MONITORING THE LONDON AMBULANCE SERVICE

PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

MONITORING THE LAS EMERGENCY OPERATIONS CENTRES & SOUTH EAST LONDON 111

REPORT AND RECOMMENDATIONS TO THE LONDON AMBULANCE SERVICE

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REPORT ON VISITS TO

EMERGENCY OPERATIONS CENTRES IN

WATERLOO & BOW

SOUTH EAST LONDON 111 SERVICE

CONTENTS

Forum Members who participated in EOC visits

- Beulah East
- Charlotte Mitchell
- Elaina Arkeooll
- Malcolm Alexander
- Natalie Teich
- Tahmina Begum

Forum Members who participated in 111 visits

- Alexis Smith
- Barry Hills
- Charli Mitchell
- Elaina Arkeooll
- Graham Mandelli
- Malcolm Alexander
- Mary Leung
- Natalie Teich

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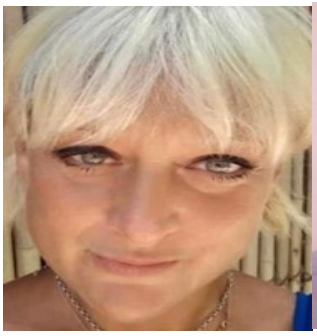

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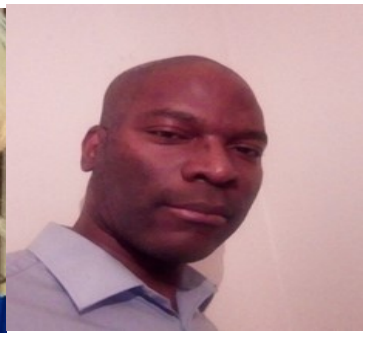

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INTRODUCTION

Eleven Forum members visited either the 111 Centre for South East London run by the LAS or the Emergency Operations Centre in Waterloo or Bow. These visits were arranged with the LAS to enable Forum members to monitor these services and make recommendations to the LAS for service improvement. All of our members were warmly received, and staff spent time explaining how the systems worked and answering their questions. All interactions with staff were excellent and all of our questions were answered. Each Forum member produced a report on their visit and the reports were combined into this single report. Each visit by a Forum volunteer lasted up to five hours. The Forum has been carrying out these monitoring activities since 2003 when it was first established.

Our recommendations for service improvement were submitted to the LAS and meetings were held with their staff to discuss our 111 report. Unfortunately, we have been unable to obtain a written response to our 111 and EOC recommendations to the LAS. Information about our visits and our recommendations follow. The 111 and EOC visits are shown separately.

Our rights under the NHS Constitution:

NHS CONSTITUTION

The NHS commits to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services.

You have the right to have your say in person or through a representative:
- in the planning of healthcare services;
- on the proposals for any changes in the way in which your services are provided; and
- on decisions which may affect the operation of these services.

www.nhs.uk/NHSEngland/aboutnhs/Documents/NHS_Constitution_interactive_9Mar09.pdf

METHODOLOGY- VISITS TO EMERGENCY OPERATONS CENTRES

Six Forum members visited the EOC in either Waterloo or Bow in March or May 2019, for up to five hours, and spent time with Call-Handlers, Allocators and CHUB and spoke to EOC Managers. (CHUB = Clinical Hub for expert advice)

Each Forum member was provided with guidance by the LAS to prepare for the visit and provided with a list of questions from the Forum that they could ask of staff whilst in EOC. The main focus of the visits was to consider the effectiveness of EOC services for patients with mental health problems, but other matters were also examined.

Each person prepared a report on their visit and this was submitted to the Forum. **The recommendations arising from these reports (below) were formally submitted to the LAS EOC director - Athar Khan, Chief Quality Officer – Trisha Bain, Heather Lawrence – LAS Chair, Commissioners** and other key partners.

We have asked to meet the LAS to discuss our recommendations and their implementation, but have been unable to obtain any response from the LAS. When these meetings eventually take place, the Forum Members who visited EOC will be invited to attend.

EMERGENCY OPERATIONS CENTRE

RECOMMENDATIONS TO THE LAS

1) Parity of Esteem - Health and Social Care Act 2012

The LAS should produce a statement for their annual Quality Account and Clinical Strategy, explaining what steps have been taken to implement and achieve parity of esteem between mental and physical health in the EOC.

