AGENDA

Meeting Health Committee

Date Tuesday 27 November 2018

Time 10.45 am

Place Committee Room 5, City Hall, The Queen's Walk, London, SE1 2AA

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www.london.gov.uk/mayor-assembly/london-assembly/health

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Members of the Committee

Dr Onkar Sahota AM (Chair)
Susan Hall AM (Deputy Chairman)
Andrew Boff AM
Unmesh Desai AM
Joanne McCartney AM

A meeting of the Committee has been called by the Chair of the Committee to deal with the business listed below.

Ed Williams, Executive Director of Secretariat
Monday 19 November 2018

Further Information

If you have questions, would like further information about the meeting or require special facilities please contact: Clare Bryant, Committee Officer; telephone: 020 7983 5520;
Email: clare.bryant@london.gov.uk; minicom: 020 7983 4458

For media enquiries please contact: Howard Wheeler; Telephone: 020 7983 5769;
Email: howard.wheeler@london.gov.uk. If you have any questions about individual items, please contact the author whose details are at the end of the report.

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Certificate Number: FS 80233

Agenda
Health Committee
Tuesday 27 November 2018

1 Apologies for Absence and Chair's Announcements

To receive any apologies for absence and any announcements from the Chair.

2 Declarations of Interests (Pages 1 - 4)

Report of the Executive Director of Secretariat
Contact: Clare Bryant, clare.bryant@london.gov.uk, 020 7983 4616

The Committee is recommended to:

(a) Note the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, as disclosable pecuniary interests;

(b) Note the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s); and

(c) Note the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at Agenda Item 2) and to note any necessary action taken by the Member(s) following such declaration(s).

3 Minutes (Pages 5 - 38)

The Committee is recommended to confirm the minutes of the meeting of the Committee held on 11 October 2018 to be signed by the Chair as a correct record.

The appendices to the minutes set out on pages 9 to 38 is attached for Members and officers only but is available from the following area of the Greater London Authority's website: www.london.gov.uk/mayor-assembly/london-assembly/health

4 Summary List of Actions (Pages 39 - 42)

Report of the Executive Director of Secretariat
Contact: Clare Bryant, clare.bryant@london.gov.uk, 020 7983 4616

The Committee is recommended to note the outstanding actions arising from its previous meetings.

5 Social Prescribing in London (Pages 43 - 50)

Report of the Executive Director of Secretariat
Contact: Lucy Brant; scrutiny@london.gov.uk; 020 7983 5727

The Committee is recommended to:

(a) Note the report as background to the discussion with invited guests and the subsequent discussion;

(b) Agree the scoping paper as attached to Appendix 1 of the report for the investigation; and

(c) Delegate authority to the Chair, in consultation with the Deputy Chairman, to agree an output from the discussion.

6 Health Committee Work Programme (Pages 51 - 52)

Report of the Executive Director of Secretariat
Contact: Lucy Brant; scrutiny@london.gov.uk; 020 7983 5727

The Committee is recommended to:

(a) Note the Health Committee work programme;

(b) Agree to use its 10 January 2019 meeting slot to discuss issues relating to organ donation for black, Asian and other minority ethnic communities;

(c) Delegate authority to the Chair, in consultation with the Deputy Chairman, to agree any arrangements for any site visits, informal meetings or engagement activities before the Committee's next formal meeting.

7 Date of Next Meeting

The next meeting of the Committee is scheduled for 10 January 2018 at 2.00pm in the Chamber, City Hall.

8 Any Other Business the Chair Considers Urgent

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Declarations of Interests

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 27 November 2018**
This report will be considered in public	

1. Summary

1.1 This report sets out details of offices held by Assembly Members for noting as disclosable pecuniary interests and requires additional relevant declarations relating to disclosable pecuniary interests, and gifts and hospitality to be made.

2. Recommendations

2.1 **That the list of offices held by Assembly Members, as set out in the table below, be noted as disclosable pecuniary interests[1];**

2.2 **That the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s) be noted; and**

2.3 **That the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at below) and any necessary action taken by the Member(s) following such declaration(s) be noted.**

3. Issues for Consideration

3.1 Relevant offices held by Assembly Members are listed in the table overleaf:

[1] The Monitoring Officer advises that: Paragraph 10 of the Code of Conduct will only preclude a Member from participating in any matter to be considered or being considered at, for example, a meeting of the Assembly, where the Member has a direct Disclosable Pecuniary Interest in that particular matter. The effect of this is that the 'matter to be considered, or being considered' must be about the Member's interest. So, by way of example, if an Assembly Member is also a councillor of London Borough X, that Assembly Member will be precluded from participating in an Assembly meeting where the Assembly is to consider a matter about the Member's role / employment as a councillor of London Borough X; the Member will not be precluded from participating in a meeting where the Assembly is to consider a matter about an activity or decision of London Borough X.

Member	Interest
Tony Arbour AM	
Jennette Arnold OBE AM	European Committee of the Regions
Gareth Bacon AM	Member, LB Bexley
Shaun Bailey AM	
Sian Berry AM	Member, LB Camden
Andrew Boff AM	Congress of Local and Regional Authorities (Council of Europe)
Leonie Cooper AM	Member, LB Wandsworth
Tom Copley AM	Member, LB Lewisham
Unmesh Desai AM	
Tony Devenish AM	Member, City of Westminster
Andrew Dismore AM	
Len Duvall AM	
Florence Eshalomi AM	
Nicky Gavron AM	
Susan Hall AM	Member, LB Harrow
David Kurten AM	
Joanne McCartney AM	Deputy Mayor
Steve O'Connell AM	Member, LB Croydon
Caroline Pidgeon MBE AM	
Keith Prince AM	Alternate Member, European Committee of the Regions
Caroline Russell AM	Member, LB Islington
Dr Onkar Sahota AM	
Navin Shah AM	
Fiona Twycross AM	Deputy Mayor for Fire and Resilience; Chair of the London Local Resilience Forum
Peter Whittle AM	

[Note: LB - London Borough]

3.2 Paragraph 10 of the GLA's Code of Conduct, which reflects the relevant provisions of the Localism Act 2011, provides that:

- where an Assembly Member has a Disclosable Pecuniary Interest in any matter to be considered or being considered or at

  (i) a meeting of the Assembly and any of its committees or sub-committees; or

  (ii) any formal meeting held by the Mayor in connection with the exercise of the Authority's functions

- they must disclose that interest to the meeting (or, if it is a sensitive interest, disclose the fact that they have a sensitive interest to the meeting); and

- must not (i) participate, or participate any further, in any discussion of the matter at the meeting; or (ii) participate in any vote, or further vote, taken on the matter at the meeting

UNLESS

- they have obtained a dispensation from the GLA's Monitoring Officer (in accordance with section 2 of the Procedure for registration and declarations of interests, gifts and hospitality – Appendix 5 to the Code).

3.3 Failure to comply with the above requirements, without reasonable excuse, is a criminal offence; as is knowingly or recklessly providing information about your interests that is false or misleading.

3.4 In addition, the Monitoring Officer has advised Assembly Members to continue to apply the test that was previously applied to help determine whether a pecuniary / prejudicial interest was arising - namely, that Members rely on a reasonable estimation of whether a member of the public, with knowledge of the relevant facts, could, with justification, regard the matter as so significant that it would be likely to prejudice the Member's judgement of the public interest.

3.5 Members should then exercise their judgement as to whether or not, in view of their interests and the interests of others close to them, they should participate in any given discussions and/or decisions business of within and by the GLA. It remains the responsibility of individual Members to make further declarations about their actual or apparent interests at formal meetings noting also that a Member's failure to disclose relevant interest(s) has become a potential criminal offence.

3.6 Members are also required, where considering a matter which relates to or is likely to affect a person from whom they have received a gift or hospitality with an estimated value of at least £25 within the previous three years or from the date of election to the London Assembly, whichever is the later, to disclose the existence and nature of that interest at any meeting of the Authority which they attend at which that business is considered.

3.7 The obligation to declare any gift or hospitality at a meeting is discharged, subject to the proviso set out below, by registering gifts and hospitality received on the Authority's on-line database. The on-line database may be viewed here: https://www.london.gov.uk/mayor-assembly/gifts-and-hospitality.

3.8 If any gift or hospitality received by a Member is not set out on the on-line database at the time of the meeting, and under consideration is a matter which relates to or is likely to affect a person from whom a Member has received a gift or hospitality with an estimated value of at least £25, Members are asked to disclose these at the meeting, either at the declarations of interest agenda item or when the interest becomes apparent.

3.9 It is for Members to decide, in light of the particular circumstances, whether their receipt of a gift or hospitality, could, on a reasonable estimation of a member of the public with knowledge of the relevant facts, with justification, be regarded as so significant that it would be likely to prejudice the Member's judgement of the public interest. Where receipt of a gift or hospitality could be so regarded, the Member must exercise their judgement as to whether or not, they should participate in any given discussions and/or decisions business of within and by the GLA.

4. Legal Implications

4.1 The legal implications are as set out in the body of this report.

5. Financial Implications

5.1 There are no financial implications arising directly from this report.

Local Government (Access to Information) Act 1985	
List of Background Papers: None	
Contact Officer:	Clare Bryant, Committee Officer
Telephone:	020 7983 4616
E-mail:	clare.bryant@london.gov.uk

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GREATERLONDONAUTHORITY LONDONASSEMBLY

MINUTES

Meeting: Health Committee
Date: Thursday 11 October 2018
Time: 2.00 pm
Place: Chamber, City Hall, The Queen's Walk, London, SE1 2AA

Copies of the minutes may be found at:
www.london.gov.uk/mayor-assembly/london-assembly/health

Present:
Dr Onkar Sahota AM (Chair)
Susan Hall AM (Deputy Chairman)
Andrew Boff AM
Unmesh Desai AM
Joanne McCartney AM

1 Apologies for Absence and Chair's Announcements (Item 1)

1.1 There were no apologies for absence.

2 Declarations of Interests (Item 2)

2.1 The Committee received the report of the Executive Director of Secretariat.

2.2 **Resolved:**

That the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, be noted as disclosable pecuniary interests.

3 Minutes (Item 3)

3.1 **Resolved:**

That the minutes of the meeting held on 17 July 2018 be signed by the Chair as a correct record.

4 Summary List of Actions (Item 4)

4.1 The Committee received the report of the Executive Director of Secretariat.

4.2 **Resolved:**

That the completed and outstanding actions arising from previous meetings of the Committee be noted.

5 Action Taken under Delegated Authority (Item 5)

5.1 The Committee received the report of the Executive Director of Secretariat.

5.2 **Resolved:**

That the action taken under delegated authority by the Chair, in consultation with the Deputy Chairman, namely to agree the response to the Health Inequalities Strategy – Draft Implementation Plan and Indicators, be noted.

6 The London Ambulance Service (Item 6)

6.1 The Committee received the report of the Executive Director of Secretariat as background to putting questions on the London Ambulance Service (LAS) to the following invited guests:

- Heather Lawrence OBE, Chair, LAS NHS Trust; and
- Garret Emmerson, Chief Executive, LAS NHS Trust.

6.2 A transcript of the discussion is attached at **Appendix 1**.

6.3 During the course of the discussion, Members requested the Chief Executive Officer, LAS NHS Trust, to provide further information on the extent of the engagement consultation of the new LAS Strategy, *A world class ambulance service for a world class city*.

6.4 At the end of the discussion, the LAS committed to attending the Health Committee on an annual basis to provide an update on the service the LAS was providing.

