London After Dark - Saving Londoners' Lives

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Good afternoon to all of you. I am pleased to have the opportunity to come and tell you something about the work of the London Ambulance Service. I shall start by talking generally about the London Ambulance Service, and then talk specifically about some of the things that go on after dark, as it were, for the Service.

The Service has been around, in one form or another, for around 100 years. During the Second World War, the service relied heavily on volunteers, particularly female volunteers, and a number of the ambulance people died during the bombings in London during the Second World War. A number received bravery awards for the work they did at that time. In the 1970s, the Ambulance Service became one ambulance service whereas it had originally been split into local government areas.

These are the ambulances that we most recently had, in the late 1980s and 1990s. These were replaced in the last couple of years with the much more modern and European yellow ambulances which are very visible on the streets in the capital. In fact, I have just spent three weeks in Auckland on holiday and the ambulances in New Zealand are all white. I do not remember seeing one at all during those three weeks, yet I saw quite a few fire engines that were red. It is a bit obsessive to go on holiday looking out for ambulances, but there we go!

We are just about to send half a dozen of these ambulances across to Mongolia, as part of a charitable donation. Some of our staff and other colleagues are going to drive these across to Mongolia, as a donation to the people in Mongolia, which is a good thing to do.

Over the years, we have had a number of our staff suffering from back injuries, inevitably, because they pick up hundreds of thousands of patients, including some large patients, and putting them into the backs of ambulances. I am pleased to say that our more recent ambulances now have hydraulic tail-lifts and special beds, which reduce the amount of lifting that our staff needs to do, and therefore we have seen a reduction in back injuries.

As was mentioned, in 2006, the number of ambulance services in England were reduced from 33 down to 11, or, if you include the Isle of Wight, 12. This has meant for much larger ambulance services, but you can see that the London Ambulance Service, whilst it is the busiest in the UK, is actually the smallest, apart from the Isle of Wight, geographically, even though we have largest population - about 7.5 million in London.

You will be aware that there is a strong view in London that, as the capital city of our country, we should have a world-class health service and we should have a world-class ambulance service. Of course, our population has changed over the years and grown and as I mentioned before, we are the busiest ambulance service in the UK. In fact, we believe that we are the biggest ambulance service in the world. This is partly because we are free; where I spent big parts of my career, people get charged for the ambulance service, and that has resulted in fewer calls for the service than perhaps other parts of world

where calls are free.

We are the only London-wide organisation, and, this year, we will receive 1.5 million 999 calls. The Audit Commission did a report, about 7 years ago, saying that the average person calls the ambulance service once every 16 years in their life. It is probably every 16 days for the LAS! We respond to a million calls. In the calendar year just finished, 2010, we responded to our millionth call on December 28th. A million is a huge number of calls. We are now, obviously, one of the busiest emergency services. In fact, in England, last month, the ambulance service dealt with more calls than the police service, for the first time ever in England. There are a number of reasons for that which I shall come onto later.

You might ask why we receive 1.5 million 999 calls but only respond to a million. There are a number of reasons for that. One of them is to do with multiple calls. In the old days, when you had a car accident, someone would try and find a phone box and you might get one or two phone calls whereas, since the introduction of mobile phones, if you get a car accident, you might get 20 to 40 calls to that, so we get a lot more multiple calls to incidents.

The other reason we get more 999 calls is because people ring back. People are impatient at times, and of course, if you are waiting 8, 9 or 10 minutes for an ambulance and it is a serious incident, then that is a long time. Our response time is eight minutes. If we all sat here for eight minutes, in silence, that would seem like a long time. Therefore, we do have a lot of people ringing back to find out when the ambulance will arrive.

Of the million people, around three-quarters go to hospital. Some do not go to hospital because they have already passed away when we arrive, some refuse to go to hospital, and some, of course, do not need to go to hospital because we manage to treat them on the scene.

We employ around 5,000 staff and have about 1,000 ambulances and vehicles. Over the past few years, we have seen demand grow at about 5% per year, so we receiving increasing numbers of telephone calls for our services.

