PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

DRAFT

THE FORUM'S STRATEGY FOR THE LONDON AMBULANCE SERVICE

AND URGENT AND EMERGENCY CARE IN LONDON

2016-2019

Patients' Forum Ambulance Services (London) Ltd

Patients' Forum Ambulance Services (London) Limited
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Registered office: 6 Garden Court, Holden Road, Woodside Park, LONDON, N12 7DG

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OUR SIX GOALS TO CHANGE EMERGENCY AND URGENT CARE IN LONDON

WORKING WITH THE LONDON AMBULANCE SERVICE

The Forum is active on nine LAS Committees as well as contributing to LAS Trust Board meetings by raising key issues regarding the improvement of services. Our members contribute to discussions on LAS policy, strategy and risk. The Forum and LAS collaborate to promote and encourage effective and positive involvement of patients and the public in LAS services, to develop high quality emergency and urgent care in London. The Forum is a 'critical friend' of the LAS.

The LAS supports the Forum by providing indemnity cover for our Members when they take part in service monitoring. They also provide meeting rooms, refreshments and photocopying of Forum papers.

FORUM REPRESENTATIVES ON LAS COMMITTEES 2016

- Clinical Audit and Research Steering Group — Natalie Teich
- Clinical Development and Professional Standards — Angela Cross-Durrant
- Improving Patient Experiences ... … … … — Malcolm Alexander
- Equality and Inclusion … … … … … — Kathy West
- Community First Responders … … … — Sister Josephine Udie
- Infection Prevention and Control … … … — Malcolm Alexander
- Mental Health … … … … … — Malcolm Alexander
- Patient and Public Involvement … … … — Malcolm Alexander
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- Quality Governance Committee … …… … — Denied Access

GOAL 1

AMBULANCE QUEUEING MUST STOP AND A&E HANDOVER WAITS SUBSTANTIALLY REDUCED IN 2016

Cat A demand is high and growing, which puts considerable pressure on the LAS and A&E departments. The Cat A, 8-minute/75% target is being met for only at the most 65% of calls. Handover waits at A&Es should not exceed 15 minutes, but may exceed one hour in some A&Es, e.g. North Middlesex, Queens Romford, King's College and Northwick Park. Patients cannot get safe and effective care if they are waiting in ambulances for treatment or laying in the road waiting for an ambulance that is queuing outside and A&E department. The following approaches have been tried and have failed to solve the problem.

- Hospitals are fined by commissioners for each patient waiting to enter A&E in excess of 60 minutes
- Hospital Liaison Officers work during peak periods to ease the flow of ambulances
- Intelligent Conveyance systems are used, where the hospital seeks to move patients to other hospitals if it is safe to do so

A major consequence of malfunctioning of the system in London is the total delay time for patients, e.g. a Cat C patient who has fallen may wait 2 for an ambulance, 1 hour outside A&E and 4 hours inside A&E. For an elderly vulnerable person this is harmful and inconsistent with high quality care.

Alternative care pathways used by the LAS are often inadequate because they are not immediately available and consequently the LAS front line crew take patients to hospital as the default position – even if this is not in the best interests of patients.

COMMISSIONING RECOMMENDATIONS

- **The closure of A&E departments must be stopped because that approach makes the situation much worse.**
- **The number of beds must be increased to meet demand.**
- **Effective discharge must be introduced into those areas that are currently failing – we know that some in some areas multi-agency collaboration is working.**

- **Alternative care pathways must be immediately available e.g. for patients with serious mental health problems, patients who have fallen and for people with dementia who do not require hospital based care.**

HOURS WASTED IN AMBULANCE QUEUES ACROSS LONDON

MONTH - 2015	30-59 MINUTE WAITS	60+ MINUTE WAITS	HOURS WAITED
December 2014	4152	726	2802
January 2015	2902	494	1945
February	2171	342	1427
March	2661	221	1551
April	2064	199	1231
May	1528	161	925
June	1468	81	815
July	1629	108	922
August	1762	196	1077
September	2147	264	1337
October	2341	140	1310
November	2797	365	1763
December	3165	476	2058
TOTAL HOURS AMBULANCE QUEUES	**------**	**-----**	**19163 hrs**

Handover Waits 2014-2015 – Data from Brent CCG – LAS Commissioners

GOAL 2

THE SUCCESSFUL DEVELOPMENT OF MENTAL HEALTH CARE AND ADVICE BY THE LAS WILL BE FURTHER DEVELOPED

The Forum has repeatedly pressed the LAS and Commissioners for improvements to mental health care provided by LAS, and we are now seeing mental health care being firmly embedded in the culture and objectives of the organisation. Significant advances include a programme of training for staff and the development within the LAS clinical hub of a cohort of experienced mental health nurses, who will eventually provide 24/7 advice (currently 3 mental health nurses, but team will increase to 6). Demands are also being made on London's mental health hospitals and local mental health teams, to provide rapid and effective access to their services for patients in crisis.

