Report on Patient and Public Involvement Committee Meeting of 27th April 2012

I attended this committee meeting in place of Malcolm Alexander who usually attends. It was particularly well attended and those present included Janice Markey, Equalities and Diversity Manager and Steve Lennox, Director of Health Promotion and Quality.

Patient & Public Involvement Team

The Public & Patient Involvement team began by explaining that there was a piece on the LAS website entitled 'A day in the life of...' which would concentrate on the work of a particular LAS employee. After the Olympics, 8 new Community Involvement Officers would be recruited internally, as no external recruitment was currently permitted. Shirley Rush and Margaret Vander reported back on the events for members of the public. April 14th had seen a well attended meeting, where 250 FT members had been signed up. These events were in place of the former Patient conferences held annually. The next event would be in Barnet. An issue had arisen which was that the LAS had had to assist the Association of Ambulance Trusts as the Assoc had no method of recording data electronically on Category A patients. A film about knife crime, made in cooperation with the Met Police, had been texted to thousands of children's phones.

Beverley Jeal from the PPI Team said that 412 events had been held for the public – feedback forms were now being filled in at such events. A new 'Stay Healthy during 2012' leaflet had been issued about how to use the LAS during the Olympic and Paralympic period. Reassurances were issued that other areas of London outside the Olympic boroughs were also being covered during the period. Steve Lennox said that a recent Westminster LINks meeting had been mainly concerned with how LAS were providing cover to other areas during the period. Some felt that the public were not sufficiently aware of this and that the LAS needed to reassure them more.

Foundation Trust Membership

Shirley Rush reported on the Foundation Trust membership. 6,170 public members and 4,850 staff members. Many people had signed up online. Three membership events were being organised. These were 1) 'Safeguarding and Quality Deliverance' there was feedback from this on the website. 2) In October there would be a meeting on 'Major Trauma'. There had also been an event on Foundation Trust membership organised by KPMG and observers from the CQC had attended. 3) In June there would be an event on 'Carbon Management Plan'. All of these events were advertised on the LAS website. I asked Shirley about the FT membership breakdown and if there had been an improvement in recruiting underrepresented groups. She said that the only group currently underrepresented were young men but that the LAS did not have concerns about any of the other demographic groups. Steve Lennox reported that there had been a recent visit from the Care

Quality Commission (CQC) and that the LAS were waiting for the formal report on this but informally they had been told that the CQC were generally quite happy, although there were some concerns about ordering controlled drugs. The CQC were particularly pleased about the improvements in dealing with both mental health patients and those with learning difficulties. Neil Kennet-Brown was keen to have a method of consulting with FT members on commissioning, which already existed with the Patients Forum.

Community Responders and other volunteers

Chris Hartley-Sharpe reported that a charity had been established to provide financial support to the Community Responder Group. First aid training was being provided for the London Ambassadors for the Games, of whom there were 8,000 but LAS could only train 2,000. Community Responders were being requested to provide additional time over the period. With Emergency Responders, the number would be increased over the Games period. There would be 6 blue light cars but these would not serve Olympic/Paralympic events. BA and Virgin Airlines cabin crew staff would be used for staffing blue light vehicles.

A question was raised about Tower Hamlets and why so few people had been recruited as Community Responders despite having attended initial meetings. Chris said that he had no explanation for this as the PPI team had put a lot of effort into this and there was no apparent explanation. There were currently 750 Community Responders and 150 Blue Light Responders. 8,000 volunteers had been recruited at static sites, such as Underground stations. In Croydon, nightclub security staff were being used. Chris was working closely with the Jewish Ambulance Service in areas such as Golders Green etc.

Janice Markey asked about the gender makeup of the volunteers and Chris said that it was about 50/50. Janice asked for a meeting with Chris regarding 'protected characteristics' and community responders as there was not enough time at the meeting to do so. Chris said that language skills held by community responders were useful in assisting ambulance crews but Janice said that Language Line should be used as the most appropriate method. The numbers of Community Responders were highest in residential areas away from busy main roads etc – Biggin Hill area was a typical one.

