

PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

Information for the CQC

Inspection of the London Ambulance Service

JUNE 2015

WWW.PATIENTSFORUMLAS.NET

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Summary of Key Points

- (i) Patients with dementia and their carers describe long waits for ambulances, sometimes of several hours, because they are not categorised as emergencies – see page 7.
- (ii) Patients who fall may experience long waits for care because of low capacity to respond to Cat C calls, causing delayed assessment and transfer– see page 8 This has led to a significant increase in the number of complaints to the LAS and possibly clinical and emotional harm to patients who wait for long periods - see pages 11, 12 and 13.
- (iii) More should be done to ensure that paramedic training and practice includes the comprehensive NICE assessment, including a comprehensive cognitive assessment that enables paramedics to identify patients who may have dementia and assists them to deal with issues like pain control – see page 9 and Appendix Two
- (iv) The committee Safeguarding Committee meets every 6 weeks and is well aware of its challenges/goals: referrals still faxed, no training database, and greater supervision required – see page 10.
- (v) There are still incidents of poor care for stroke patients because not all paramedics fully understand use of the FAST test - see page 13.
- (vi) The Forum has received concerns from the families of patients who have remained in ambulances for long periods outside A&E. Some have resulted in Serious Incident investigations because this is the requirement for all handover waits of an hour or more. Results of serious incident investigations into one hour plus waits outside A&E are not placed in the public arena, despite the need for openness and transparency - see pages 15 -16.
- (vii) The Forum has observed that increases in call-out activity in the evening sometimes coincide with shift changes that occur between 6-7pm. The gap in capacity during this shift change can have a particularly harmful impact on responses to Cat C calls, as is set out in the example patient complaint – see page 17.
- (viii) Complaints about poor ‘attitude and behaviour’ of some LAS staff have recurred annually for many years, suggesting that this issue and other recurring issues are not leading to lessons being learned. The Forum is concerned about this failure to learn from complaints. A more effective system is also needed to collect patients’ views on the LAS - see pages 19 and 20.
- (ix) Despite the Chief Medical Officer confirming to the Forum in 2011 that re-use of blankets for patients is always unacceptable, our intelligence from front line staff is that multiple blanket use continues - see page 20.

- (x) The LAS operates a Location Alerts Register to warn paramedics of possible risks of violence or abuse on entering certain premises, based on previous instances involving LAS staff and/or the police at that address. The list is not usually person specific – just address. For multi-occupancy addresses, there does not appear to be a process to determine whether the original person(s) involved in an incident still actually live(s) at the address. This can delay and jeopardise care for residents at the address, even though a risk assessment is carried to determine whether it is safe for LAS crews to enter the premises without the presence of police – see page 21.
- (xi) The care and transportation of bariatric patients from their home to hospital can be complex and hazardous for the patient and clinical staff. Appropriate procedures and equipment are not always available. A Forum member described delays with the provision of care for patients who require special equipment and ambulances. We should welcome the CQCs evaluation of the effectiveness of these procedures as part of the inspection of the LAS. The importance of hearing the voices of users of bariatric care would be a valuable component of the inspection – see page 22.
- (xii) LAS services are variable for people in a mental health crisis. Patients sometimes encounter ambulance staff (and hospital A&E staff) who do not treat them sensitively or show an adequate level of understanding of their needs. Patients with both mental health and learning problems sometimes found it difficult to access appropriate emergency care - see pages 23 – 24.
- (xiii) The use of the Co-ordinate my Care system and Advance Care Plans is still under developed for patients requiring ‘end of life’ emergency care. Evidence of compliance with Advance Care Plans is not available but needs to be produced by the LAS and other health bodies. Continuous training and updating of frontline LAS staff in end of life care throughout 2015-6 and beyond is essential - see pages 24 – 25.
- (xiv) The LAS’s approach to equality and diversity is fragmented and there is a great deal to improve - for example in relation to many of the ‘protected categories’ and in important areas of direct service delivery. Additionally, the LAS Board has consistently failed to ensure that its membership reflects the diversity of London. It appears that there are no specific plans to address the LAS’s equality responsibilities across the full range of protected characteristics, i.e. a list of key goals in each area, time scales, feedback from staff and patients, data which can be demonstrated and is in the public domain - see page 25.

We hope that all of the issues/points raised above and in this report will be pursued by the CQC and we look forward to seeing the draft CQC report and attending the ‘Summit’.

Patient and Public Involvement (PPI) in the LAS

The Patient's Forum for the LAS was set up in 2004 and brings together people with a wide range of interests and experiences, including those from Local Healthwatch covering many London Boroughs. All are committed to developing high quality health services in general ... and highly effective emergency ambulances services specifically. Members who attend regularly include people who are active in health condition support groups (for example, mental health, sickle cell and physical disabilities), and are knowledgeable and experienced in monitoring and influencing services ... and passionate about the NHS. Most members have experience as service users, carers, former NHS and Local Authority staff, and are 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 Forum is active on 8 x LAS Committees. Our members join LAS colleagues at these meetings and contribute to discussion on LAS policy, strategy and risk. Through our work on the LAS PPI Committee, we participate in plans for the enhancement of PPI in the LAS, and senior staff in the LAS is always willing to answer questions put by the Forum - and usually respond very quickly and in depth.

Outreach work by the LAS, across London, is highly successful and engages LAS staff as volunteers to meet wide and diverse groups and communities; providing them with information and knowledge about how the LAS works and how to save lives. But evidence of service improvement through community engagement is lacking. We believe the LAS should demonstrate where - through their engagement with communities - that they have influenced and enhanced services provided by the LAS.

Secondly, we have asked many times for Foundation Trust members to be invited to our monthly meetings held at LAS HQ, but our requests have always been refused and we are told that FT members are only invited to meeting when LAS staff is present. We believe LAS should no longer deny Foundation Trust members access to public Forum meetings where there are regular discussions about all aspects of LAS services.

FORUM REPRESENTATIVES ON LAS COMMITTEES

-	Clinical Audit and Research Steering Group	...	Natalie Teich
-	Clinical Safety, Development and Effectiveness Committees	... ..	Angela Cross-Durrant Kathy West Malcolm Alexander
-	Community First Responders	... ..	Sister Josephine Udie
-	Equality and Inclusion	... ..	Kathy West
-	Infection Prevention and Control	... ..	Malcolm Alexander
-	Mental Health Committee	... ..	Malcolm Alexander
-	Patient and Public Involvement Committee	...	
-	Safeguarding	... ..	Leslie Robertson

What Patients and Carers have told the Forum about the Care of People with Dementia

Patients with dementia and their carers describe long waits for ambulances, sometimes of several hours, because they are not categorised as emergencies.