The LAS should provide more effective and rapid care for patients with suicidal ideas. The response is in some cases too slow and the key objectives of parity of esteem are not being met, causing in some cases death and serious harm.

Significant advance have been made with the transport of patients being assessed for admission under the Mental Health Action. The system is meeting need in the pilot areas and must be extended to the whole of London as soon as possible. This approach meets the requirement of the parity of esteem duty. However, the response to patients who are sectioned under s136 must be substantially improved and should include the rapid deployment of paramedics and/or nurses who are expert in the care of people suffering a mental health crisis. In our experience rapid, sensitive, expert care at a time of mental health crisis is often transformative. Access to places of safety and mental health beds must also be substantially improved to ensure that patients in crisis do not remain an ambulances whilst crew search across London for a place of safety.

The crowded state of many A&E departments makes admission to A&E for a person suffering a mental health crisis a very poor and potentially harmful option. We strongly recommend that all mental health trusts are commissioned to provide rapid response teams to provide care for people suffering from a mental health crisis in order to prevent inappropriate admissions to A&E.

COMMISSIONING RECOMMENDATIONS

A) Risks to the lives of patients, and 'parity of esteem', require that patients who have suicidal thoughts must get an emergency response from the LAS. Services should be commissioned to ensure that the considerable risks for patients with suicidal ideas or who have attempted suicide are mitigated – especially at times when the LAS is under considerable pressure.

B) Commissioners should ensure that the transport of patients detained under s136 of the Mental Health Act to a 'place of safety' is undertaken sensitively, expertly and in the shortest possible time, with the leadership of clinical staff skilled in the care of people in a mental health crisis. The current system results in more severely ill people waiting longer for transport to a place of safety. The excellent NETS system for people assessed in their home for detention under the MHS should be extended to the whole of London as soon as possible.

C) Mental Health Trusts must ensure that they have sufficient beds, staff and facilities for people in a mental health crisis, who are brought to the hospital by ambulance. Turning ambulances away when they are trying to admit patients in crisis must be stopped.

D) A&E Departments must have MH liaison teams active and ready to receive and care for people in MH crisis.

E) The findings of the Independent Commission on Mental Health and Policing set up in 2012 must be implemented so that a dedicated response from specially trained paramedics and nurses is provided for the care of patients in mental health crisis in a public place or in private premises. Commissioners should emphasize through the contract that restraint is only used in the most exceptional circumstances.

Independent Commission on Mental Health and Policing
Recommendation 23 – Implementation Within 12 months (by 2013)
NHS England should work with Clinical Commissioning Groups, Health and Wellbeing Boards and the CQC to ensure that:
a) No person is transferred in a police van to hospital;
b) Funds are made available through an appropriate dedicated response for mental health,
for instance provision of a dedicated paramedic in a car; and
c) Demand management systems of the LAS be reviewed, and changes implemented in
order to ensure parity of esteem between mental and physical health.

GOAL 3

END OF LIFE CARE

'End of Life Care' has been prioritised by the LAS and Commissioners for a CQUIN. It is most important to ensure that the wishes of people who have a terminal illness, or who are close to death, are clearly communicated to the LAS, respected by the organisation and carried out to the letter. It is essential that the specific choices and wishes described in Advance Care Plans (ACP) by people requiring end of life care are flagged on the LAS Command Point system directly by Connect my Care (CmC), and effectively communicated to front line staff.

In November 2015, CmC launched a new IT system to improve access to care plans 24/7. Since 2012 when the CmC system was started, 25,000 electronic advanced care plans have been produced in London, but this number is low compared with the number of people who might wish to develop an ACP. The new CmC IT system reduces the time it takes to create and update CmC ACP. The next phase for CmC includes increasing interoperability with GPs, the LAS, community services and acute and urgent care IT systems, leading eventually to a seamless service.

Although considerable progress has been made we would like commissioners to ensure that CmC and the LAS Command Point system are working effectively so that advance care plans, containing clear information about the patients' wishes, are transmitted from CmC to the LAS and to front line staff. Plans which are unclear must be subject to referral back to CmC or GPs to ensure that staff carry out patients' wishes – sometimes within short time scales. The communication system between GPs and front line paramedics must also be enhanced for automatic transmission.

