

**Updated Information for the**

**CQC Inspection of the London Ambulance Service**

**2017 UPDATES ONLY**

**FEBRUARY 2ND 2017**

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**FORUM OFFICERS in 2016-2017**

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The names of individuals who have contributed information to this report have been removed.

**PURPOSE OF THIS REPORT**

**This report was given to the CQC when the Forum met them on January 24th. It is an updated version of the report given to the CQC in 2015 on their previous visit to the LAS. The previous report can be found on:**

http://www.patientsforumlas.net/uploads/6/6/0/6/6606397/cqc\_report-20-5-2015-(ph1)\_final\_document-ma.pdf

**HIGHLIGHTING: Paragraphs highlighted in red are those where we have been unable to get updated information from the LAS.**

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1. **PATIENT AND PUBLIC INVOLVEMENT (PPI) IN THE LAS**

CURRENT 2017

1.1) There has been a significant cultural change in the LAS since our previous report to the CQC. The culture in relation to work with the Forum and other community organisations is now inclusive, listening and willing to negotiate with patients and the public in order to make changes to services.

1.2) The Forum works closely with the LAS PPI Committee led by Margaret Luce and Briony Sloper. We attend their meetings, are invited to present progress reports on our public involvement work and collaborate with the PPI team to promote public involvement. The PPI team also support our monthly public meetings by providing a meeting room, photocopying and refreshments.

1.3) There is now evidence of service improvements as a result of engagement with the public. The changes to services for people with mental health problems, dementia and those requiring ‘end of life’ care are highly significant. The LAS works closely with **‘Hear Us’ a mental health charity based in Croydon** and this has led to significant improvements in healthcare for people with mental health problems.

1.4) In November 2015 the Forum held a public meeting in the LAS jointly with the **Sickle Cell Society** in the LAS Conference Room. The meeting attended by a large number of people with sickle cell disorders and their families, as well as the Medical Director for the LAS and several senior LAS staff.

1.5) People with sickle cell disorders described their experiences of the LAS several of which were unsatisfactory. The Medical Director apologised to those who spoke and promised that services would be improved. The following actions followed:

* Sickle Cell CQUIN designed to improve services
* Survey of PRFs and service users by CARU
* Enhanced staff training
* Good evidence of significant improvements to services provided by the LAS, e.g. in relation to pain control and arrangements for transfer of patients from their home to the ambulance.

# 1.6) Work between the LAS and Sickle Cell Society has continued throughout 2015-7.

# 1.7) On January 16th as a result of collaboration between the LAS, Patients’ Forum and the Merton Sickle Cell & Thalassaemia Group, there was a joint event between the LAS and the sickle cell group. Many issues were discussed concerning service users experiences of care and treatment by the LAS. A further event is due to be held on February 6th. Both the sickle cell group and the LAS are optimistic about the progress which is being made in the care and treatment of patients with sickle cell disorders. A report on the January 16th meeting (and photos) is available.

1.8) The LAS carried out a detailed survey of 58 people with **sight disabilities,** in collaboration with the RNIB. Findings included proposals to re-design uniforms for front line staff that are easier to recognise for people with sight disabilities, improving visual and tactile identification badges including the use of Braille, and improving staff training especially in relation to patients with multiple disabilities.

1.9) The Forum collaborated with **Diabetes UK** and the LAS on November 14th 2016 (World Diabetes Day) to bring together a large number of people with Type 1 diabetes, including people with diabetes and eating disorders. The meeting was addressed by Roz Rozenblatt on behalf of Diabetes UK and by people with diabetes who described their experiences of LAS care. The meeting was then addressed by Jaqui Lindridge, Consultant Paramedic who agreed to take forward the issues raised by people with diabetes. A meeting then took place on January 16th between the LAS, Diabetes UK and the Forum to discuss implementation of the proposals put to the public meeting. A report on this meeting and progress with implementation is due shortly.

1.10) Our requests to the LAS for **FT members** to be invited to our monthly Forum meetings have now received a very positive response leading to large number of FT members attending Forum meetings and participating in activities of the Forum including training, ride outs and participation in the NHSI review.

