PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

ACTION POINTS

FROM MEETING HELD
Monday 12th March 2012

www.patientsforumlas.net

1) **We regret to announce that Mike McConnell – Croydon – May Day Hospital Patients' Assembly has resigned as a member of the Forum.**

2) **HEARING LOOP AT LAS HEADQUARTERS**

- This matter has been raised with the Chair of the LAS, Richard Hunt who has agreed to take action.

- Janice Markey has taken up the matter with Martin Nelhams, the Head of Estates, and together they will ensure that an induction loop is obtained. It is likely that this will be a portable one for use in any of the meeting rooms in the building, and will be held at Reception.

3) **FUTURE OF THE LAS – A STRATEGIC REVIEW – Report from the London Assembly Health and Public Services Committee – February 29th 2012**

- Access a copy of the report - http://tinyurl.com/bpsal8j

- LAS response to the report - http://tinyurl.com/7wnkb7m

- The Commissioners response has been requested.

4) **COMMITMENT OF THE LAS BOARD TO PUBLIC INVOLVEMENT**

- Joseph Healy, Lynne Strother and Malcolm Alexander met with Richard Hunt, Chair of the LAS on March 26th. A report will be provided and the issue placed on the agenda.

5) **EMERGENCY CARE AT THE OLYMPICS**

- A copy of Lynn Sugg's slides is attached to the papers for the April Forum meeting.

- A copy of the GMC protocol for temporary registration of doctors for the Olympics is attached.

- There is some very high level material on our website - http://www.gmc-uk.org/doctors/registration_applications/olympics.asp.I attach a paper which sets out our approach to registration of doctors for the Olympics. I've assumed your interest is in the team doctors who are here on a temporary basis as opposed to extra staff being drafted in to help on the site or local Hospitals such as the Homerton.If you want more detail than I can arrange for you to have a briefing from head of the team running the registration operation. Luke Bruce, Assistant Director, Strategy and Communication, General Medical Council

6) SUICIDAL PATIENTS

- A copy of the LAS protocol for responding to patients or callers with respect to attempted suicide requested from the Steve Lennox at the LAS
- LAS procedure for callers who initially present with suicidal Intent
  KUDA DIMBI CLINICAL ADVISOR FOR MENTAL HEALTH

Callers Who Initially Present with Suicidal Intent

As per the bulletin 2nd June 2011, see details below:

- In the event that an EMD (Emergency Medical Dispatcher) receives a call from a patient presenting with suicidal intent the call MUST be triaged using the appropriate protocol and completed. In this way a resource will be assigned to ensure that the patient receives appropriate care.

- Even if a patient informs the EMD that an ambulance is not required the call must still be triaged and completed. These patients should be considered a potential risk to themselves having considered suicide an option and making a call to an emergency service. The LAS has a duty of care to ensure that these patients receive help via the appropriate care pathway.

- In addition, during the call, EMDs should attempt to obtain the details of the callers GP and/or Next of Kin.

- Crews dispatched to scene should carry out an appropriate search and attempt to locate the patient, checking with neighbours etc.

- In the event of the crews being unable to locate the patient they should be stood down and advised to complete a 'notification of high risk form'.

- The OCM should also be advised of the notice, they will request Clinical Support Desk to listen to the call from the patient and liaise with the on call Medical Directorate for the next steps.

- CSD will then complete a welfare report and forward to the patient' GP

7) ABUSIVE BEHAVIOUR

- Information requested from Gary Bassett, Head of Patient Experience at the LAS on the analysis of abusive/aggressive behaviour reports in the relation to the point on a paramedics/technicians 12 hour shift that the incident occurs.
- There has not been any systemic analysis I am aware of but certainly we have looked at previous shift events and other possibly relevant factors (for operational shift changeover, whether a meal break has been achieved, the training opportunities afforded those staff who only work nights, etc) in particular cases; we also always review the clinical care provided, even where the complaint is not ostensibly about this, which has evidenced the notion of poor manner corresponding with poor clinical care. As you will be aware, I have long proposed a profile analysis to consider the impact of working patterns etc and am now trying to develop this with CARU. Sometimes complaints about staff being intimidating or aggressive are where the staff have deemed it appropriate to be assertive, for example to persuade a patient to control their breathing in the event of an anxiety attack, it is all to some extent determined by the subjective experience. More often the complaint is about the staff presenting as seemingly uninterested/unsympathetic. From the trends we are seeing in complaints being about challenging the validity of a 999 call, I suspect this is linked to interpretations of corporate messages - but this is only my personal theory. Gary Bassett,

- **Impact of Shift Work on Paramedics**

  This literature review identified and assessed the published research on the impact of shift work on prehospital emergency providers. A database search yielded 226 articles, only 9 of which met the inclusion criteria for the review. A further three papers were identified from the reference lists of the included papers. The authors discuss the sparcity of papers and call for more research to prevent the physiological and psychological effects of shift work impacting upon the safety and quality of care. issues of patient safety, work-related fatigue and the cumulative effects of shift work.

  Sofianopoulos S, Williams B, Archer F. Paramedics and the effects of shift work on sleep: a literature review. Emergency Medicine Journal 2012;29 152-155 http://emj.bmj.com/cgi/content/abstract/29/2/152?etoc

  This related study was published last year:

  This study investigated the impact of shift work on fatigue, sleep and psychological factors among a sample of 60 Australian paramedics. Fatigue and excessive daytime sleepiness, including falling asleep while driving in some cases, were reported in varying degrees by between 30% and 92% of the study group. 68% reported poor sleep quality with mild and moderate depression noted by 27% and 10% respectively. The authors discuss the impact of shift work on both job performance and home life, calling for further research with a larger study group to investigate issues including patient safety.