We have been very fortunate, in the past decade, as have other parts of the NHS, because we have had a large level of investment in our service. It is fair to say that, certainly when I joined the Ambulance Service in London some years ago we struggled quite a lot with our vehicles and with our staffing. I am pleased to say that in the past 10 years, and particularly the past 4 or 5 years, we have had extra investment into our service. In fact, in the past three years, we have recruited about 700 new staff to work on ambulances. This has been a good thing to do, and we now have large numbers of staff in our organisation that we previously did not have.

In all, we have 70 ambulance stations across the capital. We have 26 main ambulance stations but you can see that we cover the whole of the M25 area. As you might expect, the central area is busier during the week and, as people spend more time outside London on the weekends, then during the day particularly, we get less work in Central London during the day at weekends though it gets busier at night-time as people come back into the capital. It is interesting that most of our sicker patients tend to be on the outskirts, where we have got a more elderly population, particularly in South London.

We deal with numbers of types of patients, as you would expect, within those million calls that we attend each year. We have some critically ill patients, although they only make up about 10% of our calls. There is a misconception that the ambulance service is constantly attending car crashes, heart attacks and those sorts of calls, but actually, most of our work is fairly what we call routine work - patients who have a problem, but which is not necessarily life-threatening.

However, we do receive those life-threatening calls. As you would expect in London, there are lots of languages, as we have a very diverse population, so it is not always easy, on the end of a 999 call, when something is going on and people are panicking. Often, it is very hard to get the exact facts of what is actually happening at the scene, and therefore, sometimes, what has been told over the phone is quite different to what has actually happened when our staff arrive at the scene.

Of course, we have non-emergency transport, which is mainly our minibus type transport. Our staff transport people to and from clinics, and this is a separate piece of our activity altogether and is not part of the million calls. This is what you would expect the London Ambulance Service to attend, and it does form, obviously, a very important part of our work. Often, time is of the essence for these calls, and we work very closely with the fire service and the police at these types of events. We have the other types of calls. We receive an increasing numbers of alcohol-related calls particularly in the evenings and weekends - there are tens of thousands that we attend in London each year. We have been doing a lot of work with the police, and with other parts of the NHS, to try and make sure that these patients get dealt with properly.

We want to be the world-class ambulance service for the capital and we want our patients to be very satisfied with the service we give. As you would expect in an organisation that attends a million calls, we do not always get it right and not everyone is always happy with what we do. Nevertheless, by and large, we receive very positive feedback from patients, and in fact, we enjoy the highest level of satisfaction from patients in the NHS. Last year, we received about 1,200 letters and emails from patients who were seen by the ambulance service, thanking us for our care and looking after patients.

Our priorities are, obviously, to get to people luickly, especially with 999 calls where people have an urgent need; and to try and find ways of taking patients who need treatment to other facilities rather than A&E Departments. We have about 30 A&E Departments across London, they are very busy, and it is not always appropriate for patients to sit and wait to be seen in A&E. It may be better to go to a walk-in centre, to see their GP, a mental health crisis team or a range of other NHS professionals. Therefore, increasingly, we are trying to encourage our staff and have the right support in the field for our staff to be able to transport patients who need to go to hospital to different facilities besides an A&E Department.

Of course, as we are aware, the current economic climate means that we have to be very careful and conscious about the costs of providing an ambulance service in the capital, and that is something on which we have to concentrate fully over the next two to three years.

We have a national standard that is outlined by the Department of Health; our calls are categorised into three types of categories – A, B and C. Of those million calls that we respond to each year, around 35% of those are classified as life-threatening. That is very different to the 10% figure I mentioned earlier but because we err on the side of safety, inevitably, more calls are categorised as being serious - this is a safety measure that we have.

