

LONDON AMBULANCE SERVICE STRATEGIC INTENT – 2018/19-2022/2023 - PUBLIC ENGAGEMENT STAGE

**OUR RESPONSE TO THE LAS STRATEGIC INTENT -**

**Executive Summary**

The document is just an 'intention’. It sets out what the LAS would like to do and asks whether their intentions are the right ones. Depending on what comes out of the engagement events that have taken place the document ought to translate into a strategy document, supported by an operational plan - with deadlines. The usual method of production is to begin with priorities. But before any of that, we have a few questions.

Looking at the whole document, we would first say that it remains very aspirational (perhaps overly so).Several - or many - of the aspirations depend so much on all the other agencies that have been mentioned complying, and we wonder whether the aspirations in full will ever materialise, at least not until several/many years ahead. Also, much will depend on the influence the LAS can bring to bear on its strategic 'partners'.

Secondly, the only places where a first-year priority is mentioned are on pp 41 and 42, relating to the estate and to the fleet respectively. While these things are important, what is marked by its absence is any reference to people until p 44/45. It is only here that reference is made to a change of culture (a drastic change being needed). Nothing is said about people management deficiencies anywhere in the document. There is no recognition of this significant shortfall, though a passing reference is made to bullying and harassment in (3.4.3). It is almost a self-delusion to explain that staff leave to go to work for other ambulance services because of competition, i.e. poaching. However, it is not a case of paramedics giving up the work. They obviously enjoy what they do, but would rather do it elsewhere. No connection, of course, with poor people management.

Then there is the case being made for reducing conveyance to A&E. For ‘end of life’ patients, the point is well made. As for the rest, how much influence does LAS have over handover times? It is easy to say that if 111 and 999 were used properly there would be fewer inappropriate patients flooding A&E. However, since much is made of analytics/data and metrics, where is the evidence that the LAS can prevent inappropriate visits to A&E under people's own steam, or that it is known how many people get to A&E without an ambulance having ignored advice from 111, etc, etc.? How many 'inappropriate' patients are actually taken to A&E by ambulance? The LAS cannot prevent abuse of the A&E service. It can only mitigate it in some small way.

What would the outcome be for fleet usage if all handover times were within e.g. 15 mins? Are there analytics to answer this? How can LAS influence A&E handovers? What is happening to work already being done about good and poor planning and management of A&E?

The LAS makes a claim that quicker travel to and handover would be improved via better IT. Just how does IT (? sat nav) plot quicker routes? Could it be that if vehicles had to manoeuvre narrow roads because of bike lanes, slow routes because of road humps, that sat nav could plot an *alternative* route that might be quicker not because it is quicker per se, but because taking the most direct route is unacceptably or even dangerously slow because of the bike lanes and humps?

**At our meeting with you on December 19th at 5.30pm we would like to discuss the following priorities:**

1. People management skills to address front-line stress, bullying & harassment, the management of change and organisation-wide understanding of a new culture. **Reason** - people make an organisation work.
2. Recruitment, to include E&D. **Reason** - better people management needed, turnover lessened, E&D long, long, long overdue.
3. How will the organisation ensure that it does not return to Special Measures at it moves forward with the new strategy and how will it ensure adequate funding in view of London’s rising population of diversity of need?
4. Steps being taken to have **real** influence on 'CCG and STP partners', A&E, establishing the consistency needed across all providers and all parts of London. **Reason** - need to plot the steps taken so far, outcome so far, what next steps needed to achieve high level objectives.
5. Alternative/Appropriate Care pathways - and again, steps being taken to have real influence on strategic partners including CCGs and STPs as they rapidly move forward to a new paradigm. **Reason** - As above.
6. Fleet upgrade, equipment and maintenance. As per pp 41 & 42 in document.
7. The estate changes and expected improved care outcomes. As above.

We should also like to see the draft implementation plan, with deadlines, people responsible for managing the action/s, and milestones required to monitor and achieve the required outcomes.

Because this document is largely aspirational, we feel that it will already have had the agreement of most that have seen it. Our fear is that while what is aspired to makes some sense (but not the order of priority), prioritising it, implementing and managing it in a realistic timeframe, and doing so with a range of kaleidoscopic 'partners' is altogether another thing. In other words, the 'How' will be problematic - but hopefully not impossible.

The Patients’ Forum produced its strategy for the LAS in 2016-7 and this is attached in the appendix and has been sent to the LAS Strategy Team.

