The People's Inquiry: One Year On

Evidence presented by Malcolm Alexander (MA)
Thursday 11 December
Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
You are a health-watcher. You will be pleased to know that London Ambulance Service is going to balance its books according to evidence provided by Adam Roberts! Let's press on.

MA:
What I am going to talk about mostly I think is about the London Ambulance Service, the current problems, which are really quite severe. I think there's been quite a lot of media about this, for example the *Evening Standard* last week had this (Appendix 1), and a major piece in the BBC television last week.

I come from this particular work, of chairing the Patients' Forum for London Ambulance Service. That is a body which has been going for a number of years, about 10 years now. It meets every month inside the premises of the London Ambulance Service and basically gathers information from officers from the London Ambulance Service who are brought into our meetings – public meetings on the premises of the London Ambulance Service. We call their staff into our meetings and we put questions to them about LAS performance. We also sit on several of their internal committees. This is all lay people participating in the internal operation of the London Ambulance Service.

We get quite a lot of information about what is going on and we engage in lots of different ways, numerous ways. What I am going to tell you about is partly the performance issues. At the moment performance of London Ambulance Services has dropped quite dramatically. If you want some specific data, the figures (Appendix 2) show that the standard for category A cases with the London Ambulance Service is to arrive 75% of the time within 8 minutes. That performance has dropped dramatically from 75% for 8 minutes – which it has been for many years – to between about 45 and 60%. So this is a really dramatic drop.

In some parts of London the performance against that 75% target is very poor: in Waltham Forest has dropped to 50%. In Haringey it is 47.84%. In Ealing it is 51.47%.

What you are seeing here is a really dramatic deterioration in performance, one which affects all the people in London.

The thing which has also changed – and this is much less well understood I think – is that the nature of the patient is changing dramatically because of exclusion of patients. So these figures look bad, but actually they are very much worse than it appears. I will give you some simple examples of how the situation has changed.

I came across an ambulance station on Saturday morning, and in front of me there was an older woman and she suddenly fell in the road. As she fell, she fell on her hand and she broke her thumb. Her thumb was visibly broken. I helped her up off the road. I called an ambulance. They refused to

come. They said 'we don't do those kind of minor incidents'. I then went into a meeting of 70 clinicians, which is where I was heading for, and I presented to these clinicians from a central London health trust: 'What do you think is the most appropriate health care for an older person who has fallen in the road? We don't know why she has fallen. She may have had a TIA or some other reason for her fall. They all said 'surely an ambulance would have been called?'. So it was quite strange. I had to get her into a taxi and get her to an A&E department that way. That was quite shocking really, because it brought to light to me things which I've been familiar with.

Another example: last week an elderly man in his seventies fell, and he has fell, cracked his head, it was bleeding quite badly. His wife called an ambulance at 7 in the evening. At 9 in the evening an ambulance hadn't arrived despite the fact she had called them several times. She then phoned back and said 'I am going to take him to hospital by car'. They said rather promptly, 'Well if you do that you will lose your place in the queue, you realise that don't you?'. She was just so angry, because she was so frightened that he could have suffered a brain haemorrhage from his fall. That's what's going on in the equation.

SR:
Is there somebody on the other end of the phone who is categorising them against some criteria?

MA:
Yes. I will describe the way it works. There is a room where there are call handlers who are not clinically trained. They use an algorithm. The amusing thing is that they all sit there in green uniforms and hobnail boots. Nobody knows why they sit there in these strange uniforms as call handlers but nevertheless they do. They will use the algorithm to determine the severity of your call. I've listened in, I've sat with them, they do a very professional job. That's the way the call is categorised.

The next room is full of clinically trained people of various grades, there are senior people as well as a clinical support desk. Mostly they will allocate the call to a certain grade of call, which could be A1 or A2, C1 or C2, C3 or C4 so there are various grades. If they feel they are uncertain they have this clinical support desk of paramedics and nurses to whom they can refer if they are uncertain about the severity of the case. They can also refer to the Helicopter Service if they think that is appropriate, so that is the way in which the call is categorised.

But the way the system works is incredibly complicated, because they might call an ambulance that's on their way to you – the bells are clanging away – but that ambulance might suddenly stop and turn around and go somewhere else. If they decide that somebody else comes in who is more seriously ill then that call categorisation will effectively change.

SR:
So you can slip from an A to a C because there is a higher order A coming in?

MA:
Well you won't slip from an A to a C. It doesn't quite work like that. B's have been abolished. B's have become A2's. They are not down graded quite in that way. But there is a similar process which says that a heart attack or a stroke or a major trauma is going to be more serious than other forms of injury. The trick is, if you want the ambulance get someone to say you are unconscious. You will get the ambulance there I promise you.

