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| **PATIENTS’ FORUM****`/** |
| **AMBULANCE SERVICES (LONDON) LTD** |

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| **ANNUAL REPORT AND****FINANCIAL STATEMENT 2022** |

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| **SOME OF OUR KEY OBJECTIVES FOR THE LAS AND NHS*** **Reforming emergency care for people in a mental health crisis.**
* **Supporting the work of the All Party Parliamentary Group on Black Maternal Health.**
* **Effective emergency care for older people in a health crisis.**
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**THE DUTY TO WHICH THE LAS MUST ASPIRE**

**Complying with the NHS Constitution for England**

“The Patient will be at the heart of everything the NHS does.

NHS services must reflect - and should be co-ordinated around and tailored to the needs and preferences of patients, their families and their carers. The NHS (LAS) will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services”.

 *NHS Constitution*

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**FORUM OFFICERS**

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| --- | --- | --- |
| POSITION | NAME AND CONTACT | HEALTHWATCH |
| Company SecretaryDirector/Trustee | John Larkin, Fornham Lodge, 4 Verna Street, Marham Park, near Fornham All Saints, Bury St Edmunds, Suffolk, IP32 6FU | - |
| ChairDirector/Trustee | Malcolm Alexander patientsforumlas@aol.comTel: 0208 809 6551 / 07817 505193 | Hackney Healthwatch |
| Director/Trustee | Louisa RobertsTel: 0208 986 8972 | - |
| Vice ChairDirector/Trustee | Sister Josephine Udiesisterjossi@hotmail.com  | Lewisham Healthwatch |
| **Registered Office** | **Patients’ Forum Ambulance Services (London) Ltd,** **30c Portland Rise, N4 2PP** | - |

Our four Director/Trustees have remained in office for the whole of the period since the 2006 launch of the Company, including the year ended 31 December 2022.

**SPECIAL THANKS TO …**

* Our **fantastic members** for their high level of involvement and engagement in our activities, and for helping to make the Forum so effective.
* Our wonderful Vice Chair, **Sister Josephine Udie**
* **John Larkin**, Company Secretary, for his outstanding governance work and support for the Forum.
* **Polly Healy** for maintaining our website and ensuring that our publications are produced, and copy edited to the highest standard.

**Patients’ Forum Newsletters:** [**https://www**](https://www)**.patientsforumlas.net/newsletters.html**

**TWITTER@ForumLas**

**We hope you will find our Annual Report informative and helpful. If you wish to learn more about the Forum and participate in our activities, you are welcome to attend our Public Meetings and become a member – membership is open to the public, Healthwatch and the voluntary sector organisations.**

 **SPECIAL ADVISORS TO THE PATIENTS’ FORUM**

|  |  |
| --- | --- |
| SISTERJOSEPHINE UDIE | CARDIAC RESUSCITATION & EQUALITY AND DIVERSITYPromoting the installation of defibrillators and the training of communities in CPR and use of defibrillators |

|  |  |
| --- | --- |
| ALEXIS SMITH | MENTAL HEALTHExperience of the London Ambulance Service – Suicide and Self-Harm Prevention |

|  |  |
| --- | --- |
| COURTNEYGRANT | STROKE AND HUMAN FACTORSExperience of serious harm due to delay in diagnosis of Stroke by the LAS |

|  |  |
| --- | --- |
| Dr. JOSEPHHEALY | LGBTQ – EMERGENCY CAREQuality and Diversity in the LAS – Safe and Effective Services for London’s LGBTQ Communities. |

|  |  |
| --- | --- |
| ARCHIE DRAKE | HEALTH INEQUALITIESLAS and The Inverse Care Law – Exploring Health Inequalities in London using LAS Data |

|  |  |
| --- | --- |
| SEAN HAMILTON | EPILEPSYIdentifying Service Improvements for the LAS to enhance clinical care of patients have Epileptic seizures |

|  |  |
| --- | --- |
| VIC HAMILTON | EPILEPSY and CARERIdentifying Service Improvements for the LAS to enhance clinical care of patients having epileptic seizures |

|  |  |
| --- | --- |
| MIKE ROBERTS | LOCAL GOVERNMENTExpert in analysing and influencing Local Government and health services.  |

**INTRODUCTION**

The Patients’ Forum promotes the provision of effective emergency and urgent carethat meets the needs of people in London. This Annual Report outlines our aims and achievements in relation to our charitable objectives during 2022. Central to our work is the place of patients, their relatives and carers in our campaigning activities. We monitor the LAS in relation to its effectiveness, safety and responsiveness to patients needing urgent and emergency care. We encourage the LAS and Commissioners to listen to service users and we promote improvements in clinical care. The LAS is an organisation that struggles to listen to the voice of patients and use their experiences to improve patient care. This was also an important finding by the London Assembly Health Committee/

The Forum wants the patient’s voice to be heard loud and clear, valued and respected during the planning and design of services, and in the development of new clinical, quality and performance strategies. We have used this model with respect to services for people from LGBTQ communities, those with sickle cell disorders, epilepsy, acute mental health problems, stroke, and women who have experienced poor service during pregnancy. We now want to explore the impact and effectiveness of emergency care provided by the LAS on health inequalities of people living in London.

It is also essential that the diverse voices of service users are continuously heard and valued as a catalyst for the evolution of more effective care, provided in collaboration with health and social care services in every London Borough.

