



## PATIENTS' FORUM AMBULANCE SERVICES

# Developing LAS Care and Treatment Recommendations for Commissioners

DRAFT

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# **Developing the LAS**

## **Draft Recommendations for Commissioners**

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### **Vision Statement**

The Patients' Forum is an unregistered charity that promotes the provision of ambulance services and other health services which meet the needs of people who either live in London or use services provided in London. The Forum will influence the development of better emergency health care and improvement of patient transport services by speaking up for patients and by promoting and encouraging excellence.

### **Mission Statement**

- (1) We will optimise existing working arrangements with London Ambulance Service, the Commissioners of ambulance services and other ambulance services in the UK.
- (2) We will work with existing networks that champion patients' and users' rights.
- (3) We will continue to develop our campaigns for better and more effective ambulance services by approaching all stakeholders and petitioning for generic, effective and consistent approaches to service provision that reduce death and morbidity.
- (4) We will work to put in place effective systems for all patients and carers to communicate their clinical conditions effectively to ambulance staff and receive effective and timely responses.
- (5) We will promote the development of patient led quality standards for all ambulance services.
- (6) We will promote research to assess the clinical outcomes for all those who call 999 and were allocated a Cat A8 (life threatened) response, but did not get an ambulance within eight minutes.

(7) We will work with partners to develop services for the care and transport of people with severe mental health problems and their carers that respect their wishes. The Forum will be sensitive to their vulnerability, safety, culture and the gravity of their situation.

(8) We will work with the LAS to develop effective protocols, to respect the wishes of patients with Advance Directives, to ensure that their care is provided in accordance with their prior decisions.

(9) We will work with LAS Diversity and Equality groups to develop a work force which reflects the ethnic diversity of communities across London, and provides care based on culturally and ethnically based needs where this is appropriate e.g. in relation to sickle cell and mental health problems.

(10) We will work with the LAS Diversity and Training Departments to promote effective training of all LAS front line staff in diversity and the care of people in the protected groups identified in the Equality Act.2010

## **1) End of Life Care and Advance Care Plans**

### **Background**

London CMC (Coordinate my Care) is a single electronic register for storing clinical information and end of life care plans of patients with life-limiting illnesses. The service coordinates care, gives patients choice and aims to improve the quality of life by allowing the seamless capture and sharing of information across multiple locations in the acute and community health care sectors. It is confidential and can only be accessed by professionals who have a legitimate relationship with the patient. The CMC plan enables the coordination and delivery of appropriate care at the right time. The system will be accessed by a range of health professionals including GPs, community and acute nursing staff, the London Ambulance Service, hospice teams and NHS 111 staff. CMC gives patients the opportunity to make decisions and express their views and wishes about their medical care, which are then recorded in a safe environment. It offers a consistent approach to sharing and storing patient data, allowing the sharing of information between health professionals irrelevant of healthcare sector and location. CMC reduces unnecessary hospital admissions - 74% of registered patients died at a location outside of hospital, which is in line with the national End of Life QIPP (Quality, Innovation, Productivity and Prevention) strategy which aims to reduce deaths in hospital by up to 60,000 a year by 2021. Using the QIPP estimate of cost, which is around £3,000 per hospital death, this would translate to a potential reduction in hospital costs nationally of £180m per annum. NHS 111 clinical staff will have access to the CMC register. This will ensure patients in the final stages of their illness or their carers can quickly and easily access their care plan, and contact the services they need to ensure their end of life care meets their wishes. If a patient or carer calls NHS 111 the clinical staff can examine the patient's CMC record and provide appropriate advice to the caller. This will benefit patients because if they have any doubt who to call or how to access their care they will simply have to call NHS 111.