They do perform for those sort of cases, where somebody has got a heart attack. At the moment if you have a heart attack they might get there in 9 minutes instead of 8. But you have to remember something really funny about this. I said 75% of category A calls get there in 8 minutes. For years we

have been trying to find out what has been happening to the other 25%. Out of that 25% some will get there within 19 minutes and some, we've discovered every year there is 2,000 that seem to disappear and despite numerous questions we can't actually find what's happened to those 2,000 people.

But the situation is much worse than that, because there is the other category which is C1. C1 are patients who should receive a response within 20 minutes 90% of the time. These are people who haven't had a heart attack but they are going to be people who everybody is going to be very concerned about. Because they could be the 80-year-old person who has tripped in the street and broken their hip. They could be the person laying at home having had a fall, maybe with some blood around them. For those people the target is 90% in 20 minutes. That 90% has been cut in half. So 90% should arrive in 20 minutes.

You could imagine the people I am talking about, these are people who could be really seriously ill. They may be lying in the road, somebody could have fallen off a bike and they are in the middle of the street, and because we have such an odd society which is kind of highly proficient in some ways ('don't move the patient whatever you do; they are in the middle of the road, don't move them) this is a big problem because they should be moved. It's much safer for somebody who has broken their leg or their arm of if they have suffered an injury to move them to the kerb, but people have been told not to move them but put them into the recovery position. Being in the recovery position in the middle of the A2 doesn't help you much. There are quite a few cases of people who have fallen off their bike, they've had an accident, they have been knocked down they are lying in the road and they are lying there for several hours.

What we are seeing is a massive deterioration. This is catastrophic. This is a massive deterioration of the level of care which is available to people who I think by tradition for all the people I have mentioned we would imagine that they would have had ambulance pretty quickly, if not within 8 minutes then maybe within half an hour.

PT:
Can you define the category difference between a C1 and an A2? How does somebody know? Somebody has fallen of their bike in the road that could be really serious? How do they know it's not an A?

MA:
Because of the algorhythm. If there are conscious and talking. To be an A1 you had to have had a heart attack, an obvious cardiac arrest, or you have had an obvious stroke, or you have fallen off a building. So these are very, very serious Injuries.

RL:
I suspect you could entertain us all evening with the catastrophic events. But I am conscious of the time. What I was hoping you would do for us is to give us your view on really why this catastrophic fall-off has occurred. Give us your thoughts on why this happened, and the extent to which you can identify the reasons for it.

MA:
Just one small piece of data in addition. That is just some data about people waiting outside hospitals to get in. Because Table 1 shows for example in November there were 192 patients at Northwick Park who waited more than an hour to be transferred from the ambulance into the cubicle inside the A&E department.

Hospital Site	Number of Breaches
Hillingdon Hospital	26
Northwick Park Hospital	192
Princess Royal University Hospital	35
Whittington Hospital	1
Queens Hospital	9
Queen Elizabeth Hospital (Woolwich)	25
St George's Hospital	1
West Middlesex University Hospital	5
North Middlesex University Hospital	2
St Helier Hospital	2
Barnet Hospital	1
University College Hospital	1
Chelsea and Westminster Hospital	6
Ealing Hospital	13
Royal Free Hospital	2
St Mary's Hospital, Paddington	2
Total	323

Table 1 60-minute handover waits, November 2014

Then if you look at people waiting more than 30 minutes to be transferred from an ambulance into A&E, over 200 patients in a month, including Ealing and Hillingdon and Northwick Park and Princess Royal and Queen's and St George's and North Middlesex.

SR:
Each of those has over 200?

MA:
Yes. Each of those has going up to 300. These are huge numbers of people who not only are highly stressed having been brought to ambulance by A&E but they are also waiting very, very long periods of time.

RL: So each of the hospitals you've just mentioned?

MA: Yes.

RL: So it's over a 1,000?

MA: Yes. There are over 3,565 incidents where patients have waited more than half an hour in November to transfer from an ambulance into a cubicle in an A&E.

JL: The hospital trust gets fined?

MA: Yes.

RL: They get out of it if they declare something don't they?

MA:
If it's more than an hour the hospital declares a serious incident. That goes through the serious incident process. There are fines yes, almost certainly. But I don't know the details of the fines.

The first and most important reason is the huge numbers of paramedics who are leaving the service. For example, at the moment in November there were 304 vacancies for paramedics.

SR: What's the total number of staff leaving the service?

MA: That's a good question. I will have to let you have the total number.

RL: Do you regard that as exceptional or is that normal figure you get?

MA: No, it's vast. Normally the numbers would be 60-70.

RL: And the vacancies would be created by what?

