London Ambulance Service
NHS Trust

Station/Department/Unit
Headquarters
220 Waterloo Road
London
SE1 8SD

Tel: 020 1234 5678
Fax: 020 1234 5678

www.londonambulance.nhs.uk

20th February 2019

Dear Malcolm

Feedback on Quality Account 2019-20: London Ambulance Service NHS Trust (LAS)

The LAS welcomes your comments on our annual Quality Account and the valuable contribution that you and your members make throughout the year to improving the care of our patients, I will provide feedback on each of your recommendations as provided in your response.

1) CO-PRODUCTION WITH THE LAS

Our collaboration with you and your team is very positive and creative and has led to some important developments, including the Complaints Charter which is now being highlighted in acknowledgement letters to all those who have made complaints to the LAS. We are also value the joint development of the Patient Specific Information leaflet for patients and carers.

We also welcome the collaboration from the Patient Forum and will continue to work with you on the development of a collaboration charter during 2019-20

2) MONITORING EOC AND 111 SERVICES – MENTAL HEALTH CARE

Your recommendations in relation to EOC/111 and Mental Health Services

a) Further development of mental health triage in EOC. Despite the significant developments of the mental health team, the duty of 'parity of esteem' is not being adequately exercised. As an example, most mental health related calls are not currently directed to a mental health nurse, and consequently some responses to patients lack the expertise that mental health nurses can provide, e.g. in relation to suicidal ideation. Thus, patients with similar conditions may get a very different response.

We are currently piloting this model and have a mid-project evaluation report, shared with you earlier this year. We anticipate that the solution to this is in our collaborative work with the MPS and mental health trust who agree that we require a pan-London Mental Health Hub. This would work similarly to out LAS clinical hub bit would be solely responsible for

taking calls and directing patient sin mental health crisis to appropriate pathways of care. We will continue to inform you of progress during the year.

b) *As an initial step the mental health card should be expanded to include mental illnesses or events, e.g. anxiety, depression, psychosis and risk of suicide.*

These categories are already include within our current system.

c) There needs to be more mental health nurses on site, because when there is only one mental health nurse available, access to specialist mental health support is insufficient. If more mental nurses were available more mental health calls could be directed to a specialist support team.

As per our response to a) and b) the current project is in pilot phase and once we have worked with all relevant stakeholders our aim is to increase the number of mental health nurses available (via a rotational model with providers) across the whole of London.

d) There is a need for greater access to psychiatric liaison/relationship building with all local mental health teams, to reduce the risk of patients being sent to A&E as default. At the moment it appears that where a mental health nurse is already familiar with the team in a particular area, that the relationship works well and local services can be assessed more easily. This collaborative working relationship needs to be extended to all mental health trusts in London.

We currently work closely with mental health providers and as part of the roll-out pan-London of our service we anticipate all providers to ensure equity of access to mental health patients through the agreement of standard pathways of care.

e) The continuing use of a question to patients with mental health problems regarding their potential use of violence is inappropriate and should be stopped. Similarly, the advice to patients in a mental health crisis waiting for a response

We use standard questions that are set via nationally agreed standards, however we will review this as part of the overall programme of work with all relevant stakeholders.

f), *not to eat or drink should be abandoned as poor practice.*

As per response to (e)

3) ACCESS TO THE SECURE ENVIROMENT FOR EMERGENCY RESPONDERS - Category 1 and 2 ARP calls.

Currently no data is available on the time taken for paramedics to reach patient in prisons, immigration removal centres and youth offender institutions. Once an ambulance arrives at the prison gates, it appears that the clock stops, despite the fact that a core aspiration of ARP was to be 'patient centred' rather than 'target centred'. The Forum is attempting to gather data on this problem from the Home Secretary and Prison Minister.

WE RECOMMEND -

a) The LAS collects data on the response times for all Cat 1 and Cat 2 calls to secure estate gates for a period of 3 months.

b) *The LAS requests paramedics and EACs who respond to calls to the secure estate, to record the time taken from arrival at gates to patient contact, for a period of 3 months*.

We very much appreciate your support in this regard. We have discussed your thoughts (a and b) previously and as you are aware the time it would take to manually collate this data may in itself impact on further delays to patients. However as we are now accelerating our implementation of ePCR we anticipate we will be able to collect this data early next year.

4) SICKLE CELL DISORDERS

There has been significant progress in relation to the training of front line staff into the needs of patients sickle cell disorders, and CARU audits have shown how this training has enhanced patient care. Work continues with the Sickle Cell Society and the LAS Academy in relation to pain control for children and young people, and production of a staff training video, which should be available in 2019.

WE RECOMMEND -

a) That comprehensive staff training in relation to sickle cell disorders is kept up to date for all front line staff.

This is now included in our CSR training and will be on-going programme

b) That CARU carries out a new survey of people with sickle cell disorders who have used LAS services, to determine if the quality of care for sickle cell patients remains of high quality and continues to improve.

Thank you for acknowledging the work of CARU they are currently carrying out an audit into sickle cell disorders and we will share the outcome once published.

5.0 COMPLAINT INVESTIGATIONs

The Forum is working closely with the LAS Chair, Complaint's and quality teams, to carry out joint audits of complaints. We will jointly recommend how the process can be made more sensitive to the needs of people who have complained, and how the complaints system can positively improve front line services.

WE RECOMMEND -

a) Recommendations produced as a result of complaint investigations should be widely publicized, to give people who make complaints the assurance that their complaints contribute to enduring service improvements.

We are reviewing how we gain feedback and provide feedback to patients, public and stakeholders as part of developing out strategy. We will include the sharing of thematic data from complaints which is currently shared in our annual Quality Account and bi-monthly quality report.

b) The joint team reviewing complaints should have the opportunity to write to complainants to seek their views on the investigation of their complaints.

We have discussed this with our legal advisors and as part of the current GDPR recommendations we would not be able to provide the names of patients to enable this recommendation to take place.

Once again the LAS would like to thank you and your members for the support you provide the organisation, I look forward to continuing our mutually beneficial working relationship.
Kindest regards

Dr Trisha Bain
Chief Quality Officer