

The future of the London Ambulance Service

A strategic review

December 2011



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The Health and Public Services Committee agreed the following terms of reference for a review of the London Ambulance Service in March 2011:

- To examine the operational, financial and organisational challenges facing the London Ambulance Service and consider how these can be met;
- To consider what role the Mayor of London should have in relation to the governance, commissioning and delivery of the London Ambulance Service.

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Contents

	Chair’s foreword	7
	Executive summary	9
1	Introduction	13
2	Current service performance	17
3	Strategic challenge: managing demand to improve patient outcomes	22
4	Strategic challenge: delivering more for less	36
5	A role for the Mayor in the strategic leadership of the LAS	48
	Appendix 1 Recommendations	53
	Appendix 2 Views and information	55
	Appendix 3 Ambulance performance indicators	57
	Appendix 4 Foundation Trust governance	59
	Appendix 5 LAS and NHS structural reforms	60
	Appendix 6 Demand from other public services	61
	Appendix 7 Orders and translations	62

Chair's foreword

The London Ambulance Service (LAS) is a vital part of London's blue-light emergency services, along with the police and fire services. It is also the gateway to the NHS for Londoners needing immediate life-saving treatment.

The traditional view of ambulance services' role as simply transporting patients to hospital is no longer accurate. The LAS does much more than this: many of its staff have the skills to save patients' lives in that crucial "golden hour" of a medical emergency, as well as providing a range of support and advice to patients with less urgent conditions, often in their own homes or over the phone.

To continue providing a reliable, high quality service to Londoners the LAS has some serious challenges to overcome in the coming years as resources are squeezed and commissioning arrangements change. In the immediate future the LAS must prepare for its critical role in 2012, when London will invite the world to join us in celebrating the Olympic and Paralympic Games.

As Londoners we have a responsibility too; 999 calls are for emergency, potentially life threatening, incidents. There is a challenge to manage rising demand and we all need to look at other ways of asking for advice and medical assistance. For too long, "well, just ring an ambulance" has seemed the easy option, but if we want the best treatment for life saving emergencies, then we have to have a range of other services available including out of hours services, walk-in clinics and, when it is up and running, the new 111 number for when we urgently need medical help or advice but it is not a life-threatening situation.

The LAS is examining the whole patient journey from the initial call to treatment in order to ensure the best patient outcomes and reduce wasted time, making use of resources effectively, whether this is achieved by treating the patient at home or taking them to hospital. Further efforts will be needed to ensure monitoring of what happens to patients after they have received care from the LAS. The LAS is seeking to work more efficiently with a particular emphasis on "see and treat" – with paramedics responding to calls for immediate treatment – this is often both more efficient and quicker than sending patients in an ambulance back through London's crowded streets to hospital. The Health and Public Services Committee are of the view that the more highly trained those arriving at a life-threatening



situation are, the more lives will be saved; over the longer-term there must be a case for testing whether deploying doctors in ambulances can make a real difference to patient outcomes.

In this strategic review the Committee set out to examine how the LAS can best meet these challenges. In particular we have identified how closer working relationships with other NHS agencies could help the LAS ensure its patients access the most appropriate care, and generate more efficient ways of working. We also recommend ways to create closer integration, through the office of the Mayor, with the Metropolitan Police Service and other police services, the London Fire Brigade and Transport for London, which will yield tangible benefits for all those Londoners who need emergency care.

I would like to thank fellow Committee Members and officers for helping to produce this report. We are very grateful to all those who participated in our review by speaking at our hearings or submitting views and information. In particular, we have benefited from the ongoing support of the London Ambulance Service, the LAS commissioning team at NHS North West London and the LAS Patients Forum, and look forward to future discussions with each on how the service can meet its strategic challenges.

Victoria Borwick AM

Chair of the Health and Public Services Committee

Executive summary

Ambulance services have traditionally been seen as services intended merely to transport patients from one place to another, usually the nearest hospital. That is no longer the case. NHS ambulance services are increasingly embedded in wider primary care services. As well as providing a rapid, life-saving response in the 'golden hour' of a medical incident, ambulance services also care for patients by treating them in their own homes or public settings, providing telephone advice and referring them to other health services.

The London Ambulance Service NHS Trust fulfils its core purpose to a high standard: providing a rapid response to Londoners who need medical support in an emergency. To maintain this performance and expand the scope of its services, the LAS will need to overcome the strategic challenge of responding to increasing patient demand against a backdrop of reduced funding, while ensuring improved patient outcomes. It can only do this by working in new ways with a range of partner organisations in the wider NHS, and also in the Greater London Authority (GLA) Group. A role for the Mayor in the strategic performance of the LAS would catalyse these new working relationships.

Challenges facing the LAS

The LAS performs well against national response time targets for serious, life-threatening incidents, although targets for less urgent cases have been missed in recent years. This year the focus of the LAS performance regime is shifting onto patient outcomes rather than just response times, which the Committee welcomes.

A tough set of challenges must be overcome, however, if the LAS is to continue delivering a high-quality service in the future. Firstly, the growing demand for ambulance services in London needs to be managed effectively. Demand is already higher for the LAS than other regional ambulance services, and the number of incidents attended by the LAS has increased 12 per cent in four years; this growth cannot continue unchecked. In particular, three quarters of calls to the LAS are for non-emergency incidents; some of these could be prevented or directed to more appropriate services and we look at ways to do this.

Secondly, the LAS needs to become more efficient. The organisation is being forced to make large budget reductions after a sustained period of growth. These will see the LAS lose almost a fifth of its current workforce in the next five years, including 560 frontline staff.

We have identified opportunities for more efficient working, including reducing unnecessary ambulance dispatch and establishing shared facilities with other emergency services.

Another strategic challenge is for the LAS to respond to the government's far-reaching plans for reform of the NHS, which will affect the LAS in several ways. The organisation is expected to become more autonomous as a Foundation Trust, without the oversight of NHS London, and will be accountable to General Practitioners (GPs) rather than primary care trusts. These changes present risks for the LAS, but also opportunities to develop closer working relationships with key partners, including the Mayor and the GLA Group.

The vast majority of the steps that need to be taken by the LAS to manage future demand and improve efficiency can only be achieved in partnership with other agencies and the wider health service.

Relationships with the NHS

The LAS is part of the NHS. Other urgent care services within the NHS could help relieve demand for the LAS – particularly for non-emergency cases – by providing more appropriate sources of support. These include the new 'NHS 111' telephone service, GP out-of-hours services, walk-in centres and specialist services for people who have fallen or those with mental health conditions.

Improving the availability of these other health services will also make the LAS more efficient. Instead of incurring the high cost of dispatching an ambulance to almost every call and transporting patients to Accident and Emergency, the LAS is increasingly seeking to support patients by assessing them and referring them to other care providers. As this type of activity grows, this should save costs for the LAS – and for the NHS as a whole, considering that all trusts are expected to deliver significant savings – and deliver more appropriate care for Londoners.

Whether these changes take effect is largely going to depend on the decisions made by the new commissioners of health services, GPs. Linking up urgent care in a strategic way is vital. Patients have to be able to access the right support when they need it, wherever they live, without always having to rely on ringing 999 as the fallback option.

Relationships with the GLA Group

Many parts of the GLA Group have an impact on the work of the LAS, and vice versa. Working in a more integrated way could deliver mutual benefits in several respects.

The Metropolitan Police Service requests support from the LAS 100,000 times a year, but only rarely is this to respond to a life-threatening incident. By working more closely together, the police and the LAS could direct people to more appropriate sources of support.

The LAS is also a key partner of Transport for London (TfL) in the effort to improve door-to-door transport services. The failings of these services create additional demand for the LAS. TfL needs to work with the LAS and others to ensure a more reliable, integrated service for mobility impaired people.

The preventative work on public health that the GLA will be leading from 2013 would benefit from the expertise and regular patient contact of the LAS. In turn this work could help reduce demand for the LAS, for instance by more effectively addressing the problem of binge drinking, although any positive impact of this work would be some years in the future.

Efficiencies could also be created for the LAS and the GLA Group by more joint working. The LAS and London Fire Brigade each have dozens of stations across the city; a small number of these are shared, but progress in delivering more shared stations has been very slow. Across the GLA Group, the procurement of goods and services like fuel or facilities management could be coordinated with the LAS, generating savings for all agencies.

Mayoral role

Proposals have been made during the course of this review for a more formal, ongoing relationship between the Mayor and the LAS. We believe this will help facilitate the measures identified above to manage demand and generate efficiencies; it would also improve accountability to Londoners and give the LAS a political champion.

The LAS should remain an integrated part of the NHS, while in the long-term developing a closer relationship between the GLA Group and LAS. We believe that a sensible first step is for the LAS to appoint

a Mayoral representative, which may be an Assembly Member, to its new Council of Governors, the body that will oversee the Board of the LAS. To ensure the LAS and GLA Group are able to fully exploit this opportunity for joint working, representatives from the police and fire services, and Transport for London, should also join the Council. To enable this, the LAS should specify the GLA Group bodies as partner organisations in its new constitution. Thereafter we propose that the governor appointed by the Mayor could also apply – through the open appointment process – to join the LAS Board, to have a more direct influence on joint working.¹

¹ Please see Appendix 4 for a diagram of the governance structure the LAS will adopt when it becomes a Foundation Trust.

1 Introduction

- 1.1 Every year, Londoners make almost 1.5 million 999 calls to request an ambulance. In many cases these are emergency situations where an immediate response is required. The timely arrival on scene of a medically trained professional, to treat the patient or transport them for treatment elsewhere, is vital to saving a person's life.
- 1.2 The London Ambulance Service NHS Trust (LAS) is London's frontline response service for these emergencies. The LAS is part of the National Health Service (NHS), providing patient care directly and a gateway to NHS primary care services. It is also rightly considered as one of London's 'blue-light' emergency services, alongside the police and the fire services, which are overseen by the Mayor of London.

Ambulance services in London

- 1.3 A traditional view of this service is that an ambulance is dispatched following a 999 call, and after arriving at the scene will transport a patient to a hospital accident and emergency (A&E) unit. While this remains the case for a majority of incidents dealt with by the LAS, the service may provide a variety of other responses.
- 1.4 In recent years the LAS has increasingly sought to respond to patients in alternative ways. Clinicians are able to treat patients at the scene of an incident, for instance in their own home, without taking them to hospital. Non-clinical staff can also provide advice to patients at home or over the telephone, referring the appropriate sources of support rather than transporting them by ambulance. Ambulances are also stationed in places of likely incidents – for instance in town centres on weekend evenings – rather than only responding to 999 calls.
- 1.5 The LAS employs around 5,000 staff, operating out of 70 ambulance stations across the capital. The frontline workforce of the LAS includes approximately 1,400 paramedics, 500 student paramedics, 900 emergency medical technicians and 400 accident and emergency support officers. The Trust has an annual budget of approximately £280 million. The LAS delivers a range of services, including:²
 - Emergency service: responding to 999 calls (88 per cent of LAS income).

The LAS is seeking to treat more patients at home or over the phone, rather than taking them to A&E.

² 2010/11 income, based on forecast at end of February 2011. Financial review (Item 6.2), London Ambulance Service NHS Trust Board, 29 March 2011

- Patient Transport Services: transporting patients to pre-arranged medical appointments (2.9 per cent).
- Chemical, biological, radiological and nuclear (CBRN) decontamination team (2.7 per cent).
- Hazardous area response teams (HART): two specialist teams that respond to major incidents and provide life-saving care in hostile environments (2.5 per cent).
- Commercial activity, including ambulance cover at stadia and airports, and providing training (0.6 per cent).
- Emergency Bed Service: locating hospital beds for seriously ill patients and arranging for patient transfers (0.4 per cent).

1.6 There are other ambulance services working in London, although the LAS is the only NHS service and the only recipient of 999 calls. London's Air Ambulance is a charity that works closely with the LAS, providing a helicopter response to some medical emergencies, with crews containing doctors and paramedics. The St John Ambulance and British Red Cross are first-aid charities that provide ambulance cover at many public events and also act as a backup to the LAS during major incidents, or when demand necessitates additional resources. Hatzola is a charity providing an ambulance service to the Orthodox Jewish community in parts of north London. There are also a number of private companies that provide non-emergency transport for NHS patients to medical appointments.

Olympic and Paralympic Games

1.7 The Committee's review has taken place at a time when London is preparing for the challenge of hosting the Olympic and Paralympic Games in 2012. The LAS is playing a key role in planning for a safe Games and delivering a response to any incidents that occur. The LAS is a member of the London Resilience Forum, which is led by the Greater London Authority and also includes the police and fire services and a range of other organisations. In addition, the LAS is providing ambulance and clinical support to the London Organising Committee of the Olympic and Paralympic Games (LOCOG) within the venues to athletes and spectators as part of the Host City Contract.