Dementia is not usually the main reason for calling the LAS; the 999 call is usually for falls, acute infections (e.g. urinary tract infections), stroke, 'transient ischaemic attack' and difficulty in breathing. Sometimes the LAS may be dealing with people with dementia who are not yet diagnosed, but who present with cognitive impairment due to dementia and, sometimes, severe pain. Many hospitals are struggling to ensure that people with dementia are admitted and discharged appropriately.

Patients with dementia are more likely to be admitted to hospital with a complex diagnosis and a vague care plan. Once admitted, they often stay in hospital for extended periods and their experience of care is sometimes disturbing, resulting in confusion, poorer cognitive awareness and higher mortality. Typically being moved from ward to ward creates confusion and loss of functionality.

However, access to appropriate pathways of care in the community, which includes active care and treatment from specialised community teams can reduce the need for hospital admission and provide more appropriate care.

Front line LAS staff is faced with a difficult situation because appropriate care pathways for dementia are uncommon in the community, so they take patients to hospital A&E because it is the safest option, e.g. to prevent a further fall, but it is not the best option for the patients health.

A Category C response (see details below) can be very low with 65% of ambulance failing to arrive within the target time (20 minutes-for 90% of Cat C1 calls).

Our Vision for the LAS – Pre-Hospital Dementia Care

The Commissioners for the LAS have expressed interest in improving care for people with dementia, but this is a considerable challenge for the LAS because, as a result of the considerable shortfall of staff, and high number of leavers (30/month in 2015), providing care for patients with dementia, when the LAS also must meet its Category A targets is a considerable challenge.

Until the LAS is able to meet its Cat A and Cat C targets, patients with dementia who have fallen or suffered some other indicator associated condition, may wait many hours for care. Alternative pathways of care are rarely available for these patients. **Dementia care is a CQUIN priority for the LAS in 2015-16.** The Forum's proposals to the LAS for significantly enhancing the quality of dementia care can be found in Appendix 2.

Patients who fall, often wait long periods for care

Patients who fall - whose clinical needs are designated as requiring a category C response - are clearly not a high level priority for the LAS compared to patients requiring a Cat A response.

Falls can happen at home, in the street - and we include people who have had accidents in the road, for example those who have peddle bike accidents. Some of these patients will have sustained a fracture. Waiting for several hours for an ambulance is not uncommon.

The practice of some care agencies of leaving patients alone to wait for an ambulance, after they have suffered a fall, is also of even greater concern if the response times run into hours instead of the 20 minute target.

The Forum has raised with the LAS the issue of both effective clinical assessments and clinical pathways for people who have falls. Two key issues are:

- Delayed responses because of low capacity to respond to Cat C calls, causing delayed assessment and transfer
- Absence of rapid access to specialised local 'falls teams' for LAS clinicians to refer to when a patient has suffered a fall

The system for transferring patients to local falls teams has been abandoned because CCGs would not co-operate, preferring instead for patients to be referred to GPs. As a consequence - in some cases following long delays - patients are taken to A&E for assessment, admitted to hospital and then in some cases referred to falls teams on discharge.

The role of local falls teams should be to provide expert advice, support and rehabilitation for patients who have had falls. Easy access to such teams would relieve some patients - and the LAS - of the need to go through a complex process of admission A&E and enable clinical staff to respond to patients with more acute needs.

Guidelines produced by NICE on falls - (Falls (CG161):

<http://guidance.nice.org.uk/CG161>

The Guidelines deal with the assessment and prevention of falls in older people, including falls prevention in community settings. It recommended that older people (aged 65 and older), who have fallen - or who are at risk of falling - should be identified, risk assessed, and considered for an individual, bespoke intervention.

CG161 states: 'This document is for healthcare and other professionals and staff who care for older people who are at risk of falling' - so is of relevance to paramedics.

The Forum included the issue about patients who fall, when asking the LAS Board the following question:

"In relation to the NICE Guidelines - CG161 - will the Board require training for front line staff assessing patients who have fallen, to include a full multifactorial assessment to identify the patient's individual risk factors which follow?"

- Cognitive impairment
- Continence problems
- Falls history, including causes and consequences (such as injury and fear of falling)
- Footwear that is unsuitable or missing
- Health problems that may increase their risk of falling
- Medication

- Postural instability, mobility problems and/or balance problems
- Syncope syndrome (fainting which can be caused by dehydration, medications, diabetes, anaemia, heart conditions)
- Visual impairment

The Forum believes that there is a need to develop effective care for patients who have fallen, and that the LAS should press for paramedics to have direct access to local Falls Teams to prevent inappropriate transfers to A&E, and to ensure expert clinical care for patients who have fallen.

LAS Update on Acces to Falls Teams – 14 May 2015

We are currently referring directly into either borough falls teams or 'single point of access' teams who forward on, in Wandsworth, Kingston and Richmond, Merton and Sutton, and Enfield. We are in discussion with colleagues in Barking and Dagenham, Havering, Redbridge, Lewisham and as you say Lambeth. Interestingly, we had some very positive feedback from Merton and Sutton. Ordinarily they would expect to receive around 4 to 6 referrals a month from GPs; in the first 2 weeks of our direct referral they received 22 referrals. Although there's more work to be done to understand this data properly, it certainly looks like evidence that this model has much to recommend it.

Safeguarding

There had recently been an excellent Safeguarding/MH Conference for staff, organised by Safeguarding Officer Alan Taylor. The LAS is in a complex situation having to liaise with a large number of organisations that the Butler-Sloss Report emphasised was crucial to being effective where referrals are concerned. The Committee meets every 6 weeks and is well aware of its challenges and goals, eg: referrals are still faxed, there is no training database, and greater supervision is required.

A Patient Forum member during a ride-out that commenced at St Helier Ambulance Station, met Paramedics who displayed outstanding interpersonal skills when assessing patients at incidents - and making when making 'life and death' decisions. One of the paramedics had a £34,000 overdraft as a result of his University education. It is a 'political' decision that paramedics pay for their education but nurses, for example, do not. Will the CQC consider the effects of these loans on retention and recruitment of Paramedics, especially in the current climate of major shortages, during their deliberations?

