PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

REVIEW OF THE LAS

LONDON ASSEMBLY HEALTH COMMITTEE

PUBLIC MEETING AT CITY HALL

JULY 17th 2018

Patients' Forum Ambulance Services (London) Ltd. Registered in England.
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ATTENDING FROM THE PATIENTS FORUM AND HEALTHWATCH FOR THE PUBLIC SESSION OF THE LONDON ASSEMBLY'S HEALTH COMMITTEE ON JULY 17, 2018

AUDREY LUCAS, BEULAH EAST, CATHERINE GUSTAFI, CATHERINE MCLOUGHLIN, DAVE PAYNE, DHANESH SHARMA, GREAME CRAWFORD, JAMES GUEST, JAN MARRIOTT, JOSEPH HEALY, KYLIE CRAWLEY, LYNN STROTHER, MALCOLM ALEXANDER, MARY LEUNG, MICHAEL HEMBEST, NICK MANN, RASHID ALI, SAMAD BILLOO, SEAN HAMILTON, SHIVAKURU SELVATHURAI, SISTER JOSEPHINE, VIC HAMILTON, VISHY HARIHARA, WENDY MEAD,

TERMS OF REFERENCE

The London Assembly Health Committee invited Forum members to discuss the future of the London Ambulance Service on: July 17 at 3:30pm at City Hall. The Committee also invited members of the public to share your views and experiences of the London Ambulance Service with the committee using healthcommittee@london.gov.uk

The Health Committee's key questions prior to the meeting were are follows:

- What are the key challenges facing the performance of the London Ambulance Service
- How can the Mayor and Greater London Authority group further support the London Ambulance Service to provide a more modern, efficient and effective emergency service for all Londoners
- How can the LAS be made more open and accountable to the people of London

The Health Committee's Investigation

The London Ambulance Service (LAS) is the busiest ambulance service in the country. In 2016/17 it handled over 1.8 million emergency calls from across London and attended more than 1.1 million incidents.

There were growing concerns about operation and performance of the LAS, which led to it being placed in Special Measures by the CQC in 2015. They emerged from

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Special Measure in 2018. Unlike the other blue light services, the Mayor and GLA currently have no formal role in holding the Service to account. The Assembly has previously called for this anomaly to be addressed; to make the LAS more democratically accountable to Londoners, and to facilitate improved co-working between the LAS, Metropolitan Police and London Fire Brigade.

Meeting on July 17th is one of several to be held by the Health Committee seeking:

1. Views of Londoners on the performance and future for the ambulance service
2. The views of the LAS senior management and key strategic partners including the Met, TfL, London Fire Brigade and the NHS
3. Views and experiences of frontline staff - paramedics and call centre workers.

Key areas for investigation include:

- Increased patient demand
- Performance on response times
- The potential impact of service reconfigurations
- Changes to the workforce
- Governance and accountability

1.0 INCLUSION IN THE WORK OFTHE LAS

1.1 The LAS is a very inclusive organisation and we regard inclusion as important form of public governance. It is open to discussion and ideas and proposals for change to the operation of its services. The Forum's members are active on 13 LAS committees. Our members join LAS colleagues at these meeting and contribute to discussions on LAS service development, policy, strategy and risk. Through our work on the LAS PPI Committee, we participate in plans for the enhancement of PPI in the LAS. Senior LAS staff are always been willing to answer questions from the Forum about the operation of services and usually respond quickly and positively.

COMMITTEES THAT FORUM MEMBERS PARTICIPATE IN:

- CLINICAL SAFETY – **MALCOLM ALEXANDER**
- CLINICAL AUDIT AND RESEARCH STEERING GROUP - **NATALIE TEICH**
- CLINICAL EFFECTIVENESS & STANDARDS – **BEULAH EAST & MALCOLM A.**
- COMMUNITY FIRST RESPONDERS – **SISTER JOSEPHINE UDIE**
- END OF LIFE CARE – **ANGELA CROSS-DURRANT**
- EQUALITY AND INCLUSION – **AUDREY LUCAS & BEULAH EAST**
- INFECTION PREVENTION AND CONTROL – **ADRIAN DODD**
- LAS ACADEMY – PPIP – **POLLY HEALY, JAN MARRIOTT, MALCOLM A.**
- MENTAL HEALTH – **BEULAH EAST & MALCOLM A.**
- PATIENT AND PUBLIC INVOLVEMENT – **MALCOLM A.**
- PATIENT EXPERIENCE & FEEDBACK – **ADRIAN DODD**
- PATIENT SAFETY – **BEULAH EAST & MALCOLM A.**
- SAFEGUARDING - **ADRIAN DODD**

