

**REPORT FOR THE CQC INSPECTION OF THE LONDON AMBULANCE SERVICE**

**MARCH 9th 2018**

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**FORUM OFFICERS in 2018**

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**INTRODUCTION**

The Patient's Forum brings together people with a wide range of interests and experiences, including people who have directly experienced care from the LAS, and organisations that work with us to improve care and treatment provided by the LAS, e.g. Diabetes UK and the Sickle Cell Society. All are committed to developing high quality health services in general and specifically highly effective urgent and emergency ambulances services.

About 25 members attend our monthly Forum meetings, including people who are active in health condition support groups (for example, mental health and physical disabilities), and are knowledgeable and experienced in monitoring and influencing health services. Most members have experience as service users, carers, former NHS and local authority staff and maybe active in Local Healthwatch and other voluntary sector health organisations. They share the belief that direct involvement of the public helps to develop and maintain high quality public services.  Membership of the Forum is open to all.

The culture of the LAS in relation to work with the Forum and other community organisations is positive and inclusive. The LAS listens to the Forum and is willing to discuss with patients and the public potential service improvements, e.g. the collaboration between the Forum and Diabetes UK, which asked the LAS to consider introducing tests to measure ketones in patients with Diabulimia.

The Chief Quality Officer, Trisha Bain has gone out of her way to include the Forum in the Quality Oversight Group - QOG, including providing the Forum with a place on the agenda to present examples of successful co-production between the Forum and the LAS. We have also been invited onto most sub-groups of the QOG and our members are able to play a full part in the work of these groups. Briony Sloper ensures our access to many aspects of service development in the LAS - especially in relation to mental health care and end of life care.

**1.0 FORUM REPRESENTATIVES ON LAS COMMITTEES**

**1.1** The Forum is active on 13 LAS committees. Our members join LAS colleagues at these meeting and contribute to discussions on LAS service development, policy, strategy and risk. Through our work on the LAS PPI Committee, we participate in plans for the enhancement of PPI in the LAS. Senior LAS staff are always been willing to answer questions from the Forum and usually respond quickly and positively.

- CLINICAL SAFETY – MALCOLM ALEXANDER

- CLINICAL AUDIT AND RESEARCH STEERING GROUP - NATALIE TEICH

- CLINICAL EFFECTIVENESS & STANDARDS – BEULAH EAST & MALCOLM A.

- COMMUNITY FIRST RESPONDERS – SISTER JOSEPHINE UDIE

- END OF LIFE CARE – ANGELA CROSS-DURRANT

- EQUALITY AND INCLUSION – AUDREY LUCAS & BEULAH EAST

- INFECTION PREVENTION AND CONTROL – ADRIAN DODD

- LAS ACADEMY – PPIP – POLLY HEALY, JAN MARRIOTT, MALCOLM A.

- MENTAL HEALTH – BEULAH EAST & MALCOLM ALEXANDER

- PATIENT AND PUBLIC INVOLVEMENT – MALCOLM ALEXANDER

- PATIENT EXPERIENCE & FEEDBACK – ADRIAN DODD

- PATIENT SAFETY – BEULAH EAST & MALCOLM ALEXANDER

- SAFEGUARDING - ADRIAN DODD

**2.0 PATIENT AND PUBLIC INVOLVEMENT IN THE LAS**

**2.1 LAS Engagement Work**

Outreach work by the LAS is led by Margaret Luce and operates across London. Her team is highly successful at engaging LAS staff as volunteers to meet wide and diverse groups and communities; providing them with information and knowledge about how the LAS works, health promotion and training in CPR. The team also runs the PPI Group which the Forum is invited to present to early in the agenda.

The development of the Insight project was an outstanding example of the team’s work and involved collaborative events with people with COPD, sickle cell disorders and personality disorder.

The Insight Project, funded by NHSE added considerably to demonstrating the LAS’s commitment to improving patient care by listening to patient voices, including:

- The Lewisham Breathe Easy Group - for people with COPD

- The Merton Sickle Cell & Thalassaemia Group

- The Oxleas Trust ResearchNet Peer Support Group for people with personality

disorders.