Concerns about Cat A and Cat C calls and performance

This Report provides many examples of the impact of poor response times to Cat A and Cat C calls (data shown below). The response times for cardiac arrests, stroke and major trauma have been safeguarded, but many patients are traumatised by long waits for paramedic care. The increase in the number of complaints about delays to the LAS is significant as the data for 2014/15 shows:

2014 / 2015

Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	TOTAL
33	50	72	62	45	65	87	95	71	70	50	700

Response times for Cat A calls dropping below 50% (Haringey and Barnet) in some parts of London is of very great concern. Of even greater concern is the fact that in some cases 19 minute Cat A responses are below 90%, eg: Waltham Forest, Enfield and Westminster.

We have great concerns about impact of very poor Cat C response times for patients who do not have life threatening conditions, but may be very ill, vulnerable and frightened. Older people who have suffered falls and are in pain; people who have taken overdoses; parents of children with peripheral injuries and people who have fallen following a cycle accident, have told us about long waits for ambulances. In practice, there has been a major change in the nature of responses in relation to non-life threatening conditions, without public knowledge or consultation. This has led to a significant increase in the number of complaints to the LAS, and possibly clinical and emotional harm to patients who have waited for long periods.

The LAS is working very hard to increase staffing levels, particularly through recruitment of recently qualified staff from Australia, but a failure to actively engage with school and University students in London over the past 5 years to encourage them to choose a career as a paramedic, has undermined the LAS's capacity to recruit locally.

A Forum member who has worked as a nurse for several health care providers in South London, spoke about the long delays occurring when ambulance are called for people with serious health problems. He gave the example of an incident on 22nd April 2015, when an ambulance took 20 minutes to arrive after the patient's son telephoned the LAS and explained that his father had suffered a cardiac arrest.

The Forum member described being proud of the LAS, knew that the LAS was working hard to address the problem of conveyancing to meet patients' needs appropriately, but added that it would be a hard job for them to get conveyancing right, so that the service meet patients needs more adequately and appropriately.

FEBRUARY 2015 CLINICAL CARE GROUP AREA	Category A			Category C1 – 90% IN 20 MINUTES	
	Incidents	% reached in 8 mins	% reached in 19 mins	Incidents	% reached in 20 mins

Havering	1185	63.71 %	95.70 %	119	59.66 %
Barking & Dagenham	989	58.95 %	94.74 %	127	49.61 %
Redbridge	1268	58.12 %	90.62 %	135	40.74 %
Waltham Forest	1272	53.30 %	88.60 %	131	35.88 %
Outer North East	4714	58.40 %	92.21 %	512	46.09 %

Kingston	623	65.33 %	91.33 %	67	52.24 %
Croydon	1621	55.64 %	91.12 %	209	48.33 %
Wandsworth	1004	60.26 %	95.32 %	135	48.89 %
Richmond & Twickenham	570	59.65 %	92.28 %	63	44.44 %
Merton & Sutton	1420	66.13 %	95.49 %	176	58.52 %
South West	5238	60.96 %	93.26 %	650	51.23 %

Bromley	1226	52.94 %	91.84 %	132	46.21 %
Greenwich	1162	62.74 %	94.84 %	121	46.28 %
Bexley	1099	60.33 %	93.18 %	122	40.98 %
Lambeth	1490	65.57 %	94.03 %	201	47.76 %
Southwark	1516	62.14 %	90.04 %	176	47.16 %
Lewisham	1215	55.97 %	94.16 %	163	47.24 %
South East	7708	60.20 %	92.92 %	915	46.23 %

Barnet	1491	48.29 %	91.08 %	165	32.73 %
Enfield	1460	52.47 %	89.79 %	129	39.53 %
Haringey	1150	49.57 %	93.13 %	149	34.90 %
Camden	1245	68.51 %	90.28 %	138	48.55 %
Islington	1111	59.95 %	91.09 %	115	36.52 %
North Central	6457	55.37 %	91.00 %	696	38.22 %
Hillingdon	1385	58.05 %	85.70 %	142	43.66 %
Hammersmith & Fulham	792	61.62 %	92.68 %	92	42.39 %
Ealing	1487	52.66 %	93.21 %	180	36.11 %
Hounslow	1159	56.77 %	92.49 %	143	37.76 %
Brent	1530	55.23 %	90.98 %	173	36.42 %
Harrow	897	55.96 %	90.97 %	97	51.55 %
Kensington & Chelsea	661	59.76 %	92.59 %	74	39.19 %
Westminster	1565	62.81 %	89.01 %	149	46.31 %

North West	9476	57.60 %	90.67 %	1050	41.05 %
City & Hackney	1261	62.17 %	90.96 %	202	43.07 %
Tower Hamlets	1250	65.60 %	90.80 %	127	50.39 %
Newham	1461	62.70 %	93.36 %	224	47.77 %
Inner North East	3972	63.44 %	91.79 %	553	46.65 %

TARGETS

CATEGORY C TARGETS

C 1 – 90% within 20 minutes, 99% in 45 minutes

C 2 – 90% within 30 minutes, 99% in 60 minutes

C 3 – 90% within 60 minutes, 99% in 90 minutes

C 4 – 90% within 60 minutes, 99% in 120 minutes (from time it is identified that transport is required)

We believe another long-term problem standing in the way of progress, is active deployment of paramedics, rather than station-based deployment of staff on 12 hours shifts. This system of deployment has a deleterious effect on the morale and probably health of staff.

In the short term, concerted action is needed to better meet the needs of patients categorised as Cat C, especially when they suffer long traumatic waits and are in pain. This should include work with local agencies that can support people in the period before the ambulance arrives.

Action is also need to ensure that information from complaints about delays is used to help in the redesign of the LAS response system from the patients' point of view. The LAS needs to better understand what action needs to be taken during long waiting periods to support and reduce distress. Community responders may have a role here.

Fast Test for Diagnosis of Strokes

Better understanding by paramedics of the FAST test will avoid incidents such as the example one set out below:

“My partner and mother of my three-year old child (who was only one years old at the time), was working as the store manager at a store in Brixton, when she suddenly collapsed to the floor. She was hyperventilating, unable to speak and not able to move her right side effectively.

An emergency call was made and the FRU Paramedic arrived swiftly - and he was able to quickly calm my partner down. The FRU Paramedic stated that she was just having an anxiety attack.

The Ambulance Paramedics arrived shortly after, and according to their statements on the incident, said that my partner was “by no means hyperventilating” when they first arrived on the scene. This is important, because this means that they should not have attributed her continued inability to speak to hyperventilation / anxiety attack, because this was no longer an issue.

VERY early on in the incident, one of my partner’s colleagues said to the paramedics that she didn’t think she was “just having a panic attack” and said that she thought she was having a stroke, because she saw the right side of my partner’s face “go” before she collapsed. Despite this, the paramedics, in their own words, made the decision to allow her “several minutes to recover”.