Our requirement is to reach 70% of our Category A patients, our life-threatening calls, in 8 minutes and we have achieved that for the past 7 years even though it is a tough target to hit. Imagine trying to drive around London with the congested traffic and some of the issues we face. We have had a difficult winter in London, which makes it quite a challenge for us, but I am pleased to say that we have achieved this target for the last 7 years. We then have the other patients who could be serious but are not necessarily. We have a 19 minute target although we have struggled more with that one and have been unsuccessful over the past few years. Finally, there are patients who have something which is not serious at all, and we can agree locally about how to treat those patients. A number of those patients get telephone advice which has been very successful over the years.

Our ambulance crew have a little computer screen in all the ambulances, and in our cars. When the call comes in, we are able to give that call to the crew within 15 seconds. From the time the 999 call starts to the time the ambulance crew have got that on their screen in their cab can be as quick as 15 seconds. Our ability to give the call, either as red, amber or green, is fantastic – I think it is the quickest in the world.

In our efforts to reach patients more quickly, we despatch our crews often with the address details only, which brings its own challenges. Sometimes, we are sending our staff out with the address so they head in the right direction to the call, and then subsequent information can come through which indicates that the call is not serious. Therefore, we downgrade the call although this can be a bit frustrating for our staff. We are trying to address that, but there is no easy fix to that.

This is an example of what the ambulance crew have in their cab of their vehicles. It is a little computer screen, and they not only have a satellite navigation screen, like we see now in cars but they are also able to put into their different destinations for patients. For example, if a patient has had a stroke, they can find out the location of the nearest stroke unit; if the patient has some major trauma – they might have been in a very serious car accident – they can locate the nearest trauma centre or minor injuries unit. This is a very important piece of technology that our ambulance crews rely on. It gives times, information about the patients, information about the hospitals and it shows how to get to the scene without having to rely on map books. This is a very important part of what we need in our ambulances to help speed up the calls.

We prioritise our calls, as I have said, in our control room, and we use an international product called Priority Medical Despatch System. We are able to ensure that our control room staff, when the 999 call comes in, are able to find the right category of call for that patient. Often, when the call comes in, it is often from a relative or a friend, which, at times, makes it even more difficult to get the right information.

This is our control room at Waterloo. This is the largest ambulance control room in Europe, and it handles the 1.5 million 999 calls that we get. Our 999 call-takers do a fantastic job: on average, we answer the phone in three seconds. When I joined a few years ago and we were short of staff, and money, it was not uncommon for the telephone to ring for two minutes, and then the answerphone would come on and just as if you ring the gas company it would say "Which service would you like? Press 1 if you want an ambulance." I am being a little flippant there, but it was not uncommon then for us to be so stretched that we were unable to answer the calls quickly. However, I am very pleased to say that we have some really good people in our control room, we have been given extra funding, and we answer the telephone, on average, in two to three seconds.

How do we respond? We obviously have 408 Mercedes frontline ambulances. We have the HEMS, the emergency helicopter, based at the Royal London Hospital in Whitechapel. We provide the paramedics, and the Royal London Hospital provides the pilot and other doctors to attend the scene, and this gets used between three and four times every day to attend major incidents. It also relies on sponsorship and, as you can see, this is sponsored by Virgin. This is partially funded by the Department of Health and the rest comes from sponsorship and donations. It has done a great job in the many years in which it has been around and it supports us in our daily responses to patients across the capital city although it is not easy to land. I spent most of my career, in New Zealand – it is different landing a helicopter in rural parts of Northumbria or even in Norfolk to landing a helicopter in Hyde Park, Regent's Park or in Oxford Street so this represents quite a challenge for the pilots and staff involved.

Increasingly, we have numbers of fast-response cars. These are staffed by ambulance staff who respond to find out what is wrong and what has happened at the scene. Of course, they are able to get through the traffic much more quickly because of their size, and we have around 150 of these cars around the capital city. We also have a number of motorbikes which, again, are based mainly in the centre of the city and are very quick to get to the scene, do a great job, and provide care until additional help arrives at the scene. We also have push-bikes, which have been very helpful. We have these across the capital, and we have a

number at Heathrow. If you can think of the size of the terminals at Heathrow, trying to get around Heathrow Airport in cars or on foot is quite difficult, so these do a great job. Also, in Leicester Square, we get a lot of people, on weekends, and during the week, who have been drinking and collapse or fall over. We are able to save one of the big ambulances and send one of our single-response cycle units to go and look at what is going on. Often, when we get to scenes, people have absconded. Someone else will have rung an ambulance because they have seen someone fall over or collapse, and we get there and there is no one there. Our cycle response unit is very useful because they can go and can cancel the ambulance and say, "Listen, there's no one here," or "It's not serious".

