PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

VISION FOR THE FUTURE OF EMERGENCY MEDICINE

Report on Patients' Forum Public Meeting

Monday, 13 November 2023

DR. FIONNA MOORE

Dr. Moore's experience of ambulance service development over the time she has worked for the London Ambulance Service and South East Coast Ambulance Service.

Hosted by Healthwatch Hackney

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PATIENTS' FORUM FOR THE LONDON AMBULANCE SERVICE

The Patients' Forum has monitored the LAS and other urgent and emergency care services across London for 20 years.

Its members are patients and local people who examine services both as users and active lay people. It obtains the information it needs to monitor health services from many sources including, service users, the LAS, the Commissioners and NHS service providers across London.

The Forum raises awareness of the needs and views of patients and the public and attempts to place them at the centre of health service decision-making.

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VERY SPECIAL THANKS TO:

- **Dr Fionna Moore our outstanding speaker**
- **Kanariya Yuseinova, Healthwatch Hackney for hosting the meeting.**
- **Alan Alexander, for managing the meeting.**
- **Malcolm Alexander for Chairing and organising the meeting.**
- **Polly Healy, for her very hard work in converting lengthy tape into this report.**

Permission was given by those who attended to record the whole meeting.

DR. FIONNA MOORE
MBE, QAM, FRCS, FRCSEd, FRCEM, FIMA

Dr. Moore has more than 40 years' experience of emergency medicine in the NHS. She was, until recently, Medical Director of the Southeast Coast Ambulance Service (SECAmb), and prior to that role, the Chief Executive and Medical Director of the London Ambulance Service. Fionna has a wealth of experience in emergency medicine, including her role as an A&E Consultant for 30 years, most recently at Charing Cross Hospital. The Forum worked closely with Dr. Moore during her time at the LAS, and she showed a great commitment to patient and public involvement and creating enhanced services through co-production with the Patients' Forum and other user groups.

INTRODUCTION

The purpose of the meeting was to hear about Dr Moore's experience of ambulance service development over the time she has worked for the LAS and SECAmb, and to learn about her vision for the future.

We have seen so many valuable and creative developments in ambulance services in their interaction with patients, and acute and community medicine over recent years, but we still suffer appalling queues outside some A&Es.

This situation is deeply frustrating for patients and staff, but we don't see tangible solutions at times of greatest demand. Is it about funding, or the failure of the different components of the NHS and social care system to link up and respond quickly and appropriately to demand and need?

Sometimes 111 is brilliant and at the heart of meeting need, and other times it seems disconnected, and patients can wait a long time for a response and feel quite confused about the relationship between 111 and ASs.

It seems that co-ordinating patient care between different services and systems, despite all the great advances is still sometimes dysfunctional. There are so many pathways to creating consistently good, effective and responsive urgent and emergency care, but it sometimes seems difficult to provide effective emergency care because those pathways are sometimes overwhelmed or short of staff. Dr Moore shares her ideas and aspirations for the future development of Emergency Medicine

CONTENT

WELCOME TO FIONNA MOORE FROM THE PATIENTS' FORUM

Malcolm Alexander welcomed Fionna Moore to the meeting recalled that, over many years, the Forum worked with Fionna on many issues in the London Ambulance Service. The Forum has always thought Fionna to be outstanding in the work that she has done for the London Ambulance Service and for local communities.

FIONNA MOORE

Disclosures and Conflicts of Interest

Fionna thanked the Forum for being invited to the Meeting. She mentioned that the presentation covers entirely her own opinions.

The views expressed are from her experience with the London Ambulance Service (LAS), South East Ambulance Service (SECAmb), other emergency medicine services and now with the Air Ambulance Charity Kent Surrey and Sussex (KSS).

What I have Learned

I shall talk about how I became involved with the Ambulance Services, and some of the fantastic opportunities given to me … some of the really memorable bits and then some of the issues that we have as a health service and as an ambulance community.

My Background

I am a Consultant in Emergency Medicine. I always wanted to be a doctor – with the brief flirtation with flying fast jets! I qualified from University College Hospital in London, in 1974.

My initial career choice was Paediatrics, but decided that surgery would be my initial career, particularly focusing on plastic surgery. I moved to Emergency Medicine in 1982 and became a Consultant at University College Hospital (UCH) and Middlesex Hospital in central London in 1985. Shortly after starting that job, they closed the Emergency Department at the Middlesex Hospital and consolidated the service with UCH. After nine years, I moved to Oxford before returning to London in 1996 and I hold an Honorary Contract at Imperial College Healthcare Trust, which runs Charing Cross Hospital.

Fionna's Major Roles in Emergency Ambulance Services

- Chair, London A&E Consultants Group from 1985
- Chair, Paramedic Steering Committee from 1987
- London Ambulance Service Medical Director 1997 – 2015
- LAS CEO 2015 – 2017
- Medical Director, South East Coast Ambulance Service – 2017 – 2023
- Interim CEO, South East Coast Ambulance Service - April – September 2019
- Currently Senior Medical Advisor, Air Ambulance Charity Kent Surrey and Sussex

SIGNFICANT SERVICE DEVELOPMENTS

Gay Pride

Fionna highlighted Gay Pride events within the London and the South East Coast in support of colleagues and residents from the LGPTQ+ communities. However, services have not managed to give the same consideration to colleagues from ethnic minority backgrounds – although, the LAS has been much more successful in recruiting staff and increasing the diversity of the workforce. Fionna said that the South East Coast Ambulance Service does not yet reflect the diversity of the population it serves.

The LAS also ran successful campaigns around public safety, e.g. to decrease the risk of harm to people who went out drinking during the Christmas and New Year party season.

Defibrillators

Another success was the 'Shockingly Easy' Defibrillator Scheme in London – encouraging gyms and leisure centres to purchase a defibrillator and registering it with the LAS in order to reduce the risk of death when a person suffers a cardiac arrest.