Data regarding the compliance with patients requests through CmC should be published to demonstrate that the system is working effectively. We strongly support the proposals to develop the NETS system for the transport of patients requiring end of life care.

RECOMMENDATIONS TO COMMISSIONERS

1) **Commission the NETS service to provide an efficient, timely and sensitive service for people requiring end of life care.**

2) **Ensure that the LAS, CmC and GPs are collaborating and listening to patients and families, to enable Advance Care Plans to accurately reflect patients wishes and be rapidly transmitted to front line crews.**

3) **Establish KPIs that require data to be available to monitor collaboration between partners in the CmC systems and evidence of successful completion of CmC request to the LAS regarding ACPs for patients at flagged addresses.**

4) **Require training of front line clinical staff ensure that they are fully aware of the importance of fulfilling the patients' requirement described in ACPs.**

GOAL 4

EQUALITY AND INCLUSION

The CQC identified serious concerns about the effectiveness of the LAS in relation to its responsibility to show due regard to the duties which arise from the Equality Act 2010, the

Public Sector Equality Duty and EDS2 (Equality Delivery System). This requires the LAS to eliminate discrimination, advance equality of opportunity and foster good relations for people with protected characteristics. Performance has been poor, although there are some notable and very positive exceptions, e.g. staff included within the LGBT protected characteristic. The Forum has raised this issue repeatedly with the LAS over a period of 10 years with very little progress. There is strong evidence that without a concerted approach by Commissioners that little progress will be made and the lack of focus on diversity and inclusion prevents the skills, abilities, culture, ethnicity, sex, disabilities of all staff being adequately valued.

An example of performance in relation to the protected characteristic of race is shown below for paramedic recruitment: Data for 2014-16 are awaited.

Year	Total no Paramedics	Total no of Paramedics of "BME" 'heritage'	% "BME"	"BME" paras as % staff on frontline (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
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

Recruitment of BME staff in London has failed because there is no strategic recruitment plan focussed on the recruitment of BME staff and no concerted effort to recruit young people from school six forms and six from colleges and encourage them to take up a career as a paramedic.

COMMISSIONING RECOMMENDATIONS

1) Commissioners need to agree a detailed work programme with the LAS to ensure compliance with the Equalities Act and EDS2, and to ensure due regard is shown to meeting the needs of patients and staff with protected characteristics.
2) The LAS should be required to have 'whole systems approach' for each protected characteristic and provide regular feedback from 'equalities champions' who are designated for each protected characteristic.
3) Recruitment of BME staff in London will only succeed if significant resources are put into recruitment from school six forms and six from colleges and attempts made to encourage them to choose a career as a paramedic.
4) Assurances are needed that accurate staff records are kept for example in relation to ethnicity, disabilities/related health issues and other protected characteristics so that progress can be measured, appropriate resources allocated, policies updated and changes made

GOAL FIVE

LAS AS A PROACTIVE NEGOTIATOR FOR PLANNED URGENT AND EMERGENCY CARE

A major problem with the current organisations of urgent and emergency care is the lack of accountability for the way in which services work across London. Consequently, the LAS provides care and presumptive diagnosis for patients and often takes them to hospital even they know this is not the best clinical decision and want to provide appropriate and adequate clinical care. The services paramedics need access to often don't exist or are available tomorrow or the day after that. Immediate transfer of patients to right service, the rights team and the right care first time is currently a distant ambition. The consequence of our badly planned system is that many patients are traumatised by receiving inappropriate hospital care and some die as a result though hospital acquired infection.

The LAS is dependent upon the leadership, good will and commitment of CCGs to provide alternative and appropriate care services. The Forum believes the LAS needs to become a leader in these negotiations not just a grateful recipient. The LAS needs to have the power to require that the right clinical service is available to paramedics when they see patients, not as a matter of luck but as a requirement. The LAS must be able to stipulate, in relation to the needs of the patients they see, what type of clinical outreach services should be available locally and at what time of day. This may refer to patients with mental health problems, dementia, falls and many other conditions. The LAS should be in partnership with CCGs and hospitals and care should be jointly planned to meet need, and joint audit of outreach clinical services by CCGs and the LAS should be a priority.

CASE STUDY

An example is the service provided for patients who fall. Many people are designated Category C status when they call 999, have suffered a fall either at home, in the street or on the road. Some of these patients will have fractured bones, or suffered soft tissue trauma, that need to be assessed by paramedics. Unfortunately, these patients are not regarded as priorities and may wait several hours for assessment and treatment. The consequences of long waits can be severe, e.g. people lying on pavement or road, especially in winter, are at risk of further injuries, trauma and infection. People lying on their own floors for many hours at home, especially if elderly, are at greater risk of pneumonia or urinary tract infections. Patients taken to hospital, as the safest option, may suffer from infections caught in hospital and disorientation.