1.8 The Games will require the LAS to work closely with its emergency service partners, who will be co-located at all venues in London during the Games. The Committee conducted a previous investigation into

The LAS has a vital role in planning and delivering a safe Olympic and Paralympic Games in 2012.

the health and emergency service preparations for the Games, publishing a report on this topic, *Business as usual?* last year.³ We identified the need for further joint working, for instance cross-organisational testing, to prepare for the Games. The opportunities for collaboration between the LAS and other emergency services have been further considered in this report.

- 1.9 Our previous investigation also highlighted the importance of emergency service access to the Olympic Route Network (ORN). The ORN, which is managed by Transport for London (TfL), includes a number of Games Lanes that will ordinarily be reserved for Games athletes and officials. The LAS will have access to these lanes for blue-light emergencies; further discussions with TfL are ongoing about the full extent of the LAS's access to the ORN. The Assembly's Transport Committee is currently examining this topic in more detail.⁴

The Committee's review

- 1.10 This report sets out the findings of the Health and Public Services Committee's review. We have explored the full range of operational and strategic challenges facing the service. Primarily, we have addressed how the LAS could maintain and improve its services to deliver better patient outcomes, while facing increasing demand from Londoners and implementing stringent efficiency savings in response to reduced funding, in the context of the proposed structural reforms.
- 1.11 In doing so the Committee has gathered views and information from a wide range of individuals and organisations. We have received submissions from hospital trusts, London boroughs, medical professionals, the Department of Health and other individuals and organisations. We studied ambulance services in other cities, speaking to experts from Berlin and New York in particular about how their ambulance services operated and how they work closely with, or even as part of, the fire service. In early 2011, we held a series of meetings in public with experts and key stakeholders including a number of senior LAS officers, the North West London Commissioning Partnership, the Mayor's health adviser, the Royal College of GPs, the London Fire Brigade (LFB) and the LAS Patients Forum. We also

The Committee set out to explore how the LAS could meet the challenges of rising demand, reduced funding and structural reforms.

³ *Business as usual? London's emergency and health services' preparations for the 2012 Olympic and Paralympic Games*, London Assembly, October 2010

⁴ The Transport Committee is following up its recent report on 2012 transport; *Clearing the hurdles: transport for the 2012 Olympic and Paralympic Games*, London Assembly April 2011

visited the LAS Emergency Operations Centre at Waterloo, to view the facilities and talk to staff. For further details of the submissions received and meeting participants please see Appendix 2.

1.12 Our report highlights a number of smarter ways of working between the LAS and partner organisations within the NHS and the GLA Group. Many of these proposals feature in the LAS's plans, but appear stalled or need further support from partner bodies. The report seeks to reinvigorate those changes to improve patient outcomes and save money across the public sector.

1.13 The report is structured in the following way:

- Chapter 2 provides an overview of the performance of the LAS, based on targets the service is required to meet.
- Chapter 3 discusses ways to better manage demand for the LAS, particular in relation to non-emergency calls.
- Chapter 4 sets out the budget reductions that the LAS is required to introduce in the coming years, and discusses measures that could generate efficiency savings.
- The concluding chapter examines the government's planned reforms of the LAS in detail, and explores the potential Mayoral role in the LAS.

2 Current service performance

2.1 The London Ambulance Service provides a good service to Londoners, particularly in life-threatening incidents. For less urgent cases, LAS performance has fallen short of response time targets, although these may not be the best way to measure service quality. The recent change in the performance regime will re-focus the LAS on patient outcomes.

Calls to the LAS

2.2 The LAS receives 1.5 million 999 calls every year, and dispatches a response to 1.1 million emergency incidents.⁵ This level of demand is higher than the demand for other ambulance services in England. In 2010/11 there were 0.19 calls per person to the LAS. Across England as a whole there were 0.15 calls per person to an ambulance service, meaning that the LAS receives 24 per cent more 999 calls per person than other ambulance services.⁶

The LAS receives 24 per cent more 999 calls per person than other ambulance services in England.

2.3 Until the end of 2010/11, incidents attended by the LAS were divided into three separate categories based on their urgency:

- Category A – immediately life-threatening incidents. In 2010/11, 33 per cent of incidents attended by the LAS were in this category.⁷
- Category B – serious but not immediately life-threatening incidents. In 2010/11, 43 per cent of incidents attended by the LAS were in this category.⁸
- Category C – not serious or immediately life-threatening incidents. In 2010/11, 24 per cent of incidents attended by the LAS are in this category.

2.4 Demand for the LAS is growing: both the number of emergency calls received and the number of incidents attended by the LAS have risen significantly over recent years. Since 2007/08 there has been an eight

⁵ The primary reason that the number of calls exceeds the number of incidents is that a single incident may generate multiple 999 calls to the LAS, particularly incidents occurring in a public place. *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011

⁶ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011; *Annual Mid-Year Population Estimates*, Office for National Statistics, June 2011

⁷ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011

⁸ This category was abolished in April 2011. For further discussion see from paragraph 2.10 of this report.

The LAS is meeting national targets on response times for life-threatening incidents.

per cent in rise calls, and a 12 per cent rise in incidents attended.⁹ All ambulance services in England have experienced similar increases.

- 2.5 Department of Health research has identified a number of reasons why demand has increased, many of which are beyond the direct control of ambulance services. Identified factors include increasing numbers of older people, higher prevalence of medical conditions such as diabetes, increased alcohol consumption, the spread of mobile phone technology enabling calls from any location, reduced GP out-of-hours provision and the shift within the NHS to care for people at home rather than in hospital.¹⁰

Response time performance

- 2.6 Until the end of 2010/11, performance of all ambulance services was measured primarily through response time targets, with different targets depending on the categories of incident. The London Ambulance Service has performed well against targets for life-threatening cases, but performance against targets for less urgent cases is mixed.

Life-threatening calls

- 2.7 For Category A calls, all ambulance services must meet a national target: to have a response at the scene of the incident within eight minutes, on 75 per cent of occasions. The LAS has achieved this target in each of the past three years, with an average performance of 75.4 per cent; this is slightly above the England average of 74.5 per cent.¹¹
- 2.8 As well as national response time targets, the LAS has local performance indicators for how it responds to stroke, heart attack and major trauma patients. The NHS in London has been establishing networks of specialist centres in London for these conditions, and the LAS plays a key role in identifying the most seriously ill and injured

⁹ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011. In 2011/12 so far, greater use of telephone advice has helped to reduce the number of incidents the LAS is attending; information provided by NHS North West London Commissioning Partnership, November 2011

¹⁰ *Tackling Demand Together*, Department of Health, 2009

¹¹ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011

patients and conveying them to a specialist centre. Recent figures show that targets have been met for each of these:¹²

- 98 per cent of major trauma patients are conveyed to one of four major trauma centres.
- 92 per cent of stroke patients are conveyed to one of eight hyper-acute stroke units.
- 93 per cent of heart attack patients are conveyed to one of eight heart attack centres.

Changes to the performance regime

- 2.9 The government has recently reformed the performance measurement regime for ambulance services, with changes introduced in April 2011. The existing Category A response time targets remain in place, while the 19-minute Category B response time target (for serious but not life threatening incidents) has been abolished.¹³
- 2.10 A new set of eleven performance indicators has been introduced, to be measured alongside the remaining response time targets. These indicators will shift the focus of the performance regime. They include outcome measures for stroke and heart attack patients, for example the proportion of cardiac arrest cases who survive to discharge. They also measure other aspects of the ambulance service, for instance how quickly calls are answered, or the proportion of calls resolved with telephone advice.¹⁴ Please see Appendix 3 for a full list of the new indicators.
- 2.11 Views about these changes to the performance regime are mixed. During the Committee's review, we identified a supportive consensus among stakeholders and experts about the introduction of patient outcome indicators. But the removal of the Category B response time target has been more contentious.

The ambulance service performance regime has been modified to focus on patient outcomes.

¹² *Major Trauma Care Pack*, London Ambulance Service, October 2010; *Cardiac Care Pack*, London Ambulance Service, March 2011; *Stroke Care Pack*, London Ambulance Service, December 2010

¹³ Category C targets (not serious or life threatening incidents) continue to be set locally. The 60-minute response time target remains in place, with supplementary performance standards for four sub-categories of call with Category C.

¹⁴ The Department of Health publishes monthly performance figures for these indicators and the Category A targets at www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performanceandstatistics/AmbulanceQualityIndicators/index.htm

The LAS must monitor the impact of performance regime changes on patients.

- 2.12 The main argument in favour of removing the Category B target is the lack of clinical evidence to justify it: there is no proven link between patient outcomes and the provision of a response with 19 minutes for these types of cases.¹⁵ Furthermore, a recent National Audit Office (NAO) review of all ambulance services concluded that the 19-minute target for Category B cases led ambulance services to adopt practices that were not cost-effective: specifically, dispatching a rapid ambulance response to calls that did not require one.
- 2.13 However, the Committee also heard concerns about the potential impact of this change on patients. Over a third of calls to the LAS were in Category B in 2010/11.¹⁶ The LAS told the Committee that as it will no longer be required to dispatch an ambulance in response to these calls, it will seek to provide only telephone advice to some patients.¹⁷ Malcolm Alexander, Vice-Chair of the LAS Patients' Forum, has suggested this may cause distress as it is not the service people expect to receive after calling 999; furthermore, alternative care pathways may not yet be available locally for patients to use instead of relying on ambulances.¹⁸
- 2.14 Overall the Committee supports changes to the performance regime to focus more on patient outcomes, alongside response times for the most time-critical cases. Ultimately, Londoners need the LAS to help save lives. Where this depends on an ambulance arriving rapidly at the scene of an incident that is exactly what should happen. Other types of response may be appropriate for non-urgent calls. However, we note concerns over the removal of the Category B target and access to suitable alternative care pathways and ask that the LAS monitors this impact of the change. When patients with less urgent needs call 999 the LAS must continue to ensure it provides a service that meets the needs of these patients. This depends to a large extent on how the

¹⁵ Professor Malcolm Woollard, Coventry University, Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 12. Minutes and transcripts of Committee meetings are available at www.london.gov.uk/moderngov/ie/ListMeetings.aspx?CommitteeId=148 or from the London Assembly secretariat

¹⁶ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011

¹⁷ Written submission from London Ambulance Service, February 2011, page 4. Copies of the written submissions received by the Committee are available on our website at <http://www.london.gov.uk/who-runs-london/the-london-assembly/publications/health> or from the London Assembly secretariat

¹⁸ Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 10. The LAS Patients' Forum has asked the Department of Health to conduct an Equality Impact Assessment on the removal of the Category B target.

LAS works with its partners within and beyond the NHS, a topic which will be discussed in the following chapters of this report.

3 Strategic challenge: managing demand to improve patient outcomes

- 3.1 The Committee has examined a number of ways in which the LAS might reduce the number of 999 calls it receives, or change the way it handles those calls to reduce the number of ambulances dispatched. Primarily we have focused on non-life-threatening calls, as there is potential for these to be diverted to more appropriate services.
- 3.2 Very few demand reduction measures could be implemented by the LAS alone. Invariably the measures we have examined involves the LAS relying upon or working in partnership with another part of the public sector, including other parts of NHS and the organisations in the GLA Group. In this chapter we identify five key areas where changes in ways of working could improve patient outcomes:
- Alternative non-emergency care services
 - Specialist community health services
 - Demand from the Metropolitan Police Service
 - Door-to-door transport services
 - Public health programmes

Alternative non-emergency care services

- 3.3 People are encouraged to telephone 999 in a medical emergency. Increasingly, however, 999 calls are made in non-emergency situations. Alternative services to respond to these calls are available, and are being developed further.
- 3.4 GP out-of-hours services could reduce demand for the LAS by providing an alternative source of urgent care; however, provision is patchy across London. Since the agreement of a new national GP contract in 2003, GPs have been able to opt out of delivering an out-of-hours service. A National Audit Office investigation following the introduction of the new contract showed that 70 per cent of GPs had opted out of providing out-of-hours care within a year, leaving primary care trusts to commission alternative provision.¹⁹
- 3.5 The Committee has heard that these changes led to a reduction in the availability of GP out-of-hours services, with greater demands being placed on the LAS as a result.²⁰ A recent national review of services

GP out-of-hour services need to provide a reliable alternative to the ambulance service.

¹⁹ *The Provision of Out-of-Hours Care in England*, National Audit Office, May 2006

²⁰ Dr Andrew Steeden, NHS North West London Commissioning Partnership, Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 31; Professor Malcolm Woollard, Coventry University, page 20

led by the Department of Health identified low quality standards at some out-of-hours service providers and a lack of rigorous monitoring by PCTs.²¹ Peter Bradley, LAS Chief Executive, told the Committee that the government's plan to give GPs responsibility for commissioning ambulance services creates an incentive for GPs to look again at providing effective out-of-hours care.²² We will continue to take up this issue in discussion with NHS London.

