**MEETING WITH TRISHA BAIN AND ADAM LEVY - DRAFT**

**JUNE 20TH 2019**

**1a) Mental Health Pilot –** the pilot with a paramedic and mental health nurse operating in an ambulance car, has been operating for 6 months in south east London. A 3 month review has been carried out by Alex Metcalf which has included a focus on outcomes. The ambition is to develop the model and extend it to each of the five London regions, and to agree an arrangement with each mental health trust, for a mental health nurse to work in an ambulance car with a paramedic. The LAS is working with David Sloman, NHSI regional director for London to develop a funding source for five London MH teams. It is hoped to develop this by the end of 2019. Work has is ongoing with Oxleas and SLAM MH trusts. There are currently six mental health nurses working for the LAS. T

Many patients in a mental health crisis are taken to A&E which is the worst environment for them, and they may remain in A&E for many hours. Whilst the mental health car will reduce the number of patients taken to A&E, getting appropriate care for patients taken to A&E is a major issue.

**Action: I suggested that if the project is spread across London, it would be valuable for mental health nurses and paramedics to attend joint training sessions to ensure that they are clear about objectives and roles.**

**Action: TB will send copy of the review to MA.**

**1b) Other Mental Health Responses** - Hear and treat calls for mental health care make up about 60% of the total which are received by the emergency operations centres.

**1c) Responding to s135, s136 calls**– I raised our concerns that in view the of ‘parity of esteem’ that people detained on these sections of the Mental Health Act should be seen immediately by the most experienced mental health staff rather than leaving the matter to the police to handle. People who take overdoses should also get the highest level of response.

TB said that this was not current policy, but the Blue Light Collaborative (with police and fire brigade) would focus on this area of practice.

Another major problem is the number of patients who are forced to wait in police cars outside hospital ‘places of safety’ until the emergency team is ready to see them.

**Action: Invite Mind to work with the Forum on raising the priority of ‘parity of esteem’ in relation to s135,136 and patients’ who take overdoses, and long waits outside ‘places of safety’.**

**2.0 Falls Service**

**2a) Fall Team:** The LAS has a single team in north west London that specifically supports patients who have had falls. Weekly data is collected but there has been no evaluation. Six months of data has been collected. The LAS wants to role this project out across London using rotational paramedic roles. Linking with OT services is another opportunity to secure the safety in the homes of people who have fallen.

**2b) Case Study** – Malcolm described the case of a women who requested help from the LAS after her husband had fallen. Three ambulances were sent but only the third ambulance had a ‘manger elk’ required to assist lifting the patient back into bed.

**ACTION:** Malcolm agreed to send TB a statement from the family.

**3.0 Athar Khan – ACP Review**–

3.1 Athar co-chairs the pan London ACP group which evaluates the effectiveness of ACPs. This work is carried out in collaboration with CCGs and STPs and aims to produce reliable and accurate data, that will provide assurance to front line staff that they can transfer care to a local care team, that is expert in the type of care required by the patient.

**4.0 Maternity Pioneer Service**

4.1 This service is not resourced by the CCG commissioners. The focus is on staff training, education and upskilling, and the development of appropriate maternity pathways. The current system is based on discussion with the patient or front-line staff by phone. If resources become available as a result of the business case submitted to the CCG, there will be a focus on appropriate front line maternity and gynaecology care. There are currently three midwives employed in the LAS with Amanda as their leader.

**5.0 End of Life Care**

5.1 Forum members are participating in this development. The service is funded by Macmillan and is led by Di Laverty, Macmillan Nurse for Consultant Palliative & End of Life Care.

**6.0 Urgent Care**

This is operated in four boroughs to enable advanced paramedics to see patients at home and agree with them a care plan to prevent them from going to A&E. The project may extend to Ilford. Links may also be made with GPs and community teams (ACPs). The model is similar to the Paradoc model used in City and Hackney.

**7.0 New Director of Communications**

7.1 Antony Tiernan from NHSE will join the Trust as the director of communications and engagement in August. He is currently responsible for strategic communications at NHSE. He will focus on external and internal communications, partnership, volunteering and building effective relationship with patients and the public in London.

**8.0 Care for Patients’ with Epilepsy**

8.1 Malcolm reminded Trisha of the Forum’s proposals for service developments for patients suffering epileptic fit, which was formally submitted to the LAS on April 15th 2019. He requested a response.

**Improving Care for Patients who Suffer Epileptic Seizures**

Dear Trisha, the Forum agreed the priorities below following the meeting on epilepsy led by Ian Wilmer. Could I suggest that our lead on epilepsy Sean Hamilton is given the opportunity of addressing the LAS Board meeting on the issues below? If you agreed he would be accompanied by his father Vic Hamilton who is his carer and has his own unique experiences of epileptic seizures.

**1)To identify service improvements in the LAS that would enhance the clinical care of patients who have epileptic seizures.**

**2)    Examine progress regarding Tap2Tag methodology.**

[**https://www.tap2tag.me/what-is-tap2tag-medical-alert/**](https://www.tap2tag.me/what-is-tap2tag-medical-alert/)

The Tap2Tag approach, with NFC secure and encrypted patient/summary record access and bio, can be co-ordinated with MedicAlert whose emergency operations centre is we understand contracted with the LAS

 [(www.medicalert.org.uk/about-us/](http://      (www.medicalert.org.uk/about-us/) )

**3)    Areas for improvement -**

**Priority No1**: LAS wide & stakeholder education, not just epilepsy or seizures but the factors and components that often come with it such as auras in the period leading up to a seizure, which is the ictal stage.