Of course we rely heavily on our control room staff at Waterloo Road. We have people who give telephone advice in our control room. They are paramedics or ambulance technicians who have been trained and are able to give advice to patients over the telephone. That can often mean that we do not need to send an ambulance, so that is an important element of what we do.

I have mentioned our attempts to try and find the most appropriate care pathway for our patients. If you think about it, a lot of the patients we attend are elderly patients, and nearly half the patients that we take to hospital end up being admitted to hospital and spend three or four days in hospital which is not always necessarily the right thing for them. Therefore, we believe that it is important to find more appropriate pathways of care and we have evidence to show this. We get a lot of people who have fallen over in the home - 60,000 of our calls are elderly fallers. A lot of those elderly fallers do not have any injury but they require social care or some help, and we are able to try and improve that by getting falls teams or district nurses to come and visit them. We have both ends of the spectrum: people who can be treated at home, people who can go to a minor injury unit, people who can go to A&E, and of course, for the really serious and sick patients, people who can go to a trauma centre or a stroke unit and end up in an Intensive Care Unit. We cover a full spectrum, and of course, we do have quite a few babies born in ambulances as well.

It was quite funny because I took my wife across to New Zealand. She had never been before and so I found myself telling her of all the calls I had been to in Auckland - she got bored after a few minutes. You will get bored too, but I shall stop with one! We went across the Auckland Harbour Bridge – it is not quite as flash as the Sydney Harbour Bridge - about four weeks ago, and I was telling my wife about how I had delivered a baby on top of the Harbour Bridge. The husband was too frightened to come in the ambulance, for some reason, so they followed in a taxi, over the Harbour Bridge. We stopped the ambulance right on the top of the bridge, and I remember delivering the baby and then opening the side of the door and shouting out "It's a boy!" There was a huge traffic jam, but everyone was very happy! The taxi driver seemed particularly happy that she had not had the baby in the taxi, so that was good!

We have come a long way as an ambulance service. There are still things to do, we are not perfect and there are areas of improvement, as in any organisation, but we have had some good things and it is important that we do focus on the good and the not-so-good at times. We have our Category A target. We do not spend more money than we get, which is important, as an NHS organisation. We have saved lots of lives and I have already mentioned our Control Room, which was recently awarded an excellence award for the fantastic job it does. We have also done some work with a range of people, including with some ethnic minority issues. We have been working with the Bangladeshi community, and we have done a really good job with that community in East London. We have been working with rough sleepers, in Ilford. We have also had a number of our staff receive bravery awards for their fantastic efforts in saving lives. Overall, we have a few things that we are proud of achieving, but there is more to do.

We have seen survival rates improve. We have treated more patients outside hospital, and we have improved – we have had fewer complaints because we do get to people more quickly, and time is a very important thing for patients who call the ambulance service. They want a quick response.

For 5 years, we have been taking patients who have a specific type of heart attack directly to a specialist

centre, so they can have an angiogram and have, where necessary, have angioplasty. So if people have had a particular type of heart attack, our members of staff are able to do a 12-lead ECG of the person's heart, find out whether they have had a heart attack, and then, if they have, we can then take them to a heart attack centre, directly. They can get an angiogram literally within 15 minutes of us arriving. That has saved lots of time and improved lots of people's lives – it is better than going to A&E and then doing another 12-lead ECG and then transporting a patient for an angiogram. This has been fantastic - our staff are able to diagnose heart attacks at the scene and then take patients directly to an angioplasty centre. In the old days, certainly where I used to work, there were some ambulance services which used to try and electronically send the copy of the ECG to a doctor in a hospital for them to interpret it, to decide whether the person had had a heart attack. We have cut out that process and our staff do that themselves. We know that by people being able to get angioplasty within an hour of the ambulance being called, that has saved lots of lives of people in London which is unbelievable.