2) Parity of Esteem - mental health nurses

It would be of great benefit to patients if more mental health nurses could join the LAS EOC team. Weekends can be particularly stressful for patients, when mental health services are less available in the community.

3) EOC clinical staff mental health training

In view of the duty of Parity of Esteem between patients with physical and mental health problems, and the low numbers of mental health nurses in EOC, more emphasis should be placed on the training of all staff in the clinical hub, to engage with patients suffering a mental health crisis. The training and experience that paramedics are receiving through the south east London mental health car, is an exemplar for how this can be done well.

4) Call Handlers – mental health training

Mental health training for call handlers needs to be substantially improved beyond the two compulsory days (year one only). Although staff have the option of further mental health training this is not compulsory. We recommend that all Call Handlers participate in Mind's Blue Light training.

5) Responding to patients in a mental health crisis - data

Data should be provided showing the number of calls received by EOC for patients in a mental health crisis (including suicidal ideation) each day, and the capacity of the LAS to respond to these calls. Data on time taken for mental health nurses to respond to patients in a mental health crisis should also be provided.

6) EOC mental health card

The LAS should review and redesign its EOC mental health flow chart, used to assess the severity of mental health emergencies. The flow chart for mental health is poorly designed, says little, has a poor script with non-specific information and makes it difficult to respond to mental health calls appropriately.

7) Call handlers' access to mental health nurses

Call Handlers should continuously be provided with information on the availability of mental health nurses in EOC, to enable them to respond adequately and appropriately to new callers suffering from a mental health crisis.

8) Role of mental health nurses

The roles of mental health nurses should be clarified, e.g. at a particular time, whether a mental health nurse's primary role is to engage directly with patients, with front line staff, or to arrange transport to mental health facilities. The lack of data may be leading to emergency ambulance responses, when other more appropriate, patient specific responses might be best for the patient.

9) Under-evaluation of the needs of suicidal patients

Clarification is needed about LAS responses to patients experiencing suicidal ideation - some of are provided with a Cat 3 response – 2 hours: but response times may be much longer, putting patients' lives at risk of death or serious harm. There should be a greater focus on effective responses to patients experiencing suicidal ideation. Better collaboration is needed with specialised local mental health services, to respond quickly and effectively to save lives and reduce harm.

10) LAS support for patients detained by the police

Where a patient is suffering from serious mental health problem and the police detain the person, as they are not clinically trained, advanced mental health Paramedics or mental health nurses should always attend, to take over clinical responsibility for the patient and take the person to a statutory 'place of safety'. Patients subject to police detention under s135/136 should have a Cat 1 (ARP) LAS response.

11) Alternatives to A&E in a mental health crisis

Alternative clinical services are needed for seriously ill patients in a mental health crisis, who have not been Sectioned, but need inpatient care. Taking them to an A&E department, is often inappropriate and can be a disastrous experience.

12) LAS Mental health car - access

Data should be produced to show outcomes of LAS MH car interventions and frequency of post visit calls from patients who have received this service. Parity of response to patients whose calls are received at Bow and Waterloo should be demonstrated.

13) Monitoring the outcomes of mental health care

CARU should carry out an audit of patients who have received mental health care from paramedics, and those who have received care from the south east London mental health car, to ascertain how often the mental health crisis is resolved, and how often patients receive acute mental health care from a hospital over the following few weeks. (CARU – Clinical Audit Research Unit)

14) Access to summary care records and CmC

We would like assurances that paramedics and mental health nurses visiting patients in a mental health crisis, always have access to their 'summary care records' and care plans/CmC, if they have been placed in the patient's records/notes.

15) 'No eating and drinking' while waiting for an ambulance

Patients in a mental health crisis waiting for an ambulance, are told not to eat or drink, except for sips of water. This advice is inappropriate for this group of patients, may be harmful and can have negative consequences for the patient's mental state.

16) Mental health – inappropriate assessment questions

1) The EOC script for patients in a mental health crisis that asks the patient (or a carer in relation to the patient: a) Do you feel violent? b) Is there a risk of violence? This is inappropriate and inconsistent with statutory duty of parity of esteem. Most violence is from patients who are intoxicated, not those in a mental health crisis. Patients in a mental health crisis are more likely to be the victim of violence rather than the perpetrator. This question should be deleted from the LAS script.

2) The LAS should review its emphasis on threats of violence in the assessment of patients in a mental health crisis, because this approach to mental health assessments lead to inappropriate responses from the LAS and police.