6.5 **Resolved:**

(a) That the report, and subsequent discussion, be noted; and

(b) That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree an output from the discussion.

7 Response to the Committee's Report, Young-onset Dementia (Item 7)

7.1 The Committee received the report of the Executive Director of Secretariat.

7.2 **Resolved:**
That the response from the Mayor of London to the Committee's report, *Young-onset dementia,* attached as Appendix 1 of the report and the impact tracked attached as Appendix 2 of the report be noted.

8 Health Committee Work Programme (Item 8)

8.1 The Committee received the report of the Executive Director of Secretariat.

8.2 **Resolved:**

(a) That the work programme be noted;

(b) That the meeting slot on 27 November 2018 be used to discuss the Mayor's proposals for social prescribing in London; and

(c) That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any site visits, informal meetings or engagement activities before the Committee's next formal meeting.

9 Date of Next Meeting (Item 9)

9.1 The date of the next meeting of the Committee was scheduled as Tuesday, 27 November 2018, Committee Room 5, City Hall, The Queen's Walk, London SE1 2AA.

10 Any Other Business the Chair Considers Urgent (Item 10)

10.1 There were no items of business that the Chair considered to be urgent.

11 Close of Meeting

11.1 The meeting ended at 3.40pm.

Chair Date

Contact Officer: Clare Bryant, Committee Officer; telephone: 020 7983 5520;
Email: clare.bryant@london.gov.uk; minicom: 020 7983 4458

London Assembly Health Committee – Thursday, 11 October 2018

Transcript of Item 6 – London Ambulance Service

Dr Onkar Sahota AM (Chair): That brings us to today's main item with the London Ambulance Service (LAS). This is the second of two meetings looking at how the Mayor can support a more effective and transparent Ambulance Service in London. Can I please welcome Heather Lawrence [OBE], Chair of the LAS National Health Service (NHS) Trust, and also Garrett Emmerson, the Chief Executive Officer of the LAS. Welcome to the Committee. Thank you very much for coming along.

This is the opening question. Perhaps you each could give me an overview of how the LAS is currently performing. What do you think are the challenges facing the LAS?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Thank you. It is performing well. I will ask Garrett to give you specific details, but I think you will know that in 2015 it was a particularly difficult time for the LAS and the Care Quality Commission (CQC), one of our key regulators, put us into special measures. Well, I should say the other regulators did, but they made it 'inadequate' overall. Since appointing Garrett and working with the new team, we have been deemed to be 'good' overall with 'outstanding' for care. I should emphasise that the frontline services were always recognised for their outstanding care, but the organisation now has systems and processes in place to ensure and assure that we can continue to do the things we need to do in a safe and appropriate way.

One of the other things we have done is change the focus. I think before it was on frontline staff and that is very laudable, but it takes, as you will know, ten or 11 different people to get a crew out there. The importance of having our vehicles made ready, having good human resources (HR) processes, training and risk management, all of those things are in place and we have a new Strategy, which we can talk about, which fits very neatly into what everybody is seeing in London and where we need to be. We now have supporting Strategies for the overall Strategy that we are gradually getting, and we are working on the whole workforce. One of the big issues is moving towards having integrated and interoperable information technology (IT) systems with other providers, which is another year or so away, but we are working on that. It has moved significantly. It has been recognised that we are not a cause of concern to any of the regulators and we are doing well on our performance. Garrett?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes. In terms of operational performance, the ambulance services in the United Kingdom (UK) moved to a new way of measuring performance, response time performance, last year. We are still in the process of transforming our operational organisation to truly optimise that. However, currently we are meeting all of our main standards most of the time. We are typically in the top three of the 11 ambulance trusts in the country in terms of operational performance, consistently meeting our most urgent response times, the so-called category 1 time, which is a seven-minute average standard. We are hitting that consistently.

Dr Onkar Sahota AM (Chair): Thank you for that. I know there is this new initiative of 'hear and treat' or 'see and treat' by the paramedics. How are we getting the message across to Londoners that this is a new approach the LAS is taking?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): This is an absolutely key point that you highlight and it is central to the Strategy that we launched earlier this year, which is around seeking to do more seeing and treating on-scene, recognising that treating patients on-scene, providing you have the right skills, the right equipment and the right capabilities, is better for the patient, faster for the patient and also more effective in terms of being able to get on and deal with the next patient. One of the big challenges we face in London of course is the volume of demand, which is steadily increasing as the population grows, both the resident population and the jobs-related population.

Being able to see and treat more over the time, increasingly using the skills of our paramedics and developing those skills, creating new capabilities, new job opportunities and so on, is good for patients and the wider health system, and indeed good for retention of our skilled resources, which obviously is a major concern to us.

Dr Onkar Sahota AM (Chair): Is there a target from the commissioners for the LAS to reduce the number of patients that are being transferred to hospitals, in order to support 'hear and treat'?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes. We have set a target for ourselves in our Strategy over five years to look to reduce conveyance to hospitals by up to 10%. In terms of specific targets set by our commissioners, we have an existing target this year of a 1% reduction but that is reflective of a lot of the work we are just beginning to do in terms of putting in place pioneer services and new ways of treating patients that we can explore later on if you wish. It will grow but it is very much a focused commitment to do that.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Just to add, we are required to work with the five Sustainable Transformation Partnerships (STPs), as they now are, and clearly as part of that on the pathways and how we do it. Our Trust worked very well and led last winter on queueing in hospitals and reducing demand with the winter room, and that is being used. Again, it was seen as good practice and London actually did better than the rest of the country.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We saw a 15% reduction in overall delays at hospitals last winter compared to the winter before, which was in contrast to most other areas of the countries, which saw some degree of increase.

Dr Onkar Sahota AM (Chair): Yes. Great. You said that you work with the five STPs but Brent Clinical Commissioning Group (CCG) is the main commissioning body for you, is it not?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Currently, on behalf of the other CCGs.

Dr Onkar Sahota AM (Chair): Right. In the commissioning arrangement, does Brent speak effectively for the voice of all of those five STPs?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I think they have a very challenging role because, as you know, they have 32 other CCGs to get on board. Clearly the sectors in London can be different and CCGs can be different. They have done a good job. Our view is the commissioning model will need to change and that is a discussion we are having with a range of people.

Dr Onkar Sahota AM (Chair): Also, before I hand you over, what can the Mayor and the NHS do to improve the arrangements for transferring patients to these services other than the accident and emergency (A&E)

department after an ambulance call-out? What other options are there available to the Ambulance Service apart from the A&E department?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): In terms of enabling more alternative care pathways?

Dr Onkar Sahota AM (Chair): Yes.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Well, as the Chairman says, key to that is the close work with the STPs, the Sustainable Transformation Partnerships, and the development of the right care pathways in the right areas. I think a lot of this is about raising awareness of the way in which we work, the opportunities, and the fact that a lot of our work is not about transporting patients to A&E departments, it is about either treating people on-scene or using alternative pathways, making sure that the right pathways are available at the right times and the right times of day. Being a 24/7 service, it is often in the middle of the night or the weekends when you need key pathways to be available.

It is supporting the work we do to raise awareness of that and having a wider public understanding of the nature of ambulance provision, because it has changed radically. We are now in a position where we have highly skilled paramedics on ambulances who are capable of doing a lot of 'see and treat' already. We only transport 63% of the patients we see to A&E today. That is down from about 74% eight or nine years ago, and as I say, we have a vision to deliver a similar step-down again. That is only possible through increasing capability, both in terms of our paramedics and our crew on-scene, and also in terms of pathways and the ability to take people to other, more appropriate care pathways.

Susan Hall AM (Deputy Chairman): My section is about transparency and accountability. Before we start that, you said, Garrett, "meeting all standards most of the time". Which standards do you not meet?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): There are a series of 14 ambulance quality indicators that are monitored on a weekly basis by NHS England. Obviously, depending on demand, our ability to respond and the ability of all other ambulance services to respond fluctuates. When we see really high levels of demand we take slightly longer, and when we see lower levels of demand we often exceed them by quite a margin. The overall standard metrics are around averages. On the category 1, the highest category, we are consistently hitting the seven-minute target.

On category 2, which is the 18-minute response, we have more of a challenge and we are a few seconds over the 18-minute standard overall. That is largely because we have not yet fully readjusted to responding to the new standards. They require a very different mix of ambulances versus cars and they require a different range of rosters and times of crews on shift. That is a process that is taking a while to do and that leads into a discussion we can have about the need to purchase more ambulances. We need to go from, broadly speaking, a 50/50 mix between ambulances and fast response cars, to 75% or higher ambulances. That means buying more ambulances. We also need to change the rosters around because obviously two people on an ambulance is very different to one person on a fast response car. We are confident that when that is fully developed, we will be able to meet all of those standards consistently.

Susan Hall AM (Deputy Chairman): The timeline on that?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We will be in a much better position by the end of this financial year.

Susan Hall AM (Deputy Chairman): Lovely, thank you. I will go into my section now, which is on accountability and transparency. Who scrutinises you at the moment?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): The CQC, NHS England, NHS Improvement (NHSI), and of course our Patients' Forum.

Susan Hall AM (Deputy Chairman): Across the board, on your finances, arrival times and everything else?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Yes. That would be NHSI and NHS England on those issues and the CQC on the quality of our services, whether they are efficient, effective and safe.

Susan Hall AM (Deputy Chairman): Brent Commission is in charge of all the other ones? Do I have that right?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): On behalf of.

Susan Hall AM (Deputy Chairman): On behalf of?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): "On behalf of" would be the phrase.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Technically we are commissioned by all 32 CCGs in London --

Susan Hall AM (Deputy Chairman): Yes, but Brent takes the lead on that.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): -- but they appoint a Lead Commissioner to negotiate and actually commission us.

Susan Hall AM (Deputy Chairman): How often do you see them? How often do they sit and question or scrutinise you?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We have weekly teleconferences with them in terms of performance. We meet them quarterly at a Strategic Commissioning Board and various other meetings. Similarly, with NHSI we now meet them bi-monthly, once every two months. Previously we have had much more regular meetings, but the level of oversight has reduced somewhat now that we are in a much better operational position.

Susan Hall AM (Deputy Chairman): Do you accept the need for the LAS to become more accountable and transparent to the community it serves?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I would say we are transparent. We have open Board meetings. We discuss pretty much everything and as Garrett will tell you, I am always pushing for things to be in the open Board meeting, not the closed Board meeting. We now have alternate month Board meetings because we are in a pretty good place. We still have Strategies to develop, so we do those in briefing sessions separately. We livestreamed our Annual General Meeting.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I think we are transparent. I sit on another health board in London and I would say we are very transparent.

Susan Hall AM (Deputy Chairman): What are your views on bringing the LAS under mayoral oversight in a similar way to the Metropolitan Police Service (MPS) and the London Fire Brigade (LFB)?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): The difference is that probably a good 90% of what we do is about healthcare. We have talked already about different care pathways and the reality is our relationship with the other healthcare providers is crucial to getting it right. We take about 9,000 maternity calls and 10% of what we do is mental health. When it comes to what we do that links to police and fire, it is about 1% of our activity. While we see it is as important to have blue light collaboration and working with the Mayor, to get the right service for Londoners we need to be integral to that NHS, shift of care pathways and funding resources.

Susan Hall AM (Deputy Chairman): On a survey we did the view was shared, including by the Patients' Forum, that perhaps there should be more scrutiny. What would you say to that?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): More scrutiny?