There is some inevitable confusion at times between a heart attack and a cardiac arrest. Increasingly, I find that the two get confused with each other. When people have a heart attack, part of their heart muscle gets blocked so part of their heart dies. They get pain and they can recover from that. A cardiac arrest is where someone actually dies or their heart stops completely, for whatever reason. In these cases, we have to provide full resuscitation to these calls, and we attend 9,000 cardiac arrests a year in London - 30 a day. These are patients who have had a sudden cardiac arrest and, for all intents and purposes, are dead. Increasingly, we are trying to do two things: firstly, to reach these people as quickly as we can to help provide care; and secondly, to try and give telephone advice. So, if someone rings in and says, "My father has collapsed on the floor, he is not breathing, he does not have a pulse," our 999 call-takers give telephone advice to advise them how to do CPR. I would encourage colleagues in the room to learn at least the cardiac massage side of that, and that will really help. If someone has a collapse from a cardiac arrest, and you can start the resuscitation immediately, the chances of survival are dramatically increased. For every minute that goes by without some form of resuscitation, the chances of survival decrease quite dramatically.

In London, we have been working very hard to arrive more quickly, by singling out these particular calls and sending resources, sending two or three vehicles as quickly as possible; secondly, to give telephone advice; and thirdly, to encourage people to provide basic life support until the ambulance arrives.

This graph shows that the number of people who have had a cardiac arrest linked to a cardiac event and survived has increased massively, which is fantastic. Last year, for example, 97 people who were technically dead, were successfully resuscitated by London Ambulance staff, with support from the public, and people like London Underground as well, and were discharged, alive, from hospital. Ten years ago, that number was 17, so we have seen a big increase in the survival, and we are doing more and more to do that.

Part of our efforts to improve cardiac arrest survival to discharge has been to put defibrillators in lots of places around London. With support from the Department of Health and the British Heart Foundation, we now have hundreds of defibrillators around the capital. We have 90 at Heathrow Airport alone. We have some at Victoria Bus Station, underground stations, train stations, and lots and lots of the underground and transport staff have been trained in the use of defibrillators and have saved lots of lives - I think that we have saved 20 or 30 lives alone at Heathrow Airport. There is a joke that warns you not to fall over at Heathrow Airport, because if someone sees you, they will defibrillate you, even if you are not dead! We have had some fantastic stories of people, at a young age, who have been successfully brought back to life by a combination of LAS staff and members of the public and underground staff and transport staff. This is a very important part of what we do.

We also have campaigns to try and encourage people who have chest pain – a heart attack could result in someone having a cardiac arrest if the heart muscle gets damaged. Therefore, we have had a number of campaigns. As you would expect, you also get people ringing in with indigestion, and the public are

susceptible to these campaigns, as you would expect. So when this advert first went live, we received an extra 50 calls a day, and a number of them were for indigestion. What was quite interesting, or potentially funny – see what you think – was that, when this first advert with the leather belt came out - on buses, the underground and in a range of other places - we got calls to people's houses who had put a belt round their chests, because they thought that was what they should do. They changed it to a skin-coloured belt on it so that people would not get confused. We were worried about a stroke campaign and whether they going to put belts round people's heads! However, it does show the power of advertising and how that can influence what people do, so it is very important to get the message right.

As I have mentioned before, most of the cardiac arrests that we go to are at 9 o'clock on a Monday morning. Whether that is a combination of people going to work and getting stressed out about the prospect of another heavy week on a Monday I do not know. Some of these people have been there by themselves all weekend, and we have found them on the Monday morning. Either way, most of our cardiac arrests are on a Monday morning, between 8 and 9am. This is some advertising that we have done to try and encourage the public of London to be trained in basic resuscitation to save lives.