17) Improving the CPR script

When a caller to the EOC is asked to give chest compressions (CPR), the Call Handler counts out the beats. But if the phone is not near the caller, they cannot hear the beats being called out, nor can the Call Handler hear what the person is doing. If it is not currently the case, we recommend that the Call Handler should advise the caller to put their phone on "speaker" and be placed nearby. The same would be the case if the caller was asked to carry a task to assist the patient, or to ensure the safety of the patient, or to open the door before the ambulance team arrives.

18) Rest break agreement – shortage of ambulances

The Rest-Break Agreement may result in raised pressure at 5.30am and a serious shortage of ambulances, which could lead to potentially harmful delays in the treatment of seriously ill patients. We recommend the LAS provides an explanation for this situation, evidence of any harm and details of action being taken to mitigate harm to patients.

19) Access to clinical data for front line staff

Access to clinical data for paramedics regarding previous recent calls, responses and outcomes is very limited. A paramedic could visit a patient who has been seen several times in the recent past, and have no access to relevant previous clinical data. This situation in inappropriate and should be urgently transformed to ensure continuing access for historical clinical data.

20) Responding to call when the signal drops

It was reported by Call Handlers that the phone signal often drops during EOC calls and contact is lost with caller. We would like sight of the relevant policy and advice provided to Call Handlers experiencing this situation and the risk analysis in relation to these cases.

21) <u>Clinical hub - SoP</u>

The following wording in the Clinical Hub SoP should be reviewed:
"Additionally, the following patient groups should be treated with **caution;** mental health patients, under 18s, substance abuse, the elderly, patients who are alone or have significant co-morbidities". The word "caution" should be replaced with e.g. "special care" (Assessment and the Manchester Triage System, 2018).

22) <u>Optical contamination</u>

Patients experiencing optical contamination from unset plaster, paint or other hazardous substance should be taken or advised to travel directly to Eye Casualty, e.g. at Moorfields, St Thomas' or the Western. A 111 referral is not appropriate in these cases.

23) <u>Maternity</u>

More input is needed from maternity staff for woman suffering traumatic or difficult births at home. The maternity card used in EOC should be reviewed, updated and improved.

24) <u>Training – major incidents</u>

There is a need for more 'major incident' simulation training for EOC staff.

25) **<u>Training - interdisciplinary</u>**

We recommend improved interactions and interchange between front-line ambulance staff and Dispatchers – to better understand each other's roles and how their interaction could be improved.

PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

VISITS TO THE SOUTH EAST LONDON 111 SERVICE

RECOMMENDATIONS TO THE LAS FOR SERVICE IMPROVEMENTS

EXECUTIVE SUMMARY

In March/April 2019, nine Forum members visited the 111 Centre in Croydon, which provides the 111 service for five boroughs in south east London (Lambeth, Southwark, Lewisham, Bexley and Greenwich). The service is run by the LAS (as is the north east London 111 service) and has become an 111/IUC (Integrated Urgent Care) Centre.

The Integrated Urgent Care specification requires the service to provide the following patient care services:

- Access to urgent care via NHS 111, either a free-to-call telephone number or online;
- Triage by a Health Advisor;
- Consultation with a clinician using a Clinical Decision Support System (CDSS) or an agreed clinical protocol to complete the episode on the telephone where possible;
- Direct booking post clinical assessment into a face-to-face service where necessary;
- Electronic prescription; and
- Self-help information delivered to the patient.

(Integrated Urgent Care service specification: www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf)

Each of our members observed the 111 service for four-five hours, spent time with a Call Handler and clinician and wrote a report on their findings. Members were provided with a provisional list of questions about services for callers with mental health problems and some more general questions. Members were not required to ask all of the questions, but could select those questions most appropriate to the situation they experienced in the 111 Centre.

Mental health care was chosen as a priority theme, because of the Forum's concern about access to appropriate and adequate services for this cohort of patients, and because this issue has been prioritised by the LAS, in relation to mental health nursing in the Clinical Hub and the mental health cars across London.

Statements produced by our members arose from their observations and discussions with 111 Centre staff, and from the substance of our full report. 25 recommendations were made to the LAS following our visits to 111.

Members were received in a very positive way by Centre Managers, Call Handlers and Clinicians. We are very grateful to excellent leadership team: Tracy Pidgeon, Clinton Beale and Anne Jones for supporting and enabling our visits.