Susan Hall AM (Deputy Chairman): Yes. Well, that it should be taken under the guise of the Mayor to look at.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I would go back to the fact that very little of what we do is high-end stuff. Yes, we dealt with six major emergencies last year and worked very effectively with blue light services and the Mayor in London, but of the 1.2 million incidents we do, 99% or a very high percentage are about health. They are people who fall over, have complex needs or are mental health clients, and we are working on alternate pathways if you look at our Strategy. That is not the Mayor's main area of interest, as I would understand it.

I think we are very heavily scrutinised. When we were in special measures the executive team had very little time to do anything other than be scrutinised. The difference now that we are in a much better place is that we are able to get on and continue to improve services.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): The key to delivering lower conveyance and faster, better patient care is also very much about closer integration with 111 integrated urgent care services. Ultimately, my vision is that it should not matter whether a patient rings 999, 111 or contacts us online; we will get them to the right level of care, whatever that may be. That is very much the focus of our Strategy, that is very much the focus that I think the whole healthcare sector wants ambulance trusts to move in, if you move the Five-Year Vision, if you read the recently published Carter review of ambulance services across the NHS, we are very far from an organisation that is solely about transport. Yes, we have a transport element to our clinical service, but our primary role is to provide frontline clinical healthcare services for many millions of Londoners every year.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Picking up on an earlier point, "What could the Mayor do?", there is still a perception out there that we are a transport service, but these are professional healthcare operators in our service. They are part of the health system and need to be more integrated with urgent and emergency care across the health sector.

Susan Hall AM (Deputy Chairman): Yes. No, we understand that. Do you find scrutiny helpful?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Of course.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Quite seriously, it is invariably helpful. The survey that you carried out, which I am sure you will want to talk to, was really helpful to us. It gave us an opportunity to talk in the media about exactly the things that we had been highlighting around the nature of provision and the way we deliver healthcare services. Absolutely. It has to be.

Andrew Boff AM: Could I just ask about that 1% figure that you just mentioned? You are saying only 1% of your activity is with the other emergency services, is that correct?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Yes. Let Garrett elaborate.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): In terms of serious incidents that we respond to jointly with either the MPS or the other police services or the Fire Brigade or both, that is typically around 30 to 50 events a day. That wraps up to around 15,000 to 20,000 incidents a year. We respond to 1.2 million incidents a year overall in terms of all categories of health.

Andrew Boff AM: In terms of the origination of some of those calls, we were told in previous scrutiny meetings on this Committee that a vast percentage of the dispatch was directly via contacts with the police. That does not look like 1% to me. It looks to me like you have quite an intimate relationship with the police while doing your job.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We have quite an intimate relationship with the police in terms of dealing with issues. We have a desk in our control centre that is linked directly to the police and we deal with a significant proportion of calls and contacts from them. They do not all necessarily result in a response or incident. They can frequently be advice.

Andrew Boff AM: So, there is quite an overlap?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Certainly, in the incidents that we deal jointly with them --

Andrew Boff AM: That "1%" belies --

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): They are obviously at the more significant end of what we do. They are the bigger, more serious incidents, naturally, but they represent in volume terms a small proportion of what we do. We respond, for example, to around 100,000 mental health-related calls a year. Some of those we receive through the police, from the police, but they are not a co-response with the police.

Andrew Boff AM: You mean you are not on the scene with them. Thank you very much. Sorry to take up time.

Unmesh Desai AM: Good afternoon. Mr Emmerson, you talked about the survey that we [the Health Committee] did being very helpful.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes.

Unmesh Desai AM: The survey also showed that many Londoners have misunderstandings about how the LAS works and should be used. To some extent we have already touched upon this area of community engagement and public awareness in your earlier answers, but can I formally ask you for your views about the findings of the survey that Londoners have a misunderstanding about how your service works and should be used?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): First of all, I would like to point out that we are very gratified by the degree of confidence that Londoners showed in our overall provision. To have a survey that says that nearly 90% of Londoners have confidence in what we do was reassuring and is very much appreciated by those of us who work within the service.

But you are right, it highlights a number of issues, particularly around younger people relative to older people being less confident in feeling they know how to use the service correctly. That is the kind of thing that is really helpful because it helps us focus our work. That is not something that is completely new to us. We do target an awful lot of what we do in terms of public engagement activity towards the younger end of the population. We did 540 public engagement events last year across the service. Nearly half of those, 243, were in the 11 to 18 age group, targeting those people who perhaps have less confidence to use our services correctly. We know that it does result in some really good positive response and some really good success stories in terms of younger people who now do know how to use the service correctly. There is a limit to what we can do, I suppose is probably the key message.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It goes back to the Strategy of linking 999 with 111 so that we can steer people to the more appropriate response. Then it can be upgraded or downgraded according to what the problem is.

Unmesh Desai AM: You talk about confidence and also you talked about raising awareness and widening public understanding, but the Patients' Forum certainly do not seem too impressed. They say that engagement with the public and patients on your new Strategy has been minimal.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I think we would disagree with that. We have engaged with nearly 30 organisations and we liaised several times directly with the Patients' Forum. We produced a Statement of Intent document in advance of our main Strategy, which we published widely, communicated on and indeed had responses back from the Patients' Forum and many other organisations before we produced our final Strategy in the spring.

Unmesh Desai AM: The briefing note that I have says that there was only one meeting, attended by 12 people, three of whom were Forum members, and three office meetings between the Forum and your strategy team.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We would disagree with those. I am happy to get you our view in terms of the extent of our engagement separately.

Unmesh Desai AM: That would help. We have done this survey and we have you here before us. How do you intend to further engage the public, in light of our survey findings and your own experiences, with your plans to transform the service? Can the Mayor be of any help?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): The starting point is we are developing a new User Engagement Strategy. We are saying, "How can we engage more widely with the public and other organisations?" That work is in train. Clearly all communication is good and different channels, and we use as many as possible. We will be looking to use a much wider channel than we have before.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I do think this is one of the areas where the organisation is transforming itself. It is certainly true to say, and I think we would accept that in the past we have been quite an insular organisation and have not engaged widely. However, I think that has changed. We are engaging much more extensively across the healthcare sector. The Chair [of the LAS NHS Trust Board] has already spoken about the need and the work we are doing across STPs and the wider healthcare sector. We have obviously always engaged and worked closely with the emergency services, but I think now, in terms of broader London engagement, we are getting much better at that. We have a very good working relationship with the Mayor. The Chair [of the LAS NHS Trust Board] and I meet him on a regular basis. We work not only in terms of --

Unmesh Desai AM: With the Mayor?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): With the Mayor, yes.

Unmesh Desai AM: How often is that? You said "regular".

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Quarterly.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): About three or four times a year. We work not only in terms of external engagement and public-facing activity, but we also work in terms of collaboration across the Greater London Authority (GLA) group. Indeed, not two weeks ago we were represented at a group that is looking for the opportunity to work more closely across back office services, support services, IT and so on. There is a much, much greater degree of collaboration, both in terms of organisational engagement and in terms of public engagement.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): An example would be the maternity work that our Consultant Midwife has done. Do you want to talk about that? She is engaging with groups, mothers and the supporting groups and what their views are. In looking at our pathways, we are hearing from the people who are using the service. We are doing much more of that in all the pathway work.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Particularly in terms of specific patient groups, maternity is exactly one case but we have done similar work with mental health patient groups, with sepsis and with the Sickle Cell Society. We are in a very different position in London in terms of something like sickle cell, where we have 70% of the UK's sickle cell susceptible population. It is absolutely right that we work specifically with those groups. It is very targeted in terms of identifying issues within patient groups. We organise and run many focus groups and workshops specifically in relation to that, bringing in appropriate groups - groups of carers, groups of patients - to continually improve the organisation. Part of the transformation has been to become much more of a learning organisation that learns and

encourages more work to go on to identify issues and learn from them to improve care. We are seeing quite a lot of the benefits of that, I think, in terms of the quality of the care. That is supported by what the CQC have said in moving us to being 'outstanding' for caring.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): One of the areas of good practice they noted is that at the Board meeting, in the open Board meeting there is a message about transparency. Alternatively, we have a patient story or a staff story. One of the patient stories was a sickle cell patient. It was in the open meeting. They explained what the pathway was like. We worked with the Sickle Cell Society and consultants in that area and we listened to what that patient's story was and how we have changed our pathway accordingly. We take the good with the bad. We have had a mental health patient tell us how it was through VideoLink. That is where I personally learnt about mental health cafes, which helps us take it forward. As a Board, we are very open to listening and learning.

Dr Onkar Sahota AM (Chair): Thank you for that, Unmesh. I heard a lot of you talking about linking organisations but how do the public face you? If I ask a member of public what they think the job of the LAS is they probably will say to me, "It is to take me from place A to B". How are they getting the message that you are more than just a conveying service?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): As you know, if you are a hospital or a general practice, you have a group of patients who know specifically what you do and you have an ongoing relationship with them. That is not the case for an ambulance service. People, as you know, call us when they need us, and it may be once in a lifetime or never. It is something we have to work on, which is why working with the patients and the groups in the pathways. Although we have five pioneer services at the moment, we are going to extend those and we know what the next two will be. We are trying to get at the public that way. If you say, "What can the Mayor do?" it goes back to any discussion about ambulance services, not referring to it as a transport service at all but as a health service with healthcare practitioners who are professionals and are offering a professional service linked to the rest of the Health Service.

Dr Onkar Sahota AM (Chair): This transformation or different way of working, how are you communicating that, say, to the general practitioner (GP) population? I will come to specific cases in a minute, but how are you linking up with the GPs? How are the GPs understanding the new role of the LAS?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): That is about our new strategy, which is brand new this year. We have only launched it for a few months. We do have to work through the CCGs as a vehicle to GPs but others as well, other healthcare professionals. It is a journey that is not going to be quickly fixed.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): That is also where the opportunities are huge in terms of us getting more involved in 111 integrated urgent care. We are now not only answering 111 calls but we are also providing GP advice, clinical advice and pharmaceutical advice. We have direct access in terms of managing out-of-hours GP appointments through 111. It is a much more enhanced level of clinical care.

It is about joining up those pathways. The catchphrase on our strategy is about becoming London's primary integrator of access to emergency and urgent care. We are the only London-wide Trust. We are the only people who are really in a position to do that across London. It will take some time to develop and evolve but given, as the Chairman says, we are only three or four months into the delivery of our Strategy, we have already seen some major steps forward with the implementation of the full 111 integrated urgent care service

in North East London and we are now geared up for the mobilisation of a similar service in South East London. All of that comes together.

Also, more broadly, you talked about what the Mayor could do to support us in terms of public awareness and public engagement. One of the things that the Mayor does do very well in supporting us is in terms of public campaigns, particularly around Christmas, alcohol and so on. They are the kinds of thing where we can really benefit from a joint message, an integrated message, and of course things like this. You asked if we enjoyed scrutiny. One of the reasons we do enjoy scrutiny is because it is an opportunity to get those messages out. There are some key misconceptions that we do want to change about the nature of the way we work, the fact that our ambulances and our crews are on the road 24 hours a day, seven days a week. They do not wait around in ambulance stations, waiting for a call. They are going literally from call to call because we are very busy and very highly utilised. What it does mean is that when you need us most, we are literally around the corner. We are able to respond quickly. It is one of the reasons why our response times are so good, particularly for the most urgent calls.