1.2 **Evidence of service improvement** through community engagement is recognised as important by the LAS, but achievement of significant change is a slow and difficult process. It is always hard for patients and the public to bring about changes to NHS organisations; we therefore believe the LAS should do much more to demonstrate in detail, where through engagement with the public, communities and the Forum, that enhanced services have been created for patients.

1.3 The Forum holds open public meetings every month attended by 25-30 members of the public and with speakers from the LAS, commissioners or other organisations. The LAS support this activity by providing a meeting room, photocopying of papers and contact with 5000 Foundation Trust' members who are invited to Forum's monthly meetings held at LAS HQ.

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1.4 The Forum monitors services for patients provided by the LAS, by carrying out 'enter and view' visits which include the Emergency Operations Centre, 'ride outs' on ambulances, and visits to ambulance stations and ambulance staff at A&E departments.

2.0 Governance & Accountability

2.1 From the experience of the Forum the LAS Board is less accountable to patients and the public now than it has been since the Forum first started working the Board in 2004. Participation in the work of the Board was active, but at the present time the Board will not send Board papers to the Forum in advance of its meetings. The Forum has therefore stopped attending meeting of the Board. We regularly put questions to public meetings of the Board, which were answered throughout the meeting as the relevant issue arose, but the response during the meetings diminished. Now questions are usually answered at the end or after Board meetings, which, we believe, has undermined core principles of inclusion and good governance.

2.2 Board meetings tend to last for 4 hours or more which is contrary to good governance, because members of the public do not have facilities to observe meetings in comfort. The papers are provided only at the meetings, but there is nowhere to lie them. We regard the organisation of the Board meetings to be focussed entirely on the needs of Board members whilst ignoring the needs and contribution of the public.

2.3 Public consultation and engagement on LAS strategies is generally poor, an exception being the Clinical Strategy, to which the Forum was invited to actively contribute by the Medical Director of the LAS, Fenella Wrigley. She has followed this up by agreeing to share with the Forum details of progress with achieving the objectives set by the Clinical Strategy.

2.4 In the case of the annual Quality Account, which requires statutory engagement, the Forum is fully engaged and engagement is promoted and supported by the Chief Quality Officer, Trisha Bain with whom we meet monthly to achieve agreement about delivery of shared objectives. **www.patientsforumlas.net/quality-accounts.html**

2.5 In relation to the overall LAS strategy and other LAS strategies there has been no public consultation, because in the view of the LAS their five year strategy does not propose significant changes to the services they provide. We were told by the LAS:

"Large parts of the LAS STRATEGY will be about the internal workings of the organisation and would therefore be inappropriate for a public

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consultation. However, the Trust wants service users to ensure it is improving the outcomes and experiences of its patients. This will be done in different ways that best meet their needs, and will provide the richest feedback possible".

Public engagement on the overall LAS STRATEGY was minimal despite claims to the contrary by the LAS leadership:

> 21. Questions from members of the public (TB/18/21) 21.1. The Patients' Forum had asked the following question: "Does the Board agree that effective public engagement and co-production in strategy development should be always events? If so why has there been virtually none in the development of the new LAS Strategy". Board members noted that an answer had been provided earlier in the meeting (paragraph 8.3, ref: TB/18/08). A formal response would also be provided.

> 8.3. The Chair reported that she had received a question from the Patients' Forum with regard to the extent to which the Trust had entered into public engagement and coproduction in the development of the strategy. GE referred to Appendix B of the strategy ("How we developed our strategy"), which detailed that the Trust had followed established best practice in developing its strategy and had undertaken substantial engagement with its staff, patients and the public, partners and stakeholders throughout. This had ensured that it had been able to benefit from the insight of those who delivered and those who experienced the Trust's services when arriving at a view of how the organisation needed to change. It also meant that these groups had invested in, and own, the strategy.

