**Patients Forum for the LAS**

**Meeting with Elizabeth Ogunoye**

**Commissioner of the LAS**

**August 9th 2017**

1. **Downgrading of Cat C Targets**

We discussed the downgrading of Cat C targets from a 20 minute/90% (C1) and 30minute/90% (C2) response to 45 minutes >50% (C1) and 60 minutes >50% (C2). We have been unable to discover who had agreed to the contractual changes for the downgrading of response time. It was agreed to meet with Dr Johal, the Chair of the CQRG (Clinical Quality Review Group) to discover more about the target changes.

1. **Ambulance Response Programme - ARP**

We noted that the ARP would be introduced in 2017. The previous Cat A and Cat C targets will be replaced with four categories of response and that whilst the response would be faster for the equivalent of Cat A1 calls (life threatened) and for patients suffering strokes, that the two lower categories would require a response within 120 minutes and 180 minutes.

NHSE has claimed that no deterioration in patient care has occurred as a result of implementation of ARP in other parts of the country.

Agreed to raise with Trisha Bain the need to carefully monitor the implementation of ARP using clinical audit, monitoring of complaints, investigation of serious incidents and genuine feedback from patients, i.e. asking patients about their experience of the LAS before and after ARP introduction. We proposed that this issue be raised with the CQRG.

We discussed the likely impact of ARP on ambulance queues outside hospital A&E, but no data is currently available on the potential outcome of ARP in this issue. Noted that the Secretary of State has agreed to implement ARP.

The Forum will write to Professor Benger regarding the review of ARP and what methodology would be used.

1. **Tethering Trial**

Noted that the LAS will introduce a Tethering Trial in an attempt to ensure that ambulances remain whenever possible in the Borough they are based. They will leave their Borough only for responses to life threatened patients.

1. **Language Line**

Noted that the effectiveness of this service needs to be checked to make sure that it is of a high enough quality for the new ARP system, where it appears that responses will be considerably delayed. Communication with patients must be of the highest standard to reduce harmful delays.

1. **Complaints Meeting**

We discussed out current plans to monitor LAS complaints. This is being done in cooperation with Trisha Bain and Gary Bassett and is currently delayed pending agreement in relation to patient confidentiality.

1. **Q-Volunteering – Promoting Volunteering from BME Communities**

Progress with this project was discussed. Unfortunately, problems with the project have led to a risk of half of the budget of £100,000 having to be returned to the Department of Media, Sport and Culture. The project is being taking forward by Helen Ko on behalf of the Royal Voluntary Services. Communication about the early development of the project was disappointing and missed opportunities for community development which were available through Forum members.

1. **Forum Meetings**

Noted that the September meeting will be about ‘Race Equality in the LAS’, with a presentation by Patricia Grealish (Director of People and Organisational Development. The October meeting will be about public involvement and the ARP. We also informed Elizabeth that elections to the Forum were current.

1. **Meeting with Dr Johal, Chair of the CQRG**

Noted this meeting would take place on August 15th. Issues to be discussed would include: ARP, Cat C calls, Forum newsletter, sepsis and patients who fall.

1. **CQUINS**

Noted that the current CQUINS are nationally driven, whereas in previous years many CQUINS have been locally determined. In the period 2015-16 CQUINS included improving IT communications for front line staff including access to clinical data for patient assessment, and improving bariatric care. In both cases progress with implementation of new systems has been slow. In the case of bariatric care the LAS were paid for developing a plan but not developing a service. Information is being sought from the LAS about improvements in bariatric care, but access is difficult despite improvements in bariatric care being a CQC priority for the LAS – see below.