Many service improvements are needed, including much enhanced responsiveness to emergency calls. The performance of the LAS in relation to meeting their targets for getting to patients within specified target times and handover at A&E is often disappointingly poor. Other improvements are needed in relation to mental health care, responding effectively to patients’ complaints within a shorter time frame, and the transformation of the LAS in relation to equality, diversity and inclusion. We co-produced an excellent ‘Complaints Charter’ with the LAS to improve their handling of complaints, but they have since withdrawn from promoting this Charter to those with complaints against the LAS. **https://tinyurl.com/26v7vrdm**

**We also agreed a Co-Production Charter with the LAS Director of Quality** [**https://www.patientsforumlas.net/co-production-with-the-las.html**](https://www.patientsforumlas.net/co-production-with-the-las.html)**. The LAS would do well to listen to our recommendations for service improvements and implement our proposals in a way that is long term, sustained and enduring. This approach would substantially improve patients’ experience of the LAS.**

**MEETINGS OF THE FORUM AND SPEAKERS 2022**

The Forum invites lay and professional speakers to address our meetings and to hear the voices of service users, carers, and the public.

Our meetings are intended to influence the development of emergency and urgent care services, to better meet the needs of patients, engage in Speaker’s debate with our members, share experiences and help find solutions when services need improvement.

**ALL FORUM PAPERS ARE PLACED ON THE WEBSITE:**

[**https://www.patientsforumlas.net/meeting-papers-2020-2021--2022.html**](https://www.patientsforumlas.net/meeting-papers-2020-2021--2022.html)

**PUBLIC MEETINGS OF THE PATIENTS’ FORUM – 2022**

|  |  |
| --- | --- |
| 17 JANUARY  | Sir Norman Lamb, Chair of South London and Maudsley Trust … Parity of Esteem |
| 28 FEBRUARY  | Mark Docherty, Director of Nursing and Clinical Commissioning, WMAS … Performance of Ambulance Services Across England |
| 21 MARCH  | Derek Prentice, RCEM … Devastating Waits in A&E \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chris Hartley-Sharpe … Training and Leading LAS First Responders |
| 25 APRIL  | Dr. Doug Green – Leader of Paradoc, City and Hackney |
| 23 MAY  | Briony Sloper – Deputy Director, NHS Health and Care in the Community … Covid 19 Response  |
| 20 JUNE | John James, Chief Executive of the Sickle Cell Society … Impact of Covid on Sickle Cell Disorders  |
| 18 JULY | Peter Walsh, Director, AvMA … The Quest for Patient Safety and Justice  |
| 21 SEPTEMBER  | Joseph Healy … Zero Covid Campaign |
| 01 NOVEMBER | Marie Gabriel, Paul Gilluley, Dean Henderson … Mental Health Emergency … Crisis in A&E |

**DESCRIPTION OF THE FORUM FROM THE LAS WEBSITE …**

**What is the Patients’ Forum?**

The Forum is an independent body that monitors the LAS for the benefit of the public.

**Who makes up the Patients’ Forum?**

It is made up of members of the public who are involved in LAS monitoring, audit, research and policy-making committees.

**Officially, Patients’ Forums were abolished in March 2008 and are no longer statutory bodies.**

However, we have continued to have an effective relationship with our Forum and work with them in the following ways:

- Our Senior Managers attend Forum Meetings to present information and invite

 discussion on a range of topics. This gives Forum members the chance to have a

 say on key issues and decisions.

 - Ad-hoc meetings have been held, and action taken, to take forward issues of

 particular interest to Forum members.

- More recently, we have run a series of visits to the Control Rooms for Forum

 members and have also run a basic Life Support Session for them.

**THANKS TO DAVE PAYNE AND ROTHERHITHE CONSOLIDATED CHARITIES – CONTRIBUTION TO FORUM**

Thanks very much to Rotherhithe Consolidated Charities for their very kind gift of £200 to the Patients’ Forum for the London Ambulance Service.

The Forum has been running for about 17 years and throughout that time has continuously campaigned to bring about improvement to urgent and emergency care, for patient suffering from serious medical conditions.

We suffered a drop in activities during the Covid period, but we are glad to say that we have now revived, and we are running very successful public meetings together with leaders of health and social care services. Our last one was with a national leader of ambulance services and our next will be with the Royal College of Emergency Medicine.

Your contribution is very important in enabling us to influence public policy on health and social care for the benefit of patients. Our members are very grateful to you for supporting our very important work.

**ANNUAL GENERAL MEETING OF PATIENTS’ FORUM AMBULANCE SERVICES (LONDON LTD)**

**The 2022 ANNUAL GENERAL MEETING of the Company PATIENTS’ FORUM AMBULANCE SERVICES (LONDON) LIMITED was held via Zoom on November 1st, 2022, at 5.15pm.**

**Attendance:**

Malcolm Alexander, Carol Ackroyd, Graeme Crawford, Sally Easterbrook, James Guest, Polly Healy, Coral Jones, R. Kensley, Stephen Lancashire, Mike Roberts, Marion McAlpine, Adrian Dodd, C. Lohendran, Penny Crick

**Minutes**

1. It was **AGREED** that the Reports and Financial Statements of the Company for the years ended 31st December 2019, 2020 and 2021 were received and adopted by the meeting.

[**https://www.patientsforumlas.net/annual-reports.html**](https://www.patientsforumlas.net/annual-reports.html)

1. It was **AGREED** that John Garth Larkin, as a Director retiring by rotation in pursuance of the Company’s Articles of Association, and being eligible for re-election, be re-elected as a Director of the Company.

1. MENTAL HEALTH CRISIS IN OUR A&E DEPARTMENTS - 12-HOURS PLUS WAITS

This matter was discussed with the following speakers:

* Marie Gabriel, Chair, North East London ICB
* Paul Gilluley, Medical Director, North East London ICB
* Dean Henderson, ELFT Mental Health Trust

Dated this 1st day of November 2022

By ORDER OF THE BOARD

JOHN LARKIN

Director and Company Secretary

**KEY ISSUES AND RECOMMENDATIONS – 2022**

**COVID ACTION - Covid Is Not Over - JOSEPH HEALY**

Covid Action is a grassroots campaign of individual activists and labour and trade union organisations, working together to call for a different approach to the ongoing Covid-19 Pandemic.