2.6 The Forum has been unable to find evidence of any "substantial engagement with … patients and the public…". There was a single meeting attended by 12 people, 3 of whom were Forum members, and 3 office meetings between the Forum and the LAS strategy team.

2.7 LAS STRATEGY – The Forum will submit a statement on the LAS Strategy to the Health Committee shortly.

2.8 DIVERSITY OF THE LAS BOARD: Non-Executive Directors of the Board are composed of people of a single ethnicity. We have formally complained about the lack of ethnic diversity on the Board many times since 2006, but there has been no resolution. A new associate NED from a BME heritage has recently been appointed but has no voting rights, which fails to comply with the WRES.

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3.0 KEY CHALLANGES FACING THE LAS AND SERVICE USERS

3.1 Ambulance Queuing

We regard a major pan-London issue limiting the effectiveness of the LAS to be the problem of ambulance queuing. Ambulance queuing prevents emergency ambulances from responding to emergencies. It is an appalling indictment on NHS London, that this problem has continued for a number of years under their watch without resolution. We regard ambulance queuing as a breakdown in the quality and safety of emergency care provided to patients taken to A&E by the LAS - it is particularly harmful to older people who have fallen and those laying in the road following an accident waiting for an ambulance. Long delays and complex delivery is harmful particularly to people with cognitive impairment for whom moving between home, ambulance, A&E and wards can be traumatic and add to their level of confusion.

Responses to questions put to several London acute hospitals on this issue (Barts and the Royal London, Hillingdon, Northwick Park) can be found at: www.patientsforumlas.net/upcoming-meeting-papers.html - see May 14th 2018

Situation re ambulance queuing February to June 2018.

Feb – 6199 hours lost across London's A&Es
March- 7503 hours lost across London's A&Es
April – 5026 hours lost across London's A&Es
May – 4467 hours lost across London's A&Es
June – 3779 hours lost across London's A&Es

There has been a substantial decrease in ambulance queuing since the Forum's public meeting on this issue at City Hall on April 9th 2018, and our meeting with the Mayor's health team and the Chief Executive of the LAS on December 8th 2017.

Hospitals with the worst ambulance queuing problems in London - June 2018:

Queen's Romford – 334 hours lost in June 2018
Hillingdon Hospital – 302 hours lost in June 2018
Northwick Park – 268 hours lost in June 2018
King's College – 247 hours lost in June 2018
Newham – 214 hours lost in June 2018 (queues unusual in Newham)
North Middlesex – 195 hours lost in June 2018
Royal Free – 190 hours lost in June 2018

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The time spent queuing outside of A&E departments or in the entrance waiting for handover, is time when the ambulance crew should be attending to the needs of other patients who may have suffered a cardiac arrest, stroke or other serious incident. The LAS has worked hard to resolve this problem, but patients are the victims of an NHS system, in which hospitals have too few beds and discharge from hospital is often impossible because of a shortage of social care and community health care services.

A new policy called ‘fit to sit’ has been introduced into A&E, which aims to move patients brought in to A&E as emergencies onto seats instead of trolleys, and in some cases asking them to stand if there are not enough seats. In some cases nurses or paramedics are asked to manage the care of a group of ‘fit to sit’ patients, while they are waiting for clinical handover from paramedic to A&E.

Ambulance queuing and handover delays are examples of the consequence of the appalling underfunding of emergency care services.

We would like to see the LAS leadership, the Mayor and London’s STPs show collective leadership and resolve this appalling problem.