**OUR DETAILED RESPONSE:**

1. **Period of engagement** 6th November to 15th December was much too short. The document was submitted to the Board for agreement on October 31st 2017. It is not possible to fully response to a detailed policy document in such a short time. This draft response will be submitted on December 19th. Public consultations usually last for 12 weeks – we understand that this document is not subject to a formal consultation. The document does not explain how the LAS will consult on its ‘draft strategy’ which follows the Strategic Intent engagement period. Producing the final strategy early in the New Year gives very little time to consult on the actual strategy, as opposed to the Strategic Intent.
2. **There is only one photograph in the report of an LAS clinical staff member who is black**. The range of photographs does not demonstrate that the LAS sees itself as an ethnically diverse organisation.
3. The document’s introduction commits the LAS to ensuring that that strategy is: “understood and believed in”. We would suggest therefore that the use of the term “differentiated” is removed because it is confusing.
4. **1.2 High Vacancy Rate for Paramedics** – we believe that recruitment from within London needs to be a major 10 year strategic goal. We have seen no evidence that the LAS is operating at the level of professional and strategic recruitment of paramedics required to meet the needs of an increasing population with more complex needs.

**5) 1.2 Mitigating demand.** We would like to see the evidence base for this concept. Unless CCG commissioners agree to commission the following services and work in effective collaboration with the LAS, we do not believe that safe mitigation is possible. Need will merely be hidden and deterioration a greater risk to patients. We need:

**a)** Well advertised, coordinated local urgent care services in each London borough, which are available when required 24/7

**b) Home care teams (mental health, falls, end of life care etc.)** that can care for people as required 24/7 and are subject to effective governance procedures to ensure these services are safe, effective and available when required. Without these assurances the LAS focus on four groups (1.4-3) will put patients at greater risk and is not consistent with the high level objective to “maintain an absolute focus on quality and safety” (2.1). This aspiration has been discussed for the past 10 years with virtually no progress over that time in terms of enhanced provision of urgent care and home care. The only real advance has been in telephone advice services.

 6) 1.4 – We welcome the commitment in the document for the LAS to be London’s primary integrator of urgent and emergency care, but the document contains no strategic plan to achieve this objective, except for entering into discussions with STPs.

 7) 1.4 – 1 Please explain: “supported by analytics” and “multi-channel single point of access and triage...” and differentiated clinical services. These phrases are obscure to us.

8) 1.5 We do not believe that the 5 enabling initiatives will be adequate to meet the needs of patient in the proposed redesigned system.

9) 2.2 Is this an error? Refers to North East London CSU, commissioning the South East London 111 service.

**10) 3.3.1 Increase in 999 call volume.**

Whilst acknowledging your concern about increased funding to match the increased population by 2022, surely it is the essence of a long term strategy that adequate funding to match need and demand is one of the paramount priorities. It is by getting the right approach in negotiations with government and NHSE that the LAS will secure adequate funding. Population increases automatically result in substantial increases in tax receipts and these resources are designed to provide funding for services.

 **11) 3.3.2. Increase in 111 call volume**

 We feel this is wrongly expressed. 111 decreases pressure on the LAS by

 diverting calls to urgent instead of emergency care.

 **12) 3.3.3. Interaction with health services**

 We are aware of the role of the Clinical Hub and that the governance

 of the Clinical Hub needs to be improved. We are not clear what is meant

 by ‘enabling remote clinicians to provide expert advice to our frontline

 staff through a wider range of technology’.

 **13) 3.4 Organisational Challenges**

 Providing patient care in any NHS service is not a burden but a duty and a

 commitment for clinicians. To describe it as a burden on A&E suggests a

 fundamental misunderstanding of the relationship between the patient, LAS and

 A&E.

 **14) 3.4.1. Recruitment and 22% turnover**

 Despite a great deal of work to reduce bullying and harassment, there is still a way

 to go to retain staff. Issues that are frequently are reported to the Forum include

 inappropriate pressure on staff who are sick, and anxiety that filling in the annual

 staff survey will identify and harm staff if their views are negative or critical. BME

 heritage staff are leaving in about the same numbers as those joining the service.

 Flexibility in working hours according to home/domestic/career/educations needs

 should be looked at in more detail. The model being used by the army to attract

 staff back may be worth looking at.

 **15) 3.4.2.Information technology**

 The Command Point systems costs were as follows:

 The tendered costs of the system up to the implementation date, as specified in the approved Full Business Case (FBC) was £25.5m, of which £9.8m was payable to Northrop Grumman. The implementation period covered the financial years 2008/09 to 2010/11.

The amount spent to 31st January 2012 was £20.9m.