An 'aura' is the term people use to describe the warning they feel before they have a tonic clonic seizure. An epilepsy 'aura' is in fact a focal aware seizure. Focal aware seizures (FAS) are sometimes called ‘warnings’ or ‘auras’ because, for some people, a FAS develops into another type of seizure. The FAS is therefore sometimes a warning that another seizure will happen.

In the postictal state, which is the period that typically follows seizures and is part of the recovery/brain resetting process, some patients appear unintentionally aggressive or hostile, even sometimes violent. It is important to remember that this behaviour is not who that person normally is - it’s part of their condition and can at times be made worse when clinical staff don’t listen or respect the patient’s requests or guidance. The postictal state can last for hours in some cases or even days. For others their postictal state may mean they need to sleep. On some occasions the patient may present or even give the impression they fully recovered when in fact they are not.

More experienced paramedics fully understand these states and try to support the patient in any way they can, sometimes up to and including taking them home by request, or consulting the next of kin for clarification.

Patient Specific Information (CmC) need to be accurate and up to date, particularly if the patient has more than one major condition, e.g. epilepsy and a cardiac condition. It is essential to widely publicise PSIs and CmCs and for GPs to be receptive to these requests from patients, who have major conditions and to facilitate their production. Education of the LAS front line, GPs, STPs, CCGs and NHS Trust is essential.

**4) To propose learning modules focussed on treatment of epileptic**

 **seizures to be included in the CSR for front line staff.**

In addition to the regular CSR programme, the ‘Whose Shoes’ methodology could be adopted for paramedics, EACs and their managers to experience seizures through the eyes of patients. This could also provide insight for patients, especially regular service users, to understand what its like for paramedics and they can also give something back to the amazing crews who have cared for them.

**5)    Ensure focus is on each stage of epileptic seizures – before – during and after the seizure, including pre and post-ictal care and associated behaviours.**

See the following web sites for detailed, patient centred information.

[www.epilepsy.com/learn/about-epilepsy-basics/what-happens-during-seizure](http://www.epilepsy.com/learn/about-epilepsy-basics/what-happens-during-seizure)

<https://www.epilepsysociety.org.uk/what-epilepsy>

<https://www.epilepsysociety.org.uk/epileptic-seizures#.XFMpZvZ2vOg>

<https://www.epilepsysociety.org.uk/living-epilepsy#.XFMpa_Z2vOg>

**6)    To make recommendation regarding enhancing the expertise of staff in the**

 **EOC clinical hub.**

This might include the development of a handbook on the complexities of epilepsy and seizures (and an app) specifically for staff in the Clinical Hub. The handbook could be developed through co-production between service users, epilepsy charities, Clinical Hub staff and the LAS pharmacist. It will include a section on carers and how LAS can assist & relieve some of their pressure. See also the Co-Production Charter.

**7) A focus on POTS – Postural Orthostatic Tachycardia Syndrome**

POTS can sometimes be confused with epileptic seizures. Some patients with epilepsy also suffer with POTS or other similar conditions & their cardiac condition can trigger a seizure. The reverse can also happen:

<http://www.potsuk.org/types_of_pots>

<http://www.heartrhythmalliance.org/stars/uk/conditions>

**8)   To promote a focus on empathy, which is essential for effective care of patients who have had a seizure.**

A useful approach could be role reversal, perhaps with people who have epilepsy and students studying in the LAS or university to become paramedics, in order to provide first-hand insight into what its like to live with a complex, hidden condition.

**9)   Developing a training video on epileptic seizures for the CSR**

1. A Forum member is obtaining footage from TFL of his latest seizure at North Greenwich station, which included the escalator, where LAS crew attended to him, which can be incorporated into an LAS training video.
2. A key message is that no two seizures are the same even if they are epileptic in nature/ origin. A seizure may not appear as a paramedic has previously experienced it or learnt about it during their training. Diversity in the presentation of seizures is a key issue.
3. The use of rescue medications such as Midazolam and how its administered could also be included using the experience of both clinicians, service users and Epilepsy Society First Responders.

**10) To look at the possibilities for conveyance of a person who has had a seizure to a place of safety, e.g. their home rather than A&E. This could include coordination between ambulance services.**

Often referred to as ‘Home by Request’. This is consistent with the LAS ‘leave at scene’ approach, i.e. not taking patients to A&E if it is not required. This approach is used at the discretion of an EOC manager following a risk assessment and transfer to a place of safety and can reduce the risk of further seizures, because the patient is in a safe, less stressful environment.

**12)  Suggest to the LAS Academy re possibility of Sean Hamilton talking to students at the Academy.**

**Copy to Ian Wilmer, Paramedic, epilepsy lead, Fenella Wrigley, Medical Director, Tina Ivanov, Deputy Director, Clinical Education and Standards**

**END**