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Handover data for June 2018 at each London hospital:

Non-blue calls. Arrival at hospital to patient handover, June 2018

	Arrived to Handover						
	Total Conveyances	Total Handovers	Handovers exceeding 15 mins	% over 15 mins	Overrun per breach (mins)	Total time lost over 15 mins (hrs)	12 Week Trend
Barnet	1510	1412	421	30%	6	42	
North Middlesex	2402	2248	1328	59%	9	195	
Royal Free	1465	1315	925	70%	12	190	
University College	1762	1615	965	60%	10	156	
Whittington	1426	1328	572	43%	7	70	
Homerton	1363	1272	367	29%	4	26	
King Georges	1167	1045	913	87%	12	185	
Newham	1967	1688	1330	79%	10	214	
Queens Romford	2975	2792	2164	78%	9	334	
Royal London	2172	1957	1188	61%	8	156	
Whipps Cross	1770	1585	1187	75%	10	197	
Charing Cross	1176	1089	613	56%	5	55	
Chelsea & West	1293	1205	482	40%	5	42	
Ealing	1248	1164	419	36%	7	47	
Hillingdon	1774	1645	1257	76%	14	302	
Northwick Park	2871	2700	1224	45%	13	268	
St Marys	1865	1744	1150	66%	8	158	
St Thomas'	2249	2051	1303	64%	7	152	
West Middlesex	1851	1751	780	45%	7	88	
Kings College	2320	2154	1644	76%	9	247	
Lewisham	1460	1318	770	58%	7	85	
Princess Royal	1818	1637	496	30%	7	62	
Queen Elizabeth II	2418	2337	408	17%	6	43	
Croydon	1925	1780	1208	68%	9	177	
Kingston	1412	1316	809	61%	5	69	
St Georges	1977	1794	1143	64%	7	135	
St Helier	1230	1126	687	61%	8	89	
LAS TOTAL					8	3,779	

Non-blue calls. Patient Handover to Green, June 2018

	Handover to Green						
	Total Conveyances	Total Handovers To Green	Handovers exceeding 14 mins	% Over 14min	Overrun Per Breach (Mins)	Total Time Lost Over 14 Minutes (Hrs)	12 Week Trend
Barnet	1510	1412	824	58%	7	89	
North Middlesex	2402	2248	1297	58%	8	176	
Royal Free	1465	1315	669	51%	7	73	
University College	1762	1615	987	61%	8	132	
Whittington	1426	1328	711	54%	8	93	
Homerton	1363	1272	715	56%	8	101	
King Georges	1167	1045	493	47%	6	51	
Newham	1967	1688	858	51%	8	111	
Queens Romford	2975	2792	1556	56%	7	174	
Royal London	2172	1957	1163	59%	7	145	
Whipps Cross	1770	1585	804	51%	7	94	
Charing Cross	1176	1089	538	49%	6	50	
Chelsea & West	1293	1205	703	58%	7	83	
Ealing	1248	1164	554	48%	5	48	
Hillingdon	1774	1645	759	46%	6	71	
Northwick Park	2871	2700	1334	49%	6	135	
St Marys	1865	1744	896	51%	7	102	
St Thomas'	2249	2051	1100	54%	7	122	
West Middlesex	1851	1751	817	47%	5	69	
Kings College	2320	2154	1013	47%	7	110	
Lewisham	1460	1318	579	44%	5	52	
Princess Royal	1818	1637	789	48%	5	64	
Queen Elizabeth II	2418	2337	994	43%	3	54	
Croydon	1925	1780	964	54%	5	77	
Kingston	1412	1316	637	48%	5	53	
St Georges	1977	1794	900	50%	6	90	
St Helier	1230	1126	539	48%	5	46	
LAS TOTAL					6	2,464	

3.2 Use of Taxis to transport patients

The Forum is concerned about the use of taxis by the LAS. We presented a detailed case to the LAS concerning a patient who had had a recent cholecystectomy and was taken to hospital by taxi with severe right sided abdominal pain. We have had detailed and useful discussions about this case with Briony Sloper, the Head of Nursing for the LAS, but continue to have concerns about the use of taxis.

The patient received a face to face assessment in her home from her GP, who was fully aware of her medical history and medication. Despite the patient deteriorating throughout the day from the onset of symptoms at 9am, the face to face GP assessment was replaced by the less robust triage system. The patient was in

severe pain and immobile. The taxi driver was not an appropriate person to assist a patient in severe pain with mobility problems. This situation needs to be reviewed in relation in relation to the needs of other patients who are in severe pain and immobile, where a taxi is not appropriate as a means of transport to ED.