The amount spent to 31st January 2012 together with the sums spent to the end of

 the implementation period, gave the total project cost of £22.5m, i.e. a further £1.6m

 spent from 1st February 2012 to the end of the implementation period.

It is of great concern that the Strategic Intent suggests that a more robust technology platform is required if performance is to be sustained. It is unclear what is meant by the statement that: “To date we have been unable to use the deep and unique data sets we have, to deliver significant improvements in performance”.

16) 4.1 National and Regional Context

The focus should be on both need and demand. Too much focus on demand creates a negative view of patients and their need for urgent and emergency care services. The delays at A&E may be caused by poor management and underfunding of beds and community services.

17) Ambulance Response Programme

4.3 Since the start of ARP we have been unable to get access to performance data from the LAS or Brent CCG (the commissioner). Whether, the new system is working well is a matter of belief rather than evidence. Making patients wait for 2-3 hours or more, instead of 20 or 30 minutes does not seem to be consistent with claims of service improvement, and the number of complaints is rising as a result of delays.

 **18) Patient Flows**

 **4.4 Delays are caused by a shortage of beds,** because the number of

 beds available across London does not match rising patient demand. Secondly, the delivery of discharge plans is thwarted by the paucity of multidisciplinary discharge teams across acute and community sectors, who can support patients through discharge to their home and ongoing care. There is also a shortage of intermediate care facilities for higher level discharge planning.

 **19) The needs and priorities belong to patients** – STPs are there to support

Patients’ needs and priorities. They should be supporting the aims of the LAS to

 provide timely, effective and safe care.

**20) We do not know what is meant by: “changing attitudes amongst the**

 **public** and changing system processes or customs that have long been established”. The focus should be on meeting the needs of patients and this requires CCGs and STPs to fund and help create appropriate and effective care pathways 24/7 that enable the transfer of care of patients who do not require acute care in a hospital setting. We see little evidence of this happening.

**21) 5.0 Ambition and Strategic Intent**

 We do not think this is sufficiently coherent, e.g. what is the London wide stakeholder community? How is this different from the NHS? Strategic aim ONE is not a strategic aim because it is too vague. What does “consistent approach” mean as a strategic aim? The second aim would require the LAS to take over all 111 services which is a good idea, but probably unrealistic in view of the desire of the NHS to use private providers. The third aim we think is reasonably aspirational, but the term “differentiated” needs to replaced by “Patient needs led”

22) We do not believe CCGs and STPs have a commitment to providing resources required to create appropriate and effective care pathways 24/7 that will enable the LAS to achieve a 40% reduction in conveyances to A&E. We believe achieving this goal will simply leave patients to deteriorate at home or other locations without adequate support, and will lead to the LAS having to deal with more emergencies,

as deteriorating patients and their families demand emergency care. The approach is theoretically a good one, but without a funded multi-agency agreement between health and social care partners across London, it is unachievable. The proposed cut of 10% in the funding of A&E departments and 4% on non-elective inpatient services is in our view completely unrealistic at a time of rising demand, increasing need and

population growth.

23) We think it extremely unlikely that the competing ambitions of increasing ‘see

and treat’ and reducing on scene time can be achieved by using more specialist staff – in practice more specialist staff will spend more time on scene.

**24) More efficient routing of vehicles** to reduce response time seems unlikely to succeed at a time when roads are being made narrower by the introduction of bike lanes.

**25) We do not understand how hospital handovers can be reduced in time,** except by hospitals getting more beds and improving discharge arrangements as described above. IT can’t care for patients who need urgent and emergency care and treatment. The ambition to reduce the number of vehicle hours required to respond to increasing demand is in our view fanciful without a major transformation of multidisciplinary community care.

**26) 5.1 Experience and Expertise – What we will do**

We agree with most of this section, but the reference to being supported by

analytics needs to be explained, and the outcomes described in the 3 bullet points are confusing.

27) 5.1.2 The 3rd bullet point referring to confidence in a differentiated services is vague, as is the referral to 'rotations through other healthcare settings'.

**28) 5.2.1 the diagram appears to describe the current system.** The reference to improving the communications system for people with communication difficulties is very welcome, but the other references to enhanced communications need to be explained in detail, e.g. what are the benefits of webchat in communicating with EOC as opposed to mobile or landline. Are there benefits or are they just options to achieve the same result?

**29) The development of the clinical hub** by increasing the number and type of professionals is welcome. Governance arrangements will need to be enhanced for all clinicians.

