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**MINUTES of FORUM HELD MONDAY**

**NOVEMBER 13th 2017**

**ATTENDANCE: FORUM MEMBERS AND ASSOCIATES**

Adrian Dodd – Waltham Forest – Healthwatch

Audrey Lucas – Enfield- Executive Committee

Arthur Muwonge – Croydon

Barry Hills – Kent

Colin Hill – Berkshire

David Payne – Southwark

Graham Clark – Greenwich CFR

Inez Taylor - Southwark

James Guest – Ealing

Jan Marriott - Richmond

Jon Vangorph – British Red Cross

Justin Harrison – West London

Lynn Strother – City of London Healthwatch – Executive Committee

Malcolm Alexander – Chair, Patients’ Forum

Mary Leung – Harrow

Michael English - Lambeth

Mike Roberts - Hampshire

Natalie Teich – Healthwatch –Islington

Philip Ward – Hammersmith and Fulham

Rashid Ali Laher – Healthwatch Kingston

Simon Mott - Tooting

**SPEAKER:**

**STUART CRICHTON**

**London Ambulance Service:**

Samad Billoo – LAS - EOC

**Commissioner’s Representatives:**

LAS Commissioning Team - Nil

**APOLOGIES**

Angela Cross-Durrant – Kingston – Vice Chair

Arif Mehmood - Newham

Beulah Mary East - Hillingdon

Catherine Gustaffe – Southwark

Christine Kenworthy– Kent

Dhanesh Sharma

Graeme Crawford – Ealing

Jan Duke - Southwark

John Larkin- Company Secretary

Jos Bell – Socialist Health Association

Joseph Healy – Southwark - Forum President

Kathy West – Southwark

Robin Kenworthy – Kent

Sean Hamilton – Greenwich

Sister Josephine Udine – Croydon- Vice Chair

Vic Hamilton – Greenwich

1. **Minutes of the meeting held October 9th 2017 were agreed a correct record.**
2. **Matter arising**

2.1For matters arising see ACTION LOG which is attached.

1. **TETHERING TRIAL**

**3.1**– it was explained that the 10 week trial was designed to test whether ambulance supporting patients who were not life threatened could remain within the geographical area of their home sector. The intention is to ensure paramedics and EACs have a deep local knowledge of services and are able to have a rest break in their local station in order to reduce the diminished number of crew available at the end of shifts. The trail will be evaluated after 10 weeks. James Quest suggested that the tethering project would be pointless in area like Northwick Park where ambulances are not able to move because of ambulance queues and asked if the project would in practice extend handover waits? Stuart Crichton said that the impact of tethering would include an assessment of impact on patients in all areas of London where the project was live.

**Paul Woodrow and Paul Gates**, **Consultant Paramedic has been asked for access to the project evaluation.**

1. **LONG HANDOVER WAITS AT LONDON A&Es**

**4.1 Issue raised with Mayor of London and followed up by Southwark assembly Member Caroline Pidgeon. Mayor agreed to meet Forum and LAS**

**4.2** Compile a data set of local information on breaches for meeting.

**4.3** Ask Assembly Members for their support and to refer to the Mayor’s Health and Wellbeing duty and raise the issue with:

* Local Healthwatch
* AGMs of London’s CCGs
* GLA Health Committee
* London Councils (pan London representative body)
* Overview and Scrutiny Committee of most affected boroughs and with joint OSCs
* Jeremy Hunt

**4.4** CCG has withdrawn access to data about long handover waits. No validated data available for public scrutiny.

1. **COMPLAINTS CHARTER**

**5.1** Noted that the Complaints Charter has been revised following further discussion with head of complaints – Gary Bassett and Chief Quality Officer, Trisha Bain. It will be presented to the LAS Board meeting in October.

5.2 Review of LAS complaints - confidentiality document to be completed and then arrange new dates for visits. Long delay. Beulah East, Audrey and Malcolm Alexander agreed to participate.