MA:
Just let me tell you, in October 26 paramedics left the service in one single month. Why are paramedics leaving? They are leaving I think because the nature of the service has changed from one where the ambulances were based in stations and went out to jobs, as they call them, to one of active deployment, where a paramedic will sit in an ambulance for 12 hours. That might be extended to 13 or 14 hours. Then they've got the next day for another very long shift. Maybe because they do overtime they might do that again. In the course of a week, one of the token comments is 'you don't know what it's like sitting for 12 hours with someone you don't like'. There's two people in an ambulance waiting on a street corner somewhere to pick somebody up and take them in. There is a huge sense of disgruntlement.

RL:
That's using strategic deployment software isn't it? That's where they forecast where an incident is most likely.

MA:
If you look at it, it's fantastic. You can see these spots all over London where they know the incidents are happening and they deploy an ambulance there. But what has happened is that at the centre the paramedics have lost their route because if you saw how it was before the ambulance station was like a village. If you went into them they were growing plants!

PT: But any manager would say it's a better system. To have people actually out like the police.

MA:
Of course it makes sense, but what has happened is the paramedics have become exhausted and worn down. There are two aspects to sitting in an ambulance. One is it's non-stop. It keeps your adrenaline going: you see a patient, you finish seeing a patient and suddenly it's 'click' and you're off again. Then there's a 'click' and you're off again. You go tearing around the streets. It's also quite a big dip. Because at the end of the shift sometimes the paramedics don't want to leave because the adrenaline is so high. It's very unhealthy, they tend to die quite young.

The relationship between the front line and headquarters management is a very poor one. There is very little respect from the front-line paramedics for the senior managers. Managers love the front

line but don't seem to have had any communication with it. There is this kind of stand-off which I think is quite destructive.

RL: So industrial relations are poor.

MA:
It's the attitudes. If you go to an ambulance centre and speak to the paramedics, they will spill their heart out about how awful the service is and how bad the categorisation is. There is a rather unpleasant term used sometimes. Which one doesn't like to hear, it's not very professional. What they mean is they have been called out to cases which are not emergencies.

I just think there is a real sense that there is something wrong with the system about the privatisation, so paramedics very often feel that they are not quite doing the jobs with the appropriate acuity and there's huge pressure on them not to take people to A&E departments but as we all know there are no alternatives.

RL:
Do the London Ambulance Service deploy the technique so if it needs a couple of stitches putting in the paramedics will do that?

MA:
The paramedics are very clinically skilled. They won't stitch, they carry a lot of drugs. These are clinicians, they are very highly qualified clinicians. There is a sensible paradocs service. It's a doctor and a paramedic going out to see people to keep them out of hospital. What you basically see – this is a magnificent service if you want to see the NHS at its best – is there is this ambulance going around providing the most magnificent primary care.

You will see lots and lots of people who are not dangerously ill. But they are trying to keep them out of A&E departments by deploying a very, very expensive and technically and clinically effective resource because primary care is often failing.

RL: That is funded by the CCG obviously.

MA: The ambulance service is funded by all CCGs.

RL: I meant the paradocs service.

MA: The paradocs service is funded by the CCGs in Hackney.

RL: As part of the 'keep you out of hospital campaign?

MA: Yes.

RL: Has anyone got any questions of comments?

LI:
I know a paramedic who gave up. He left. He was very dedicated as an NHS worker but he said that he was very demoralised by things like where they dispatch a little car first of all so they could tick the box about arriving within a certain time to a stroke patient, but actually they don't take the stroke patient in, and they could be that way for 2 hours to actually get the proper ambulance to take them into hospital. Is that something you've come across?

MA:
Not a stroke patient. I do think that for cardiac arrest and for strokes the system in London is I think extremely high quality but the clinical performance is dropping.

For example, 27% of cardiac arrests for September, patients who were resuscitated sustained ROSC, which is Retention Of Spontaneous Circulation, but that is an 11% decrease on the previous month. These are the most seriously ill people and there was a significant decrease in the number of people who achieved a level of clinical recovery that was sufficient for them to live. That figure itself is absolutely appalling.

RL:
We only have a few minutes left. You were taking us through what you felt the reasons for this were. You've got the fall-off in paramedics and unfilled vacancies. Do you have any other reasons?

MA:
Historically, we believe the reason is the failure to invest in people in London. What they do at the moment they are bringing in paramedics from Australia, about 150 in January. The problem is there has never been a proper investment in local people in terms of encouraging them to join the ambulance service. If you look at the staff of London Ambulance Service they tend to live outside London, they tend to live on the periphery of London.