The arrangements for the 'handing over' of patients in serious pain at urgent care/A&E should be reviewed. In this case the patient was dumped outside the A&E and left to make her own arrangement for getting care. It took several hours to get appropriate care and treatment, and it was discovered that she had an internal bleed.

There should be a duty to ensure that a patient in great pain is assisted by an LAS clinician to get to access to appropriate urgent triage and assessment. There is a considerable difference between a clinical handover by LAS paramedics, which includes the handover of clinical information, and that of a taxi company, which can only leave patients outside the hospital. Taxis should not be used for patients in serious pain who require immediate pain relief and appropriate handover.

This problems is caused by the shortage of ambulances and crew partly due to the impact of ambulance queuing.

4.0 Emergency Operations Centre (EOC)

The Forum carried out a detailed examination of the EOC and the service manager has spoken to a Forum meeting. Our report and the presentation from Pauline Cranmer, who manages the EOC can be found on our website: www.patientsforumlas.net. Key problems facing the EOC are a severe shortage of staff and the fact that staff remain with the LAS for shorter periods than previously. Over the past 18 months, 126 staff have been recruited and 83 left. 73 new posts have been identified. A major problem is low wages, particularly for EOC call handlers, who carry out the critical role of receiving 999 calls from the public. Their wages are below those of police and fire brigade call handlers. The diversity of staff in terms of ethnicity, is greater in the EOC than any other part of the LAS. The career structure in the EOC is being revised but opportunities for advancement are few.

The EOC (which is based in both Waterloo and Bow) has faced major challenges, which include the introduction of the Ambulance Response Programme (ARP) in August 2017, which fundamentally changed the response times to patients requiring emergency care.

The is an urgent need for the wages of EOC staff to be substantially increased and for there to be a robust process for career advancement .

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5.0 ARP – AMBULANCE RESPONSE PROGRAMME

Until August 2017, LAS 'see and treat' response targets were based on Cat A responses at 8 and 19 minutes and Cat C[1] & C[2] responses at 20 minutes (90% of the time) and 30 minutes (90% of the time). In August 2017 the target for Cat C was increased to 45 minutes. There was no consultation or discussion on this change. In practice patients were being advised that the waiting time was 45 minutes, but were often waiting well in excess of 45 minutes. The introduction of ARP towards the end of 2017 meant that patients who would have been given a 45 minute target time were instead seen within 2 or 3 hours.

The response to the most critically ill patients should have improved, e.g. patients suffering a cardiac arrest, but as there is no outcome or comparative data (before and after ARP) it is hard to tell what has happened. We were assured by Professor Benger, that by April 2018, data would be available for specific clinical conditions before and after the introduction of ARP, to show how well the service is responding to patients with particular clinical conditions. We have been told that no evidence has been found of harm due to ARP, but we have seen no evidence of improved outcomes for patients either.

The LAS is enthusiastic about the ARP, which it appears constitutes a recognition of scarce resources and the duty to focus on those patients who are most critically ill, at the expense of those who are less critically ill. Alongside the major problem of ambulance queuing, there does seem to be a core systems failure in relation to meeting the needs of patients who are very ill or injured but are not at risk of death.

Ambulance response targets are now:

C1 - 7 minutes
C2 - 18 minutes
C3 - 2 hours
C4 - 3hours

Comparative data between the old and new systems is still not available and we find it impossible to assess whether the system is better for patients, except in the case of the seven minute target which is clearly better for patients who previously waited 8 minutes for high level emergencies and but only got an 8 minute response 75% of the time.

It took a long time to get ARP performance data from the LAS and commissioners. **It is now available on a monthly basis and we can share this data on request.**

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6.0 WORKFORCE

6.1 LAS Academy

A major problem for the LAS has been the recruitment of Paramedics and it has consequently recruited from Australia for a number of years. In a couple of years the Paramedic profession will be degree entry only, but there will still be opportunities for entry to training grades through apprenticeships. Pay grades for paramedics have been uplifted so that they made be paid on either band 5 and 6.

