following responses to the questions raised:

How is the London Ambulance Service currently performing, and how can performance be improved

EHT contact with LAS is via the 999 emergency service and there are no major concerns. Historically LAS were used for Patient Transport Services (PTS) but the Trust now uses a private provider.

How can the increasing demand for the services of the LAS be managed

The Trust assumes that LAS use strict protocols to determine the level of response required for 999 calls.

What services should be provided by LAS

LAS should be the sole provider of emergency services to London but we see no reason why inter trust transfers or PTS services should be protected from competition

What would be the Implications of the LAS becoming a Foundation Trust?

It would be assumed that the LAS would be more aggressive in competing for PTS and trust transfer work but this should not detract from their emergency focus.

What would be the Implications of the move from PCTs to GP commissioning of ambulance services.

It is still unclear as to the size and the number of GP consortia within London, but if in excess of the present number of PCTs it is a concern that this will result in extra complexity and this will be an issue for the LAS and subsequently acute providers

To what extent should ambulance services in London be subject to greater competition?

Emergency provision should be exempt from competition due to the complexities of emergency planning within the capital. But there is no reason why transfers between trusts (i.e. transfers to tertiary centres) and PTS should not be open to other providers.

What should be the relationship between Mayor of London and the LAS?

There is no clear line of accountability as afar as we are aware but there is no reason why the Mayor should not have a right of scrutiny on an annual basis.

Yours

David James
Board Secretary

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Sub-006

Comments on LAS for London Assembly from Emergency Department, Chelsea and Westminster NHS Foundation trust

How is the London Ambulance Service currently performing and how can it improve?

Considering the volume and nature of the calls put through to the LAS, the service performs very well.

However, the volume of calls is unsustainable and there is a need to free up capacity to attend to those patients who really need services in the ED.

The move to the new 111 number replacing 999 and NHS Direct is going to further improve and simplify the service. However, this will require giving thought to activation system criteria and the skill mix at the call centre. At present, the LAS call takers are relatively low skilled. For a new number to work effectively, particularly if NHS Direct is discontinued in its present form, there needs to be a robust framework in place at the call centre with doctors, suitably qualified nurses and paramedics available at all times as referees rather than actual call takers. We appreciate that there is work in progress to replace the AMPDs system with a Pathways system which is more sensitive in identifying seriously ill patients.

How can the increasing demand for services be managed?

An ageing population and increasing expectations among patients will inevitably increase demand unless care pathways are radically reformed and prevention is taken more seriously. However, we recognise that the LAS alone will not be able to reduce demand and that the rest of the health service needs to offer assistance.

There are some interesting international and national examples of good practice – though often robust evidence is lacking. The French ambulance service SAMU delivers tailored care to the patients in their own homes and this is something that could be explored in the UK to manage demand. Pre-hospital care provision forms part of the Emergency Medicine Trainees

curriculum and there are a significant number of practitioners who would view a rotation with the LAS, including manning a Fast Response Unit, as a rewarding part of their training. Anecdotal evidence suggests that this model works well for the HEMS in North East London.

The standardisation of the many units that provide non-scheduled care in London would be hugely beneficial. The LAS is the only pan London NHS organisation and as such could be designated as leader in the provision of a framework in how these services can be provided. At present, we have a plethora of differently branded providers throughout the metropolis, ranging from Major Trauma Centres to Walk In Centres and Urgent Care Centres.

The LAS could play a larger role in co-designing health infrastructure. For example, not all emergency departments are currently co-located with UCCs. Also, opening hours could be specific and the same in all localities (e.g. 8-8, 365 days a year) to provide more standardisation.

Under these circumstances it would be possible for the central call centres and the crews on the road to give advice to patients who are mobile about where to attend; or in some circumstances to convey those patients to the provider units. At present the system is extremely confusing particularly as crews no longer work in their own localities alone.

Similarly, falls pathways should be standardised throughout London and intensive training given to the crews to enable them to leave a percentage of elderly fallers at home in the knowledge that they will have timely follow up from the requisite services.

GPs play a key role in managing demand e.g. through providing more flexible opening hours. Also, UCC use should be monitored more systematically to pick up particular local patterns and work with relevant GPs to reduce numbers. The frequent default to *call 999 go to A and E* should be challenged where appropriate.

The public education campaign in the use of Emergency Services plays a key role too and should continue. Managing patient expectations is paramount. For example, in conditions of extreme weather or pandemics there should be

information given out to the public around waiting time changes as under those circumstances even the most robust systems will be overwhelmed

The education of children in schools in the recognition of life threatening conditions has worked extremely well in the Scandinavian countries and as well as preparing them to act as enabled bystanders it ensures that they have an understanding of when the emergency services should be called.

What service should be provided?

The aim is: the right patients to the right place at the right time. As specialist services develop on different sites a new picture will emerge and that picture should inform the shape of emergency services in the capital.

The provision of paramedics on motor bikes and pushbikes should be increased as they can administer life saving intervention to patients on scene.

We need a paramedic with experience on every vehicle that brings a sick patient to the ED, and a paramedic on every vehicle that performs an urgent transfer.