Over an hour after first arriving on the scene, the Paramedics eventually decided to treat my partner as having a suspected stroke to “err on the side of caution”.

The explanation from the Paramedics, in their statements on the incident, included the following:

- “A FAST test was inconclusive. There was no speech to assess ... repeated assessment yielded the same limited results”

The medical reviews of the incident by two of the LAS’ Assistant Medical Directors (including the stroke lead), included the following:

- “Inability to speak makes a person FAST positive. The statement ‘not speaking so FAST inconclusive is WRONG”

However, the official explanation that I received from the LAS in response to my complaint said the following:

- “As a neurological event could not be ruled out, a FAST test was carried out but this was inconclusive as Miss R was still unable to speak (so her speech could not be assessed)”
- “A FAST test was carried out on three occasions”
- “We do not have any concerns about the clinical care provided”

Therefore, in addition to the Paramedics wasting crucial time on scene to due incorrect knowledge of FAST, the LAS provided me with an official explanation that they KNEW was based on an incorrect assertion.

I was determined to ensure that the LAS do not get away with this, and carried out EXTENSIVE research on stroke and FAST and sent emails to the world's leading stroke authorities. I now have emails from The President of the World Stroke Organization, The UK Stroke Association and the NHS Clinical Director for Stroke, and all categorically confirm that being unable to speak is a DEFINITIVE FAST positive symptom and a MAJOR warning sign of a stroke. Embarrassingly for the LAS, their own Clinical Guidelines also state the same thing, as well as the official NHS stroke webpage, which there is a direct link to from the LAS stroke webpage.

The Parliamentary and Health Service Ombudsman has already confirmed that their preliminary view is that they will uphold my complaint. I should be receiving their draft report shortly.

As the LAS say themselves, TIME IS BRAIN...

The Paramedics wasted crucial time on scene due to their lack of understanding of definitive stroke symptoms, and denied my partner the chance to receive stroke treatment within the optimum 90 minute timeframe, which according to research published on the NHS website, gives you more than double the chance of making a full recovery.

My partner's stroke was so severe that she needed to have one-third of her skull permanently removed, otherwise she would have died that same night due to the pressure building up inside her skull. Before she had the operation, the Neurosurgeon told me that that even if she does survive, she is going to be severely disabled for the rest of her life.

Fast forward to now, and my partner has no movement whatsoever in her right arm. She also has limited movement in her right leg, and has severe apraxia and expressive aphasia. She is limited to living in two rooms in our house because of her severe mobility problems. She is only 32 years old."

Patients Complain of Queuing in Ambulances

The Forum has received several concerns from the families of patients who have remained in ambulances in long periods outside A&E. This includes people with serious chest infections and those with mental health problems, where access to A&E is denied because the local Place of Safety is full.

We closely monitored hospital turnaround time throughout 2004-2005, using validated data provided by LAS and its commissioners. The data shows that in March 2015, there were a number of hospital A&Es, where ambulances waited for over an hour before the patient being cared for could be transferred to A&E clinical staff for emergency care:

60 minute included the following hospitals:

- Northwick Park – 93 patients waited 60 minutes or more
- Princess Royal University Hospital - 48 patients waited 60 minutes or more
- Queen Elizabeth Hospital – 26 patients waited 60 minutes or more
- Barnet Hospital – 24 patients waited 60 minutes or more

30 minute waits for the same hospitals were:

- Northwick Park – 358 patients waited 30-60 minutes
- Princess Royal University Hospital - 145 patients waited 30- 60 minutes
- Queen Elizabeth Hospital – 81 patients waited 30-60
- Barnet Hospital – 143 patients waited 30-60 minutes

30 minute waits for other hospitals were:

- Ealing Hospital – 188 patients waited 30-60 minutes
- Hillingdon Hospital - 199 patients waited 30- 60 minutes
- Royal Free Hospital –210 patients waited 30-60
- Queen’s Hospital – 248 patients waited 30-60 minutes
- St Georges – 215 patients waited 30-60 minutes
- North Middlesex Hospital - 112 patients waited 30- 60 minutes
- St Mary’s Hospital – 235 patients waited 30-60

In March 2015, 221 patients across London waited for 60 minutes or more for emergency care in an ambulance outside A&E and 2661 patients waited more than 30 minutes.

All A&E hospital must investigate 60 minute plus waits as ‘serious incidents’, provide ‘root cause analysis’ of the reason for the long delay, and produce a plan of action to prevent recurrence of further long waits. The Forum has never been able to gain access to these reports.

Such long waits outside A&E are a major factor in reducing the effectiveness of emergency and urgent care and severely limit access to LAS services for patients’ needs emergency and urgent care. While ambulances are queuing they cannot treat the next patient in need.

When an ambulance waits for more than one hour to handover a patient to the A&E clinical team, the hospital must investigate this delay as a Serious Incident (SI), but the Forum has never seen the outcome of any of these investigations.

We hope that the CQC LAS inspection will use a whole system approach to this problem, in order to understand both the how these delays undermine the LAS duty to respond to seriously ill patients, and the 'crisis of access' in some hospitals causes several hundred very sick people every month, to wait in ambulances for long periods to get into their local A&E.

Urgent action is needed by CCG Commissioners, Monitor and NHS England in collaboration with affected hospital to eradicate all LAS waits outside A&E departments. This will free up between 1500 hours per month of access to emergency vehicles for critically ill patients requiring a Cat A response.

CCG must also ensure that the outcomes of Serious Incident investigations into one hour plus waits outside A&E, should be acted upon and placed in the public arena, so that the public can see what action is being taken.

Gaps between Shifts – Impact on Patient Care

The Forum observed that increases in activity in the evening sometimes coincided with shift changes that occur between 6.00pm -7.00pm, and which can have a particularly harmful impact on responses to Cat C calls. In response, the LAS and its Commissioners told us that they are carrying out a review of their capacity to respond to Cat A and Cat C calls, and that this review would include the impact of shift patterns on patient care and compliance with Cat A and Cat C targets.

We remain concerned about the impact of shift changes on the ability of the LAS to respond adequately to patients in need of an urgent response.

Formal complaint made to the LAS

This 90 year old lady, living on her own, dialled 999 to request an emergency ambulance at approximately 17.50 hrs. Despite Miss X being very elderly and frail and in pain, three further calls had to be made to the LAS to get help. The family was desperate for help and unsure how badly she was hurt. She was unable to raise herself, was incoherent and agitated.