What is trauma? Trauma, in this case, relates to people who have something which is life-threatening that has resulted in a trauma. If you have been hit by a car or a bus, or you have been stabbed or shot, then something traumatic has happened – it is not a chest pain or a stroke; it is a trauma that affects your body. As a result of that, increasing evidence shows that you need to go to somewhere that can provide instant treatment and surgery for that injury. It is an injury-related thing.

In London, a decision was taken a couple of years ago that for patients who have had some major trauma and are literally dying – they may have been shot in the head – and will die unless they get immediate surgery then they should go to a major trauma centre, where you know you get high level definitive care very quickly. We are very supportive of this. This was a big decision to make for the capital city. Ambulance staff from around London, where they get a patient with major trauma, now take them to one of four centres, and will bypass other A&E Departments. That is the right thing to do and early evidence is showing that that is saving lives. Our staff make that decision based on the signs and symptoms of the patient's injury, and then transport them directly to those. They are waiting for us when we get there, and we have had some very good results with that.

This shows the first three months of the types of calls we went to last year, with this new procedure. You can see that 19% of those were falls, 38% were road traffic accidents, a massive 27% were stabs or shot and 5%, were assaults and some other unknown ones. One of the unknown ones there was "kicked by a cow" and the person suffered a major trauma. You would not think, in London, the capital city that there would be people getting kicked by cows. Another one involved someone on one of the mobility scooters that got involved in a serious car accident. Things do happen that are out of the ordinary. This gives a sense of the types of calls that we are attending where someone has a major trauma.

Then we have Stroke – this has been a big campaign, as you have seen. It has been around for two or three years now, but there has been a big campaign for people to try and have early recognition of stroke, and hence the FAST test. This has been widely publicised on TV, radio, hoardings, underground stations, and even some ambulances, as you can see here, and this test gives a good indicator as to whether someone has suffered a stroke and is very important. Often, it is 3, 4 or 5 hours after the person has had a stroke before an ambulance is called, and the advertising is aimed at cutting that time down. If a person has had a stroke, and they have a clot-related stroke, the sooner we can get that treated, by giving them some clot-busting drugs then their chance of having full recovery from a stroke, which is unheard of, is greatly increased. We are keen to make sure that, if someone has had a stroke, they call the ambulance straightaway. We will then respond within 8 minutes and transport these patients to a hyper-acute stroke centre. Much like the discussion a minute ago about the trauma patients, we now take patients who have had a FAST positive stroke, with symptoms, within three hours directly to one of these nine centres. We bypass the local hospital, and these patients get an immediate CAT scan on their brain. If the person has

had a thrombotic stroke and they have a clot on the brain, then they can get thrombolised and get the clot dissolved – it has been very successful. This has been going for about a year as well, and we have seen some fantastic results. Here is a patient who is an example of a patient who had paralysis on one side, and would potentially have spent the rest of his life in a care home or a nursing home, and is now at home and able to play his accordion. Apparently, he could not even play the accordion before he had the stroke. This has been very successful, and of course, there are far more stroke patients than trauma patients. We have tens of thousands of patients who have strokes, so this is a very important piece of work that we have been doing. The hospitals have done a fantastic job and we have been supporting them with this. This is quite powerful, because you actually see the patient, who would otherwise have had a very poor outcome, almost fully recover, which is fantastic to see.

Our current challenges are: getting to patients in 8 minutes, in the capital despite the traffic and the road works. They always seem to be repairing the Victorian water mains and gas mains and, as you might have seen, one little roadwork can have a massive impact for traffic! It is a big challenge. Another challenge is providing more care outside hospital for patients so this means providing our staff with more training and support, so they feel confident to transport patients to other places besides A&E. We need to get a new computer system to replace our old 999 system, which is fairly old, and that is being replaced on 8th June 2011. The big Olympics for the capital will be a big thing for the London Ambulance Service – it is the biggest event we have ever had. We also need to deal with demand on our service, which is increasing year on year. I have already mentioned that each year, in England, there are another 300,000 extra thousand calls a year. It costs £200 on average to call an ambulance, so that costs the NHS an extra £60 million a year by increasing use of the ambulance service.