All of that helps and comes together. Having a higher profile, I would say, in the media than perhaps we have had in the past, has enabled us to get those messages out. For instance, the publicity you did in relation to the survey you launched. On the back of that, we were able to do some significant media on talk radio and through other channels that starts to highlight those issues I have just described. The fact that the *Evening Standard* was able to put the launch of our new strategy and to leave it there throughout the edition illustrates that we are getting our message through to the public in many more ways, much more effectively than perhaps we have done in the past.

Dr Onkar Sahota AM (Chair): I am sure this is an area we will explore. I know one of my colleagues will be picking them up, so we will come back to them. Andrew, over to you.

Andrew Boff AM: You have touched on some of my questions already so if I go over them again, just give the same answer. What sources of information held by other public services would help the LAS plan and operate its services more efficiently? Obviously, the Mayor has control over a number of data sources. We are just trying to get an idea of whether or not they would be useful to you.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We made significant use of data held by the Mayor's Office, the GLA, Transport for London (TfL) and other bodies in terms of the development of our strategy, to understand the planned growth of London, the nature of the demographics, the nature of the population growth and so on. All of that data is really useful to us. One of the things that I was really keen that we did in terms of developing that strategy is that we did not look short-term, we looked long-term and we understood, 20 years out, what the future of London looks like. The challenges that face us, to be honest, are the challenges that face many other public sector bodies in terms of providing increased volumes of services in a more intense, densely populated environment and so on. To be able to understand that and understand where growth is taking place, because growth is not taking place evenly spread across the whole of the city, helps us greatly in terms of our future planning. Yes, we do make quite a lot of use of that close working relationship.

Andrew Boff AM: Have you been involved in the Mayor's Smart Cities data programme, which is there to use data to make the city run more smoothly?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Not personally and not to my knowledge but I could stand corrected on that.

Andrew Boff AM: One of the things that the Mayor is quite big on is volunteering. You have a number of volunteer responders, as I understand it. How does the LAS intend to boost volunteering and how could the Mayor help, bearing in mind we have quite an expertise in finding volunteers?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): That is a very interesting question because it is something that we are developing at the moment. We have done some consulting with our staff on volunteering and the Volunteering Strategy is about to come to the Board. As you will know, we have co-responding volunteers and we want to look at volunteers linked to our pioneer services. The issue for us is about recruitment of Londoners. We see a cohort. If we can get young people coming to be volunteers, it should help. We want to attract people into the service. That is an area I think we would both be keen to see developed.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, absolutely. We are in the process now of shaping a Volunteer Strategy. We have both seen for a while that it is an area we want to develop. Yes, you are right that we have two sorts of volunteers: we have community responders and we have emergency responders. The former are community, un-uniformed, in normal cars. The latter are fully trained, uniformed and blue-light-capable emergency responders who support our frontline paramedic crews in terms of being first on-scene. I think we can go a lot beyond that. Our vision is to have the ability to bring in volunteers right across the service of perhaps all ages and all levels of commitment, through from more junior volunteers in terms of developing what I am sure will not be called a 'cadet scheme', but that sort of thing in terms of developing future clinicians, to members of public of all ages who perhaps want to dedicate a small amount of time a week. Potentially, through the development of some of our new services, we could have a lot of opportunities for people to get involved in many different ways. That would go through, as I say, to the higher levels of commitment that involve significant training and significant work alongside our frontline crews.

There is a lot of opportunity. One of the questions we are debating at the moment is how we do that. You are absolutely right to point out that the Mayor has a lot of ability to bring in volunteers. So do some of our other partner organisations, some of the charitable trusts we work alongside and some of the other major Trusts, who also have significant amounts of volunteering. I think there was a recognition at the recent planning away day that we held that there is not a lot of sense in all of us trying to do separately and we should look for ways to join up, but we have not yet got to an answer of how that should work.

Andrew Boff AM: Have you had a conversation with Team London?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): No, not directly. Not at this point.

Andrew Boff AM: I should really ask questions, but it seems daft not to. They know everything there is to know about volunteering.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): If you could put us in touch, that would be really great. It is a very live issue for us in terms of developing that strategy.

Andrew Boff AM: Yes. You are quite right, why reinvent the wheel when people have been through the pain of trying to get that engagement? Is it something you would wish to do, to talk to Team London?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Yes.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Definitely.

Andrew Boff AM: This is a rather obvious question, this one, but to what extent do London's congestion problems affect ambulance service operation?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): You are the expert on this [Garrett].

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I should answer this one, should I not? Obviously, London is a very densely trafficked city and that inevitably has some implication on the management of all mobile activity. We are obviously in a fairly fortunate position as a blue-light responder in that we are able to use blue-light capability to get to our most urgent cases quickly. Our response times are very quick. We do meet the most urgent response times in terms of the seven-minute response.

Without getting too technical, the nature of the way traffic is managed in London is quite helpful to an emergency responder because of the extent of the traffic control, the traffic lights and the grouping of traffic. It means that we can use the traffic lights to get to the front of queues, safely get across junctions and make progress, and actually we do that quite a lot more effectively than you are perhaps able to do in some other parts of the country.

We were approached, interestingly, by a company that was working in a city elsewhere in the UK where they were looking at whether they could join up ambulance tracking with the control of traffic signals to help smooth the flow of the ambulance within the traffic to speed it up. We would probably find that a disadvantage because the ability for us to manoeuvre around the traffic, get to the junction and get across it on blue-light is probably more effective for us.

Andrew Boff AM: So, what you are saying is that congestion --

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It is not as big a problem as you might think.

Andrew Boff AM: Yes. Congestion sometimes assists you.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It could do, yes. I would not say so much congestion. I would say the carefully managed nature of traffic in London.

Andrew Boff AM: Would greater access to TfL's traffic data improve your efficiency?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Not that I have been able to determine in the last 18 months since I moved from that world.

Andrew Boff AM: I am assuming you use live data of where there are problems --

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes.

Andrew Boff AM: -- crashes and so on, like everyone does. There is no extra bit that you would need in terms of support?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): No. Obviously, I have facilitated a number of discussions between TfL's traffic managers and our operations staff to understand whether there are areas where we can improve through joint activity. We work very closely together, physically as well as in terms of relationships. That is quite a productive working relationship. In fact, more generally across the two organisations since I have taken the job we have been able to bring together a large number of events and initiatives that have come about jointly through TfL activities, whether it is on the Tube in terms of promoting activity to encourage people, if they fall ill, to wait until they get to stations and so on, which is a big challenge on the Tube. We have been able to very actively help in that. That helps us too, in terms of getting to patients quicker. We have more recently done a joint initiative with the London taxi trade around trialling defibrillators in taxis, which is again something that we worked together jointly with the Mayor's Office and TfL, as well as the London taxi trade. There is a very good working relationship, as you might expect, developing that.

Andrew Boff AM: Quite recently, within the past couple of months, Uber have opened up their traffic data. Is that something that you would probably want to have a look at?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I cannot immediately see whether there would be significant benefit, but on the other hand I would certainly have no reason not to want to look at it. If we could make use of it, of course we would want to.

Andrew Boff AM: I know somebody you could call.

Dr Onkar Sahota AM (Chair): I just wanted to ask you about TfL's weather data, whether you access that data and if it has any impact on the ambulance service.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): TfL requires weather data of a far more granular nature than we generally require. Obviously in extreme weather and so on that can be useful, but our need for weather data is more around advance planning, understanding when it is going to get particularly cold or particularly hot and the implications in terms of demand, whereas TfL's weather data is very granular in terms of different parts of town and very live, almost hour by hour, in terms of freezing points and things like that. We have very different demands in terms of weather. Nonetheless, I have learnt in many jobs over a long career that you can always explain performance, whatever you are doing, in some way, shape or form, by the weather.

Andrew Boff AM: You mentioned earlier your involvement with the emerging STPs. To what extent have you sat in on the meetings and involved yourself with those plans? You originally said to us that it was not that active an involvement.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): The STPs in London are at varying degrees of development and they have some major issues to address that are more acute-focused or not involving us. Where they are of particular interest is hospital handover and obviously urgent care. We do have a CQIN [Continuous Quality Improvement Network], to use one of the -- how would you describe a CQIN?

Andrew Boff AM: Quality improvement target?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): We have a quality improvement target linked to involvement in STPs but I would say from the executive side it is greater than the non-executive at this stage.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I think so. I meet regularly with all of the accountable officers of the five STPs and have productive discussions and relationships with them. My colleagues sit on and go to Urgent and Emergency Care Boards in the regions and indeed the London-wide operation, and we have a team of sector engagement managers - one in each of our five operating sectors, which tie in with the five STP regions - who do a lot of the close day-to-day relationship work, a lot of the building of care pathways and so on. There are relationships at all levels of the organisation.

Andrew Boff AM: You go on about those different care pathways. Do you need further support from the wider healthcare system to progress your plans on more tailored services?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, very much so. In terms of the three main themes in our strategy, the third theme is very much around developing that partnership working and developing those care pathways. An element of the lowering of conveyance that we might be able to achieve is very much dependent on that partnership working effectively.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It goes back to the 33 CCGs. You cannot have 33 pathways for, say, mental health. We might be able to cope with five, one for each sector, but it is very difficult for crews who are in different patches to be having to think, "Which pathway today for this particular client?" That is where the close working comes. It is really important we know what the pathways are, what the possibilities are, and that we are looking at the whole pathway together.

Andrew Boff AM: You do think you have the administrative capacity to feed into those STPs and get what you need out of them?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Yes.

Andrew Boff AM: We were told before that the participation in the strategy and service development had been previously limited.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): If you talk to most chairmen in London, they would say that at the stage that we have been at. As you know, they are new-formed organisations. It is a development in process.

Andrew Boff AM: Right. Thank you. Do we need to revisit the approach to alcohol-related incidents?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Probably.

Andrew Boff AM: In any particular way?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): To answer that generally, I think, as the Chair says, the answer is yes. In terms of future pioneer service areas, it is at the top of the list that we want to look at.

Andrew Boff AM: You yourselves say that alcohol is a factor in around 6% of the callouts, which is a significant number. One paramedic has been quoted as saying that of the injuries that they have seen, it could be between 60% and 80% in the West End and central areas that are related to alcohol. That is an anecdote, it is not data. While certainly this committee has seen activity taking place with regard to alcohol abuse and the London Ambulance Service, we do not know whether it is getting any better.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I do not have any data that could either support or contradict that. I think you have hit the nail on the head a little bit when you talked about alcohol being a factor, because often alcohol is a factor in an incident or an injury that has a physical component to it or indeed a mental component. To treat alcohol as a type of incident on its own I think could be quite misleading and is one of the reasons why we have to be careful. However, you are right that alcohol is certainly a factor in incidents at certain times of the week or the weekend and in certain parts of the city where it is higher than over all. Looking at an average figure is probably not a lot of help either.

Andrew Boff AM: We were talking, prior to this meeting, among the Committee about the alcohol services. I am eager to come and see how it is working, perhaps prior to Christmas, that awful period of time, it must be, for the London Ambulance Service. Would that be something that could be arranged?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Absolutely, yes.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): When I talk about alcohol services, I am thinking of the services that people are referred to when they have a known alcohol problem, which is different to us trying to deal with people who present on Fridays and Saturdays, in particular in the centre. What I have read and learned is that historically it would only be Saturday night but it seems people's behaviours after work have changed and the combination of drugs and alcohol make it a different problem. We deal with it when it is a crisis rather than in a preventative way.