A solution to all these problems is the development of ‘locally based falls teams’, which can provide care for patients quickly and make sure they are in the safest possible environment until paramedics arrive. A competent falls team can cancel an ambulance response based on their assessment, take over care following a paramedic assessment, and ensure effective discharge arrangements if a person is admitted to hospital. Thus, an effective, highly trained falls team can provide safe care, as close as possible to the person’s home or site of their fall, as well as providing continuity of care. Falls teams are funded by some CCGs but not all and what they offer varies across London.

RECOMMENDATION TO THE LAS COMMISSIONERS AND THE LAS

The LAS should become a leader in negotiations for the provision of alternative and appropriate clinical services in the community. The LAS must have the power to require that the right clinical service is available to paramedics when they see patients, as a requirement. The LAS must be able to stipulate, in relation to the needs of the patients they see what type of clinical outreach services should be commissioned and available locally and at what time of day. This might refer to patients with mental health problems, dementia, falls and many other conditions. The LAS should be in partnership with CCGs and hospitals and care should be jointly planned to meet need. Joint audit of these outreach clinical services by CCGs and the LAS should be a priority.

GOAL SIX

COMMISSIONERS MUST ENSURE THAT URGENT AND EMERGENCY CARE IN LONDON IS COORDINATED, PLANNED, SAFE AND ACCESSIBLE WHEN NEEDED - PATIENTS MUST HAVE ACCURATE INFORMATION ABOUT ACCESSING THESE SERVICE

For years the public has been told that the urgent and emergency care system is becoming better planned, coordinated and effective. The 111 service was offered a solution to many of the weaknesses of the system, but irresponsible commissioning of the service has led to London have a number of poorly coordinated and poorly planned 111 services that have not earned the confidence of patients or clinicians. The failure to plan services effectively leads to increasing numbers of people calling 999 to peaks of use in May as well as in the winter months.

The urgent and emergency care system in London is confusing for patients and staff, and leads many to take what they believe is the safest option when they are sick: going to A&E. Many patients go to A&E because it is quicker and more reliable than primary care – even where the clinical quality of primary care is excellent.

The Forum has highlighted the extent of this confusion on many occasions, but instead of getting easier to use, the system gets more confusing, leading to more unnecessary visits to A&E. The problem is the poor integration and communication between different parts of the system:

> *A Forum member fell in the street on a Saturday evening causing severe pain to his ribs. The pain increased and he thought he had fractured a rib, so he phoned his GP on Sunday morning and was told to contact 111. They told him he should visit an Urgent Care Centre (UCC), but didn't transfer any information from their patient assessment to the UCC. When he got to the UCC they told him that they couldn't x-ray his chest because they had no facilities for that type of x-ray, and if the urgent doctor had thought an x-ray was necessary, he would have to travel two miles to the nearest A&E. He waited two hours to see a doctor in the UCC and was told that an x-ray was not necessary because there was no evidence of a fracture. The doctor said she could not write a clinical note to the patient's GP, because there was no system available to communicate directly with the GP, so she asked the patient to write a note himself to his GP.*
>
> ***The Forum member told us that had he gone to A&E he would have got a better, quicker and safer service.***

Unecessary pressures on the LAS and A&E departments will continue and A&E filled with people not needing emergency care until efficient, integrated, well organised and publicized patient centred UCC and GP care is available to all.

Currently, there are eleven 111 bases in London and numerous UCCs offering a range of different services at different times. The 111 Directory of Services (DoS) does not provide consistent information across London and there is no guarantee that the services they recommend will be open and available. Patient experience data about 111 services is negligible.

UCCs and GPs should be the bedrock of provision for effective urgent care. The provision of accurate information about these services directly to the public is essential and should be done through every available means: messaging, letter box, bus stops, stations, supermarkets etc., etc. People will go to dedicated urgent care centres if such centres are competent, effective and reliable. Why wait hours in unreliable UCC, when you can go to a reliable A&E? Why go to A&E if you have access to highly effective local UCCs and GPs?

RECOMMENDATIONS TO COMMISSIONERS:

A) THE LAS SHOULD NO LONGER BE THE DEFAULT, GO TO SERVICE, BECAUSE OF THE FAILURE OF CCGS AND NHS ENGLAND TO ORGANISE EFFECTIVE URGENT AND PRIMARY CARE SERVICES.