**Evidence of service improvement through community engagement is growing - we believe the LAS should demonstrate in more detail and depth, where through their engagement with communities, that they have been influenced and consequently provided enhanced services to the community.**

**2.2 Communicating with ‘Foundation Trust’ Members**

5000 Foundation Trust’ members are now invited to all of the Forum’s monthly meetings held at LAS HQ, and many have attended and played a significant part in the work of the Forum. Invitations to our monthly meetings were formerly withheld from FT members, but the decision by the LAS to change their policy on this issue has had an important impact on the work of the Forum and our capacity to influence.

**2.3 Emergency Operations Centre**

Members of the Forum have played an active role in monitoring the Emergency Operations Centre at Waterloo and Bow and have produced a number of recommendations for the EOC and Board of the LAS, which are currently being considered. We have particularly emphasized the need for Trust Board members to actively show support for EOC staff who are a low paid, highly important group of staff, who keep emergency services running 24/7 and provide an outstanding services during major incidents. A- **Final Draft Report Attached**

**2.4 Mock CQC Inspections**

Our members participated in Mock CQC inspections of the LAS and visited many sites across London on November 29th and 30th. We have shared our report with the CQC.

We found it very difficult to get feedback from the LAS to demonstrate that our findings had been acted upon. This was disconcerting because it is the second time that we have participated in significant numbers and then found it difficult to get feedback. On the first occasion we could extract no data whatsoever from the LAS or NHSI. However, on this occasion Trisha Bain responded to the case we presented for access to data, by providing a detailed report (Burn Down) showing the progress that had been made.

**It is a basic premise of PPI work that our contribution as lay people will be met with a willingness to demonstrate that progress has been made towards better services and enhanced patient care. This is an approach that the LAS fully accept, but we are still on a journey to achieve that goal.**

**3.0 MANAGEMENT OF THE LAS**

3.1 The Forum continues to get feedback about team leader, middle and senior management issues. The findings that senior managers do not always 'live the values' or are not visible, or do not care sufficiently about those they manage, leading to a significant 'disconnect', or do not address incidents of prejudice, harassment and even bullying have continued for many years, and while somewhat reduced still do occur in some quarters (one quarter is too many.)  We believe this has contributed to staff turnover, and that change is not happening quickly enough. Moreover, accounts of poor management practice at various levels suggest a lack of understanding of the need for particularly contextualised management training.

3.2 While there is probably generic management training, it seems little has been or is being done to develop skills for managing staff facing trauma and stress every day of every week of every month of every year (although the LINC service does provide an immensely important service to traumatised staff).  But offering counselling should not be seen as an alternative to insightful people management.  Much of the response from management regarding some of these findings arising from the Mock CQC Inspection, focus largely - and arguably myopically - on ensuring staff 'understand policies', which ignores the management training issues.

3.3 The LAS's Strategic Intent rests squarely on a significant change of culture and large-scale organisational development.  It is very widely acknowledged that little can be achieved unless there is a culture change, but this in turn is unlikely to be reached while management recruitment, training and practice remain as they are.

**4.0 LAS STRATEGIC INTENT**

4.1 The Forum contributed to the development of the LAS strategy at an early stage (October/November 2017), but since then have been disappointed with progress. The only public event that we are aware of took place first thing in the morning and unsurprisingly attracted very few people. We submitted two detailed responses to the Strategic Intent document and have had three meeting with the Strategy Team, but have received no written response from the Team to our critique of their proposals. A response has been promised but considerable time has passed since our submission.

4.2 We asked the Board for a process of consultation on their draft Strategy, which should be available in the near future, but at their Board meeting on January 30th 2018 this was refused on the following grounds:

21.2.1 Large parts of the LAS strategy will be about the internal workings of the organisation and would therefore be inappropriate for a public consultation.  However, the Trust wants service users to ensure it is improving the outcomes and experiences of its patients. This will be done in different ways that best meet their needs, and will provide the richest feedback possible.

**The Forum does not believe this response is adequate, reasonable or consistent with the commitment to public involvement, which is expected of the LAS as an NHS Trust or their values as a body serving the needs of London. If public involvement around the strategy is not adequate, then it is very likely that the strategy will not be adequate. Effective long term strategies need to be grown with the support of staff and patients.** Attachment B

**5.0 LAS ACADEMY**

5.1 Work with the LAS Academy has been outstanding. Three members of the Forum and 3 senior staff from the Academy paramedic programme have formed the Patient and Public Involvement Panel (PPIP). We have jointly signed the terms of reference and this PPIP is leading new approaches to PPI in the Academy.

