PATIENTS' FORUM

AMBULANCE SERVICES (LONDON)

JULY 2020

WE SALUTE THE MAGNIFICENT FRONT-LINE STAFF SERVING LONDON IN AMBULANCES, AMBULANCE CARS, EOC AND 111

PATIENTS' FORUM NEWSLETTER

FROM ALEXIS SMITH:
FORUM LEAD ON ACUTE MENTAL ILLNESS

MY EXPERIENCE OF THE LONDON AMBULANCE SERVICE - SUICIDE AND SELF-HARM -

WORKING WITH THE PATIENTS' FORUM

A few years ago, I joined the Patients' Forum for the LAS having been a serious casualty due to self-harm and suicide attempts.

As you can imagine I wanted to give something back, which led me to a very privileged position of working as a volunteer with the Forum, helping to monitor the effectiveness of LAS services and the strategic direction of the LAS, especially in relation to its mental health emergency services response model

Alexis Smith, Forum Lead on Acute Mental Illness

PATIENTS' FORUM FOR THE LONDON AMBULANCE SERVICE
Patients' Forum Ambulance Services (London) Ltd.
Registered office: 6 Garden Court, Holden road, Woodside Park, London, N12 7DG.
Company Limited by Guarantee Company Number: 6013086

CONTEXT – REMEMBERING CAROLINE FLACK

In light of the recent tragic death of Caroline Flack, I wanted to highlight the need for the LAS to approach mental health care with the same urgency as physical trauma.

I am campaigning with the Forum to help the LAS avoid further systemic failures that have led, and are continuing to lead, to self-harm and death. If a patient who appears emotionally traumatised refuses to go to hospital but is physically visibly well, in terms of that patient's welfare advocacy, there should be a mental health specialist on-call and rapidly available to provide face-to-face care. Not occasionally, but always and without delay.

MY PRAISE FOR THE LAS & CRITICISM OF HOSPITAL CARE

In my personal experience Paramedics and other front-line LAS staff, are the ones who deserve praise, for they have saved my life many times.

But on waking in hospital from an overdose, coming out of the Resus Unit, transferring to a Ward and waiting for a Consultant referral - as well as the ongoing observations, a care plan and general mental health follow up – I have experienced many failings.

These were mostly due to there being poor discharge arrangements and very little or no intervention from GPs or CPNs following discharge. That is why mental health advocacy for a person who has self-harmed needs to start shortly after recovery from the overdose, and tighter protocols need to be put in place for referral pathways to quickly become operational.

We need to open a dialogue with the LAS on suicide and care pathways for people with suicidal thoughts. The message here is loud and clear; one cannot quantify mental illness as one can with physical illness. Therefore, every patient must be taken very seriously and treated with care when they are in highly vulnerable circumstances.

The Forum's ten 111 Call-Centre visits included questions and answers on how they operate. The 111 staff team were happy to answer our questions and were compliant in relation to physical health, but unfortunately our questions on mental health care were not answered adequately. This situation needs to be addressed urgently, but the LAS has consistently failed to respond to our recommendations on the mental health care provided by their 111 service.

THE ROLE OF HOSPITAL ACCIDENT & EMERGENCY DEPARTMENTS

These are the scariest places to go when you suffer a mental health crisis. There are often long delays before seeing an A&E Clinician, and they are usually not well equipped to provide expert mental health care. The duty of Parity of Esteem is often absent in A&E – whilst dealing with physical illness is an area of great expertise, mental health care is often poor.

WHAT NEEDS TO CHANGE IN LAS & MENTAL HEALTH SERVICES

There is very little intervention or psychiatric follow-up, when a patient's cognitive functions, speech and appearance appear normal. This element is crucial and is a missing link in the development of effective urgent and emergency mental health care by the LAS.

After 20 or so years, I still have a serious and chronic mental health condition. Living on anti-depressants has not cured me. The practice of GP's dishing out tablets needs to change, and we need to TALK more. In all my hospital admissions I was rarely allocated a Therapist, nor did I get a visit from a CPN during or after hospital treatment.

LAS PRACTICE NEEDS TO CHANGE

Perhaps now, having been able to speak openly and stimulate debate, some things in the mental health system may at last change. This includes not assuming that a person 'left at scene' by the LAS will quickly recover, as if they had just had some minor injury. Many people will need ongoing community mental health support, if the large numbers of patients who tragically self-harm or kill themselves is to be substantially reduced.