Andrew Boff AM: In many ways it can be a factor or the main reason. There are a number of things there. It certainly is something that this Committee has had an interest in the past.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It is a big challenge.

Andrew Boff AM: Do you feel it is worth revisiting?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It is certainly worth revisiting from the point of view of campaigns, which is a big area. We have had a few for a while. Campaigns in relation to alcohol need to be fairly direct to get the message across. Of course, there are conflicting priorities in terms of how you want to get the message across. If I am a publican or a licensee, I might have a different view about how that message was communicated than if I was an ambulance service. There is a public debate about how best to communicate. The message of safe, responsible drinking is obviously something we would support.

Andrew Boff AM: To be fair to publicans, it is not in their interests for their customers to be blind drunk.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): No, but we have certainly been involved in debates in the past about the nature and tone of what an appropriate campaign could look like.

Andrew Boff AM: Thank you very much.

Dr Onkar Sahota AM (Chair): These questions are under the section of integrated health and social care and I want to explore one or two other themes. How is the London Ambulance Service affected by lack of access to community services for the mentally ill? It must impact on you when you are called to a mental health case, the availability of social services. How does that impact on your decision-making on whether to convey the patient to hospital or leave him at home?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Quite significantly, is the short answer to that. If you read the recently released Carter Review into ambulance services you will see that not only do we have proportionately more mental health patients than any other Ambulance Trust, regardless of size, but also we end up having to convey more of them to hospital at the moment than any other Trust. Some of that is about the availability of alternative pathways. In the past we have struggled to build those relationships.

However, I do think that has changed. That is changing, and we now have a very positive working relationship with the Mental Health Trust in London. We are working hard to deliver a number of new pathway opportunities, including, as the Chair has already referred to, the development that we will soon be able to take patients to mental health crisis cafés as an option, which I think will make a difference.

We now have mental health nurses in our control room, providing bespoke advice to crews on the ground. I think there is a lot of opportunity and a lot of potential for us to change that. That could make a big difference in terms of the overall percentage of people that we are able to see and treat in the future.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It links to what we were trying to describe before, that over the last few years we have been taking a more strategic and inclusive approach to all of these things, not trying to do it on our own but working with the Mental Health Trusts. Garrett goes to the Chief Executive, Mental Health Trust meeting. We are much more outward facing and working with people rather than thinking crisis and that is all we can do.

The mental health cafés, if they evolve, are a really exciting opportunity because if you are in crisis with a mental health problem, A&E is probably not the right place for you. A police cell is not either. It is not good for the client, it is not good for the A&E staff or the police and it is not good for our staff. Being able to take them where they are known clients to somewhere that is more calming and has skilled people, that is much better. We see that as something positively moving forward.

Dr Onkar Sahota AM (Chair): The other cases are if you have been called for a patient who has fallen out of bed, for example, an elderly patient. You probably make an assessment they have not broken any bones. How does the availability of social services for that patient impact on your decision-making? What is going to be preventing the patient falling out of bed again or what social care is available in the community? Does that impact on your decision-making?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): There is work with CCGs on fallers and knowing who the fallers are and where they are and how frequently they fall. As you will know as a GP, the care homes and nursing homes are part of that. I am sure you have been called to a nursing home because somebody has fallen, and that is not really appropriate either. For our crews, having access to either the Co-ordinate My Care record - or as we get them on to an electronic patient record and they can access the record - will help them keep people at home.

We talked before about volunteering. I can see occasions where somebody may be able to stay at home, but the health or social care support cannot come. If we had volunteers who could go and sit in with them and maybe make a cup of tea, it will aid our staff in leaving people behind. That is why the volunteering strategy is so important, as well as the electronic patient record and linking systems.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I would emphasise that the future value of transferral electronic patient care records and the whole general move towards interoperability assistance will make a huge difference in terms of the ability of a crew to understand the broad medical history of the patient in front of them. If they have low blood pressure or something like that but they know that is normal --

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): To make a risk assessment.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, that can transform our ability to make decisions.

Dr Onkar Sahota AM (Chair): I have had representations from doctors on the issue I am about to raise now. On the one hand we accept that the paramedics are experts in treating emergency situations, but they are not doctors. I have had cases referred to me where a GP has called the ambulance crew to convey a patient to the hospital. The ambulance crew has arrived there and made a decision not to convey the patient, to override the GP, which causes anxiety and stress to the patient and to the GP. How do you address those conflicting needs? Here is your crew under a directive or under an incentive to delay conveyancing to hospitals, here is a GP who has called an ambulance thinking the patient needs to go to a hospital, and that discussion has taken place in front of the patient. I have had this representation made to me and I am worried about that.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): You raise a very tricky issue, because equally what happens is a GP will sometimes instruct a paramedic to do something they are not trained to do. The whole relationship bit is important. One of the things we have is our Clinical Hub. We have doctors in our Clinical Hub. We have doctors in the 111 service who can take advice. I would say where that happens we encourage the healthcare professional to raise it as an issue and we will look into it.

Sometimes, as you would know and I know, it is a communication issue of understanding where the other person is coming from and getting a mutual assessment. It is difficult to respond to an individual case here but we do see, where people are concerned, they will raise it as a healthcare professional. We will look at it and respond and if there are development needs for our crews we will do that.

Equally, it has come to our attention quite recently that it is important that our crews, if they are responding to a 999 call, do not follow instructions from somebody else, particularly when it is a bystander who happens to be a GP and is not even the patient's GP. They contact our Clinical Hub and take advice because it is a risk. You raise a difficult issue.

Dr Onkar Sahota AM (Chair): I raise it because it is an issue on the ground and something that causes a problem.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): We would urge people to let us know and we will look at them.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): One of the other areas worth talking about in terms of healthcare calls is that we have an almost unique visibility across the system. One of the things that Hospital Trusts, Acute Trusts, will often say to us is, "You are sending too many patients to us. Can you not manage the conveyance fairly or more evenly across A&Es?" Frequently when we are asked specific questions about specific times it is the healthcare transfers that are predominantly creating the surge in transfers. There is not visibility at the GP end in terms of, "This patient needs to go X hospital now", when there are already ten ambulances there because nine other GPs have made the same call and we are in the middle of winter. Getting better visibility and better ability to understand where we can be flexible across this and where we absolutely cannot will improve the flow of patients through the system much more generally.

Dr Onkar Sahota AM (Chair): The other thing that has been raised to me from the Patients' Forum is your call centre, emergency centre, has said that it calls a category 1 or 2 - this is in relation to prisons and the immigration removal centres - the ambulance arrives there within seven minutes but then there will be a delay at the gates of the prison or at the immigration centre of accessing the patient and conveying that patient to the hospital. How often does that happen and are these breaches recorded by the LAS?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): All breaches are recorded.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): That is not a specific issue that has been raised with me before, but I am very happy to take that away and look at it.

Dr Onkar Sahota AM (Chair): I will send you a copy of the letter that I received. This letter was sent to the Director of Public Health Services. It has been raised with me by a Patients' Forum and I will certainly share this letter with you and you could get back to me to respond to that.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, I am very happy to respond to that.

Susan Hall AM (Deputy Chairman): Collaboration with other services. How has the new duty to collaborate affected your relationships with the MPS and the LFB and what specific steps has the LAS taken in the last year?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): There has historically been very good working relationships across police, fire and ambulance. I think, if anything, that has been enhanced in the last year or so. There is a blue-light collaboration group that they are working on. We have our own governance arrangements and we fit it in. In our organisation it goes through one of the subcommittees of the Board, because we cannot have it operating outside. We look at things, but we do have to look not just at the blue-light collaboration, we have to look at other ambulances and the rest of the Health Service. We have to weigh up what is the best thing to do. Garrett, you have some specific examples.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes. It is probably fair to say that we already had a very close working relationship with the London emergency services, and that continues. I meet regularly with the two Commissioners of the MPS and the London Fire Service and also with the Chief Constables of British Transport Police and the City of London Police. That relationship is there and that is reflected all the way down. Between us and the MPS and the LFB we have an overarching strategic agreement

that focuses on six themes that are around prevention, response, control services, people, support and infrastructure and strategy. Underneath that there is a lot of joint working.

We are currently doing a piece of work jointly funded by the Home Office around the future of control-room operation, for instance, across the services and what opportunities there are to integrate that. We are also talking on a whole range of issues from IT to people management. We are currently talking about whether there is greater scope for collaboration around occupational health support across our services. There are multiple avenues that we are exploring to work jointly.

The Chair is right, we are not in a unique position but a very privileged position in that we have opportunities to collaborate across the emergency services world. We also have opportunities to collaborate across the health sector world in London that we do and of course the ambulance sector across the UK. Indeed, a significant part of our more specialist emergency response we provide as part of a national response in collaboration with the other Ambulance Trusts in terms of our Hazardous Area Response Teams and so on. We train very regularly with all of our emergency services colleagues, not only the major training events that you might see in the media, but on an ongoing week-by-week basis.

Has it changed the nature of the relationship? I do not think it has changed the nature of the relationship, I think it has probably intensified and focused the mind on are we doing everything we possibly can and are we taking advantage of the opportunities that we do have to work together.

Susan Hall AM (Deputy Chairman): Where do you think it could be even better? Where do you wish it would be better?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): If I saw a big area or a big gap, we would be doing something about it and we would be talking about it. The opportunity for it to get better is sustained working overtime, as we do. On some of the things I have been talking about and bringing to fruition, we will understand where the opportunities to do more lie. It is a very healthy working relationship and I have been very impressed by the depth and breadth of the relationship that we do have across all three Services.

Susan Hall AM (Deputy Chairman): If we look at estates. Obviously, things are getting more and more difficult financially as we go forward with everything. I am a great fan of collaboration in these areas. What do you think more about sharing estates with, say, the LFB?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): We do. We are in Union Street.

Susan Hall AM (Deputy Chairman): I know, and I have been to Stratford and I was very, very impressed with that. I do appreciate that but going forward.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): That is the Cycle Response Unit, is it not, in Stratford? There are opportunities like that and we do, as you say, use joint estate for standby response points and things like that. If your question is directed more around major operational bases, what you have to remember is we operate, as we discussed earlier, in quite a different way, in that we have vehicles on the road 24/7. Our requirement is to have facilities that can produce and service and maintain those vehicles and provide facilities for staff at shift-changeover points to get out on the road. We need to do that in a more concentrated way.

We make ready vehicles at 14 locations across London and put them out right across London. They operate either from main stations or substations or standby points, but the business of preparing ambulances, putting all the kit on them, making sure that they are properly cleaned and infection free and so on and providing the equipment for the crews is a much more centralised approach than it would be for a fire-engine response, where the requirement is much more to have vehicles available locally.

Susan Hall AM (Deputy Chairman): Is there any area that you are being slowed with the desire to incorporate more by the police or the LFB? Are you finding any resistance anywhere?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): No, I do not think so. There are genuine opportunities where we can do this, particularly in relation to standby points.

Susan Hall AM (Deputy Chairman): Yes, because there are more facilities, quite frankly. There are so many fire stations in and around London. I have somewhere at the bottom of my road where and ambulance or an ambulance car is constantly. There are no facilities there. If you have people in standby areas, would it not be more help if they were in more fire stations?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): The first requirement is to make sure they are in the right points so that they can get to patients within the time requirements. That does constrain where we put stations. There is no point in having a first-response car in a fire station if it is the wrong location to get to patients quickly.

