**MINUTES of the PATIENTS’ FORUM MONDAY** **APRIL 9th 2018**

**ATTENDANCE: FORUM MEMBERS AND ASSOCIATES**

Angela Cross-Durrant – Kingston – Vice Chair

Arthur Muwonge – Croydon

Audrey Lucas – Enfield- Executive Committee

Barry Hills – Kent

Catherine Gustaffe – Southwark

David Payne – Southwark

Graeme Crawford – Ealing

Inez Taylor - Southwark

James Guest – Ealing

Jan Marriott - Richmond

Jos Bell – Socialist Health Association

Joseph Healy – Southwark – President of the Forum

Malcolm Alexander – Chair, Patients’ Forum

Mary Leung – Harrow

Mike Roberts - Hampshire

Natalie Teich - Islington

Sister Josephine Udine – Croydon- Vice Chair

Tom O’Sullivan – Bromley

G.Dixon – Lambeth

A.Levy – Westminster

P.Ward – Hammersmith

Dr Charles House, Medical Director, University College Hospital London

Zed Stipnieks - SMS

**SPEAKERS:**

**-James Guest – Patients Forum for the LAS**

**-Dr Kuldhir Johal – Chair Clinical Quality Review Group for the LAS**

**-Paul Woodrow – Director of Operations for the LAS**

**-Dr Nick Mann – GP Hackney**

**-Dr Katherine Henderson – Royal College of Emergency Medicine and Emergency Medicine Consultant, Guy’s and St Thomas’**

**COMMISSIONERS REPRESENTATIVES:**

Elizabeth Ogunoye – LAS Commissioner - Brent CCG

**LONDON AMBULANCE SERVICE:**

Dr Fenella Wrigley – Medical Director

Paul Baron

Samad Billoo – EOC

Zafar Sardar – EOC

**APOLOGIES**

Adrian Dodd – Waltham Forest – Healthwatch

Alexis Smith - Bromley

Anthony John – Tower Hamlets

Arif Mehmood – Newham

Beulah Mary East – Hillingdon

Colin Hill – Berkshire

Dan Brennan – Southwark Carers

Garner Bertrand - Newham

Jan Duke – Southwark

John Larkin- Company Secretary

Kylie Crawley – Southwark

Louisa Roberts – Tower Hamlets

Lynn Strother – City of London Healthwatch – Executive Committee

Michael English - Lambeth

Philip Ward – Hammersmith and Fulham

Rashid Ali Laher – Healthwatch Kingston

Robin Kenworthy – Kent

Sean Hamilton - Greenwich

Vic Hamilton – Greenwich

**1.0 Minutes of the meeting held 12th March 2018 were agreed a correct**

1.1 Matters Arising: Also see Action Log.

**1.2 Emergency Operations Centre Report**: date for presentation by Pauline Cranmer is May 14th

**1.3 Complaints Charter:** LAS Communications Department are designing Charter in line with the NHSE Accessibility Standard.

**1.4 Gender Equality in the LAS:** Noted that the LAS will publish details of their gender pay gap by March 31st 2018. See:www.patientsforumlas.net/

**1.5 CQC assessment of the LAS:** Noted that the CQC has agreed to attend a meeting of the Forum to feed back on their assessment.

**1.6 Noted that the engagement exercise on the LAS Strategy** had finished and that there had been virtually no public engagement or involvement in the development of the Strategy. No response received to the Forum's submission on the LAS Strategy which had been sent to the LAS Strategy Team.

**1.7 Co-production with the LAS –** a Forum report had been submitted to the Clinical Quality Review Group of Brent CCG - ATTACHED

**1.8 Redcarding of patients:** Noted that Forum has carried out a survey of acute hospitals in London to determine how many patients had been barred from entering A&E departments. The survey was carried out because some A&E departments, by refusing to accept patients, are leaving them in ambulances and the LAS is forced to take them to other A&Es, sometimes to several A&Es. The total number of patients barred from London A&Es was found to be 19 but some data is outstanding.

* Chelsea and Westminster – 11
* Homerton -1
* Lewisham and Greenwich – 5
* North Middlesex – 2

Dr Fenella Wrigley said that legally patients cannot be barred and that keeping patients in an ambulance is unsafe. She added that this issue is being taken up with the pan-London Emergency Departments group.

Action: Publish outcome of survey and liaise with Drs Wrigley and Henderson. Raise formally with Professor Cummings at NHSE, in view of unlawful practice of barring.

**1.9 Stroke Care –** Meeting being arranged between Courtney Grant (expert by experience) and Dr Neil Thompson (Assistant Medical Director) to better inform stroke care from a patient’s perspective.