These are the top 10 types of calls that we attend. Our staff write this on the patient report forms so these are the types of calls that we attend. As you can see, there is a huge range – fractures, alcohol, minor cuts and bruising, difficulty in breathing, no injury or illness or being generally unwell.

We do not think that people who are generally unwell should be calling 999. However, people often call us as a last resort when they think that they have nowhere else to go. That does not make it right, but that is what happens. We have to find a way of making sure the emergency ambulance service gets used for genuine emergencies and that other parts of the Health Service can pick that up other concerns.

We do not get many hoax calls although we get quite a lot of inappropriate calls. A hoax call is a malicious call - the fire brigade get lots of hoax calls. I wonder why we do not get many. It is partly because it is pretty boring watching someone on a push-bike arrive. If a little kid says "There's been a fire at a house," and it is a malicious call, three fire engines and 15 fire-fighters arrive – that is quite exciting to watch! If someone has had an accident on Leicester Square and someone on a push-bike arrives it is a bit boring. I would say that less than 0.5% of our calls are hoax calls, but probably 20-30% of our calls could be seen as inappropriate use of the ambulance service, and our staff are quite demoralised by that. They see themselves as highly trained professionals who are there to provide emergency life support and, at times, some of the calls that we get should be going to other parts of the NHS. If you have had a cold for three weeks, you should not be calling an ambulance! One of my favourite ones was: "I cannot dance – can I have an ambulance?" I cannot dance, I do not call an ambulance, but there we go! That would classify as a hoax call I would say.

The sorts of things that affect demand are, as you would expect, seasons. We get more calls in winter and we get more calls in summer: winter because of slips, trips, falls, car accidents; summer because alcohol, then more alcohol, more tourists coming to the capital and there being more people out and about. One of our busiest days is the first shopping day after Christmas, because people are out and about. When people are mobile, it creates work for the ambulance service.

People are living longer so we have more people with long-term conditions. We have frequent callers,

people who ring us 100 times a week, often with mental health problems. We have about 150 regular calls. We do a lot of work – we have got a Frequent Callers Unit actually, and their job is to work with Social Services and other parts of the NHS to try and provide appropriate care. Often, these people are lonely and they have mental health problems, and they call us a lot. We are often quite successful in moving some of those off there but then some more come onto our list of people who we attend regularly.

You will be all aware of deprivation. There is a very strong link between the use of the NHS and deprivation. Whatever part of the NHS you look at in London, it is a big issue. We know that if you go on the Jubilee Line between Westminster and Hackney, you lose a year of your life for each stop. The average age for a man in Westminster is 84, and it is something like 69 or 70 in Hackney or Stratford. There is a huge issue around depravation and around life expectancy.

Alcohol, as I have already mentioned, and changes to patient care also affect demand. Obesity is an increasingly big thing – we have had to buy some bigger ambulances. The media came and talked to us, some of the media, and said they understood that we were getting some new ambulances for patients who are bigger which was right. The headline was: "LAS buys fat ambulances!"

Finally, of course, there exists social attitude change. People now have a lower threshold for calling an ambulance. If you are 70 or 80, you will only call an ambulance if you are really sick, generally speaking. People who are 25 or 30 are not bothered as they are not paying for it. There is a completely different attitude now from society about the use of things. People are a lot more interested in themselves perhaps.

5% of our calls are alcohol-related - whether the issue is a car accident, domestic violence or an assault, alcohol plays a huge part directly or indirectly. The trend for the number of people that use the ambulance service, by age group, per population follows as you would expect. People who are 90+ use the ambulance service a lot more than a 5 year old. However, I find the number of actual calls by age group is very interesting. This is a little bit old but the biggest users of the ambulance service are the 20-30 year olds, which is a surprise. You would think that it would follow the same trend as the usage. Actually, the group of people which calls the ambulance service the most is the 20-30 year olds, which goes back to the alcohol and to social attitude generally. Demand is rising. A small number of patients, account for disproportionately large activity – some of our regular callers. Many of our patients go to hospital and get discharged quickly; people are used to getting quick treatment in the NHS now, these days.