The provision of the dashboard system [already used in some hospitals] means that we should be able to preview incoming patients and be ready for them spatially and medically. The hospital turn around time needs to be kept to an absolute minimum so that crews can be freed up to get to the patients that will benefit more quickly and the hope is that the dashboard will inform central control of which hospitals are struggling.

Wherever possible the Acute Trusts and the LAS should liaise over

- Vulnerable children and Adults
- Patient Specific Protocols for patients with specific needs and Specific End of Life Care Pathways.
- Psychiatric patients with particular attention to those on sections 136s
- There needs to be work done in Care Homes for the Elderly throughout the capital so that there are plans in place to ensure their dignity and comfort in their last hours, and unnecessary blue light ambulances are

used to convey patients who may well have a DNR order to the Emergency Department

Acute providers could also consider offering training to the LAS and vice versa with an NHS passport serving as a placement agreement in both directions.

What would be the implications of the move from Primary Care Trusts to GP commissioning of ambulance services?

As set out above, GPs should play a vital role in managing demand. We therefore expect that this move would strengthen the relationship between GPs and LAS. However, there are also risks of greater fragmentation and consequently reduced efficiency which should be considered.

To what extent should ambulance services in London be subject to greater competition?

We are aware that a level of competition exists in other European countries and we are sure that you are considering the evidence on outcomes from those examples. Making ambulance services contestable has the potential to increase efficiency and reduce costs. However, relatively high set up costs may prevent the market from being fully competitive and other ways of driving efficiency should be considered (e.g. price benchmarking within the UK or Europe or separating infrastructure from the actual running of the service).

Sub-007

Submission to Review of the London Ambulance Service

The Author

I am a member of the public who provides assistance to the London Ambulance Service (LAS) on a voluntary basis. I am a member of St John Ambulance (SJA) and a Community First Responder (CFR) in a joint SJA/LAS scheme.

As a member of SJA I assist with emergency first aid at large public gatherings and stadia events. I am also a member of the SJA Forward Incident Team (FIT). This is a group of individuals who specialise in working within dense crowds to stabilise and recover patients to a place of safety, in circumstances where ambulance access is impractical. This team comprises people at the highest levels of training within SJA and works closely with LAS at am operational level. SJA and specifically FIT are a component of the LAS Major Incident Plan.

As a CFR, I have been trained and assessed by both SJA and LAS. When on call (typically a single fie hour shift per week) I respond to emergency 999 calls within the Edgware/Stanmore area. These calls are allocated by the LAS dispatch desk and my attendance is co-ordinated with that of Single Responders and crewed ambulances. Full details of this role are defined in the LAS CFR protocol. In essence the role is to provide an effective prompt response to critical calls (Chest Pain. Difficulty in breathing, collapse etc.) and to help to improve the patient's experience of the service and their chances of recovery.

In all of these roles, I had undergone training, assessment and regular requalification together with an ongoing requirement for Continuing Professional Development (CPD).

This submission is based on my own experience and observations. As such I will only comment on those questions where I feel competent to do so.

The opinions expressed in this document are entirely my own. I make no representation to speak on behalf of either LAS or SJA.

How is the LAS currently performing and how can performance be improved?

The performance levels of the LAS are well documented. I would simply say on this point that performance levels should be measured in terms of Patient Care and not simply Response Times and Call volumes. I accept that the latter are far easier to record and measure but they are not always a good measure of performance.

It is important to note that LAS is dealing with some very sick patients, for whom there is no possibility of survival even with the best possible care.

Metrics such as Response Times, Call volumes and Survival Rates can be useful indicators but the trends in these figures are of more value than the empirical figures themselves. It is equally important to acknowledge when it is appropriate to expect improvements and when the current levels represent a good level of service and success can be expressed in maintaining the existing levels.

It is well recognised that some 60% of 999 calls do not require urgent ambulance transport.

> "Only around 10% of the Service's patients are in immediate danger of dying and around another 10% also require an immediate response because, unless attended to quickly, their condition may deteriorate seriously.
> Around another 20% of patients are in no danger of dying but nevertheless need the LAS to be there quickly, often because of the pain they are experiencing or complications which might develop if help does not arrive within half an hour[i]"

The key area for performance improvement is in the appropriate treatment of all patients. Each non-urgent patient who is not conveyed by ambulance increases the availability of resources to those who really need them.

This means that a reduction in patients conveyed may actually be a positive measure. It is impossible to decide whether or not to convey a patient without a physical attendance and assessment of their condition. LAS already recognises this and this is behind the provision of solo responders who can attend, assess and treat patients but not convey them. More could be done in this area to encourage solo responders to consider whether an emergency ambulance response is appropriate. CFR's are not as highly trained as regular ambulance crews and cannot make these assessments, nor is it appropriate that they should.

CFRs are an important and valuable resource and they need to be used effectively. In this respect it needs to be remembered that LAS is unique as the only ambulance service which does not have to cover any sparsely populated areas. As such, LAS need to consider how best to utilise this resource.

The role of the ambulance service has changed from a transport service to a primary healthcare provider in its own right.

There has already been a major increase in the range of treatments provided by LAS. Many patients are no longer conveyed to an Accident and Emergency (A&E) department. They may be taken to specialist centres for cardiac or brain (Stroke) treatment, NHS Walk-In centres or referred to GP services.