B) A SINGLE 111 SERVICE SHOULD BE COMMISSIONED IN LONDON AS PART OF THE LAS.

C) 111 SERVICES IN LONDON MUST BE ABLE TO DIRECT PEOPLE TO THE RIGHTS SERVICE USING A SINGLE ACCURATE PAN-LONDON DIRECTORY OF SERVICES AVAILABLE THROUGHOUT THE NHS AND TO THE PUBLIC SO THAT PATIENTS AND CARERS CAN ACCESS THE RIGHT CARE FIRST TIME.

D) INFORMATION ABOUT ACCESS TO URGENT CARE AND 111 SERVICES MUST BE EASILY AVAILABLE TO THE PUBLIC BY EVERY AVAILABLE MEANS, E.G. TWEETS AND E-MESSAGING, PUBLIC PLACES, BUS STOPS, STATIONS, DIRECT PERSONAL COMMUNICATIONS ETC.

APPENDIX ONE – PROTECTED CATEGORIES

AGE

Where this is referred to, it refers to a person belonging to a particular age (e.g. 32 year olds) or range of ages (e.g. 18 - 30 year olds).

DISABILITY

A person has a disability if s/he has a physical or mental impairment that has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

GENDER AND REASSIGNMENT

The process of transitioning from one gender to another.

MARRIAGE AND CIVIL PARTNERSHIP

In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple. Same-sex couples can alternatively have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act 2010).

PREGNANCY AND MATERNITY

Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

RACE

Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality, (including citizenship) and ethnic or national origins.

RELIGION AND BELIEF

Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

SEX

A man or a woman.

SEXUAL ORIENTATION

Whether a person's sexual attraction is towards his or her own sex, the opposite sex or to both sexes.

APPENDIX TWO - FORUM OFFICERS IN 2015

Company Secretary	John Larkin Registered Office: 6 Garden Court, Holden Road, Woodside Park, N12 7DG
President of the Patients' Forum	Dr Joseph Healy drjhealy@yahoo.com
Chair	Malcolm Alexander patientsforumlas@aol.com Tel: 0208 809 6551/ 07817505193
Vice Chair	Sister Josephine Udie sisterjossi@hotmail.com
Vice Chair	Angela Cross-Durrant acrossdurrant@yahoo.co.uk
Executive Committee Member	Lynn Strother lstrother@ageuklondon.org.uk
Executive Committee Member	Kathy West kathy.west1@ntlworld.com
Executive Committee Member	Leslie Robertson (Resigned June 2015)

APPENDIX THREE

OBJECTS OF THE PATIENTS' FORUM AMBULANCE SERVICES (LONDON) LTD

Members of the statutory Patients' Forum formed the Company alongside the London Ambulance Service, as a not-for-profit company with exclusively Charitable Objects. The statutory Patients' Forum was abolished on 31 March 2008.

The Company is committed to act for the public benefit through its pursuit of wholly charitable initiatives, comprising:

(i) The advancement of health or the saving of lives, including the prevention or relief of sickness, disease or human suffering; and

(ii) The promotion of the efficiency and effectiveness of ambulance services.

The Company is dedicated to the pursuit of its Objects as a small unregistered Charity with a view to registration with the Charity Commission, as and when appropriate.

APPENDIX FOUR - OUR MISSION STATEMENT

The Patients' Forum is an unregistered Charity that promotes the provision of ambulance services and other health services that meet the needs of people who either live in London, or use services provided in London.

The Charity aims to influence the development of better emergency and urgent health care and improvements to patient transport services, by speaking up for patients and by promoting and encouraging excellence. It will:

(1) Optimise working arrangements with London Ambulance Service and other providers and commissioners of urgent and emergency care.

(2) Work with other networks that champion patient and user groups.

(3) Develop our campaigns for better and more effective ambulance services, by petitioning for more effective and consistent approaches to service provision that reduce deaths and disability.

(4) Work towards better systems for all patients and carers to communicate their clinical conditions effectively to ambulance clinical staff, and receive effective and timely responses.

(5) Promote the development of compulsory quality standards for Patient Transport Services.

(6) Promote research to assess the clinical outcomes for the 25% of Category A (emergency) patients that did not get an ambulance within eight minutes.

(7) Work with partners to develop better services for the care and transport of people with severe mental health problems and their carers that respect their wishes and meet their needs. The Forum will promote sensitivity to their vulnerability, safety, culture and the gravity of their situation.