At the moment the LAS Academy in Fulham has a two year programme for the training of Emergency Ambulance Crew and Technicians to become HCPC registered paramedics. EACs and Technicians are not HCPC registered.

The Forum works closely with the Academy by promoting patient and public involvement in the training of staff, volunteering as mock patients for assessment of staff, monitoring the process of assessment by Academy staff and working jointly with Tutors to raise standards and ensure high level PPI in the work of the Academy.

6.2 Redesign of the workforce

The LAS is also enhancing the care it provides to patients through the employment of mental health nurses in the EOC clinical hub, midwife tutors to enhance maternity care and jointly with Macmillan's, the employment of end of life care nurses. The Forum has been involved in the interviews for these staff.

For the future the Forum would like to see the development of advance paramedics who specialise in mental health care. Providing appropriate care for patients who are severely ill and suffering from a mental health crisis is complex, and ensuring that the response is appropriate and sensitive to the patient's needs of fundamental importance. Ensuring that mental health care is a health matter and not a police is essential. The LAS is currently operating a car with a paramedic and mental health nurse to assess whether this service will meet the needs of patients in a mental health crisis.

6.3 Equality, Diversity and Inclusion in the Workforce

Equality, diversity and inclusion in the LAS and are essential to the delivery of effective health care. We believe that workforce diversity brings valuable knowledge and 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. We have persistently asked the LAS to use targeted recruitment across London to create a more local and more diverse workforce. This is now happening.

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Recruitment - there now evidence of active recruitment campaigns for EACs and Paramedics being led by the new head of recruitment. This work is partly being funded by the **Health Education England** grant of £500,000 given to the LAS for developments toward a diverse workforce.

WRES 2 - Melissa Berry continues to successfully drive forward implementation of WRES 2 and is fully supported by the Chair of the LAS and Patricia Grealish the Director of People and OD. WRES = workforce race equality standard.

Annual VIP Awards: We asked the LAS to introduce an award to be given to the staff member who has shown greatest leadership in the promotion of race equality in the LAS. Our proposal was initially welcomed by the Director of Communications and Heather Lawrence, Chair of the LAS and Melissa Berry who leads on WRES, but it was later converted into a Diversity VIP award. The award was won in 2018 by Samad Billoo who will attend the July 17th meeting at City Hall. www.londonambulance.nhs.uk/working_for_us/vip_staff_awards/how_to_nominate.aspx

Racial Diversity in the LAS – Paramedics. There has been no improvement in the ethnic diversity of LAS Paramedics since 2015/16. Only 4.2% of front line paramedics were from a BME heritage in 2016-7, a reduction of 0.4% compared to 2015-6. The number of BME heritage staff leaving the LAS is about the same as the number joining.

Year	Total no Paramedics In the LAS	Total no BME Paramedics	% BME Paramedics	BME % frontline Paras direct patient contact	"BME" Paras as % of total workforce
2003/4	685	22	3.21	Not Known	0.54
2004/5	734	26	3.54	1.07	0.65
2005/6	832	26	3.13	0.99	0.62
2006/7	816	27	3.31	1.00	0.62
2007/8	836	32	3.83	1.19	0.74
2008/9	881	31	3.52	1.04	0.70

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2009/10	917	34	3.71	1.01	0.68
2010/11	1025	41	4.00	1.22	0.83
2011/12	1385	64	4.62	1.98	1.38
2012/13	1648	93	5.64	2.97	2.01
2013/14	1611	95	5.90	3.09	2.04
2014/15	1707	106	6.20	3.49	2.30
2015/16	1991	139	7.0	4.6	2.80
2016/17	1969	134	7.0	4.2	2.60
2017/18	2050	133	6.4	3.9	2.5

Gender of front line staff: Data accurate as at 31st March 2017.

Frontline %	Female	Male	Grand Total
Non-para	40%	60%	100%
Paramedic	48%	52%	100%
Frontline (Headcount)	**Female**	**Male**	**Grand Total**
Non-para	509	771	1,280
Paramedic	839	895	1,734
Grand Total	1,348	1,666	3,014

We have raised with the LAS Academy and the LAS Equality and Diversity Group, our concern about the low number of women non-paramedics applying for conversion to paramedic through the Academy. We have requested a survey of female non-paramedics to gather information about their reasons for not applying.