1. **LONDON DEFIBRILLATOR CAMPAIGN**

6.1 FOI requests – Responses are currently being received from local councils and a report will be given to the November meeting of the Forum.

6.2 Vice President of Boots invited to December meeting of the Forum.

* 1. Meeting arranged by Dave Payne with MP for Southwark, Neil Coyle on Oct 5.

**7.0EQUALITY AND DIVERSITY**

7.1 New Equality and Diversity committee to meeting on October 9th. Forum unable to attend. Kathy West stepped down. Audrey Lucas and Beulah East to attend meetings.

**8.0 OUTAGE – JANUARY 1st 2017**

8.1 Independent IT and Business Resilience Review was published on 21 April 2017. A report on the achievements of objectives was submitted to the LAS board on October 3rd.

8.2 Inquest held on man who died during the Outage and Beulah East attended on behalf of Forum. Report with September papers.

1. **MENTAL HEALTH CARE**

9.1 Successful meeting held with the Healthy London Partnership on August 29th and attended by 16 members and LHW. Many issues raised including classifying long waits for patients requiring mental health care as Never Events. Case to be made to NHS Improvement.

**10.00 DOWNGRADING OF CAT C TARGETS AND INVENTION OF ARP**

10.1 LAS and Commissioners have changed the Cat C targets in a way that substantially reduces response time for patients and falsely shows the LAS as achieving much higher levels of response against Cat C Targets, whereas in practice performance is much worse. Forum is concerned that the lower targets will cause harm to patients by delaying patient care. Meeting held with Chair of CQRG Dr Johal and Elizabeth Ogunoye, Deputy Director for LAS Commissioning and NWL Provider Performance on August 15. No explanation for downgrading of targets. Overtaken by ARP.

**11.00 Stuart Crichton Assistant Director of Operational Service Improvement**

**AMBULANCE RESPONSE PROGRAMME**

11.1 Stuart said that his work and passion had been focussed on developing effective clinical responses to patients since 1991 and that in addition to working professionally for the LAS also operates as a Community First Responder in his local area of Barnet. He said ARP had been trialled in several area of England and was now a national project. He said that the LAS started working on the project in February. Stuart explained that the traditional system regarded getting to a patient ten seconds late but saving the person’s life as a failure, but getting to a patient in under 8 minutes, who dies, as a success. He said that responding to targets in the absence of assessment of clinical outcomes was a poor way of assessing the success of the response and patient care. Stuart explained that the Cat A (8 minute) target was introduced in 1974 and reinforced in 1996 but was not based on objective clinical criteria.

11.2 Jonathan Benger, the National Director for urgent and emergency care has led the ARP since 2015 and it has been trialled in the South West, Yorkshire and the West Midlands ambulance services. It has now been rolled out to all AS except for the Isle of Wight service. Sheffield University has evaluated 14 million calls since the ARP project started.

11.3 The ARP system is intended to priorities responses to the sickest patients. Stuart said it is research based and he believed would put an end to unacceptably long waits, especially to lower acuity patients. He said that stroke, cardiac arrest and major trauma patients will get a quicker response, and the response to supported by major expert organisations, e.g. the stroke association. He said there will be more time for assessment in the EOC and the because the right clinicians and vehicles will be sent to the patients that less time will be wasted in the patients home and patients would get to hospital more quickly. He said the trail would start on November 1st and go fully live on November 30th 2017.