Joseph said that the organisation was previously known as Zero Covid, and that the campaign is continuing to put forward a **Vaccines Plus** strategy, aimed at eliminating community transmission of the virus. He also explained that Covid Action is campaigning on the wide range of Pandemic-related issues that need to be confronted. These include Long Covid, patent waivers to enable global vaccination, funding for research, development of the next generation of vaccines and antivirals, and the crisis in the NHS and social care.

Covid Action campaigns and demands action from the Government, Local Authorities and businesses, on the following major priorities:

●       The return of free Covid testing for all and mask-wearing on public transport

 and crowded indoor spaces, including shops.

●       A public sector test-and-trace system.

●       Safe working, studying and socialising spaces and Covid-safe workplaces.

●       Independent SAGE’s Covid Safety Pledge - <https://tinyurl.com/2tmtyae7>

●       Ventilation – widespread installation of HEPA filters and CO2 monitors, and

 the establishment of mandatory criteria for air quality in indoor spaces.

●       Vaccination – mass vaccination and booster campaigns in the UK,

 in schools and the wider community, as well as prioritising research into new

 vaccines to meet the threat of Covid variants.

●       Waiver of intellectual property rights for to enable global Covid-19 vaccination.

●       Long Covid – financial support for those impacted by Long Covid and for it to

 be recognised as a disability under the Equality Act, and as an occupational

 disease; and funding for ongoing LC research.

●       Publication of the UK Covid-19 Inquiry’s interim conclusions within the year to

 inform ongoing and future Pandemic responses and planning.

**ACCESS TO DEFIBRILLATORS IN BOOTS PHARMACIES**

The Forum’s campaign to persuade Boots pharmacies to install defibrillators in all their stores continued throughout 2022. The following letter was written to the Vice President of Boots: **Andrew Thompson, VP, General Council, Boots UK**

Dear Mr Thompson, on November 10th we wrote to you and other leaders of Boots UK, to encourage a transformation in your policy towards saving lives of staff, patients and other people in communities located close to a Boot’s stores. We are very disappointed that you and your colleagues have ignored our letters, which were handed into your southern HQ in Weybridge, Surrey.

As a major supplier of medicines and healthcare to communities across the UK, I am sure will agree that you have a responsibility towards the NHS and residents, who have supported the financial sustainability and growth of Boots for 170 years. Surely, you acknowledge that your company has both a moral and ethical duty to support and sustain the longevity and restoration of life of those who fund you – those who pay taxes, which pay for the medications you provide, and the profits from the wide range of products that all of your stores sell across the country.

Our campaign will not stop because you have decided not fund defibrillators for local communities. We believe that the 30,000 people who have already signed our letter to you, and their relatives and friends will create a highly significant and influential body of opinion and action, which will ultimately convince you and your colleagues to change your policy in relation to saving lives of those who suffer cardiac arrests.

On December 14th at 1pm, we will call at your Weybridge HQ to deliver a letter to you with 30,000 signatures, calling for a reversal in your Defibrillator Policy, and we will invite a large group of our supporters to join us. I hope you will make yourself available on that date and personally address our supporters to explain why Boots refuses to save lives of those who suffer from cardiac arrest in or near your stores.

We shall also be accompanied by a colleague who will be available to teach CPR to our demonstrators and of course to you and your colleagues. I do hope you will be available on December 14th at 1pm to participate in the ‘Save Lives Event’ outside your Weybridge HQ.

 

 Malcolm Alexander Roxana Khan-Williams

Chair Campaign Leader

**Patients' Forum for the LAS Organise**

**A Partnership to Save Lives**

**‘East London man taking on Boots over their refusal to pay for life-saving equipment outside every shop’.**

**Martin Bagot, Health & Science Corres,** [**Lucy Williamson**](https://www.mylondon.news/authors/lucy-williamson/)**, Snr Reporter –**

Bottom of Form**My London**

**Pensioner Malcolm Alexander has started a campaign via an online petition to have lifesaving defibrillators installed in Boots.**

Top of Form

Bottom of Form

Thousands of people are demanding that Boots installs lifesaving defibrillators in its High Street stores. The pharmacy giant is refusing to provide the devices that restart the heart despite having staff in store specially trained to use them after a cardiac arrest. The man at the forefront of the campaign is MalcolmAlexander, 73, from Stoke Newington in East London.

Malcolm took on other major retailers such as Sainsbury’s, persuading them to agree to put defibrillators in all larger stores and is demanding Boots does the same. Malcolm's petition has gained 25,000 signatures and is continuing to grow.

Malcolm told My London: "Boots would be the ideal place because they've got pharmacists that are trained in CPR and the use of defibrillators. They told us we [the voluntary sector] have to pay for them, which I thought was scandalous. Their absolute refusal was quite astonishing.

"They can't expect local communities to pay for something which should be absolutely basic to Boots. When fewer than 1 in 10 people survive an out of hospital cardiac arrest, having a nearby defibrillator is absolutely vital.

"The point is, if someone collapses you give them CPR, but the quicker you get to a defibrillator, the quicker you save someone's life. If you leave it for half an hour, the person is dead. People think CPR saves lives, but it doesn’t - it just keeps your heart pumping. You need a defibrillator nearby to save a life."

A defibrillator provides an electric shock that jolts the heart back into a normal rhythm. Public-access defibrillators are used in less than 10% of cardiac arrests, with almost all other cases seeing the patient die before they get to hospital.

Malcolm runs the Patient Forum for London Ambulance Service and has been in correspondence with Boots dating back five years, lobbying for defibrillators to be installed. Last June Boots said they could be installed on the outside of its buildings if his voluntary group paid for them.