(8) Campaign to convince the Commissioners for the LAS and the LAS Board to develop the clinical effectiveness, assessment and care provided for people who suffer from cognitive impairment and dementia.

(9) Work with the LAS to develop effective protocols, to respect the wishes of patients with Advance Directives, to ensure that their care is provided in accordance with their prior decisions.

(10) Work with the LAS Equality and Inclusion leads to promote effective training of all LAS front-line staff in diversity and in relation to all protected groups identified in the Equality Act 2010.

(11) Work with the LAS Equality and Inclusion Committee to develop a workforce that reflects the diversity of communities across London, and provides care based on culturally and ethnically-based needs, when this is appropriate – for example, in relation to sickle cell disease and mental health problems.

APPENDIX FIVE - THE FORUM'S PRIORITIES

(1) **Equal access and choice of services and treatment**

LAS services should be fully accessible and available to all. Neither physical nor mental disability, health problems, language nor any aspect of a person's social, ethnic or cultural being, should reduce access or delay access to services.

(2) **Clinical partnerships with other care services**

The LAS should work jointly and proactively with hospital A&E Departments and other healthcare services, jointly to improve care and care pathways for patients.

(3) **Training of Paramedics and Technicians and A&E Support Workers**

The LAS should ensure that all Paramedics and A&E support staff have continuous access to appropriate training, and ensure their development as effective practitioners. This should include joint multi-disciplinary clinical audit of care provided by front-line staff, and joint reviews of patient care between front-line clinical staff from the LAS and hospital A&Es.

(4) **Alternative ways of providing emergency and urgent health care**

New ways for the LAS to provide urgent care through the 111 system and community-based services are welcome, but these new pathways must be robust enough to give confidence to the public and LAS crews, that they will be available when required, clinically appropriate, fully-funded and subject to regular clinical audit tests of reliable and continuous access.

(5) **Urgent care must improve**

The LAS must demonstrate compliance with Cat C Commissioner's targets and ensure that vulnerable patients – for example, older people who have fallen at home or in a public place - have rapid access to appropriate and adequate care.

(6) **Mental Health services**

Significant improvements are needed to ensure that people with severe mental health problems who become ill in the street or in their homes, and require emergency care, are treated by paramedics and technicians with specialist training in the care of people with mental health problems.

(7) **Developing care for people with cognitive impairment and dementia**

The LAS should ensure effective staff training for the recognition and assessment of cognitive impairment, and ensure that appropriate pain control and multi-disciplinary care are always available for patients with dementia.

(8) **Patient Transport Services (PTS)**

The LAS should provide services that are compliant with the Patients' Forum's Quality Standards for PTS. These promote highly effective patient transport services that are built around dignity, the needs of users and their active involvement in the monitoring, assessment and development of the service.

(9) **Complaints about services provided by the LAS**

The LAS should further develop its approach to learning from complaints submitted by service users. All recommendations for service improvements arising from complaints should be published with evidence of consequent and enduring service improvements.

(10) **Communication with the public**

The LAS and the '111 out of hours' service should launch a joint information campaign to ensure that all Londoners know how to access safe, effective and appropriate emergency and urgent care.

(11) **LAS Board and the public**

The LAS Trust Board should meet with LAS service users from each London Borough, to get feedback on services provided by the LAS and proposals for service development. The LAS Board should reflect the diversity of London, and its members should act in a way that recognises their accountability to patients and people who live in London.

APPENDIX SIX – CORRESPONDENCE WITH NHS ENGLAND AND THE TRUST DEVELOPMENT AUTHORITY (TDA)

Professor Keith Willett,
Medical Directorate
NHS England
December 13th 2015

A&E Patients and the Winter Crisis

Dear Keith, we are very concerned about the pressures on London's acute services caused by the closure of A&E departments in west London, and the underfunding of acute hospitals and A&E services. Closure of A&E departments over the past few years appears to have had the inevitable effect of ensuring that sick people wait appalling lengths of time for treatment.

Imagine an elderly person falling in their home and being unable to get up, and then waiting hours for an ambulance, and then queuing outside an A&E department for up to an hour, and then lying in a cubicle in A&E for 4 hours before discharge or admission - 8 hours of queuing to get a bed or get home.

Surely, NHS England is responsible and accountable for these delays because they have closed services and have failed to deal with the ambulance queuing outside some of our major hospitals that has gone on for years.

