PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

www.patientsforumlas.net

ACTION LOG - Arising from the meeting held October 8th 2012

1) **NEW LAS CHIEF EXECUTIVE**

Agreed to seek meeting with new LAS Chief Executive when appointed. Ann Radmore has been appointed and invited to January 2013 PF meeting.

Ann Radmore is Chief Executive of NHS South West London. She was appointed Sector Chief Executive for South West London in 2009 and led the establishment of the SWL Cluster in early 2010. She was previously Chief Executive of NHS Wandsworth, appointed in November 2006 leading the PCT out of financial turnaround to be a high performing PCT. In 1998 she led the team in Greenwich, which achieved the first signed PFI deal in London for a major acute hospital development. She moved to south west London in 2000 firstly as Deputy Chief Executive and Director of facilities/Mayor project in the community Trust, then establishing a Shared Services Partnership across the on sector before being appointed to the Strategic Health Authority as Director of Strategy in 2003.

2) **PATIENT CASES PRESENTED TO THE LAS BOARD AND THE FORUM'S QUESTIONS**

Richard Hunt, Chair of the LAS Board has been asked by the Forum to provide evidence that patient's stories presented to the Trust Board have demonstrably outcomes in terms of improved services for patients. He has responded as follows:

We will also ensure that any follow up to the patient's story is clearly identified along with minuted comments. I will be asking Steve Lennox to provide a six monthly review of the patient stories, together with any follow up action requested by the Board. That said, it may well be that there is no follow up action and that the "story" was just for board information as part of general governance. Richard Hunt,

I have only now had an opportunity of meeting with Sandra Adams to discuss how we ensure that responses to Patients Forum questions are clearly identified in the minutes. We have looked back at the last few meetings and I enclose some extracts from the minutes of those meetings which do identify the question raised by the Patients' Forum and the minuted response. However, in order to reinforce this, I will ensure that in the review of minutes at the meetings and any matters arising, that the response to questions both from the Patients Forum and more generally to the public, are specifically highlighted. Richard Hunt

3) INFLUENCE OF THE LAS ON LOCAL AUTHORITY PLANNING

Ask AOMs (Ambulance Operation Managers) what influence they feel they have on local issue, e.g. redesign of road, road humps and strategic changes in health provision.

- LAS policy on traffic calming attached.

Dear AOM, at the last meeting of the Patients' Forum an issue was raised about the effectiveness of the relationship between the LAS and local councils. With so many changes happening at local authority level including the establishment of Health and Wellbeing Boards and the establishment of Local Healthwatch, we wondered if you felt the LAS was sufficiently included in local decision making, about such issues as the development of local health services, traffic calming measures and major road works that might affect the performance of the LAS. I would be very grateful to hear your views. We can provide a briefing on the development of Healthwatch if that would be useful.

4) ACCESS TO ESTATES FOR LAS CREW

Ask London Councils what action they will take to ensure that estates entrances and exits and building names are properly signposted.

Dear Ms Winbeck, **Access for Emergency Ambulance to Housing Estates**
I am writing on behalf of the Patients' Forum for the London Ambulance Service which is an independent body that monitors the LAS and is also works closely with LINks across London (www.patientsforum.net). Concern has been express at our meetings that some local councils do not clearly signpost access to buildings on housing estates, and that exits are sometimes not clearly marked, with the consequence that vital minutes can be lost in locating a person who is acutely ill and also taking a person from their home to hospital. As you know for a person who has suffered a cardiac arrest every minute is vital in saving lives and reducing harm. We are writing to ask if the Transport and Environment Committee could ask local council to audit their estates for clear signage for both day and night, to ensure that an emergency ambulance can quickly find address on all estates and that exit signs are clearly signposted and visible both day and night. We would be very grateful for your support in this crucial matter.

5) QUALITY ACCOUNTS

The Forum has repeatedly asked the LAS to respond to the Forum's contribution to the annual Quality Account. Steve Lennox, Director of Health Promotion & Quality has now agreed to meet the Forum to discuss how the LAS will respond to the Forum's recommendations for 2011-2012. The Forum has also sought advice from the DH on this issue.

http://tinyurl.com/ablxyr7

6) DIVERSITY AND INCLUSION

Mary Clarke from NHS London was asked for an update on the impact of the Equality and Diversity System (EDS) (a tool to help the NHS promote equality and diversity). Liz Delauney the Equality and Diversity Lead has provided an update on progress (see short report at end of this document.