Alongside this increase in diversity, has been an increase in the diversity of available resources such as Fast Response Units (FRUs), Emergency Care Practitioners (ECPs) etc.

In addition to this there has been an expansion in the provision of volunteer resources. This includes CFRs, BASICS (GPs providing emergency responses), Blood Bikes etc. It is essential that the LAS uses these resources to their full potential. This may require a greater involvement of LAS in defining those areas where this type of

resource is deployed most effectively and then providing or coordinating with other agencies, such as SJA and the British Red Cross, to provide appropriate training regimes, agreed qualification standards and operational protocols.

How can the increasing demand for the services of the LAS be managed?

This is not an area where I feel qualified to comment.

What services should be provided by the LAS?

Broadly speaking there are two service areas, Emergency Response and non-urgent patient transport.

Emergency Response

LAS should provide the end-to-end emergency ambulance response service from the receipt of 999 calls through to the delivery of the patient at the most appropriate treatment centre. This includes a prompt assessment of the patient and the delivery of appropriate “out of hospital” treatment.

I cannot see any benefit in breaking up this service either on a regional basis or by having multiple service providers. The 999 service has to be a single point of contact and by operating across the whole of London, LAS is able to balance resources in “real time” to accommodate localised demand peaks. This could only become mere difficult if the service were to be fragmented.

Non-Urgent Patient Transport

Much of this work is already carried out by a range of ambulance service providers. Anecdotal evidence seems to suggest that Patient Transport Service (PTS) contracts are often not renewed with the existing provider. If this is genuinely the case, it is worth considering why this might be so.

PTS work is important to LAS for two key reasons. Firstly it is an important training ground and experience route for new and developing ambulance crews. Secondly, as has been mentioned above, some 60% of 999 call require PTS Transport or no transport at all. LAS my be deterred from downgrading Emergency Transport to a PTS call if they are not able to provide the required levels of PTS.

What would be the implications of LAS becoming a Foundation trust?

This is not an area where I feel qualified to comment.

What would be the implications of the move from Primary Care Trust to GP commissioning of ambulance services?

This really depends on how GP commissioning of services, in the wider context, is operated. The number and size of the GP consortia will be crucial to this. If they are roughly equivalent to the Primary Care Trusts (PCTs) they replace, then there may be

very little difference. If however, the number of GP consortia is significantly greater thant the existing PCT's, there is a real risk of service fragmentation. Futhermore the administrative overhead of such a move could be considerable.

To what extent should ambulance services in London be subject to greater competition?

To some extent, this has been addressed above. There is already strong competition for PTS ambulance services.

It seems to me that there would be no benefit and considerable risk if a competitive element were to be introduced into the provision of Emergency Ambulance services.

What should be the relationship between the Mayor and the LAS?

I believe that politicisation of the LAS would be dangerous move. Although I did not make any detailed comments on the LAS Foundation Trust question, I believe that that would be a far more appropriate way to provide LAS accountability to the public.

I am unconvinced that the additional bureaucracy would provide any meaningful benefit.

Julian Green

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[i] LAS Strategic Plan (Jan. 07 TB) Final Version 6.0 (Strategic Plan 2006/07-2012/13) p7

Sub-008

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City of Westminster

From the Leader of the Council
Cllr Colin Barrow CBE

James Cleverly, AM
Chair, Health and Public Services Committee
City Hall
The Queen's Walk
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10 March 2011

Dear Mr Cleverly,

Re: Review of London Ambulance Service

Thank you for your letter of 7 February regarding the above review and inviting me to submit a response on behalf of London Councils.

As the experience and views of local authorities in relation to the London Ambulance Service will vary according to factors such as whether they are inner or outer London authorities, proximity to acute hospital services etc, it would not be appropriate on this occasion for me to make a response on behalf of all the London boroughs.

As part of this review, it may be helpful for the Health and Public Services Committee to contact local authority lead members for Health and Adult Social Services and also Chairs of Health Scrutiny Committees.

Following your letter to my Chief Executive, I would like to take this opportunity to raise some issues / suggestions from a Westminster City Council viewpoint which I hope the review can explore further.

Ambulance response to mental health emergency admissions to hospital

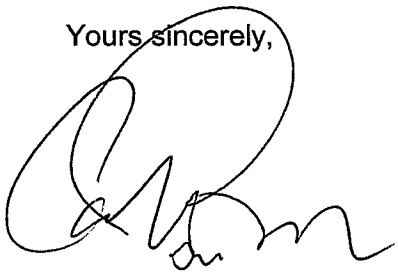
- Westminster's Independent Chair of the Adults Safeguarding Board has raised with the ambulance trust concerns raised by social care staff about the availability of LAS transport for a planned Mental Health Act assessment. The current system is based around pre-booking, however it has not been possible to book some requests within six days. This presents a huge potential risk to service users, families and mental health staff
- We have been actively working with LAS and our police colleagues to address these issues; however the situation remains a significant concern locally. Therefore anything the review can do to look at the situation London wide and suggest improvements would be helpful
- A recent letter to the London Ambulance Service Chairman and accompanying paper summarising concerns which were sent in July 2010 is attached for information