We need concrete evidence that being 'left at scene' does not mean leaving the person alone and isolated, and with no means of benefiting from continuity of care, i.e. ongoing support until the crisis is resolved. Often the GP or community mental health support that is offered by LAS clinicians during a mental health crisis, does not materialise, at least not within a time-frame that is meaningful for a person in a mental health crisis and at risk of harm.

I think the LAS mental health cars (Paramedic and Mental Health Nurse) are a really great idea, but how do we know the patient isn't 'left alone at scene' to cope as best as they can until the next crisis?

COMPLIANCE WITH THE DUTY OF CANDOUR

There is a long history in the LAS of front-line staff not meeting with patients who have complained about the quality of LAS services. Discussion and apology often solve complaints and should lead to enhanced services. Apparently, staff are usually too busy to meet with patients who have complained.

Sadly, a complaint left unresolved, can traumatise the person who has submitted the complaint throughout their life.

CO-PRODUCTION IN ABEYANCE - RECOMMENDATIONS TO THE LAS

We have submitted the following recommendations to the LAS and for their annual Quality Account. Trisha Bain, Chief Quality Officer, has acknowledged receipt - but has not responded to our recommendations. This has become the cultural 'norm' for the LAS, in our experience.

RECOMMENDATION ONE

In responding to patients in a mental health crisis, Call Handlers should always end the call by guiding the patient onwards. Leaving the patient uncertain about the next steps can be very harmful. The system needs to be preventative.

RECOMMENDATION TWO

When a patient has suicidal ideation, their level of vulnerability must be understood more clearly by 111 and 999 services, so that a more appropriate and rapid response can be provided. The 111 service should always have mental health professionals available to respond to a patient in crisis.

RECOMMENDATION THREE

All clinical staff in 111 services should have mental health training to assist patients with, for example: suicidal ideation, autistic spectrum disorder and bi-polar. Call Handlers create a link with the patient, which is important, but onward appropriate referral is essential.

RECOMMENDATION FOUR

999 LAS capacity for people who are thinking about self-harm needs to be expanded. For instance, a patient might say: "I want somebody to step in and help to stop me cutting myself". The LAS needs to ensure they have the resources to respond **rapidly** to patients in this situation**.**

RECOMMENDATION FIVE

When a patient has suicidal ideation, or intends to self-harm, a referral by LAS clinicians to a GP is not usually an adequate pathway. Rapid face-to-face care with a mental health clinician is usually essential.

RECOMMENDATION SIX

Patients should know what the range of options is when they have self-harmed or are thinking of doing so. Information should be provided to these patients by the LAS following face-to-face or telephone responses, e.g. can they be fast-tracked to a CPN who is an expert in crisis care, or could they request a further visit by an LAS mental health team?

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RECOMMENDATION SEVEN

The LAS should work with the MH acute sector including Local Authorities, to ensure that Crisis Lines (hospital and Local Authority) are functional. Often the responses on these lines are slow and referral capacity minimal.

The Crisis Line system needs to provide an immediate response and a plan for further care and active support during at least a 12-hour period if the patient is focussed on self-harm. Strict governance of crisis telephone lines – making sure that they answer calls and can provide a real service and referrals when needed is essential.

DRAFT CO-PRODUCTION CHARTER BETWEEN LAS AND PATIENTS' FORUM

www.patientsforumlas.net/co-production-in-the-las.html

The Charter was agreed with the Chief Quality Officer of the LAS, Trisha Bain, on 17 October 2019 in a meeting attended by Joseph Healy, President, Patients' Forum for the LAS, and Malcolm Alexander, Chair, Patients' Forum for the LAS.

THE LONDON AMBULANCE SERVICE (LAS) AND PATIENTS' FORUM FOR THE LAS (PFLAS) AGREE THAT THE CO-PRODUCTION CHARTER:

SUMMARY

1) Provides an effective means of designing, shaping, and delivering services in a partnership between the LAS and people who have used the service or may use it in the future.

2) Enables delivery of our shared objectives for the creation of better services and outcomes for patients.

3) Sets out the potential outcomes that people can expect from the co-production of urgent and emergency care services and other care services provided by the London Ambulance Service.

4) Sets out the responsibilities of people taking part in the co-production of services.

5) Establishes principles which are intended to achieve a vision of service users as equal partners in the production of effective urgent and emergency care.

6) Signals the direction of travel for integrated service development between the LAS, patients, and the public.

7) Enables the LAS and the PFLAS to work collaboratively in the best interests of service users for the enhancement of their care.