Fast Response Cars

London Masons donated 4 Fast Response cars to the LAS for use by Emergency Responders trained by LAS to support patients suffering medical emergencies.

Career Developments

The Advanced Paramedic Practitioner profession in the LAS now includes both Critical Care and Urgent Care Advanced Paramedic Practitioners. This is taking the career development of Paramedics up to a much higher level.

Consultant Midwives

Consultant midwives are critical strategic leaders working within the urgent and emergency environment in ambulance service NHS Trusts. The role function enables both 999 call-handlers and those clinicians attending patients, to be equipped with responsive emergency maternity training and in particular, enables life-saving clinical manoeuvres to be undertaken by advanced Paramedic practitioners - vital in saving the lives of mothers and their newborns.

The leadership role enables learning from research evidence, particularly in relation to the high mortality and morbidity experienced by black and brown women and their babies and the action needed to stop excess mortality.

The LAS was the first UK Ambulance Trust to employ a consultant midwife to lead significant developments in both call-taking and the skills of front-line staff in providing high quality emergency maternity care. The role of Consultant Midwife initiated by the LAS, has now been adopted by at least four other Ambulance Services. This role should be adopted by all ambulance Trusts.

Life Support at Football Matches and other Events

Fabrice Muamba suffered a cardiac arrest on the football pitch at Tottenham Hotspur's White Hart Lane Stadium. He was defibrillated numerous times and then taken to Barts Hospital Cardiac Centre. He is now campaigning for the routine screening of footballers to see if they are vulnerable to cardiac arrest and getting that message out to the field of play Doctors, Paramedics and Football Club staff.

2012 Olympics and London Underground Bombing Incident

On 06 July 2005, an announcement was made that London was going to host the 2012 Olympic Games. The following day 3 bombs exploded in the London Underground and one on a bus near Tavistock Square. When the bombs exploded there were over 500 trains on the underground system, with over 200,000 passengers and around 2,500 staff on duty at Stations. All live casualties were evacuated within one hour. Ambulance

and other Emergency Services were highly commended for the effectiveness of their response.

The Inquest following the London Underground Bombing Incident

There was a period of about six years before the Inquests were undertaken. This was extremely tough, not only for family members of the 52 people who died, but also for all the staff who had gone through such a traumatic time during the rescue attempts - and then having to re-live it all at the Inquest.

The way in which patients are triaged today, in the event of a major incident, has been developed from this major incident. One individual undertakes triage, whilst others undertake life-saving interventions which may save lives.

Introduction of New Computer Aided Dispatch System

The introduction of CAD 2020 (Command Point) – Computer Aided Dispatch, a system for the collection and analysis of ambulance data - was delayed and became CAD 2011. The system collapsed within hours due to overcomplicated demands on an 'off the shelf' product. However, the system was 'up and running' six weeks before the Olympics. The LAS has now moved to more reliable software and a hardware system called CLERIC, which is in use within 3 other Ambulance Services, including SECAmb.

The 2012 Olympics

The LAS set up the Olympic Deployment Centre – converting a huge warehouse in East London into a very sophisticated dispatch point, where staff would come in, pick up their kit, get fed, pick up their vehicles, drive off and manage urgent and emergency care at the Olympics. The LAS ensured all staff, including those staff from other English ambulance services were fully trained through training courses held at the University of Greenwich in preparation for the Olympics.

Realising the Olympics Legacy

It was hoped the Olympics would encourage the children of London to undertake more activities and that did happen within the first year. However, it seems that this has not been sustained and because of Covid, the ability and the opportunities for young people to undertake physical activity has declined dramatically.

Many of the Olympic venues still exist and the Olympics helped to regenerate under-developed areas in East London.

The London Trauma System 2012

Setting up the London Trauma System followed on from the work undertaken by Healthcare for London. In 2009, we set up a system initially involving three major Trauma Centres at The Royal London, King's College Hospital and St. George's Hospital and, at a later stage, St. Mary's Hospital. All the Hospitals had to undertake a very detailed Accreditation procedure.

The development of this system has resulted in a significant increase in survival rates from major trauma both in London and in the rest of the country. There are now four major Trauma Networks in South East of England based at the four London Major Trauma Centres.

I now Chair the South West London and Surrey Major Trauma Centre network and, starting on November 14th, 2023, there will be a review of trauma units in our area, to make sure they continue to perform to the standards that have been set. One of the areas that we assess is the training that the staff in trauma units and in the major trauma centres, are able to undertake.

Difficult Days – Strikes in 2014/2015

Concerns were about how does one run a 999 service without staff?

- 80% of front-line staff either did not attend or worked to rule.
- All but 20% of Control Room staff continued to work.

The ambulance services have had help from the military with a number of ambulances parked outside Wellington Barracks.

There were 'squaddies' driving ambulances who were not allowed to use the 'blue light' function, but they worked along with and those Paramedics who were working with the LAS, to provide a fairly basic service during this difficult period.

The NHS is 75 Years Old

The NHS is:

- The envy of the world.
- Free at the point of delivery.

- Employer of 1.5 million staff – more than any other organisation in the UK.
- Responsible for Eradicating Polio and Diphtheria.
- Pioneered many new treatments, e.g. heart and liver transplants, and mechanical thrombectomy for stroke).
- Great track record in research and innovation.

However:

- The NHS is overspent by almost £6 billion during 2022-2023.
- Has a shortage of Nurses – at 33%.
- The number of potential recruits to nursing is falling.
- Number of student and qualified midwives is below the required numbers.
- Number of Doctors applying to enter General Practice is falling.
- Difficulty for patients, particularly the elderly, seeing a GP face-to-face – even though the evidence suggests that General Practice is seeing more patients than ever before.
- Significant issues around pensions and contributions.
- National shortage of Paramedics – around 4,000.

And …

- We have disillusioned and disaffected staff.
- 25% report bullying and harassment.
- Ambulance staff went on strike over pay and conditions (2014, 2022).
- Junior Doctors went on strike over their Contract (2016) and have recently been on strike again. They have been joined by consultant Doctors.
- A&E 4-hour performance worst since records began (<80%).
- Waiting lists for elective surgery, diagnostic tests and outpatients running at over 8 million.