**30) 5.3.1 Providing a high quality and efficient service –** **What we will do.**

The first sentence repeats the bland statement which has been repeated many times in the document. However, this section is probably the best in the document, except in relation to the section on Treating more people on scene, where the first two objectives are insufficiently detailed to convey any real meaning. The incorporation of physiotherapists and occupational therapists into the LAS would be a great step forward, but would the numbers required be realistic or would the physios and OT become managers rather than clinicians. We find the section on Falls in Table 2 rather confusing and poorly put together as a model of care, whereas the section on mental health is very positive except for the part referring to s136 which seems contrary to the Mental Health Act as a s136 detention is a detention by the police, which is followed by handover to clinicians. The sections on Maternity and End of Life Care are excellent.

31) 5.4.3 We suggest changing the name. At first look it appears to say Nazi.

**32) 6.0 A major enabler will be successful negotiations with commissioners and providers of health and social care and the STPs.** This section does not deal with delivery to a significant degree – it provides a closer examination of the big issues described earlier in the document.

**33) 6.1.1 Improved clinical decision making**

It is not clear what is meant by pioneer services as these services are already operational, i.e. mental health nurses and midwives. The LAS already has specialist leads for these services.

**34) Alternative care pathways (ACPs) –** should these be called AppropriateCare Pathways to emphasize that they are based on the needs of the patient, rather than just another care pathways? Safe care is paramount.

**35) It is essential for the LAS to produce evidence, borough by borough of the need for alternative care pathways.** The LAS needs to produce data, which shows how many patients would get better care from ACPs in each borough, what these pathways are, who will provide them, where the money will come from and what the governance arrangements will be to ensure safe and effective care for these patients. The worst case scenario would be failing to take patients to hospital, based on a belief that alternative services are available, but which in practice are not adequate to provide effective, safe, continuing care. Accountability for ACPs must be clear.

36) Figure 18 is confusing.

37) 6.1.2 - 1 – It is not clear what is meant by a time-dependent clinical condition – does this means cardiac arrest and stroke?

38) 6.2.1 Volunteer responders para two. The LAS should commit to working with pharmacies who have CPR trained staff, to fix external defibrillators to each of their London premises.

39) 6.2.2 Recruitment of Paramedics – we would like the LAS to publish their recruitment strategy for paramedics. We believe the LAS has consistently failed to produce a strategy and action plan for local recruitment, based on the use of professional recruiters working in schools and colleges in London boroughs with a high percentage of percentage of residents from a BME heritage.

ATTACHMENT – OUR LETTER TO PATRICIA GREALISH - APPENDIX

40) 6.3.2 Benefits for patients and staff. Good communications are fundamental. The Priority should be enhanced communications with people who have disabilities and those who do not speak English.

41) 6.4.1 Estate. We are not sure what is meant by “... dedicated ambulance community response posts...where staff are able to reside whilst not engaged in responding to patients”.

42) 6.4.2 Clinical effectiveness. The strategy also needs to demonstrate how systems will evolve to ensure that staff always have the equipment they need to perform their clinical work. There is a long history of staff not consistently having the diagnostic equipment they need.

43) Finding patients. We are concerned that the Strategy says nothing about the GPS failures in some parts of London, e.g. the Barbican and the east London Olympics stadium. We have raised this problems with Ross Fullerton the Chief Information Officer and have received a detailed response.

**44) Customer satisfaction** – we are not clear why this term has been used. Patients' are not customers. Staff work in vehicles as well as many other environments/location.

**45)** 6.5.1 Transformation. We welcome the statement on diversity and inclusivity**,** but we are concerned at the lack of progress in this field, e.g.

compliance with the [Workforce Disability Equality Standard](https://www.england.nhs.uk/about/equality/equality-hub/wdes/)

**46) Continuous improvement –** it is essential this includes learning from

staff. People on the front line of all specialities have unique experience and

knowledge to contribute to the development of the LAS and enhanced care.

We welcome the LAS's commitment to work with the Forum and other community organisations on the development and co-design of this strategy. We were disappointed that this did not happen in relation to the event held on December 7th. We advise the team to be sensitive to the needs of volunteers as they give their time and experience freely, and being invited to a 9am meeting on a busy work day is not consistent with good practice in public involvement work.

**Patients' Forum for the LAS – Executive Committee**

**18th December 2017**

APPENDIX ONE – THE FORUM'S STRATEGY FOR THE LAS

APPENDIX TWO – LETTER TO PATRICIA GREALISH ON STAFF RECRUITMENT

Patricia Grealish

Director of People and Organisational Development

London Ambulance Service

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25-10-2017

Dear Patricia,

Thank you so much for your excellent presentation to the Forum meeting on September 11th.