### **Forum Commissioning Proposals**

The Forum would like to see the following developments within the LAS operational system and between the LAS and other bodies:

- a) A public commitment by the Commissioners and the LAS to developing services that meet the needs of people who require end of life care (EoLC)
- b) Ensure that EoLC ACPs held by the LAS are appropriately shared with A&E Departments and other appropriate providers of health and social care.
- c) Promote through the network of CCGs in London effective communication between A&Es and the End of Life Care providers to ensure effective transfer of information regarding EoLC ACPs
- d) Fund the LAS to ensure that it has the capacity to process and manage data from Coordinate My Care (CmC) resulting from the expected increase in people registered with ACPs from 1000 annually now 50,000 plus in 2013/2014.

- e) Ensure staff training and support enables all staff to support people who are dying and to deal with complex situations where there is uncertainty about the validity of an ACP or a dispute between the owner of the ACP and their family.

## 2) Care for People with Dementia

**When people with dementia receive care from the LAS and are taken to hospital staff should understand how they can receive the best treatment in a way that is sensitive to their needs.**

People with dementia are core users of health care. At any one time, a quarter of hospital beds are occupied by people with dementia aged over 65. Evidence suggests there are ongoing problems with the quality of care for people with dementia in hospitals, and that there are many avoidable admissions.

The Royal College of Psychiatry Audit of dementia care in general hospitals found only a third (32%) of staff reported feeling that training and development on dementia care was adequate. Half reported they had received insufficient training on how to communicate with people with dementia and more than half (54%) said they had not received enough training on responding to challenging symptoms of dementia (Royal College of Psychiatrists, 2011). The report follows a paper by the Care Quality Commission (CQC) in 2011 showing many hospitals were not meeting basic care standards on nutrition or dignity (CQC, 2011a). Furthermore, around one in 10 respondents to: Support. Stay. Save. (Alzheimer's Society, Jan 2011) claimed the person with dementia was admitted to hospital unnecessarily because of insufficient care and support in their own home. This is underscored by data from the NHS Atlas of Variation (NHS Right Care 2011) showing that many areas are still struggling to provide enough support in the community to ensure that people with dementia are not admitted to hospital when it is not in their clinical interests to be admitted. The Atlas showed a 4.1-fold variation in admission rates to hospital for people over 74 with a secondary diagnosis of dementia. Admission rates for people in residential or nursing care showed even greater variation, with a 767-fold variation across PCTs in England. Even excluding the top and bottom five PCTs, variation was still 69-fold.

These findings support the conclusions of Counting the Cost (Alzheimer's Society, 2009), which found unacceptable variation in quality of care for people with dementia on general hospital wards. The report's research found nearly half (54%) of carer respondents felt the person's dementia symptoms worsened as a result of their time in hospital. Nearly half (47%) reported that the person's general health deteriorated. Individuals were staying in hospital longer than other people who were admitted for the same reason but did not also have dementia. Around one in three people with dementia who went into hospital from their own home were discharged into a care home. In short, many hospitals are struggling to ensure that people with dementia are discharged appropriately.

However, there are examples that show that it is possible to reduce the number of bed days for people with dementia. The Liaison psychiatry service offered in Leeds is a multidisciplinary mental health team offering support to a number of hospitals. It is

made up of psychiatrists, psychiatric nurses, an occupational therapist and health support workers. The service has reduced the average length of stay for people with dementia by 54%, from 30 to 13.9 days. This is the equivalent of 1,056 bed days per year (APPG, 2011). In addition, in 2007 the NAO highlighted a case study from Lincolnshire of successful reallocation of resources from acute to community services. A bed usage survey identified that most people with dementia on acute wards no longer needed to be there. Resources were successfully reallocated to home-based services and improving early diagnosis, potentially benefiting 500 people a year and using at least £6.5m more effectively (NAO, 2007).

Overall the evidence suggests that many hospitals are struggling to provide care for people with dementia. However, there is growing recognition of the need to improve care. In England, the 2012/13 Operating framework identifies care of people with dementia in hospital as a priority. The framework also set out a Commissioning for Quality and Innovation (CQUIN) target on improving diagnosis of dementia in hospitals (Department of Health, 2011).