The Impact of Covid 19

We are still recovering from Covid and the impact that Covid has had, in particular, on:

- The vulnerable.
- Children and young people.
- Health services
- The race for vaccines.

One thing not optimised is the use of volunteers. During Covid, we worked with an enormous number of people who were prepared to volunteer to help the NHS – one individual on every street in the country!

We need to develop our recruitment of volunteers to help individuals in the community who are vulnerable, or elderly – and who need social support and company.

Vision for Ambulance Service – 2020 and Beyond (AACE Strategy 2015)

Ways in which ambulance services should develop.

- Becoming mobile healthcare providers with a multitude of roles, including: Navigation - Co-ordination – Diagnostics – Treatment – Transport
- Extended range of settings within which care is offered and range of services available.
- New model of care enabled by technological development and increasing use of tele-healthcare.
- Variation across Trusts in the extent and specific nature of Urgent Care activity, depending upon local circumstances, but underpinned by shared values and commitment to the mobile healthcare provider vision.
- Increasing role in health promotion.
- Increased number of Advanced Paramedics working alongside Paramedics in fully integrated multi-disciplinary Urgent Care Teams.
- Ambulance services playing a key role in system leadership and effectively working with all parts of the NHS in the achievement of its strategy for the future.
- Ambulances as technical hubs facilitating the delivery of diagnostic services and treatment.

Current Challenges for Ambulance Services

- Call Handling – October 2023
    - Target telephone pick-up time is within 5 seconds.
    - Currently the national mean is 9 seconds.
    - LAS is 9 seconds (90th centile is 20 seconds).
    - SECAmb is **22 seconds** (90th centile 83).

- Response Times – October 2023
    - Category 1 - national mean 8 minutes (target 7).
    - Category 2 - national mean 41.40 minutes (target 18).
    - Category 2 - 90th centile 90 minutes (target 40).
    - Category 3 - mean 2 hours 31 minutes.
    - Category 3 - 90th centile 6 hours 6 minutes (target 2 hours).

For Category 3, the mean time to get to these patients is 2.5 hours. The 90th centile - the target used to be 2 hours, but performance is currently 6 hours. Many of those are elderly patients, often laying on the floor, so these are people who require an urgent

response, because if there is somebody on the floor, you can do all the telephone triage you like, but ambulance services are still going to have to attend to that patient … and what strategies are we able to employ to do that? Patients laying on the floor are also vulnerable to addition harm.

I have not put the Category 4 targets up, because the numbers are so small.

As a result of those figures, we have seen some fairly high-profile stuff in the media – for instance, ambulances stacked outside UCH which resulted in a 90-minute delay in attending a patient with a heart attack – and the **House of Lords Report** on Emergency Services was highly critical of ambulance response times. Ambulance services are 'right in the eye' of the public, at the moment.

NHS 111

- Introduced 2013 to replace NHS Direct.
- Currently handles over 22,700 million calls per annum.
- Algorithm based (NHS Pathways). Average call taking time is 340 seconds.
- Allows calls to be redirected to the most appropriate service.
- 12.6% directed to ambulance Category 2 … 8.6% to ambulance Category 3.
- Criticised by ambulance staff – but conveyance rates equivalent to 999 calls.
- Allows flexibility and response to health emergencies.
- Used as a default service by primary care. 111 was set up as an 'out of hours' service, not to provide this default service.

What Have We Learned?

- The need to address **cultural change.**
- Better incident reporting – demonstrates a more blame-free culture.
- Clear strategy and direction of travel.
- Medicine Management – keeping drugs safe and secure, e.g.
    - Staying within the legal guidelines.
    - Management of Controlled drugs.
    - Temperature control of medication storage.
    - Medical gases and the possibilities of abuse.
- Security of vehicles and premises – particularly as an ambulance can go anywhere without being questioned of challenged.

Next is Now?

This is about the people:

- How do we recruit and retain the best staff?
- How do we educate them for 80% of the work?
- How do we protect them from the stress of 20%?
- How do we maximise professionalism?

It is also about maximising the benefits of technology.

The Future: Control Rooms, Integrated Clinical Hubs, Developing the Paramedic Profession

- Maximise the benefits of technology, video streaming and AI in Control Rooms.
- Establish staff rotations through Primary Care, Emergency Departments, Minor Injuries Units and Integrated Clinical Hubs.
- Multi-disciplinary service; let's welcome Nurses, Pharmacists and Midwives.
- Ensure continuing development of the Paramedic profession.
- Appoint Clinical Directors to support Medical and Nursing colleagues.

Celebrate Success and Highlight Good Practice

It is so easy to be really negative about all things that do not go according to plan. It is important that we celebrate success.

We have a cohort of 70 Critical Care Paramedics in South East Coast Ambulance Service – covering three Counties, and their impact on the care of critical and seriously ill patients has been massive.

We have two new Control Rooms in SECAmb, and the LAS has refreshed the Waterloo Control Room and also opened a new one in Newham. SECAmb opened a new Control Room in Gatwick to replace the very outdated portacabins in Banstead.

SECAmb have also developed Urgent Care Paramedics to look after patients who have multiple co-mobilities and who work with primary care in managing these patients.

Potentially, developing 'Virtual Wards' for these patients, although I am concerned that the benefit of 'Virtual Wards' may be overstated, because patients on wards do need somebody to assist them in some of the activities that they will have to undertake at home. Just being allocated to a Virtual Ward does not necessarily mean that you do not

need somebody to come and support the carers in the day-to-day clinical activities that that patient may require.

SECAmb piloted ‘Make Ready Centres’ which allow vehicles to be restocked internally, externally and also cleaned internally and externally – including deep cleans. This has improved infection prevention and control within the ambulance service.

… And Now?