A spokesperson for Boots said: "If a local need for a defibrillator is identified, we are happy to support local groups who provide them by having them sited where possible on the exterior of our stores so they can be accessed 24 hours a day.

"Our opening hours are often much shorter than supermarkets and many of our local pharmacies do not open on Sundays, which is why we believe our strategy to support defibrillators to be positioned on the outside of our stores where they can be accessed at any time by a network of local responders best suits the local communities in which we serve."

Malcolm said his passion for campaigning for patient safety began in the 80s, when he successfully led a campaign to prevent the closure of St. Leonards Hospital in Hackney. "I could see what we could achieve by banding together to fight for better healthcare," he added. But his latest bid is for defibrillators to be commonplace.

**Appendix**

**Romeo, age four, has a complex heart condition which means he could go into cardiac arrest at any time**.

A mum from Camden, whose son was diagnosed with a serious heart condition whilst she was pregnant, agreed quick access to defibrillators is vital. Now age four, Romeo requires care 24 hours a day and risks going into cardiac arrest at any time, but there is not currently a defibrillator at his school. However, schools without a defibrillator are to be provided one by the end of 22/23 academic year, under [**new Government plans.**](https://www.gov.uk/government/news/every-school-will-have-a-life-saving-defibrillator-by-2223#:~:text=Since%202012%20we've%20fought,now%20be%20equipped%20with%20them.)

[**www.mylondon.news/news/health/east-london-man-taking-boots-25194291**](http://www.mylondon.news/news/health/east-london-man-taking-boots-25194291)

 **EQUALITY AND DIVERSITY IN THE LAS**

**Equality and Diversity Leads:**

Sister Josephine Udie, Dr Joseph Healy, Malcolm Alexander

Comprehensive data on the ethnic diversity of paramedics in the LAS is shown below. The percentage of paramedics from a BME heritage has only increased from 3.21% in 2003/4 to 11% in 2021/22. During 2016-2018 the number of BME paramedics decreased by 6, but during the period 2018 to 2021 the number increased by 130. Bearing in mind the that 46% of the population of London has a BME heritage, the LAS performance in this respect continues to be poor.

We have been unable to obtain details of the LAS performance for 2022-23.

**READ OUR REPORT ON RACE EQUALITY IN THE LAS**

[**www.patientsforumlas.net/equality--inclusion-and-diversity-in-the-las.html**](http://www.patientsforumlas.net/equality--inclusion-and-diversity-in-the-las.html)

**LAS PARAMEDIC WORKFORCE STATISTICS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Year* | *Total No.**Paramedics* | *Total No. of**Paramedics of BME**heritage* | *Actual**Increase**BME**Paramedics**On previous year* | *% BME* | *BME Paras**As % staff on front line (direct patient contact)* | *BME Paras**As % of**total workforce* |
|  |  |  |  |  |  |  |
| 2003/04 | 685 | 22 |  | 3.21 | Not known |  0.5 |
| 2004/05 | 734 |  26 | +4 | 3.54 | 1.07 | 0.65 |
| 2005/06 | 832 |  26 |  0 | 3.13 | 0.99 | 0.62 |
| 2006/07 | 816 |  27 | +1 | 3.31 |  1.00 | 0.61 |
| 2007/08 | 836 |  32 | +5 | 3.83 | 1.19 | 0.74 |
| 2008/09 | 881 |  31 | -1 | 3.52 | 1.04 |  0.7 |
| 2009/10 | 917 |  34 | +3 | 3.71 | 1.01 |  0.68 |
| 2010/11 | 1,025 |  41 | +7 |  4.0 | 1.22 | 0.83 |
| 2011/12 | 1,385 |  64 |  +23 | 4.62 | 1.98 | 1.38 |
| 2012/13 | 1,648 |  93 |  +29 | 5.64 | 2.97 | 2.01 |
| 2013/14 | 1,611 |  95 |  +2 |  5.9 | 3.09 | 2.04 |
| 2014/15 | 1,707 | 106 |  +11 |  6.2 | 3.49 |  2.3 |
| 2015/16 | 1,991 | 139 |  +33 |  7.0 | 4.6 | 2.8 |
| 2016/17 | 1,969 | 134 | -5 |  7.0 | 4.2 | 2.6 |
| 2017/18 | 2,050 | 133 |  -1 |  6.4 | 3.9 | 2.5 |
| 2018/19 | 2,104 | 158 |  +25 |  7.5 | 4.8 | 2.7 |
| 2019/20 | 2,274 | 204 |  +46 |  9.0 | 6.1 | 3.5 |
| 2020/21 | 2,278 | 225 |  +21 | 10.0 |  10 | 3.5 |
| 2021/22 | 2,370 | 261 |  +36 | 11.0 |  12 | 3.9 |
| 2022/23 |  |  |  |  |  |  |

**DEREK PRENTICE**, **LAY MEMBER** **ROYAL COLLEGE OF EMERGENCY MEDICINE – RCEM**

Derek Prentice described his lifelong commitment to the NHS and his leading role in representing consumers’ interests as a lay member of the General Dental Council, Chair of the Board for the Dental Complaints Service, a Board member of King’s College School for Medicine and Dentistry, and King’s College Hospital.

Referring to the current problems with ambulance queuing, which is partly related to the Covid Pandemic, Derek said he is concerned about the interaction between ambulance services and Emergency Departments, because of the pressures on both services. He said that the chronic shortage of staff and beds, is exacerbating the current problems of ambulance queuing. Derek added that accessing good quality data was difficult, that some NHS data is not of proven quality and consequently, the RCEM has produced its own data.