Actions: Review LAS equality data for front line staff – request made to Janice Markey for data for the period 2009-2012

"I will ask colleagues in IM&T for this information and get back to you asap". **Janice Markey**

7) INTERPRETATION SERVICES PROVIDED BY THE LAS

Agreed to ask for the latest audit of translation service provided to LAS
patients by Language Line to ascertain effectiveness. The data shown below was provide by Jason Killens:

The table below shows data from January 2012 through to September. The average call connection time has been between 1 and 9 seconds with the appropriate interpreter being available in excess of 98% of occasions within around 30 seconds.

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT
Total N° of Minutes	11,700	11,359	10,912	9,261	10,197	8,597	8,223	8,254	9,552
Total N° of Calls	1,358	1,317	1,273	1,185	1,269	1,058	1,030	1,029	1,157
Total N° of Calls Connected	1,341	1,303	1,291	1,168	1,252	1,052	1,024	1,009	1,140
Total N° of Lost Calls	17	14	18	17	17	6	6	20	17
% of Lost Calls	1.25%	1.06%	1.41%	1.43%	1.34%	0.57%	0.58%	1.94%	1.47%
Average Answer Time (Seconds)	1	1	1	1	3	3	9	9	4
Average Connection Time (Seconds)	25	26	28	26	24	28	33	26	31
Interpreter Availability	98.70%	99.10%	98.80%	98.80%	99.00%	99.50%	98.90%	98.40%	98.50%
Average Length of Call (Minutes)	8.62	8.62	8.57	7.82	8.04	8.13	7.98	8.02	8.26

Language	Calls	Minutes	Avg Length of calls	% of total calls
POLISH	144	1105	7.7	11.57%
ROMANIAN	94	989	10.5	10.35%
TURKISH	95	748	7.9	7.83%
RUSSIAN	59	602	10.2	6.30%
TAMIL	74	523	7.1	5.48%
ARABIC	60	513	8.6	5.37%
PUNJABI	66	492	7.5	5.15%

8) **HANDOVER TIMES AT CROYDON UNIVERSITY HOSPITAL**

Michael Parker, the Chair of Croydon University Hospital agreed to attend the meeting of the Forum to be held on November 12th to discuss their plans to deal with the major handover problems from LAS to Croydon UH A&E.

9) HIGH RISK REGISTER - LAS

Noted that there are several hundred addresses on the LAS 'High Risk Register'. These are addresses where there have been incidents in the past and LAS crew were not required to enter these premises to provide emergency care unless accompanied by police. The situation has changed in most parts of London and staff now enter people's homes after a dynamic risk assessment and only call police if necessary Malcolm met with LAS to discuss and a full report is attached to papers.

10) REMODELLING OF LAS SERVICES

Joint project between LAS and Commissioners to review demand and capacity in relation formal requirements and targets. The project team is looking at 28 variables including; activity levels, resources levels and rostering and will report in November 2012

- Obtain joint LAS -Commissioners Terms of Reference – see below
- Requests report from Neil KB – attached to agenda
- Place on agenda for November Forum meeting
- Examine plans for evidence of adverse impact on the effectiveness of LAS services.

The broad objectives of the modelling are as follows:

- To gain a detailed understanding of current LAS operational model & its capacity to meet the demand and to provide a clinically safe service over the next three years.
- Identify optimum model of operation in line with the Trust strategy of ensuring a safe and high quality service is provided to every patient.
- Create a detailed plan moving from current operational model to new model of operation
- Understand any potential additional resource requirements, in the context of the overall NHS Operating Framework (including efficiency requirements) and delivery of QIPP
- Work with the new Commissioning System to ensure effective implementation, including consideration of impact on the 2013/14 Contract

11) FOUNDATION TRUST APPLICATION

- Alwen Williams has been appointed 'Relationship Manager' for the LAS by the NHS Trust Development Authority (NHS TDA) and will provide governance and accountability advice to the LAS to support their application for foundation trust status. http://www.ntda.nhs.uk/about/meet-the-team/

- The process is expected to take a year and be finished by April 2014

- Sandra Adams, Director of Corporate Services has provided the following update:

> We are starting the process again given the time that has elapsed since the last application and the introduction of the new single operating model (SOM). Alongside this we have new board members coming in and have to build this into the timetable. The SOM timeline from preparatory meeting through to submission of the application to the DH is 12 months. This includes many of the processes we have already undertaken such as the quality governance review, the board governance assurance framework, due diligence 1&2, and public consultation. On this timeline and taking into account the current time it takes for an application to progress through the DH and Monitor, our likely licensing date is 1st June 2014. Ann Radmore, Martin Flaherty, Richard Hunt and I are meeting Alwen Williams, Director for Development & Delivery for the NHS Trust Development Authority, on 9th November for the preparatory meeting. The next formal stages then take place from March 2013 through to October 2013. We will be discussing the issue of refreshing the public consultation at that meeting as it is over 3 years since we last did so and the external environment has changed under the 2012 Health and Social Care Act which does have a small impact on the make up of the Council of Governors for example.

