PATIENTS' FORUM

AMBULANCE SERVICES

Information for the CQC

2013 Inspection of the London Ambulance Service

Patients' Forum Ambulance Services (London) Ltd.

Patients' Forum Ambulance Services (London) Ltd.
Registered in England. Company Limited by Guarantee. Company Number: 6013086.
Registered office: 6 Garden Court, Holden Road, Woodside Park, LONDON, N12 7DG

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FORUM'S CONTRIBUTION TO THE LAS QUALITY ACCOUNT FOR 2012-2013

CARE OF VULNERABLE PEOPLE – URGENT CARE

The Forum is very pleased that the LAS has achieved its Cat A targets and shares its concern about the poor performance of the LAS, for patients requiring a Cat C response. We are particularly concerned that these patients are often vulnerable and in need of urgent care and are sometimes having to wait long periods to receive appropriate care. These patients are high priority but not suffering from a life threatening condition.

SHIFT PATTERNS

We welcome the decision of the LAS to work with front line staff to change shift patterns. At the moment patients requiring paramedic care at shift handover times sometimes have to wait for unacceptable periods of time. These delays can impact severely on the treatment and care and prognosis of patients.

A PARAMEDIC ON EVERY VEHICLE

The proposal to ensure that there is a paramedic on every vehicle is one we strongly support. However, as the proposal will result in paramedic teams being replaced by teams with a single paramedic, it is essential that a new system is developed to enable paramedics to learn from each other's clinical experience. Team work between health care professionals is essential and the paramedic-A&E support worker model, whilst having many strengths, must not undermine the daily communication between paramedics and the opportunities for learning from each other. The Clinical Support Desk may fulfil some of paramedics needs, but cannot replace colleague to colleague communication on clinical matters, in terms of speed of access or clinical guidance regarding a patient in front of a paramedic. This is especially important for newly trained paramedics. The clinical consequences/outcomes of this plan need to be carefully assessed.

ALTERNATIVE CARE PATHWAYS

With regard to the use of Alternative Care Pathways (ACPs), which channel patients into more appropriate care and attempt to avoid the unnecessary use of A&E, we are concerned that access to these pathways is sometimes inadequate and unhelpful. Governance of ACPs is weak and in the case of the falls and mental health ACPs, there are serious problems regarding access, particularly at night and at weekends.

MORE STAFF AND BETTER VEHICLES

We are very pleased that the LAS will have greatly increased resources to employ more staff and to reduce the use of voluntary and private ambulances. The cost of these alternative fill-in services is very high and is a misuse of NHS resources. It is essential that in addition to more staff the maintenance of LAS vehicles improves. The quality of workshop support for the maintenance and both the routine and deep cleaning of vehicles is inadequate and this impacts on the safety of vehicles, the risk of infection and makes the service less efficient.

SHORTAGES OF EQUIPMENT

The statutory Quality Report drew attention to the shortage of some types of equipment on ambulances. We were delighted to receive Sandra Adam's (Director of Corporate Services) report on June 16th 2012 about the steps taken to address these shortages including the bar-coding of equipment and systems to check equipment in and out of vehicles. We are still getting reports of shortages of thermometers, oxygen probes, BP cuffs, ECG dots and tech-packs. It is also obvious (visually) that carrying bags which are often frayed and worn creates a poor impression of the services for patients and carers.

IMPACT OF LONG SHIFTS

The Forum has expressed concern on a number of occasions about the impact of long shifts on patient care and on the health and wellbeing of front line staff. We would like to reiterate that 12 hour shifts without adequate meal breaks and rest are in our view harmful to staff, harmful to patient care and generate complaints. As vehicles are now mostly on active deployment and eating in vehicles in not permitted, further work needs to take place to ensure that the shift work length and pattern are consistent with best practice for patients and staff.

HANDOVER

The Forum is pleased to note the collaborative work between the LAS and acute hospital Trusts to reduced handover time, whilst noting there continues to be severe pressure on Croydon University Hospital. We welcome the aim to further reduce handover times. We also wish to draw the LAS's attention to the need for staff to have time to complete their clinical investigations, prepare vulnerable patients for a safe journey into the A&E department with appropriate manual handling, ensure effective clinical handover to A&E staff and ensure that vehicles are cleaned down adequately to prevent cross infection.

REPORTING TO THE NRLS – NATIONAL REPORTING AND LEARNING SYSTEM

The NRLS is a central database of patient safety incident reports set up in 2003. Information submitted is analysed to identify hazards, risks and opportunities to improve the safety of patient care. We would like the LAS to publish details of the number of incidents reported to the NRLS each month and the categories of incidents reported. As incidents are submitted confidentially, we recognise that only limited information can be put in the public arena.

DEMENTIA CARE

People with dementia are more likely to be admitted to hospital and once admitted their length of stay is longer and their experiences are often poor resulting in worse outcomes such as worsening cognitive status and higher mortality. Some of these admissions are for preventable ambulatory care sensitive conditions (ACSC) which could be managed in the community. But the admission rate for ACSC for people with dementia is higher than for people who do not have dementia. Problems for front line staff include difficulty in taking history and assessing pain, and viable alternatives to transport to A&E (particularly out-of-hours) for people with cognitive impairment. Dementia is not usually the main reason for a call, e.g. many are for falls, acute infections (UTIs), stroke and difficulties in breathing.

We should like the LAS to design care approaches to improve the care delivered to patients with dementia. This could include training of front line clinical staff and setting up dementia referral pathways. Other ambulance trusts have done this very successfully and the most successful are being used as models of good practice. There is no reason why the LAS could or should not follow suit especially in view of the Prime Minister's Dementia Challenge.

USE OF CAGES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

The LAS subcontracts for the use of caged ambulances for the transport of some patients with mental health problems. The Forum believes that the use of caged vehicles, except with the most dangerous patients, should be stopped. We believe it is an abuse of the rights of patients to be held in a cage during transport to hospital, instead of being treated with respect, dignity and care.