I no longer work for a statutory Ambulance Service, but for Air Ambulance in Kent, Surrey and Sussex (KSS). The Service attends nine calls a day to the most seriously ill and injured patients in 3 counties. There are more calls to seriously ill and injured patients in Kent than there are in Surrey and Sussex together, and this may reflect the increased ‘rurality’ in Kent.

If you are looking to support a charity – along with the London’s Air Ambulance – the Air Ambulance in Kent Surrey and Sussex is a very worthwhile charity and one where I believe we work really hard to save lives and improve the quality of lives of the patients we see.

QUESTIONS and ANSWERS

Mike Roberts – Budget Review of SECamb

I am resident in the SECAmb area. The concern I have is that we are coming up to the SECamb Budget Review. Are you looking for maintenance in real terms, or in money terms, regarding outcomes from that Review at this stage in the process?

Fionna Moore

The answer is that I am not sure. In addition to Call Handling, I have given response times that show the response to C1 calls has been pretty well maintained, but what really worries me is that the C2 national mean was at a target of 18 minutes, but currently, the national mean is 41 minutes 40 seconds. That is well outside the 18-minute target.

The chance of getting back to 18 minutes is pretty remote. I am particularly worried about Call Handling because of potential harm caused by not being able to pick up calls (particularly during a strike period). Effective call handling is absolutely crucial. Moving the C2 target to 30 minutes (strokes, heart attacks, and other conditions requiring an emergency response) is very concerning.

There is a lot of work going on to segment the C2 group of calls and that will have a major impact – the 'bucket' of C2s is very large and it may be possible to identify those calls where an 18 minute or less response is critically important. Equally, at the lower end of the acuity profile, some calls could be managed by telephone triage and possibly redirecting to another provider. We are currently really failing on the C2 targets, hence the importance of a successful budget review.

Cynthia White – Interaction between patients and ambulance crew

Thanks for your fascinating and stimulating history – and all the contributions that have brought us to where we are today. It is immensely encouraging.

I'd like to focus on a number of areas, drawing from my husband's and my own experiences of ambulance services:

1. **Do ambulance crew rely heavily on satnavs?** When my husband collapsed half a mile from the Royal London Hospital, the ambulance that was called came from

south London and the crew had no idea where they were and drove up a cul-de-sac, where we got stuck, delaying our arrival at A&E.

Last week, we were trying to get to St. Wilfrid's Hospice – not as an emergency, but urgently – the satnav was being used by my family, and we were being taken round the houses and hugely delayed.

2. **The protection and care of LAS staff.** I was horrified on one occasion that the ambulance crew had not had a meal for 12 hours. I personally went and got them sandwiches – they just shrugged and said that they 'were used to it'.

3. **How do we prepare patients for the arrival of the LAS when they're providing urgent and emergency care?** Should we still put our list of drugs in plastic tubes on the front door so that the ambulance crew can find out what medications we are on, or is that 'ancient history? How do we prepare patients and carers to be helpful to ambulance crew?

4. **Patients in inaccessible locations**. I know a dementia patient of 90 years of age, who has been stuck on the 12th Floor of a block of flats in London, with the only two available lifts being 'out of service'. How will the patient get down to the ambulance crew, or the crew get up to him?

Fionna Moore

1. There is a satnav in all ambulances and ambulance cars. It does not always work well. That is partly because the gazetteer is not always kept up-to-date. It is also because, sometimes, postcode doesn't accurately reflect the actual location.

   Ambulance staff often get asked if you can use the 'What Three Words' App. This App is worth downloading to your mobile phone because it locates you to within three feet of where you are. However, if you don't get the words absolutely correct - including full-stops and capital letters, you might mistakenly get a location in Afghanistan!

   Satnavs are important, in spite of their shortcomings. If a crew cannot find a location, they contact the ambulance Control Centre, and they check with the patient as to whether they have the correct address and if there are any particular issues like a 'one way street' or bollards.

2. In terms of care of LAS staff, it is shocking that some staff do not always get a meal-break. SECAmb has a little fridge at the front of their ambulances for chilled food – and all staff are issued with a 'meal box'. They are expected to bring their own food to work.

   One thing that ambulance staff do is to manage their time so that generally they do take a meal break. They do have a 'turn-around target' but you can generally find one job where you get a bit of extra time if you have off-loaded a patient quite quickly. Almost every hospital that crews go to has a Costa Coffee Cafe or a machine where you can get some food. I have never done a shift when I have not managed to get something to eat, at some point.

3. In terms of information, patients are asked to get their drugs out for the ambulance crew, and they are asked to put any dogs away and to look out for the ambulance's arrival. It is amazing how many people live in premises where one cannot see a door number on the building – or a light has not been put on at night. Basically, a bit of common-sense is critical. If you have called an ambulance, then: **'put the light on, open the front door, put your dogs away and get your drugs out'.**

4. Concerning access. I sometimes wonder if the people who build blocks of flats ever put an ambulance trolley in the lifts to make sure that they fit in. If you are 12 floors up, the only way that an immobile patient is going to get down, if the lifts are not working, is for the ambulance crew to carry them down. That is absolutely backbreaking. Everybody in the ambulance service accepts that they are going to have to do some lifting and shifting, but they do try to avoid breaking their backs.

   The most common reason for ambulance staff to take early retirement, is muscular skeletal injuries – and many of them are back and shoulder injuries relating to the lifting that they do, because lifting in the ambulance service often means that you are going to be doing an awkward lift, twisting or bending – all of which are much more difficult to do in a controlled environment.

Dr Nick Mann – Diagnosis of Stroke and Heart Attack

The over-promise of AI is vast, as is reliance upon algorithms. We are such a long way from effective AI – we cannot even run a decent postal service on AI, let alone a medical service! I am very wary about how reliant we should be, when we should be relying on the knowledge and skills of well-trained clinicians.

I have had – in the last 3 weeks – two Heart Attacks and a Stroke. At no point, unfortunately, was I able to get an ambulance. For the 2 Heart Attacks I decided that as Category 2s were probably quicker to go by car – and so I chose to take the car to hospital A&Es on both occasions.