Commissioners have failed to deal adequately with the crisis as the following figures for October 2015 and November 2014 show:

Patients waiting in an ambulance for up to an hour outside casualty in October 2015 - compared to November 2014:

Hillingdon Hospital 210 (222 in 2014)
Northwick Park 342 (326)
Queens 244 (355)
North Middlesex 213 (205)
Ealing 180 (221)

Not only are patients who are seriously ill waiting in ambulances for admission to A&E, but the ambulances and their highly trained crews are stuck in queues and can't get away to attend to the next patient suffering from stroke or cardiac arrest. Delays can cause serious harm to seriously ill patients.

We believe that NHS England must accept responsibility for a failure in the provision and organisation of emergency and urgent care.

What action will NHS England now take to ensure that the resources that London needs to get rid of ambulance queues and inappropriate patient waits are made available immediately?

Malcolm Alexander
Chair, Patients' Forum – Ambulance Services – London

23/12/2015 – REPLY FROM PROF KEITH WILLETT – AMBULANCE QUEUES

Dear Mr Alexander,

Firstly, can I thank you for your recent contact and I note the issues you raise.

Secondly, can I apologise for not being able to make the follow-up call you had kindly accepted planned for today. I was called away on a national priority issue. However I am happy to cover in this email what I was going to cover in that call, be it less personal.

The intention of my call was to explain that my role in NHS England is to lead the design and development of Urgent and Emergency Care services as part of the Keogh Review. As you are aware all A&E and Ambulance Services are commissioned by CCGs and they also hold the statutory authority for service design. Something I know has been to the fore in NW London. The oversight of operational and clinical performance by NHS England is through our Regional Offices and so I have spoken to and brought to their attention the concerns you and your Forum members have raised. Your correspondence has been forwarded to Dr Andrew Mitchell to respond.

We are all acutely aware of the service provision and demand placed across the whole urgent and emergency care community from general practice and the community, through 111 and 999 to hospital admissions and delayed discharges. That in the medium to longer term is what the UEC Review is attempting with colleagues in the NHS to address through redesign. Perhaps you would however clarify in any further correspondence with Dr Mitchell the data you put in your letter about increased handover delays. Clearly delayed handovers are a real issue for patients' care and ambulance operational performance. As I read the numbers though, comparing the months of November 2014 and October 2015, there has been a reduction from 1329 to 1189 in total delayed handovers which, adjusted for days in the month, looks like a 13% improvement.

Yours sincerely

PROF KEITH WILLETT

REPLY FROM TDA + NHSE

NHS Trust Development Authority NHS England

Malcolm Alexander
Chair
Patients' Forum for the London Ambulance Service
30c Portland Rise
N4 2PP

12 February 2016

Dear Mr Alexander,

Thank you for your letter of 8 February 2016 regarding Ambulance queuing outside A&Es in London and your concerns about the impact these delays have on patients. As the letter mentions the role of NHS England in relation to this issue, we felt a joint response would be appropriate.

We recognise and share the concerns that you have raised. LAS performance data illustrates that 60% of all ambulance handovers since November 2015 have taken longer than 15 minutes and clearly this position needs to improve. We would however draw your attention to the general decline in the number of 'black breaches' (ambulances waiting over 60 minute for handover) year to date compared to last year as illustrated below to assure you that action is being taken across the system to improve performance:

2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Total	157	154	63	96	88	181	314	321	860	501	342	221	3298
2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Total	200	146	80	108	196	264	140	365	481				1980

As part of our actions we are working closely with all stakeholders including Monitor, LAS, CCGs, the Emergency Care Improvement Programme and Providers to hold Acute Trusts and LAS to improve ambulance handover times. There is now daily information shared with the system as to handover delays more than 15 minutes and the impact this is having on LAS. This ensures targeted actions can be taken in a timely manner. Performance is then monitored via weekly calls with LAS and at a monthly Regional Oversight Group as well as via Performance Contract meetings with Acute Trusts. We are also working with LAS Commissioners and LAS via the contracting round for 2016/17 to drive improvements in job cycle time and other areas within the gift of the Trust.

One of the outcomes of the LAS Quality Summit held in December 2015, following the publication of the CQC Report, was a commitment to work with the trusts with the most significant handover delays. The NHS England (London) Emergency Care Task Force established a programme to address handover delays with the most

challenged trusts and these trusts submitted plans to make improvements to the process in January. Furthermore, bespoke support will be offered to several sites to identify areas where improvements can be made and offering guidance as to possible actions to implement.

The first week of January was challenging for London acute trusts and for LAS with a spike in over 60 minute handover delays and crew hours lost. This has led to the preparation of a workshop to be held in late February to further raise the profile of handover delays and to strengthen the actions that can be taken to safely manage the handover process. In advance of the workshop, site visits have been undertaken to learn from those at varying stages of their handover plans.