**Progress and Recommendations with Bariatric Care**

After discussions were held, the BWG came to an agreement regarding several factors relating to bariatric service provision in the LAS. Consideration was given to aspects such as training, supplemental equipment provision and designing a system that worked efficiently to provide the best care to bariatric patients and that could be delivered within a reasonable timeframe. The recommendations are as follows:

* To source the agreed equipment listed in Appendix 1. A business case is being created to determine the costs and numbers of each piece of equipment.
* To source three specialist bariatric vehicles that can also dual-purpose as a category 4 infectious disease vehicle in the event of an outbreak. Assistance from Fleet and Logistics is currently being sought for creating a specifications sheet and business case for the vehicles.
* The vehicles would be placed at three separate, geographically disperse locations.
* Several scenarios have been set out by the BWG regarding staffing which are discussed below. The agreed skill level for the staff is that of first person on scene (FPOS) with enhanced manual handling training and blue light capability.
* Further training for frontline staff regarding bariatric clinical care and manual handling skills.
* Development of a process to accurately capture bariatric patient journeys.

**Recommendation 1: Equipment**

The equipment was selected and trialled during the away day at Cody Road, and the combination of equipment approved (Appendix 1) was agreed by all members of the group that were present at the meeting. As a marked LAS vehicle that will be used for transporting unwell bariatric patients, it was deemed necessary for the vehicle to carry kit that matches the current profile for fast response units (FRUs); this was also in the event of the vehicle coming across a ‘running call’ and being able to provide assistance. The specialist equipment will be able to cater for patients that are up to 55 stone in weight; with limits of 35 stone for the EZ glide chair, larger patients can be extracted from upper floors using the evacuation mat. A vast majority of bariatric patients requiring journeys are below 55 stone, therefore this weight limit was selected; if this weight limit were increased, there would be a large upturn in expenditure and the equipment starts to become unwieldy in its use on a daily basis. The experiences of the SECAmb bariatric teams were that they had an exceptionally low number of patients that exceeded the weight limit of 55 stone, with the primary requirement for such specialist equipment relating to a person recorded as the heaviest man in the UK who had previously resided in Kent.

**Recommendation 2: Vehicles**

The recommendation of the BWG is to provide three specialist bariatric vehicles evenly distributed geographically across London. Using three vehicles to provide a 24/7 service would keep travel times to bariatric calls at a minimum, which is key in providing care to these patients as extraction is usually a protracted event, already delaying definitive care for time critical conditions. In the event of one ambulance becoming unavailable for calls, the other two could cover the area and still provide a clinically safe service. One issue that was identified during the inspection of LAS bariatric service provision was that the LAS PTS and external provider vehicles were being tasked to jobs outside of their bariatric remit, therefore when they were required to attend an urgent bariatric call they were unable to do so until they had become available from the previous call. This delay is unacceptable and has been related to serious incidents in the past. For this reason the BWG has suggested that the vehicles are targeted to bariatric calls and not made available for standard frontline calls; to maximise efficiency it was also suggested that the vehicles are multi-purpose for other low frequency calls; such as category 4 infectious diseases. An additional benefit to the service of dual purposing these vehicles is that the existing frontline A&E ambulances used by HART for category 4 infectious disease transport can then be returned to standard frontline service. Bariatric calls also have a higher incidence of increased job cycle time, usually due to difficulties in extracting the patient from their environment. This increase in time spent with a single patient necessitates the need for more than a single vehicle, which would be prevented from assisting another bariatric patient for an extended period of time.

It was decided by the BWG that the placement of the vehicles should be in central, east and west locations. The two HART bases are already ideally positioned to cover the west and east, and if the vehicles are to be dual-purpose Category 4 infectious disease assets they will need to be close to HART for their deployment, however, space availability at these locations to accommodate such units would need to be investigated further. An additional central location would be required to base the other vehicle, maximising its access to patients across London. The precise location will be clarified by further modelling from BI to determine which area of London may have the highest number of incidents.