With the Stroke, the algorithm is based on whether I could raise my arm, whether I could raise my leg, and how I could move at my face and articulate a named phrase. Unfortunately, I was refused an ambulance and was told to contact 111, because the algorithm simply did not recognise that I was having a Stroke.

I am a doctor of 30 years, and I know that the most basically trained clinical staff working in 999 emergency care, would be able to recognise a Stroke, without question. I fear that we are losing the plot here with the algorithms that we are currently working to – we are failing to deal with the basics – ensuring patients see an appropriately trained clinician, if they are having a possible stroke.

Fionna Moore

I am sorry that you have had such a negative experience. In terms of taking yourself to Hospital, this is really contentious because, if you had telephoned 999 and asked if you should take yourself to hospital, they would almost certainly have said 'no'.

There have been occasions when we have been holding over 200 calls in a stack, and if somebody has got a car and they are within reasonable reach of a hospital, they ought to get themselves there – if their diagnosis is consistent with that decision.

It is clearly a risk because, if you go by car there is a chance that you could collapse en route, and the person who is driving you would be in a very difficult position.

Equally, if you have a presumptive diagnosis of 'stroke' and the ambulance is not going to get to you for 90 minutes, and on the basis that 'time is brain cells', then the quicker you get to hospital the better. It is a risk benefit decision.

I take your point about AI, but I think that the evidence from Denmark suggests that it does have some use in Control Centres. We know that voice recognition for certain key phrases and key words has been quite useful in diagnostic work. Clearly, there is much more work to do. For possible stroke, the algorithm looks for a positive FAST test, but it will not pick up Posterior Circulation Stokes.

We have done some quite interesting work in SECAmb with FAST- positive patients, where the ambulance crew using their iPad to enable 'face-time' between patients and the Stroke Nurse or Stroke Doctor at the local Stroke Centre – who then has a conversation with the patient to establish a diagnosis.

Face-Time: Direct personal interaction or contact between two or more people at the same time and physical location using a mobile or iPad device.

Of the patients that we assessed through that means:

- 55% of patients were transported to a Stoke Centre.
- 35% of patients were transported to their local Emergency Department because they were having a Stroke 'mimic'.
- 15% of patients were referred to a TIA Clinic.

but that can only work once you are communicating well with the patient. Video streaming does add the potential for real benefit so that, in the Control Room, the Clinician rings the patient back and gets them to open up their mobile phone.

People who do not use mobile phones will be disadvantaged, but if you open up your mobile phone then the clinician in the Control Room can see how you are behaving, potentially count your pulse rate and see what your facial colour is like. This is much more valuable information than you would get from someone following an algorithm. Going forward, we have been looking at getting Emergency Physicians to work with Paramedics in the Control Room to identify those patients who could better be streamed to or redirected to an alternative response or location, rather than waiting for an ambulance.

Logie – Ethnic Diversity in Ambulance Services

1. Why are BAME people not becoming Paramedics?
2. What is the difference between a qualified Paramedic and a Physician Associate?

Fionna Moore

1. In terms of why we do not attract more people from a BAME background, I think that is more around 'role models' and going into schools at the stage when students are looking to choose their 'A' Levels. If we did that, we would have the opportunity to influence students to train to be Paramedics. They would need at least one Science 'A' Level. We need to encourage people – aged 15 or 16 – to consider joining an ambulance service, or going to university to study Paramedic science. Getting to students when they are at the age of 18 is too late, they have already made their 'A' Level choices, which may not be the correct ones to pursue a university career to be a Paramedic.

In SECAmb, we have really powerful 'role models' from a BAME background. However, if you are in an environment where you do not have appropriate 'role models, it is not something that is likely to be an attractive career choice.

2. Physician Associates mostly work in Primary Care and Secondary Care. They have not been used in ambulance services. It is a different training programme. A lot of a Paramedic's training is 'on the job'. Physician Associates work alongside Doctors often in primary care and it is sometimes unclear to patients whether they are seeing a doctor or whether they are seeing a Physician Associate.

   Because Paramedics wear a uniform, and because they have their designation on the uniform, it is much clearer to patients who they are dealing with. Patients do tend to consider anybody wearing a green uniform to be a Paramedic and, of course, we have individuals who are qualified, but not 'registered'. Paramedics are registered professionals, whereas technicians and 'associate ambulance practitioners' are qualified technicians, but not 'registered' clinicians.

Gay Lee – 111 Service

To what extent do 111 services employ skilled clinicians and how far do they rely upon algorithms? Obviously 111 services are very important in making clinical decisions, alongside the Control Centres of ambulance services.

Fionna Moore

The 111 call-handlers are not clinicians. They follow an algorithm, and they are audited on a regular basis against compliance with the algorithm. They can pass the call to a clinician and that clinician is generally a nurse – or could be a Paramedic or pharmacist. There is software support for clinicians, but they can go 'off-piste' and use their own clinical skills and clinical knowledge.

Malcolm Alexander – Ambulance Response Categories

Regarding Category 2 calls, when the new category system was introduced, we were expecting a much more effective response to patients in relation to defined Categories – C1, C2, C3, C4.

It does seem devastating that the 'waits' for Category 2 ambulance responses – especially for people who have had strokes – have been so long. What do you think can be done to address that situation?

Fionna Moore

This is multi-factorial. Firstly, there are the delays in releasing crews at hospitals and, although that has improved, it is still a significant drain on the resources of an ambulance service. I am not sure what the position is in London, but SECAmb lose between 130-160 hours a day through delayed hand-overs.

Across the country, there are certain hospitals that have been complete 'outliers', University Hospital, Birmingham being the worst, but the Royal Cornwall Hospital in Treliske has days when an ambulance crew will start their shift taking over from a crew queuing outside A&E, and will stay with patient for the entirety of their shift. That means the ambulance will be unavailable for another call for the entire 12 hours of the crew's shift. The Princess Alexandra Hospital in Portsmouth is another really difficult one.