Derek said that as a result of the bed crisis that many EDs are not achieving their 4-hour target (95% of patients admitted or discharged within 4 hours) and that there are many reports of patients remaining in ambulances and EDs for 12 hours or more, and this includes patients for which a decision to admit has been made. He explained that the problem of patient flows through hospitals has been severe for some time and that Covid has made the situation much worse. He described as ‘corridor medicine’ the current practice of treating people in corridors because there was no other space in ED available. He expressed concern about the higher risk of death due delays in treatment, and the importance of looking at the mortality data to examine the impact of broken systems in more detail. Derek said that delays kill people, but it is difficult to persuade Government of the critical need for a recovery plan to stop ambulance queueing and restore the 4-hour target. Unfortunately, the Government wants to abolish the 4-hour ED target. He said before the 4-hour target was introduced, that 24 hours waits in ED were common and that ED staff were often blamed for the long waits.

Due to the shortage of beds and staff, the RCEM has been campaigning for access to more social care, so that patients can be discharged earlier - in one study 47% of patients who were ready for discharge, could not be discharged because there were no suitable services and facilities available for their care. He said that whilst the ED is always there for patients, that the number of people using this service is rising, because some community services are not working effectively, and in some cases have closed. The priorities are for more beds, better management of acute services and to stop blaming ED for overloading the hospitals. He added that England is short of 3000 ED consultants, that there has been no recent workforce review for EDs, and that there needs to be a realisation that the ED is the hospital’s front door.

**Questions and Answers - Derek Prentice**

1. **Why is there so much variation in performance between EDs? What can be done to support EDs that have persistently experienced problems with handovers from ambulance services and admission to hospital wards?**

**Response:** Some EDs are great. The RCEM is not keen on persuading people not to use their local ED, because that is the place where they will get the best urgent and emergency care. However, if other local community and primary care services are poorly provided, EDs can become the service of choice despite long waits. Local services should be designed with patients at the heart of effective delivery, i.e. appropriate local services should be available and accessible so that patients do not unnecessarily go to ED.

1. **Why isn’t Emergency Medicine given greater priority in the NHS?**

**Response:** Hospital administration appears to look down on EM and uses strange financial methods to fund it. Some Chief Executives don’t visit their ED and consequently don’t understand the pressures they are under. This suggests a failure by Trusts, NEDS and their Chief Executives to understand ED problems as part of a whole hospital issue.

1. **What problems are EDs having to deal with as a result of a system which is poorly organised and sometimes dysfunctional?**

**Response:** Temporary facilities are being placed in some car parks which increases demands on ED staff. It is hard to get staff from other specialities to help in ED and that leaves ED staff feeling isolated and issues of concern are not being dealt with. There are EDs which are fantastic like the Homerton and the Royal Devon and Exeter, where these problems have been resolved. GP triage and clinical reviews by consultants can resolve problems that cause ambulance queues outside EDs.

1. **How can the problem of bed blocking be resolved?**

**Response:** New models are needed that connect EDs to other parts of hospitals where appropriate services and support can be provided. Social work departments in hospitals can assist by enabling patients to go home safety, and thereby increase the availability of beds within the hospital.

1. **How can discharge from hospital from hospitals be improved?**

**Response:** This problem particularly affects people who are poor – better off people can transfer to care homes either short or long-term. Poor people face eviction orders, which can seriously affect their health and cause serious deterioration in their wellbeing. What is needed is greater support for people who are most deprived, and better ‘end of life’ care for people in their own homes, rather than hospital wards.

**FAREWELL TO A GREAT LEADER OF THE LAS –**

**CHRIS HARTLEY SHARPE**

Chris Hartley-Sharpe, First Responder Lead for the LAS retired in 2022 after 26 years leading major projects on First Responders, CPR and Resuscitation. He gave a presentation about his work to the March 2022 meeting of the Patients Forum.

He described the great work of First Responders, who help save so many lives by arriving quickly at the scene of patients suffering a cardiac arrest and providing CPR and defibrillation until an LAS crew arrives. Chris described training a wide variety of volunteers who agreed to work with the LAS, including Forum members, faith communities, schools, colleges and other community organisations. Chris described his interactions with well-known supporters of community resuscitation and installation of defibrillators, e.g. former Health Minister, Tessa Jowel and actress Helen Mirren. He spoke about LAS work with ambulance services in Kenya, Tanzania and Uganda.

Chris described the Accreditation Scheme for defibrillators and the Good Sam App:

* 30,000 people have a Cardiac Arrest each year in the UK whose lives can often be saved with early CPR followed by defibrillation.
* National survival is < 9%, yet in places where CPR and defibrillator use occurs quickly (e.g. Heathrow Airport) it is > 80%.
* The GoodSAM Community saves many lives by providing early high-quality CPR and defibrillation. **https://www.goodsamapp.org/**
* GoodSAM responders are from the NHS (e.g. nurses, doctors, paramedics, therapists), Police and Fire Brigade, First Aiders and others trained in CPR.
* The GoodSAM app is integrated with most UK Ambulance services, and when a cardiac arrest call comes in, the system automatically alerts nearby responders.
* On average, responders receive only 1 to 2 alerts each year - but their key skills save many lives.
* If the first person alerted can’t attend it's not a problem, the next nearest person is alerted, and the nearest ambulance to take over on arrival.

**We wished Chris Hartley Sharpe well for his retirement and presented him with a certificate of Patient Forum Appreciation.**

A **first responder** is a person with specialized training to provide assistance at the scene of an emergency, e.g. cardiac arrest. First responders typically include paramedics, EMT's (emergency medical technicians), firefighters and volunteers.

**A**[**certified first responder**](https://en.wikipedia.org/wiki/Certified_first_responder)  is a person who attends medical emergencies until an ambulance arrives.

**78-Year-Old Joe Kerr, Describes the Appalling Care he Received from the LAS**

Dear LAS, I have a very traumatic story regarding services provided to me by the LAS, I have multiple health problems including severe problems with my hip, despite having surgery on that hip several times. I had an acute onset of pain on my bad hip which started at 1700 hrs on April 1st, 2022. The pain got worse and more acute, I tried to sort it out by sitting, standing in every way possible but to no avail. Pain killers were of no use.