1.11) FORUM REPRESENTATIVES ON LAS COMMITTEES

- CLINICAL AUDIT AND RESEARCH STEERING GROUP - **NATALIE TEICH**

- CLINICAL SAFETY, DEVELOPMENT AND EFFECTIVENESS COMMITTEES–

 **ANGELA CROSS-DURRANT & KATHY WEST**

- COMMUNITY FIRST RESPONDERS – **SISTER JOSEPHINE UDIE**

- EQUALITY AND INCLUSION – **KATHY WEST**

- INFECTION PREVENTION AND CONTROL – **MALCOLM ALEXANDER**

- MENTAL HEALTH COMMITTEE – **KATHY WEST**

- PATIENT AND PUBLIC INVOLVEMENT COMMITTEE – **MALCOLM ALEXANDER**

- SAFEGUARDING – **MALCOLM ALEXANDER**

**2) CARE AND TREATMENT OF PATIENTS WITH DEMENTIA**

CURRENT 2017

2.1) Progress with dementia care has been very significant and has included the use of dementia focus groups and the production of a video called Dementia Care Matters in the Ambulance Service. The training video Barbara’s Story has also been used for training of staff. An excellent draft strategy has been produced on dementia care with 5 key aims. We have confidence that the strategic plan will be implemented by the Quality team.

The developments by the LAS in relation to dementia care have been highly significant since our joint public meeting with the Alzheimer’s’ Society in December 2012 and our Dementia Challenge to the LAS.

2.2) Our major concern however, is the impact of ambulance queuing due to full A&E departments, which causes patients to wait in ambulance and trolley queues. This is especially harmful to people with cognitive impairment for whom moving between home, ambulance, A&E and wards can be particularly traumatic. The A&E problem results not only in ambulance queues, but also delays emergency LAS responses to other patients.

2.3) The pressure on the LAS results in extended waits for Cat C responses to patients with dementia. This is not the fault of the LAS, but the LAS is providing a lower response rate to patients with dementia, because of hospital acute sector crowding. Patients with dementia will nearly always have a primary clinical condition, which requires diagnosis care and an appropriate response - which is proving difficult to achieve in the current situation.

2.4) Work is also being undertaken to understand how the Trust can better support patients who have a **learning disability, including those with dementia**. This work is in its early stages and is led by Ricky Lawrence, the LAS clinical advisor on equality and safeguarding.

**3) PATIENT WHO HAVE FALLS**

CURRENT 2017

3.1) The Forum continues to press for effective local falls teams, to enable, when appropriate, for patients without serious injuries to be cared for at home with an expert and supportive local healthcare team, able to provide continuing care.

3.2) The LAS have been referring directly into either borough falls teams or ‘single point of access’ teams in Wandsworth, Kingston and Richmond, Merton and Sutton, and Enfield. They have been in discussion with colleagues in Barking and Dagenham, Havering, Redbridge, Lewisham and Lambeth. Feedback has been positive in some parts of London, e.g. Merton and Sutton, where a large number of referrals have been made from the LAS to the falls team.

3.3) However, there are IT problems that prevent the LAS from linking directly with ‘single point of access’ teams, which prevent them from ensuring the best service for each patient and often requiring transfer to a hospital even if this is not the best disposition for the patient. The default position is that all patients are referred to their GPs – which causes long delays for patients who may need continuity of care and support.

3.4) Response to Category C calls is also a problem for this group of patients, who are mostly elderly fallers, but include people who fallen following a road accident and may remain lying in the road for long periods – sometimes several hours.

**4) SAFEGUARDING**

CURRENT 2017

4.1) Significant progress has been made by the LAS in the development of responses to the needs of patients who require safeguarding referrals. Two staff have been employed to provide expertise in adult and child safeguarding. Transfer of referral data by paramedics to the EBS is now via telephone rather than fax with onward transfer of data to local authorities by datix. The system is now working much more effectively.