The Forum values the annual LAS Quality Account and welcomes the opportunity to contribute. However, the LAS has never provided any detailed response to the Forum's recommendations for improvements to patient care. Community contributions are treated like 'ticking a box' rather than listening to ideas and proposals from the public.

PATIENT AND PUBLIC INVOLVEMENT (PPI) IN THE LAS

The Forum works actively with Margaret Luce (Head of Patient & Public Involvement and Public Education) and her team and we play an active role in the LAS PPI Committee, including providing a report to each meeting on the activities of the Forum. Margaret and her team regularly attend Forum meetings, and make presentations about their progress in public involvement and public education

The LAS give significant support to the Forum by providing meeting rooms, photocopying, refreshments and access to information about many aspects of policy and operational performance.

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FORUM REPRESENTATIVES ON LAS COMMITTEES

- CLINICAL AUDIT AND RESEARCH STEERING GROUP - NATALIE TEICH
- CLINICAL QUALITY, SAFETY AND EFFECTIVENESS COMMITTEE – ANGELA CROSS-DURRANT
- EQUALITY AND INCLUSION – KATHY WEST
- INFECTION PREVENTION AND CONTROL – MALCOLM ALEXANDER
- LEARNING BY EXPERIENCE – MALCOLM ALEXANDER
- MENTAL HEALTH COMMITTEE – MALCOLM ALEXANDER
- PATIENT AND PUBLIC INVOLVEMENT COMMITTEE – JOSEPH HEALY
- SAFEGUARDING – LYNN STROTHER

THE DEMENTIA CHALLENGE TO THE LAS

People with dementia are more likely to be admitted to hospital and once admitted their length of stay is longer and their experience of care is often disturbing, resulting in worse outcomes, e.g. poorer cognitive status and higher mortality. Some of these hospital admissions are for chronic conditions, which can lead to preventable acute episodes, e.g. congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Appropriate interventions and active care and treatment in the community can reduce the need for hospital admission. However, the indications are that the admission rate for people with these conditions who have dementia is higher than for people who do not have dementia (‘Counting the Cost', Alzheimer's Report, 2009).

Dementia is not usually the main reason for a call to the LAS; the 999 call is usually for falls, acute infections (e.g. urinary tract infections), stroke, ‘transient ischaemic attack’ and difficulty in breathing. There are numerous forms of dementia, including Alzheimer’s Disease, vascular dementia, Pick’s Disease (frontal temporal dementia), dementia with Lewy bodies, Korsakoff’s syndrome, and Creutzfeldt-Jakob disease (CJD). There are other rarer causes of dementia, e.g. multiple sclerosis, motor neurone disease, Parkinson’s disease, Huntington’s disease and Binswanger’s disease. The wide range of dementia types and causes needs to be understood by

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those who treat patients requiring urgent or emergency care, and during hospital admission. Sometimes, the LAS may be dealing with people with dementia who are not yet diagnosed, but who present with cognitive impairment due to dementia.

People with dementia are core users of acute health care. At any one time, a quarter of hospital beds are occupied by people with dementia aged over 65. Evidence suggests there are ongoing problems with the quality of care for people with dementia in hospital, and that there are many avoidable admissions. Counting the Cost (Alzheimer's Society, 2009) found unacceptable variation in quality of care for people with dementia on general hospital wards. The report's research found over half (54%) of carer respondents felt the person's dementia symptoms worsened as a result of their time in hospital. Nearly half (46%) reported that the person's general health deteriorated. Individuals were staying in hospital longer than other people who were admitted for the same reason but did not also have dementia. Around one in three people with dementia who went into hospital from their own home were discharged into a care home. In short, many hospitals are struggling to ensure that people with dementia are discharged appropriately.

Overall the evidence suggests that many hospitals are struggling to provide care for people with dementia. However, there is growing recognition of the need to improve care. In England, the 2012/13 Operating framework identifies care of people with dementia in hospital as a priority. The framework also set out a Commissioning for Quality and Innovation (CQUIN) target on improving diagnosis of dementia in hospitals (Department of Health, 2011).

As a result of the £50 million Department of Health funding made available following the Prime Minister's Dementia Challenge, for 'dementia friendly environments', some London Hospitals are among the 116 successful projects to have received DH funding. Some, e.g. Guy's and St Thomas' Hospitals, have set up ground-breaking approaches to providing care for patients with dementia. It appears that most of the projects concentrate on complex care once a patient has been taken to hospital or social care. There does not appear to be a London-based project that deals specifically with pre-hospital urgent and emergency care.

A dementia referral pathway ought to address this and ensure the right kind of care in the right kind of setting, where clinical staff have experience of dealing with patients who have dementia. This approach could reduce length of stay in hospital and the sometimes harmful effects of hospital admission (e.g. infection and depression) and reduce overall NHS costs. The East of England referral pathway, for example, has a proven record of leading to a reduced length of stay and reduced costs and because of its success, the pathway is being evaluated for use in Basildon, Southend and Ipswich NHS Trusts.

OUR VISION FOR THE LAS – PRE HOSPITAL DEMENTIA CARE

Given the Prime Minister's Dementia Challenge, the Patients' Forum is committed to campaigning for the development of dementia care pre-hospital pathways for patients in London.

Although the Commissioners for the LAS previously expressed a great deal of interest in improving care for people with dementia, their priorities have changed due to the serious challenges faced by the LAS to meet both category A and C targets.

The Patients' Forum for the LAS recommends that the LAS, CCGs and the LAS Commissioner adopt the following measures to improve the care of people with dementia.

1) Develop clear effective dementia pathways between the LAS and the LAS commissioners (CCGs), together with acute hospitals and where possible community care professionals to ensure 'right care first time'.

2) Unnecessary hospital admissions should be avoided.

3) Always aim to provide care for people with dementia in an environment they are familiar with. This reduces stress and anxiety.

4) Evidence that the LAS Clinical Support Desk has the expertise to advise clinical staff on meeting the needs of people with dementia, especially with regard to assessing cognitive impairment and pain.

5) Production and dissemination of 'clinical advice' for 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.

6) Effective Dementia Training for LAS Frontline Staff:

    - Create better information sources for clinical staff to enable them to gain access to more information about pre-hospital dementia care including the website of the Alzheimer's Society.