There are a couple of Hospitals that are not great in South East Coast, but by and large, the delays are minimal compared to some of the others. Hospital handover delays are often not the fault of the Emergency Department, it is about the flow within the Hospital and getting the patients out the other end.

Ambulance services have a high level of sickness, particularly around mental health. If you look at the sickness levels in an acute trust, it tends to run at 4% - 5%. Ambulance services tend to run at 10% -11%. Much of that is mental health related and the mental health issues are generally around stress.

Ambulance services are finding it increasingly difficult to retain Paramedics. We are even finding that students studying Paramedic science at university, sometimes go straight into primary care at the end of their degree rather than doing their NQP training with an ambulance service. I think that is really short-sighted.

At the higher end of the Paramedic career gradient, we are seeing a lot of Urgent Care Paramedics moving into GP practices. The attraction is working from 9.00am–5.00pm, in a warm and dry environment, rather than full shifts in inclement weather. Some of them do not realise that they will have challenging targets to meet in primary care. On an ambulance shift, one is – to some extent – the master of one's own destiny, in that providing care and treatment to patients takes as long as it takes.

I have had really interesting discussions with crews about 'if you provided a 'bronze or silver service' to your patients, rather than a 'platinum plus service', you would actually see more patients in a shift'. The response I generally get is that "you will be taking away the satisfaction of my job. I do my job to give the absolute best service to every patient." That is fine, but actually you have a responsibility to all the patients being held in a queue in the ambulance service Control Centre – not just to making sure that you give a 'platinum service' – fantastic though that may be.

For individuals working in primary care and visiting patients in their homes, they will not be able to dictate how much time they can spend with each patient. They will have a list of patients that they will be required to get through within that practice's allocated time slots. I think that they will find that quite an 'eye-opener', compared to the practice of emergency medicine.

Malcolm Alexander

On the subject of recruitment of Paramedics in schools and colleges – do you think that a significant additional resource is needed to be able to develop that level of communication with a far greater number of schools and colleges? There are also a lot of faith organisations with large numbers of people attending services, which might provide a good opportunity for recruitment.

It seems to me that the focus is often on recruitment meetings, rather than going out to different types of organisations. Clearly that would require additional resources, but would that be a solution to recruitment?

Fionna Moore

Potentially, I think that it would, but I am not sure that Commissioners would be prepared to pay for it. I think that you are right, and you could use staff on 'light duties'.

In London it would be a huge 'ask' because there are so many schools, but even targeting specific areas, and perhaps picking up on the issue of recruitment from BAME communities and targeting those areas with a high proportion of residents of BAME heritage and recruiting there, would be beneficial.

Taking staff off the frontline to aid recruitment in schools is just not going to happen when Category 2 performance is so woefully poor.

OUR RECOMMENDATIONS AND CONCERNS

Rec 1) Calling 999 and 111

Ambulance services and 111 services should clarify for patients the connection between these two services in emergencies, e.g. patients who phone 999 may be told to phone 111 to get an ambulance, which may be sent from the 999 service that the patient originally called. This can cause confusion and distress for patients and carers.

Rec 2) Alternative Care Pathways - ACPs

A wide range of ACPs are available to ambulance crew who are looking to provide right care first time for patients, e.g. by referring a patient who has fallen to a specialist falls service rather than taking them to A&E. Staff report that the ACPs that should be available often operate for a limited number of hours or have little capacity when required. ASs and ICPs should collaborate more closely to ensure that ACPs are available when required – this would substantially reduce ambulance waits outside A&E.

Rec 3) Consultant Midwives

Consultant Midwives train and equip front line staff to assess and, in some cases, manage obstetric emergencies in the community. This development was led by the LAS and has been vital in saving the lives of mothers and their newborns and learning how to undertake advanced clinical manoeuvres.

This development should be adopted by all UK ambulance services and should also include recognition of the high mortality of black women and the babies of black women, and the action needed to stop excess mortality. It is our recommendation that all ambulance Trusts, at a minimum, employ a midwife operating in a strategic leadership role, within their clinical leadership team.

Rec 4) Defibrillators in Schools and Training of School Children – Saving Lives

The Oliver King Campaign persuaded the Government to fund the provision of Defibrillators in every UK school. Now the Department of Education should actively promote the training of all school children in CPR and for older children the use of Defibrillators.

Rec 5) Shortage of Paramedics and Paramedic Recruitment

The national shortage of Paramedics is estimated at around 4,000. Many NHS staff feel disillusioned and disaffected, and 25% have reported bullying and harassment. The Paramedic profession has been neglected in relation to assertive and proactive campaigns to raise the status, reputation and to promote recruitment to this inspiring career and profession. By failing to deal with long waits outside A&E Departments, the Government is seriously harming patients and driving Paramedics away from the profession.

We recommend that specialist teams are developed to visit schools and colleges in all parts of the UK to promote the Paramedic profession as an outstanding career opportunity.

Staff on 'light-duties' should be encouraged to participate in recruitment activities. The ICS needs to provide additional resources to facilitate active engagement with students in schools and colleges, community bodies and faith organisations that have large weekly attendances. It is also essential to focus on areas in London with the highest levels of diversity in view of ambulances services continuing difficulty in achieving much greater ethnic diversity of their frontline staff.

Rec 6) Ways in which Ambulance Services should Develop

We fully support the following developments proposed in the 2020-03 AACE Strategy and we have invited the AACE leadership to speak at a future PF meeting.

- By becoming mobile Healthcare providers with a multitude of roles, including: Navigation - Co-ordination – Diagnostics – Treatment – Transport.
- New model of care enabled by technological development and increasing use of tele-healthcare.
- Increasing role in health promotion.
- Increased number of Advanced Paramedics working alongside Paramedics in fully integrated multi-disciplinary Urgent Care Teams.
- Playing a key role in system leadership and effectively working with all parts of the NHS in the achievement of the NHS long-term strategy.
- Ambulances as technical hubs facilitating the delivery of diagnostic services and treatment.