3.6 Another service for non-urgent medical services is NHS Direct, which is being replaced by NHS 111. The 111 telephone number will replace the existing NHS Direct number by April 2013. NHS 111 is intended to provide a more comprehensive service than NHS Direct, by assessing callers' needs at the first point of contact and directing them straight away to the appropriate local service, taking into account their location, the time of day and the capacity of services. NHS 111 will place greater emphasis on providing a 'gateway' to other parts of the NHS, potentially booking appointments on patients' behalf and eliminating the need to wait for a 'call back' where possible. The 111 number is distinct from the national non-emergency number introduced by the police service, '101', through which people can contact their local police service for non-emergency calls.

The new NHS 111 service has the potential to re-direct non-emergency calls away from 999.

3.7 The NHS 111 service may help to reduce demand for the LAS, if the public are made aware of its availability and confusion with the police's 101 number is avoided. Peter Bradley, LAS chief executive, anticipates that because 111 is a memorable number and will be free to call, it will be used by people who otherwise would have called 999 in non-emergency situations.²³ The introduction of NHS 111 will be accompanied by a public information campaign to promote it to Londoners, led by NHS London. The Committee has heard that this could be an effective way of diverting calls away from the LAS, provided that the campaign has an appropriate message about the benefits of 111, not simply discouraging use of 999. As Professor Malcolm Woollard of Coventry University told the Committee:

"One of the things we must be very, very careful about is not advertising that people should not use the 999 service; if we do that

²¹ *General Practice Out-of-Hours Services: Project to consider and assess current arrangements*, Dr David Colin-Thomé and Professor Steve Field, January 2010

²² Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 20

²³ Peter Bradley, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 7

we will push up demand. If we have big banners up anywhere saying 'Do not dial 999, dial this number instead', people will dial 999 in ever greater numbers. They have tried this in the USA and successfully pushed up demand by 10 per cent overnight."²⁴

- 3.8 The NHS 111 service has the potential to reduce the number of 999 calls made. We look forward to more details about the communications plan for 111 from NHS London, as this is vital to the effort to reduce the number of 999 calls.

Specialist community services

- 3.9 Some community health services are specialist services for patients with a particular long-term condition, who are more likely to be regular users of health services. Easier access to these services could also help reduce demand on the LAS. The South London Healthcare Trust (which runs the Queen Elizabeth Hospital in Woolwich) explained how this could work:

*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.*²⁵

- 3.10 The LAS is already ahead of other ambulance services in identifying the patients that are frequent users of its service. The LAS has put in place an individual 'frequent caller procedure' for over 3,500 patients in London; these patients account for about three per cent of all calls to the LAS.²⁶ The LAS works with other NHS and social care services to hold case conferences for these patients, refer them to appropriate services and draw up individual care plans.²⁷

At least 3,500 Londoners are 'frequent callers' to the LAS, accounting for three per cent of total demand.

²⁴ Transcript of Health and Public Services Committee meeting, 17 March 2011, pages 20-21

²⁵ Written submission, South London Healthcare NHS Trust, March 2011, page 2

²⁶ Data for June 2011; *Ambulance Quality Indicators: System Indicators, Ambulance trusts in England*, Department of Health, August 2011. Most ambulance services have not yet identified any frequent callers; only the Yorkshire Ambulance Service has identified more than 100.

²⁷ *Caring for frequent callers*, London Ambulance Service, August 2011

3.11 The Committee has explored with stakeholders and experts two specialist services in particular with which the LAS could coordinate with further in order to reduce the number of 999 calls:

- *Mental health services.* Approximately nine per cent of calls to the LAS are to assist patients with mental health problems.²⁸ There are mental health crisis teams in parts of London that can respond to these patients, or to whom the LAS can refer people rather than taking them to A&E. Services are complex and variable, however, and the LAS requires much better live-time information from the NHS about the availability of a “place of safety” where vulnerable people can be properly cared for.²⁹ This is an area where the LAS has identified improvements to be implemented in 2011/12, including setting up new working arrangements with mental health organisations.³⁰
- *Falls services.* Approximately 13 per cent of incidents attended by the LAS are a result of a person having fallen.³¹ This is a particular problem among older people, for whom falls are more common and potentially more serious. As with mental health, there are dedicated services to respond to falls in some parts of London, to which the LAS can refer people as an alternative to conveying them to hospital, but provision is variable.³² The LAS is currently working to establish a ‘falls pathway’ for these patients in every borough so they can be referred appropriately.³³

3.12 The Committee welcomes these initiatives, and encourages the LAS and partners to press ahead with plans, although inevitably they will take time to produce a reduction in calls to the LAS. Much depends on the decisions to be made by the new commissioners of the LAS, the local GP consortia. We do not yet know if GPs will recognise the value of commissioning alternative services to reduce demand for the LAS, or what incentives they will have to do this. It is vital the LAS is able to influence GPs’ commissioning strategy; in discussions with NHS

The LAS needs to coordinate with specialist services such as mental health services to provide effective support to patients.

²⁸ *Quality Account 2010/11*, London Ambulance Service, 2011

²⁹ Dr Andrew Steeden, NHS North West London Commissioning Partnership, Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 32; Peter Bradley, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 7

³⁰ *Quality Account 2010/11*, London Ambulance Service, 2011

³¹ *Falls Awareness Week 2011*, London Ambulance Service, June 2011

³² Written submission, Chelsea and Westminster NHS Foundation Trust, March 2011, page 2

³³ Richard Webber, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 5

London we will urge them to ensure mechanisms for this to happen are built into new commissioning arrangements.

Demand from the Metropolitan Police Service

3.13 The Metropolitan Police Service (MPS) is overseen by the Mayor. It is currently accountable to the Metropolitan Police Authority (MPA), which is appointed by the Mayor. Under the Police Reform and Social Responsibility Act, the MPA will be abolished. The Mayor will become the elected police commissioner for London, and establish a Mayor's Office for Policing and Crime to oversee the MPS.

3.14 The Committee has obtained data on how much demand there is for the LAS from other public services, as shown in Table 1 below. This reveals that the MPS is the biggest organisational source of demand for the LAS. Approximately 107,000 incidents attended by the LAS in 2010/11 came at the request of the MPS: this represents ten per cent of the total LAS workload for the year.

The Metropolitan Police Service generates about ten per cent of the total LAS workload.

Table 1: LAS incidents initiated by other services, 2010/11³⁴

Service	Incidents	Category A incidents	Percentage Category A
Metropolitan Police Service	106,694	363	0.3%
GPs ³⁵	96,824	31,372	32.4%
Public transport ³⁶	16,489	6,879	41.7%
Hospitals	9,603	2,868	29.9%
London Fire Brigade	3,561	745	20.9%
NHS Direct	421	178	42.3%
All other incidents ³⁷	824,540	305,270	37.0%

³⁴ See Appendix 6 for a diagram illustrating this data. Information provided by London Ambulance Service, April and August 2011. A large number of calls to the LAS are from care homes, although this data is not recorded in the same way; Peter Bradley, London Ambulance Service, Oral Evidence, Public Accounts Committee, 29 June 2011.

³⁵ The data for GP services is those incidents categorised as 'Card 35' incidents, where calls are received from healthcare professionals. The vast majority of these are from GP surgeries and out-of-hours services.

³⁶ 'Public transport' includes calls from staff of London Underground, London Buses providers, British Transport Police and National Rail providers. Protocols between the LAS and transport providers govern how and whether ambulances respond to a range of incidents, for instance the removal of dead bodies from the network.

- 3.15 Only a minority of the incidents initiated by all other public services were life-threatening incidents. In most cases, however, the proportion of Category A calls from these services is in line with or above the proportion of Category A calls from the general public. For the MPS, a much smaller proportion of the incidents it requests the LAS to attend are in Category A: 0.3 per cent in 2010/11. In summary, last year 300 ambulances were dispatched daily at police request, but only one of these was needed to save a life.
- 3.16 The LAS has informed the Committee that a new way of categorising calls from the police has been introduced this year. This has led to 8.9 per cent of calls from the police to the LAS being identified as Category A calls, so far in 2011/12.³⁸
- 3.17 In a written submission to the Committee, the Metropolitan Police Authority (MPA) explained the main circumstances in which the police will request an ambulance:³⁹
- When police officers assess that a member of the public they are dealing with requires medical assistance.
 - Where police telephone operators assess from information provided by a caller that an ambulance is required.
 - A serious incident in which injuries are likely to have been caused, even if no details of any specific injury are known (such as a report of a traffic collision from a third party).
 - Police operations where risk assessment identifies injury may occur.
- 3.18 The LAS responds to calls from the police in a different way to regular 999 calls. While most 999 calls go through a triage process with call handlers to determine whether an ambulance is required, this does not apply to calls to the LAS from the police: ambulances are dispatched automatically in response to police requests. Peter Bradley, LAS Chief Executive, told the Committee that this system was introduced two years ago because a lack of resources in the LAS call centre meant there were often long delays in dispatching a response.⁴⁰ He explained this has led to some incidents being attended unnecessarily

The vast majority of requests from the police for LAS support are for non-emergency incidents.

³⁷ This includes 999 calls from members of the public, as well as calls from some other institutions such as care homes, which are not recorded in the same way.

³⁸ Information provided by London Ambulance Service, November 2011

³⁹ Written submission from Metropolitan Police Authority, August 2011, page 1

⁴⁰ Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 12

Enhancing police officer training or deploying paramedics on police patrols could help manage demand for the LAS.

by the LAS. The lack of resources in the call centre has since been addressed with the recruitment of more call handlers, although the automatic dispatch system remains in place. In contrast to the police, calls from the London Fire Brigade are triaged in the same way as other 999 calls; an ambulance is not dispatched automatically in response.

- 3.19 The LAS and the MPA have both confirmed to the Committee that there are ongoing discussions about this topic between the two services.⁴¹ One recent change agreed was that calls from police custody suites would no longer be granted an automatic ambulance dispatch, although there are no proposals to extend this to calls from the police generally.
- 3.20 A number of other proposals for managing demand from the police have been explored. Neil Kennett-Brown, the lead commissioner for the LAS, explained that unnecessary attendance by the LAS might be reduced through a review of police protocols and further skills development among police officers.⁴² This could include skills in life support and triage, and enhanced knowledge of the health service; Peter Bradley suggested the LAS could provide this training to the police directly.⁴³ Another proposal that has recently been trialled in two areas of London is to have paramedics join police patrols, to assess patients and advise on whether an ambulance is required.⁴⁴
- 3.21 Demand from the police could be better managed in two ways: the MPS could reduce the number of requests made for ambulance support, and the LAS could change the way it handles these requests. Although the Committee has heard of several potential solutions in this area, it is disappointing that there is no clear, joint programme in place to deliver these. Such a programme would seek to implement changes within both the MPS and the LAS aimed at reducing the number of incidents to which an ambulance is dispatched unnecessarily. Other police services in London, specifically the City of

⁴¹ Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 12; Written submission from Metropolitan Police Authority, August 2011, page 2

⁴² Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 32

⁴³ Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 13

⁴⁴ Peter Bradley, Transcript of the Health and Public Services Committee meeting, 6 April 2011, pages 13-14

London Police and British Transport Police, could participate in this work also. We envisage pilot programmes for testing new processes can be trialled reasonably quickly. Particularly as both organisations are facing reduced budgets in the coming years, it is time that significant progress was made in this area. The establishment of the new Mayor's Office for Policing and Crime represents a new opportunity to initiate this.

Recommendation 1

The Mayor's Office for Policing and Crime should commission a review of the processes used by the London Ambulance Service and the Metropolitan Police Service, for making and handling police requests for ambulance support. The review should aim to recommend steps that would help reduce the number of incidents attended by the LAS as a result of police requests, without having a detrimental effect on patient outcomes. The British Transport Police and City of London Police should also be invited to participate in the review; other partner organisations such as the London Fire Brigade should also be consulted.

Recommendations should focus on shared resources or improvements to working practices. The review should begin its work as soon as possible in the new Mayoral term, commencing in May 2012, and aim to complete its work within three months.

Door-to-door transport services

- 3.22 Door-to-door services provide pre-booked transportation for people with mobility problems who are unable to use public transport. The NHS Patient Transport Service, of which the LAS is currently a provider, is one type of door-to-door service; there are many other types.⁴⁵ Transport for London directly provides the Dial-a-Ride minibus service, which offers free minibus transport to registered

⁴⁵ The LAS Patient Transport Service transports patients with a clinical need to pre-booked hospital appointments. The LAS is contracted by 19 different NHS trusts to provide this service, carrying out around 200,000 patient journeys per year; *Annual Report 2010/11*, London Ambulance Service, 2011. There are a range of other private providers of NHS Patient Transport; the LAS has less than 10% per cent of the market for this service in London.

members. TfL also funds Taxicard and Capital Call, which provide subsidised taxi services, again for registered members. The main other types of door-to-door service are NHS Patient Transport, social services transport and a variety of charitable 'community transport' services.