    - Develop more effective training and resources for LAS clinicians to enable them to carry out more comprehensive assessment at home and gain direct access to alternative care pathways leading to treatment at home, respite and where necessary admission to units that are 'dementia aware'.

    - Develop communication tools in conjunction with other agencies, for front-line staff, that can be used in the person's home to include a variety of information sources such as the patient's likes and dislikes, previous occupation and other useful information which will assist in gaining the patient's trust and minimising anxiety.

- **Alzheimer's Society Dementia 2012 Report http://www.alzheimers.org.uk/dementia2012**

- **Improving services and support for people with dementia, NAO http://www.nao.org.uk/publications/0607/support_for_people_with_dement.aspx**

- **Living well with dementia: A National Dementia Strategy Good Practice Compendium – an assets approach. Section 26 (pg 91) Improving the clinical care provided by ambulance clinicians. Great Western Ambulance Service (GWAS)**

STREET LEVEL ALCOHOL RECOVERY SERVICES

In 2011/12 the LAS provided care to 66,254 patients as a result of excessive drinking (6% of total LAS workload). That is equivalent to 181 patients/day, who are at a significantly greater risk of injury, illness, liver and heart disease, dementia and death. The highest proportion of heavily intoxicated patients in London receive emergency care in the boroughs of Westminster and Camden.

The LAS has a specialised PTS response vehicle, called a 'booze bus' based in Waterloo, that responds to patients who have become ill due to excessive alcohol use. The LAS also operate the 'Soho Alcohol Recovery Centre', near Soho Square on Friday and Saturday evenings (and 2-3 weeks over Christmas), which provides an alternative to A&E for some patients who are ill through alcohol intoxication. This is commissioned by London CCGs and mostly provides support for young people who are heavily drunk rather than people who are alcoholics.

Attempts have been made to extend this service to Croydon, Redbridge and Shoreditch but local CCGs and NHS Trusts have not been supportive by providing funding or staff despite the increasing human cost of alcohol.

A clinical audit by CARU (the LAS Clinical Audit and Research Unit) of 200 patients suffering from alcohol intoxication showed many patients refused to communicate with or allow staff to undertake basic observations. Almost all of the patients who allowed observations to be undertaken received an assessment of their vital signs. For patients with a reduced level of consciousness, most also had their blood sugar level measured. **The main reason for staff not undertaking a blood sugar level assessment was missing equipment.** Since commencement of this clinical audit, diagnostic bags have been allocated to every ambulance vehicle that should increase the number of patients who have their blood sugar level measured.

A history of the presenting complaint for this patient group was poorly recorded by paramedics; consequently a poster was sent to every ambulance station reminding staff of the importance of documenting the patient's clinical history.

The Patients' Forum strongly supports the further development of the LAS alcohol service. Young people are especially under pressure to buy cheap alcohol which is glamorized in supermarkets and cheap 'booze shops'. The LAS needs the active support of public health and community alcohol projects that target heavy drinkers, and follow them up with active messages about the dangers of continuous alcohol intoxication in relation to liver disease and serious incidents and accident.

RECOMMENDATIONS:

1) **London CCGs and the LAS Commissioners should fund the LAS to considerably increase access to specialist alcohol services and follow up care.**

2) **CCGs should be advised to raise this issue with the Health and Wellbeing Board in each London Borough.**

3) **The Forum should raise this issue with Duncan Selbie, Chief Executive of Public Health England, to get support for a pan London approach to reducing the pathological effects of excessive alcohol use.**

ROLES AND RESPONSIBILITIES OF LONDON'S EMERGENCY SERVICES DURING MAJOR INCIDENTS

Richard Barnes – Deputy Mayor of London and Chair of the GLA's London Resilience Forum (LRF) - addressed the January Forum meeting on the Roles and Responsibilities of the London Emergency Services during a major incident. He told the Forum that the LRF acts as a co-ordinator looking at risk assessment, planning meetings , terrorist threats, pestilence, flu epidemics, flooding, telecommunication etc. Roles and responsibilities have been updated following the Coroners 7/7 inquest. He said that Recommendation 9 relates to the air ambulance, but was out of the Mayor's jurisdiction, and referred to the capacity of the air ambulance service – there is only 1 helicopter in London – and the restrictions on when it can fly. On 7/7 the air ambulance brought in specialist doctors to carry out major trauma care and treatment, but did not transport patients to hospital.

Coroner's Recommendation 8 on air ambulances (http://tinyurl.com/ldvkayg):

- "I recommend that the LAS, together with the Barts and London NHS Trust (on behalf of the London Air Ambulance), review existing training in relation to multi casualty

triage (i.e. the process of triage sieve) in particular with respect to the role of basic medical intervention".

Coroner's recommendation 9 on major trauma care:

- "I recommend that the Secretary of State for Health, the Mayor of London, (the London Resilience Team) and any other relevant bodies review the emergency medical care of the type provided by London Air Ambulance and MERIT and, in particular (i) its capability and (ii) its funding".

The LAS responded to the Coroner on June 29th 2011 confirming that the following changes have been made in relation to multi-casualty triage:

- Multi-agency training
- Use of plain English in communicating with other services
- Recording the administration of medicines at the scene of a major incident and the plan to provide paramedics with morphine
- Covering of deceased people
- First aid training in the community

There is only one air ambulance in London and the service operates 24/7 using a helicopter during the day and cars at night. London Air Ambulance says they need two helicopters, e.g. for when the helicopter is being serviced. The LAS view is that there is no evidence that additional helicopters would improve response to major incidents and that MERIT teams (Medical Emergency Response Incident Team) have provided double the number of trauma doctors to enable an adequate response for major trauma patients.

The helicopter is paid for by the London Air Ambulance charity, to enable patients with major trauma to receive life-saving treatment on the scene and on the way to hospital. Patients are taken directly to a major trauma centre after initial treatment. The service delivers life-saving, highly specialised trauma doctors and paramedics to a patient's side within minutes of an incident or accident. The team performs life-saving procedures on the scene, e.g. open chest surgery, blood transfusion and anaesthesia: http://www.londonsairambulance.co.uk/.