FORUM MEMBERS WHO PARTICIPATED IN MONITORING THE III CENTRE
Alexis Smith, Barry Hills, Charli Mitchell, Elaina Arkeooll, Graham Mandelli, Malcolm Alexander, Mary Leung and Natalie Teich.

NEXT STEPS
We had useful meetings with staff from the 111 service, but we have been unable to get a written response from the 111/IUC to our report and recommendations. We will be visiting other 111 services to observe alternative operational approaches to running this service.

RECOMMENDATIONS FOR IMPROVEMENTS TO THE 111/IUC SERVICE

1) PARITY OF ESTEEM FOR PATIENTS IN A MENTAL HEALTH CRISIS

That the 111 service employs mental health nurses in their clinical team 24/7, and develops better remote access to mental health workers/psychiatric liaison professionals. This will ensure that Call Handlers can quickly refer a caller to a clinician with the most appropriate clinical knowledge, experience and access to specialist services. Patients should always feel 'heard' and able to describe their distress or trauma to an experienced mental health clinician.

2) PARITY OF ESTEEM AND MENTAL HEALTH CARE IN THE LAS CLINICAL HUB

In order to achieve parity of esteem for patients suffering a mental health crisis, the LAS Clinical Hub should aim to ensure that all mental health referrals to the Hub receive a response from a member of staff qualified and/or trained in mental health care.

3) 111:999 LIAISON

A review of the liaison between 111 Croydon and the LAS EOC's should take place to improve access to EOC clinical hub nurses and the LAS mental health cars.

4) ACCESS TO THE LAS MENTAL HEALTH CAR

Staff in the 111 centers should be provided with better information about access to the London mental health cars. Staff seemed to have little awareness of this service, or whether they are able to refer patients to this high-quality LAS development.

5) CALL HANDLER AND CLINICIAN TRAINING

Enhanced mental health training should be given to all Call Handlers to improve the triaging process, and to clinicians to ensure that there is a shared understanding and appreciation of risk in the 111 centers in relation to patients in a mental health crisis.

6) COMMUNICATING WITH PATIENTS EXPERIENCING A MENTAL HEALTH CRISIS

Call handlers and clinical staff should receive specific training to communicate effectively with patients who may struggle to explain their mental health problems during a call to 111.

7) WORKING WITH THE VOLUNTARY SECTOR

111 service should develop better contacts with Mind and other mental health charities, to provide support for people needing ongoing community support following a mental health crisis.

8) SEVERE GYNAECOLOGICAL ISSUES

The 111 service should focus more on the needs of patients with severe gynaecological issues, i.e. sensitivity to the needs of women who experience painful and extreme symptoms of menstruation.

9) DENTAL CARE

A survey should be carried out to identify the location of callers requiring urgent dental care over a 3-month period, and advice given to NHSE to commission appropriate and adequate levels of local dental care, including urgent dental care. Guy's Dental Service should be commissioned to provide urgent dental appointments via the 111 service clinicians/navigators. It surprised us that so many people were contacting 111 for urgent dental care.

10) ACCESS TO FALLS TEAMS

The capacity for clinicians to make direct referrals to 'borough based' falls teams should be developed and enhanced, to enable the 111 service to provide a more rapid and safer service to patients who have suffered a fall.

11) SAFEGUARDING REFERRALS

When safeguarding referrals are made by the 111 service to the local authority, outcome reports should be considered a mandatory requirement for each referral, to ensure the referral was appropriate, enhanced the safety and care of the referred patients, and promotes learning for staff about effective safeguarding referrals.

12) CARE PLANS AND COORDINATE MY CARE

An enhanced process should be developed to ensure that clinicians always have access to Patient's CmC records and GP 'summary care records', and to advise patients and their GPs about the benefits of developing a CmC plan and how these are accessed by the LAS and 111.

13) TIME FRAME FOR CALL-BACKS

There should be a time-frame for call-backs from clinicians, so that callers know at what time to expect their call-back. At the time of our visits this information was not available.

14) ACCESS TO GPs

The 111 service appears to respond to many patients who cannot get adequate access to their GPs. The 111 service should collect data on geographic areas, where access to GPs is most problematic, and advise CCGs of the need to enhance primary care access in those areas. Surveys of patients to identify other issues regarding the quality of primary care would be an invaluable resource to aid the development of this service.