We discussed recruitment and diversity at a recent meeting of our Executive Committee and focussed on the low number of front-line paramedics from BME heritages. We took the opportunity of reflecting on what you and Melissa reported to the Forum regarding the LAS’s attempts to increase potential recruits from these heritages. It is clear that work is taking place to interest and engage pupils in their last year at school and this is very much welcomed. However, it was somewhat surprising to hear that the thrust of the work so far has been to help pupils who have considerable difficulty regarding letters of application and other attendant documents that might well be needed when considering their next steps. Evidently, the thrust of this initiative is to try to encourage interest in non-paramedic posts since it appears that the LAS are of the fairly definite view that the level of educational achievement they come across in schools is not high enough to achieve success in getting a place on a university paramedic course. .

The EC would like to propose, again, that not enough is being done with Level 3 students (equivalent to A level) in London who are on Public Services courses at Further and Higher Education Colleges. Colleges in other parts of the country provide rich sources for potential front-line staff in, for example, the fire service, the police service (some run courses for ‘beat’ police staff right through to forensic science courses) and the ambulance service. Some students are not sure which service to enter until their second year of study and are encouraged to learn initially about all three services, and in some colleges the armed services are also included. These students are intelligent enough to move on to under-graduate courses [Level 4] if they achieve high enough Level 3 outcomes.

There is no “wrong time” to engage students on these courses with the services they might aspire to. Students receive speakers from the services at various times of the academic year. College staff collaborate with local stations, use service staff to help develop the curriculum, receive ‘real life’ case studies, students visit stations, they are engaged in live work experience.

Adults are another potential rich stream of dedicated future workers who may aspire to become paramedics. Access to HE is a tried and tested programme that has been in existence since the 1990’s. Access courses are delivered up and down the country for a range of vocational careers including health, science and social care courses, and might include paramedic careers for adults (over 19 years old) who need to change career paths. Access courses work in collaboration between Further Education Colleges and Universities. They jointly design the course in line with the end career in mind, taking in the requirements of the sector. Some programmes also deliver preparation to access courses to bring some adults up to the full access programme. It is important to speak to colleges outlining the requirements of the LAS. Access courses are very diverse in the recruitment of students and would be attractive to BME applicants. Colleges are now in preparation to begin recruitment to their courses early in the New Year.

If the LAS hopes to increase the number of BME front-line staff, it would be appropriate for existing BME paramedics to be involved in this kind of promotion and collaboration with local colleges. It is not unusual for aspirations to be raised following visits to, and work experience in, actual stations. Level 3 and Level 4 students in London could be a rich source of future paramedics, including specifically those from BME heritages. While embracing lesser capable pupils/students is nonetheless welcome, the EC would like to encourage the LAS to put a stronger focus on students who are perhaps more able, who have exhibited sufficient interest to enrol on a Public Services course, and who might well find paramedic posts enthralling – especially when they are introduced to them by appropriate role models. Much more could be done by introducing to school pupils the prospect of Public Services courses in colleges – emphasising paramedic work.

A list of the London FE Colleges has been provided to Trisha Bain (and Heather Lawrence), with an explanation that the staff need to target in the first place those who lead and/or teach on Public Services courses. Even if paramedic work has not been high on the college’s promotional materials, the sooner it appears from now on the better. In the meantime, for those students who are in their first year and perhaps are equivocal about which route they will take ultimately, this current academic year is moving on. There may be opportunities to speak ‘differently’ to first- and second-year students. The first steps, however, remain establishing which colleges run Public Services courses and making contact with relevant staff. It might be that some staff themselves need to be enlightened about possibilities for their students, and especially for BME students, of whom there are very many. That in itself could start an interesting train of events.

We understand that efforts are continuing to recruit trained paramedics from Australia/New Zealand. They still need to get to understand practice here, to learn their way around London, and to deal with pressures unlike anything they are used to. We suggest strongly that alongside that recruitment effort, much more could be done to grow our own wood – particularly from BME students in London.

We hope you will take these suggestions seriously enough to begin pursuing lines of enquiry, and we look forward to seeing your strategy and action plan for the development of a workforce that truly represents the population of London.

Yours sincerely,

Angela Cross-Durrant Malcolm Alexander Sister Josephine Udine

Vice Chair Chair Vice Chair

Copy to: Garrett Emmerson, Fergus Cass, Melissa Berry, Trisha Bain, Tina Ivanov