12) CLOSURE OF A&E DEPARTMENTS IN LONDON – Impact on LAS effectiveness in delivering emergency care

- Collect LAS modelling data regarding the impact on emergency care of closing A&E departments, e.g. Chase Farm
- Gather data on the impact of closing the Chase Farm maternity service on the care provided at Barnet and North Middlesex Hospitals
- Visit Friern Barnet ambulance station to gather front line information on the impact of the Chase Farm closure
- Consult with Dr Brian Fisher, Lewisham LINk on the proposals to close Lewisham A&E and evidence that potential impact on patient care and patient safety has been researched in detail.

Martin, I wondered if you could give me your views on the following issue which will come up at our next Forum meeting on November 12th? Very best wishes. Malcolm

-The plan is to downgrade Lewisham A+E so that it no longer takes blue lights. It will become an urgent care centre.
-Have you modelled where flows would then go?
-The Trust Special Administrator (TSA) seems to think they would be diverted to Woolwich, which might be upgraded. We think flows will go west to KCH.
-What view have you come to and what is the evidence?
-Also, the TSA says that the extra journey time is likely to be 6-9 mins. Is that the case and if so what would the clinical impact be in terms of increased mortality and morbidity?
-Woolwich and KCH A+Es are full to bursting now. Would they be able to cope with the (probably more than) the diverted patients flow of 20% +

13) ROAD HUMPS – IMPACT ON PATIENT CARE

Jason Killens, Deputy Director of Operations described LAS policy as supportive of road calming measures where these reduce incidents and where 'sleeping policemen' (bump built across road to deter motorists from speeding) covered the entire width of the road the LAS would oppose them, but they were acceptable when divided into three portions.

Jason agreed to provide a copy of the LAS - Policy on Traffic Calming – received and available to the Forum

14) GAPS BETWEEN SHIFTS – Impact on Patient Care

Noted that increases in activity in the evening sometimes coincided with shift changes which occur between 6-7pm and have a particular impact on response to Cat C calls. Noted that the LAS and commissioners are carrying out a review of the impact of shift patterns on patients care and compliance with targets Cat A and Cat C. The review will be completed by the end of 2012 and will identify capacity gaps and changes proposed might include varying the times of shift changeovers.

Information has been requested from the LAS on the review.

Formal Complaint to LAS - August 19th 2012

This 90 year old lady living on her own dialled 999 to request an emergency ambulance at approximately 1750 hrs. Despite Miss X being very elderly and frail and in pain, three further calls had to be made to the LAS to get help. The family were desperate for help and unsure how badly she was hurt. She was unable to raise herself, was incoherent and agitated. It is unbelievable and appalling that no ambulance resource was provided until 19.30 that evening: 1 hour and 40 minutes after the call was made. The crew said they had only come on duty at 7pm. and were located at Friern Barnet and therefore could not answer the call earlier. The crew were very professional and kind in the way they related to Miss X, but it is unacceptable that despite the repeated requests for help that you had no clinical staff available to provide care for a very vulnerable person. The call handlers said there were no ambulances and were unable to give any indication how much longer we would have to wait. We were asked continuously if she had deteriorated and we replied that we did not have the clinical skills to respond adequately to that question, and it was implied therefore that Miss X's situation was not an emergency. We did not know if she had a fracture. Whilst I appreciate that a fall is not as serious as a heart attack or stroke, nevertheless if the LAS does not have the resources or humanity to provide a service for an elderly frail woman of 90, then your service if failing very seriously. You have a duty not just to provide a service within a reasonable time, but to provide on going information which is accurate and provides reassurance. Miss X eventually arrived at the RFH casualty at 20.15 in a very distressed state. I believe that the LAS has seriously failed to provide reasonable and adequate care to Miss X and I would like a full investigation.