Public and Patient Involvement Plan

The PPI Action Plan will feed into the Stakeholder Engagement Plan being drawn up by Angie Patton. Any feedback or comments re the PPI Report should go via Margaret Vander. Margaret is writing a plan on CQUINS (PPI) including drugs, alcohol, mental health etc. A public eduction group is being established to monitor this. Neil Kennet-Brown said that a large emphasis was being placed on alcohol by the Met Police and that the LAS would need to be involved with this. Janice Markey asked about working with Stonewall on alcohol around LGBT clubs and venues in London such as Soho, where there was a real and tangible problem.Margaret will have the PPI Plan written soon. Steve Lennox reported that LAS Trust board

meetings were now including a patient story and this seems a very positive development.

Dr Joseph Healy

LAS Patients Forum 16/4/12 – Report of a meeting of the LAS Clinical Quality Safety & Effectiveness Committee on 12/3/12

This Report confirms the oral Report given at the Forum Meeting on 12th March

1.0 Record of the Meeting on 7/2/12

I had issue with 3 of the Minutes

- **Minute 03.18 :** cancellation of call relating to a patient who declared himself suicidal. The outcome was to continue previous risk based practice contrary to CQC guidelines : however, the Minutes omitted to record that there had been voices in favour of the CQC line and I had commented on this in support of an earlier intervention relating to the **process** bias of LAS action, as reported last time. As the outcome achieved its purpose I had not asked for a correction
- **Minute 07.04 : Rule 43/ recognition of Necrotising Fascstitsi :** I considered the Minute, as written, left this issue unresolved; it was accepted to provide more detail so that there was complete clarity : done
- **Minute 207 : Incomplete information from defibrillation :** The discussion was recorded entirely in process terms – why the information was short and entirely omitting my pointing out that the situation had been passed over on several occasion whereas my question had revealed a potential for a life threating situation albeit rare. Agreed to extend the Minute : done

2.0 Patient Transport :

Discussion around risks in relation to the use of Third Party Providers Reminded CQSE of Forum's specification for Patient Transport and that any risk for a vulnerable patient was unlikely to be unacceptable. Point accepted advised that this transport – Taxis – was for ambulant patients requiring transport home or to Minor Injury Unit

3.0 **NPSA Alerts : Patients showing signs of life after declaration of death by Attending Paramedic :**

It was normal practice for a Paramedic to certify that death had taken place following attempted resuscitation, when called to a patients home, leaving that patient with the family for removal. An NPSA alert had identified that there had been rare occasions when, subsequently the patient had then appeared to show 'signs of life' causing substantial family alarm and anxiety. The discussion was around how best to brief families that such an event could occur but would not be such as to change the situation – I explored how this would be done.

4.0 Needs of Bariatic Patients :

LAS had had delays for lack of suitable vehicles - often sub contracted – which resulted in patients need not being met. I raised this issue in relation to LAS contribution to 111 Project and it was agreed that it would be explored further.

5.0 Integrated Learning from incidents/PALS/Complaints, claims, Inquests and Learning Experience Reports

- **Complaints :** large increase between Q2 and Q3 (+ 76%) and 2011 and 2010 (+ 33%) but on overall small numbers although around a quarter of all complaints related to staff attitude/behaviour. I suggested that there could be a causal relationship of stress/fatigue, which was well known factors around the end of shift and enquired whether any study had related such complaints to its time on the shift. The information was to the contrary although some indications were that they were late into the shift. However, at various times, various possible contributing factors had been examined although these seemed to obfuscate the issue and there was resistance from Operations Management to actually doing such a study. After discussion, the Medical Officer agreed that a study should be initiated.

6.0 command Point :

Delay in activation could have resulted in the death of the patient.

Note : *At the Forum meeting a Report on Command Point stated that no relationship had been found which seemed to contradict the Report to the CQSE.*

Barry Silverman : April 2012