As an example, and I think this is significant, only something like 5% of front-line paramedics are from a black or ethnic minority background. That has been exactly the same for the past 10 years and we have been kept begging for 10 years with the London Ambulance Service to try to get them to do something about this, but they won't.

You do hear of strange kind of not exactly a racist language but you do hear strange things said in the ambulance service sometimes about 'black people don't like to wear uniforms', or 'people from different ethnic groups don't like to work as paramedics', there are all sorts of strange cultural evasions.

SR: I think the same applies to the London Fire Service.

MA: It's a strange thing. We think that their failure to work with local communities to encourage them to go into what is actually a magnificent job in my view is a really big failing.

LI: What about cuts? Have there been cuts in ambulance stations but also cuts in actual funding? I read a BBC article from 4 years ago which predicted what was going to happen.

MA:
Five years ago there was a significant cut in the funding. They cut the number of paramedics by about 500. At the moment they have had an increase in their funding but you know a lot of the money is being spent on private ambulance services at the moment. They are commissioning four private ambulance services to support their activities, and looking in detail at what's going on with the private ambulance services it's quite clear that they are not performing in the same way as the London Ambulance Service

For example they don't participate in this process of producing clinical performance indicators. If you ask what has happened to their PRFs (the patient report forms) they seem to be getting significant numbers of patient report forms from the private ambulance services which means they can't do a

clinical appraisal of how effectively the service is working. Although I have letters which say 'yes everything is fine' when I look at other bits of their internal documentation I find that this desperately important clinical information is not coming through.

There has also been a massive increase in complaints about delays (Appendix 3). In one year, October 2013 there were 53 complaints about delays. By October 2014 that's gone up to 87 complaints about delays.

The paramedics are very unhappy. The patients are very unhappy. The feelings are absolutely appalling and the last 2 years have been the worst period I have observed in the London Ambulance Service since I have been working with them.

PT: How long does it take to train to be a paramedic?

MA: It's about 2 years.

PT: Is it on-the-job training?

MA:
Increasingly that's been prevented as much as possible. The plan is that within 2 years every ambulance team will be led by a paramedic. Bear in mind paramedics are state registered, technicians are not – which means there are numerous teams across London at the moment that are led by a clinician who is not state registered. Which is fine for a cardiac arrest, but is not fine for other things.

One of the ways in which performance is achieved, again showing how poor performance, is if you have a community responder who is a lay person who is trained to do CPR, the minute that that community responder gets to the person to start resuscitation that goes against the category performance target. You can see that there is almost cheating that way. When you see these defibrillators in stations, every time someone grabs a defibrillator as a lay person and uses it to resuscitate somebody, that goes against the figures that London Ambulance Service counts for their performance.

What I have shown you are very poor performance figures but they are very much worse than I have shown you. Lots of ways are used to try to massage them to try to make them look better.

RL: That's a very useful analogy you have illustrated for us. Can we have those?

MA: Yes (Appendix 2).

RL: And can I say thank you very much.

Over 50% of ambulances miss response time targets

Evening Standard 4/12/2014

Ross Lydall
Health Editor

999 CREWS ARRIVING IN EIGHT MINUTES

Bark & Dag	55%	Greenwich	59%	Lewisham	58%
Barnet	48%	H'smith & Ful	64%	Merton & Sutton	65%
Bexley	55%	Haringey	48%	Newham	60%
Brent	53%	Harrow	55%	Redbridge	53%
Bromley	59%	Havering	59%	R'mond & Tw'ham	56%
Camden	66%	Hillingdon	58%	Southwark	66%
City & Hackney	60%	Hounslow	55%	Tower Hamlets	60%
W'minster	64%	Islington	55%	Waltham Forest	50%
Croydon	54%	Ken & Chelsea	62%	Wandsworth	62%
Ealing	51%	Kingston-u-T	65%		
Enfield	52%	Lambeth	64%		

Source:LAS

EMERGENCY ambulances are reaching less than half of critically ill people in parts of London within NHS target response times, it can be revealed today.

Performance has plummeted to a modern-day low, with up to seven boroughs a month seeing the eight-minute national target missed on more than 50 per cent of 999 calls.

These include the highest-priority patients who have stopped breathing and do not have a pulse, and those who have had a suspected stroke or fit.

Today the London Ambulance Service said it was receiving more calls than at any time in its history – about 35,000 a week – as it pleaded with Londoners not to abuse the service.

It has been hit by a spate of "unnecessary" calls, ranging from a patient demanding help because the buses had stopped running, to a cat with a broken leg and a woman with period pain.

NHS England warned that the LAS's response to the second highest priority of emergencies was the worst ever recorded across the health service.