  Sofianopoulos S, Williams B, Archer F, Thompson B. The exploration of physical fatigue, sleep and depression in paramedics: a pilot study. Journal of Emergency Primary Health Care, Volume 9

8) PATIENTS SAFETY IN UK AMBULANCES PROJECT

- Mike Smyth, Clinical Instructor with West Midlands Ambulance Service) will be invited to address a meeting of the LAS patients' forum. He has agreed to attend the May 2012 meeting.
- Details of the project can be seen on: http://www.netscc.ac.uk/hsdr/files/project/SDO_PRO_10-1008-12_V02.pdf

9) RECRUITMENT OF ETHNIC MINORITY STAFF

- The Forum has contacted the Runnymede Trust re the recruitment of ethnic minority staff.
- Kathy West will report back to the Forum on how this report might enhance LAS recruitment procedures.

10) COMMAND POINT

- Report form Angie Patton, Director of Communications LAS:
- "You will be aware that we will be bringing our new 999 computer system, CommandPoint, in early tomorrow morning (Wednesday 28 March) with a plan to keep it live permanently. The decision to go ahead was taken after we successfully carried out live tests with CommandPoint on three separate occasions over the last few weeks. As we have done previously, we will closely monitor 999 calls once we go live to ensure our most seriously ill and injured patients continue to receive a fast response. As with the introduction of any complex technical system, we anticipate there may be some teething problems and we recognise it will take time for our staff to get used to the new system. However, we are confident that lessons have been learnt from our first attempt to bring the system in, and the problems we encountered last time have been corrected. We will continue to keep you informed of progress".
- A brief update about CommandPoint – April 10th 2012 – from Angie Patton

  "We've been operating on CommandPoint successfully for almost two weeks now. Certainly during the first week, demand on the service was very high, and staff are still getting used to the system. However, our response times to Category A patients have been better than we expected as have our call answering times. And to date, there have been no clinical issues identified."

11) HOSPITAL TURNAROUND TIMES AND PERFORMANCE

- Request to Neil Kennett-Brown, LAS Commissioner
- "Could you please clarify for me what has happened about accessing data concerning turnaround times? Can we get the data more quickly? Are you now getting it the same day or are there still delays of up to 2 weeks? Can we access the SI reports on turnaround times of over one hour? Where do these reports go and who analyses the data? Is it you and/or the SHA?"
- Request to Richard Webber, Director of Operations, LAS

- Could you tell me if any work has been done on the possible delays in responses to Cat A calls as a result of the introduction of 111. We are concerned that sub-optimal, poorly governed services might delay calls to you for a Cat A response. Is there any evidence that this might be the case and are you working with the 111 suppliers to ensure they are responding appropriately? Are your IT systems locked into theirs?

12) GOVERNANCE OF THE LAS WHEN IT BECOMES AN FT

- Request to Shirley Rush, FT Membership Manager, LAS
- “Can you tell me whether there exists a governance document about the proposed relationship between FT governors and the LAS Board? What rights of access and speaking rights might FT governors have with respect to the LAS Board?”
- “The only documentation we have available at the moment is on our website. The following web pages set out the role of the Council of Governors and includes a link to our membership strategy, which sets out the intention for membership and actions for governors – though neither explicitly refer to the proposed relationship between the Council of Governors and the Trust Board. Council of Governor web pages

  I’m afraid it will not be until we’re nearer the point of FT authorisation that such documents will be available as they are part of the application process”. Shirley Rush

13) MANAGEMENT OF PAIN

- Fionna Moore, Medical Director of the LAS, has invited forum members to contribute to a protocol on how to manage people who are in pain.
- Kathy West will report back to the Forum.

14) USE OF CAGE AMBULANCES TO TRANSPORT PATIENTS WHO HAVE BEEN SECTIONED

- Request to Dr Ed Glucksman, Clinical Director - Trauma, Emergency and Acute Medicine. If no reply send FOI to Kings’
- We have recently been told that patients on Sections of the MHA are sometimes transferred from King's to the Maudsley using 'cage ambulances'. Can you tell me if you are aware of the use of such vehicles and if so who has given consent for their use?

15) DETERMINATION OF DEATH

- Request to David Whitmore - Determination of death – action by paramedics.
- Attached checklist that must be followed and completed every time a member of LAS Staff verifies the fact of death, (this is also referred to as recognition of life extinct). This is very different from the completion of a Medical Certificate of Cause of Death (MCCD), which essentially can only be completed by a doctor on the GMC Register. (There is also a Neo-Natal Death Certificate, and a Still Birth Death Certificate).

  When will a death be reported to the coroner, (even if a MCCD has

been issued)?

- after a fatal accident or injury
- following an industrial disease
- during a surgical operation
- before recovery from an anaesthetic
- if the cause of death is unknown
- if the death was violent or unnatural - for example, suicide, accident or drug or alcohol overdose
- if the death was sudden and unexplained - for instance, a sudden infant death (cot death)

In addition to this, if the deceased was not seen by the doctor issuing the medical certificate after he or she died, or during the 14 days before the death, the death must be reported to the coroner. Anyone who is concerned about the cause of a death can inform a coroner about it, but in most cases a death will be reported to the coroner by a doctor or the police. I am unaware of any problems over paramedics lacking competence in this area. That said though, there has often been problems arising if someone moves a body that has been verified as dead. (All bodies in a public place fall under the jurisdiction of HM Coroner. Deaths in a private place / hospital / hospice etc… (with the exception of those scenarios above – do not).

END OF ACTION POINT REPORT