Some more general suggestions around the review questions you highlighted are provided below:

- How is the London Ambulance Services currently performing, and how can performance be improved?
    - *Useful to compare how the service performs against other ambulance services in large British cities. What lessons could be learnt.*
- How can the increasing demand for the services of the London Ambulance Service be managed?
    - *Useful to explore the types of incidents ambulances are being called to and the appropriateness of these calls. This is likely to expose issues concerning health literacy and the understanding that local populations have of health services*
    - *Useful to explore links between LAS, Metropolitan Police Service and licensing particularly in terms of the excessive consumption of alcohol within the night time economy and how this contributes to demand*
- What would be the implications of the London Ambulance Service becoming a Foundation Trust?
    - *How will this change lead to improved outcomes for patients?*
    - *What might be the relationship in future between the LAS and local health and wellbeing boards which have a key role in co-ordinating health services in their area?*
- What should be the relationship between the Mayor and the London Ambulance Service?
    - *The Mayor should have a role in helping to co-ordinate any pan-London activity, perhaps the Mayor's potential role could be explored in relation to the role he is due to have in pan-London public health activity*

I look forward to hearing more about the outcomes of your review.

Yours sincerely,



Cllr Colin Barrow
Leader of the Council

Email: cbarrow@westminster.gov.uk

Cc. Mike More, Chief Executive, Westminster City Council

Sub-009

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Date 14.03.2011

Re London Ambulance Service Review

Dear Sir,

Thank you for the opportunity to contribute to the review.
I am the Managing Director of Medical Services, the largest independent provider of Patient transport to the NHS in Greater London. Our organisation employs 500 staff and is headquarted in the City of London. We also provide patient transport and non-emergency ambulance services in other UK regions.
Having been in post for 3 years, my views have been formed over a relatively short period but in that time I have taken an active interest in the provision of ambulance services in London, and I am a member of the London Ambulance Patients Forum and attend LINks elsewhere in England
I would like to separate our organisations views on the LAS Emergency service from that of the LAS Patient Transport Service.

The Emergency Service

As a Londoner, I have full confidence in the Emergency Service. It is not perfect but it is not broken either. It does appear expensive to the taxpayer but that may point to other deficiencies in the spectrum of services and not a fault of the ambulance service alone. Our organisation has no axe to grind with the Emergency Ambulance Service and we have no special insight or comment that others are not better placed to make.
We do have a serious concern relating to the partnership working by LAS and private providers of patient transport in relation to civil contingencies but I wish to cover that further on.
Should ever a competitor or competitors emerge for the provision of emergency ambulance services in London, I would not be surprised if the brightest and best in LAS did not jump ship for the freedoms enjoyed by the independent sector to re-model and re-design. Monopolies are rarely models of efficiency.
Certainly, our organisation has had recent contact from domestic & international organisations that have a commercial eye on the provision of emergency services in the UK and are actively waiting for the political and regulatory movement necessary to enter the sector.

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Cntd/

The London Ambulance Patient Transport Service

Given that this is the area of operation in which our organisation has relieved the London Ambulance Service of much of its client base I do feel that our view is useful.

It is commented on frequently by management at hospital Trusts across the capital that LAS for many years looked upon Patient transport as the" Cinderella service" and it was never given equality of attention or investment by LAS management. It is not a sexy service, it is not photogenic compared to the blue light drama of its sister service and you would be hard pressed ever to recall a fly on the wall documentary about PTS. The staff working in this service do not receive the accolades of their Paramedic colleagues as PTS is primarily a service for the elderly and naturally, things are done at a much slower pace.

I believe that of all the Acute Trusts across the capital (Twenty one?) only one or two now contracts with LAS. This reversal from a monopoly to token service has happened in 10 years and without the impetus of a White Paper or legislation to point to for causation. Trust boards have been willing to take potentially politically unpopular decisions and place provision of these services into hands of independent partners that have brought flexibility, price competition, technology, investment and commercial drive.
Those ten years have allowed a fledgling independent ambulance sector to grow in London, and then outward across the UK. This growth was unregulated and awkward and with more than a few problems along the way. This year, independent providers will be for the first time will be required to register with the CQC and comply with the "Essential Standards of Quality & Safety".

It is our view that the London Ambulance Service management team should be freed of the diversion of managing down a residual Patient Transport Service, whose morale has been at low ebb for a decade. Recent and proposed legislation (Comparable Pay, Equity and Excellence: Liberating the NHS, Open Public Services) will allow more competition, and further integration of services delivered by independent (non-emergency) providers.

Whilst the LAS Senior management direct both Emergency & PTS services, there is a very concerning lack of communication or working in partnership in relation to major incident planning. 10 years ago, LAS escalation plans relating to Major Incidents and other emergencies (Pandemic flu, disruption to fuel supplies etc) required the support of the PTS Crews and vehicles.

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These crews and their ambulances (although due to Tupe regulations they are the same people with the same skills), are now employed by Independent providers. Acute Trusts are compelled to have Major Incident plans prepared and although our organisation has been regularly asked to submit these, there is no statutory communication with the LAS or LRF's.