The scale of the challenge facing LAS was highlighted this week when cyclist Angie Cook, 63, was left lying injured in the road for 90 minutes due to the shortage of ambulances after colliding with a car in Teddington.

Today an Evening Standard investigation found the number of priority calls receiving a response within eight minutes fell to 44 per cent in Redbridge in September.

It was one of seven boroughs that month – others included Haringey, Barnet and Waltham Forest – and three in October where less than 50 per cent of "category A" calls were reached on time. The NHS minimum is 75 per cent.

Across London, response rates to the most serious "life threatening" calls within "category A" crashed from 81 per cent in March to 64 per cent in October, with July the worst at 61 per cent.

At the same time, the capital has fallen below the national average for the percentage of cardiac arrest patients discharged alive from hospital, and for those arriving at a hyper-acute stroke unit within an hour.

Malcolm Alexander, chairman of the London Ambulance Service Patients' Forum, feared increasing pressures and staff shortages were causing a breakdown in relations between LAS executives and front-line staff.

He said: "I think they are not coping. We have been monitoring the London Ambulance Service for 10 years and it's never been down to anything like this. If it went down to 70 per cent we would consider it to be a disaster."

Problems were exacerbated by crews being forced to keep patients in the back of ambulances for more than an hour on hundreds of occasions, due to A&Es being full.

At one hospital, Queen Elizabeth in Woolwich, 209 patients waited more than an hour in an ambulance between July and September. Over the same period across London, 5,852 patients waited in an ambulance for more than 30 minutes – double the 15-minute maximum. Last week the Standard revealed that Boris Johnson had written to Health Secretary Jeremy Hunt warning of the pressure facing LAS as it entered its toughest time of year.

The LAS treated 10,187 seriously ill and injured patients last week – 10 per cent more than last year. About 3,500 of the 35,000 calls it takes each week receive phone advice rather than an ambulance.

A national shortage of paramedics has resulted in more than 400 LAS vacancies. It hopes to recruit 1,000 new front-line staff by next year.

LAS director of operations Jason Killens said: "We're very busy, please only call us in a genuine emergency and at all other times call NHS 111, visit your GP or pharmacist or alternatively make you own way to hospital."

In June, only 5.7 per cent of cardiac arrest patients – 17 out of 296 – on whom resuscitation was commenced were subsequently discharged alive from hospital, compared to national average of 8.5 per cent.

A spokesman for Lewisham and Greenwich hospitals, which runs Queen Elizabeth hospital, said it had made 46 extra beds available last month which had helped to reduce the number of ambulance delays.

Editorial Comment Page 16

power is the only way of making these

Evening Standard 4/12/14.

Ambulances in crisis

THE London Ambulance Service gets more calls now than it has ever done, about 35,000 a week, and the result is that the service is sometimes dangerously slow to respond to calls from critically ill people. As we report today, in up to seven London boroughs a month, in more than half of cases emergency ambulances fail to respond to 999 calls within the NHS target of eight minutes. In London overall, the response to serious emergency calls within the target time fell from 81 per cent during March to 64 per cent in October. In some cases the problem is exacerbated by the shortage of space in A&E departments: ambulance crews may wait up to an hour before they are able to bring a patient into a hospital.

This is a genuinely disturbing development, with life-threatening implications. There are plans to increase the numbers of paramedics to meet rising demand; it can't happen too quickly. Yet we too must play our part: the service says that it is beset with frivolous 999 calls from people with trivial complaints. That has to stop.

Ambulance service needs our support

AS YOUR report last week on the London Ambulance Service revealed, while those with life-threatening conditions usually get the attention they need, a large number of seriously ill people are waiting unreasonably long for the expert care that the LAS should provide.

Paramedics often work 12-hour shifts day after day, and if there is an emergency at the end of a shift they might work 13 or more hours in a day. They are London's unsung heroes but the pressure on them is too great; many are exhausted and every week several leave the service for higher-paid, less stressful jobs elsewhere.

We need action now. Health minister Earl Howe should publicly state his commitment to our emergency ambulance services, ensuring paramedics are paid a wage that enables them to live in London.

The boss of NHS England, Simon Stevens, should stop wasting money on consultants doing more research into ambulance services and guarantee that the LAS has the resources it needs.

The LAS must make sure that all paramedics feel valued and respected, and focus on recruitment. Long-term sustainability of the paramedic workforce requires active and continuous recruitment – neglecting this process and then recruiting from Australia (as the LAS is now doing) is no long-term answer to our problems.