5.2 We are attending Academy HCPC paramedic programme Steering Group meetings and have developed a teaching programme detailing patient and public involvement for the Academy syllabus, which will be delivered later this year. There are currently 85 students going through cohorts 2-6 at the Academy en route to becoming paramedics.

5.3 Our members are participating as mock patients for the assessment of potential candidates and for the training of student paramedics. We are also scrutinising the three elements of assessment for potential candidates, which are: the interview, response to cardiac arrest and clinical assessment. Our role here is to assess the assessors and the process of assessment. Our recommendations are well received and are being used to enhance the work of the Academy. We are also working with the paramedic programme clinical tutors on the module development within the programme to capture patient experience and assist with specialised development.

**6.0 COMPLAINTS CHARTER FOR URGENT AND EMERGENCY CARE**

6.1 The Forum designed the ‘Urgent and Emergency Care Complaints Charter’ and presented it to LAS Executives and the formally to the LAS board, who accepted it with minor amendments. The Charter is on the LAS website and discussions are currently taking place with the Communications Department regarding its redesign to meet the NHSE Accessibility Standard. We hope it will be widely distributed to FT members and though the Communications Department’s Facebook page and Twitter account.

**We have asked the Communications Department to confirm that Complaints Charter is now in the process of being converted to the Accessible Information Standard prior to it being launched, and asked for it to be widely distributed and publicised through social media.**

**7.0 ASSESSING THE EFFECTIVENESS OF COMPLAINTS INVESTIGATIONS**

7.1 We have been trying for some time to implement a system of auditing and monitoring the outcomes of complaints investigations, but the LAS governance process for the Forum to carry out an audit has still not been agreed after many months. We are happy to monitor complaints anonymously, or with the consent of the complainant, but after six months of discussion we still seem quite far off resolution of this issue.

7.2 The LAS gets very few positive responses to their complaint investigations, and the Forum has 3 experienced Members who would like to assess the quality of complaints investigations from the lay perspective, and whether outcomes of investigations lead to LAS or system change, and whether complaints investigations are empowering for patients and relatives who complain. The Patient Experiences Department fully supports this initiative.

**8.0 Q VOLUNTEERING – SOCIAL ACTION – OFFICE FOR CIVIL SOCIETY**

8.1 This project was designed to promote the involvement of BME volunteers in the work of the LAS. Unfortunately, there were communications difficulties within the LAS and between the LAS and the Office for Civil Society. Nevertheless, Briony Sloper, Deputy Director of Quality and Nursing has led a highly successful project using half of the allocated funds in collaboration with the RVS. This involves working with volunteers in Merton and Hackney, the majority of whom are from BME communities.

8.2 It has not been possible to agree how the remaining 50% of the project income will be used. In light of this situation, the Forum produced a project plan which was presented to the Chair and Chief Executive recently, was well received and we have had an excellent meeting with them on this issue. However, the time to complete the project is too short in this financial year. The Forum has written to Paul Casey who is the Policy Adviser to the Social Action Team Office for Civil Society (DCIM) asking for consideration to be given to our project proposal and to extend the time available for completion.

**We include information on Q Volunteering because it is a good example of collaboration and we hope co-production, in a complex situation where the skills and insight of the Forum are valued and where collaboration might lead to a successful project that promotes diverse forms of volunteering and promotes recruitment to the LAS. As a result the Chief Executive of the LAS has proposed collaborative work with the Forum on a volunteering strategy. C-** ATTACHMENT

**9.0 WORKING WITH SICKLE CELL ORGANISATIONS**

9.1 The outstanding work between the LAS, Sickle Cell Society, the ‘Merton Sickle Cell and Thalassaemia Group’ and the Patients’ Forum continues and has led to the production of 3 reports from CARU. These reports demonstrate significant improvements in care, from the patient’s perspective, as a result of public pressure and effective training of front line staff.