15) IMPACT OF TRAUMA ON CALL HANDLERS AND CLINICAL STAFF

The 111 service should provide clear information to all staff regarding debriefing, counselling and support, to deal with trauma caused through interaction with traumatised patients. We make this recommendation because the answers we received from staff on this issue were sometimes vague, unclear and inconsistent with the advice from the trauma lead.

Staff Support, Counselling and Occupational Health Services Manager for the LAS said:
"I was not aware that we had a "Pulse on-line computer system. It might be regarding the PAM generic OH referral online system (O.H.I.O), but, again, I have repeatedly raised concerns about the fact that using O.H.I.O contravenes confidentiality guidelines".

However, all 111 staff can be referred for a TRiM consultation when they have to deal with a particular challenging call – like every other member of staff. The email address for TRiM Consultation referrals is TRiMConsultations@lond-amb.nhs.uk. Staff should not be referred to counselling after a potentially traumatic job because it can exacerbate symptomology".

16) REPORTING AND LEARNING FROM INCIDENTS

111 service should acknowledge best practice in the way Call Handlers respond to calls from distressed and abusive patients, who should be encouraged to report every incident.

17) WORK EXPERIENCE

111 staff should be offered the opportunity to go on ride-outs and observation sessions to EOCs and Clinical Hubs, to get a better insight into other parts of the LAS urgent and emergency care system.

18) CAREER DEVELOPMENT FOR CALL HANDLERS

A greater focus is needed on career development for Call Handlers, including access to careers such a nursing and paramedic science. We believe this would sustain and advance recruitment to the 111 service.

19) 111 SERVICE QUALITY

More information should be provided to assure the public about the standards of care and support available from the 111 service. The public need to know about high quality, good governance and effectiveness of the 111 service.

20) FOLLOWING UP CLINICAL OUTCOMES AND PATIENT CENTRED FEEDBACK

In liaison with CARU, the 111 service should develop follow-up for some clinical cohorts of patients to determine whether their 111 response was effective from the patient view and in relation to effective clinical outcomes.

21) FEEDBACK FROM THE LAS CLINICAL HUB

To enhance the quality and effectiveness of the 111 service and the skills of staff, clinicians should be enabled to receive feedback from the EOC Clinical Hub, in relation to referrals they have made to the Hub, and the services/care provided to the patient.

22) CALLER'S CLINICAL HISTORY

Data should be available for Call Handlers and Clinicians to review callers 111 history. This is especially important for people suffering from chronic illnesses, e.g. mental health crises and some gynaecological problems.

23) ACCESS TO HISTORICAL CALLS

The 111 service should consider re-design of their data storage systems, to enable access and examination of clinical information from previous calls to and referrals by 111, in order to promote continuity of care.

24) REVIEWING REGULAR CALLERS

Data should be available demonstrating how often callers have called 111. Regular callers should be contacted to determine whether there are receiving a positive and therapeutic service.

25) SECURE ACCESS TO KEY INFORMATION SOURCES

Evidence should be provided that the 111 system is secure in relation to providing key information sources, e.g. BNF information. We assume that clinical staff have mobile phones with BNF apps, which can be used if there is a system failure, but this alternative source of information needs to be validated.