Malcolm Alexander, chair, Patients' Forum for the London Ambulance Service

Performance by Primary Care Trust (New measures)

Date from: 01/10/2014
Date to: 31/10/2014

	Category A			Category C1		Category C2		Category C3	Category C4	Total Demand
Primary Care Trust	Incidents	% reached in 8	% reached in	Incidents	% reached in	Incidents	% reached in	Incidents	Incidents	Incidents
Ward										
Havering	1260	58.89 %	93.33 %	141	46.81 %	704	49.01 %	79	436	**2620**
Barking & Dagenham	1212	54.79 %	92.41 %	144	36.11 %	612	46.90 %	66	266	**2300**
Redbridge	1482	52.70 %	89.41 %	169	44.97 %	691	41.68 %	121	391	**2854**
Waltham Forest	1299	49.65 %	89.07 %	142	42.96 %	646	42.11 %	82	355	**2524**
Outer North East	**5253**	**53.91 %**	**90.96 %**	**596**	**42.79 %**	**2653**	**44.93 %**	**348**	**1448**	**10298**
Kingston	622	65.11 %	92.60 %	82	43.90 %	441	58.96 %	68	315	**1528**
Croydon	1774	53.78 %	93.12 %	222	45.95 %	1077	49.12 %	116	630	**3819**
Wandsworth	1172	61.86 %	94.88 %	154	51.30 %	719	60.36 %	107	458	**2610**
Richmond & Twickenham	713	55.68 %	91.73 %	85	36.47 %	399	48.62 %	64	308	**1569**
Merton & Sutton	1577	64.55 %	95.43 %	214	57.48 %	1025	60.39 %	161	690	**3667**
South West	**5858**	**59.73 %**	**93.87 %**	**757**	**49.01 %**	**3661**	**55.61 %**	**516**	**2401**	**13193**
Bromley	1359	59.16 %	94.04 %	167	44.91 %	816	52.33 %	129	592	**3063**
Greenwich	1243	59.29 %	94.21 %	154	50.00 %	707	54.60 %	102	378	**2584**
Bexley	1085	55.39 %	93.00 %	134	41.79 %	635	51.81 %	104	400	**2358**
Lambeth	1524	64.44 %	93.44 %	236	47.46 %	970	57.63 %	189	568	**3487**
Southwark	1614	66.23 %	94.18 %	241	53.53 %	964	52.28 %	194	483	**3496**
Lewisham	1330	58.12 %	94.29 %	190	45.79 %	741	53.31 %	110	466	**2837**
South East	**8155**	**60.90 %**	**93.88 %**	**1122**	**47.77 %**	**4833**	**53.80 %**	**828**	**2887**	**17825**
Barnet	1663	47.81 %	88.27 %	195	36.41 %	831	44.04 %	106	515	**3310**
Enfield	1589	52.11 %	86.97 %	188	39.89 %	804	38.81 %	127	455	**3163**
Haringey	1294	47.84 %	92.58 %	192	37.50 %	659	40.67 %	110	340	**2595**
Camden	1565	65.75 %	87.92 %	167	43.71 %	720	50.83 %	137	379	**2968**
Islington	1276	55.09 %	90.52 %	150	39.33 %	615	48.94 %	120	363	**2524**
North Central	**7387**	**53.80 %**	**89.06 %**	**892**	**39.24 %**	**3629**	**44.45 %**	**600**	**2052**	**14560**
Hillingdon	1588	57.75 %	86.71 %	193	53.89 %	860	48.02 %	164	631	**3436**
Hammersmith & Fulham	907	63.51 %	93.16 %	104	39.42 %	429	48.25 %	53	207	**1700**
Ealing	1632	51.47 %	93.32 %	188	40.96 %	748	45.32 %	129	489	**3186**
Hounslow	1391	55.00 %	93.67 %	137	41.61 %	641	45.09 %	100	373	**2642**
Brent	1640	53.23 %	90.06 %	202	36.14 %	733	39.97 %	127	458	**3160**
Harrow	1017	55.36 %	90.36 %	106	42.45 %	503	42.54 %	56	307	**1989**
Kensington & Chelsea	811	62.15 %	91.99 %	84	36.90 %	402	49.50 %	67	227	**1591**
Westminster	2084	63.82 %	88.00 %	213	40.38 %	936	48.82 %	188	406	**3827**
North West	**11070**	**57.52 %**	**90.55 %**	**1227**	**41.89 %**	**5252**	**45.91 %**	**884**	**3098**	**21531**
City & Hackney	1473	60.35 %	89.48 %	178	44.38 %	810	54.81 %	158	377	**2996**
Tower Hamlets	1490	60.34 %	88.86 %	178	42.13 %	704	56.25 %	139	302	**2813**
Newham	1661	59.36 %	93.80 %	252	48.02 %	873	52.58 %	165	363	**3314**
Inner North East	**4624**	**59.99 %**	**90.83 %**	**608**	**45.23 %**	**2387**	**54.42 %**	**462**	**1042**	**9123**
Out of London	0			0		0		0		**0**
Out of London	**0**			**0**		**0**		**0**		**0**
_none	0			0		36	97.22 %	0	0	**36**
_none	**0**			**0**		**36**	**97.22 %**	**0**	**0**	**36**
LAS Total	**42347**	**57.65%**	**91.47%**	**5202**	**44.23%**	**22451**	**49.82%**	**3638**	**12928**	**86566**