AACE – Association of Ambulance Chief Executives

https://aace.org.uk/wp-content/uploads/2020/12/AACE-Strategy-2020-2023.pdf

Rec 7) Category 2 and 3 Performance Targets - Major Governmental Failure

Despite high levels of public and political concern, long waits for ambulances, long waits outside A&E and inside A&E continue to be common and are being normalised by the Government – e.g. by lowering performance targets.

Joint action is required between MPs, House of Lords, AACE, National Healthwatch, Trade Unions and numerous other public and community bodies, to persuade the Government to take responsibility for ensuring that all ambulance services meet national response targets for each category, thereby reducing the risk of deaths and serious harm.

Actual Response Times for Category 2 and 3 in 2023

Category 2	National Mean **41.40 minutes (target 18 minutes)**
	90th Centile, 90 minutes (target 40 minutes).
	Includes patients with **stroke, heart attack, sepsis and major burns**.
Category 3	Mean Time to get to these patients is 2.5 hours. For the 90th Centile, **the target used to be 2 hours, but performance is currently 6 hours**.
	Includes **elderly patients, often lying on the floor** in need of an urgent response because they are vulnerable to additional harm, e.g. pneumonia.

Research and Evidence Base:

- Ambulance response times – Nuffield Trust - http://tinyurl.com/3yke6885.

- Emergency Healthcare in Crisis: House of Lords, Public Services Committee - http://tinyurl.com/2p8xx4j8 Report highly critical of ambulance response times.

- NHS England – Statistical note: Ambulance Quality Indicators https://tinyurl.com/2534a8mv

Case Study - Dr Nick Mann – My Experience of Care following Stroke and Heart Attack:

"I have had – in the last 3 weeks – two Heart Attacks and a Stroke. At no point, unfortunately, was I able to get an ambulance to take me to A&E.

For the two Heart Attacks, I decided that Category 2s were probably quicker to go by car – and so I chose to take the car to hospital A&Es on both occasions.

With Stroke, the algorithm is based on how long I could raise my arm, for how long I could raise my leg, and how I could move at my face and articulate a named phrase.

Unfortunately, I was refused an ambulance and was told to contact 111, because the algorithm didn't recognise that I was having a stroke.

I am a GP of 30 years, and I know the most basically trained clinical staff working in 999 emergency care, would be able to recognise a stroke, without question.
I fear we are losing the plot here with the algorithms that we are working to, by failing to deal with the basics, e.g. ensuring patients see an appropriately trained clinician, if they are ? stroke". **See also Appendix 2**

Rec 8) Maximising the Benefits of Technology

- Video streaming and AI in Control Rooms without losing the essential role of 'face to face' clinical assessments and treatment.
- Welcoming 'Virtual Wards' to enhance discharge, but only when this genuinely meets the need of patients and recognises that patients may need clinical and care staff to assist them with activities they will need to undertake at home.
- Establish staff rotations through Primary Care, Emergency Departments, Minor Injuries Units, and Integrated Clinical Hubs to enhance staff expertise.
- Creating multi-disciplinary ambulance services – to include Nurses, Pharmacists, Doctors and Midwives to work alongside ambulance crew.
- Appointing Clinical Directors to actively support medical and nursing colleagues.

APPENDICES

APPENDIX ONE: SYSTEMIC FAILURES OF THE EMERGENCY CARE SYSTEM DESCRIBED BY DR FIONNA MOORE.

C2 Emergences – Dr Fionna Moore's Assessment

The chance of getting back to 18-minute response times is pretty remote.

I am particularly worried about Call Handling because of potential harm caused by not being able to pick up a call (particularly during a strike period).

Effective call handling is absolutely crucial. Moving the C2 target to 30 minutes (strokes, heart attacks, and other conditions requiring an emergency response) is very concerning.

There is a lot of work going on to segment the C2 group of calls and that will have an impact – the 'bucket' of C2s is very large and it may be possible to identify those calls where an 18 minute or less response is critically important.

Equally, at the lower end of the acuity profile, some calls could be managed by telephone triage and possibly redirecting to another provider.

We are currently really failing on the C2 targets, hence the importance of this work.

- There are the delays in releasing ambulance crews from hospitals because of long waits to discharge patients to A&E. Although that has improved, it is still a significant drain on the available resources of an ambulance service.
- South East Coast Ambulance Service lose between 130-160 hours a day through delayed hand-overs.
- There are outliers, hospitals where the situation is extremely serious, e.g. University Hospital, Birmingham, Queen Alexandra Hospital in Portsmouth and the Royal Cornwall Hospital, which has days when ambulance crews will start their shift taking over from a crew already queuing outside A&E and will stay with a patient in an ambulance for their entire shift. Ambulances consequently are unavailable for the entire 12 hours of the crew's shift.
- Hospital handover delays are often not the fault of the Emergency Department, but due to the flow within the hospital and getting patients appropriately discharged.

- Ambulance services have a high level of sickness amongst front line staff, particularly due to mental health problems and stress. Sickness levels in Acute Trusts, tends to run at 4%-5%, but ambulance services tend to run at 10%-11%.

- The state of urgent and emergency care in some hospitals results in some Urgent Care Paramedics leaving acute medicine and moving into primary care where they can work 9.00am–5.00pm, in a warm and dry environment, rather than full shifts in inclement weather. This change of clinical base results in a loss of autonomy for Paramedics in relation to their freedom to provide care and treatment within time scales they believe to be most appropriate.

- Ambulance services find it increasingly difficult to retain Paramedics and some newly qualitied Paramedics go to work in primary care, without first doing their NQP (Newly Qualified Paramedic) training in an ambulance service. NQP courses are a structured two-year a programme to integrate newly qualified Paramedics into the profession with the opportunity to apply academic knowledge, skills and placement experience.

APPENDIX TWO: QUESTIONS AND ISSUES REGARDING STROKE SERVICE DEVELOPMENT

Statement by Dr Nick Mann regarding the LAS response to stroke.