Susan Hall AM (Deputy Chairman): No, I accept that.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): There are some limitations like that. Notwithstanding that, I think there are opportunities to collaborate across a number of public sector areas. It is not just about the Fire Service or indeed the police. TfL is an opportunity. Network Rail is an opportunity. We are talking to all of those public sector organisations.

Susan Hall AM (Deputy Chairman): Is there a desire to push forward, from the LAS point of view?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes. As I say, though, it needs to be within the context of what works in terms of the service that we have to provide patients. Yes, within that context, absolutely.

Dr Onkar Sahota AM (Chair): I want to talk to you about the Emergency Services Network, which was commissioned in 2011 and has now been delayed for two years, I understand.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): This is the replacement for Airwave?

Dr Onkar Sahota AM (Chair): Yes. Are there any ongoing costs for the LAS for that delay?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Not directly that I am aware of. Again, I could be corrected there. As I understand it, we have contracts or there are contracts being put in place that will enable us to maintain the existing system, the use of the existing system, for a number of years. The existing system is still working for us effectively.

Dr Onkar Sahota AM (Chair): It is still working satisfactorily and the costs of repairing or replacing have not gone up?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): No. The important thing is that when we have a replacement system it is a replacement system that delivers everything it needs to and we do not have a problem with a new system.

Dr Onkar Sahota AM (Chair): Are you confident that the new system will be reliable and that we can get it delivered on time, even though it is already two years delayed?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I probably do not have the level of detail that I could give you that assurance sitting here but we are working very closely with the Home Office and with the other emergency services to make sure that is the case.

Joanne McCartney AM: Yes, I want to ask about workforce retention and recruitment. Your Board papers from February [2018] noted that your vacancy rate for paramedics was at around 10% and in your call-handling staff it was around 20%. Are those still the right vacancy rates or do you have up-to-date figures?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, our vacancy rate for paramedics is very low indeed now because we have been focusing on recruiting them. We are almost at 0% vacancy rate for paramedics, if we include our advanced paramedics and so on in that. That has been a deliberate decision. However, that is only half the story, because for emergency ambulance crew, who are the non-registered clinicians, we still have a significant vacancy rate there. Some of that is because we have been focusing on recruiting paramedics in the short term. We now need to go back and recover that.

In terms of call-answering vacancies, that is also much lower now. Part of the reason for the figures you quote is because last October [2017] we took a decision to increase the establishment, the number of posts we had, by 73 posts. We had about 400 call-answering staff. We increased by 73. We were about 30 short at that point but then we went to 103 short. We are now just under 40 posts short and by Christmas we will be about ten posts short. That has been a process of creating the capacity to recruit and train more people, because, broadly speaking, we had the training capacity to sustain turnover and sustain the establishment we had but we have had to build a greater capacity to increase to a higher level, which has taken a bit of time. There are constraints not only around the numbers of trainers but also the physical space to train people and the IT, the kit, to enable us to train people offline so they are not using live equipment while we are training them how to be call answerers.

Joanne McCartney AM: That is very positive news. I know particularly with your paramedics you were recruiting abroad, I think from Australia and New Zealand. Do you have any breakdown as to how many of your staff are European Union nationals, for example?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I do not have the exact number, but relatively few. We are probably much less exposed than other sectors of the Health Service to European Union nationals in terms of risk. Most of our overseas recruits have historically come from Australia. We are now recruiting in other parts of the world, potentially recruiting in Canada and New Zealand and potentially Poland as well but we have not yet done that.

Joanne McCartney AM: The Immigration White Paper that has just come out indicates that to qualify for highly skilled work visas you will have to have an earnings threshold, which is currently around £30,000, and I think your entry for a paramedic is just over that threshold. If that threshold is changed and is higher, will that present you with problems?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I think it will present a problem for the whole of the Health Service. If I understand that - I am not sure I have the full understanding - on lower salaries people can come in but they do not have leave to remain and they have to go away again, which would cause disruption. I sure we have all seen the media coverage in the catering industry and care homes and so on. It would be a problem.

The issue for us is that English universities do not currently have sufficient places for the number of paramedics we need in this country. Therefore, we need to work with health education and others to make sure that the profession is seen as attractive with career opportunities. At LAS we have done a lot to create opportunities for people so that you do not just come out as a graduate and stay there. We create a trajectory on what you could do. For us it should also be about interchangeability with other healthcare workers in the urgent-care space. However, we need to make sure that places are commissioned and that universities are encouraged to have more places, because it is a great limiting factor.

Joanne McCartney AM: That is interesting to know. You will be making some representations on the Immigration White Paper, is that right, as that goes through Parliament?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I am sure we will, yes.

Joanne McCartney AM: That will be useful. Before I return to recruitment and retention, are there any other Brexit risks that you have identified? I know Ross Lydall from the *Evening Standard* talked about you bulk-buying ambulances.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): That is a good opportunity to correct that, I think.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): There are two things there. Our ambulance stock is very old, and we needed to get on and replace them. At some point there may be a decision to have one type of ambulance, but it is not here yet. The lead-in time to get the ambulance built is a long time. It is partially true - and it came from me, I think - that the reality is that with Brexit, and because ours are Mercedes, we do not want to get stuck with parts not here. We do need it but it was more about getting the ambulances fit for purpose and be able to move forward.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We are locked into a five-year investment plan to renew our full-size ambulance fleet. We need to do that both because, as Heather says, the fleet we have is quite old and outdated and needs updating but also because we have agreed a memorandum of understanding with the Mayor around the Ultra Low Emission Zone (ULEZ) that gives an exemption from the charges through until October 2023. That is on the condition of compelling a compliant fleet by that date, which effectively means that all our ambulances need to be 2015 or newer.

We have just completed the rollout of 140 new ambulances that we ordered at the beginning of last year. We have secured additional funding from the Department of Health to buy a further 30 and put them on the road

this year. We will put another 80 on the road next year, another 60 on the road the year after that and so on through until 2023 so that the whole fleet of about 550 full-size ambulances will be ULEZ compliant.

Joanne McCartney AM: That is a long-term plan?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It is a long-term plan, yes.

Joanne McCartney AM: I know the Health Service itself is talking about stockpiling drugs in the event of a no deal. Does that affect you?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): No. The Department of Health is monitoring whether people are doing that or not. It is less of an issue for us than it would be for a hospital. We have looked at Brexit as a risk, for our risk register, and said we need to look at our external contracts. Obviously, it remains an issue for everybody, but it is not as significant for the LAS as it is for other Health Services.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We will work to Department of Health [and Social Care] guidance as and when it is issued.

Joanne McCartney AM: Thank you. Coming back to recruitment and talking about retention now. In the past evidence has been it has been the high cost of transport and housing in London that is responsible for your high staff turnover. Do you have any other more comprehensive understanding about why in the past you have had that significant turnover?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Many of our staff have been with us for many, many years. We have a really stable core workforce, 30 years plus. I gave an award to somebody who had had 50 years. It is extraordinary the length of time people do stay with us. It is a call-centre level that we get high turnover and in other similar support working. It is true that if you are on a paramedic wage or salary you cannot live in central London. Therefore, housing is an issue. The other issue is our paramedics have to carry very big bags around. We are working to have a paramedic bag that is vehicle-based and therefore they do not have to lug it.

The other issue for us used to be that our staff were late off duty, which meant they might be an hour late off duty and then they have an hour to travel home. We have become much better at getting people off on time and we are sorting out the bag. Housing does remain an issue and if there is something the Mayor could do on affordable housing, that is clearly something we would be very keen to work on.

Joanne McCartney AM: Is there anything you think the Mayor could help with?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I think the affordable housing.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): I am not sure it is something that is specific to LAS but, yes, you are right to point out that the cost of living in London is a challenge for us, even with London weighting and so on, in terms of attracting and retaining staff. There are other things we can do and are doing though to retain staff. A lot of the staff that we historically lost we have not necessarily lost to London, we have lost them to the ambulance service as they have sought to go off and do other jobs to develop their career within the health service.

A big part of what we have been doing has also been around developing career pathways. We talked earlier about the development of more bespoke services, pioneer services, developing the skills of our crews to deal with more complex incidents and so on. That is also very beneficial in terms of providing opportunities for clinicians, both registered and non-registered, to develop their careers and so on and encourage them to stay within the LAS. We are just developing a couple of particular roles that will allow crews to rotate around skill mixes and so on for a period of time to help them broaden their career development experience and enable them to stay within the ambulance service rather than having to go off to an urgent care centre to develop their career and we lose them. There are a number of things there.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): The other things would be what we are doing to make it a more attractive place to work, how we support the staff who have stress. We have done a lot of work on mental health, on counselling of how to deal with the angry clients, how you support them. In our call centres, for example, they have a beanbag room where they can go and just chill out. They have support from somebody working next to them, the occupational health service, and a whole range of different initiatives that our excellent HR people and organisational development (OD) directors put in place working with staff. If you talk to staff, what is quite interesting to see is that people who have left and come back say it is a very different place and they are excited about being there. We are more encouraged that people want to work for us now.

Joanne McCartney AM: My final question is around the diversity of your staff. Across the Trust as a whole I believe your black and minority ethnic (BAME) percentage is 13.9% but that hides a big disparity because on the front line it is only 8.1% and at your Board level it is even less. I believe that only one non-executive director is from a BAME heritage background.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It is a major issue for the Trust and it is one that I and Garrett take very seriously. We are leading the issue about culture. I will deal with the board and then go to paramedics. You are right, although it is a diverse board insomuch as we have women, because diversity is a much wider thing than BAME. In fact, there are probably more women on your team than men. But I have recruited two female non-execs and clearly at that time I was looking for people with particular expertise in the digital world and in the HR agenda and we were able to attract very high-calibre people for that.

I am not allowed to advertise because we are a foundation Trust, but I put a thing on LinkedIn saying that I was looking for people from diverse backgrounds to join our Board, and that I have pulled that process because we do not have the people that we need. We are actively seeking somebody who can join our board from that background. You are right, we have an associate non-executive director who is from a BAME background and Garrett has a director, but not an executive director, from a BAME background, though it is something we are very mindful of. Garrett sits on the national steering group for workforce race equality.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): The National Race Strategy Group.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I sit on the London Chairman's Group for that and you meet with the Chief Executives. It is an issue in London to get it right. For people from a BAME background it is difficult, and it has historically been so for the LAS. Something to draw to your attention: only 7% - and tell me if I have this wrong - of the supporting cast of paramedics who qualify are from a BAME background and our number of BAME background paramedics is exactly 7%. Now we know

that the population from London is 44% people from an ethnic minority, so we are very conscious of the need to address that. Across the organisation we aim to be at about 20% in two years' time but it is going to be a long journey. What we are working on is making sure that when we do attract people, it is a place they want to work.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): The point about paramedic graduates is quite significant because in that field we are recruiting from a national pool of graduates to bring paramedics into the organisation, and the national pool of paramedics simply does not reflect the London population. That is difficult for us.

In our control centre you will see a very different range of diversity. I think we have about 28% BAME, so we are certainly not at the London-wide average, but we are much further forward. We are moving forward insofar as two years ago we were at 11%, we are just under 14% now, and we have a target to be 15% by the end of this year and 20% by the end of 2020. There is a whole range of activity going on. We have a very dynamic Race Equality Scheme (RES) Action Plan that we are just in the process of refreshing and strengthening further to tackle this issue. So, yes, I think we both accept that there is a significant issue for us to tackle, both in terms of recruitment and retention and in terms of workplace experience of those colleagues that we do have from a BAME background.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I think that people from a BAME background in the organisation now feel that it is on the agenda for us and that we are taking it seriously and taking it forward. They are working with us and they tell us things are improving, but when you look at the statistics, the different things that we should look at, it is not telling that story yet.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It is also fair to say that this is an ambulance-wide, sector-wide problem. This is not just a LAS problem.