It is unbelievable and appalling that no ambulance resource was provided until 19.30hrs that evening: 1 hour and 40 minutes after the call was made. The crew said that they had only come on duty at 15.00hrs and were located at Friern Barnet, therefore, could not answer the call earlier.

The crew was very professional and kind in the way they related to Miss X, but it is unacceptable that, despite the repeated requests for help, the LAS had no clinical staff available to provide care for a very vulnerable person. The call handlers said there were no ambulances and were unable to give any indication how much longer the family would have to wait. The family was asked continuously if she had deteriorated and replied that they did not have the clinical skills to respond adequately to that question - and it was implied, therefore, that Miss X's situation was not an emergency.

The family did not know if she had a fracture. "Whilst I appreciate that a fall is not as serious as a heart attack or stroke, nevertheless if the LAS does not have the resources or humanity to provide a service for an elderly frail woman of 90, then your service is failing very seriously. You have a duty not just to provide a service within a reasonable time, but to provide on-going information which is accurate and provides reassurance. Miss X eventually arrived at the RFH casualty at 20.15 in a very distressed state. I believe that the LAS has seriously failed to provide reasonable and adequate care to Miss X."

Action must be taken to stop vulnerable patients, who are in pain or who have fallen, having to wait long periods for an ambulance response.

Families should not have to make repeated calls to the LAS to get help – to the affected patients and their families, these delays suggest a major breakdown in care provision. Alternative pathways of care must be available in these cases.

The organisation of shift patterns that leads to low front line capacity at critical times in the day must be immediately reformed.

Action is needed to ensure that patients waiting for a Cat C response, who are frail, in pain, in an exposed place or vulnerable in other ways, must not be forced to make repeated calls to the LAS.

Where there is a delay, Emergency Operations Centre staff must keep up live, proactive, professional communications with the patient/carer/family, and ensure that they provide advice, reassurance, alleviate distress and communicate effectively in a way that is understood by the patient.

Complaints about Attitude and behaviour

The Forum has been concerned about the number of complaints from patients about the attitude and behaviour of front-line staff. There are about 20 such complaints each month. We have been particularly interested to know if any link has been demonstrated between length of shift and the point of the shift when the incident occurs.

The LAS told us that there has not been any systemic analysis, but would support research into the impact of working patterns on complaints type and frequency. We have asked if CARU will carry out this research (Clinical Audit and Research Unit). They also told us:

“Sometimes complaints about staff being intimidating or aggressive are where the staff has deemed it appropriate to be assertive - for example to persuade a patient to control their breathing in the event of an anxiety attack. More often the complaint is about the staff presenting as seemingly uninterested/unsympathetic.”

Response from the LAS

We asked the CQC, at our Public meeting on 13 May, if it would look at data on attitude and behaviour complaints over a number of years. The CQC told the Forum that it would only look at data for the current year. We believe this denies the inspectorate the ability to:

- (a) Look at trends to see if anything has changed and been learned from complaints,
- (b) Denies the CQC the opportunity to assess whether lessons are learned from Sis or complaints and to see if there are trends.

We should also like to see a more proactive system for collecting information from patients about their experience of the LAS. The only system is the ‘Friends and Family Test’ that is useless as a means of collecting genuine comment on services.

LAS conduct and behaviour complaints: 2014-15

Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
20	22	16	27	18	23	33	37	19	32	25	272

CARU should be commissioned by the LAS 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 that the event took place, and to look for other recurring complaints in order to determine what, if anything, has been learned.

The LAS must ensure that evidence is sought on the effectiveness of Appraisals for staff, following 'attitude and behaviour' complaints against them.

The CQC should examine at least 3 years of complaints' data, to see if learning from complaints has been integrated into the Governance structure of the LAS.

Concerns about Infection Control – Multi-Use of Blankets

The LAS has a very effective infection control lead and a Committee - 'Infection Prevention and Control' - which is attended by a Forum representative.

However, it was established many years ago that the use of blankets for more than one patient being cared for by LAS clinicians was not acceptable. Dame Sally Davies, Chief Medical Officer, wrote to the Forum in **2011** confirming that re-use of blankets for patients is always unacceptable. The Forum has consistently raised this issue with the LAS, but has never received a satisfactory answer. The multiple 'use' of single blankets for many patients continues.

We were told that the LAS would implement a major project to totally change the way in which blankets are 'managed' by the LAS. But our intelligence from front-line staff is that multiple blanket use continues.

The LAS must ensure that multiple blanket use stops immediately. It is a potentially serious cause of cross infection.

LAS High Risk Register - (Location Alerts Register)

For many years, the LAS has operated a High Risk Register (now called the Location Alerts Register), to warn paramedics of possible risks of violence or abuse on entering certain premises. As a consequence, in some cases paramedics wait outside a house to which they have been called to attend to a medical emergency, until the Police arrive to assist them.

The Register is a list of addresses where there has been an incident involving LAS staff, or the Police. The consequence of an address being on the Risk Register is that, in the past, LAS crews would not enter the premises unless the Police was present. In some cases, crews responding to Cat A calls (life threatened patients) have waited 'round the corner' until the Police arrive to accompany them into the house or flat.

The Register is not 'person' specific, so all residents in a house on the Register may have to wait for emergency treatment until the Police arrive. This has led to tragedies and two Serious Incident investigations. The Forum had a number of discussions with the LAS on this issue and raised questions at the LAS Board Meeting. The following issues cause the Forum most concern:

- 1) Historical addresses are on a Register because of a past event, but there is not necessarily a reasonable evidence base for their inclusion on the current Register.
- 2) There does not appear to be a reasonable process of audit to determine whether a person or persons who either committed a crime or acted in a threatening way, actually still live(s) at the address.
- 3) The process of determining whether any person who lives at an address has any objection to the house remaining on the Register is flawed, because in a multiple occupation house it is possible that nobody will open the LAS inquiry letter, or a disinterested person may open the letter and do nothing.
- 4) Without appropriate audit and communication, the past violent or threatening actions of one person, who may or may not still live in the house, could potentially result in a person who has suffered a heart attack or stroke, not receiving appropriate care within the prescribed time, eg: eight minutes for a heart attack, serious trauma or stroke.
- 5) The civil liberties of a large number of people could be affected by the denial of medical care in an emergency, because some multi-occupied houses in London may have between 10 - 20 residents, none of whom is aware of the house's entry on the Register, or that an incident has happened in the past.

- 6) The new system requires a Risk Assessment to be carried out by paramedics before entry into the premises. We have no idea how effective this system will be - especially as, if the Police are called - they are not obliged to arrive within any mandatory time.