RECOMMENDATIONS:

1) We recommend the LAS and the Air Ambulance Service formally review the capacity of the Air Ambulance Service in relation to the needs of patients in London.

2) We recommend the London Assembly Health Committee reviews the Coroner's Rule 43 recommendations (8) and (9) to ensure that the Coroner's intentions have been achieved.

3) We recommend Health Ministers to review adequacy of the arrangement whereby the funding of the Air Ambulance Service relies on charitable donations, rather than being funded as a vital service as part of the NHS.

The Patients' Forum has asked the LAS to confirm that all elements of the LAS response to the Coroner are regularly reviewed and for a recent risk assessment to show whether there are any weaknesses in compliance with the Coroner's recommendations.

http://tinyurl.com/m7svs7l THE LONDON RESILIENCE FORUM - Background
http://tinyurl.com/m995dmw THE LONDON RESILIENCE FORUM **-** Minutes

PATIENTS WHO FALL AND NEED ASSESSMENT FROM THE LAS

The Forum has raised the issue of effective clinical assessment and pathways for people who have falls. The key issues raised by the Forum are:

- The primary assessment of patients by front line clinical staff
- Delayed responses because of low capacity to respond to Cat C calls
- Absence of specialist 'falls teams' for LAS staff to refer to in the community

The proposal for paramedics to transfer some patients who have had falls to local 'falls teams' instead of taking them to A&E has been abandoned, because GPs on local Clinical Commissioning Group (CCGs) would not support this improved approach to patient care. The intention was to secure immediate, expert advice, support and rehabilitation for patients who have had falls, but instead paramedics will either take patients who need additional care to A&E or refer them to their GP. Referral to GPs for patients requiring urgent follow up care does not appear to be in the best interests of patients.

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 asked 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

This issue is being followed up with Dr Fionna Moore, the Medical Director of the LAS.

RECOMMENDATIONS:

1) The Forum recommends that Commissioners review again the need for paramedics to have direct access to local Falls Teams, in order to prevent inappropriate transfers to A&E and to ensure expert clinical care for patients who have fallen.

2) Research should be carried out to analyse the clinical consequences of referring patients who have fallen to their GPs.

3) Paramedic training and practice should include the comprehensive NICE assessment, including a comprehensive cognitive assessment that enables paramedics to identify patients who may have dementia.

CAT A CALLS AND PERFORMANCE

Calendar Year 2012

NUMBER OF CAT A INCIDENTS	429,400
- Reached within 8 minutes	320,050
- Reached within 19 minutes	421,938
- Longer than 19 minutes	7,462

We asked the LAS Board, in view of their current limited resources, how confident the Board is that LAS has enough fully trained frontline staff to properly and effectively meet the increased and possibly increasing demand in relation to patients with life-threatening conditions?

The Forum is pleased that £14 million has been made available by Commissioners to enable the LAS to employ 240 A&E Support Workers who will support paramedics on the front line. This plan includes provision for every ambulance team to be clinically led by a paramedic. However, we are also concerned that in addition to the massive increase in calls received during 2012 there were 7462 Cat A patients who did not get a response within 19 minutes.

75% of Cat A patients must get a response within 8 minutes 95% of Cat A patients must get a response within 19 minutes

The LAS only investigates outcomes for the patients who do not receive a Category A response within 19 minutes if there is a query, a complaint or any other sort of clinical concern. The LAS will then look into the circumstances of the call, and the clinical condition of the patient when the LAS arrive on scene and the impact on the patient.

RECOMMENDATION:

- **The Forum recommends that a more proactive approach is taken by the LAS to ensure that the 7462 failed Cat A responses do not include patients whose clinical needs are not adequately met and consequently suffered harm.**
- **Consideration should be given to these failed responses being investigated as Serious Incidents.**

HOSPITAL TURNAROUND

The Forum has closely monitored hospital turnaround time throughout 2012 using data provided by LAS commissioners and the LAS. The data shows that in December 2012, 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. E.g. in December 2012:

- Croydon University Hospital – 36 patients waited 60 minutes or more
- Princess Royal University Hospital - 16 patients waited 60 minutes or more
- St Helier Hospital – 10 patients waited 60 minutes or more

In December 2012, 115 patients across London waited for 60 minutes or more for emergency care in an ambulance outside A&E. However, the positive news is that in 2012 there was a 60% reduction in waits of 60 minutes or more since December 2011.

In October 2012 the Forum invited Michael Parker, former Chair of the Croydon University Trust and Richard Parker, the Director of Operations to a public meeting of the Forum, to discuss the consistent pattern of long waits outside the A&E department and their plans to resolve this problem. Since that meeting significant improvements have been made to Croydon A&E and we acknowledge and welcome the impact of the improvements, which have led to much lower numbers of patients waiting in excess of an hour in an ambulance.

A key joint requirement for all A&E departments is to report 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.

Such long waits outside A&E are a continuing scandal in the provision of effective urgent and emergency care. Despite hundreds of Serious Incident investigations by acute hospitals and continuous pressure from LAS commissioners, there is still a major problem of delays which has an untoward effect on seriously ill patients. The Forum acknowledges that the problem has been partially mitigated during 2012.

RECOMMENDATION:

The Forum recommends that CCG Commissioners and NHS England take urgent action to eradicate all LAS waits outside A&E departments. This will free up between 100-200 hours per month of access to emergency vehicles for critically ill patients requiring a Cat A response.

LAS BOARD – COMPLIANCE WITH PUBLIC INVOLVEMENT DUTIES

The Forum is concerned that Richard Hunt, LAS Chair decided to stop the Forum participating in Trust Board meetings. The Forum's participation in Board meetings was made difficult because contributions are only welcome at the end of the meeting after the business of the Board has finished, or occasionally during the meeting if the Chair is willing to receive the Forum's view. Acoustics in the Board Room are also very poor.

However, an agreement was eventually reached with Richard Hunt in 2012, that the Forum could submit written questions to the Board, which would be answered during Board meetings and responses published in the Board minutes.