15) FORUM'S PROGRAMME OF MEETINGS

- November: a) Michael Parker, Chair, Croydon University Hospital
  b) Commissioning Priorities for the LAS

- December: Care of people with dementia
- January: New LAS Chief Executive will be invited
- February: Emergency care for people with a mental health crisis
- March: Review of equality and diversity in the LAS

16) COMMISSIONING OF EMERGENCY AMBULANCE SERVICES - TIMESCALE

- **Neil Kennett-Brown – PRESENTATION (**Slides available on request).
- October – November 2012
  - First draft commissioning intentions developed
  - Strategic Commissioning Board comments on draft
  - Revised Commissioning Intentions circulated to stakeholders

- December 2012
  - Commissioning Intentions updated following
    - DH Operating Framework 2013-14
    - London-wide Commissioning Intentions

- January 2013 - Strategic Commissioning Board approves final Commissioning Intentions and negotiating strategy

Forum Process to Engage with Commissioners

- Consult with members, services users, voluntary organisations to identify priorities.
- Renew focus on compliance with the Equality Delivery System, e.g. low numbers of BME staff on the front line and no capacity or commitment to communicate in languages other than English.
- Priorities might include care for people with dementia, care for homeless people, mental health, stroke and heart disease.

17) CQUIN- (Clinical Quality Incentive Scheme)

- Obtain copy of the LAS recovery plans - Request made to Sandra Adams, LAS
- CQUINS for 2013-4 are likely to include: mental health, alcohol recovery and diabetic care

18) SARAH MULENGA INQUEST

The Forum requested a number of documents from the LAS about their procedures in relation to the care provided to Ms Mulenga and these have been provided.

19) NHS CARE IN PRISON

Noted that the following arrangement will be set up by the NHS Commissioning Board for the care of people in prison.
Contact made with Frances Newell re arrangements for commissioning of appropriate care by ambulance services for those detained in prisons and immigration detention centres.

http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf

Commissioned by the NHS Commissioning Board	**Commissioned by the local Clinical Commissioning Group**
Health services (excluding emergency care) and public health services for people in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites)	Emergency care, including 111, A&E and ambulance services, for prisoners and detainees present in your geographic area Health services for adults and young offenders serving community sentences and those on probation. Health services for initial accommodation for asylum seekers

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20) SERIOUS INCIDENT INVESTIGATION

- Doubt about the capacity of staff to undertake **serious incident (SI) investigations** and/or to write up the subsequent reports. 40 people had been trained for the tasks, but often they are reluctant (or refuse) to undertake the duties because of competing priorities. There are no measures against which those trained can be held to account if they do not undertake investigations and report-writing. Agreed to arrange presentation on the process of investigation and the impact of outcomes of Sis.

'Governance &Compliance (G&C) has recently changed the approach for SI investigations, as it is clear that having one lead officer assigned adds considerable effort to their workload and causes delays. The most recently declared incidents have been managed under a panel approach, utilising expertise from all areas concerned in a Serious Incident. This is proving extremely effective, evidenced by the report being made available well in advance of the NHS London deadline. A meeting has been scheduled with the Deputy Director of Operations in November 2012 to discuss the process for identifying appropriately skilled operational staff who can participate in investigations to ensure SI reports are submitted within timeframe and to meet NHSL and Commissioner deadlines.' Carmel Dobson Brown, Assistant Director Corporate Services

21) BARIATRIC CARE – a review of the use of resources and vehicles for bariatric patient underway. More information requested from Dr Fenella Wrigley

This is not a question that is asked during emergency clinical triage – we need to ensure that every patient receives exactly the same initial response. If, once on scene, the clinician feels additional resources / equipment is needed this is then requested through EOC. A few patients have patient specific protocols which alert us to their medical condition during despatch. Dr Fenella Wrigley

22) **MULTI USE OF BLANKETS**. It is claimed that this stopped following last winter's audit of the use of blankets. Angela reported that she asked for it to be audited again and was told that the acting Chair would request that it be so for this winter. Steve Lennox has been asked for an update.

Malcolm, As you know we have been auditing blanket use as part of our audit cycle and I am please to say that we closed the month of May with all but two complexes achieving 100% compliance with the single use policy. In terms of the specific action for a common pool of blankets this is not an easy deliverable as it requires individual negotiation with 32 hospitals and leaves us with a gap when we take patients to urgent care centres. I have asked for an options paper that sets out some choices as we clearly need to change the way we stock up our blanket supply. We will track progress through the Infection Control Committee. Regards Steve Lennox, 9/6/2011

23) **SAFEGUARDING**. Learning from Reports and Publications. The safeguarding adult action plan was still in final stages of preparation. Its author is on long-term sickness leave and the LAS are advertising for a replacement to finalise and implement the plan.

More information sought from Clive Palmer, Social Work Liaison Officer, Patient Centred Action Team,

24) **END OF LIFE CARE**. Currently, the service has difficulty covering the thousands of people receiving palliative care, mainly for terminal illnesses such as cancer. This remains a key issue that both social services and health services ought to be working on together. The Forum needs more information about and how readily LAS staff can access information about palliative care patients.