Bariatric Care

The care of bariatric patients can be very undignified and cause considerable anxiety for both patient, family and ambulance clinical staff. Transportation of patient from his/her home to hospital can be complex and hazardous for both the patient and clinical staff. Specially designed lifting equipment is essential to carry the patient to the ambulance, and specialised training is essential to reduce the risk to the patient and to the clinician.

Appropriate procedures and equipment to provide the best care to bariatric patients is not always available. A member of the Forum has described delays with the provision of care for patients who are heavy and require special equipment and ambulances.

PTS (Patient Transport Service) vehicles may be used to transport bariatric patients, but out-of-hours private vehicles are used. Specialised HART vehicles may also be used for heavier patients. The newest range of LAS ambulances have a trolley bed that is capable of carrying patients weighing up to 50 stone.

The Forum has discussed with the LAS the approach used by staff in the EOC in the assessment of needs of heavier patients, eg: whether questions about weight were asked during initial telephone triage stage in order to ensure that the right resource was supplied. We also raised questions about the problems at weekends, when bariatric vehicles need to be obtained through a private provider.

The LAS told us that: “The issue of the patient’s weight is not a question that is asked during emergency clinical triage. The LAS needs to ensure that every patient receives exactly the same initial response. If, once on scene, the clinician feels additional resources / equipment is needed, this is then requested through the Emergency Operations Centre. A few patients have patient specific protocols which alert the LAS to their medical condition”.

In view of the risks associated with care and transport of bariatric patients, we should welcome the CQCs evaluation of the effectiveness of these procedures, as part of the inspection of the LAS. The importance of hearing the voices of users of bariatric care would be a valuable component of the inspection.

See: Hignett, S. & Griffiths, P. (2009) Manual handling risks in the bariatric patient pathways in acute, community and ambulance care and treatment. *J.Prev, Assess & Rehabilitation*. 33, 2, 175-180. <http://ncbi.nlm.nih.gov/pubmed/19713627>

Care of People in a Mental Health Crisis

The Forum is an active member in the LAS Mental Health Committee and welcomes the development of services that are more sensitive to the needs of users of mental health services. The employment of mental health nurses in the Clinical Support Desk is an important step forward, and this is complemented with the training of front-line staff in mental health care, although a great deal more needs to be done to ensure that all front-line staff is adequately trained in mental health care.

In a Forum Meeting with users of mental health services, the following issues were identified:

- LAS services are very variable for people in a mental health crisis.
- Patients sometimes encounter ambulance staff and hospital A&E staff that do not treat them sensitively, or show a professional level of understanding of their needs.
- No specialist mental health teams in the LAS on the front-line (but there are now 3 MH specialist nurses in the Clinical Hub).
- Many hospital A&Es do not have specialist mental health teams 24/7, making effective clinical handover difficult.
- Inappropriate use of restraint - and sometimes transport in Police vehicles.
- A&E staff sometimes turn away ambulances with patients that are 'mental health emergencies' - and patients may be driven to several A&E Departments until accepted.
- Services for patients with both mental health and learning problems, found it difficult to access appropriate emergency care.
-

We should like to see action taken to improve care data in the following areas, and hope that the CQC will consider these issues during their inspection:

Data on the following issues:

- **Long delays – sometimes of several hours – when LAS crews are attempting to find a 'place of safety' for a person with severe mental health problems who has been sectioned under the MHA.**
- **Delays in handing over patients with severe mental illness to London A&E departments because of A&E capacity problems.**

- **Handover to A&E data showing waits of over 30 minutes and over one hour for patients with a mental health diagnosis.**
- **The percentage of LAS clinicians who have received advanced training in the assessment and clinical care of patients with mental health problems.**

The LAS Commissioners told the Forum that it did not have specific mental health KPIs (Key Performance Indicators) within the contract, and that all performance standards are applied equitably across all illness types.

The development of outreach teams of paramedics that specialise in the care of patients with a mental health diagnosis - (see the Independent Commission Report on Mental Health and Policing chaired by Lord Adebowale).

The development by the LAS of specialised care pathways for patients that have both learning disabilities and a mental health diagnosis.

End of Life Care

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

This issue has been prioritised as a CQUIN by LAS Commissioners for 2015-2016.

We asked the LAS how the wishes of people who have a terminal illness or who are close to death, are communicated to LAS clinical staff. One of the issues of concern is how paramedics and A&E Departments know that a patient has an Advance Care Plan (ACP), and whether Command Point (the LAS emergency control system) will make it easier to communicate this information at the critical time.

The system used by the End of Life Care (EoLC) networks to register ACPs in London, is called CoOrdinate My Care (CmC). Whenever a new patient is entered on the system, it sends an automatic e-mail and the LAS flag the address. The patient numbers are low at the moment - approximately 1,000 (but may well rise to between 57K and 60K).

The LAS is trying to devise a system that does one of two things:

- A) CmC automatically flags the address for the LAS, but progress will be slow as the CmC system is a London-wide system, and will be used by hundreds of clinicians.

- B) Alternatively, the LAS will cease to flag addresses, but ensure the staff is always alert to the possibility that the patient has an ACP. This would require significant levels of training. If a crew is presented with a valid Advance Decision, or DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form, it will attempt to follow it, but families can very often change their minds at the last minute.

The LAS told us that:

- 1) CoOrdinate My Care (CmC) is being rolled out across London, and is funded for the next couple of years by NHS England.
- 2) The LAS Information Technology Department is working with CmC to identify CmC patients should they dial 999 for assistance. Addresses may not be flagged in the first instance. A Request for Change to the Command Point system has been submitted to develop automatic flagging of CmC calls.

We suggest that the CQC examines the LAS achievements in relation to:

- * **Evidence of compliance with Advance Care Plans by the LAS**
- * **Evidence of continuous training and updating of front-line LAS staff throughout 2015 – 2016, and beyond.**

Equality and Inclusion

Equality and Inclusion in the NHS is essential to delivering effective health care. The social context of London and the UK is changing, making these key principles even more important. We believe that workforce diversity brings many positive insights, 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.

The Forum has tried to play an active part in the work of LAS in this area, which is essentially fragmented across the organization. A member of the Forum attends the Equality and Inclusion Steering Group which has made impressive progress in shaping the LAS to become a more aware employer and service provider to gay, lesbian, bisexual and trans-sexual people. But there are many gaps in the delivery of successful equality and diversity management and services.