4.2) Staff training has increased significantly, including Trust Board members. We are uncertain however whether Bank staff are adequately trained. Bank staff training falls within the CSR training programme and staff should be booking themselves onto the CSR. Nevertheless, there are concerns that the LAS does not have full governance over the training of bank staff and this matter has been raised by staff leading the safeguarding programme with the LAS Executive, the IPEC and Quality Committee. The Safeguarding Committee has suggested that there needs to be a corporate risk on the risk register regarding the training of Bank staff.

The Forum also has concerns about the training of staff of Private providers. This matter is being closely audited by Alan Taylor and Jon Goldie in relation to safeguarding and they have recently issued warning notices to both St John and MSL ambulance services. We have been assured by the LAS that in this respect that private companies are fully scrutinized.

4.3) There is a weakness in the ability of the LAS to get outcome data from local authorities Safeguarding Committees that could be used for learning, appraisal and reflection for front line staff on the effectiveness of safeguarding referrals.

4.4) Mental health referrals have been an area of concern but the LAS prioritised this area of work and front line staff are now fully aware of the requirement regarding mental health safeguarding referrals.

4.5) Unfortunately, the annual LAS Safeguarding Conference that was due to be held on January 26th was cancelled due to lack of funds. In the past this conference has been an excellent way of creating awareness of major safeguarding issues.

4.6) The Forum submitted the following question to the LAS Board at its public meeting on January 31st “Safeguarding Training: Will the Board ensure that they exercise full governance over the Safeguarding training of Bank staff in view of the inadequate levels of training through CSR for this group of staff?”

**5) CONCERNS ABOUT CAT A and CAT C CALLS AND PERFORMANCE**

CURRENT 2017

5.1) Category A calls are closely monitored using national targets, whereas Cat C calls are not prioritised in the same way. The prioritisation system must work on the basis of responding to the patient who is most dangerously or seriously ill, but is under- resourced to provide essential care for less seriously ill patients who may be at considerable risk. This under-resourcing causes great distress for patients who wait extended periods of time for care and treatment.

5.2) In January 9-15th 2017, the number of patients needing a Cat A response was 20% higher than the level funded by commissioners. That is equivalent for 1900 additional patients needing a Cat A response. Cat A performance for this period was 61% against the national target of 75%. The cumulative performance since April 1st 2016 to Jan 15th 2017 is 65.4% which is well below the 75% target for immediately life threatened patients. For A19 responses the performance is 93.42% against a target of 95%.

5.3 Patients receiving a Category C response may not be life threatened but they are often vulnerable, frail and suffering from serious, but not life threatening illnesses, including mental health problems and suicidal ideation (EOC receive about 300 mental health calls each day). They are in need of an urgent response by the LAS. The LAS Cat C target changed in August 2016 (see table) because of severe pressure on the system, which changed to apparent level of responsive to Cat C calls.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Cat C Target | Original Target | Ave Compliance in August 2016 | New Target | Ave Compliance in Oct 2016 |
| C1 | 90% response in 20 minutes | 63.3% | >50% response in 45 minutes | 74.16% |
| C2 | 90% response in 30 minutes | 67.21% | >50% response in 60 minutes | 77.47% |

**6) DIAGNOSIS OF STROKE**

CURRENT 2017

6.1) The Forum was very concerned about some aspects of the diagnosis and treatment of patients with a presumptive diagnosis of stroke. The case study in our previous report alerted the LAS to weaknesses in their approach to diagnosis.

www.patientsforumlas.net/uploads/6/6/0/6/6606397/cqc\_report-20-5-2015-(ph1)\_final\_document-ma.pdf

6.2) The CARU survey of responses to patients with a presumptive diagnosis of stroke has given us confidence that issues around the diagnosis of stroke have now been addressed.

6.3) The findings of CARU’s research showed that the median response time for patients with symptoms of stroke is now 10 minutes and the median response time on scene is now 32 minutes, during which the FAST, blood glucose and blood pressure are tested. The CARU survey found that 99% of patients are taken to a stroke centre and that median conveyance time to hospital is 30 minutes.