Joanne McCartney AM: There are a whole host of questions that could come from the back of that. It is good about your call centre staff but obviously they are the lower-paid end of your staffing. You talked about trying to make paramedic a career choice and working with higher education institutions. Are you working with higher education institutions here in London, which do tend to have, in some respects, a much broader and more diverse --

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, we absolutely are, but I think that there is more scope and your point about the control centre staff and so on is absolutely right. That is why I refer to workplace experience and developing career opportunities, the opportunity for people in the control centres to either develop their career within the control centre or develop their career in terms of moving to frontline ambulance activity, becoming an emergency ambulance crew person, as well as the opportunities for emergency ambulance crew to develop their career by becoming paramedics. That is the area in particular where we are working more broadly with the system here in London to enable more people from a more diverse background to train to become a paramedic in the future.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): We have developed our strategy to attract young people, who might come from a variety of different backgrounds, to see that it is an attractive career choice.

Joanne McCartney AM: Certainly, I know from policing that when the role of Community Support Officer was introduced that was much more proportionate of the population as a whole. Then, from that, those

recruits to community police went on to become police officers and it had quite a dramatic effect. Not as much as it should have done, but it did. It seems to me that your volunteering work you are doing could really target certain groups in that.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): That is our aim.

Andrew Boff AM: Just on that 7% figure you were going on about, you are saying that paramedics in general are only 7% BAME. Is that a London figure or a national?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): That is a national figure.

Andrew Boff AM: I think that figure is going to be higher in terms of recruitment in London.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It should be but remember they do not necessarily do their degree in London.

Andrew Boff AM: I beg your pardon?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): People do not necessarily take their undergraduate training at a university in London.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Neither do a significant proportion of --

Andrew Boff AM: But for London only to have the national average just seems like underperforming because we are more diverse than the rest of the country.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Absolutely. That is a new statistic --

Andrew Boff AM: Do you see what I mean?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): We do, and to be fair we had only just got that number, so we need to drill down more. If it is like nursing, it could be that they are attracted but do not complete. We do not know. We need to look into it further, but we do know that we need to attract people in London from a BAME background into the profession. As Garrett said, starting in the call centre is a way.

I met a young man only last week who was at a consultation on the restructuring and it was very revealing. He did not want to be called a "Call Handler" because he is not in a food chain. He might be helping somebody deliver a baby or he might be dealing with a mental health case. He would like to be called something that was more fitting to that name. I think all these things are important for people to feel valued to help them go on that journey.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Just in terms of that figure, to me the reason why that is significant is because at degree level we are recruiting from much more of a national background, whereas for the call centre and in terms of emergency ambulance crew we are recruiting much more in London. Therefore, you should expect that more readily to reflect the population of London, or

more quickly. The goal absolutely is to get up to the point where our organisation as a whole, both in terms of numbers and in terms of seniority, is much more reflective of the population of London as a whole.

Joanne McCartney AM: My final question is on that final point you have just made about seniority. Are you looking at your internal processes to see what you can do to make sure there is no unconscious bias and that you are mentoring and sponsoring talented staff?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): From the Board down, we are involved in mentoring and reverse-mentoring schemes. All of our recruitment fairs externally now have somebody from a BAME background on that process. We have modernised the process so that you cannot necessarily tell where somebody comes from and at a board level we do have to get better at having more people. But we do challenge those sorts of questions and I think we are looking to learn from other organisations who do better than us, including the MPS.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We are also rolling out unconscious bias training to senior employees and recruiters at the moment and plan to roll it out to up to 700 middle managers over the next 12 months or so. On all job interview panels, senior job interview panels - 8A and above in terms of National Health Service grades - we have the Diversity Manager, and the aim is to have diverse panels for all of our recruitment as soon as we can. There is a lot of activity. I would encourage you to look it up, our new RES Action Plan when it comes out.

Joanne McCartney AM: Thank you.

Dr Onkar Sahota AM (Chair): Just while we are talking about recruit retention, of course primary care is also recruiting a lot of paramedics and it is competing with those, but there may be opportunities to develop career pathways for your paramedics too.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Absolutely.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): That has to be the way forward.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We would very much like to do that.

Dr Onkar Sahota AM (Chair): What is one thing that the Mayor could do to support the LAS? If there is one ask you have of the Mayor, what would that be?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It is difficult to identify one thing. The Mayor has been incredibly supportive of everything we are doing and has been very willing to lend his voice and his publicity to highlight key issues. I would encourage him to keep doing that, getting across key messages about how we are involved in the service and picking up the messages that were in your survey around the bits of the service we provide where perhaps Londoners do not have a clear understanding. That might be where they do not see the nature of the 'see and treat' element of the service, or the fact that just because you call an ambulance does not necessarily mean you are going to get an ambulance - you might get a different type of care - or indeed that, if an ambulance arrives, you are necessarily going to get taken to hospital to have your care, because we have clinicians there that are more than capable of resolving your issue on-scene. It is in terms of getting all of those messages across, including developing an understanding that we

are an on-the-road 24/7 service. We are not a service that waits in an ambulance station for your call, we are around the corner when you need us most and we are continually going from job to job. It is all of those things, to me.

The Mayor is in a unique position, as the leader of political government in London, to raise public awareness and I suppose that extends to some of the other things we have been talking about around, campaigns and things like that. They are the most valuable things that the Mayor can do for us.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It is telling a story and it is telling that story about the different pathways but also the role of paramedics and how that has emerged.

Dr Onkar Sahota AM (Chair): What would be the main messages you want to get out to Londoners about the LAS?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): It would not be about the LAS, and that goes back to our strategy. It is about accessing the right care, the right point of care, which includes the NHS 111. It is the appropriateness of calling an ambulance at the right time and what pathway you need to take. We all need to work on that.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): We are playing an increasing role in 111 integrated urgent care and we would like to play a bigger role still going forward. We think we can offer a uniquely high-quality service because of the ability to join up, not only through the call answering element of 999/111 but also the clinical support in terms of the Clinical Hub and in terms of using the capability that we have to manage across London and join up with the wider healthcare sector. That is a unique thing that the LAS has. We are the only London-wide healthcare provider. There is the opportunity to be that focal point for access into the urgent emergency care system, whether it is on the phone, whether it is through dealing with patients on-scene or increasingly, as we get into the digital age, whether it is helping with being able to provide access to services through digital portals. I think that is really the future of the service and probably the biggest opportunity we have. That is how I think we will ultimately go from talking about having to manage growing demand to talking about a system whereby we can meet growing demand.

Dr Onkar Sahota AM (Chair): I speak on behalf of the Health Committee in that we have found this investigation very useful from our point of view and Londoners have found this very useful, the opportunity of investigation into the LAS. I think you have found the experience also very helpful in getting your message across. Do you think it would be a good idea if you came to the Health Committee on an annual basis to give us an update on the service that the LAS is providing?

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): I think it is very sensible to have an ongoing dialogue and if once a year did that we would be very up for doing that.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Yes, I agree.

Dr Onkar Sahota AM (Chair): We will make this an annual event at the London Assembly.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): Could I ask that we think about when is a good time to come so we have something to tell the Committee?

Dr Onkar Sahota AM (Chair): I am sure the secretary can arrange that, but I think that it is very important that Londoners get an opportunity to hear from you on an annual basis and we get an opportunity to ask questions that are relevant to Londoners.

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): It is a good opportunity to track progress on the delivery of our Strategy.

Dr Onkar Sahota AM (Chair): Indeed, indeed. Thank you very much. Is there anything else you wanted to say before we close the meeting?

Garrett Emmerson (Chief Executive Officer, London Ambulance Service): Not at all.

Heather Lawrence OBE (Chair, London Ambulance Service NHS Trust Board): No, thank you very much.

Dr Onkar Sahota AM (Chair): Thank you very much for your coming here.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Summary List of Actions

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 27 November 2018**
This report will be considered in public	

1. Summary

1.1 This report sets out details of the outstanding actions arising from previous meetings of the Health Committee.

2. Recommendation

2.1 **That the Committee notes the outstanding and completed actions arising from its previous meetings.**

Meeting on 11 October 2018

Minute item	Subject and action required	Status	For Action
6.	**London Ambulance Service (LAS)** During the course of the discussion, Members requested the Chief Executive Officer, LAS NHS Trust, to provide further information on the extent of the engagement consultation of the new LAS Strategy, *A world class ambulance service for a world class city*. That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.	Ongoing Ongoing	LAS NHS Trust Scrutiny Manager
8.	**Health Committee Work Programme** That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any site visits, informal meetings or engagement activities before the Committee's next formal meeting.	*This delegation was not used.*	

Meeting on 17 July 2018

Minute item	Subject and action required	Status	For Action
6.	**London Ambulance Service** That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.	Ongoing	Scrutiny Manager

Meeting on 28 June 2018

Minute item	Subject and action required	Status	For Action
9.	**Health Inequalities Strategy – Draft Implementation Plan and Indicators** During the course of the discussion, Members requested the following additional information: Further information on whether all schools in London have drinking fountains for their students and details of the city-wide Plan to have London as a zero-suicide city, including when it will be published; and The target for mental health first aid trainers by 2020.	Ongoing. Ongoing.	Statutory Health Advisor to the Mayor Senior Advisor to the Mayor, Health Policy

Meeting on 14 March 2018

Minute item	Subject and action required	Status	For Action
4.	**The Mayor's Health Agenda** During the course of the discussion, Members requested the following additional information: A list of seminars and consultation meetings held for the consultation on the Health Inequalities Strategy, including which groups were targeted; and The framework on how marginalised groups are being reached through the Thrive LDN programme. That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.	Ongoing Letter sent 20 March 2018 Ongoing	Statutory Health Advisor to the Mayor

List of appendices to this report:
None.

Local Government (Access to Information) Act 1985	
List of Background Papers: None.	
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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Social Prescribing in London

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 27 November 2018**
This report will be considered in public	

1. Summary

1.1 This report sets out background information and context to the Committee's discussion with invited guests on social prescribing in London.

2. Recommendations

2.1 **That the Committee notes the report as background for the discussion with invited guests on social prescribing and the subsequent discussion.**

2.2 **That the Committee agree the scoping paper attached to the report as Appendix 1 of the report.**

2.3 **That the Committee delegates authority to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.**

3. Background

3.1 The Health Committee is investigating how the Mayor intends to achieve the ambition set out in his Health Inequalities Strategy[1] to make social prescribing a more routine part of health and care in London. A copy of the scoping document for the investigation is attached as **Appendix 1**.

3.2 The terms of reference for this investigation are:

- To examine the current landscape for social prescribing in London; and
- To examine the Mayor's proposals for increasing access to, and uptake of, social prescribing in London, particularly for the most disadvantaged Londoners.

[1] https://www.london.gov.uk/sites/default/files/health_strategy_2018_low_res_fa1.pdf

3.3 Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides General Practitioners (GPs) with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing. Social prescribing enables a GP or other healthcare professional to refer the patient to an organised scheme which usually involves link workers or navigators taking time to understand what the patients' needs and goals are, helping them to access appropriate services. Those services are most commonly provided by local voluntary organisations. Examples of social prescriptions could include physical activity or exercise classes including gardening, arts on prescription, educational classes, debt advice, volunteering or peer support.