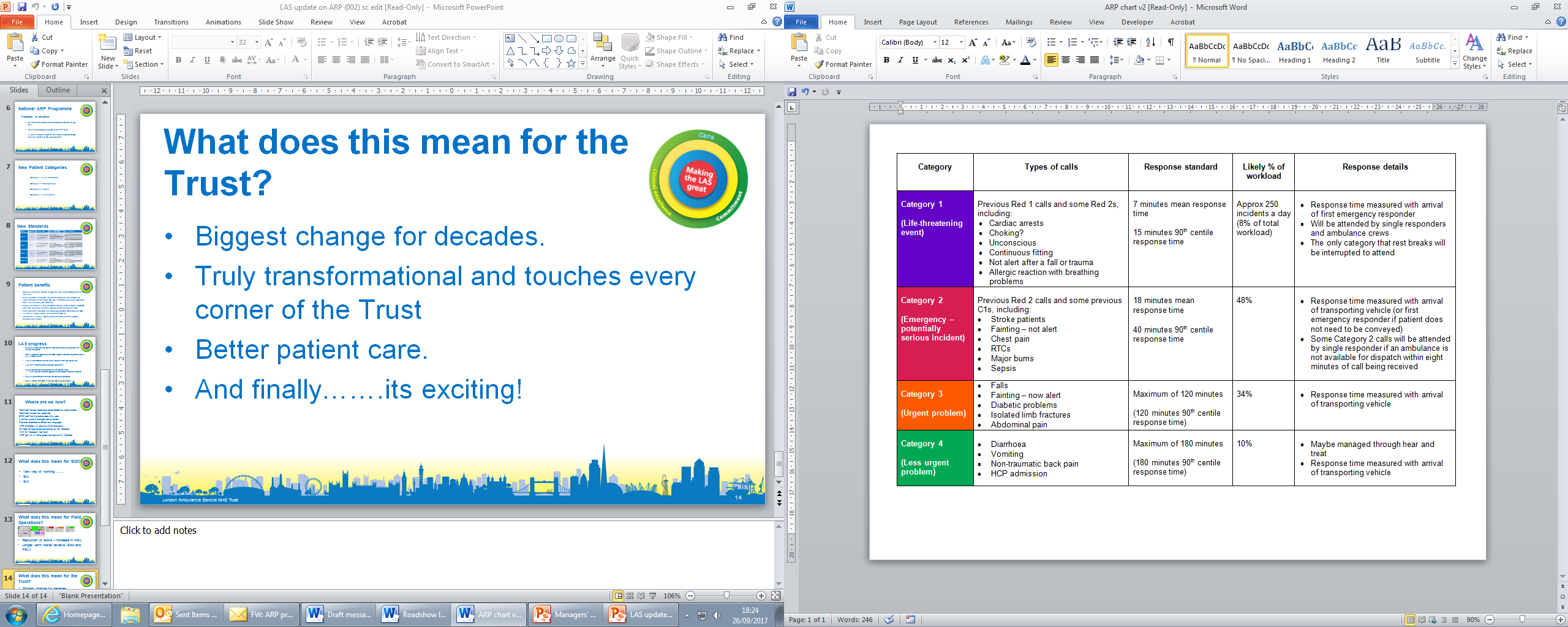
11.4 The Four categories are as follows:

**Category One:** Life threatened patients. About 250 patients each day in this category which is equivalent to 8% of the LAS workload, whereas currently, category A patients make up 58% of the workload. The mean response will be 7 minutes (15th minutes 90th centile response).

**Category Two**: includes stroke, chest pain sepsis and major burns. These patients will have an 18 minute mean response (40 minutes, 90th centile). 48 % of workload.

**Category Three**: Falls, faints (now alert), abdominal pain, diabetes and limb fractures. Target is 120 minutes response (120 minutes, 90th centile). 34% of workload.

**Category Four:** This target is 180 minutes and includes hear and treat, diarrhea, vomiting, HCP referrals and non traumatic back pain (180 minutes, 90 centile). 10% of workload.



**Question to Stuart Crichton.**

11.5 **STROKE** - James Guest asked why stroke has been placed in Category 2. Stuart replied that stroke patients will get an ambulance (not a car) and will go rapidly to hospital stroke unit for thrombolysis. He said this time is well within the guidelines provides that transit to hospital is rapid once a presumptive diagnosis has been made.