Summary

Whilst accepting that opponents of private sector involvement will comment that our organisation of course would advocate that LAS completes it withdrawal from PTS, as an attempt to take commercial advantage. We would point out that this argument in London is almost over anyway. Independent providers have more growing up to do, but Hospital Trusts have made the business case already.
However, without LAS as a competitor, independent providers could be used in the area of civil contingencies and as an operational resource to dip into in peak activity times or to support less urgent requests, freeing the paramedics to do concentrate on genuine emergency situations.
If the Emergency Service is answer the key questions on performance, increased demand and governance (which no doubt will be commented on widely by others), we believe it needs to be free to focus on its core activities and call on the independent sector as it sees fit. We believe it has the senior management capable of delivering the service and that management has the confidence and support of Londoners.

Yours sincerely

J.P.Sheehan
Managing Director

Sub-010

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Health Policy & Economic Research Unit

Our Ref: F:\HPERU\Consultations\2011\London Ambulance Service/Mar11

10 March 2011

Dear Sir / Madam

Review of London Ambulance Service

Thank you for inviting the BMA to respond to the review of the London Ambulance Service. The BMA has considered the consultation and by way of response the comments below constitute some general points relating to the implications of GP commissioning of ambulance services.

The BMA's General Practitioners Committee believe that the commissioning of ambulance services should be undertaken at a level above consortia. The ambulance service is a key part of the national resilience infrastructure in England. During major incidents it coordinates the out-of-hospital response, while it underpins the Hazardous Area Rescue Team in the NHS. The current integrated 999 service is second-to-none. We do not wish to see the proven benefits of the current arrangements put at risk by the introduction of a locally commissioned service that will rely on the unproven expertise of local commissioners. We are very concerned that this will lead to a fragmented ambulance service

Within the present structure there is already a robust interface between the ambulance service, general practice and out-of-hours services, a well as links with NHS Pathways. These links are still evolving, and to significantly reform the commissioning of ambulance services at this time will add too many uncertainties and variables to this system. That is not to say that all ambulance services are perfect – it is important that commissioners find ways to raise standards and develop better protocols and pathways for service delivery. However, this will be much easier to achieve when worked out and applied across a large area. Moreover, ambulance services will be harder to organise without the allegation of a postcode lottery if consortia are to commission ambulance services.

With regard to the implications of the London Ambulance Service becoming a Foundation Trust. The BMA has concerns that by becoming a Foundation Trust, the financial incentive to provide services in a more cost effective manner may lead to service reduction or a lack of desire to provide services such as non-acute transfers or inter-hospital transfers.

In terms of the extent to which ambulance services in London should be subject to greater competition, our response to the NHS White Paper '*Equity and Excellence: Liberating the NHS*' opposed the proposal for greater competition in the NHS, including the 'any willing provider' policy. We believe that the NHS should remain the principal provider for primary and secondary care, to avoid fragmentation of services and ensure continuity of care and financial sustainability.

I hope these points are of use. We would be interested in receiving a copy of the consultation report once it has been produced.

Yours faithfully,

Jon Ford
Head of Health Policy and Economic Research Unit

Sub-011

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Thursday, 10 March 2011

Mr J Cleverly
Chair
Health and Public Services Committee
City Hall
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Dear Mr Cleverly

In response to your letter dated 7th February 2011 please note the answers to the questions that you raised below -:

Q1 The current performance is average, with room for improvements. The service means different things to different people within the community which is resulting in an increase on demand. LAS needs to be able to focus on those customers that need the service and not simply be an inappropriate mode of transport for others

Q2 Increasing demand could be better managed through the ambulance crews having greater authority to decide which patients actually require the service, to identify patients who could be transferred to a primary care provider and to have the means to manage more calls at the call site/home. This may require a review of skills of LAS crews to enable the management of some minor injuries.

Q3 The services that should be provided by LAS include resuscitation, identification of critically ill patients (life or limb) and the safe transportation of these patients. There should be more engagement in early warning systems to receiving Trusts, and engagement with local population to educate on appropriate use of the service. The service should be empowered to re-direct patients appropriately to a range of services

Q4 Implications of becoming an FT would be increased accountability both financially and clinically, which would drive the suggested improvements made in previous responses.

Q5 The move to GP commissioning would allow the core services of LAS to be assessed in line with the new commissioning boundaries and align revised LAS protocols with improvements in primary care (i.e. could support the desire to treat more patients within primary care, with improved access to primary care services alongside greater authority for LAS crews to 'triage' patients to an appropriate place of treatment)

Q6 Greater competition would drive greater improvements in efficiency and service, where alternative providers meet required clinical guidelines.

Should you require any further assistance please do not hesitate to contact me.

Many thanks

Clare Panniker
Chief Executive

Sub-012

London Assembly Review of the London Ambulance Service

Response of the Ambulance Services Network, NHS Confederation.