7.0 **LAS ACCOUNTABILITY TO PATIENTS**

Complaints from patients are a major source of qualitative data on their experience of LAS care. Responding effectively to complaints and changing services when complaints demonstrate the need for change is an important aspect of the LAS's accountability to patients.

7.1 Complaints Charter for Urgent and Emergency Care

The Forum designed the 'Urgent and Emergency Care Complaints Charter' and presented it to LAS Executives and formally to the LAS board, who accepted it with minor amendments. The Charter is now formally an LAS document and has been published in accordance with the NHS England Accessibility Standard. It has been sent 5000 LAS members and is on the LAS website. **https://tinyurl.com/ycnfoh2m**

7.2 Assessing the effectiveness of complaints investigations.

We have been trying for a year to work with the LAS to implement a system to independently audit and monitor the investigations and outcomes of complaints submitted to the LAS. Currently, the LAS governance process will not allow this to happen – although KPMG is allowed access. We are happy to monitor complaints anonymously, or with the consent of the complainant. On July 16th the Forum submitted a document: GOOD GOVERNANCE IN COMPLAINTS AUDIT – 'Our Proposal for Reviewing LAS Complaints Procedures' to Trisha Bain, Chief Quality Officer, proposing redaction and a 'whole complaints process' review on a sample of complaints. She immediately accepted our proposal.

7.3 The LAS gets very few positive responses to their complaint investigations, and now the Forum's 3 experienced Members will be able to assess the quality of complaints investigations from the lay perspective, and whether outcomes of investigations lead to LAS or system change, and whether complaints investigations are empowering for patients and relatives who complain. The Patient Experiences Department fully supports this initiative.

8.0 PATIENTS' VIEWS AND EXPERIENCES OF THE LAS

8.1 WORKING WITH SICKLE CELL ORGANISATIONS

There has been outstanding work between the LAS, Sickle Cell Society, 'Merton Sickle Cell and Thalassaemia Group' and the Patients' Forum, which has led to the production of 3 reports from CARU. These reports demonstrate significant improvements in care, from the patient's perspective, as a result of public pressure for more effective training for front line staff.

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Eula Valentine from the Merton Sickle Cell Group was invited to speak to an LAS Board meeting and presented a number of high level recommendations to the Board, which are now being considered. These recommendations arose from Focus Groups with people with sickle cell disorders, which were developed from the Sickle Cell Insight Project during 2017. The Chair of the Sickle Cell Society, Kye Gbangbola also made a presentation to the Board advising them about ways of improving their care of patients with sickle cell disorders. The Sickle Cell Society are working closely with the LAS Academy.

8.2 CARE OF PATIENTS WITH DIABETES

Following our joint project with Diabetes UK a great deal has been done to ensure that the care of patients with diabetes and especially 'diabetes with eating disorders' is included in the CSR for the training of all front line staff. Jaqui Lindridge, Consultant Paramedic led on this work for the LAS. We have promoted the idea that front line staff should have ketometers to assist in the diagnosis of patients with Diabulimia and have received the following response, which is a good example of our continuing, but incomplete collaborative work with the LAS. The LAS is now considering a trial with **Ketone Testing Kits.**

Diagnosing DKA – Response from Jaqui Lindridge, Consultant Paramedic

"Tim Edwards and Racheal Fothergill, are going to have a discussion regarding any opportunities for the use of capnography in suspected DKA. There appears to be some data on this in the literature, and is a test we already have access to. Mark Whitbread will be nominating one of the critical care APPs to lead on diabetes going forward, and should be in touch shortly".

8.3 STROKE CARE

A Forum member whose partner suffered a stroke, leads on stroke diagnosis and care. He has proposed amendments to the PRF form used by paramedics in relation to asphasia in the diagnosis of stroke. A meeting has taken place with the Deputy Medical Director, Dr Neil Thompson, to discuss this issue and it is expected that the new ePRF will have amended wording in relation to asphasia. In addition the LAS invited the family to participate in the making of a video on stroke diagnosis for the training of LAS staff. The filming has taken place.