Not Our Service	3	2
North East	3	2
West	3	2
East Central	1	1
PTS	1	1
Total	**144**	**100%**

Complaint Themes

REAP remains at Level 4 following a persistent period of high demand. As a result the Trust has seen increasingly lengthy response times to lower acuity patients. Surge Purple has also been fairly regularly implemented as call rates continued to be above average.

Complaints relating to delay (87) and staff conduct (33) continue to be the main themes. These are increasingly inter-related.

Table 2 **The following table shows complaint subjects October 2013 to October 2014**

Complaints by subject 2013 - 2015	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	August	Sept	Oct
Delay	53	41	38	22	29	24	33	50	72	62	45	65	87
Conduct	30	19	11	29	16	22	20	22	16	27	18	23	33
Road handling	10	8	9	8	12	7	8	9	9	14	9	7	7
Non-conveyance	8	11	10	10	11	7	5	5	16	19	16	8	6
Not our service	1	1	2	3	0	1	0	0	2	0	1	0	3
Treatment	13	11	6	12	13	4	8	7	12	12	17	4	1
Patient Injury or Damage to Property	4	2	1	2	0	0	1	0	1	0	1	2	3
Location Alert referral	2	2	1	0	0	0	0	1	1	1	1	0	2
Conveyance	3	1	2	0	3	2	1	1	1	1	2	1	1

PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

Steve Lennox
Director of Health Promotion & Quality
London Ambulance Service
220 Waterloo Road, SE1 8SD

June 20th 2014

Dear Steve,

QUALITY ACCOUNT FOR 2013-2014

Thank you so much for inviting the Forum to contribute to your Quality Account for this year. We present below our contribution to the LAS's Quality Improvement Priorities for the Quality Account.

1) **OUR RELATIONSHIP WITH THE LONDON AMBULANCE SERVICE**
The Patients' Forum values continuous engagement with the LAS in relation to discussions about all aspects of LAS performance and clinical care. This engagement takes places at the seven internal LAS committees on which the Forum is represented: Patient and Public Involvement, CQSEC, Learning from Experience, Equality and Inclusion, Mental Health, Infection Prevention and Community Responder. We also actively engage with the Trust Board at their meetings and at meetings with leaders of the LAS. The Forum also values the contributions by the Chair, Chief Executive, Directors, the Head of Patient & Public Involvement and Public Education and other LAS leaders to our monthly Forum meetings held in the LAS Conference Room. Close regular contact with the commissioners for the LAS also enables the Forum to exercise influence in relation to the quality and performance of LAS services.

2) **QUALITY ACCOUNT FOR 2012-2013 - REFLECTIONS FROM BERWICK**
We have received no formal feedback to the Quality Account Statement we submitted for the previous period.

3) **PROTECTING PATIENTS FROM AVOIDABLE HARM – THE HIGHEST PRIORITY**
We welcome the LAS's commitment to take all patient feedback very seriously, and their review of the management of the investigation of serious incidents. In keeping with the priorities highlighted by the Francis and Berwick Reports, providing the safest and most effective care for patients must be the highest priority for the LAS. Reporting, investigating and learning from patients safety incidents and complaints must be fundamental to ensuring patient are safe and evidence produced that learning on incidents and accidents is constantly taking place. Patients must always be told when they have been harmed due to clinical errors. The LAS should ensure that all ambulances carry equipment that is clean and sterile; shortfalls in infection control are always taken seriously and acted upon; required clinical equipment is always available, e.g. tympanic thermometers, when needed, is intact and up to date.

WE RECOMMEND that the LAS publishes in the public arena the outcome of all incidents, complaints and accidents investigated, where there are recommendations for service improvement; with evidence demonstrating enduring improvements to service quality and safety, and evidence of staff and organisational learning and implementation of recommendations.

4) **PRE-HOSPITAL DEMENTIA CARE WILL BE TRANSFORMED**

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

WE RECOMMEND the LAS should produce evidence to demonstrate that front line staff have continuous education and training in this area. This should include access to Health Education England training resources. See also section on mental health (4) below. Access to appropriate care pathways for patient with cognitive impairment must become fundamental to providing right care, first time.