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USE OF LANGUAGE LINE

LANGUAGE	AUG 18	SEP 18	OCT 18	NOV 18	DEC 18	JAN 19	FEB 19	MAR 19	APR 19	MAY 19	JUN 19	JUL 19	TOTAL
ROMANIAN	229	208	243	286	283	357	370	360	345	319	363	338	**3701**
POLISH	274	225	203	246	274	257	220	288	271	328	268	223	**3077**
BENGALI	148	180	230	189	290	269	248	252	238	298	262	276	**2880**
ARABIC	104	134	139	159	184	181	147	122	175	139	255	270	**2009**
TURKISH	108	116	109	105	150	136	160	158	123	141	125	160	**1591**
SPANISH	93	123	101	104	162	134	115	148	116	141	144	165	**1546**
PUNJABI	85	105	121	122	113	121	112	126	143	171	104	160	**1483**
URDU	70	75	74	87	79	83	102	105	82	82	113	104	**1056**
RUSSIAN	62	72	76	91	108	97	79	98	120	100	77	74	**1054**
ITALIAN	63	64	74	84	106	99	113	89	67	93	73	81	**1006**
TAMIL	53	93	76	81	84	68	92	88	86	83	58	65	**927**
BULGARIAN	50	51	59	63	82	81	73	78	60	82	110	80	**869**
FRENCH	64	52	67	63	90	72	54	74	63	87	67	87	**840**
PORTUGUESE	52	58	69	65	67	56	55	55	58	103	89	56	**783**
SOMALI	40	56	55	52	59	49	53	53	56	63	68	76	**680**
FARSI	43	49	62	47	57	57	55	63	51	47	74	74	**679**
MANDARIN	41	33	55	54	79	67	64	58	45	51	51	70	**668**
LITHUANIAN	46	31	43	44	62	55	57	44	65	47	26	33	**553**
ALBANIAN	21	41	41	47	59	50	47	50	41	36	59	46	**538**
HINDI	45	38	39	33	37	46	36	37	56	61	57	47	**532**
GUJARATI	13	18	20	27	38	25	32	25	30	36	24	28	**316**
CANTONESE	32	40	24	14	18	29	17	19	18	20	18	30	**279**
GREEK	17	12	16	22	25	21	22	32	26	41	30	15	**279**
HUNGARIAN	20	27	16	16	18	29	13	20	19	30	14	17	**239**
Portuguese Br.	16	5	12	14	23	15	15	20	26	23	28	18	**215**
SORANI	10	12	16	15	12	21	13	21	14	24	15	29	**202**
TIGRINYA	6	7	15	9	19	21	17	16	15	16	18	16	**175**
VIETNAMESE	4	15	16	13	16	22	11	8	18	18	18	15	**174**
AMHARIC	8	13	10	14	10	21	13	17	11	20	19	16	**172**
PASHTO	7	11	14	10	12	17	10	18	6	21	13	15	**154**
SYLHETTI	0	3	4	11	13	14	11	12	9	16	18	21	**132**
GERMAN	13	4	6	5	3	7	7	8	4	10	10	3	**80**
DARI	4	2	3	7	7	11	7	2	8	8	3	6	**68**
NEPALI	2	5	4	7	7	7	4	4	6	8	3	10	**67**
KOREAN	2	1	1	7	8	5	7	6	7	5	5	5	**59**
JAPANESE	4	5	2	6	1	4	8	5	3	3	6	5	**52**
SLOVAK	2	3	7	3	7	3	6	3	7	2	6	3	**52**
TAGALOG	4	1	1	4	0	6	10	2	8	3	5	4	**48**
CZECH	3	2	7	0	5	1	6	5	5	2	5	4	**45**
HEBREW	5	0	2	2	2	4	4	1	4	9	8	1	**42**

THAI	4	0	4	1	0	1	5	3	8	4	5	3	**38**
UKRAINIAN	2	1	0	3	4	3	3	1	4	2	5	5	**33**
Portug.Creole	4	1	3	4	3	3	2	1	4	1	4	2	**32**
SWAHILI	4	1	3	2	3	2	3	2	2	4	2	2	**30**
AKAN	1	4	2	1	3	4	3	2	3	1	2	1	**27**
MALAYALAM	0	0	5	3	0	3	3	1	2	4	3	1	**25**
SINHALESE	0	0	1	3	4	5	1	1	2	3	1	1	**22**
LATVIAN	1	1	1	1	2	2	2	3	5	1	2	0	**21**
YORUBA	0	0	2	1	1	3	0	3	3	3	2	2	**20**
ARMENIAN	1	2	0	2	2	2	1	2	1	1	3	1	**18**
DUTCH	2	2	1	0	2	2	4	0	3	0	0	0	**16**
OROMO	1	0	0	2	1	1	6	4	0	1	0	0	**16**
BOSNIAN	0	2	0	0	0	0	1	4	0	0	3	0	**10**
CROATIAN	1	4	0	0	0	0	1	1	0	0	1	2	**10**
HAITIAN CREOLE	0	0	1	0	3	0	1	0	1	0	0	4	**10**
KURMANJI	1	0	0	0	1	4	0	0	0	0	0	4	**10**
LINGALA	0	1	0	0	1	2	1	0	4	0	0	1	**10**
MOROCCAN ARABIC	0	0	1	2	0	0	1	0	0	2	2	2	**10**
BURMESE	1	3	3	0	0	1	0	0	1	0	0	0	**9**
MONGOLIAN	1	0	0	0	0	0	2	1	0	1	0	4	**9**
SERBIAN	1	0	1	0	1	0	0	0	2	1	2	1	**9**
YIDDISH	0	0	0	0	0	2	0	1	2	0	1	2	**8**
SUDANESE ARABIC	0	0	0	1	0	0	1	1	1	1	1	1	**7**
TELUGU	0	1	0	0	2	0	0	1	1	1	0	1	**7**
GEORGIAN	1	0	3	0	0	0	0	2	0	0	0	0	**6**
KINYARWANDA	0	0	0	0	0	1	0	1	2	0	2	0	**6**
BEHDINI	0	0	0	1	0	0	1	1	1	1	0	0	**5**
IGBO	1	0	0	1	0	1	1	0	1	0	0	0	**5**
LUGANDA	1	0	0	0	0	1	0	0	1	0	0	2	**5**
LAOTIAN	0	0	0	0	0	0	1	0	0	1	0	2	**4**
WOLOF	0	0	0	0	0	1	0	2	1	0	0	0	**4**
CHIN	0	0	1	1	0	0	0	1	0	0	0	0	**3**
INDONESIAN	0	0	0	0	0	0	1	0	1	1	0	0	**3**
MACEDONIAN	0	0	2	0	0	0	0	0	1	0	0	0	**3**
KUNAMA	0	0	0	0	0	0	2	0	0	0	0	0	**2**
MALAY	0	0	0	0	0	0	1	0	1	0	0	0	**2**
MANDINGO	0	0	1	0	0	0	0	1	0	0	0	0	**2**
MARATHI	0	0	0	0	0	1	0	1	0	0	0	0	**2**
Nigerian Pidgin	1	0	0	0	0	0	0	0	1	0	0	0	**2**
ROHINGYA	0	0	1	0	0	0	0	0	0	0	1	0	**2**
TAIWANESE	0	0	0	0	0	0	0	0	0	0	0	2	**2**
ASSYRIAN	0	0	0	0	0	0	0	0	0	0	1	0	**1**