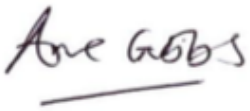
These pieces of work are progressing in tandem with outputs to be shared across London for all Providers to utilise. LAS are working closely with us on this project whilst also reviewing actions they can take in order to reduce handover times.

In relation to your reference to the changes to the A&E configuration in NWL and the impact this has had, we would refer you to the independent review of the implementation of North West London A&E changes from July 2015 which can be found here. The review found that:

"There was deterioration in A&E performance in NW London A&E sites during and after the A&E transition. However, this deterioration was in line with deterioration across London and England and the review found it was not related to the A&E changes."

We will be happy to keep you updated on progress in reducing handover delays.

Yours sincerely,



Jo Ohlson
Acting Director of Commissioning Operations
NHS England, NWL

Anne Gibbs
National Programme Director - Transactions
North West London Portfolio Director
NHS TDA, London

Cc Andrew Hines, Associate Director of Delivery and Development
Simon Wheldon, Chief Operating Officer – London
Dr Fionna Moore, Chief Executive LAS

APPENDIX SEVEN – LETTER TO SANDRA ADAMS, LAS, EQUALITY AND INCLUSION

Sandra Adams
Chair of the Equality and Inclusion Committee
London Ambulance Service
220 Waterloo Road
SE1

17/2/16
Dear Sandra,

As you know, for some time, we have been concerned about the LAS's achievements towards achieving adequate and reasonable progress in relation to the objectives of the Equality Act and its Public Sector Equality Duty. This requires the LAS to take continuous steps towards adequately meeting the needs of patients and staff with all of the protected characteristics described in the Act.

As the CQC highlighted this matter, we feel it is essential that the opportunity is taken to achieve significant improvements in the short term; unfortunately, the agenda for the Equality and Inclusion meeting to be held on Thursday February 18th 2016, does not seem to reflect the steer suggested by the CQC report.

Given the very positive changes that are being put in place in other parts of the organisation as the result of the CQC assessment, we believe this is an excellent time to re-evaluate the impact of equality and inclusion over the whole of LAS. Currently, the lack of focus on diversity and inclusion prevents the skills, abilities, culture, ethnicity, sex, and disabilities of all staff being adequately valued.

We believe that the E&I Committee urgently needs a holistic plan if it is to move forward. The excellent work with Stonewall needs to be integrated and replicated with every protected characteristic. The strategy needs to clearly lay out what is to be achieved and by when, but with the current strategy the LAS would not achieve compliance with its public sector equality duty for many years. We would also strongly recommend getting the support of Inclusive Employers, given that LAS has recently joined this excellent organisation.

With regard to the Equality Forums, the E&I Forward Plan does not seem to set out exactly what the Forums plan to do, how they are monitored, what their aspirations and achievements are, how patients will benefit and what the targets and milestones are. We would like to suggest that the Forums need implementation plans and milestones, so that we can regularly monitor progress, and a quarterly reporting back mechanism on achievements.

We would like the Terms of Reference to be updated and serious consideration given to accountability of staff for decisions made by the E&I Committee. We would also appreciate having access to the policies mentioned in the press release by Stonewall and to have assurances that the Terms of Reference of the Equality and Inclusion Committee reflect what is in these policies.

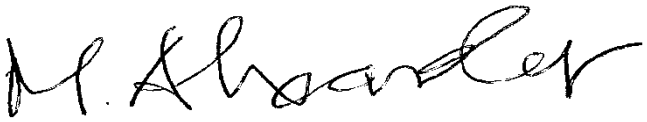
Assurances are needed that accurate staff records are kept, for example in relation to ethnicity, disabilities/related health issues and other protected characteristics. If these characteristics are not accurately recorded, the E&I Committee can't measure progress or ensure that appropriate resources have been allocated, policies updated and changes made.

We would like to request that each of the LAS Champions who have agreed to provide leadership in relation to protected characteristics, report back regularly and demonstrate progress in the areas where they have agreed to provide leadership for the LAS and its patients.

The Equality and Inclusion Committee does not currently have the resources to ensure that these issues are taken up adequately across the organisation, and in our view it is necessary for all LAS committees to ensure that these issues form part of the substance of their work programmes. This would be of enormous benefit to both patients and staff.

There is clearly a long way to go to get to grips with the duties that are laid on the LAS to achieve real progress in relation to each of the protected characteristics, but we hope that these suggestions will help and we will continue to monitor progress through our representation on the committee.

Very best wishes



Malcolm Alexander

Chair
Patients' Forum for the LAS