- 3.23 In general door-to-door services cannot be used to take people to hospitals or other medical facilities.⁴⁶ Dial-a-Ride cannot be used to take people to any appointment or treatment at a hospital, clinic or other facility to which the patient has been referred by a medical professional. Taxicard and Capital Call can be used for some medical appointments, although members are advised not to use the service to travel to hospital. Only NHS Patient Transport providers can take people to hospital, following a request from a medical professional.
- 3.24 The London Assembly Transport Committee published a report on TfL's door-to-door services in 2010.⁴⁷ The report found that services were inefficient and had low levels of public satisfaction, especially with the restricted availability of journeys. It argued that the provision of numerous, overlapping door-to-door services with separate eligibility criteria and booking processes led to replication and poor service.
- 3.25 Where patients call 999 asking for transport to a pre-booked medical appointment, the LAS refers callers directly to their hospital or the contracted Patient Transport provider. Where patients want to attend a medical facility without an appointment, evidence suggests that the LAS's emergency service is being used in instances where patients might have relied instead on one of the door-to-door services, such as Dial-a-Ride or Taxicard.
- 3.26 Firstly, the LAS already books private hire vehicles to transport some of its emergency patients, that is, patients who have phoned 999 to request an ambulance. The LAS only books private hire vehicles for patients after a phone assessment by a qualified clinician, and in cases where the patient cannot make their own arrangements for transport to hospital. Approximately 1,200 emergency patient journeys were

⁴⁶ *Your guide to Dial-a-Ride*, Transport for London; *Assisted transport services in Greater London*, Transport for London

⁴⁷ The report is available at: <http://www.london.gov.uk/who-runs-london/the-london-assembly/publications/transport/door-to-door-2010>

delivered by a private hire vehicle booked by the LAS in 2010/11,⁴⁸ and the LAS has stated it expects to increase expenditure on private hire vehicles to transport 999 callers with non-emergency conditions.⁴⁹ This suggests that the LAS is meeting demand from patients to be conveyed, even where the LAS deems the patient does not need the support of trained ambulance staff.

3.27 Secondly, the LAS directly provides a large number of emergency patient journeys in low-priority cases. In 2010/11 the LAS conveyed 193,000 patients to hospital or another destination in response to Category C calls, which are defined as not serious or life-threatening.⁵⁰ Although it is not necessarily the case that these patients did not require an ambulance, it is possible that a door-to-door transport service could have been deployed to convey many of these patients, if the initial assessment of the patient suggested that medical support was not required at the scene or during the journey.

3.28 The comparative costs of the two types of service suggest that transferring some patients from the LAS emergency service to other door-to-door services may lead to overall cost savings for the taxpayer. The LAS spends an average £225 on each incident attended by an ambulance crew; Dial-a-Ride spends approximately £24 per journey and Taxicard £10.⁵¹

3.29 In 2009, TfL and London Councils established a door-to-door services project board. NHS primary care trusts and service users are also represented on the project board, although the LAS is not. The board has a specific remit to develop proposals for the integration of door-to-door services.⁵² In September 2010, a strategy produced for the project board made detailed recommendations about the establishment of an Integrated Transport Unit, which would provide for consistent eligibility criteria for all services and a centralised call

Door-to-door transport services run by Transport for London and boroughs could help reduce demand for the LAS.

⁴⁸ Private hire vehicles. Information provided by London Ambulance Service, September 2011

⁴⁹ Freedom of Information Act response, London Ambulance Service, 6 May 2011

⁵⁰ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011

⁵¹ *Travel in London: Report 3*, Transport for London, 2010

⁵² *Developing the Door to Door Strategy*, London Councils, September 2010

handling and scheduling facility. However, no firm plans have yet been developed to implement this proposal.⁵³

- 3.30 Demand on the LAS could be reduced if the current failings of door-to-door services were addressed. The LAS is already trying to manage demand differently for less urgent cases, for instance by providing telephone advice rather than a patient journey; the introduction of the NHS 111 service should also redirect some non-urgent calls. In some cases, the LAS could also explore the option of referring calls to door-to-door services, which should be less expensive than conveying patients unnecessarily by ambulance. For this to happen on a large scale requires improvements in the delivery of door-to-door services, and the development of common processes between the LAS and the various door-to-door providers. This will also require amending rules precluding the use of door-to-door transport services to take people to medical facilities.
- 3.31 The Mayor should take action now to encourage TfL and London Councils to improve door-to-door services, particularly by taking forward the proposals for integration that have already been developed. Londoners with mobility problems need holistic support from door-to-door services, incorporating NHS, TfL, London borough and local community services. So that changes in door-to-door provision can help deliver a long-term reduction in ambulance passenger journeys, the LAS should become a full partner in this work.

Recommendation 2

As Chair of Transport for London, the Mayor should invite the London Ambulance Service to participate in the project board developing proposals for the integration of door-to-door services.

Thereafter, the project board should develop a comprehensive plan to establish an integrated door-to-door service that supports people with mobility problems to get around the city and access health services.

The Mayor should confirm the invitation to the LAS in his response to the Committee by the end of February 2012.

⁵³ Separately, the (NHS) London Procurement Programme works with commissioners of NHS Patient Transport to develop shared services, for instance delivering a joint Patient Transport call centre for several hospitals.

Public health programmes

- 3.32 The GLA is gaining new responsibilities in public health as part of the government's NHS reforms. The Mayor will chair a new London Health Improvement Board (LHIB), which will oversee funding of London-wide public health programmes. The money for these programmes is drawn from a 'top-slice' of the public health budgets that are being transferred from primary care trusts to boroughs.
- 3.33 The LHIB is currently meeting in shadow form before being formally established in 2013. Its membership includes representatives of several London boroughs, the Mayor's Office, NHS London, GPs, primary care trusts and academia. It has set three early priorities for its work: alcohol, childhood obesity and the diagnosis and screening of cancer.⁵⁴
- 3.34 Public health programmes run by the Mayor and LHIB may include a variety of activities, including public information and education campaigns, delivered directly in communities or through the media. For instance, increasing the provision of defibrillators in public places such as shopping centres and major stores, and training the public in their use, will save the lives of people suffering cardiac arrest. This type of programme presents an opportunity for the LAS to help reduce demand and improve patient outcomes, both by preventing incidents and by encouraging appropriate use of urgent care services. Peter Bradley, LAS Chief Executive, told the Committee that the LAS has run preventative campaigns such as this – for instance, on preventing knife crime and road traffic collisions – but has lacked resource to do more:

*"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... 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."*⁵⁵

The Mayor's new London Health Improvement Board will address alcohol misuse, one of the drivers of increased demand for the ambulance service.

⁵⁴ London Health Improvement Board, Greater London Authority, September 2011

⁵⁵ Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 11

3.35 In a written submission to the Committee, the LAS proposed that the organisation could become more involved in the GLA's work on public health:

*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.*⁵⁶

3.36 Clear parallels exist between the London-wide public health work that the Greater London Authority will be leading through the London Health Improvement Board, and the London Ambulance Service's work to promote public education and prevention of ill health, particularly in relation to the LHIB's priority workstream on alcohol. A 2009 investigation by this Committee found that alcohol misuse among young people was placing great strain on London's emergency services.⁵⁷ The expertise possessed by the LAS and its contact with the community means it is a key partner for the LHIB.

3.37 The resources of the LHIB could be usefully spent in a way that keeps Londoners healthy while helping the LAS effectively manage demand for its service. As the future commissioners of the LAS are represented on the LHIB, this also presents an opportunity for some of the funding they control to be pooled with LHIB resources for this purpose. Any preventative work led by the LHIB would almost certainly take a number of years to make a significant impact on ambulance demand; this is most appropriately conceived of as a long-term objective.

Recommendation 3

The Mayor should invite the London Ambulance Service to join the London Health Improvement Board, in order to explore opportunities for joint working on public education and the prevention of ill health. The Mayor should confirm the invitation to the LAS in his response to the Committee

⁵⁶ Written submission from London Ambulance Service, February 2011, page 4. 'Health and wellbeing boards' are being created in every borough. The London Health Improvement Board is effectively a London-wide health and wellbeing board.

⁵⁷ *Too much too young? Alcohol misuse among young Londoners*, London Assembly, July 2009

by the end of February 2012.

4 Strategic challenge: delivering more for less

The LAS is planning to reduce its frontline workforce by 560 posts over the next five years.

- 4.1 The NHS is required by the government to make total savings of £20 billion per year by 2014/15;⁵⁸ trusts throughout the NHS therefore have efficiency targets of around 4–6 per cent per year.⁵⁹ In order to meet this, in April 2011 the LAS announced a five-year ‘cost improvement programme’.⁶⁰ This programme includes:
- A reduction of £54 million in the LAS budget by 2015/16 (19 per cent reduction, compared to 2011/12).
 - A reduction in LAS staff posts of 893 (18 per cent reduction).
- 4.2 The staff reductions include 560 ‘frontline’ posts (staff directly responsible for patient care), and 333 management and support posts.⁶¹ Michael Dinan, LAS Finance Director, told the Committee that the staff reductions will be achieved primarily by not filling vacancies as staff leave or retire, rather than redundancies.⁶²
- 4.3 Figure 2 overleaf illustrates how the LAS budget has changed in recent years, with future projections. This shows how the planned reductions in LAS resources will be introduced after a long period of growth, including a series of above-inflation budget increases.
- 4.4 The Committee’s investigation has identified a number of processes and policies of the LAS that could be modified to generate efficiencies. As with demand reduction measures, in many cases the LAS will rely on cooperation with NHS and GLA Group partners in order to make savings in these areas. In this chapter we discuss:
- Alternative ways of responding to calls
 - Ambulance dispatch
 - Patient handover to A&E
 - Shared station facilities
 - Shared functions and services

⁵⁸ *Department of Health – Spending Review 2010*, Department of Health, October 2010

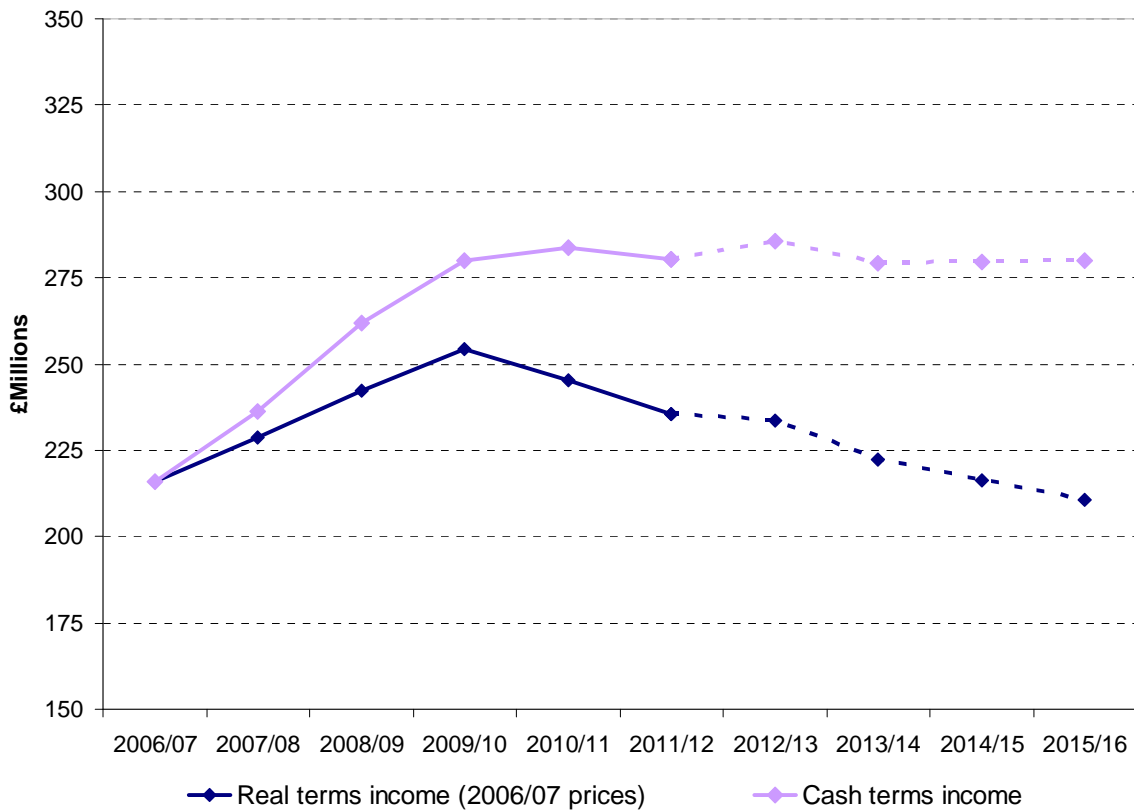
⁵⁹ *How is the NHS performing: Quarterly Monitoring Report*, The King’s Fund, July 2011

⁶⁰ *Service launches five year cost improvement programme*, London Ambulance Service, April 2011

⁶¹ Call handling staff in the Emergency Operations Centre are categorised as support staff.