Background

The Ambulance Services Network (ASN) is part of the NHS Confederation. It has 19 member trusts representing the views of the NHS ambulance service across England, the devolved administrations and Crown dependencies of Guernsey, Jersey and the Isle of Man. Our roles are:

- To work with national and local government to ensure that the role of the ambulance service is understood, particularly its impact on and dependencies with other parts of the NHS and emergency services, and that policy and guidance reflects this and supports the further development of the service for the good of the public whom it serves.
- To ensure that our members are kept up to date with and understand the implications of new and existing policy as this pertains to local ambulance services and their role as part of the NHS and with other emergency services.
- To network members so that learning opportunities are maximized and that good practice is shared, encouraged and used to develop clinical practice to the benefit of patients using the range of services delivered by ambulance trusts.

The London Ambulance Service (LAS) is one of 12 English NHS ambulance trusts, all of which are represented by the network. LAS, in keeping with other ambulance trusts, does not just provide core emergency services but is a key component in the wider urgent and emergency care system. It has been actively involved in the network's activities over the 3 years that ASN has been in place.

ASN welcomes the opportunity to provide evidence to the inquiry. We hope that the following will support the evidence already provided by London Ambulance Service. We have not sought to answer all of the questions outlined but rather to give an overall response on some of the broader issues raised.

Overall context– improvements to efficiency and the quality of care

Five years ago, as a result of a service led change strategy called "Taking Healthcare to the Patient", a major programme of transformation of NHS ambulance trusts was undertaken which reduced the numbers of organisations from 36 to 12. In so doing, money was saved on back office functions, enabling resources to be reinvested in improving the quality of patient care. LAS was the only service in England not directly affected by the organisational restructuring, however much has been done to reduce its overheads and improve its response times and service offer. It now offers some of the fastest and most consistent 999 call answering in the UK and has the largest ambulance control centre in Europe. The time to answer calls is on average 4 seconds for an annual call volume of 1.4 million 999 calls in 2010/11.

Like other NHS bodies, ambulance trusts have to make cost savings over the course of the next 3 -4 years, in line with the overall need to save £15-£20bn to reinvest in the NHS. At the same time, the amount of unscheduled activity has been increasing by about 5.5% to 6% per annum. Within the finite resource envelope for the NHS, efficiencies need to be made in a way that maintains or improves patient care.

NHS ambulance trusts, including LAS, have developed new approaches which have changed the face of their activity from being one that is primarily a patient transport service to one which provides treatment and advice. Increasingly, ambulance services "hear and treat", "see and treat" and convey patients only when this is the most appropriate and clinically relevant response. In London, this has included the development of telephone advice, referral to falls teams, specialist social work support for frequent callers and transport to urgent care centres rather than accident and emergency (A&E) departments where appropriate.

It is vital that ambulance trusts work as an integrated part of the local urgent care system and are a key component of the NHS response to pressures on unscheduled care. As well as the financial challenge, the NHS is currently subject to pressures including increasing numbers of very elderly people with multiple medical conditions, rising costs of medicines and equipment and an increase in lifestyle diseases and behaviours which impact on the NHS, such as excessive drinking, obesity, etc. NHS ambulance trusts overall constitute only 1.5% of the expenditure of the NHS but have an impact, it has been estimated, on 20% of overall NHS costs. Changing the way in which patients are treated by skilled call handlers or paramedics can improve the quality of clinical response and the effectiveness and efficiency of A&E units and acute NHS services more generally.

LAS, together with other trusts, has developed innovative services over recent years which has improved NHS efficiency and the quality of care to patients. LAS paramedic staff assess and transfer patients directly to specialist centres in the capital for immediate treatment rather than to local A&E departments. It is estimated that the centralisation of stroke and trauma care from April 2010 will save 500 lives a year and reduce long term disability for many more. Rates for heart attack survival have also improved since direct transportation to primary angioplasty services began over two years ago.

In addition, LAS is supported by mutual aid arrangements with surrounding ambulance trusts to give added capacity should there be a major incident, such as a terrorist attack or natural disaster. Not only do ambulance trusts use neighbouring ambulance services but they will also use other elements of their own service, for example patient transport services (PTS) to support 999 ambulances as appropriate. Separating 999 from other elements of ambulance services should therefore be considered carefully as it may bring with it a reduction in capacity during major incidents or when 999 services are under stress e.g. in poor weather.

Implications of the NHS reforms on LAS

Commissioning arrangements

LAS has helped improve patient outcomes, for example in stroke, heart attack and trauma care, as part of a pan London network of organisations involved in London's Urgent Care Strategy. It is important that the commissioning of such pan London programmes is able to continue following the abolition of the NHS London by April 2012 and primary care trusts by April 2013.

The changes from the current arrangement, where a lead PCT commissions ambulance services on behalf of all London PCTs, to GP commissioning will take place over the next two years . ASN believes that regional commissioning of 999 services for LAS should be retained, most probably through the development of a lead consortium arrangement. Indeed, Simon Burns, MP, Minister of State in the Department of Health has suggested in Parliament that this would be a preferred option for the future.

The development of the new NHS111 number, which will give callers the option of a range of urgent care services rather than ringing 999, will be a critical tool in the managing of the rising demand in unscheduled care and this too, we believe, should be commissioned regionally.

We remain unclear as to the extent to which "any willing provider" competition in these areas is appropriate or indeed desirable without well structured and monitored agreements about the necessity of mutual aid and resilience. As highlighted above, separating 999 from other

elements of ambulance services for the purpose of enabling entry into the market of other providers should be considered carefully as it may bring with it a reduction in capacity during major incidents or when 999 services are under stress.