**1.10 Confidential audit of complaints submitted to the LAS.** Noted that the LAS has not been able to develop a system that would allow independent audit of complaints by the Patients’ Forum.

**2.0 ENDING AMBULANCE QUEUES AT LONDON’S A&Es**

**2.1** The following documents were received:

* Handover Delays in January, February and Marcy 2018
* Letter from Jane Cummings – Regional Director – NHS England - attached
* Letter from Alwen Williams – Barts Healthcare - attached
* Letter from Shane de Garis – Hillingdon Hospital - attached
* Patient who told 999 he had rare disease dies after waiting 5 hours for ambulance – 28-3-18 – Evening Standard
* Ambulance handover delays at A&E putting 999 response at risk –

2-4-18 – Guardian

* NHS is facing year-round crisis, say BMA – 2-4-18 – Guardian
* Your A&E Deserves Better – Tell Your MP A&E Deserves Better – Royal College of Emergency Medicine.

2.2 Dr Fenella Wrigley agreed to discuss with the Forum details of the death

publicised by the Evening Standard.

**2.3 Key Objectives of the meeting were to consider:**

1. Poor 4 hour emergency care performance in London’s A&E and the impact on the clinical care of patients.
2. The impact of deteriorating performance on ambulance queues and consequent handover delays.
3. The potential harm to patients waiting for an ambulance and evidence of actual harm.
4. Whether winter A&E pressures are becoming all year round pressures.
5. What resources are needed to resolve ambulance queuing and delayed hand-overs.
6. The impact of A&E patient queues on hospital and LAS staff.
7. What action is planned and needed to resolve these critical issues.

**2.4 James Guest for the Patients’ Forum – Key Points**

James’ report is attached

* James described the huge number of hours lost every week as a result of ambulance queuing outside A&E departments for more than the target of 15 minutes.
* The difficulty of getting good quality data about LAS performance for each London borough.
* The impact of winter pressures on patients waiting to get into A&E and to be discharged when their care is completed.
* The significant differences in performance between hospitals with similar pressures and the differences between inner and outer London hospitals re handover/waiting.
* Variation of performance at different times of the week.
* Impact on patients using Northwick Park despite a great deal of system work going on to improve performance.
* The range of explanations given for the long delays in handover.
* The potential impact of service improvements through the linking up of 111 and 999 in South East London (and North East London).
* What will happen when Ealing Hospital A&E closes? How will this impact on LAS performance and patient care.
* The need for more highly trained, stable and experienced staff in the acute sector.

**2.5 Dr Kuldhir Johal – Chair, Clinical Quality Review Group**

Dr Kuldhir’s and Paul Woodrow’s joint report is attached

* A&E should only be for patients requiring emergency care.
* The Ambulance Response Programme is intended to ensure that patient get the right response in relation to the severity of their condition.
* London has developed high quality centre for the treatment of stroke, heart disease and trauma care.
* Alternative Care Pathways (ACPs) should enable some patients to be treated more appropriately outside hospital – this will be enhanced with the aid of digital platforms that staff now have (IPADS).
* The use of Coordinate my Care (CmC) will help to ensure that patients, e.g. those requiring end of life care, are treated at home or in a hospice if this is the right option.
* The emergency care system must concentrate on getting the right clinical outcomes and this may need transformational changes.
* The whole system is changing including social care.
* Need to educate the public as to how to use NHS better, e.g. flu vaccine
* Joint workshops between partners in emergency and primary care medicine are enabling these changes.

**2.6 Paul Woodrow – Director of Operations - LAS**

* LAS now working collaboratively the CCGs and the acute sector.
* Pressures on NHS are changing - LAS has to change to meet this challenge.
* Winter pressures are highly significant, e.g. the impact of flu and cold weather which cause peaks in certain conditions.
* Winter planning must start much earlier – a year earlier.
* NHSE has set up a national ‘winter room’ to propose solutions to winter pressures.
* Between 2016/17 and 2017/18, the total number of one hour handover breaches reduced by 660 (31%). 5830 patients waited an hour or more.
* Time lost in excess of 15 minutes at handover decreased by 15% (4907 hours). That is 28, 442 hours lost in handovers 17/18.
* Delays are multifactorial and can only be solved with a wider system approach, with high levels of collaboration and over a longer period.
* The traditional model of using A&E as a failsafe must be challenged.
* LAS has high quality data and system intelligence and an effective ‘business intelligence department’ for data analysis.
* The ‘system’ is now collaborating better and recognises that some hospitals are more challenged. Resolution requires greater proactivity by the LAS.
* Progress has been good and this will continue with new and innovative ideas.