⁶² Transcript of the Health and Public Services Committee meeting, 25 May 2011, pages 5–6

Figure 2: London Ambulance Service income, cash and real terms⁶³



Alternative ways of responding to calls

- 4.5 Currently, the LAS responds to most 999 calls by dispatching an ambulance to a patient, and conveying them to A&E. The number of incidents dealt with in this way in 2010/11 was 785,000. Only a third of patients taken by ambulance to A&E were Category A cases; the remainder were not in life-threatening conditions.
- 4.6 Alternative ways of responding to calls are available, particularly 'see and treat', 'hear and treat', and conveying patients to non-A&E destinations, as recommended recently in the National Audit Office's recent review of ambulance services.⁶⁴ Table 2 overleaf explains what

⁶³ Information provided by London Ambulance Service, November 2011. Dotted line indicates projected income. The inflation measure used in this graph is the Retail Price Index, excluding mortgage interest payments (RPIX); historic inflation data was obtained from the Office for National Statistics, 30 September 2011; forecast inflation data was obtained from the Office for Budget Responsibility's RPIX inflation forecast, 19 August 2010

⁶⁴ *Transforming NHS ambulance services*, National Audit Office, June 2011

these methods are, how they are currently used by the LAS, and the estimated savings that can be achieved through greater usage.

Table 2: Alternative ways of responding to calls

Method	Definition	LAS usage, 2010/11 ⁶⁵	Financial implications ⁶⁶
'See and treat'	Incidents are resolved by treating patients at the scene, without conveying them to A&E or any other medical facility. This method does not incur the cost of conveying a patient to a medical facility.	For 246,000 of the incidents attended by the LAS (24 per cent of all incidents), patients were treated at the scene rather than conveyed to a medical facility. This is slightly below the England average of 27 per cent.	Estimated saving of £32 per incident. Potential LAS annual saving of £2.6 million if mean national forecast is met (31% of incidents by 2015/16).
'Hear and treat'	Calls are resolved through telephone advice, including by referring patients to other services, rather than dispatching an ambulance. This method does not incur the cost of dispatching an ambulance.	50,100 calls to the LAS (3.4 per cent of all calls) were resolved through telephone advice. This is slightly above the England average of 3.0 per cent.	Estimated saving of £66 per call. Potential LAS annual saving of £7.6 million if mean national forecast is met (11% of calls by 2015/16).
Convey to non-A&E destinations	Patients are conveyed by ambulance to a destination other than A&E, such as a walk-in centre. This method generally involves shorter journey times and patient handover times.	The LAS conveyed 27,600 patients to a non-A&E destination (3.4 per cent of all emergency journeys). This is significantly lower than the England average of 12 per cent.	Estimated savings of £16 per journey. Potential LAS annual savings of £1.2 million if mean national forecast is met (13% of journeys by 2015/16).

Skills of ambulance staff

4.7 The LAS is already using these response methods to some extent, and is seeking to increase usage further.⁶⁷ A key factor in doing this is the skill levels of ambulance staff. The frontline ambulance service workforce includes several different types of officer, with different skills depending on the incidents they need to respond to:

- Ambulances have a two-person crew, a combination of paramedics, student paramedics and emergency medical technicians (EMTs). Paramedics train for three years, and have advanced skills in life-

⁶⁵ *Ambulance Services, England 2010-11*, NHS Information Centre, June 2011

⁶⁶ *Transforming NHS ambulance services*, National Audit Office, June 2011 [Background research by Deloitte]. Potential annual savings for 'hear and treat' and 'see and treat' are based on LAS achieving the mean forecasts across all ambulance services for their increase in the use of each method by 2015/16; 'non-A&E destinations' forecast assumes a 10% shift from A&E to non-A&E conveyance, derived from Deloitte analysis rather than ambulance service forecasts.

⁶⁷ Written submission from London Ambulance Service, February 2011, page 4

saving treatment; they are able to perform complex medical procedures, for instance advanced airway procedures, and dispense a range of medication, such as for asthma attacks, treatment of diabetics or allergic reactions. EMTs support paramedics, and train for around three months with a further year working under supervision; they have extended first aid and patient support skills and can administer a range of drugs in an emergency. Both paramedics and EMTs are trained to identify patients who have suffered from a ST segment myocardial infarction (STEMI), a form of heart attack, and convey them to a specialist facility.

- Paramedics and EMTs are also deployed as single-responders to some incidents, in cars or on motorbikes or bicycles.⁶⁸ This often involves being the first officer to treat a patient in a life-threatening condition. However, it also involves supporting patients who may not require an ambulance: in these situations the single-responder paramedic assesses patients, and may treat them at home or refer them to another service. The LAS workforce previously included a role of ‘emergency care practitioner’, specifically to provide this home-based support to patients, but this role has been phased out in favour of upskilling paramedics with advanced assessment skills.
- For less urgent calls, the LAS often deploys A&E Support staff, who receive two months’ training in basic clinical and patient care skills for the role. A&E Support staff can assess patients’ needs, provide basic care for non-serious conditions and transport patients to hospital; they also respond to out-of-hospital cardiac arrests and deliver basic life support, backed up by a paramedic or EMT.

4.8 The increasing emphasis on ‘see and treat’ as a response method, in particular, requires further development of the skills of ambulance staff. As Dr Fionna Moore, LAS Medical Director, told the Committee:

“...it is about upskilling the staff we have got because we do have the opportunities now to work differently, and to ensure that patients do get more choice to [access] care that is available to

Enhancing the skills of ambulance crews would help them to treat more patients in their own homes.

⁶⁸ The LAS intends to make the single-responder role one that is fulfilled only by paramedics.

*them locally and care that is more appropriate to them, rather than just [saying], 'We just go to the emergency department'.*⁶⁹

- 4.9 The LAS is the first response to a patient calling 999; the immediate care provided is crucial to achieving the best patient outcomes in the most efficient way. The predominant response of the LAS to 999 calls is still to dispatch an ambulance and transport the patient to hospital. The LAS and its partners accept, however, that highly-trained ambulance service staff can provide care to patients quickly and efficiently. Both paramedics and A&E Support staff need to have the skills and confidence required to resolve incidents at the scene, for instance in the patient's home, without necessarily taking them to hospital.
- 4.10 The LAS might be able to further enhance its ability to treat patients at the scene of an incident if it deployed doctors in ambulance crews. This could happen for specific types of calls, where 'see and treat' is deemed the most appropriate type of response. London already has an example of this arrangement: London's Air Ambulance, which works in close partnership with the LAS, has doctors and paramedics among its crew.⁷⁰

Health services

- 4.11 In order to increase its use of 'see and treat', 'hear and treat' and non-A&E destinations, the LAS will also depend on the availability of other NHS services and information about them:
- Community services such as GP surgeries and mental health crisis teams could be alternative sources of support that some 999 callers are referred to, as discussed in the previous chapter.
 - Conveying patients to non-A&E destinations requires walk-in centres and minor injury units to be established by NHS commissioners and providers. London currently has fewer of these facilities per person than the rest of the country;⁷¹ efficiency

⁶⁹ Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 9

⁷⁰ *What we do*, www.londonsairambulance.co.uk, November 2011

⁷¹ 20 walk-in centres and 15 minor injury units exist in London, equating to one facility for every 226,000 Londoners. Across the rest of England, there is one facility for every 134,000 people. NHS Choices, June 2011; *Annual Mid-Year Population Estimates*, Office for National Statistics, June 2011

measures across the NHS may place further pressure on their availability.

- To ensure information about other services is available, a London-wide directory of health services is being developed. This directory would be shared throughout the NHS, and enable the LAS to access accurate and comprehensive information about where to refer or convey patients.⁷²

Ambulance dispatch

- 4.12 The LAS could become more efficient by reducing the number of occasions on which it dispatches more than one vehicle. Services often dispatch multiple vehicles to an incident to ensure there is a response on scene as quickly as possible. This includes occasions where a motorcycle or bicycle is sent ahead of an ambulance, and occasions where multiple ambulances are dispatched for the same patient. In a recent review on ambulance services, the National Audit Office recommended reducing the number of multiple dispatches.⁷³
- 4.13 The LAS explained how and why a single incident will often receive multiple responses. Peter Bradley, Chief Executive, told the Committee that because the LAS has a relatively high concentration of resources in a small geographical area (compared to other ambulance services), it will often have two ambulances available in the vicinity of an emergency incident. Call dispatchers are aware of all ambulance locations, so for example when they see two close to the incident, they would tend to dispatch both.⁷⁴ After one ambulance has reached the incident, the other would be recalled if it is not required.
- 4.14 London has a higher level of multiple dispatch than other regional ambulance services. Across England, ambulance services dispatched more than one vehicle to 49 per cent of all incidents, on average, in 2009/10.⁷⁵ For the LAS this figure was significantly higher at 61 per cent. The proportion of life-threatening incidents in London, where the response time is most critical, was only 32 per cent. This means

In 2009/10 the LAS sent more than one vehicle to 61 per cent of incidents.

⁷² Neil Kennett-Brown, Transcript of the Health and Public Services Committee meeting, 17 March 2011, page 8

⁷³ *Transforming NHS ambulance services*, National Audit Office, June 2011

⁷⁴ Peter Bradley, London Ambulance Service, Oral Evidence, Public Accounts Committee, House of Commons, 29 June 2011

⁷⁵ *Transforming NHS ambulance services*, National Audit Office, June 2011

that the LAS sent multiple resources to approximately 290,000 incidents that were not life-threatening emergencies.⁷⁶

- 4.15 The LAS is aiming to reduce its level of multiple-dispatching to around 40 per cent within two years.⁷⁷ This will be facilitated by the recent changes to the performance measurement system: the removal of the 19-minute Category B target means that there is less compulsion for ambulance services to send a vehicle response to these less urgent calls and to arrive on scene in the shortest possible time.⁷⁸ We expect the LAS to continue monitoring the level of multiple dispatch, and maintain efforts to reduce it.

Patient handover to A&E

- 4.16 The 'patient handover' process between the LAS and hospital A&E departments can be inefficient and variable. Hospitals must comply with targets to limit the length of time between the arrival of an ambulance at A&E and the formal transfer of the patient to A&E staff: it must be within 15 minutes on 85 per cent of occasions. When the handover process is delayed this is inefficient for the LAS, because its staff must wait at the hospital instead of being available to respond to new calls.
- 4.17 Performance against the 15-minute handover time target is poor throughout London. Recent performance figures show that each of the 34 A&E departments in London is missing the target.⁷⁹ On average, only 51 per cent of patient handovers were completed within 15 minutes in June 2011, down from about 70 per cent a year earlier.
- 4.18 The LAS and its lead commissioners (NHS North West London Commissioning Partnership) have recently taken steps to improve the handover process. For instance, many A&E departments now have display screens linked to the LAS, so A&E staff can see real-time information on incoming ambulance patients.⁸⁰ The lead commissioners have recently launched an improvement project for

LAS ambulance crews often waste time waiting at A&E for patients to be transferred to hospital staff.

⁷⁶ Assuming that all Category A calls received a multiple dispatch, a further 29% of incidents received a multiple dispatch but were not Category A; *Ambulance Services, England 2009-10*, NHS Information Centre, June 2010

⁷⁷ Peter Bradley, London Ambulance Service, Oral Evidence, Public Accounts Committee, House of Commons, 29 June 2011

⁷⁸ Ibid.

⁷⁹ Information provided by NHS London, August 2011

⁸⁰ Notes of Health and Public Services Committee visit to LAS Emergency Operations Centre, 26 May 2011. Available at <http://www.london.gov.uk/moderngov/mgConv ert2PDF.aspx?ID=4075> or from the London Assembly secretariat

patient handover; as part of this, every hospital trust is producing a joint action plan with the LAS to identify further steps to take. In its recent review of ambulance services, the National Audit Office recommended NHS commissioners introduce stronger incentives in hospital contracts to ensure A&E departments meet handover targets.⁸¹ We welcome this proposal and urge NHS commissioners to implement it.