QUESTIONS PUT TO THE LAS BOARD BY THE FORUM

We asked Richard Hunt, the Chair of the LAS Board, how he would respond to questions to the Board put by the Forum. He replied:

"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 was very pleased when in 2011 the LAS started 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 has 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 provide 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".

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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 point of the shift when the incident occurs.

The LAS told us that there has not been any systemic analysis but would support analysis to consider the impact of working patterns on complaints type and frequency. A proposal is being developed with CARU (Clinical Audit and Research Unit).

> "Sometimes complaints about staff being intimidating or aggressive are where the staff have 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." Comment from LAS

RECOMMENDATIONS

1) 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.

2) Evidence should be sought of the effectiveness of appraisals for staff following 'attitude and behaviour' complaints against them.

MULTI USE OF BLANKETS – INFECTION CONTROL

It was established some 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 her view that reuse of blankets for patients was always unacceptable.

It has been claimed that this practice stopped following an audit of the use of blankets. The Forum asked for a further audit as reports from front-line staff indicated that the practice continued in some areas.

We received the following reply from the LAS:

"As you know we have been auditing blanket use as part of our audit cycle and I am pleased to say that we closed the month of May 2012 with all but two complexes achieving 100% compliance with the single use policy. In terms of the specific action for a common pool of blankets this is not an easy deliverable as it requires individual negotiation with 32 hospitals and leaves us with a gap when we take patients to urgent care centres.

I have asked for an options paper that sets out some choices as we clearly need to change the way we stock up our blanket supply. We will track progress through the Infection Control Committee".

The LAS will now implement a major project to totally change the way in which blankets are managed by the LAS.

- LAS will withdraw all red blankets currently in circulation and fund the initial acquisition of a defined quantity of new hospital-type blankets corresponding to the difference in overall circulation.
- Acute Trusts and other high-volume LAS destinations will be commissioned to enter into a linen-sharing agreement through which LAS staff will perform a clean-for-dirty swap of one blanket and one sheet for every patient conveyed. Those Trusts will make preparations for the inevitable 'cross-pollination' of linen stocks between Trusts and laundries although there will be no net impact for any individual Trust in terms of overall volumes, once the LAS-related increase has taken place.
- All linen will be laundered through existing acute Trust laundry agreements; the LAS laundry contract will be terminated.
- LAS will maintain a further small supply of new blankets for surge capacity.

COMMAND POINT – Emergency call command and control system

The Forum monitored the initial failed roll out of Command Point and the final successful roll-out on 29th March 2012, following major changes to the software and an extensive staff training programme. Questions were put to the LAS Board about any associated morbidity or deaths associated with defects in the new system and the costs associated with the first roll out. No serious incidents were identified by the LAS as a result of delays or defects in the system.

We asked the LAS:

- If Northrop Grumman had to remit part of their fee (as a penalty) because of the errors with the system when it first went live?

- If the LAS were contractually obliged to pay additional costs to Northrop Grumman over the original price because of defects in the specification provided by the LAS?

The LAS told us that: "The delay in go-live caused financial implications for both parties (LAS and Northrop Grumman), but they mutually agreed to resolve the matter and any related issues by waiving any claims against the other".

The LAS also told us in April 2012:

"We've been operating on Command Point successfully for almost two weeks now. Certainly during the first week, demand on the service was very high, and staff are still getting used to the system. However, our response times to Category A patients have been better than we expected as have our call answering times. And to date, there have been no clinical issues identified."

BARIATRIC CARE – THE CARE OF LARGE OR HEAVY PATIENTS

The care of bariatric patients can be very undignified and cause considerable anxiety for both patient, family and ambulance clinical staff. Transportation of the patient from their 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. Some hospitals have not developed appropriate procedures, space and equipment to receive bariatric patients.

The Forum is concerned about 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 and out of hours private vehicles are used. If the patient is very large the LAS can use specialised HART vehicles. The newest range of LAS ambulances

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have a trolley bed which is capable of carrying patients weighing up to 50 stone. There is an LAS 'task and finish' group working on finding an in-house solution to safely carrying bariatric patients and transporting them to hospital.

We asked if a question about weight was asked during initial telephone triage to ensure that the right resource was supplied and we raised questions about the problems at weekends when bariatric vehicles need to be obtained through a private provider.

The LAS replied that: “This is not a question that is asked during emergency clinical triage – we need to ensure that every patient receives exactly the same initial response. If, once on scene, the clinician feels additional resources / equipment are 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”.

The LAS has now set up a Bariatric Working Group to develop service provision for this group of patients.

RECOMMENDATIONS

1) The Forum would like to collaborate with the LAS in a survey of bariatric patients who have been transported from their home to a hospital A&E department to hear about their experiences of care and treatment.

2) We recommend that the LAS Bariatric Working Group carries out a survey of London A&E departments to ascertain whether they have developed appropriate procedures, space and equipment to receive bariatric patients.

Hignett, S. and Griffiths, P. (2009) Manual handling risks in the bariatric (obese) patient pathway in acute, community and ambulance care and treatment. WORK. A Journal of Prevention, Assessment &Rehabilitation. 33, 2, 175-180.

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 would wait outside a house to which they had 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 were 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 maximum time for critical Cat A calls is 8 minutes from call to arrival. The Register is not person specific, so all residents of a house on the Register may have been subject to waiting for emergency treatment until the police arrived. 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, e.g. 8 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.

7) There are 700 people on the High Risk Register, placed there by the police, which are not subject to any process of audit or verification.

ACTION:

The Forum has sought advice from Liberty, the human rights charity, and will raise the issues above with the LAS Board.

CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS

1) Mary Roberts, a mental health activist, addressed the Forum in February 2012 on urgent and emergency care for people with mental health problems. Members with experience of mental health care with the LAS also contributed to the Forum's work on this issue. The Forum is also active in the LAS Mental Health Committee.