Dear Malcolm,

I should like to comment further regarding the PFLAS meeting with Fionna Moore. Whilst I found the meeting overall both informative and instructive, I remain concerned that 'high level' strategic plans have not kept pace with the reality of changes to patients' actual experiences of medical pathways.

As an experienced medical doctor, I covered some shifts in the LAS Control Centre during the strike. My main duties were to triage lists of category 2 calls according to either the dispatch of urgent ambulances to patients, or the downgrading of responses, which often involved re-directing patients to urgent community response pathways (alternative care pathways), using bespoke software between two separate systems.

It was notable that many of the so-called new models of care for 'urgent community response' were either unavailable, or available but did not respond, or re-directed patients to other services at inappropriate times. In many cases, much time and effort resulted in calling standard GP services as the 'urgent community response' services did not function appropriately.

Experienced LAS Doctors, including GPs and Paediatricians have been used as a 'new model of care' to supplement less experienced LAS 'Call Handlers', increasingly using algorithms to triage urgent 999 patients. In addition to the costly use of medical clinicians, it is possible to video call patients to obtain more detailed audio or visual information.

Little reliable detail of actual changes to LAS pathways, resulting in careful detailed analysis of changes to medical pathways and outcomes exists. I will give two real-life examples from my own experience.

Firstly, the latter changes have been made in the context of several years of rising and unsafe levels of Category 2 calls, e.g. patients requiring a Category 2 response, now routinely experience average 40-minute waits instead of 18-minute safe maximum waits. How many patients are the LAS excluding from their performance data, due to patients choosing to opt to attend A&E by taxi, instead of calling an ambulance?

I recently opted to be driven to A+E during a heart attack because the wait for an ambulance was likely to be very long, putting my health at severe risk.

Secondly, I was recently refused a 999 ambulance during an acute stroke, following a call by a poorly trained call handler who was using an algorithm. Despite telling the call handler that I was a doctor and knew that I had had a stroke, I was refused an ambulance and was told that I should call 111.

During the Patients' Forum meeting, Dr Moore suggested that Call Handlers could improve response times by using video calls during patient consultation. However, the FAST algorithm failed to pick up my parietal lobe stroke and a video call would not have increased the likelihood of detection over an experienced doctor, directly informing 999 staff that I had had a stroke. What is clear is that the use of algorithms is a poor substitute for an experienced and well-trained call handler, Nurse, Doctor or Paramedic.

The benefits of algorithms in medical care have been poorly examined and under-evaluated. Its benefit is that it is cheaper.

The reality is that technology's claims for medical AI have been over-claimed and often dangerously under-perform. There are clear examples of this with 'chatbot technology'. The rush to 'transform' expert medical diagnosis into 'technologies' comes from consultancies and industry, instead of development from medical experts working with the developers of technology. LAS is a poorer service for patients as a result, and years will be spent compensating simply for the loss of trained individuals in medical care.

Yours sincerely,
Dr Nick Mann

APPENDIX THREE: AIR AMBULANCE CHARITIES

Dr Fionna Moore now works for the Air Ambulance service in Kent, Surrey and Sussex (KSS). The service attends nine calls a day to the most seriously ill and injured patients in 3 counties. There are more calls to seriously ill and injured patients in Kent than there are in Surrey and Sussex together, and this may reflect the increased 'rurality' in Kent.

She said:

"If you are looking to support a charity – along with the London's Air Ambulance – the Air Ambulance in Kent Surrey and Sussex is a very worthwhile charity and one where I believe we work really hard to save lives and to improve the quality of lives of the patients we see".

London Air Ambulance
https://www.londonsairambulance.org.uk/donate?reason=up-against-time-appeal

Air Ambulance in Kent Surrey and Sussex
https://aakss.org.uk/ways-to-give/

APPENDIX FOUR: GLOSSARY

AACE	Association of Ambulance Chief Executives
A&E	Accident and Emergency Department
ACP	Alternative Care Pathway
AI	Artificial Intelligence – simulates human intelligence
BAME	Black, Asian and Minority Ethnic Groups
CAD 2010	Computer Aided Despatch
CLERIC	Supplier of software solutions to the UK Ambulance Services
CPR	Cardiopulmonary Resuscitation
FAST	**Facial** weakness **Arm** weakness **Speech** problems **Time** to call 999
FRCS	Fellow of the Royal College of Surgeons
FRCEM	Fellow of the Royal College of Emergency Medicine
FRCESEd	Fellow of the Royal College of Surgeons (Edinburgh) Scotland
GP	General Practice
ICP	Integrated Care Partnership
KSS	Air Ambulance Charity Kent Sussex Surrey
LGPTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MBE	Order of the British Empire
NQP	Newly Qualified Paramedics
National Mean	Relates to the whole of the country, rather than to part of it.
PA	Physician Associate
QAM	Service medal for Distinguished Services in England
SECAmb	South East Coast Ambulance
TIA	Transient Ischaemic Attack – the same as a Stroke and is a medical emergency
UCH	University College Hospital

APPENDIX FIVE: STATUTORY AMBULANCE RESPONSE TIMES

Category 1: Life-threatening

Time critical life-threatening event needing immediate intervention and/or resuscitation, e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; hanging.

Category 2: Emergency

Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport.

Category 3: Urgent

Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe.

Category 4: Non-urgent

Problems that are not urgent but need assessment (face-to-face or telephone) and possibly transport within a clinically appropriate timeframe.

The Addendum to the NHS Constitution requires all Ambulance Trusts to:

- Respond to Category 1 calls in 7 minutes on average and respond to 90% of Category 1 calls in 15 minutes.
- Respond to Category 2 calls in 18 minutes on average (amended to 30 minutes for 2023/24) and respond to 90% of Category 2 calls in 40 minutes.
- Respond to 90% of Category 3 calls in 120 minutes.
- Respond to 90% of Category 4 calls in 180 minutes.