Shared station facilities

- 4.19 The LAS could save money if it shared more stations with other emergency services in London. We have particularly examined opportunities for joint facilities with the London Fire Brigade (LFB). The LFB is overseen by the Mayor, who appoints the London Fire and Emergency Planning Authority, the LFB's executive body.
- 4.20 There are 70 ambulance stations in London, and 113 fire stations. The LAS estate is worth approximately £80 million, and the LFB's £283 million.⁸² Both organisations have told the Committee that they are open to developing more shared facilities, and have regular discussions about opportunities to do this.⁸³ Shared ambulance and fire stations are more common in other cities, for instance in New York, where the Fire Department largely runs the city's ambulance service.
- 4.21 There is currently a shared ambulance and fire station in Barnet, while the LAS also uses some of the facilities at the fire stations in Millwall and Acton.⁸⁴ Many other ambulance and fire stations throughout London are in very close proximity. Analysis by the Committee reveals that 41 per cent of ambulance stations have a fire station within one kilometre.⁸⁵

41 per cent of LAS stations are within one kilometre of a London Fire Brigade station.

⁸¹ *Transforming NHS ambulance services*, National Audit Office, June 2011

⁸² Michael Dinan, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 10; *Asset Management Plan (property)*, London Fire Brigade, April 2009

⁸³ Gary Dobson, London Fire Brigade, Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 11; Peter Bradley, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 6 April 2011 pages 14-15

⁸⁴ Gary Dobson, London Fire Brigade, Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 11

⁸⁵ Based on postcode locations of stations listed on the London Ambulance Service and London Fire Brigade websites; excludes Barnet.

- 4.22 The LAS explained to the Committee that it does want to modify its estate. This is partly because LAS does not need to rely heavily on stations: 80 per cent of ambulance responses to incidents are initiated from a mobile position rather than from within a station. Michael Dinan, LAS Finance Director, explained that the organisation wants to move toward having fewer stations, but which are larger in size to accommodate new training facilities.⁸⁶ The LAS is planning to make savings on its estate as part of its five-year cost improvement programme; these amount to £800,000 over the length of the programme.⁸⁷
- 4.23 The LFB is also in the process of modifying its stations. In a private finance initiative (PFI) project, nine fire stations are being rebuilt, including one on a new site. The total cost of this is £57 million. The LFB is planning to finalise agreements with contractors to deliver the stations and begin construction by late 2012.⁸⁸ Discussions with the LAS about sharing facilities at these new stations were held in 2009, although there are not yet any plans to do this.⁸⁹
- 4.24 Both organisations are also making changes to their control centres, the facilities where calls are handled and responses dispatched. The main LAS control centre is in Waterloo, and it is developing a second centre as a back-up facility in Bow. The London Fire Brigade is currently developing a new, single control centre in Morden. Michael Dinan told the Committee that there are opportunities for shared control centres to be developed.⁹⁰
- 4.25 Developing shared facilities between the LAS and LFB may also have the benefit of enabling the two organisations to adopt a 'co-responding' policy for some 999 calls. This would allow the LFB to dispatch a response to life-threatening medical emergencies in instances where a fire crew can reach the scene quicker than an ambulance crew. The co-responding model has been recommended in

⁸⁶ Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 10

⁸⁷ Information provided by London Ambulance Service, May 2011

⁸⁸ *Rebuilding our fire stations*, London Fire Brigade, 2011

⁸⁹ *Asset Management Plan (property)*, London Fire Brigade, April 2009; Michael Dinan, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 24

⁹⁰ Michael Dinan, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 11

three national reviews of the fire service in recent years,⁹¹ and proposed directly to the LFB by the LAS,⁹² but has not yet been adopted in London. Berlin provides an example of this model on a large-scale: firefighters in the city have medical training to at least the level of an emergency medical technician, and work on ambulances as well as fire engines.⁹³

- 4.26 Efficiency gains could be made through the use of more shared stations and shared control centres between the LAS and LFB. Any opportunities to reduce operating costs or to sell assets by developing these shared facilities have to be explored. Although the two organisations insist that regular discussions on this topic take place, it is not apparent to the Committee that there are any coherent plans to develop shared facilities on any meaningful scale.

Recommendation 4

The Mayor should commission a review of shared facilities and joint working between the London Ambulance Service and the London Fire Brigade. The review should aim to generate efficiencies by making specific proposals for shared stations and control centres. The review should begin its work as soon as possible in the new Mayoral term, commencing in May 2012.

Shared functions and services

- 4.27 Beyond shared stations and control rooms, the LAS could make efficiency savings by sharing back-office functions with partner organisations. There are opportunities to do this within the NHS, particularly with other ambulance services, and with the GLA Group.
- 4.28 The LAS has taken steps to work jointly with other ambulance services to save money. Vehicle design and uniforms have both been procured on a national basis, for instance. The LAS has expressed a wish to

⁹¹ *The Future of the Fire Service: reducing risk, saving lives - The Independent Review of the Fire Service*, Office of the Deputy Prime Minister, 2002; *Fire and Rescue Service*, Communities and Local Government Committee, House of Commons, 2006; *Fire Futures: an independent review of the fire and rescue service in England*, Department for Communities and Local Government, 2010

⁹² Peter Bradley, London Ambulance Service, Oral Evidence, Public Accounts Committee, House of Commons, 29 June 2011

⁹³ Written submission from Berlin Fire Brigade, June 2011

enhance this joint working, with chief executive Peter Bradley suggesting that finance and clinical audit⁹⁴ functions could be shared between ambulance services.⁹⁵ However, we have not yet seen further plans for joint work in these areas.

4.29 In some areas, the LAS could work jointly with GLA Group organisations. All of the emergency services currently coordinate activities in resilience planning, and will work closely together during the 2012 Olympic and Paralympic Games, when the services will be co-located at all Games venues London.

4.30 During the Committee's review, several ideas for ongoing collaboration between the LAS and the other emergency services have been put forward. There are a range of other goods and services that all agencies must buy, and could do so more efficiently. Examples where this has already happened are stab vests, which have been procured jointly by the LAS, LFB and MPS, and the specialist equipment purchased jointly for Hazardous Area Response Teams, which deal with major incidents. Michael Dinan, LAS Finance Director, has also suggested facilities management as an area where efficiencies could be made:

*"We own lots of small sites all over London where light bulbs need changing and taps need fixing, and we all have separate facilities management contracts. TfL has a better model with the tube stations and we are looking to access its facilities management operation. We would speak to the fire brigade as well."*⁹⁶

4.31 Another area of potential joint procurement the Committee has explored is fuel. The LAS spent approximately £5.9 million on fuel in 2010/11.⁹⁷ The MPS spent £13.6 million.⁹⁸ The London Fire Brigade spent £1.6 million.⁹⁹ It may be possible for services to negotiate a cheaper price if they can buy fuel jointly, in greater bulk, but there are

⁹⁴ Clinical audit involves reviewing the delivery of healthcare to ensure that best practice is being carried out.

⁹⁵ Peter Bradley, London Ambulance Service, Oral Evidence, Public Accounts Committee, 29 June 2011

⁹⁶ Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 24

⁹⁷ Financial review (Item 6.2), London Ambulance Service NHS Trust Board, 29 March 2011

⁹⁸ Information provided by Metropolitan Police Authority, August 2011

⁹⁹ Information provided by the London Fire and Emergency Planning Authority, August 2011

The LAS should collaborate with other ambulance services and the GLA Group to generate efficiencies.

no joint arrangements in place between these agencies. For instance, the MPS has established a network of bulk fuel sites across London, with one company contracted to supply the sites. The LFB has established a separate network of bulk fuel sites, supplied by a different company. In neither case are the sites used by any other agencies.

Recommendation 5

The London Ambulance Service should set out in its next Annual Report plans to deliver efficiencies through coordinated working with other public services. This should cover such areas as shared finance and clinical audit functions with other ambulance services, and shared procurement opportunities (such as fuel, facilities management and back-office functions) with other emergency services in London.

5 A role for the Mayor in the strategic leadership of the LAS

- 5.1 The London Ambulance Service is a provider of healthcare to Londoners and a key gateway to other NHS primary care services. Integrated working with the rest of the NHS is vital to the LAS meeting its strategic challenges; the Committee therefore welcomes proposals to strengthen its ties to NHS partners. The government is pursuing far-reaching reforms of the NHS, which will affect the LAS and the ways it relates to the rest of the NHS in several ways. While there are risks in this process, opportunities also exist to develop new ways of working.
- 5.2 The Committee has also identified ways in which the LAS can work more closely with the Greater London Authority Group. This reflects the unique position of the LAS as both part of the NHS and one of London's blue-light emergency services. Developing these relationships is also vital for the LAS in meeting its strategic challenges. To enable this, the Committee supports a role for the Mayor in the strategic performance of the LAS, through appointments to LAS governance structures. This change works with the grain of the ongoing NHS reforms, and will help ensure the LAS works closely with its GLA partners while remaining an integrated part of the NHS.

The NHS reforms will affect the way the LAS is commissioned, managed and held to account.

Proposals for NHS reform

- 5.3 Appendix 5 illustrates the proposed new NHS structures that the government is planning to introduce. The specific ways in which the LAS will be affected by the government's proposed structural reforms of the NHS are three-fold:
- *Strategic oversight.* NHS London is the strategic health authority for the capital, and will be abolished by April 2013.¹⁰⁰ It supervises and monitors the performance of both commissioner and provider trusts, and leads the development and implementation of London-wide health strategies.
 - *Commissioning.* The 31 primary care trusts in London are the commissioners of most health services, including ambulance services. In London, PCTs act jointly to commission the LAS: responsibility is delegated to one organisation, the North West London Commissioning Partnership, to lead this work. PCTs will be

¹⁰⁰ It is anticipated that the new national NHS Commissioning Board will have regional and sub-regional 'outposts' as part of its structure, including one covering London and several covering sub-regions within London. See *Nicholson: PCT clusters to survive as arms of Commissioning Board*, Health Service Journal, 21 June 2011

abolished by April 2013;¹⁰¹ The NHS Chief Executive has indicated that the LAS will continue to be commissioned on a London-wide basis, most likely with one consortium given lead responsibility for this.

- *Foundation Trust status.* The London Ambulance Service – like all NHS trusts – is expected to become a Foundation Trust. It is currently in the process of applying to NHS London to achieve Foundation Trust status. This means greater financial autonomy, for instance the ability to retain budget surpluses or borrow money to invest in services. It also means a change to governance structures. Individuals will be able to become members of the London Ambulance Service:¹⁰² the members of the trust will elect the majority of the Council of Governors, the body that appoints, following an open application process, the non-executive directors on the LAS Board.¹⁰³

A Mayoral role in the strategic oversight of the LAS

- 5.4 The debate on the NHS reforms has also included calls for the Mayor to have a formal role in the LAS. The Mayor's Office, LAS and other stakeholders have backed stronger ties between the LAS and the GLA Group. During the course of the Committee's review, a number of proposals have been made, although specific changes have not yet been finally agreed.
- 5.5 There are many potential benefits of involving the Mayor in the strategic performance of the LAS. This report has identified that by developing new processes with the Metropolitan Police Service, London Fire Brigade, London Health Improvement Board and Transport for London, the LAS can manage demand to enable better patient outcomes. Efficiencies can be generated for the LAS and the other emergency services by shared facilities and joint procurement. We believe a formal relationship with the Mayor and GLA Group will ensure an ongoing focus on these important measures. A Mayoral role

The Mayor's Office and the LAS have backed stronger ties between the GLA Group and the ambulance service.

¹⁰¹ There are currently 38 pathfinder consortia in London, covering the whole of the city. It is still to be confirmed whether this will be the final number of consortia operating in London. See *Fifth wave of GP pathfinders*, NHS London, July 2011

¹⁰² Any resident of Greater London and the East of England, South East England and South Central regions may become a member of the LAS.

¹⁰³ The Council of Governors will also comprise representatives of trust staff and partner organisations.

will also bring greater accountability of the service to Londoners. Finally, at a time of structural reform and financial retrenchment, it is important the LAS has a political champion to advocate for it at the highest levels, alongside London's other emergency services.

- 5.6 One option would involve fully integrating the LAS into the GLA Group. The LAS would have a governance structure similar to the London Fire Brigade, with the executive direction from a similar body to the London Fire and Emergency Planning Authority (LFEPA), which is appointed by the Mayor. A similar body overseeing the LAS could appoint senior officers, set performance targets and decide budgets. The Committee does not endorse this proposal; as the Mayor's office and LAS have argued, it risks weakening the LAS's relationships within the NHS.¹⁰⁴ Other ways of strengthening ties to the GLA Group are available.

A way forward

- 5.7 The Committee's preferred option would give the Mayor a more direct role in the strategic oversight of the LAS, while ensuring the LAS remains within the NHS.
- 5.8 As part of the transformation of the LAS into a Foundation Trust, we support proposals for the Mayor to have a formal role in strategic oversight of the LAS. The National Health Service Act 2006, sets out the following governance procedures for Foundation Trusts (please see Appendix 4 for a diagram illustrating the Foundation Trust governance structure):¹⁰⁵
- The governors of the trust should include representatives of the trust membership,¹⁰⁶ trust staff¹⁰⁷, at least one primary care trust and at least one qualifying local authority;¹⁰⁸ governors may also be appointed by any organisation specified as a partnership organisation in the trust constitution.