6.4) The Chief Executive of the LAS, Fionna Moore and the Chair of the Patient Forum were invited by the family whose case is described in our previous report to attend a meeting in their home. Fionna Moore put into practice the statutory ‘Duty of Candour’ on behalf of the LAS, and gave an apology for delays in diagnosis and transfer of the patient to King’s College Hospital. Briony Sloper was also present in her leadership nursing and quality role, to ensure that any healthcare issues were taken up and actioned with the family.

6.5) We still have concerns about the diagnosis of posterior strokes and look forward to seeing further work carried out on the diagnosis of this condition. We have asked for this issue to be included in the Clinical Strategy, which the LAS provided to us in January 2017 in draft form for comment and which was presented to the January 2017 Board meeting of the LAS.

**7) QUEUING IN AMBULANCES**

CURRENT 2017

7.1) There continues to be considerable delays in the handover of patients from ambulances to some hospital A&E departments. In the second week of January, about 3261 hours were lost (total time in excess of maximum handover time). These delays are not the fault of the LAS, but represent a whole system failure. An average number of 1600 hours is lost to each week though A&E queuing. The lost time should be used to responds to patients in medical emergencies.

7.2) We don’t have access to 30 and 60 minute breach data as this is no longer held by the Brent CCG commissioners.

7.3) Ambulance queues are potentially harmful to patients waiting in ambulance for diagnosis and treatment and potentially harmful for patients waiting for an ambulance to arrive.

7.4) Despite promises from NHS England that action would be taken to deal with this situation they have failed to resolve the problem and the situation is getting worse. We hope the CQC will inspect A&E departments to assess the magnitude of the problem and propose possible solutions.

7.5) We believe the LAS must be given powers to require providers to take immediate action as soon as the LAS identifies pressure building up at an A&E department, i.e. queues that are delaying the handover of patients and preventing ambulances from attending to other seriously ill patients.

7.6) Information should also be provided on the impact of long delays for patients in the ambulance queues. It is important to note that some Cat C1 and Cat C2 patients may have already waited several hours for an ambulance, and after discharge to A&E may wait several more hours before admission or discharge home.

7.7) The Forum intends to organise scrutiny of hospital ambulance queues in liaison with Local Healthwatch and voluntary sector organisations. The results will be published and shared with the LAS and commissioners.

**8) GAPS BETWEEN SHIFTS – IMPACT ON PATIENT CARE**

CURRENT 2017

We have asked Gareth Hughes, LAS the following question but have received no response:

“We were alerted to the problem of increased in activity in the evening sometimes coinciding with shift changes between 6-7pm, which can have a potentially harmful impact on responses to Cat C calls. We were told that a review of capacity to respond to Cat A and Cat C calls was being carried out, and that this review would include the impact of shift patterns on patient care and compliance with Cat A and Cat C targets.

Can you tell me if this issue has been resolved? I am aware that it is connected with compensation for loss of meal breaks, which included leaving work slightly earlier at the end of a shift and a cash payment.”

**9) COMPLAINTS ABOUT ATTITUDE AND BEHAVIOUR**

CURRENT 2017

9.1) There is a greatly increased focus in the LAS regarding their response to complaints. The Chair, Heather Lawrence is leading on this issue, together with Deputy Director of Quality, Briony Sloper.

9.2) Complaints leaflets have now been placed in every ambulance enabling all patients and those who travel with them to potentially have access to the LAS complaints system. The LAS website information on complaints investigation has also been substantially improved. But supporting people with particular communication needs and other languages is an area that still needs improvement.

9.3) The complaints team led by Gary Bassett is doing an excellent job in investigating complaints and always communicates quickly and fully with the Forum on any issues raised by the Forum.

9.4) The former Chief Executive, Fionna Moore always responded quickly to issues of concern from the Forum regarding patient care.

9.5) However, there appears to be a lack of resources to ensure that the LAS learns from complaints and that people who complained are advised about consequential sustained service improvements.

9.6) We would like to see evidence that staff appraisals for front line staff are having an impact on reducing the frequency of complaints regarding attitude and behaviour of staff.