11.6 MENTAL **HEALTH CRISES**- Lynn Strother asked what response patients in a mental health crisis will receive? Stuart said that they would be placed in category 3, but this would depend on the severity of their symptoms. He said that a s136 detention would be placed in category three (2 hour wait). He added that in the case of a serious crisis that a response would be at level two, but the response would be related to potential harm to self and others and the level of distress.

11.7 **ALCOHOL AND DRUGS** – Mike Roberts asked about the response to people who are seriously intoxicated on alcohol or drugs like spice and whether such patients would be in Category 1 or 2. Stuart replied that it depended on their state of intoxication and in some cases advanced paramedics might be dispatched if the patient was life threatened.

11.8 Stuart said that many patients had been failed by the current system, which was disproportionate, especially for those who were promised a category C response within 20, 30 or 45 minutes and instead waited many hours. He said that the ARP system would give greater benefit to patients and was more equitable. For example, sending both a car and an ambulance to a patient was inefficient and reduced the number of ambulances and cars available to respond to patients in crisis. Stuart added that 250+ lives a year are expected to be saved as a result of the ARP and added that the focus will in future be on outcomes, not a focus on vehicle availability, i.e. Car? Ambulance or taxi (if the first two are not available). He said the priority will be to go in at the right level.

11.9 Getting the right care, first time at the right place will in future be the priority. Stuart said it is not about just getting patients to A&E, but getting the patient to the right service using an appropriate pathway. He said that his included Cath Labs for patients with heart disease and specialist centres for patients suffering stroke. He added that mental health hubs are also being developed.

11.10 Referring to the development of ARP, Stuart said that that the ARP trial is the largest emergency ambulance service trial in the world and is based on modeling by a company called ORH. Fenella Wrigley, the LAS Medical Director is a key national player in the development of ARP. Stuart said that every LAS policy has to be changed to reflect the introduction of ARP, all staff retrained, a new language developed and changes made to staff rosters. In addition the 110 solo responders will be reduced to 50. 160 new ambulances have been ordered but will take time to arrive.

11.11 In conclusion, Stuart said that the ARP system was truly transformational, will take time to bed in, but will undoubtedly provide a better service to patients.

11.12 **COMPARATIVE DATE** – James asked if comparative data sets will be developed to demonstrate that the new system provides better responses and better care to patients? He also asked if data was available from OHR that the Forum could examine.

Stuart said it would be very difficult to carry out a comparative analysis of two systems, but agreed to share the OHR data.

11.13 **HEART ATTACKS** – Audrey Lucas said that at the moment a person suffering a cardiac arrest will get the fastest response possible from a car, bike or other first responder. She asked what would happen in the new system if fast response cars are being phased out. She asked if such patients would wait longer?

Stuart replied that this category of patient would be the greatest priority and that every resource would be made available to save the person’s life.

11.14 **PRISONS** - Simon Mott asked how the LAS would ensure, using the ARP system that that clock would stop when the paramedic reached the patient, rather than at the prison gates?

Stuart replied that the ARP clock stop rules are very detailed and in the case of prisons and detention centres the paramedic must be within 250 metres of the patient for the clock to stop. He said that protocols are available to cover such situations.

11.15 **COMMUNITY FIRST RESPONDERS** – Graham Clark asked how the ARP would affect the role of CFRs.

Stuart replied that the focus must always be on getting to the patients who suffers cardiac arrest as quickly as possible, but the role of CFR may change over the next two years – but patient safety is the first priority.

11.16 **TERRORIST ATTACKS -** Colin Hill asked how 999 calls relating to a major incident, such as a terrorist attack, fitted into the ARP Cat 1-4 classification.

Stuart replied they didn't fit into ARP and would be handled outside of ARP classification, although the initial few calls would be classified under the ARP scheme.  After a major incident had been declared, a separate function within EOC would be set up which would handle the incident and the incoming 999 calls related to the incident. Whilst the major incident was in progress, normal 999 calls not related to the incident would be handled normally and classified under the ARP system.