9.2 Recently Eula Valentine from the Merton Group was invited to speak to an LAS Board meeting and made an excellent presentation with a number of high level recommendations to the Board, which are now being considered. These recommendations arose from Focus Groups with people with sickle cell disorders, which were developed from the Sickle Cell Insight Project during 2017. The Chair of the Sickle Cell Society, Kye Gbangbola attended the Board meeting, sat round the table with Board members and made an outstanding presentation to the Board. We will regard this event as an example of best practice – providing the recommendations are taken on board and evidence produced of service change as a result. The LAS has written to Eula Valentine to give her assurances about progress.

9.3 In another significant event, Briony Sloper met with a patient who had complained about the LAS response when she was in a sickle cell crisis – she was promised a 45 minute response but waited many hours in terrible pain. The clinical team that arrived after many hours did not include a paramedic and therefore could not offer immediate effective pain control. This meeting with Briony Sloper took place at the North Middlesex Hospital, the location chosen by the patient and was also attended by a representative of the Forum. **The outcome was very positive and the patient reassured by the promised service improvement (Level Two – 18 minute ARP response).**

**10.0 CARE OF PATIENTS WITH DIABETES**

10.1 Following our joint project with Diabetes UK a great deal has been done to ensure that the care of patients with diabetes and especially ‘diabetes with eating disorders’ is included in the CSR for the training of all front line staff. Jaqui Lindridge, Consultant Paramedic led on this work for the LAS. We have promoted the idea that front line staff should have ketometers to assist in the diagnosis of patients with Diabulimia and have received the following response, which is a good example of our continuing collaborative work with the LAS: **They replied as follows:**

**Diagnosing DKA – Response from Jaqui Lindridge, Consultant Paramedic**

“I wanted to update you that we have now reviewed the literature on the use of ketone testing in the ambulance setting, and the attached report was taken to the clinical practice working group last week. Unfortunately, whilst ketone testing is of course standard practice in many settings, there is currently a paucity of evidence for the test in the pre-hospital setting.  In order to bring in the test, we would have to base that decision on clinical evidence. There is certainly a need for research in this area, unfortunately the LAS does not have the resources available at the moment to commit to a formal study in this area, but we will keep an eye out for funding opportunities. I’m sorry that there wasn’t sufficient evidence available to make a different decision as I know there is a strong desire to bring this in. In the shorter term, Tim and Racheal are going to have a discussion regarding any opportunities for the use of capnography in suspected DKA.  There appears to be some data on this in the literature, and is a test we already have access to. Mark Whitbread will be nominating one of the critical care APPs to lead on diabetes going forward, and should be in touch shortly”.

**11.0 STROKE CARE**

11.1 One of our members leads on stroke diagnosis and care and noticed, from looking at the blank Patient Report Forms (PRF) at an Ambulance Station, that the LAS are still using Patient Report Forum version "LA 4", which contains the exact same text under speech component of the FAST section as was the case in 2014 (i.e. no mention of "aphasia"). This is despite the assurances that the LAS provided to the Mayor of London's office on this issue: “*LAS is also looking at changing the wording on the 'FAST' section of the Patient report form on the next revision from 'Speech: Word finding difficulties or slurred speech' to 'Speech:* Word finding difficulties, **aphasia** or slurred speech'."

11.2 We have been advised by the LAS Medical Directorate that it considered this change, but thought it would be too difficult to implement on paper PRFs. They have agreed to review the wording on the PRF when they change over to an e-PRF, and Dr Fenella Wrigley recently wrote to the Forum as follows:

“The e-PRF project is just beginning to be planned and it is anticipated scoping will begin during the summer. The request re speech is one of many suggestions we have had and is on the list for consideration”.

11.3 We have been assured that guidance has been re-issued to crews on the assessment and management of patients suspected of having stroke. This has also been picked up in teaching and training materials, and covered in several issues of the Clinical Update: “FAST covers all elements of speech”.

11.4 We have sought to arrange a meeting between the Forum’s lead on stroke care and the Medical Directorate, but we have so far been unable to get agreement with the Directorate for this meeting to take place. The personal experience of our member in diagnosis of stroke, places him in the role of an ‘expert by experience’, which we believe should be highly valued by the LAS.