My first call to 111 was about 2000 hrs but there was no answer. I held on for over 15 minutes but got no answer, and then phoned 999 only to be told that there was a 6 hr wait for an ambulance. They told me to redial 111 as they can get ambulances earlier. I rang 111 again and after a very long wait they answered and told me to ring 999 again. I rang 999 again and they told they were very busy and that I was not considered to be an emergency. They told me to ring back if things changed for the worse. Later that night I rang back and said that my chest pain was increasing, that I have a serious heart condition and that the pain in my groin increasing. The pain was severe and crippling. My wife Barbara who is very unwell at the moment, stayed up all night with me to enable the ambulance crew to get into the house. I am bitterly unhappy that she was put though so much stress.

The time frame is as follows: I rang 111 at approx. **2000 hrs on Friday 1st April**, and the ambulance arrived approx. **07.00hrs Saturday morning**. I was in extreme pain for 11 hrs, despite telling 111 and the LAS that I also had severe chest pain. I remember asking the LAS how long the ambulance was going to take as my condition was worsening. They said sorry we are having very busy night and then said to me: “DONT CALL AGAIN”. What a way to treat a 78yr old pensioner. The pain increased, I had nowhere to go, and had been told not make a further call.

When the ambulance crew arrived and heard my story, they could not believe the situation I was in and had been left in without help for 11 hours. The paramedics were brilliant. When they asked how bad the pain was on a scale of one to ten, I said: “one hundred and counting”. They gave me a paracetamol drip, morphine and Entonox for about an hour, but were unable to move me to hospital until the Entonox had started to work. They could not move me until the pain was controlled, which took some time. I was in hospital for the next 3 days.

I could not walk, and I could not go to the toilet all night. I had a bladder scan, and I had to have a catheter fitted immediately. The actual urine measurement in my bladder was over 2,000 mls. The doctors were horrified. It was a horrific night.

The whole experience made me and my wife feel worthless. It was the first time I had called an ambulance for myself in many years, and I was shocked at how slow the service was, despite the serious pain and other health problems that I suffered.

I would like a detailed investigation into the terrible services that I received from the LAS on April 1st and 2nd 2022.

**Response from LAS Chief Executive, Daniel Elkeles**

**24 May 2022**

Your initial 999 call was received by our Emergency Operations Centre (EOC) at **19:50** when you explained that you were experiencing pain in your hip after surgery. The call handler proceeded with the assessment process to triage your call. At the conclusion of this process and based on the information provided, your symptoms were determined as a **Category 5** priority, of which 90% of calls will receive a telephone assessment within 180 minutes or callers will be advised to contact NHS 111 or their own GP. However, at the time of your call, we were experiencing very high demand and our Clinical Safety Plan (CSP) was in place so the call handler concluded the call by explaining that contact should be made with NHS 111 so that they could undertake a more comprehensive assessment, but to call 999 again if your condition worsened.

At **20:55** a call was passed to us by SECAMB who had been contacted by NHS 111. The call was categorised as a **Category 3** response by SECAMB (90% responded to in less than 120 minutes) and we were told you were suffering from of a hip injury. We received a further 999 call at **23:42**, which was answered at 23:44 due to a very high call volume. You explained to the call handler that you were in severe pain and were short of breath. The call handler reassessed your symptoms using the “*Sick person with abnormal breathing*” protocol, which was determined at a Category 5 response, however your call maintained its Category 3 response. The call handler advised that help had been arranged and advised you of the current wait time which was approximately **6 hours.** The call handler explained that you may receive a call back from a clinician whilst you were waiting.

At **04:09** we called you back for a welfare check. During this call you explained that you were complaining of **chest pain and difficulty in breathing**. The call handler re-assessed your symptoms using the “*Chest pain*” protocol, which resulted in a **Category 2** response (average response 18 minutes, 90% calls within 40 minutes).

At **06:30** the next available ambulance crew were dispatched, arriving at **06:47**. Following assessment, you were subsequently taken to the Princess Royal Hospital. The ambulance arrived there at **08:29** with handover to the clinical team at **08:38.**

Our review concludes that the 999 calls were managed by the LAS in accordance with our protocols and determined at the appropriate level of priority. The calls were handled in a polite manner. I do not underestimate the distress caused and can appreciate that it may seem strange that we are referring some patients to NHS 111 for further assessment or advising patients to make their own way to hospital. This is because demand on the 999 service continues to increase year on year, so we believe we have to adopt a different approach if we are to achieve a high-quality service for the most seriously unwell patients. It is therefore no longer the case that a 999 call will automatically result in an ambulance being sent. Safety instructions are routinely given to ring 999 again if a patient experiences any difficulty in accessing help or their condition changes so that they can be re-assessed. The 111 service can arrange an ambulance if their more comprehensive assessment process identifies one is needed.

**Joe Kerr was Deeply Disappointed with the Response from Daniel Elkeles to his complaint.**

**He wrote back to Daniel Elkeles, Chief Executive, LAS**

Dear Mr Elkeles, I was deeply disappointed at your response to my complaint about the appalling treatment I received from the LAS. You did not demonstrate what steps you will take to prevent other patients suffering as I did. I am very elderly, and my wife is very unwell, we expect you and your colleagues to stand up and support elderly vulnerable people – that is a major duty of the LAS.

I am grateful to you for sharing with me that that you are sorry to learn of my concerns and the distress that I suffered. You also kindly thanked me for bringing this matter to your attention and sent your best wishes. But you did not apologise for the absolutely appalling service that you provided to me. But at least staff were polite, and the paramedics were outstanding. You believe that the LAS provided a service that was managed in accordance with your protocols, and that a service was provided that was consistent with my level of priority. I can only say that the experience I suffered was like being tortured and was the most disgraceful experience I have ever had from the LAS or any other part of the NHS. If the LAS met its protocols and priorities on that day, then there is something fundamentally wrong with the determination of those protocols and priorities, because they take humans to the highest level of pain, humiliation and trauma.