### **The Forum Commissioning Proposals**

The individual and carer should receive the right care, where possible in an environment they are familiar with reducing stress and anxiety for all involved. Unnecessary hospital admissions should be avoided, which in turn will result in a potential cost saving for the NHS.

The individual and carer will receive the appropriate care and support necessary to support the best possible quality of life.

- a) Assurances that the Clinical Support Desk has the expertise for advise clinical staff on the needs of people with dementia.
- b) Production and dissemination of an information leaflet for clinicians that provides clinical and social information about the needs of people with dementia including information on communication and an awareness of the medications an individual with dementia might take.
- c) An on-line dementia training module.
- d) Information for clinical staff on where to find out more information including the website of the Alzheimer's Society and other useful websites.
- e) Communication with health and social care providers across London to develop assessment at home, direct access for front line clinicians to alternative care pathways leading to treatment at home, respite and place of safety beds all accessed.
- f) The development of communication tools in conjunction with other agencies that can be used in the person's home to include a variety of information such

as likes and dislikes, previous occupation and other useful information which will assist in gaining the patients trust and minimising anxiety.

## **References:**

- a) Alzheimer's Society Dementia 2012 Report  
<http://www.alzheimers.org.uk/dementia2012>
- b) Improving services and support for people with dementia,  
NAO [http://www.nao.org.uk/publications/0607/support\\_for\\_people\\_with\\_dement.aspx](http://www.nao.org.uk/publications/0607/support_for_people_with_dement.aspx)
- c) Living well with dementia:  
A National Dementia Strategy Good Practice Compendium – an assets approach

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_123475.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123475.pdf)

- d) Good Practice Compendium – an assets approach  
26. Improving the clinical care provided by ambulance clinicians  
Great Western Ambulance Service (GWAS)

## **3) Embedding the Duty to involve & report to the public–The NHS Constitution**

NHS bodies are under a legal duty to involve people who use health services or their representatives in decisions about those services. This duty applies to NHS trusts and NHS foundation trusts. The duty applies to the planning of health services, proposals for changes in the provision of services and decisions that will affect the way services operate.

## **The Forum Commissioning Proposal**

The LAS should be commissioned to develop a greater focus on collecting detailed qualitative data from service users and those who have criticised or complemented the service. They should be required to develop methodologies to demonstrate how qualitative data collected from patient groups, individual patients and the public has influenced LAS services. Evidenced based public involvement work in which public influence on the LAS can be demonstrated should become a normal part of LAS service evaluation and development

## **4) Involvement of Clinical Staff in Care Pathway Outcomes and Development**

## **The Forum Commissioning Proposal**

The LAS should be commissioned to improve clinical care and service quality by mainstreaming a system that enables frontline LAS clinical staff to review the outcomes of clinical care they have provided to acutely ill patients who are admitted through A&E. This could be done on a cohort basis, or through the selection of patients that LAS clinical staff have particular concerns about. The development of joint clinical meetings between LAS frontline staff and A&E staff would be an important step in meeting this important quality objective and supporting reflective practice and annual appraisal for paramedics, technicians and medical staff. **This recommendation has been made to the LAS and Commissioners on a number of occasions and we continue to regard the development of a joined up approach between LAS A&E clinical staff and Hospital A&E clinical staff as a priority for enhanced patient care.**

## **5) Mental Health – learning from patients who have suffered an acute mental health crisis**

### **The Forum Commissioning Proposal**

The Forum would like the commissioners to work with the LAS to develop targeted qualitative research with patients who have been taken by the LAS to A&E departments and Places of Safety, with a diagnosis of a severe mental illness, e.g. sectioned under s4, s135 or s136 of the Mental Health Act. These admissions are highly traumatic for patients, sometimes involve the police and can expose the patient to physical restraint when they are profoundly unwell. Learning from the experiences of these patients will help the LAS design services that are focussed more on the needs of the patient and less on the requirement to get the person to a 'place of safety'. This work will also shed light on the impact for patients of having to wait, on some occasions, several hours to handover patients to appropriate mental health practitioners are appalling.