**Dr Wrigley has now acknowledged that his input will be valuable and suggests utilising his expertise on a  pan-London level through Dr Tony Rudd at King’s who is the London Stroke Clinical Director.**

11.5 Data on LAS performance on stroke care has improved enormously and a very high percentage of patients now get to Hyperacute Stroke Centres within the target time. Attempts are now being made to enhance pre-hospital care for stroke patients to enable faster treatment once the patient arrives at hospital.

**11.6 The CARU audit of stroke care shows that there is a very high level of compliance with the stroke tool and pathway – 97% of patients are documented to have received the complete care bundle (which includes all elements of FAST, blood pressure and blood glucose measurement) and 99.4% of patients are conveyed to a clinically appropriate destination.**

**12.BARIATRIC CARE**

12.1 The Forum raised concerns about the quality and sensitivity of the LAS bariatric care service prior to the CQC carrying out its detailed inspection that led to the LAS being placed in special measures. The bariatric service is currently provided by St Johns.

12.2 A proposal for a redesigned bariatric service has been submitted to the LAS Executive Team. The proposal, which has been developed by the Bariatric Working Group, is for the provision of 3 dedicated LAS bariatric ambulances to provide 24/7 care and if agreed a dedicated bariatric team would be recruited. Key issues will be the ability of the team to move and handle bariatric patients, so specialist staff would ned to be recruited through public advertisement to work exclusively with bariatric patients.

12.5 The definition of bariatric care varies. Some organisations define bariatric patients as those being in excess of BMI 30, but the LAS believes that other characteristics such as the shape of a person's body are as important as weight. The location of patients is also very important, i.e. where and how high up the patient lives and how accessible the patient is to ambulance crew. Clinical issues: airway management and expertise in drug absorption for bariatric patients are recognised as essential to effective care.

12.7 Interim period – until the new vehicles have been purchased and staff recruited, the St John's contract will continue.

12.8 Patients' weight – this is not asked during the AMPDS algorithmic process (questions put to 999 callers). But, by not asking the patient’s weight; care and treatment might be delayed, e.g. If the first vehicle cannot provide appropriate care and treatment within the required time frame.

12.9 Flagging – would help to provide a faster service to bariatric patients if they were flagged on the Command Point system or via CMC (but this is not available in every borough).

12.10 Patient Experience Data – we discussed a survey of patients who have used the LAS bariatric care service. We would like to survey 20-30 patients to find out about their experience of LAS care and treatment and will raise this issue with CARU and Margaret Luce, and if possible agree a process for the Forum to collect data from patients/carers.

**13.0 AMBULANCE QUEUING**

13.1 Our major concern is the impact of ambulance queuing on patients – those who arrive by ambulance at A&E and those waiting for emergency care. The problem stems from A&E departments being overfull, which causes patients to wait in trolley queues which we believe is not consistent with good clinical practice or patient safety. This is especially harmful to people with cognitive impairment for whom moving between home, ambulance, A&E and wards can be particularly traumatic and add to their level of confusion. The A&E problem results not only in ambulance queues, but also delays LAS in responses to other patients.

13.2 There is active engagement between the LAS, Commissioners and acute hospitals on a weekly basis, but nevertheless, in one week from 28/1/18 to 4/2/18 – 1246 hours were lost due to ambulance queuing in excess of 15 minutes from wheel stop to clinical handover of patients to A&E. In Queens Hospital Romford, 132 hours of ambulance queuing occurred in a single week.

13.3 The current responses to this problem includes: ‘sit and wait’ i.e. providing chairs for patients who have been brought in as emergencies by ambulance, so that they don’t have to wait on trolleys. Some patients are flagged to show they are a higher priority. Instead of individual care, patients are monitored by a nurse or paramedic in groups. We regard this as a breakdown in the quality and safety of emergency care provided to patients taken to A&E by the LAS and is particularly harmful to older people with dementia and those laying in the road following an accident waiting for an ambulance. Clearly, the problem is not the fault of the LAS but their performance is seriously affected by the failure of local hospitals and local authorities to solve these problems.

**13.4 We had a joint meeting with the Mayor of London’s health team and LAS Chief Executive, Garrett Emmerson to discuss this problem and we are aware that it is a whole system problem. We would like to see the LAS leadership and London’s STPs show collective leadership and resolve this appalling problem.**

See also submission by Forum Member James Guest.