I have assumed that you are referring to an ACP as meaning an Advance Care Plan in the context of end of life care, (EoLC). Currently Emergency Departments have no notification of EoLC ACPs, except in a very, very few cases. Certainly at the moment there is no "joined up thinking" between EDs and the multiplicity of End of Life Care providers. The system used by EoLC Netwroks to register ACPs in London is called CoOrdinate My Care (CmC). Whenever a new patient is entered on this system it sends us an automatic e-mail and we flag the address. However the patient numbers are low at the moment (approc 1,000, but may well rise to some 57K to 60K patients at any one time by 2013 /14. This is a workload we cannot hope to achieve or sustain. (Don't forget as patients die, flags must be removed increasing the workload). Command Point has the ability to flag addresses at which an ACP may be known. However the problem is the physical time it takes to flag the address. Currently Management

Information are under extreme pressure to flag those addresses that we currently need to. What we are having to consider is a different approach to this. We are trying to devise a system that does one of two things:

CmC will automatically flag the address for us. However there are dangers in this and I am talking with the CmC programmers about this. However progress will be slow as the CmC system is a London wide system and will be used by, literally hundreds of clinicians in the fullness of time.

We cease to flag addresses – but hammer home to staff that if they are with a patient they check to see if an ACP has been registered on the CmC system. (There is a view, to which I subscribe, that CmC can and should be used for more than just EoLC ACPS).

LAS staff are due to receive a specific 4 hour session within the Core Skills Refresher programme for 2012 / 13 that covers all aspects of EoLC, and in particular CmC and ACPs in EoLC. Where possible staff will try and seek out information regarding ACPs and DNA-CPR decisions. However, this information can be difficult to find in some circumstances. If a crew are presented with a **valid** Advance Decision, or DNA-CPR form they will do their utmost to follow it. However, please bear in mind that families can very often change their minds at the last minute, and even in the presence of ACPs, valid Advance Decisions etc.. the crews can sometimes be left with very difficult decision to make.
Currently we will only log onto our system ACPs and DNA-CPR decisions that are notified to us by clinicians supervising the care of patients. This is done either via CmC, or by our existing sysem. I am afraid that in this time of austerity and paring down of posts, we have not been able to secure funding for more staff. David Whitmore DIMC RCSEd, Senior Clinical Adviser to the Medical Director, 13/5/2012

25) LAS is about to be **assessed by the NHS LITIGATION AUTHORITY** (NHSLA), on 10 and 11 October. The key function of the NHSLA is to "contribute to the incentives for reducing the number of negligent or preventable incidents". The idea is to enable NHS organisations to 'pool' the costs of *"any damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of their functions".*

Sandra Adams, Director of Corporate Services updated the Forum: we achieved 50/50 at level one on the recent NHSLA assessment.

APPENDIX - EQUALITY DELIVERY SYSTEM – PROGRESS REPORT

Significant progress has been made in regards to the EDS implementation across London which is demonstrated in the number of organisations which are now indicating that work across the dashboard indicators are in progress or is completed. Most significant is the work with the Clinical Commissioning Groups and emerging organisations to ensure that the EDS is embedded into the infrastructure and governance arrangements. Some organisations are continuing to take a phased approach to EDS implementation, and this is supported by the London and E&D Cluster Leads. One FT has not implemented the EDS however has appraised its progress against the EDS indicators indicating its successes on building upon its Equality Scheme, publication of its objectives as well as integration of objectives within the business planning processes of the Trust.

Key areas of note include:

1. Some Cluster areas are progressing much faster than others especially in areas where the E&D resources have been identified
2. During the Transition period, there is varying engagement between PCTs and CCGs and where engagement is robust, progress in the CCG in regards to embedding the EDS and getting a better understanding of the overall E&D agenda is much improved.
3. Engagement with stakeholders is being actively promoted and demonstrated within organisations and there are improved and increasingly developing links with staff and stakeholder groups. Areas for development will be with the “seldom heard” communities served within the local areas; and for CCGs the engagement of staff/ staff side and working with LINKS and the Local authorities.
4. Integration of Equality Objectives within the business planning process for most organisations is also improving, although it is recognised that there is still work to be done especially with the shaping of these objectives by the new clinical leaders.
5. Work is required around embedding the EDS with Private Providers; however commissioning organisations have commented that as new contracts are being developed, demonstrable evidence of Equality compliance is being requested. It is anticipated that PCT/CCGs will be able to provide this evidence from October 2012.