The fire service in London and in England has done a fantastic job. Their public education campaigns, their powerful advertising and their smoke alarm campaign has seen a dramatic reduction in house fires, and general fires that they attend, but there is no equivalent in the NHS or the ambulance service to the smoke alarm, so there is no quick fix.

We did a MORI survey of about 1000 Londoners a couple of years ago which asked people what the most important thing about the ambulance service was. Speed was comfortably the most important thing. There is an expectation that our staff will do a good job in treating patients, so they are not concerned about the treatment side. It is interesting for our staff to be aware that satisfaction comes from speed though, of course, looking after a patient when you get there is important.

Speed cameras are very common in New Zealand – they are everywhere. There are plenty in the back of estate wagons. I had a doctor friend, who worked in a hospital, who used to drive quite quickly, so he often got speeding tickets. One time he was fed up of receiving speeding tickets. He was going to a meeting and he was going too quickly. He was going 100kph in a 50kph area, so he was going about 20-25 mph too fast. A brown envelope arrived from the police and it had in there a photograph of him and a $300 fine. Being the smart doctor that he was, and the fact that he had had so many speeding tickets, he decided to write the cheque out for $300 and photographed it. He sent the photograph of the cheque back to the

police. He did not hear anything for about six weeks, and then a brown envelope arrived. He opened it up and it had a photograph of a pair of handcuffs on it, so that was good! Suffice to say, he did pay the fine.

We tried this campaign a few years ago. This did not go down very well because we got a lot of complaints as our staff felt quite empowered to go to people's houses and say, "We're not a taxi service!" and of course the patients got a little bit uptight about that. It was quite a hard-hitting campaign, but it failed to reduce demand. This was another campaign we ran. There is some evidence, overseas, that by telling people that there is a service, you actually get more demand so actually, it had the reverse effect.

Talking specifically about London after dark, we have an increase in demand, as you would expect. There are no real surprises on this list. After dark we receive more alcohol calls, more road accidents, more people falling, an increased number of patients who have absconded when we get there and there are more staff assaults. In the last year, I think 350 of our staff were assaulted in London and we get far more abuse at night. Crucially, we have a lot of demand between 11 o'clock at night and 3 in the morning, on a Thursday, Friday and Saturday night in particular, which is a big night. In fact, Thursday is one of our busiest nights now. People say that Thursday is the new Friday but it feels like every night is Thursday night sometimes. Did the 24-hour licensing change things? Not really. It took it a bit further in the evening. The peak period used to be between 11 and 12 whereas now it is between 11 and 3 so it has spread it out a bit. Nevertheless, we do struggle between those hours on those nights, and it is not easy trying to get as many staff to work in those hours because it is a hard time to work.

Of course, with the big estates we have in London, and just generally, trying to find addresses is much harder for our staff. We can get there with our satellite navigation but once you are in the street or at the estate, trying to find things can be quite problematic.

We also have a lot of rough sleepers. We have people that sleep on buses - they get on a bus, they go back to the bus depot, the bus driver gets out, and he finds someone on the back seat of the bus, asleep, and then we get called. In fact, one bus station called us 300 times in one year. We have been working with London Street Rescue – one of our paramedics has done a great job - to try and spend time on the buses trying to find homes for some of the homeless people and generally educating them about calling the ambulance. It has not been easy, but we do get more hypothermia in the middle of winter and at middle of the night. It is not an easy job anyway in the capital, at times. It is a very rewarding job, and our staff, by and large, are treated very well by the public. However, as you would expect, there are always occasions when we do have problems with some of the public.

I think the London Ambulance Service is a proud service. We have done a great job over the past 20 or 30 years to look after the public in London. We have an increasing level of demand and we keep getting there quickly. We need to manage our finances carefully over the next few years while because the NHS has less cash and we need to make sure that we are able to respond to that carefully and still provide the best care possible to the patients of London, while, at the same time, trying to change the way we run our service.

Thank you very much.