3.4 The Mayor has made increasing access to social prescribing a key component of his statutory Health Inequalities Strategy. One of the five key ambitions in the Strategy is, by 2028, 'to support more Londoners in vulnerable or deprived communities to benefit from social prescribing.' As a step towards recognising this ambition, the Mayor is currently developing a social prescribing vision for London which is due to be released in the Autumn 2018.

4. Issues for Consideration

Remit of the discussion

4.1 The Committee will hold an open discussion with invited guests to examine how the Mayor intends to achieve the ambition set out in his Health Inequalities Strategy to make social prescribing a more routine part of health and care in London.

4.2 The Committee is recommended to delegate authority to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion at this meeting.

Invited Guests

The following guests have been invited to this session:

- Dan Hopewell, Director of Knowledge and Innovation at the Bromley-by-Bow Centre and Co-Chair of the London Social Prescribing Network;
- Najnin Islam, Social Prescribing Scheme Manager at the Bromley-by-Bow Centre;
- Dr Mohan Sekeram, Merton Lead for Social Prescribing;
- Sue Hogarth, Director of Public Health, London Borough of Islington;
- Vicky Hobart, Greater London Authority (GLA) Health;
- Jill Wiltshire, GLA Health; and
- Jennifer Neff, Co-Founder of Elemental Software.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the GLA Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

5.2 Officers confirm that the scope for this review falls within the Committee's terms of reference.

5.3 The Committee has the power to do what is recommended in the report.

6. Financial Implications

There are no financial implications arising from this report.

List of appendices to this report:
Appendix 1 - Scoping paper for social prescribing investigation.

Local Government (Access to Information) Act 1985 List of Background Papers: None.	
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Health Committee meeting

Social prescribing in London

Introduction

The Health Committee is planning to investigate social prescribing in London. The aim of this investigation is to examine how the Mayor intends to achieve the ambition set out in his Health Inequalities Strategy to make social prescribing a more routine part of health and care in London. This paper sets out background and options for the investigation to be agreed by the Committee.

The proposed terms of reference for this investigation are:

- To examine the current landscape for social prescribing in London; and
- To examine the Mayor's proposals for increasing access to, and uptake of, social prescribing in London, particularly for the most disadvantaged Londoners.

What is social prescribing?

Traditionally healthcare has been provided by health professionals, such as doctors, nurses, and occupational therapists based in a range of NHS settings, including primary care. But people's health and their ability to manage it are influenced by a wide range of factors beyond the scope of these professionals' practice. Such factors include employment, housing, debt, social networks and culture, which have been estimated to account for 57-85 per cent of the determinants of an individual's health status.[1]

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing. Social prescribing enables a GP or other healthcare professional to refer the patient to an organised scheme which usually involves link workers or navigators taking time to understand what the patients' needs and goals are, helping them to access appropriate services. Those services are most commonly provided by local voluntary organisations. Example of social prescriptions could include physical activity or exercise classes, gardening, arts on prescription, educational classes, debt advice, volunteering or peer support.

The case for social prescribing

National research suggests that around 20 per cent of GP appointments are for 'non-medical' needs.[2] This causes a number of challenges:

- **For the patient**: a GP may be able to treat some of the symptoms, but not the underlying root causes, of their problem.
- **For the GP**: Time spent dealing with issues best handled by other services detracts from patients with clinical needs and creates significant additional workload.
- **For the wider healthcare system**: Congestion in the system means that people find it increasingly difficult to get a GP appointment. This has a knock-on effect for other services such as ambulance services and A&E departments. GP workload increases,

[1] https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network

[2] http://www.mertonccg.nhs.uk/News-Publications/News/Pages/East-Merton%E2%80%99s-pilot-social-prescribing-programme-improves-patient-wellbeing.aspx

contributing to burn-out and difficulty in retaining workforce. Increased competition for limited GP appointment slots means that continuity of contact between patient and GP is limited. Timely access to GP services becomes more difficult.

There is emerging evidence that social prescribing can lead to a range of positive health and wellbeing outcomes. Studies have pointed to improvements to quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety.[3] In general, social prescribing schemes appear to result in high levels of satisfaction from participants, primary care professionals and commissioners.[4]

Social prescribing schemes may also lead to a reduction in the use of NHS services. According to NHS England, social prescribing can impact on GP consultation rates, A&E attendance, hospital stays, medication use, and social care. The University of Westminster led an evidence review, looking at the impact of social prescribing on demand for NHS healthcare. They found an average of 28 per cent fewer GP consultations and 24 per cent fewer A&E attendances, where social prescribing 'connector' services are working well.[5]

Challenges for boosting social prescribing in London

According to a King's Fund analysis in 2017, 23 of London's 32 Clinical Commissioning Groups (CCGs) had invested in social prescribing programmes; nine had not. Effective social prescribing is dependent on the robustness of local voluntary and community services to refer into. There is considerable local variation in terms of available services in London. There are also differing levels of engagement with the concept from different CCGs. Early adopters include Tower Hamlets and Hackney, which have both had well established social prescribing programmes for over a decade.

There are a number of potential challenges to making social prescribing a routine and systematically embedded part of health and care in London. These include (but are not limited to):

- **The sustainability of the community and voluntary sector** (CVS). Social prescribing is heavily dependent on having a diverse and healthy CVS to refer into. However, the sector has been under sustained pressure, with many smaller organisations struggling financially. Funding for social prescribing schemes is often non-recurrent, risking effective schemes ending suddenly. This means that the range of social prescribing on offer shows considerable variation across London.

- **Patient acceptability.** 'Social prescribing' covers a huge range of potential activities, programmes and models, and it is not always clear to the public what is meant by the term. There are questions around the extent to which prospective users 'trust'

[3] Kimberlee, R. (2013) Developing a social prescribing approach for Bristol. Project Report. Bristol Health & Wellbeing Board, UK http://eprints.uwe.ac.uk/23221/
[4] https://www.kingsfund.org.uk/publications/social-prescribing
[5] https://www.england.nhs.uk/personalised-health-and-care/social-prescribing/

the social prescription. A recent study found that people who had built up a relationship of continuity and trust with their GP were more likely to take up social prescriptions when offered. However, a separate study has also shown that the number of people who are able to see their preferred GP is in decline, falling by 27.5 per cent between 2012 and 2017.[6]

- **Clinical workforce acceptability**. Nationally, around one in five GPs regularly refer patients to social prescribing. Forty per cent say they would refer if they had more information about available services.[7] Ensuring that primary care professionals are informed and confident in what social prescribing is available to their patients, and the potential benefits to both patient and GP, is therefore critical.

- **Developing the evidence base.** Robust and systematic evidence on the effectiveness of social prescribing is very limited. Much of the evidence available is qualitative and relies on self-reported outcomes. Researchers have also highlighted the challenges of measuring the outcomes of complex interventions or making meaningful comparisons between very different schemes. This can make it difficult to set out the economic case for action to persuade commissioners to invest in these services.

- **Engagement with under-served groups.** There are a number of different social prescribing models available, including some opportunities for self-referral. However, for many, the main route into these services remains through a GP. This may present additional challenges for marginalised groups where GP registration is low: this includes homeless people, migrant populations, and people being released from prison. Social prescribing schemes normally involve several sessions of intervention; this can cause issues for people living chaotic lifestyles, and for those with limited time resources.

The role of the Mayor

The Mayor has made increasing access to social prescribing a key component of his statutory Health Inequalities Strategy. One of the five key ambitions in the strategy is, by 2028, 'to support more Londoners in vulnerable or deprived communities to benefit from social prescribing.'[8] As a step towards recognising this ambition, the Mayor is currently developing a social prescribing vision for London which is due to be released in the Autumn.

[6] http://www.pulsetoday.co.uk/news/commissioning/commissioning-topics/prescribing/gp-patient-relationship-is-crucial-for-social-prescribing-uptake-study-finds/20037208.article

[7] https://www.england.nhs.uk/personalised-health-and-care/social-prescribing/
[8] https://www.london.gov.uk/sites/default/files/health_strategy_2018_low_res_fa1.pdf

Social prescribing in London

Suggested approach

The Committee will issue a call for evidence and use one committee session to discuss this topic. The Committee will also consider site visits to established and new social prescribing programmes and will gather case studies of best practice locally. Depending on when the Mayor's social prescribing vision is released, the session will either provide a critique of the Mayor's initial plans or set out areas for inclusion when the vision document is released. The Committee could also consider commissioning survey work to establish public perceptions on social prescribing.

Key questions

- What types of issues/conditions can be more effectively tackled through social prescribing?
- Can the community and voluntary sector cope with increased social prescribing?
- Do people understand and have confidence in social prescribing?
- What benefits would increasing social prescribing have for London?
- How acceptable is social prescribing to patients and clinicians?
- What are the barriers to increasing social prescribing uptake across London?
- Which particular groups could benefit most from social prescribing?
- What examples of innovative social prescribing are there in London?
- Are there any downsides to boosting social prescribing in London?
- What role can the Mayor play? Does his social prescribing vision have the right aims and focus?

Possible guests

Tom Coffey, Mayor's Health Advisor
Social prescribing service users
Healthy London Partnership/ Social Prescribing Network London leads
Michelle Drage Londonwide LMCs (GPs)
Michael Dixon- national clinical champion

Output

The Committee will produce a letter or short report summarising our findings to feed into the development of the Mayor's social prescribing vision

GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Health Committee Work Programme

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 27 November 2018**
This report will be considered in public	

1. Summary

1.1 This report sets out proposals for the Health Committee work programme for the 2018/2019 Assembly year.

2. Recommendations

2.1 **That the Committee note the Health Committee's work programme.**

2.2 **That the Committee agrees to use its next meeting slot on 10 January 2019 to discuss issues relating to organ donation for Black, Asian and other minority ethnic communities.**

2.3 **That the Committee delegates authority to the Chair, in consultation with the Deputy Chairman, to agree arrangements for any site visits, informal meetings or engagement activities before the Committee's next formal meeting.**

3. Background

3.1 The Committee receives a report monitoring the progress of its work programme at each meeting.

4. Issues for Consideration

Forthcoming work programme:

4.1 The Committee's calendar of meetings for 2018/19 was agreed at the Assembly's Annual Meeting on 10 May 2018. The Committee is scheduled to meet on the 10 January 2018 and 14 March 2018.

4.2 Initial priority areas identified by the Committee include:

- London Ambulance Service;
- Social prescribing;
- Blood and organ donation;
- Delivery of the Health Inequalities Strategy; and

- Other issues of topical importance as decided by Committee Members

4.3 The scope, approaches and timings for the work in these areas will be determined as the work programme evolves, and the Committee will consider detailed scoping proposals for any new investigation undertaken in separate reports. Evidence may be gathered through formal committee meetings, informal briefings, site visits, rapporteur projects, engagement events or a combination of approaches.

Delegations of authority

4.4 The Committee is recommended to delegate authority to the Chair, in consultation with the Deputy Chairman, to agree arrangements for any site visits, informal meetings or engagement activities before the Committee's next formal meeting.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

6. Financial Implications

6.1 Any project related costs (e.g. transport costs arising from any site visits) will be met by the Scrutiny budget. There are no other direct financial implications to the Greater London Authority arising from this report.

List of appendices to this report:
None.

Local Government (Access to Information) Act 1985	
List of Background Papers:	
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