We believe there is a great deal to improve - for example in relation to many of the 'protected categories' and in important areas of direct service delivery. A comprehensive approach to equality and diversity is fundamental to good service delivery and includes learning from service users and constructively dealing with complaints.

A selection of the Forum's areas of concern in relation to Well Led Services:

A) Employment of BME Staff on the Front Line and in Management

The LAS is not doing enough to ensure that the percentage of paramedics it employs from BME communities reflects the diversity of London's population, eg: over the period 2004 – 2014, the percentage of front-line paramedics from BME communities has increased from 3.54 - 5.0%.

We applaud the high ratings achieved by the LAS in the Stonewall Diversity Champions ratings, but do not believe this equates with protecting and supporting many or most of the people to whom the other 'protected categories' apply.

The Forum believes that the following measures would assist this process:

- More representative Directors on the LAS Board, Senior Managers, and HQ staff at all levels, to help the LAS be seen as a more equal and inclusive service provider and employer.
- Full implementation of the refreshed EDS (NHS Equality and Diversity System - EDS2) and the NHS Workforce Race Equality Standard (WRES)
- Development of the LAS Equality and Inclusion Strategy - to include all protected categories in the short and long term overseen by the Equality and Inclusion Steering Committee.

B) Composition of the LAS Board

The LAS Board has consistently failed to ensure that its membership reflects the diversity of London. After Murziline Parchment left the LAS Board as a Non-Executive Director at the end of 2012, all members of the Board are now white.

C) Equality Goals

The LAS should have specific and current plans to address their equality responsibilities across the 'protected characteristics' – ie: a list of key goals in each area, time scales, feedback from staff and patients, data which can be demonstrated and is in the public domain.

The CQC may wish to enquire whether: “All protected characteristics are included in LAS equality goals, how they measure their achievements and whether all equalities data is in the public domain”. The feedback we get from patients and staff suggests significant gaps in achievements in relation to most protected characteristics.

D) Collecting Diversity Data from People who make Complaints

There is currently no functioning system to collect diversity data from people who make complaints. Data is collected from PRFs relating to the patient who is at the centre of the complaint, but it is not generally believed that this data is accurate. There is a reluctance to request this data from complainants.

Involvement in LAS Board Meetings

Forum attendance at LAS Board Meeting is by rotation of Forum Executive Committee members. The Forum submits questions to Board Meetings at each meeting - and replies to the Forum’s questions are published in the Minutes of Board Meetings.

Richard Hunt, Chair of the LAS, stated: “I will ensure that in the review of Minutes at the meetings and any Matters Arising, that the response to questions, both from the Patients’ Forum, and more generally the public, are specifically highlighted.”

Patient Cases Presented to the LAS Board

The Forum is very supportive of the LAS Board’s decision to invite patients and carers - who have experience of LAS services - to speak at public Board Meetings about their experiences. We asked Richard Hunt, Chair of the LAS Board, to provide evidence that patients’ stories, presented to the Trust Board, have demonstrable outcomes in terms of improved services for patients.

He responded as follows:

“We will ensure that any follow-up to the patient’s story is clearly identified, along with ‘minuted’ comments. I will ask Steve Lennox, Director of Health Promotion and Quality, to prove a six-monthly review of the patient stories, together with any follow-up action requested by the Board. That said, it may well be that there is no follow-up action and that the ‘story’ was just for Board information, as part of general Governance”.

APPENDIX ONE

Forum's Contribution to the LAS Quality Account - 2014

We present below our contribution to the LAS's Quality Improvement Priorities for the Quality Account.

The Patients' Forum values continuous engagement between the LAS, in relation to many aspects of LAS performance and clinical care. This engagement takes place at the nine internal LAS Committees that the Forum contributes to. We also actively contribute to Trust Board Meetings, through the submission of key questions about the strategic and policy direction of the LAS. Forum members regularly engage with leaders of the LAS through meetings with the Chair, Chief Executive, Directors, the Head of Patient & Public Involvement and Public Education. Senior LAS colleagues regularly present to monthly Forum Meetings.

1) Patient Safety Should be the Highest Priority for the LAS

Providing the safest and most effective care for patients should be the highest priority for the LAS. Reporting, investigating and learning from patients safety incidents must be fundamental to ensuring patient are safe. Patients must always be told when they have been harmed due to clinical errors. The LAS should ensure that all ambulances and equipment are clean and sterile; shortfalls in infection control are taken seriously and acted upon; all clinical equipment is available when needed, intact and up to date.

WE RECOMMEND that the LAS publishes in the public arena the outcome of all Serious Incidents investigated, with evidence demonstrating enduring improvements to service quality and safety, and evidence of staff and organisational learning.

2) Pre-Hospital Dementia Care must be Transformed

The LAS should develop clear and effective dementia pathways with the LAS Commissioners (CCGs), acute hospitals and - where possible - community care professionals, to ensure 'right care first time' for patients with dementia and cognitive impairment. LAS should continue the development of its Clinical Support Desk, to ensure its capacity and expertise to advise clinical staff on meeting the needs of people with dementia ... especially with regard to assessing cognitive impairment and pain.

WE RECOMMEND the LAS should produce evidence to demonstrate that the front-line staff has continuous education and training in this area. This should include access to Health Education England training resources.

See also section on mental health (4) below. Access to appropriate care pathways for patient with cognitive impairment must become fundamental to providing right care, first time.

3. Patients who Fall should Always Receive Integrated Care

When patients fall and do not require access to hospital acute care, paramedics should have direct access to local Falls Teams, in order to ensure expert clinical advice and care for these patients and avoid inappropriate transfers to A&E.

WE RECOMMEND that the LAS ensures that care for people who have fallen is provided within appropriate timescales, and includes agreed care pathways and integrated care plans, with clear governance mechanisms to ensure care plans are fully implemented, and to enable appropriate access to services and demonstrate clear outcomes for the patient.

4. Care for People in a Mental Health Crisis must be Transformed

Considerable progress has been made, by the LAS, in the prioritisation of care for people with mental health problems. E-learning approaches have been adopted for training of staff, work is developing with mental health Trusts to develop mental health pathways - and the Chief Executive is providing leadership by Chairing the LAS Mental Health Committee.

WE RECOMMEND that the LAS develop a ‘specialist team’ of paramedics and nurses who are expert in the care of patients with a mental health diagnosis. All paramedics and A&E support workers should be continuously and dynamically trained in the care of people with mental health problems, bearing in mind the special needs of people with learning difficulties and the need to focus on cultural, language and age-related issues. A significant proportion of this training should be live, rather than via e-learning, as interpersonal skills and attitudes appropriate to this group of patients, needs to be practiced, evaluated and demonstrated.