There is a recognised need for emergency preparedness e.g. Hazardous Area Response Teams (HART) to be commissioned through the NHS Commissioning Board and ASN isheartened that this has been recognized in the health reforms. LAS also houses the national ambulance co-ordination centre for major incidents and events and we believe that this element of national co-ordination must be maintained into the future.

The move from targets to outcomes measures

Ambulance trusts welcome the move over time from a service which measures target response times to one which is assessed on their ability to meet improved clinical outcomes for the people they treat. We believe that this move should be welcomed by the inquiry as a positive contribution to improving the experience of Londoners in using ambulance services.

The move to Foundation Trust status

Foundation Trust (FT) status will strengthen the existing position of LAS through increased accountability to the population it serves, increased opportunities to develop new areas of business and to invest and innovate. It will also bring externally benchmarked financial rigour, which will help the service to ensure that it is able to compete as the NHS market develops.

As they develop, LAS and other ambulance providers may look to deliver more local services to meet borough or community needs. These would of necessity involve individual consortia with the ambulance trust designing and commissioning services which are responsive to local circumstances, for example triaging in hours GP calls or out of hours services.

Similarly, the development of other services such as PTS, NHS111, referral management services and public health initiatives will potentially be areas where the development of a competitive market could enhance LAS's current portfolio of services but which will need to be commissioned with individual consortia or through lead arrangements.

Relationship between the Mayor and LAS

The Mayor will be aware that the LAS can act as an important conduit for delivering public health. If every direct patient contact by LAS also had a public health element, over 7,500 people would receive health messages by LAS staff every day. Issues such as alcohol abuse and support for older people with long term conditions require an integrated approach with both

the London Assembly, individual boroughs and GP consortia working with LAS to agree the priorities.

The move to FT status will enable more Londoners to be involved in the governance and development of the Trust. The GLA may wish to have representation at senior level on the trust as an FT governor.

LAS will need to work closely with local government if they are to address their key challenges of both managing emergency responses and changing the nature of the urgent care system. However, given the complex and interdependent nature of health services, we believe that ambulance services should continue to be provided by an NHS body. Achieving FT status will enable LAS to develop its business and produce new opportunities for funding which can be ploughed back into delivering a comprehensive, high quality clinical service for the people of the capital whilst working closely with other emergency services to ensure a coherent and co-ordinated response to major incidents, events and pan London initiatives.

Sub-013

London's Air Ambulance
The Helipad
Royal London Hospital
Whitechapel
London
E1 1BB

15 June 2011

Richard Berry,
Scrutiny Manager, Health & Public Services Committee
London Assembly
City Hall,
The Queen's Walk,
London SE1 2AA

Dear Richard,

Thank you for the invitation to contribute to the review.

London's Air Ambulance has worked collaboratively with London Ambulance Service since its inception in 1988. During this time it has treated over 20000 of London's most severely injured patients. We have also provided critical medical support to many of the major incidents that have befallen the capital. The most recent of which was the 7th July 2005 bombings. Our involvement in this has been recently been reviewed by Lady Hallett at the coronial enquiries where the service received warm accolade and rule 43 recommendations were made regarding our funding and resilience for large scale events and also wider issues of emergency services in London.

The service is a unique collaboration of the private and third sector coming together to work with and help the public sector. The service provides a helicopter and rapid response cars that deliver a senior trauma trained doctor and a paramedic seconded from LAS. It operates 24 hours a day seven days a week, which is unique in the world, and helps meet the special needs of the capital.

It is our view that LAA has much to offer Londoners and the LAS. We recognise the huge contribution LAS makes to the ill and injured of London and the increasing demand on its core function. We sincerely hope we can continue to relieve some of its burden by applying our unique skills and resources in treating the most seriously injured. In particular our teams have

unparalleled experience and abilities with regard to the provision of medical support at major incidents such as terrorist attacks, rail and other disasters, the so called "MERIT" function in major incident planning guidance. We would welcome any moves that would help us facilitate this support we give to LAS.

We believe that the emergency needs of patients in day to day accidents and major incidents would be best met through collaborative inter-agency working, training and exercising; issues identified by Lady Hallett.

Yours sincerely

Dr Gareth Davies
Medical Director & Chair of the Trustee Board

Sub-014

INFORMATION FROM BRITISH CONSULATE-GENERAL NEW YORK

Subject: RE: London Assembly: Review into performance and future governance of the London Ambulance Service

How the FDNY and ambulance services work together

FDNY stations ambulances throughout the city and supplies paramedics and emergency medical technicians (EMT). 911 calls for emergency medical services in New York City are dispatched by the Communications Bureau of the FDNY's Emergency Medical Dispatch.

The Fire Department has agreements with 25 private hospitals to provide voluntary (non-profit) ambulance services in the five boroughs. These hospitals account for roughly 37% of the ambulance tours in the city, the other 66% ambulances are provided by the FDNY. Voluntary ambulances are the same as the FDNY units in terms of staffing, protocols and they carry similar equipment.