**14.0 AMBULANCE RESPONSE PROGRAMME**

14.1 Until August 2017, LAS ‘see and treat’ response targets were based on Cat A responses at 8 and 19 minutes and Cat C[1](%22%20%5Cl%20%22sdfootnote1sym) & C[2](%22%20%5Cl%20%22sdfootnote2sym) responses at 20 minutes (90% of the time) and 30 minutes (90% of the time). In August 2017 the target for Cat C was changed to 45 minutes. There was no consultation or discussion on this change that we were aware of. In practice patients were being advised that the waiting time was 45 minutes, but were waiting well in excess of 45 minutes in many cases. The introduction of ARP meant that patients who would have been given a 45 minute target time were instead seen within 2 or 3 hours.

14.2 The response to the most critically ill patients should have improved, e.g. patients suffering a cardiac arrest, but as there is no outcome or comparative data (before and after ARP) it is hard to tell what has happened. We have been assured by Professor Benger, that by April 2018, data will be available for clinical conditions before and after the introduction of ARP to show how well the service is responding to patients with particular clinical conditions. The current position is that no evidence has been found of harm due to ARP, but there is no evidence of improved outcomes for patients.

**14.3 The LAS is enthusiastic about the ARP. It appears that the ARP constitutes a recognition of scarce resources and the duty to focus on those patients who are most critically ill, at the expense of those who are less critically ill. Alongside the major problem of ambulance queuing, there does seem to be a core systems failure in relation to meeting the needs of patients who are very ill or injured but are not at risk of death.**

**15.0 USE OF TAXIS BY THE LAS**

15.1 The Forum is concerned about the use of taxis by the LAS. We presented a detailed case to the LAS concerning a patient who had had a recent cholecystectomy and was taken to hospital by taxi with severe right sided abdominal pain. We have had detailed and useful discussions about this case with Briony Sloper, the head of nursing for the LAS, but continue to have concerns about the use of taxis. Details of our concerns are as follows:

15.2 The patient received a face to face assessment on July 8th 2016, in her home from her GP, who was fully aware of her medical history and medication. Despite the patient deteriorating throughout the day from the onset of symptoms at 9am, the face to face GP assessment was replaced by the less robust triage system based on the MTS/SOP.

15.3 The patient’s condition worsened throughout the day, therefore, in view of the fact that she was post-laparoscopic cholecystectomy and on Warfarin, the patient suggested that the assessment that her condition was not time critical was wrong and consideration should be given to amendments to the MTS/SOP.

15.4 The patient was in severe pain and immobile. The taxi driver was not an appropriate person to assist a patient in severe pain with mobility problems. This situation needs to be reviewed in relation in relation to the needs of other patients who are in severe pain and immobile, where a taxi would not seem to be appropriate as a means of transport to ED.

15.5 The LAS clinician's assessment that it was safe to transport the patient to Lewisham Hospital within four hours of ‘hear and treat’ appears inappropriate in light of the risks that should have been associated with the patient’s condition and medication, i.e. haemorrhage and sepsis.

15.6 Consideration should be given to the risk of using a taxi for a patient that is deteriorating. In practice, if a patient becomes increasingly unwell, suffering significant pain and trauma whilst in a taxi, little can be done. The taxi driver or patient could call 999, but as the taxi is being used because of a shortage of ambulances and clinical staff, the chance of a rapid response by the LAS seems to be minimal and the patient’s treatment might be further delayed by waiting for an ambulance.

15.7 The arrangements for the ‘handing over’ of patients in serious pain at urgent care/A&E should be reviewed. There needs to be a duty to ensure that a patient in great pain is assisted to get to the appropriate clinician for urgent triage and assessment.

16.8 There is a considerable difference between a clinical handover by LAS paramedics, which includes the handover of clinical information, and that of a taxi company, which can only leave patients at the hospital. Taxis should not be used for patients in serious pain who require immediate pain relief and appropriate handover.

15.9 The LAS should discuss with each ED department appropriate arrangements for receiving patients who are transported to ED by a taxi arranged by the LAS. Arrangements should also be made for the transfer to ED of any relevant clinical information from the LAS or other information from the patient’s GP, which is held by the LAS.

15.10 We suggest that LAS risk 341 is reviewed in light of the concerns expressed by the patient in this case and the issues we have highlighted above.