**2.7 Dr Katherine Henderson – Royal College of Emergency Medicine**

* The Emergency system is blocked. Dr Henderson loathes ambulance queues.
* Nobody knows what is really wrong with the patient until they are in the ED.
* The ambulance queue is the ‘canary in the coal mine’.
* There is a shortage of A&E cubicles and chairs for patients to sit on.
* G&T Hospital have a ‘no-corridor’ treatment policy.
* The exit from A&E is often blocked because there are inadequate services to enable effective discharge.
* The ED is the ‘klaxon’ for the overall health of the NHS.
* Handover from LAS should be 15 minutes, but is often an hour or more, which is unacceptable. 30 minutes should be the maximum
* The 4 hour ED target for arrival to discharge or admission is not being met and is sometimes extended for up to 12 hours because of a shortage of beds and other options that would enable discharge.
* Dilemma is the ‘deteriorating walk-in patient’ may be left to wait until the ambulance queue is dealt with. Checking patients’ are safe is essential.
* Collaboration between acute, LAS, urgent care and GPs is essential, but often there are no ACPs to provide alternatives to A&E and to get the right response for the patient. (ACP – alternative care pathway).
* Crowding in A&E is making it dysfunctional – there are now queues to cubicles within A&Es and huge stress on staff.
* Other problems are morale, recruitment and retention.
* Working in ED is the greatest job in the world.

2.8 Question from Graeme Crawford:  Can IT systems be developed that are more effective in order to get high quality clinical information from paramedics with patients in ambulances to consultants in A&E.

Answer: The IT system is operating effectively; the problem is having too many patients for the level of staffing. Having ‘eyes-on nurses’ to observe patients to a certain extent mitigates the problem.

**2.9 Dr Nick Mann – East London GP and Keep Our NHS Public**

* Blaming managers, patients and doctors is not constructive – the NHS system is gridlocked
* The LAS is fantastic, but staff are being worked off their feet – they can’t be in two places at the same time.
* LAS is still in CQC Special Measures.
* Some hospital corridors are full of patients on trolleys.
* Reduction in acute services is regularly promoted by government.
* Already lost 55% of acute beds across the country – this must be reversed.
* The ratio of beds to patients is reducing.
* Shortage of medical beds and social care. System is blocked at both ends.
* Acute needs of some patients not being met & discharge increasingly difficult.
* Some improvements in hours lost during handovers but pressures growing.
* Funding main issue – NHS is £24bn short of funding compared with Germany.
* NHS is stuck into the McKinsey model of sucking the NHS into privatisation
* Jeremy Hunt claims he is appalled by ambulance waits but is doing little to solve the problem
* Nationally mortality is rising (10,375 extra deaths in first 7 weeks of 2018)

<https://doi.org/10.1136/bmj.k1090>  UCLH/Oxford university research

* Too many GPs are being lost due to stress and retirement and primary care services cannot meet need.
* Poverty is now a great health challenge.
* We have a finite need for medical care, currently not being met, STPs are predicated on further reducing acute care capacity, but these are based on unrealistic presumptions and there are few viable alternative care pathways.

Quote from the BMJ - <https://doi.org/10.1136/bmj.k1090>

Health chiefs are failing to investigate a clear pattern of worsening health outcomes. Within the first seven weeks of 2018, some 93 990 people died in England and Wales.1 Over the same weeks in the previous five years, an average of 83 615 people died.1 This rise of 12.4%, or 10 375 additional deaths, was not due to the ageing of the population. Ageing is a slow process and leads to slow, not sudden, rises in mortality.2 An additional person died every seven minutes during the first 49 days of 2018 compared with what had been usual in the previous five years. Why?

Infant mortality rates are now rising in the most deprived quintile.

**QUESTIONS**

 2.10 Jan Marriott asked whether a problem for A&E is being required to meet targets at a time of increasing demand?

Katherine Henderson replied that the 4 hour target is great, more patients are being seen within 4 hours but demand is rising relentlessly.

2.11 Angela Cross-Durrant asked why resources are not targeted more on keeping people at home with the right level of primary health and community care? Also asked why more is not being done to increase the number of people (and staff) who receive the flu vaccine? NO ANSWER – FOLLOW UP

2.12 Dr Charles House, Medical Director of UCLH said that working more collaboratively was essential and agreed that a major problem was the “exit block” from A&E and from acute hospitals. The system is focussed on the hourly availability of bed. Beds are often not available till late in the days so patients have to remain in A&E for hours, blocking access for new patients. He said that the rising mortality rate needed to be analysed and better understood. Crowded A&Es produce the worst outcomes as do placing patients in wards which are not appropriate to their needs.

The reason for the national increase in mortality (10,375 extra unexplained deaths in first 7 wks of year) needs to be understood. Could it be due to ambulance queuing, treating people in corridors, delays in getting access to GPs? Or the weather?