2) Issues identified by service users at the Forum meeting included:

- LAS services are very 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 a professional level of understanding of their needs.
- No specialist mental health teams in the LAS.
- Many hospital A&Es do not have specialist mental health teams 24/7.
- Patients frequently had to wait a very long time to see a doctor or a nurse and A&E reception and nurses often demonstrated insufficient training in mental health issues.
- Inappropriate use of restraint and transport in police vehicles or ambulance cages.
- People with mental health problems sometimes experience being treated as though they were a nuisance when they were seriously ill.
- A& E staff sometimes turn away ambulances with mental health emergencies away 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 get appropriate emergency care.
- Concern about the effectiveness of 111 in dealing with mental health crises.
- Emergency services find it difficult to deal with emergencies that occur during adolescence when young people are between children's and adult services.

The Forum has been active in pursuit of higher standards of care for people with serious mental health problems. Weakness in the training of paramedics and in the organisation of services for this group of patients has been frequently highlighted with the LAS.

3) Use of Caged Ambulances for Patients in Mental Health Crisis

The Forum has written to all mental health trusts in London asking for details of the use of caged ambulances for the transport of patients. LAS advised the Forum that they subcontract with a private company for access to 'cage ambulances' when they transport some patients with serious mental health problems.

Paul Farmer, Chief Executive of Mind, said: "We would be extremely concerned if caged ambulances were being used for people with mental health problems. Our current campaign on acute and crisis care has highlighted the importance of treating people with dignity and humanity when they are in a crisis. Please do get in contact if you'd like to discuss this further."

4) Delays in Providing Care for Patients in a Mental Health Crisis

The Forum has been concerned about the delays for patients who have a mental health crisis and need to be admitted to an A&E department. Some of these patients have been sectioned under the Mental Health Act (MHA) and need a place of Safety. There have been a number of reports from the LAS of delays of several hours before a patient is transferred to A&E. In some cases ambulances have to travel from hospital to hospital to find an A&E that will accept the patient.

We asked the Commissioners of the LAS for data on the following issues:

- Long delays – sometimes of several hours – for LAS crews being able 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.
- Handover to A&E data showing waits of over 30 minutes and over one hour for patients with a mental health diagnosis.

They told us that they do 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 Forum will further discuss access to data on patients with a mental health crisis with the Commissioners and LAS Clinical Quality Group. This issue has been raised at the LAS Mental Health Committee on several occasions and attempts are being made through negotiations between the LAS and mental health hospitals in London,

to find a solution based on admission to the 'nearest place of safety' during a mental health crisis.

RECOMMENDATIONS

1) LAS commissioners should produce data on mental health patients, showing:

- **Time taken for the LAS to take Sectioned patients to an acute hospital 'place of safety'.**
- **Time taken for handover to A&E mental health clinicians.**
- **Handover breaches of 30minutes and 1 hour.**

2) Evidence should be provided to show the percentage of LAS clinicians who have received training in the care of mental health patients.

3) The LAS should develop a specialist team of paramedics who are expert in the care of patients with a mental health diagnosis.

4) The LAS and the LAS Commissioners should ban the use of caged ambulances for the transport of patients with a mental health diagnosis.

5) The LAS should examine in detail the care it provides to patients that have both learning disabilities and a mental health diagnosis.

6) The LAS should examine in detail the care it provides to adolescent patients with a mental health diagnosis.

END OF LIFE CARE

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

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 - approx 1,000 (but may well rise to between 57K and 60K).

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

1. 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.

2. Alternatively, the LAS will cease to flag addresses but ensure staff are always alert to the possibility that the patient has an ACP. This would require significant levels of training. If a crew are presented with a valid Advance Decision, or DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form, they 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 are 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.

3) EoLC was not included in the Core Skills Refresher (CSR) for LAS front line staff, but will be included in 2014/15 CSR. Some ad hoc EoLC sessions are being delivered to front line staff, and 40 LAS staff attended a seminar run by the College of Paramedics on EoLCs.

The decision by NHS England to fund CoOrdinate My Care (CmC) for London is greatly welcomed and is a significant step forward.

RECOMMENDATIONS

1) NHS England and London's CCGs must ensure that CoOrdinate My Care (CmC) is rapidly developed to meeting needs of people who have an Advance Care Plan.

2) NHS England must ensure that all London CCGs are engaging local GPs to enter ACPs and other end of life requests onto the CmC database.

3) People reaching the end of their life must be given the choice to have preferences and requests recorded and met through entry onto the CmC database.

4) **Evidence of compliance with Advance Care Plans must be produced by the LAS and other health bodies.**

5) **Organisers of 'messages in a bottle' schemes should take proactive action to advise users to update the 'messages' to state whether there is an ACP regardless of whether it is on the CmC database.**

6) **Continuous training and updating of frontline LAS staff throughout 2013-4 and beyond is essential.**

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 6-7pm and which can have a particularly harmful impact on responses to Cat C calls.

In response, the LAS and their 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.

The review was completed by the end of 2012, identified major capacity gaps and made recommendations to immediately increase capacity of the LAS by 240 A&E Support Workers.

Formal complaint made to the LAS on August 19th 2012

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 were 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 19.30 that evening: 1 hour and 40 minutes after the call was made. The crew said they had only come on duty at 7.00pm. and were located at Friern Barnet and, 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

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and were unable to give any indication how much longer the family would have to wait. The family were 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 and I would like a full investigation.”

RECOMMENDATIONS

1) Vulnerable patients requesting emergency care must never be left waiting for an LAS response beyond the 8 minutes or 19 minutes target.

2) Expecting vulnerable patients, who are in pain or who have fallen, to make repeated calls to the LAS to get help suggests a major breakdown in care provision, and alternative pathways of care must be activated in these cases and a Serious Incident declared.

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

4) 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. An alternative care pathway must be activated to provide care until the LAS can respond effectively.

5) Where there is a delay, Emergency Operations Centre staff must keep in professional, proactive contact 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.