5. PATIENTS WHO FALL SHOULD ALWAYS RECEIVE INTEGRATED CARE

The Forum welcomes to decision of the LAS to upgrade calls from patients who have fallen, and their participation in research into the need of these patients (SAFER 2). When patients fall and do not require access to hospital acute care, paramedics should have direct access to local Falls Teams, in order to ensure expert clinical advice and care for these patients and avoid inappropriate transfers to A&E. We welcome the CQUIN for an Enhanced Falls Service for 2014/5

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

6. CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS MUST BE TRANSFORMED

We commend the LAS for the considerable progress that has been made in the prioritization of care for people with mental health problems. However, we are concerned that E-learning approaches have been adopted as the main vehicle for training of staff. We are very pleased that work is developing with mental health Trusts to create effective mental health pathways which should

help to divert patients away from A&E departments, to more appropriate community care – however, this approach needs to gather pace and speed to ensure implementation in the short term. We are very pleased that the Chief Executive is providing leadership by chairing the LAS Mental Health Committee to ensure implementation of this improvement priority.

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

7. EXCELLENT END OF LIFE CARE MUST ALWAYS BE PROVIDED

The LAS should continue to develop its excellent work with Advance Care Plans (ACP), End of Life Care (EoLC) and CoOrdinate My Care (CmC). Protocols should be developed between the LAS and London's CCGs and GPs to ensure that CoOrdinate My Care (CmC) is fully developed to meet the needs of people who have an Advance Care Plan. We welcome the CQUIN for End of Life Care for 2014/5.

We RECOMMEND that the LAS works closely with the Royal Marsden Hospital and CCGs to enable a far greater number of people to access appropriate care through CoOrdinate My Care (CmC). The LAS in collaboration with the Royal Marsden and CCGs should publish examples of good practice in 'end of life care' for front line staff, together with evidence of outcomes showing the effectiveness of appropriate and compassionate care for these patients.

8. DELAYS IN PROVIDING URGENT AND EMERGENCY CARE ARE NOT ACCEPTABLE

We congratulate the LAS on the achievement of its Category A targets. Vulnerable patients who have requested emergency care must never be left waiting for LAS care.

Patients requiring a slightly lower level of care, who are vulnerable, who are in pain, who have fallen, or taken an overdose, should not have to make repeated calls to the LAS to get help. Such delays suggest a significant breakdown in care provision and are the cause of many complaints to the LAS. This particularly concerns patients categorised as needing care classified as C1 and C2. We understand the limitations caused by a shortage of staff and resources.

WE RECOMMEND that urgent action is taken to promote recruitment to the LAS front line from schools, universities, job centres and

religious/cultural centres in London. The work-force must be enlarged to ensure that the Category C targets which follow are always met:

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

Achievement of targets in 2013/4 were as follows:
Category C1 – reached in 20 minutes – 72.88% (target 90%)
Category C2 – reached in 30 minutes – 66.88% (target 90%)

9. STAFF SHIFT PATTERNS SHOULD BE FULLY EVALUATED

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

WE RECOMMEND that the impact of long shifts on front line staff is fully evaluated by the LAS, especially in relation to the impact of 12 hour shifts, without adequate meal breaks and rest on: clinical care; the health of staff; training and complaints against staff, e.g. in relation to attitude and behaviour. Staff should be interviewed about the effects of shift work on their health and clinical practice during annual appraisals, and be involved in development of improved alternatives.

10. APPROPRIATE CARE PATHWAYS SHOULD BECOME FULLY OPERATIONAL

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

WE RECOMMEND that care pathways are developed by the LAS in conjunction with CCGs, acute trusts and providers of community care that are robust enough to give confidence to LAS crews, patients and carers that these pathways are available when required, clinically appropriate, fully-funded, subject to regular clinical audit and tests of reliable and continuous access, i.e. effective governance.

11. LAS SHOULD ACTIVELY SEEK TO BE INFLUENCED BY PATIENTS AND THE PUBLIC IN ALL THAT IT DOES

We welcome the decision of the LAS to involve patients and stakeholders in the development of their strategy and a new culture of “no decision about us, without us”. The recent meeting on the PPI strategy was exemplary. The LAS should secure public involvement in the planning, development and consideration of all significant proposals for changes and decisions affecting the operation of the LAS.

WE RECOMMEND:

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

12. EQUALITY AND DIVERSITY

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

WE RECOMMEND that the LAS embed diversity into all aspects of public education, recruitment and training and ensure full inclusion and sensitivity toward patients and staff with any protected characteristics, not solely LGBT. Changes must be made at all levels in the LAS, including the Board, to embed these duties.

Yours sincerely

Malcolm Alexander
Chair
Patients' Forum for the LAS