AZERBAIJANI	0	0	0	0	1	0	0	0	0	0	0	0	**1**
BRAVANESE	0	0	0	0	1	0	0	0	0	0	0	0	**1**
CHUUKESE	0	0	0	0	0	0	0	0	0	0	0	1	**1**
DANISH	0	0	0	0	0	1	0	0	0	0	0	0	**1**
FRENCH CANADIAN	0	0	0	0	0	0	0	0	0	1	0	0	**1**
GHEG	0	0	0	0	0	0	0	0	1	0	0	0	**1**
HAUSA	0	0	1	0	0	0	0	0	0	0	0	0	**1**
ILOCANO	0	0	0	0	0	0	0	0	1	0	0	0	**1**
SONINKE	0	0	0	0	0	0	0	1	0	0	0	0	**1**
SWEDISH	0	0	1	0	0	0	0	0	0	0	0	0	**1**
TOISHANESE	0	0	0	0	0	1	0	0	0	0	0	0	**1**
TONGAN	1	0	0	0	0	0	0	0	0	0	0	0	**1**
TURKMEN	0	0	0	0	0	0	0	1	0	0	0	0	**1**
TOTALS	**1893**	**2013**	**2170**	**2257**	**2704**	**2665**	**2533**	**2633**	**2566**	**2822**	**2752**	**2793**	**2981**

APPENDIX ONE – PROTECTED CATEGORIES

AGE

Where this is referred to, it refers to a person belonging to a particular age (e.g. 32-year-olds) or range of ages (e.g. 18 - 30 year olds).

DISABILITY

A person has a disability if s/he has a physical or mental impairment that has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

GENDER AND REASSIGNMENT

The process of transitioning from one gender to another.

MARRIAGE AND CIVIL PARTNERSHIP

In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple. Same-sex couples can alternatively have their relationships legally recognised as 'civil partnerships'. Civil partners should not be treated less favourably than married couples (except where permitted by the Equality Act 2010).

PREGNANCY AND MATERNITY

Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

RACE

Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship), and ethnic or national origins.

RELIGION AND BELIEF

Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

SEXUAL ORIENTATION

Whether a person's sexual attraction is towards his or her own sex, the opposite sex or to both sexes.

APPENDIX TWO – THE PATIENTS' FORUM LEAFLET

HOW IT WORKS

We hold monthly meetings that are open to Forum Members and to the public. These are usually held in the LAS Conference Room at 220 Waterloo Road, SE1 8SD, a few minutes from Waterloo Station. YOU ARE WELCOME TO ATTEND.