9.7) In 2015 we asked if CARU could be commissioned to examine data held by the LAS complaints department, to look for significant links between ‘attitude and behaviour’ complaints, and the location of the point on the ambulance clinician’s shift when the event took place. We also suggested looking for other recurring issues raised in complaints to determine what has been learned and what action needs to be taken. Unfortunately, although CARU agreed this was an interesting project they did not have the resources to carry out this research. CARU projects are all funded by external agencies. However, we are discussing with CARU the possibility of inviting an MSc student to undertake this research.

9.8) Data for 2014/5 and 2015/6 for attitude and behaviour complaints received each month are show below and suggests a 50% reduction in the number of complaints received for this category.

|  |  |
| --- | --- |
| **2015/16** | **Number of complaints attributed to conduct and behaviour** |
| April  | 27 |
| May | 32 |
| June | 30 |
| July | 34 |
| August | 28 |
| September | 23 |
| October | 35 |
| November | 39 |
| December | 37 |
| January | 33 |
| February | 32 |
| March | 35 |
| **Total** | **385** |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **14/15** | APR | MAY | JUNE | JULY | AUG | SEP | OCT | NOV | DEC | JAN | FEB | Tot |
|  | 33 | 50 | 72 | 62 | 45 | 65 | 87 | 95 | 71 | 70 | 50 | 700 |

9.9) We also asked, in 2015, that the CQC to examine at least 3 years of complaints data to see if learning from complaints has been integrated into the governance and learning structures of the LAS. This was not done.

**10) CONCERNS ABOUT INFECTION CONTROL AND MULTI-USE OF BLANKETS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT 2017

10.1) We have been informed of the development of a system to place four clean blankets on each ambulance at the beginning of each shift, and that negotiations have also begun with a laundry provider to develop arrangements for the cleaning and provision of sterile blankets. A ‘one for one’ swap system with hospitals is being developed and is expected to be available in the near future. This new system will be monitored by the LAS and the laundries to ascertain if this is the best and most cost effective solution.

10.3) Donia Harker, Business Manager to Andrew Grimshaw has advised the Forum that 92+% of vehicles now have 4+ blankets at the start of shift in line with the tolerance of 3% of the 95% target set out in the Quality Improvement Plan.  There should be no need to re-use blankets as there are now adequate disposable blankets and reusable red LAS blankets in circulation. She said:

 “I am now confident that our staff have access to enough linen to prevent them from ever reusing a blanket”.   Donia Harker

10.4) We understand that 10,000 new red blankets have been put into circulation for 2016-7 and that the LAS have purchased 50,000 new style disposable blankets, which were agreed with staff side to be superior to the previously used variety.

10.5) The LAS has assured us that there are always 2 boxes of disposable blankets at each main station and one box at each satellite site, providing continuous access to clean blankets at all times.   The number of blankets is increased during periods of cold weather.

**STAFF SICKNESS**

10.4) We are concerned about reports that front line staff are often working when sick and feel that they may be penalised if they take sick leave. This issue was raised with the LAS Board on January 31st at their public meeting.

10.5) We are also concerned about the low rate of vaccination for flu amongst front line staff (60%), even though this is a much higher rate than some other ambulance services. This issue was raised with the LAS Board on January 31st at their public meeting.

10.7) The Forum is a member of the Infection Prevention and Control Committee and it is clear that resources provided for infection control work are not always inadequate.

**11) BARIATRIC CARE**

CURRENT 2017

11.1) A great deal of work has been carried out by the LAS Bariatric Working Group (BWG) to develop a safe, clinically effective and dignified bariatric care services, that operate alongside other urgent and emergency care services. A detailed report has been produced on the options for progressing with a highly effective bariatric care service and this report has been shared with the Forum.

11.2) A Patients’ Forum representative attended one meeting of the BWG and a representative of the BWG has met with members of the Forum for a detailed discussion of options which included the organisation of bariatric care across London, equipment, ambulance design and dignity. There was also a useful discussion on the flagging of the addresses of people requiring special forms of transport to ensure a more rapid response from teams with the right skills.

11.3 We are awaiting a progress report on the funding and development of the bariatric care service and have written to Kevin Bate, Anne Muir, and Christopher Benson but have received no response or acknowledgement.