There are also volunteer ambulance services such as the Jewish ambulance service Hatzalah that rely on donations, government grants and volunteers to run the service. Hatzalah has reported a rise in call volume during recent hard budget times because of the belief that budget cuts have reduced the response time of city-wide ambulances.

Agreement between the City and the Hospitals

In 1996 Mayor Rudoplh Giuliani and the President of New York City Health and Hospitals corporation (HHC) executed a Memorandum of Understanding setting the terms and conditions for the transfer of Emergency Medical Services from the HHC to the FDNY.

The memorandum states that HHC will bill and receive all amounts arising from EMS's delivery of patients to HHC hospitals. The memorandum requires the City Budget Director and President of HHC jointly to project the amount of EMS-anticipated collections (projected collections) prior to each fiscal year. The amount of project collections must be repaid to the City by HHC in four payments, three at the end of each of the first three quarters, and one final payment within 60 days of the end of the City's fiscal year. The final payment may require adjustment based on differences between actual and projected collections and from adjustments or expenses incurred or paid by HHC on behalf on EMS

In 2002, FDNY assumed responsibility for billing and collection for non-Medicaid payments – third party insurance, self-pay patients and Medicare – for EMS services provided to patients delivered to HHC hospitals. Currently those payments are sent to a lockbox and transferred daily to the New York City Health and Hospital Corporation (HHC) bank account. HHC remits these amounts, less any deductions, as part of its quarterly payments to the City.

Beginning in January 2012, the Bloomberg administration plans to charge the hospitals fees based on the number of scheduled ambulance tours they operate in the FDNY's 911 system. The annual fees are expected to range from about $73,000 to $1 million per hospital.

"The 911 system cost-sharing initiative would allow the city to recoup the costs associated with 911 system dispatch and telemetry that are currently borne by the city, namely, the costs associated with the staffing and operation of the Emergency Medical Dispatch Center and Online Medical Control (Telemetry) center," John Peruggia, former Chief of EMS command, wrote to one of the hospitals. The mayor has also suggested that it is unfair for city taxpayers to pay 100% of the costs of 911 dispatch services when only 63% of the ambulance runs are operated by the city.

Sub-015

Berlin Fire Brigade

1. We understand that the Berlin Fire Brigade is also in charge of the ambulance service in city. Is this the case?

The Berlin Fire Brigade is in charge of the Emergency Ambulance service. Patient transports are organized by private ambulance companies. Emergency is defined as immediately life threatening or the danger of severe health problems without clinical treatment. For non-emergency calls we have an interface to the GP Service (comparable to a nurse advice line).

We have a two-tier system with 84 BLS (basic life support) Ambulances and 17 physician staffed ALS (advanced life support) units and a HEMS.

If the call indicates a situation where ALS is needed (30% of all calls) ,BLS and ALS units are dispatched separately and meet on scene. If ALS treatment is needed ALS and BLS transport together otherwise the BLS unit transports and the ALS unit is available again.

If the call indicates an urgent BLS treatment (70% of all calls), only the BLS Ambulance is dispatched.

2. Who has the political authority over the Berlin Fire Brigade/ambulance service. Is it the city, state or national government?

The Fire Brigade is under the political authority of the Berlin state government (Berlin is city and state)

3. We understand that private companies or charities are employed to provide the ambulance service? Is this the case?

Private ambulances provide only non-emergency patient transport service. Eleven ambulances of four charity organizations are stationed on fire stations. The German Army supports the Berlin Fire Brigade with 3 BLS ambulances and an ALS unit to train their medical personnel.

4. How many companies or charities are there providing the ambulance service in Berlin?

Aprox. 50 private companies

5. How is the ambulance service funded?

The funding comes from the health insurance companies and are paid for each transport.

6. Do the Fire Brigade and ambulance service share stations, or are they separate?

Most BLS units are on fire stations, most of the ALS units and the HEMS are stationed in hospitals

7. Does the Fire Brigade ever respond to medical emergencies? For instance, if a fire engine can reach the patient quicker than an ambulance?

Yes, all fire engines are equipped with medical equipment and an AED. All firefighters are trained at least as EMT. Since fire fighters also work on the ambulances a large amount of the staff is also trained as paramedic.

8. Do medical staff (doctors, paramedics, nurses) travel on fire engines? For instance, if there is a fire where medical assistance is needed?

As mentioned the Berlin Fire Brigade has the majority of all BLS ambulances (84) and staffs all ALS units (17) with paramedics. The physicians are hired from major hospitals, except for 5 physicians who belong to the Berlin Fire Brigade.

9. Is this system considered to be successful? Are there any proposals to change the system? For instance, to separate the Fire Brigade and ambulance service?

We believe the system is successful.
Some of the major advantages are:

- the possibility to switch personnel between fire engines and ambulances if needed (to cover ambulance peak loads)
- The advantage of having trained EMT's and Paramedics on every fire incident or RTA, even if the ambulance has not yet arrived
- A better understanding of medical and technical demands while performing technical rescue operations

The discussion about a separate service has been held twice in the past.

In Berlin (West) there has been a separate ambulance service which has been integrated into the Fire Brigade in 1967. The same happened after the reunification of Berlin.

The reasons to integrate the ambulance service into the Berlin Fire Brigade are mostly the ones I mentioned already.