¹⁰⁴ Richard Hunt, London Ambulance Service, Transcript of the Health and Public Services Committee meeting, 6 April 2011, page 14; Pamela Chesters, Transcript of the Health and Public Services Committee meeting, 25 May 2011, pages 14-15

¹⁰⁵ National Health Service Act 2006 (Schedule 7, Paragraph 9)

¹⁰⁶ Governors elected by trust members must comprise a majority of the governors.

¹⁰⁷ At least three governors must be elected by staff.

¹⁰⁸ A qualifying local authority is "a local authority for an area which includes the whole or part of an area specified in the constitution as the area for a public constituency." The GLA is not a qualified local authority for this purpose, although the LAS has suggested it will invite the Mayor to select a representative from the London boroughs to join the Council of Governors; the borough representative may also be an Assembly Member.

- The non-executive directors of the trust, including the chair, are appointed by the governors. Directors are appointed on the basis of individual credentials following an open application process, rather than as representatives of other organisations.

5.9 The LAS has suggested that its new Council of Governors should include a representative of the Greater London Authority – alongside the other stakeholder organisations, staff representatives and governors elected by the trust’s membership – arguing that this would *“provide an ideal opportunity to further develop working relationships between our Service and the Mayor.”*¹⁰⁹

5.10 The Committee agrees this represents a sensible step toward closer integration. As the Council of Governors will oversee the management of the LAS, examining service provision and appointing the non-executive members of Board of Directors, it will provide a forum to facilitate closer working between the LAS and the GLA Group. To enable this to happen, the constitution adopted by the LAS once it becomes a Foundation Trust would need to specify the GLA as a ‘partnership organisation’, which we believe it should.

The LAS’s new Foundation Trust governance structure should be used to facilitate joint working with the GLA Group.

5.11 To ensure the LAS and GLA Group fully exploit this opportunity for joint working, the Mayor’s powers of appointment could be extended beyond a single GLA representative. The Mayor’s health adviser Pamela Chesters has suggested that the Council of Governors could also include representatives from the police and fire services, in order to help improve working relationships between the organisations: she explained this might be more effective than having a single GLA representative speaking on behalf of the police and fire services without being employed directly by them.¹¹⁰ In order to progress the other recommendations in this report we would also want to see direct TfL representation on the Council. Thereafter the Committee would propose that a GLA Group representative apply to join the LAS Board, subject to the appointment process led by the Council of Governors, to have a more direct influence on the service.

5.12 The direction of travel must be toward closer integration in order to help all of London’s ‘blue-light’ services deliver better support for Londoners. We would welcome a response from the Mayor and from

¹⁰⁹ Written submission from the London Ambulance Service, February 2011, page 7

¹¹⁰ Transcript of the Health and Public Services Committee meeting, 25 May 2011, page 16

the London Ambulance Service to this report by the end of February 2012.

Recommendation 6

The London Ambulance Service should consider specifying the Greater London Authority, Transport for London, Metropolitan Police Service and London Fire Brigade as partnership organisations in the constitution it adopts upon becoming a Foundation Trust, and appoint a representative of each organisation to the LAS Council of Governors. We ask the LAS to report back to the Committee on how it will take forward this recommendation.

Following this, when the LAS becomes a Foundation Trust the Mayor should ask the GLA representative on the LAS Council of Governors (which could mean an Assembly Member) to apply to the Council to be appointed a non-executive director of the LAS, in order to begin the detailed work to bring the organisations more closely together.

Appendix 1 Recommendations

The Committee makes the following recommendations to the Mayor, the London Ambulance Service and NHS London. We ask that responses to these recommendations are provided to the Committee by the end of February 2012.

Recommendation 1

The Mayor's Office for Policing and Crime should commission a review of the processes used by the London Ambulance Service and the Metropolitan Police Service, for making and handling police requests for ambulance support. The review should aim to recommend steps that would help reduce the number of incidents attended by the LAS as a result of police requests, without having a detrimental effect on patient outcomes. The British Transport Police and City of London Police should also be invited to participate in the review; other partner organisations such as the London Fire Brigade should also be consulted.

Recommendations should focus on shared resources or improvements to working practices. The review should begin its work as soon as possible in the new Mayoral term, commencing in May 2012, and aim to complete its work within three months.

Recommendation 2

As Chair of Transport for London, the Mayor should invite the London Ambulance Service to participate in the project board developing proposals for the integration of door-to-door services.

Thereafter, the project board should develop a comprehensive plan to establish an integrated door-to-door service that supports people with mobility problems to get around the city and access health services.

The Mayor should confirm the invitation to the LAS in his response to the Committee by the end of February 2012.

Recommendation 3

The Mayor should invite the London Ambulance Service to join the London Health Improvement Board, in order to explore opportunities for joint working on public education and the prevention of ill health. The Mayor should confirm the invitation to the LAS in his response to the Committee by the end of February 2012.

Recommendation 4

The Mayor should commission a review of shared facilities and joint working between the London Ambulance Service and the London Fire Brigade. The review should aim to generate efficiencies by making

specific proposals for shared stations and control centres. The review should begin its work as soon as possible in the new Mayoral term, commencing in May 2012.

Recommendation 5

The London Ambulance Service should set out in its next Annual Report plans to deliver efficiencies through coordinated working with other public services. This should cover such areas as shared finance and clinical audit functions with other ambulance services, and shared procurement opportunities (such as fuel, facilities management and back-office functions) with other emergency services in London.

Recommendation 6

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Following this, when the LAS becomes a Foundation Trust the Mayor should ask the GLA representative on the LAS Council of Governors (which could mean an Assembly Member) to apply to the Council to be appointed a non-executive director of the LAS, in order to begin the detailed work to bring the organisations more closely together.

Appendix 2 Views and information

The Committee held three formal meetings with experts and stakeholders during this review. On 17 March 2011 we met:

- Malcolm Alexander, London Ambulance Service Patients' Forum
- Dr Junaid Bajwa, Royal College of General Practitioners London Faculty
- Neil Kennett-Brown, Director of LAS Commissioning, NHS North West London Commissioning Partnership
- Dr Andrew Steeden, Clinical Director, NHS North West London Commissioning Partnership
- Richard Webber, Director of Operations, London Ambulance Service
- Professor Malcolm Woollard, Professor of Pre-hospital and Emergency Care, Coventry University

On 6 April 2011 we met:

- Peter Bradley, Chief Executive, London Ambulance Service
- Richard Hunt, Chairman, London Ambulance Service

On 25 May 2011 we met:

- Pamela Chesters, Mayoral Adviser on Health and Youth Opportunities, Greater London Authority
- Michael Dinan, Director of Finance, London Ambulance Service
- Gary Dobson, Director of Operational Policy and Training, London Fire Brigade
- Dr Fionna Moore, Medical Director, London Ambulance Service

Agendas and transcripts from formal meetings are available from the London Assembly website here:

<http://www.london.gov.uk/moderngov/ieListMeetings.aspx?CommitteeId=148>

The Committee received written submission from the following individuals and organisations:

- Berlin Fire Brigade
- British Medical Association
- Chelsea and Westminster Hospital NHS Foundation Trust
- Department of Health
- Ealing Hospital NHS Trust

- Julian Green
- London's Air Ambulance
- London Ambulance Service
- London Borough of Haringey
- Medical Services Ltd
- North Middlesex University Hospital NHS Trust
- NHS Confederation Ambulance Service Network
- South London Healthcare NHS Trust
- Westminster City Council

Copies of written submissions are available on the London Assembly website here:

<http://www.london.gov.uk/who-runs-london/the-london-assembly/publications/health>

Committee Members visited the London Ambulance Service Emergency Operations Centre in Waterloo in May 2011. A note of this visit is available on the London Assembly website here:

<http://www.london.gov.uk/moderngov/ieListDocuments.aspx?CId=148&MId=4296&Ver=4>

Committee Members and officers held informal meetings during this review with representatives of the London Ambulance Service, the London Ambulance Service Patients' Forum, the NHS North West London Commissioning Partnership, Unison (London Ambulance Service branch), the Nuffield Trust, the Yorkshire Ambulance Service, NHS Direct, eo Consulting and the National Audit Office.

Appendix 3 Ambulance performance indicators

The London Ambulance Service has published the following list of the new performance indicators, which were introduced in April 2011.

Further information is available at:

http://www.londonambulance.nhs.uk/about_us/how_we_are_doing/clinical_quality_indicators.aspx

Outcome from acute ST-elevation myocardial infarction (STEMI)

STEMI is an acronym meaning 'ST segment elevation myocardial infarction', which is a type of heart attack.

Outcome from cardiac arrest - return of spontaneous circulation

This indicator will measure how many patients who are in cardiac arrest but following resuscitation have a pulse/ heartbeat on arrival at hospital.

Outcome from cardiac arrest - survival to discharge

Following on from the second indicator, this one will measure the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.

Outcome following stroke for ambulance patients

This indicator will require ambulance services to measure the time it takes from the 999 call to the time it takes those F.A.S.T-positive stroke patients to arrive at a specialist stroke centre so that they can be rapidly assessed for treatment called thrombolysis.

Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

This indicator should reflect how the whole urgent care system is working, rather than simply the ambulance service or A&E, as it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.

Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene)

If patients have to go back and call 999 a second time, it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are

providing safe and effective care the first time, every time, this indicator will measure how many callers or patients call us back within 24 hours of the initial call being made.

Call abandonment rate

This indicator will ensure that we and other ambulance services are not having problems with people phoning 999 and not being able to get through.

Time to answer calls

It equally important that if people/patients dial 999 that they get call answered quickly. This indicator will therefore measure how quickly all 999 calls that we receive get answered.

Service experience

All ambulance services will need to demonstrate how they find out what people think of the service they offer (including the results of focus groups and interviews) and how we are acting on that information to continuously improve patient care.

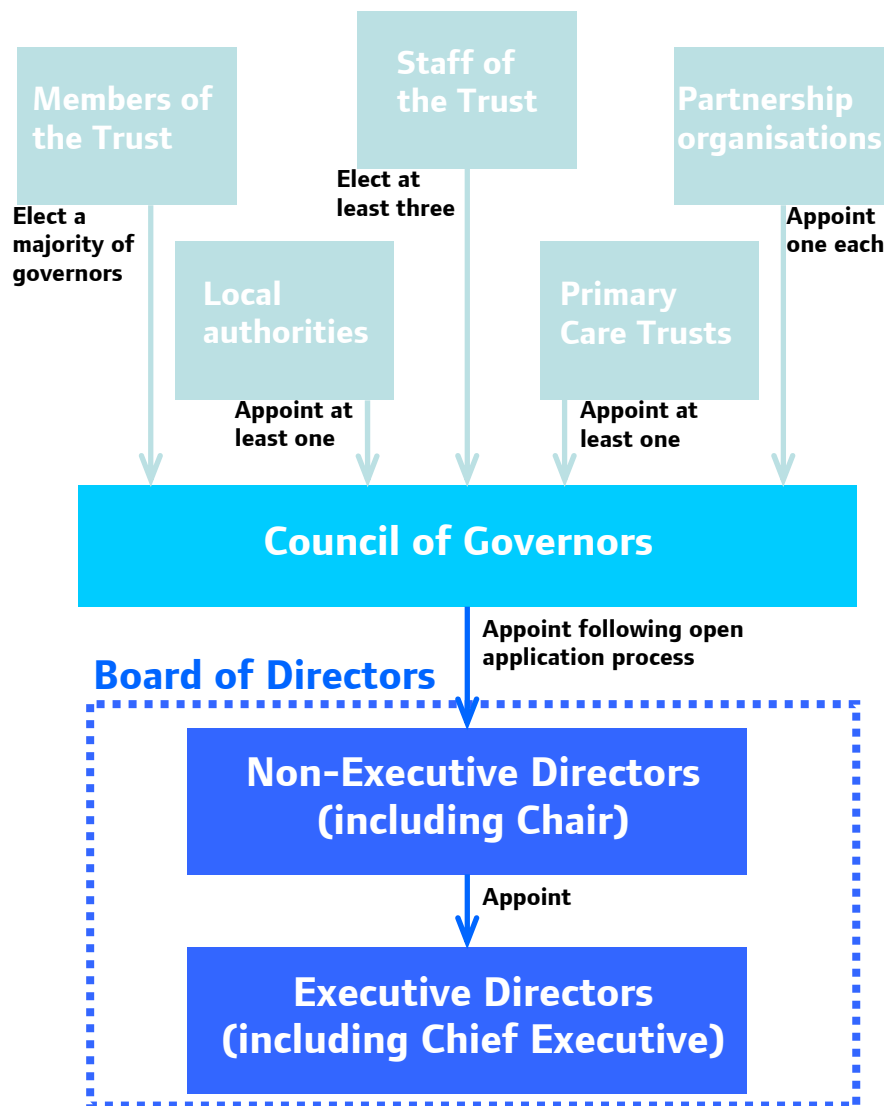
Category A 8 minute response time

This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and measures that those patients who are most in need of an emergency ambulance gets one quickly.