SICKLE CELL DISEASE

The Forum has worked closely with the Sickle Cell Society concerning the standards of care for patients with Sickle Cell Disease, most of whom are from black and ethnic minority communities. We met with the LAS to discuss their response to the Forum's recommendations for service improvements:

> "We have concerns about the care of patients with sickle cell disease. We have met with the Sickle Cell Society which is committed to working with the LAS and the Forum to improve the care of people in a sickle cell crisis. We do not believe that the LAS gives sufficient priority to the health needs of black and ethnic minority communities and strongly recommend a focus on the care of people with sickle cell disease. This would enable the LAS to demonstrate how they are prioritising the needs of protected groups".

A workshop was also held between the Sickle Cell Society and the LAS in 2011 to discuss priorities for the care of people with sickle cell disease but the Sickle Cell Society heard nothing more from the LAS following that meeting.

Steve Lennox (Director of Health Promotion and Quality) wrote to the Sickle Cell Society on behalf of the LAS as follows:

> "We will stay in touch and I hope I can pass the learning from the recent (sickle cell) incident to you once our serious incident investigation is completed."

The following priorities were identified jointly between the LAS and Sickle Cell Society:

- Minimise delays in time to reach patients with a sickle cell crisis
- Pain relief for patients in a sickle cell crisis
- Get the patient to the right hospital (or provide an explanation why this is not possible)
- Up skilling the staff to understand sickle cell disease and sickle cell crisis
- Involving members of the Sickle Cell Society in training of LAS staff

Neither the Forum nor the Sickle Cell Society has been able to obtain any further commitments from the LAS since the workshop in 2011. Further steps to better meet the needs of people with sickle cell disease, continues to be a matter regularly raised with the LAS by both the Forum and the Sickle Cell Society.

RECOMMENDATIONS

1) The LAS should build on a continuous dialogue with the Sickle Cell Society to discuss the development of more effective care, and to provide opportunities for people with Sickle Cell disease to comment on acute pre-hospital care provided by the LAS.

2) An annual workshop jointly between the LAS and Sickle Cell Society to hear the views of service users with Sickle Cell Disease, in order to share the views of direct users' of LAS services with LAS clinicians.

3) A pro-active focus on the health needs of black and ethnic minority communities in line with the LAS's duties under the Equality Act 2010, to serve the needs of protected groups.

4) A renewed focus on the needs of patients having a sickle cell crisis including:

- **Minimising delays in time to reach patients with a sickle cell crisis**
- **Greater focus on effective pain relief for patients in crisis**
- **Get the patient to the right hospital to ensure continuing care by the patient's clinical team (or provide an explanation as to why this is not possible)**
- **Up skilling frontline clinical staff to enable them to understand sickle cell disease and how to manage sickle cell crisis**
- **Involving members of the Sickle Cell Society in the training of LAS staff**
- **Ensuring that clinical staff understand the complexities of care for people with a sickle cell crisis including safe, sensitive and careful transport from the patient's home to the ambulance.**

EQUALITY AND INCLUSION

Equality and inclusion are key underpinnings of the NHS and are essential to delivering health care to all. The social context of London and the UK is changing, making these key principles even more important.

- Social inequality is increasing rapidly with the gap between rich and poor becoming greater.
- The population of London is growing rapidly, as are the proportions of residents from diverse cultural and ethnic backgrounds. It is estimated that by 2020 half of London's residents will be non-white.
- The 2013 reorganization of the NHS will mean additional conflicting pressures due to greater competition and the privatizing of services.

This suggests a number of challenges for LAS in terms of ensuring the equality and inclusion for all patients and staff in a rapidly changing environment.

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 friendly employer and service provider to gay, lesbian, bisexual and transsexual people. Another member attends the Mental Health Committee, which has encouraged a number of pan-London improvements and more joined-up mental health care.

But there are many gaps to delivering successful equality and diversity management and services. The Equality Act 2010 covers employment, occupation, provision of goods and services (including all public services), transport, education and premises. We believe LAS has made impressive progress in some key areas, but their approach is fragmented and there is a great deal to improve - for example in relation to many of the 'protected categories' (see appendix 3) and in important areas of direct service delivery.

There is much good advice available on how to take a holistic, linked and comprehensive approach to equality and diversity, and this is fundamental to good service delivery. It includes learning from service users and constructively dealing with complaints.

A selection of the Forum's areas of concern follows:

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

Forum members regularly seek feedback from patients all over London as well as through many contacts with LAS staff – and many problems still exist. Black staff have reported feelings of discrimination and patients have reported some staff as insensitive to their race, culture, inability to speak English and problems with disability.

The LAS is not doing enough to ensure that the percentage of paramedics they employ from BME communities reflects the diversity of London's population,

e.g. over the period 2004-2012 the percentage of frontline paramedics from BME communities has increased from 3.54-4.62%, i.e. an increase of 0.8% in 8 years.

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' (appendix 3) apply. There are for example, lesbian, gay, bisexual or transsexual people who are also black, or women, or have disabilities. But the majority of these employees and patients will not benefit or particularly be protected by the impressive Stonewall ratings – despite providing a scaffold for many of the underpinning structures – but each protected category of people needs to be considered, support developed, services monitored and responses provided in an ongoing programme of feedback to the experiences of staff and patients. The LAS have confirmed that they would like to see a greater representation of BME staff on the front line and have told us that they: "constantly try to achieve this".

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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).

- 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.

2) Induction Loop in the LAS Conference Room.

The Forum successfully pressed the LAS to provide a loop which is used for Board meetings and other public meetings including those of the Patients' Forum.

3) 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.

4) Equality Goals

The Forum would like to see specific and current plans to address the LAS's equality responsibilities across the 'protected characteristics' (see appendix 3): 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.

Forum Question to the LAS: Are all protected characteristics (see appendix 3) included in LAS equality goals, do you measure your achievements and is your data in the public domain? The feedback we get from patients and staff indicates significant gaps in most areas.

LAS Answer (a) We are aiming to ensure that we cover all relevant protected characteristic groups in regard to access and take-up of our services, as well as in employment and training, engagement and decision making.

LAS Answer (b) The LAS Annual Report details the progress the LAS have made over the past year and any obstacles the LAS is still facing and any intended action the LAS will be taking to address these issues.