**12) CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT 2017

12.1) 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 health care to gain access to services more quickly.

12.2) Plans for the nurses to join frontline staff as part of the ‘see and treat’ role, in order to provide expert patient assessments, and to ensure transfer to an appropriate local resource are progressing are progressing but this service is not yet available.

12.3) We also hope that the LAS will move in the direction we have proposed of developing a cadre of Advance Mental Health Paramedics.

12.4) The key staff needing to attend the CSR training in mental health are from operations specifically: East Central; North Central; North East; North West; South East; South West; West and the Emergency Operations Centre. The figures are shown below.



12.5) Patients (or the person who phones on their behalf) who phone the LAS-EOC with a mental health diagnosis are 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.

12.6) The new Non Emergency Transport Service (NETS) is outstanding. The Forum assisted with the NETS development and has participated in conference calls on the effectiveness of the service, which is primarily for patients being assessed by social workers and doctors to determine whether they should be detained under the Mental Health Act. NETS vehicles are pre-booked and there is a high certainty of them arriving at the time requested by the social worker who booked the vehicle.

12.7) The Forum continues to be concerned about delays in providing care for patients sectioned under s136 of the Mental Health Act. We believe that the requirement to ensure that ‘parity of esteem’ is implemented between physical and mental health needs further attention, so that better arrangements can be made to care for patients needing admission to a place of safety.

12.8 We were pleased to note that the new LAS Clinical Strategy presented to the Board on January 31st highlights to importance of parity of esteem between physical and mental illness.

**13) END OF LIFE CARE**

Advance Care Plans (ACP), End of Life Care (EoLC), CoOrdinate My Care (CmC).

CURRENT 2017

13.1) End of life care is now a priority for the LAS and this work is being led by Briony Sloper.

13.2) The re-launch of the CMC system in 2015 remedied many weaknesses in the system following work with users to identify problems. It is now simple and quick to use and takes about 15 minutes to create a new record for a patient. The feedback in the LAS has been very positive and the number of care plans being created is growing.

13.3) Unfortunately, some areas, e.g. NE London have a different system to the rest of London which decreases visibility of records for the LAS. A different system is also being used in Bromley. Unless the patients have a hard copy of their care plan from these different systems readily available and easily visible to ambulance crews in their home, the LAS doesn’t have sight of care plans and can’t take appropriate action to meet the patients’ needs at an early stage. Attempts are being made by Briony Sloper to address this problem.

13.4) A further positive development is the extension of the Non-Emergency Ambulance Service (NETS) to patients requiring end of life care. An agreement is being developed with hospices that should ensure that patients are able to die in the place that is most comfortable and appropriate for them.

13.5) The Forum is also pressing for something to be done about working with care homes and nursing homes because exactly the same principle should apply, i.e. that people are able to die in the place they have chosen. There are far more people in care and nursing homes around the country than in hospices, and a great many are near the end of life. GPs are being asked to ensure that residents in these homes are also added to CmC where appropriate and required by people themselves. The extent to which this is happening is difficult to assess and the Forum will continue to press for a resolution to this problem.

13.6) Briony Sloper reported to us that there has been a specific piece of work done with Coordinate My Care and care homes as part of the vanguard work with care homes in Sutton. LAS paramedic Jason Morris was central to developing this work stream and his report is being shared through NHSE guidance, which has gone to each STP and CCG commissioner.

13.6) An 'end of life' working group has been established by Briony Sloper and the Forum invited to participate in the work of the group.

**14) EQUALITY AND INCLUSION**

CURRENT 2017

**14.1) WRES 2** - A great deal of progress has been made on this issue since the CQC visit, and the Forum’s detailed study of race equality in the LAS. Implementation of WRES 2 is now a major priority for the LAS and a WRES Action Plan has been produced which Melissa Berry driving forward to ensure implementation. She is fully supported by the Chair of the LAS in this work.