The new approach you are taking does not help you achieve a high-quality service for the most seriously ill patients. On the contrary, the service denigrates and destroys the trust we once had in the LAS. If demand is rising, what is the point of sending patients to a dysfunctional 111 service? I was battered around between 111 and 999 - both services were grossly incompetent in meeting my needs, and were not even appropriately clinically connected. The location of the 111 service in the south coast area does not give the 999 and 111 services the right to work as separate entities – they are supposed to work in close collaboration. That is the point of the 111 service.

Why didn’t your clinical staff check on my GP records to which they must have access – they could have seen first-hand what my heart and hip problems were.

Rising demand means that you need more ambulances and more paramedics – not less. You can’t abandon patients because you are short of staff – you need to employ staff and purchase ambulance so that you can meet need and demand.

My wife Barbara and myself are disgusted that elderly people like us are treated so badly. Can you imagine what it must feel like to have a bladder filled with 2000mls of urine and being unable to urinate for 11 plus hours? I do not believe that you have treated my concerns seriously. We felt abandoned and abused by the LAS and are disgusted that you can defend that service provided to me.

Yours sincerely

Joe Kerr

**MENTAL HEALTH CRISIS IN CASUALTY**

**Forum’s letter to Marie Gabriel, Chair, Integrated Care System,**

**North East London**

Dear Ms Gabriel,

As you know all ambulance services across the country are in crisis, and although attempts are being made to resolve the grave problems facing ED, the resolution measures so far taken seem to be light touch. The utterly appalling situation, where seriously ill patients are remaining in ambulances for a great many hours, and paramedics and unable to attend to other emergencies because they can't handover patients to A&E is completely unacceptable. We have too few acute beds, grossly inadequate social care and too few community health staff.

The impact on patients, their safety and risk of harm and death as a result of the dysfunctionality of the system is shocking and has been much publicised. What we don't hear about are some of impacts on patients’ mental health problems - for example a patient remained in Homerton ED for over 42 hours on Section 2, because a bed could not be found for her. She twice attempted to leave ED and was brought back by staff - imagine the tragedy for a seriously ill patient in a mental health crisis waiting days in a crowded ED to be admitted to a mental health bed.

Delays in patient handovers to EDs are causing serious harm and premature deaths, and we must urgently find a resolution to what I know you will agree is a totally unacceptable situation.

There are also serious problems with the sharing of data on the gravity of the situation. The LAS refuse to share up-to-data performance data with the Forum or Hackney Healthwatch. The data the LAS currently publish on their website is for April 2022 – old data. There is also national comparative data on the NHSE website. The LAS will no longer provide detailed monthly granular data at borough level. Until early 2021, the LAS provided the Patients' Forum and Healthwatch with excellent data packs, but these are now unobtainable and concealed from the public except for ICBs. In addition, handover targets for the LAS have changed - they used to publish data on 15- and 30-minutes breaches, but now they only publish data on 30 minutes breaches - again hiding the extent of the misery suffered by patients.

Your knowledge and experience of the NHS is great, and we want to hear from you on what action is and will be taken by the NELICS to resolve the tragic issues which I have described above. We need to see and participate in the plans to stop the terrible suffering experienced by patients, who have serious and life-threatening illnesses and need emergency care now.

**The Forum held a public meeting jointly with Hackney Healthwatch on November 1st, 2022, about the Mental Health Emergency, with three excellent speakers: Marie Gabriel, Chair of the ICS for North East London, Paul Gulliley, Medical Director for the ICS and Dean Henderson, Manager of the Hackney branch of the East London Foundation Trust. The full report can be found at: https://tinyurl.com/2p9xrbm7**

**Appendix Three for Recommendations we made to the ICS, Homerton Hospital and the East London Foundation Trust following the public meeting.**

**Dr PAUL GILLULY – CHIEF MEDICAL OFFICER NEL ICS – SAID:**

***“Waits of over 4 hours, or even worse over 12 hours for patients in a mental health crisis in Emergency Departments (ED) are unacceptable - end of story”.***

***“ED is not the right place to be waiting for a bed for a person who is seriously ill. I don't think there is any excuse for that at all.”***

***“EDs are not areas where service users can receive appropriate and adequate treatment and care. They are places for assessment. It is unacceptable for patients to wait for long periods in A&E because they cannot receive the care and treatment they require there”.***

 ***“We know for a fact that there is an increased risk of harm to service users who remain within ED for over six hours. Overall, this is a patient safety issue as well as a ‘quality of care’ issue. It's really urgent that we do something about this unacceptable situation”.***

***“This is not just a NE London problem, but a national problem and it has been a national problem for many months. As a result of COVID, patients presented in a far more complex and more acute state, requiring longer lengths of stay and resulting in greater pressures on beds and inadequate funding”.***

***“This was the worse period in my whole 10 years of working in ELFT and NHS NE London”.***

***“I think it's a challenge throughout the whole of the country, but actually it has affected us in NE London very seriously”.***

***“The ICS is trying to establish an escalation process for patients who are in A&E for between 4 and 12 hours, so that senior staff, up to Chief Executive level, can take action to remove blockages to admission, and move the patient as quickly as possible to the place where they can get the right care and treatment to meet their needs”.***

**From Neziah's Mother to the Black Maternal Health**

**All Party Parliamentary Group (APPG)**

It was unfortunate that I couldn’t be at the APPG meeting, which had been set up to support black women during their pregnancy journey and their aftercare. I think this is truly needed. I applaud the MPs and activists who developed this initiative.