5) Staff Survey and Discrimination

Forum Question to the LAS: Do training policies focus on issues identified in the staff surveys, e.g. bullying and other areas of concern, in relation to staff in protected categories?

LAS Answer: Our training absolutely does take account of relevant issues highlighted in our staff surveys, such as bullying and discrimination in regard to the protected characteristic groups, from the initial induction training, through online training, to other targeted training taking place in the Trust, including new Team Leader training currently being developed.

FORUM RECOMMENDATIONS AND ACTION

A) Continue to raise these issues with the LAS Trust Board and the Equality and Inclusion Steering Committee.

B) Ensure that LAS Commissioners, the Commission for Equality and Human Rights and NHS England are aware of the Forum's concerns.

C) Ask the LAS to seek expert advice for development of a diverse workforce and Trust Board.

D) Adopt an active and holistic policy in relation to Equality and Diversity.

APPENDICES

APPENDIX 1 - FOI QUESTIONS PUT TO LONDON MENTAL HEALTH TRUSTS

USE OF CAGE AMBULANCES TO TRANSPORT PATIENTS

1) During the period April 1st 2009 to March 31st 2012, on how many occasions has your hospital arranged for a patient to be transported to another unit or hospital in a secure cell (cage) ambulance or other vehicle of this type?

2) On each occasion during April 1st 2009 to March 31st 2012 when a patient was transported using a secure cell (cage) ambulance, was the patient on a Section of the Mental Health Act?

3) On each occasion during April 1st 2009 to March 31st 2012 when a patient was transported using a secure cell (cage) ambulance, where was the patient transported to?

4) What are your criteria for using secure cell (cage) ambulances?

APPENDIX 2 – DEMENTIA CARE, GREAT WESTERN AMBULANCE SERVICE

Improving the clinical care provided by ambulance clinicians (section 26)
Great Western Ambulance Service (GWAS)

Aims:

- To enable ambulance clinicians to provide a more informed approach and a higher standard of care to people with dementia.
- To understand the challenges faced by ambulance clinicians in providing support when attending to people with dementia and provide evidence to support this.
- To increase awareness of dementia amongst ambulance clinicians and provide them with some basic knowledge and skills.
- To reduce the number of people with dementia unnecessarily conveyed to A&E**.**

Great Western Ambulance Service NHS Trust provides emergency and urgent care, and patient transport services across Wiltshire, Gloucestershire and the former Avon areas. The Trust employs more than 1,680 staff across 33 operational sites – 30 ambulance stations and three emergency operations centres. The Trust covers an area of 3,000 square miles with a population of approximately 2.2 million people.

Last year (2008-09), GWAS responded to more than 233,000 emergency calls. By far the highest proportion of calls were to the elderly, many of whom are likely to have dementia.

There had been a number of occasions where ambulance clinicians had been faced with difficulties when attending to people with dementia, for example, people being found to be at high levels of risk, problems with completing medical assessments and clinicians facing escalating aggression. Following discussion between the ambulance trust clinical lead and the Department of Health SW lead for dementia, a survey was undertaken to test a) dementia awareness of ambulance clinicians b) the level of difficulty being encountered. The results indicated that awareness levels were low and there were a range of difficulties being encountered.

Following the review five key areas were identified:

- The need for training
- The need for care / referral pathways including inter agency communication
- The need to improve the use of communication tools
- Access to assessment and treatment tools for responding to people who have dementia.
- Additional support and information to share with individuals and carers

The progress made to address these key areas includes:

- The production and dissemination of an information leaflet for GWAS clinicians that provides baseline knowledge of the condition, tips on communication and an awareness of the medications an individual with dementia might take.
- An on line dementia training module is being developed for staff
- Information on where to find out more including useful websites has been shared with all staff.
- Communication with other health care providers has begun which will start the process for agreeing alternative care routes, the plan is to include rapid assessment at home, treatment at home, respite and place of safety beds all accessed directly by GWAS clinicians.
- GWAS are encouraging the local primary care trusts to adopt the use of a communication tool at individual's home address. The communication tool can include a variety of information such as likes and dislikes, previous occupation and other useful information which will assist in gaining the patient's trust and minimising anxiety.

The implementation of this joint piece of work will support the national strategy through improved awareness and quality of care. In addition, the individual and carer will receive the right care in an environment they are familiar with, reducing stress and anxiety for all involved. Unnecessary hospital admissions will be avoided, which in turn will result in a potential cost saving for the NHS. The individual and carer will receive the appropriate care and support necessary to support a good quality of life.
Ensuring senior management support: the project was formally proposed and authorised to ensure effective governance and support and inclusion in business plan.

Releasing staff for training: Training has been included on emergency care assistant induction and patient transport service training, and access to e learning is being implemented. A module on dementia will be included in the 11/12 statutory mandatory training day. Higher education partners are reinforcing the need for additional dementia training. Achieving congruence across varied localities each with different levels of service provision, protocols and information systems. GWAS are taking the lead in co-ordinating activity to make progress on care pathways.

Basic awareness and training: the leaflet is available for others to use. It simply requires circulation and printing. Basic, generic training packages are available on the SCIE website, ambulance clinicians can be required to complete these as part of their annual learning and development plan and update their portfolios. Dementia awareness will be incorporated in basic training module using these materials as a basis for reflection and discussion.
This is effectively minimal, zero cost activity. Accessing SCIE (Social Care Institute for Excellence) materials does require access the web, which all ambulance stations have. An e-learning package is being developed and the ability to monitor completion included.

- The ambulance leaflet is available for others to use and adapt.
- The results of the study are available for others to consider.
- Any tools developed for the assessment and treatment of people with dementia, and care pathways for ambulance clinicians, will be made available.

Questionnaire to ambulance clinicians and semi structured interviews at a regional event.

Services available for care and referral pathways are being reviewed with the intention of having a directory of services available to this patient group throughout the GWAS area.

Work has begun to look at assessment tools currently available and adaptation to accommodate pre-hospital care. An information leaflet will be developed to provide individuals with dementia and their carer's advice on the additional help and support that is available within their area. Taking the training forward has been recognised and is being rewarded as a CQUIN target.

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