15.11 We propose in view of the issues we have raised concerning the Clinical Hub assessment of this patient, that governance of the assessment system in relation to the MTS/SOP and the Procedure for the use of contracted taxis should be reviewed.

15.12 The CQC has received, with the consent of the patient relevant correspondence on this case.

**16.0 CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS**

**16.1** The employment of mental health nurses has had a significant impact on the effectiveness of the LAS, in terms of providing detailed advice to front line crew who are providing care to a patient in a mental health crisis. The nurses are also able to negotiate with providers of mental healthcare to gain access to services more quickly. A lead MH nurse has been appointed and 3 more MH nurses will be appointed in the near future.

16.2 Plans for mental health nurses to join frontline staff as part of the ‘see and treat’ role are progressing well and the pilot is underway in south east London. This will enable the LAS to provide expert patient assessments, and to ensure transfer to an appropriate local resource in necessary.

16.3 We hope that the LAS will move in the direction we have proposed of developing a cadre of Advanced Mental Health Paramedics. This is especially important for reducing, as much as possible, police involvement at the interface with patients who are critically ill and may need to be detained under the Mental Health Act.

Care not coercion (including chemical restraint) is fundamental to human rights and civil liberties.

16.4 Patients (or the person who phones on their behalf) who phone the LAS-EOC with a mental health diagnosis are currently asked if there is a risk of violence. This can delay care and we feel this question is therefore not appropriate. It is not used for other categories of patients.

16.5 The Non-Emergency Transport Service (NETS) continues to work well and is being expanded to support other groups of patients. The NETS is primarily for patients being assessed by social workers and doctors to determine whether they should be detained under the Mental Health Act.

**We have been trying for some time to get feedback from patients who use this service on the quality of care provided, but no progress has been made.**

16.6 The Forum continues to be concerned about delays in providing care for patients sectioned under s136 of the Mental Health Act. We are advised that most of these patients will not be included in ARP Category 2 (18 minutes-90%), but have not been able to get performance data for this group of patients. The number of s136 detentions across London in 2017 were as follows:

June                 152

July                   149

August              158

September       159

October            130

November        141

December        120

**16.7 Progress with the development of mental health care and MH training under the leadership of Briony Sloper has been excellent. We have literally seen the development of a service that was poorly tuned to the needs of patients with mental health problems, to one where they have a high priority.**

**16.8 Our current concerns are focussed on the capacity of EOC staff to remain connected by phone to a person with suicidal ideation, at a time of huge staffing problems in the EOC, and the “red-carding” of some mental health patients by A&E departments to prevent their access. In one recent case a patient was held in an ambulance for 7 hours because 3 A&Es refused to take the patient.**

**17.0 EQUALITY, DIVERSITY AND INCLUSION**

17.1 Equality, diversity and inclusion in the LAS and are essential to the delivery of effective health care. We believe that workforce diversity brings valuable knowledge and skills, provides insight into cultural needs and makes a wider range of languages available for more effective communication during clinical engagement between staff and patients.

17.2 WRES 2 - Melissa Berry continues to successfully drive forward implementation of WRES 2 and is fully supported by the Chair of the LAS and Patricia Grealish the Director of People and OD.

**17.3 LAS Equality and Diversity meetings have resumed and have developed a proactive culture. This is markedly different from the non-functional meetings in the past.**

**17.4 Non-Executive Directors -** the Board continues to lack ethnic diversity, being composed of people of a single ethnicity. There are 3 female and 4 male non-executive directors. We have formally complained about the lack of ethnic diversity on the Board many times since 2006 but there has been no resolution. A new associate NED from a BME heritage has recently been appointed.

17.5 Recruitment - there is evidence of active recruitment campaigns for EACs and Paramedics being led by a black woman who has recently joined the LAS. This work is being funded by the **Health Education England** grant of £500,000 given to the LAS for developments toward a diverse workforce.

17.6 Annual VIP Awards: We asked the LAS for an award to be given to the staff member who has shown the greatest leadership in the promotion of racial diversity in the LAS. Our proposal was initially welcomed by the Director of Communications, Heather Lawrence, Chair of the LAS and Melissa Berry who leads on WRES, but it has now unfortunately been converted into a Diversity VIP award. We also proposed that two protected characteristics should be prioritised for the Award ceremony each year.