Time to treatment by an ambulance-dispatched health professional

It is important that if patients need an emergency ambulance response, that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

Appendix 4 Foundation Trust governance



The Chief Executive also appoints other Executive Directors. The Executive Directors must include the Finance Director, a registered medical professional and a registered nurse or midwife.

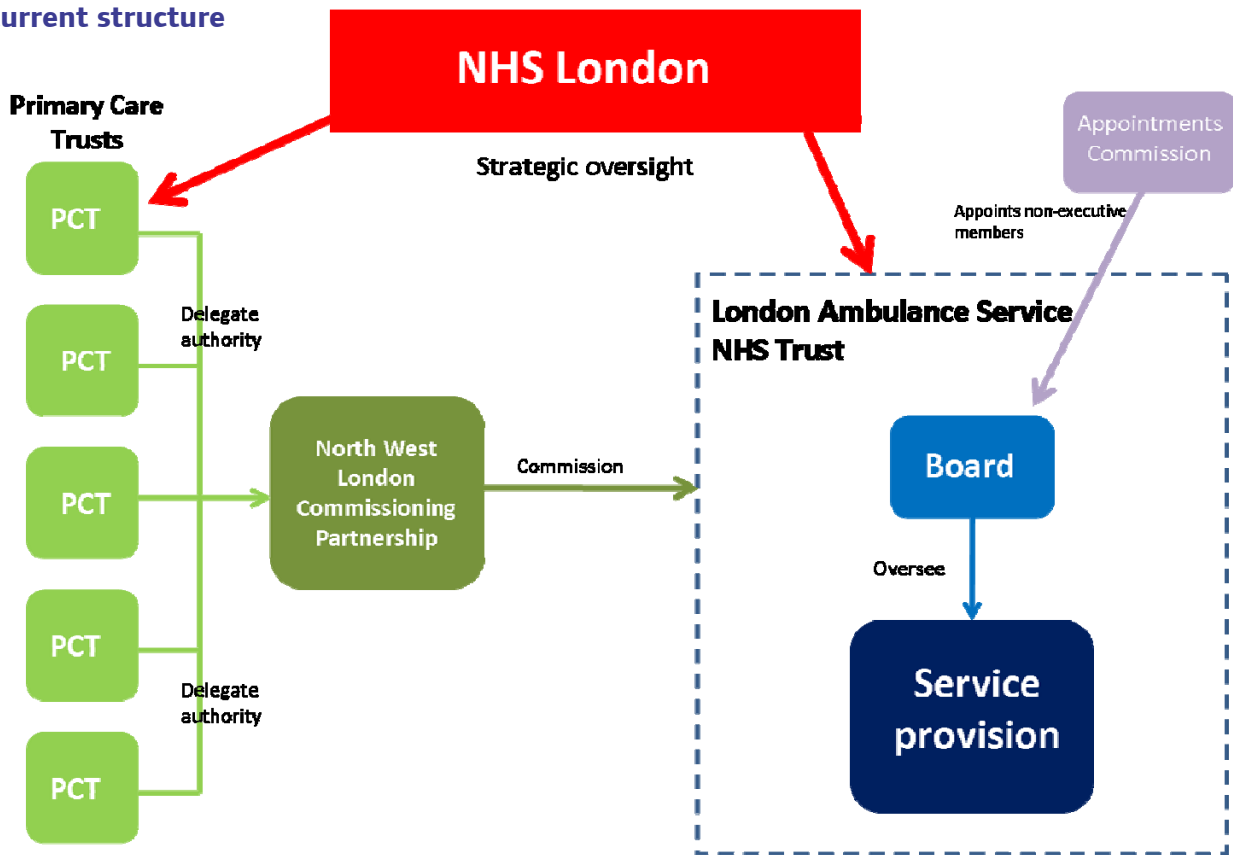
Partnership organisations are those specified as such in the Trust’s constitution.

Trust members elect governors in geographical constituencies, as specified in the Trust constitution.

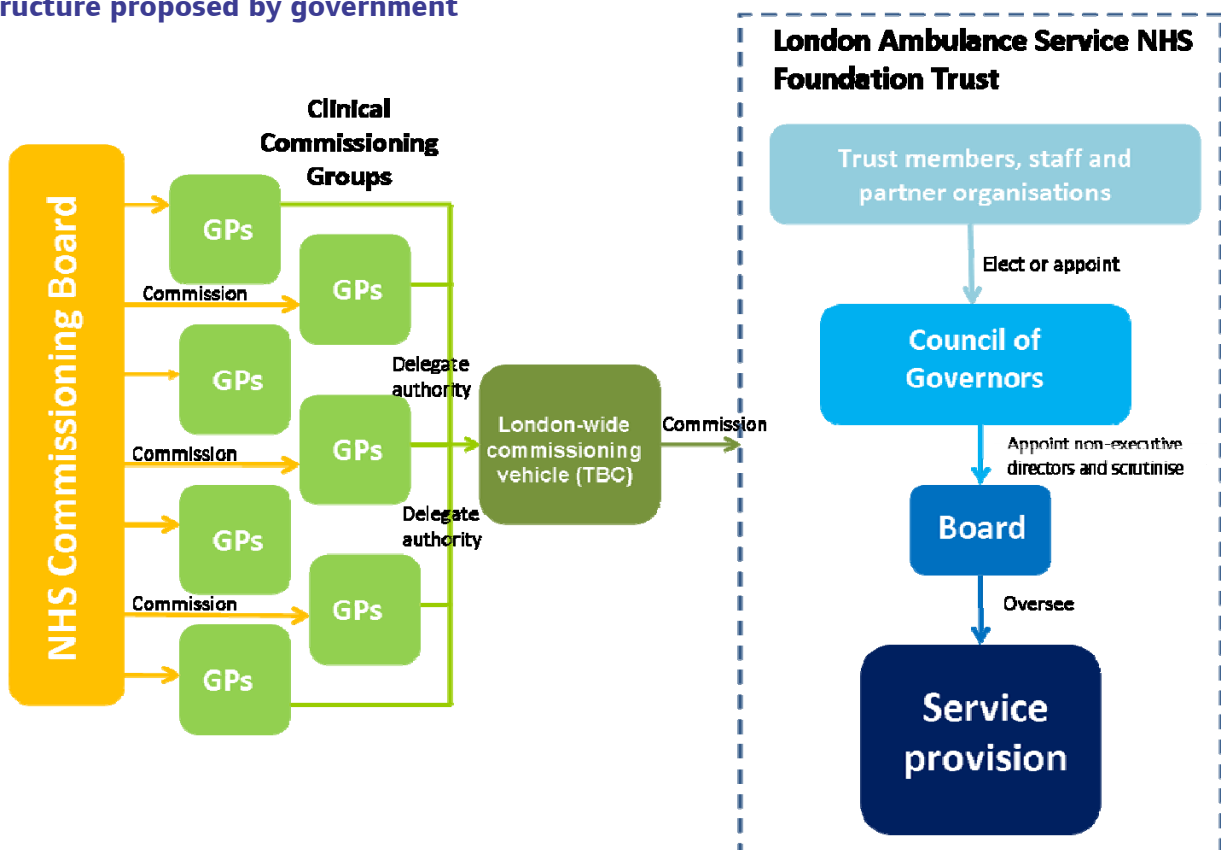
Foundation Trusts must have a governor from at least one Primary Care Trust for which they provide services, and at least one local authority covering all or part of the geographical area specified as the public constituency area in the Trust constitution.

Appendix 5 LAS and NHS structural reforms

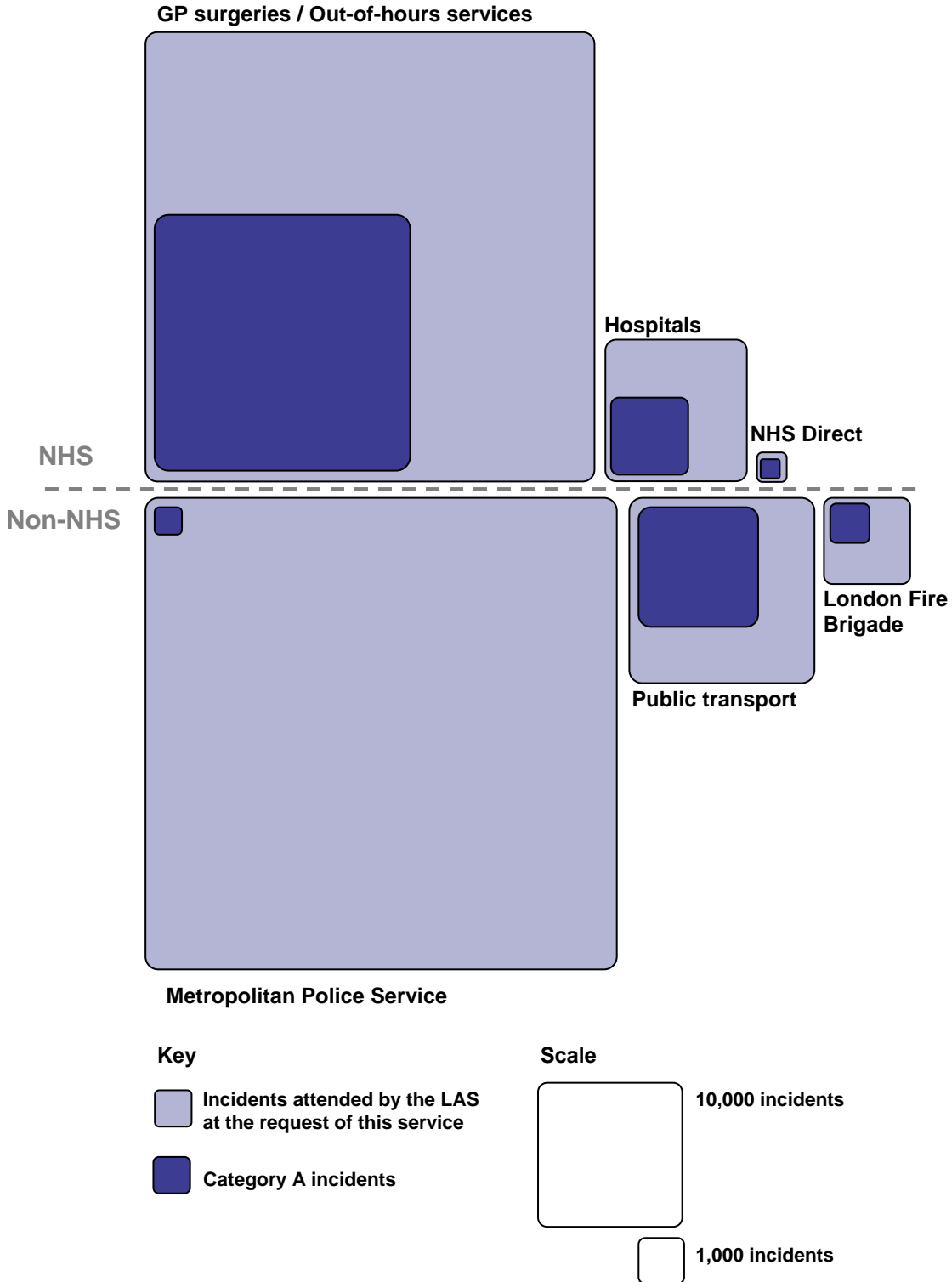
Current structure



Structure proposed by government



Appendix 6 Demand from other public services



Appendix 7 Orders and translations

How to order

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Chinese

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Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Greek

Εάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.

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Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਉਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Bengali

আপনি যদি এই দলিলের একটা সারাংশ নিজের ভাষায় পেতে চান, তাহলে দয়া করে ফোন করবেন অথবা উল্লেখিত ডাক ঠিকানায় বা ই-মেইল ঠিকানায় আমাদের সাথে যোগাযোগ করবেন।

Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں درکار ہو تو، براہ کرم نمبر پر فون کریں یا مذکورہ بالا ڈاک کے پتے یا ای میل پتے پر ہم سے رابطہ کریں۔

Arabic

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فرجاء الاتصال برقم الهاتف أو الاتصال على
العنوان البريدي أو عنوان البريد
الإلكتروني أعلاه.

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં જાણીતો હોય તો ઉપર આપેલ નંબર પર ફોન કરો અથવા ઉપર આપેલ ટપાલ અથવા ઇ-મેઇલ સરનામા પર અમારો સંપર્ક કરો.

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