We invite service users and other influential speakers to discuss a wide range of issues connected to urgent and emergency care. They address the Forum and deal with questions and recommendations for service improvements. Each month we also meet with the Commissioner for the LAS who represents all London Clinical Commissioning Groups 9CCGs) to discuss ideas for service development.

We promote equality, inclusion and diversity in the LAS.

PATIENT EXPERIENCES DEPARTMENT
Tel: 0203 069 0240
ped@londonambulance.nhs.uk

CARE QUALITY COMMISSION
Tel: 0300 61 61 61
enquiries@cqc.org.uk

NHS ENGLAND
Tel: 0300 311 22 33

HEALTHWATCH ENGLAND
Tel: 03000 683 000

WHAT IS THE FORUM?

The Forum is an independent watchdog monitoring the London Ambulance Service (LAS). We advocate for patients by keeping a watch on emergency and urgent care in London, and we campaign for more effective services.

Patients, carers, community organisations and Healthwatch, can join the Forum and contribute to our work to achieve safer and more effective services.

Our Executive Committee regularly meets with senior LAS staff and the LAS Commissioners, to raise issues and to make proposals for better and more effective care.

We meet with health groups, e.g. mental health and sickle cell, to ensure that their experiences influence LAS services.

Most LAS services are excellent - our role is to promote public involvement and ensure that all patients receive care of the highest quality.

JOIN THE PATIENTS' FORUM
Receive monthly invitations to Forum meetings, and information about developments in urgent and emergency care.

Email or telephone your details to:
patientsforumlas@aol.com
0208 809 6551 or 07817 505193
www.patientsforumlas.net

JOIN the PATIENTS' FORUM for the LONDON AMBULANCE SERVICE

Tell us about your experience of Emergency and Urgent Care

OUR ACHIEVEMENTS ...

The Forum has worked with the LAS and the Commissioners to improve care and practice in many areas, including:

* Prioritising training, care and treatment for patients with a mental health crisis and dementia care.
* Improving end-of-life care and transport for people who are terminally ill.
* Promoting the development of 'falls teams' for people who have fallen, but do not need hospital care.
* Developing joint work between the LAS and local services, to improve access to local care services.
* Encouraging a greater focus on the outcome of complaints and serious incident reports, as a means of improving services.
* Supporting and implementing Duty of Candour when optimal care has not been provided.
* Promoting equality, inclusion and diversity in the LAS.

FORUM'S EXECUTIVE COMMITTEE 2015/2016

Malcolm Alexander - Chair
Sister Josephine Udie - Vice Chair
Angela Cross-Durrant - Vice Chair
Lynn Strother
Kathy West
John Larkin - Company Secretary
Joseph Healy - President of the Forum

THE FORUM'S PRIORITIES FOR THE LAS

Emergency Care within 8 Minutes - Targets for emergency care are not being met for some patients. The LAS must be given sufficient resources to provide emergency care within 8 minutes - immediate care saves lives and substantially reduces disability.

Urgent, but not an Emergency (Category C) - LAS responses to Cat C calls are often poor. Patients who are very ill, but not life-threatened, sometimes wait hours for treatment, instead of 20 minutes. The LAS must have resources to meet Cat C targets (20 minutes for 90% of calls).

Home Care - Not Hospital Care - The LAS should develop agreements with local health and social care services in EVERY London Borough, so that immediate, effective and safe support and care is provided to patients who are frail and vulnerable, but need home care and not hospital care.

Dementia Care - Training in Dementia Care must continue to improve and to become more comprehensive - e.g: with pain control. We have recommended the film 'Barbara's Story about Dementia Care' is seen by every member of the LAS staff.

- See Barbara's Story on YouTube at **http://www.youtube.com/watch?v=DtA2sMAjU_Y**

FAST Test for Strokes - Refresher training is needed by all front-line staff to ensure that they are fully competent to identify strokes using the FAST test, and to rapidly transport patients to Stroke Units.

FAST ... ... FACE - **A**RMS - **S**PEECH - **T**IME to call 999

Mental Health Care - People with severe mental health problems who become ill on the street - or at home - and require emergency care, should be treated immediately by Paramedics and Nurses with specialist training in mental health care.

Ambulance Queueing Must be Stopped - Ambulance queueing outside A&E Departments is completely unacceptable and must be stopped. It results in very sick people waiting an hour or more for A&E care, and prevents Paramedics from treating other seriously ill patients.