[www.londonambulance.nhs.uk/working\_for\_us/vip\_staff\_awards/how\_to\_nominate.aspx](http://www.londonambulance.nhs.uk/working_for_us/vip_staff_awards/how_to_nominate.aspx)

**17.7 Racial Diversity in the LAS – Paramedics**

**There has been no improvement in the ethnic diversity of LAS Paramedics. Only 4.2% of front line paramedics are from a BME heritage in 2016-7, a reduction of 0.4% compared to 2015-6. The number of BME heritage staff leaving the LAS is about the same as the number joining.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year | Total no Paramedics In the LAS | Total no BME Paramedics | % BMEParamedics | BME % frontline Paras direct patient contact | “BME” Paras as % of total workforce |
| 2003/4 | 685 | 22 | 3.21 | Not Known | 0.54 |
| 2004/5 | 734 | 26 | 3.54 | 1.07 | 0.65 |
| 2005/6 | 832 | 26 | 3.13 | 0.99 | 0.62 |
| 2006/7 | 816 | 27 | 3.31 | 1.00 | 0.62 |
| 2007/8 | 836 | 32 | 3.83 | 1.19 | 0.74 |
| 2008/9 | 881 | 31 | 3.52 | 1.04 | 0.70 |
| 2009/10 | 917 | 34 | 3.71 | 1.01 | 0.68 |
| 2010/11 | 1025 | 41 | 4.00 | 1.22 | 0.83 |
| 2011/12 | 1385 | 64 | 4.62 | 1.98 | 1.38 |
| 2012/13 | 1648 | 93 | 5.64 | 2.97 | 2.01 |
| 2013/14 | 1611 | 95 | 5.90 | 3.09 | 2.04 |
| 2014/15 | 1707 | 106 | 6.20 | 3.49 | 2.30 |
| 2015/16 | 1991 | 139 | 7.0 | 4.6 | 2.80 |
| 2016/17 | 1969 | 134 | 7.0 | 4.2 | 2.60 |

**17.8 Gender of front line staff:** Data accurate as at 31st March 2017.

|  |  |  |  |
| --- | --- | --- | --- |
| Frontline % | Female | Male | Grand Total |
| Non-para | 40% | 60% | 100% |
| Paramedic | 48% | 52% | 100% |
|  |  |  |  |
|  |  |  |  |
| Frontline (Headcount) | Female | Male | Grand Total |
| Non-para | 509 | 771 | 1,280 |
| Paramedic | 839 | 895 | 1,734 |
| Grand Total | 1,348 | 1,666 | 3,014 |

17.9 We have raised with the LAS Academy and the LAS Equality and Diversity Group, our concern about the low number of women non-paramedics applying for conversion to paramedic through the Academy. We have requested a survey of female non-paramedics to gather information about their reasons for not applying.

**18.0 BOARD MEETINGS**

18.1 We are concerned that LAS Board meetings have extended from 3 to 5 or 6 hours, making it impossible for lay people to remain for the whole meeting – especially as lay people have to sit in silence for whole of this period. We do not think it is good practice or good governance to hold meetings in public, if the public can’t attend for the whole period, because it is unreasonable for them to do so.

18.2 When the Forum first started monitoring the LAS we were invited to sit round the table with Board members. This invitation was later withdrawn and the Forum invited to submit written questions, which were handled by the Board throughout the meeting as the issue came up. We have now reached a point where our questions are dealt with at the end of meetings, usually when no members of the public are present. Or as happened at the January 30th meeting, when our questions were addressed very quickly after three hours as our representative was about to leave.

18.3 The Forum believes that it is irrational for the Board to assume that any member of the public should remain silent for several hours during the meeting. We are also concerned that the Board fails to abide by the Public Bodies (Admission to Meetings) Act 1960, because it does not pass a resolution in public before going into private session. We also find that papers for Board meetings are sometimes only available on the website a day before Board meetings, and despite several requests, papers are still not available 7 days before Board meetings. We have been assured by Philippa Harding, that it is the intention of the Board for their papers to be available to the public 7 days before meetings in future.

**18.4 However, the Forum received no Board papers from the LAS for their February 27th public Board meeting.**