 2.13 Jos Bell drew attention to the NHSE London Plan and the plans of STPs to reduce services to fit into a diminishing financial box. She said there was an anticipated 44% decrease in beds in South West London by 2020. Jos said that ‘Shaping a Healthier Future’ the NHSE programme to reorganise hospital and ‘out of hospital’ health and care services in North West London is a disaster for Northwick Park and Ealing Hospitals. Jos added that services for dementia patients need to be improved because many people with dementia are better looked after at home unless there is a medical emergency.

2.14 Angela Cross-Durrant said that GPs are working successfully in A&E departments, which is reducing the burden of ever increasing demand. She welcomed the more collaborative ways of working between the LAS, acute and primary care sectors and the fact that the LAS is now pro-active in changing the way emergency care works.

2.15 Paul Woodrow said that sharing best practice is essential and there have been entrenched practices, which have been unhelpful to the successful operation of emergency departments. He said there is great variation between A&E departments and that by visiting A&Es as multidisciplinary teams, significant improvements have been made. He added that the LAS has to examine its own ways of operating before complaining about others.

2.16 Dr Johal described the value of shared learning and the responsibility of colleague in different parts of the system, to improve the effectiveness of emergency care in their area. She said that the aim is for the LAS/111/urgent care and GPs to create an effective system based on the needs of patients.

2.17 Cllr Mike Roberts said that social care is very much adjacent to health care and that Councils are grossly underfunded (by £2.1 billion) to provide the level of care that communities need. He said that EU staff are leaving the NHS, which is a considerable problem as 16% of nurses and 10% of doctors are EU nationals. He said that an exit strategy is urgently needed to deal with the impact of staff losses.

2.18 Dr Henderson said that the revolving door in A&Es is unhelpful. There must be more work in the community to provide care so that people don’t use A&E as the only resource available. The issues that bring people to A&E include youth violence, domestic violence, frailty and homelessness. She said that local authorities, GPs and charities need to work together to keep people out of A&E so that those with more critical medical problems can get faster care.

2.19 Sister Josephine asked why publicity about the best use of A&E and urgent care services is not more widely available. She said the public need to know.

2.20 Dr Johal said that a major next step will be the single point of access for A&E and urgent care and the development of a more effective Directory of Services.

(Note this has been said repeatedly for at least five years).

2.21 Dr Mann acknowledge the importance of these developments but emphasized the major problem of community services being run down, which would seem to undermine the aspiration to create an effective Directory of Services. He said it is essential for all NHS bodies and local authorities to build up community services and effective community teams. He added that improving self-management and healthcare education is important for prevention of disease. The role of expert patient groups is also very important.

2.21 Dr Kuldhir added that participation in screening programmes is also very important, e.g. screening for bowel cancer, as is getting vaccinated for flu.

2.22 Audrey Lucas said that funding is drying up for community organisations. They are chasing funds – which is ridiculous especially when these services are need for people with a wide range of conditions including dementia.

**Wind Up**

2.23 Paul Woodrow said that there are a huge range of issues, but working together within the system is essential. We can do better, must keep going to improve clinical outcomes for patients.

2.24 Dr Kuldhir said that NHS and local authority bodies must keep talking to reflect on, and then develop shared ideas and themes to improve urgent and emergency care.

2.25 Dr Henderson said that A&Es need to offload patients from trolleys as soon as possible and to improve the efficiency and effectiveness of emergency care.

2.26 Dr Mann said ambulance queuing and patients waiting on trolleys for emergency care is unacceptable. The NHS is being run down because of political decisions that are not focussed on the needs of patients. We don’t have to have ambulances queuing outside A&Es. The solution is political and requires public action to change government policies on the NHS

2.27 James Guest said that underlying pressures must be resolved and dealt with as demand is increasing. He acknowledged some success as demonstrated by Paul Woodrow and Dr Kuldhir, but winter pressures may neutralise this progress. He said the following are needed:

* Greater transparency of LAS and A&E performance data
* Better information for patients
* Higher productivity
* For health and social care agencies to keep together and work more closely

2.28 Malcolm Alexander agreed that collaborative working was key to dealing with problems of ambulance queuing and that the active involvement of the LAS in the collaboration was essential. He said the main problem was that the development of an effective emergency care system, was constrained by limited and reducing resources. Malcolm said that in some cases, as pressures grow, the system can seem chaotic with sick people waiting for emergency care, while front line staff and patients queue down the road to get into A&E. Healthwatch has a key role to play in the collaboration by introducing regular monitoring of A&E services and proposing solutions to deal with dysfunctional services. He said the Forum would publish recommendations for service changes both locally and pan-London. He thanked speakers and participants for their excellent presentations and contributions to the meeting.

**Meeting closed at 7.30pm**