5. Excellent End of Life Care must Always be Provided

The LAS should continue to develop its excellent work with Advance Care Plans (ACP), End of Life Care (EoLC) and CoOrdinate My Care (CmC). Protocols should be developed between the LAS and London’s CCGs and GPs, to ensure that CoOrdinate My Care (CmC) is fully developed to meet the needs of people who have an Advance Care Plan.

WE RECOMMEND that the LAS enables far greater numbers of people to access appropriate care through CoOrdinate My Care (CmC). The LAS should publish examples of good practice in ‘end of life care’ for front-line staff, together with evidence of outcomes showing the effectiveness of appropriate and compassionate care for these patients.

6. Delays in Providing Urgent and Emergency Care are Not Acceptable

Vulnerable patients who have requested emergency care, should never be left waiting hours for LAS care. Expecting vulnerable patients, who are in pain, who have fallen, or taken an overdose, to make repeated calls to the LAS to get help, suggests a significant breakdown in care provision. This particularly concerns patients categorised as needing care classified as C1 and C2. We understand the limitations caused by a shortage of staff and resources.

WE RECOMMEND that urgent action is taken to promote recruitment to the LAS front-line from schools, Universities, job centres and religious/cultural centres.

The work-force must be enlarged to ensure that the Category C targets which follow are always met:

Category C1 – 90% within 20 minutes, 99% in 45 minutes (from Clock Start)
Category C2 – 90% within 30 minutes, 99% in 60 minutes (from Clock Start)

Achievement of targets in 2013 was as follows:

- Category C1 – reached in 20 minutes – 72.88% (target 90%)
- Category C2 – reached in 30 minutes – 66.88% (target 90%)

7. Staff Shift Patterns should be Fully Evaluated

There is considerable national and international research pointing to the deleterious effects of shift work, including shift work patterns on both short and long term physical and mental health. Some staff members are not suited to shift work and able to remain healthy as well, but are excellent front line clinicians.

WE RECOMMEND that the impact of long shifts on front-line staff is fully evaluated by the LAS, especially in relation to the impact of 12 hour shifts, without adequate meal breaks and rest on: clinical care; the health of staff; training and complaints against staff, e.g. in relation to attitude and behaviour.

Staff should be interviewed about the effects of shift work on their health and clinical practice during annual appraisals, and be involved in development of improved alternatives.

8. Appropriate Care Pathways should become Fully Operational

It is critical for the LAS to work with partners across health and social care to integrate services so that patients get better, more appropriate care and experience better clinical outcomes. 'Right Care First Time' should become the norm.

WE RECOMMEND that care pathways are developed by the LAS, in conjunction with CCGs, Acute Trusts and providers of community care, that are robust enough to give confidence to LAS crews and the public, that they are available when required, clinically appropriate, fully-funded, subject to regular clinical audit and tests of reliable and continuous access.

9. LAS should Actively Seek to be Influenced by Patients and the Public in all that it does

The LAS should secure public involvement in the planning, development and proposals for significant changes to the operation of the LAS.

WE RECOMMEND:

- 1. Engagement with FT members, the Patients' Forum, patient groups, the voluntary sector and Healthwatch, to ensure patient involvement in all aspects of the LAS' work.**
- 2. Holding wider public engagement around prioritisation and service re-design.**
- 3. Promoting the public education role of the LAS.**
- 4. Developing a wide range of methods to seek public views on LAS services, and providing feedback.**
- 5. Acknowledging the value that the LAS place on the knowledge, insight and understanding of the contribution of patients and carers.**
- 6. Trust Board members enhance their public accountability by meeting with, and listening more to the public, and acting on what they say.**

10. Equality and Diversity

Excellent work has so far been done in relation to LGBT colleagues and the employment of women. Reflecting on the LAS workforce, and comparing its diversity to the current diversity of London and its future growth, demonstrates a substantial need for development. We have argued this point for several years, but have seen little change in the diversity of the LAS workforce - and no change in the ethnic and cultural diversity of the LAS Board. We should not be satisfied to be told this matter will be dealt with in the post 2020 period, bearing in mind that the difficulties experienced by the LAS to recruit locally, despite the very fulfilling professional opportunities for front-line staff, and the need to recruit from Denmark and New Zealand.

WE RECOMMEND that the LAS embed diversity into all aspects of public education, recruitment and training and ensure full inclusion and sensitivity toward patients and staff with protected characteristics. Changes must be made at all levels in the LAS, including the Board, to embed these duties.

APPENDIX TWO

The Forum's proposals to the LAS to enhance the care of patients with cognitive impairment:

- 1) Develop clear, effective joint dementia pathways between the LAS and local community nursing and social care professionals, to ensure immediate 'right care first time'.
- 2) Develop direct access to alternative care pathways leading to treatment at home, respite and - where necessary - admission to units that are 'dementia aware'.
- 3) Avoid hospital admissions if the Risk Assessment suggests that hospitalisation may worsen the patient's condition. This seems obvious, but A&E is often the default position.
- 4) Provide care for people with dementia in an environment they are familiar with, whenever possible to reduce stress and anxiety.
- 5) Further develop the LAS 'Clinical Support Desk' to ensure that it has expertise to advise clinical staff on meeting the needs of people with dementia, especially with regard to assessing cognitive impairment and pain.
- 6) Produce and disseminate 'clinical advice' to all front-line clinicians, that provides clinical and social information about the needs of people with dementia, including information on communication and an awareness of the medication that a patient with dementia might have been prescribed.
- 7) Develop more effective training and resources for LAS front-line clinicians, to enable them to carry out more comprehensive assessment, including pain management, at the patient's home.

APPENDIX THREE

Questions put to the CQC Team before their inspection

The CQC team kindly attended the Patient's Forum meeting on May 13th 2015 - held at LAS HQ - and much of this report is based on the issues raised with them at that Meeting.

We also put the following questions to the CQC Team before their inspection:

1. How large is the CQC team?
35-40

2. Do team members have experience of inspecting ambulance services?
Yes

3. What comparator is used to judge the LAS?
Previous inspected ambulance service, Nwas, SCAS and YAS.

4. Is NW England AS an appropriate comparator as it doesn't match population size, geographical distribution, ethnic diversity etc.?
LAS is the largest in the country and serves the most diverse population in the country, so there isn't really an exact comparator.

5. Are there any lessons to be learnt from comparable inspection methods of ambulance services in Paris or New York (Bureau of Emergency Medical Services)?
Can't answer this question at this point.