We have been assured that guidance has been re-issued to crew on the assessment and management of patients suspected of having stroke. This has also been picked up in teaching and training materials, and covered in several issues of the Clinical Update: "FAST covers all elements of speech".

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Data on LAS performance on stroke care has improved enormously and a very high percentage of patients are taken to Hyperacute Stroke Centres within the target time. Attempts are now being made to enhance pre-hospital care for stroke patients to enable faster treatment once the patient arrives at hospital.

The CARU audit of stroke care shows that there is a very high level of compliance with the stroke tool and pathway – 97% of patients are documented to have received the complete care bundle (which includes all elements of FAST, blood pressure and blood glucose measurement) and 99.4% of patients are conveyed to a clinically appropriate destination.

8.4 BARIATRIC CARE

The Forum raised concerns about the quality and sensitivity of the LAS bariatric care service prior to the CQC carrying out its detailed inspection that led to the LAS being placed in special measures. The bariatric service is currently provided by St Johns Ambulance.

A proposal for a redesigned bariatric service has been submitted to the LAS Executive Team for the provision of 3 dedicated LAS bariatric ambulances to provide 24/7 care, and if agreed a dedicated bariatric team would be recruited. Key issues will be the ability of the team to move and handle bariatric patients, so specialist staff would needed.

LAS believes that characteristics such as the shape of a person's body are as important as weight. The location of patients is also very important, i.e. where and how high up the patient lives and how accessible the patient is to ambulance crew. Clinical issues: airway management and expertise in drug absorption for bariatric patients are recognised as essential to effective care.

The Forum has raised this issue on multiple occasions with the LAS, but is unable to get answers on what action is being taken to develop an effective and patient sensitive bariatric care services. We have discussed a survey of 20-30 patients who have used the LAS bariatric care service to find out about their experience of LAS care and treatment, but the LAS have not been supportive of this project.

8.5 CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS

We hope that the LAS will move in the direction we have proposed of developing a cadre of Advanced Mental Health Paramedics. This is especially important for reducing, as much as possible, police involvement at the interface with patients who are critically ill, and may need to be detained under the Mental Health Act. Care not

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coercion (including chemical restraint) is fundamental to human rights and civil liberties.

Patients who call 999 for help with a mental health diagnosis (or the person who phones on their behalf) are currently asked if there is a risk of violence. This can delay care and we feel this question is therefore not appropriate. It is not used for other categories of patients.

The Non-Emergency Transport Service (NETS) works well for patients being assessed by social workers and doctors to determine whether they should be detained under the Mental Health Act. **We have been trying for some time to get feedback from patients who use this service on the quality of care provided, but no progress has been made.**

The Forum is concerned about delays in providing care for patients detained under s136 of the Mental Health Act. We are advised that most of these patients will be included in ARP Category 2 (18 minutes-90%), but have not been able to get performance data for this group of patients.

The number of s136 detentions across London in 2017 were as follows:

June	152
July	149
August	158
September	159
October	130
November	141
December	120

Our current concerns are focussed on the capacity of EOC staff to remain connected by phone to a person with suicidal ideation, at a time of huge staffing problems in the EOC, and the "red-carding" of some mental health patients by A&E departments to prevent their access. In one recent case a patient was held in an ambulance for 7 hours because 3 A&Es refused to take the patient. The Forum has carried out a pan-London survey on red-carding.

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ABOUT THE PATIENTS' FORUM

Company Secretary - John Larkin
6 Garden Court, Holden Road, Woodside Park, N12 7DG

President of Forum - Joseph Healy Drjhealy@yahoo.com

Chair - Malcolm Alexander - Tel: 07817505193 PatientsforumLAS@aol.com

Vice Chair - Sister Josephine Udie Sisterjossi@hotmail.com

Vice Chair - Angela Cross–Durrant Acrossdurrant@yahoo.co.uk

Executive Committee Members

Audrey Lucas - Audrey.lucas@healthwatchenfield.co.uk

Lynn Strother - Lstrother@ageuklondon.org.uk

Beulah East - Beulaheast@btinternet.com

Adrian Dodd - Adrian.dodd@virgin.net

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