**Recommendation 3: Staffing Options**

One of the reasons that the LAS PTS vehicles were unable to be activated was due to a lack of appropriately trained staff available at the time the vehicle was required. There were also concerns around skill fade if staff were not routinely sent to bariatric calls, which would lead to delays in deploying equipment and increasing the potential for unsafe practice using the equipment; this can lead to manual handling injuries for staff and endanger patients. The BWG has discussed several options with regards to staffing the ambulances:

1. All NETS staff could be trained and therefore capable of operating the bariatric vehicles. This maximises the number of staff available at any given time that can operate the specialist asset and increases its resilience. They could be assigned as a double crew or as single responder on the vehicle. Using this setup, however, means that the staff would not be as experienced in bariatric care as a dedicated crew;there would still be a risk of skill decay. The specialist training would have to be provided and refreshed to a much larger pool of staff than if there were a smaller, dedicated team. Sourcing NETS staff would also remove six staff from other frontline duties at any given time, potentially reducing NETS capacity. Due to the nature of the bariatric vehicle size, further driving training would have to be provided to NETS staff to complete their C1 licence and blue light driving.
2. The ambulance is staffed 24/7 by a single crew member per shift. This operative would then take the vehicle to the bariatric call and provide specialist knowledge in extraction techniques and use of specialist equipment. The crew from scene would take clinical primacy and treat the patient whilst the operative drives the vehicle to the intended hospital / location. This provides specialist equipment on scene and a member of staff who is well versed in bariatric care. To staff a 24/7 service for a year there would need to be six people employed per vehicle (18 in total). As the nature of the job involves difficult manual handling, there is a higher risk of staff injury and illness. With such a small, specialist pool, there is a risk to resilience if any long term sickness occurs. There is an issue around whether there would be enough people on scene to initiate the extraction, but further frontline resources can be called upon to assist if necessary. If the bariatric crew member drives the double crewed ambulance(DCA) crew to hospital then there is potential for it to negatively impact their job cycle time (JCT) or out of service (OOS) times, as the DCA crew would then have to be driven back to scene to collect their vehicle.
3. A double crewed bariatric vehicle operating 24/7 with dedicated staff. Similar to the scenario above, but with the added advantage of having an additional specialist operative on scene to assist with lifting, extraction and problem solving. This would require 11 staff per vehicle, per year (33 in total). Other benefits include the option to have the original crew on scene (DCA) in the back of the bariatric vehicle, whilst one operative drives and the other takes the DCA vehicle to hospital so that both crews can become available immediately. This provides a much higher level of clinical care and would help improve JCT and prevent further OOS.The previously identified risks would be mitigated by having a double crewed bariatric service vehicle. This option was preferred by the BWG and is their recommended selection.

**On-going Work and Risk Mitigations**

The BWG recognises that whilst these changes are being made there are still risks to bariatric patients and LAS staff alike. A collation of information from Datix shows that there are a number of incidents whereby staff have injured themselves during the course of a bariatric call, usually related to the use of equipment or manual handling procedures (Appendix 2).To mitigate these risks it has been suggested by the BWG that further education around the care and transport of bariatric patients is provided to staff. The medical directorate are working to prepare a clinical update and the BWG are discussing the use of clinical skills refreshers (CSRs) to inform frontline staff on these topics in the future, increasing awareness and levels of clinical practice. In conjunction with the manual handling working group and clinical education and development, it has been confirmed that CSR 2017.1 will contain a module on manual handling that incorporates information especially targeted to bariatric patients.

Another identified risk is that of the lack of method for recording bariatric patient care and journeys in the existing system; this is currently being worked on by BI and a representative from EOC. Attempts at acquiring information from local authorities, social care services and other agencies around the location of known bariatric patients in London have provided no quantifiable results; therefore current discussions centre on the creation of a database through frontline staff flagging addresses, adding information of interest (IOI) tags and writing pre-designated terms in the Command Point (CP) free text (e.g. ?bariatric). Another suggestion would be to include a process for frontline crews to flag addresses requiring specialist transport, potentially including a box on the PRF or the creation of a new form for submission. Once these locations / names have been logged it will improve future service provision to these patients should they require specialist assistance.

Overall, areas for improvement in bariatric care have been identified both internally and externally. With the establishment of the BWG the LAS has shown its commitment to improving bariatric service provision in London; forming a working group that has created a list of recommendations and that will continue to work on addressing the issues identified which threaten further harm to our patients and staff.