11.17 **TRACKING RESPONSES** – James Guest asked where tracking had taken place to determine journey time from incident clinical incident to major trauma, stroke and cardiac centres, and whether journeys would be extended because of A&E closures and A&E queues (causing extended waits for ambulances).

Stuart said that data is not yet available, but each of the conditions mentioned has a care bundle which describes essential clinical responses and times, e.g. the on scene time for stroke is 30 minutes maximum. He added that the effectiveness of the ARP system would be reviewed in March 2018.

11.18 **MENTAL HEALTH** - Malcolm Alexander asked whether the ARP targets are appropriate for people sectioned under s136 or who are suicidal or suffering a serious crisis.

Stuart replied that the ARP targets are clinically driven and deemed to be appropriate in relation to mental health care.

11.19 **111 SERVICE –** Is the service sufficiently advanced to enable interoperability between 111 and 999?

Stuart said that the LAS is working with the 111 services across London to transfer codes and ensure appropriate liaison and interaction. This work is continuing.

**11.20 Stuart was thanked for his excellent presentation and asked to keep in touch with the Forum regarding the development and effectiveness of ARP.**

**11.21 Further questions for the LAS and NHS England**

1. **Comparative Data:** Can metrics be devised to compare the previous system’s performance with new ARP performance for a period of one year, based on several high profile medical conditions, e.g. strokes, heart attacks, major trauma and sickle cell disorders? This is consistent with an evidence based approach required by the LAS/CQC improvement trajectory.
2. Have other ambulance services across the country have developed such metrics and a template. Write to Professor Benger.
3. **Stroke:** Has any work been carried out to estimate the possible delays, at different time of the day, in responding to stroke calls, and getting patients to stroke treatment centres? Treatment delays might be caused by road congestion and queues at treatment centres and the evidence shows that delays increase the risk of permanent nerve damage.

11.22 Stuart Crichton’s ARP slides are on the Forum website:

[**WWW.patientsforumlas.com**](http://WWW.patientsforumlas.com)

12.00 **MEMBERS REPORTS**

The following reports were received:

12.1 Inquest Report – September 19th Beulah East. This related to a tragic death that occurred during the January 1st EOC Outage. Beulah attended the inquest on on behalf of the Forum.

12.2 Meeting with Patricia Bain, Chief Quality Officer – Sept 28th

12.3 Meeting with Elizabeth Ogunoye – Commissioner for the LAS – October 2nd

12.4 End of Life Care Report – Angela Cross-Durrant

12.5 LAS Board Meeting – October 3rd

12.6 Bariatric Care – 2016/7 – Malcolm Alexander

12.7 Infection Prevention and Control – September 21st Adrian Dodd

Adrian Dodd drew member’s attention to the following issues:

* Flu inoculation uptake not as high as the LAS would like but they are promoting this with the staff.
* Currently recruiting in Australia where the H3N2 flu virus is active. This is included in current vaccine.
* Still a shortage of the BCG vaccine. Some concern about the low percentage of staff recruited from Australia who have received BCG inoculations.
* Blankets / Linen - all ambulances now have 4 blankets on board at the start of the shift.
* Deep cleaning of vehicles is > 90%.
* Personal Protection Equipment (PPE). Most staff not aware that PPE is available in the ambulance kit.
* This was my first meeting on behalf of the Forum.

**13.00 AGM and PERFOMANCE REPORTS**

The following reports were received:

13.8 NOTICE OF PATIENT FORUM AGM – NOVEMBER 13th 2017

13.9 LAS Performance by CCG area – Aug2017 and April 1st – Aug 31st

13.10 Overall performance

13.11 Daily Handover Breaches – August 2017 – sample

**14.0 The meeting finished at 7.20pm**