**14.2) LAS Equality and Diversity** meetings stopped a year ago but will resume on January 31st 2017. We strongly advised the LAS during our meeting with Melissa Berry and Mark Hirst that the Terms of Reference should be updated. There is no current strategy for equality and diversity in the LAS and this will be a key issue for the meeting on January 31st.

We agreed at the meeting on January 31st to develop new terms of reference and a process of critical development and influence for the Equality and Diversity Committee.

**14.3) Non-Executive Directors -** The Board continues to be composed of people of a single ethnicity and only one woman, who is the Chair. Heather Lawrence is committed to changing this situation. The Forum has asked for a place on the selection panel for future NEDS, but has been refused. We have raised this issue with NHS Improvement.

**14.4)** The LAS is now using **the Electric Staff Record ESR system** which captures a great deal of significant data about diversity. This system was not used by the LAS in the past, despite being the standard NHS system. The ESR system will include details of staff diversity including languages spoken by staff, which will help to provide an enhanced service for patients who do not speak English.

**14.5) Health Education England** has given £500,000 to the LAS Academy for developments toward a diverse workforce. The Forum has proposed and promoted the need for a **proactive strategic approach to recruitment** of paramedics from schools and colleges. The LAS is moving in this general direction but we have not seen a strategic recruitment plan for London schools and colleges. We regard recruiting from London and the rest of the UK to be a major priority in terms of diversity and to end the need to recruit from Australia. In our view the workforce should reflect the population in serves.

**14.6) Recruitment of ambulance technicians** can reflect London’s diversity more easily, because they can be directly recruited from the local area, rather than following a paramedic degree. Recruitment of BME staff in the EOC is seen by the LAS as less of a challenge, because it is easier to meet and EOC currently has the most diverse team of staff in the LAS. The call handlers are paid on Band 3 and tend to be recruited locally.

**14.7) Stepping Up Programme** - The Leadership Academy has stopped funding new entrants, but will nevertheless fund new entrants from the LAS, to enable staff to “step-up” from grade 5 to grade 7 and thus to take on senior/managerial roles.

**14.8) Resources for Equality and Diversity in** the LAS have doubled and this has enabled the LAS to appoint Melissa Berry to the interim WRES post, which she has been tackling with great commitment and enthusiasm. Two new posts will be funded by the LAS to promote equality and diversity in the workforce and with patients. The staff will work on administration, outreach work towards recruitment, and sessions with staff to understand more about their needs and to build effective relationships them.

**14.9) Listening Events for BME Staff -** The first listening event for BME staff was attended by 17 staff together with Melissa Berry and the Chair, Heather Lawrence. Further listening events will be held. Melissa and Heather will also meet staff at A&E departments while they are on duty. A BME staff conference is being planned, but the date is not yet known.

**14.10) Stonewall Top 100 Employers Index** – LAS achieved 46th place. The LAS previously believed that this index suggested that the organisation had achieved high scores for all protected groups, but is now aware that this is not the case and refers only to LGBT staff. We would like to see evidence of improvements for LGBT staff as a result of this successful assessment of the LAS, especially as this could be a model for other staff groups.

**14.11) Staff Survey:** Response rate for 2016 is 43% and the results will be available to the Forum in early March 2017. The Forum will invite Mark Hirst to speak to its meeting in March to provide details of the results. These results are very important as a source of evidence that the LAS is providing effective leadership, and that staff feel valued and no longer subject to a culture of bullying and harassment.

**14.12) 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 warmly welcomed by Charlotte Gawne, Director of Communications, Heather Lawrence, Chair of the LAS and Melissa Berry who leads on WRES.

[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)

**14.13) Racial Diversity in the LAS – Paramedics**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year | Total no ParamedicsIn the LAS | Total no “BME”paramedics | % “BME”paramedics |  “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 |

**APPENDIX ONE**

 **CQC Inspection 2017**

 We met Jane Brown, Inspector, Hospital Directorate – London

 (Jane.Brown@CQC.org.uk) and Robin Shone who is the team leader on January

 24th. We had a detailed discussion with them for just over one hour and gave

 them a copy of this report and our report for 2015. We have also invited the CQC

 to attend the Forum meeting on February 13th.