During my last pregnancy, my experience was initially ok. However, I started to bleed and when trying to secure an ambulance to go to hospital to bring my precious son Neziah into the world, my world came crashing down. It was like a movie and my life was the horror. The way I was treated after making a call to the LAS emergency centre on the 3rd of July 2015 - to my encounter with the LAS chief executive in December 2021, was appalling.

After six years the LAS eventually performed their statutory ‘face to face’ Duty of Candour; an apology for the tragic loss of Neziah. This was delivered respectfully by a medical person who was slightly in tune with my feelings. But the Chief Executive did not show the remorse for my loss during the meeting that I had expected. This was the time when he could have made peace between the London Ambulance Service and myself, and showed me his sorrow for my loss due to LAS failures.

I learned several things during this journey, one being time is everything. I called the LAS at 5.20am and they came at 6.50 am (at this time my bed and floor were soaked with blood). Whilst I was bleeding and expressing large clots, LAS individuals were unprofessional. I overheard someone in the emergency centre shout: "she is gonna have to wait!". This was shouted after the third call to the LAS control room, from the first paramedic at my house, who was anxious about the amount of blood I had lost.

I was not listened to by people within the LAS. I also felt that my son's life did not matter to these people and our lives were of no real urgency to protect, despite losing blood and producing huge-sized clots from my vagina. It just seemed weird at this catastrophic time, that it was ok for the ambulance crew members to talk over me and walk as if they were going to get a burger from Wimpy!

I know and definitely can say, that if I was a Caucasian lady and not a black woman, I would have been treated differently right from when I picked up the phone to call 999.  Neziah's Mother x

**'The Black Maternity Scandal'- Black women are four times more likely to die**

**in pregnancy and childbirth. The APPG aims to raise awareness of the issue of**

**racial disparities within maternal healthcare and offer solutions to end this.**

https://www.parallelparliament.co.uk/APPG/black-maternal-health

**PARADOC - Hospital Admission Avoidance Service**

**Dr Doug Green, Clinical Lead for ParaDoc,** described the history of ParaDoc and the reasons for its development, e.g. the tendency for care homes to call 999 for an ambulance, when patients were unwell, even though they did not meet the threshold for emergency care. He described the clinical value of GPs and Paramedics working together and with community GPs, to provide the right level of clinical care for patients. Amongst developments from the original ParaDoc model, is the inclusion of occupational therapists and other clinicians.

ParaDoc does its own administration and its own patient triage. The lead paramedic is Mark Scott. Patients referred to ParaDoc are mostly elderly, often have co-morbidities, are at risk of hospital-acquired infection, and experience long periods of hospital admission if they are treated in hospital wards. Patients who are not admitted to hospital remain in their home (or care home), having agreed with ParaDoc and carers that would be and safest and best location for provision of care.

The service is managed by the Homerton Hospital and was originally part of a collaboration with the LAS. ParaDoc’s car has a similar range of medications and equipment to that provided in an ambulance, e.g. defibrillator and lifting equipment. ParaDoc cannot be used to take patients to hospital and is dependent upon effective communications and interoperability with other clinical services.

The criteria for referral to ParaDoc are narrow and the principal target groups are vulnerable adults in City and Hackney. Patients with a mental health diagnosis are not included, because there is an alternative LAS service in City and Hackney for patients with acute mental health conditions. Patients are referred from a wide variety of sources including Telecare, care homes, Homerton Hospital ambulatory care, GPs and a wide range of care providers. The 111 service and other fast response services have direct access to ParaDoc but do not use the service often.

Major objectives of ParaDoc include keeping patients in a location where they are safe and well cared for, reducing ambulance queuing and freeing up of acute beds. Patients who are discharged home from ambulatory care or A&E, can be followed up by ParaDoc to prevent readmission. ParaDoc receives a lot of calls from Telecare which are not appropriate, because when residents press their alarm, the alert goes to an office which does not have clinical staff – so the staff often call 999.

8-10% of ParaDoc responses result in patients going to A&E and 70-80% of patients remain at home. Doug added that when older people are admitted to hospital, they often remain in hospital for long periods, at higher risk of infection and at high cost. With regard to improving the provision of palliative care, a key aspiration of ParaDoc is to keep people out of hospital and manage their care at home. Palliative care work is done in collaboration with Marie Curie and palliative care consultants.

**Paradoc slides on website -** [**www.patientsforumlas.net/uploads/6/6/0/6/6606397/healthwatch\_3\_pdf-4.pdf**](http://www.patientsforumlas.net/uploads/6/6/0/6/6606397/healthwatch_3_pdf-4.pdf)

**QUESTIONS TO DOCTOR GREEN**

**A: Does ParaDoc provide care for patients with dementia?**

**Response:** People with dementia form a large cohort of ParaDoc patients. ParaDoc also accepts referrals from ELFT and the Homerton specialist dementia nurses. **​​​​​**​

**B:  Is ParaDoc more successful than other similar services? Why is the**

 **ParaDoc model not used in other parts of London using CCG funding?**

**Response: T**he service has a unique combination of clinical skills, which work effectively in City and Hackney. The LAS uses a paramedic/nurse model in northeast London and mental health teams in London sectors, comprising of a paramedic and mental health nurse. ParaDoc has grown organically is independent of the LAS and has developed more effectively to meet local needs. The model may not have been adopted in other areas because of the belief that a doctor-led service is more expensive to run. The very effective reduction in referrals to A&E, provides an evidence base for the clinical and financial effectiveness of the ParaDoc service.

**C: Is data available comparing the effectiveness of other similar response**

 **models used across London with Paradoc?**

**Response:** There is no recent direct comparative data that I am aware of. The LAS has published data in the past that compared models and showed ParaDoc to have a far lower conveyance-to-hospital rate than others (around 10% compared to ~50% for other Physician Response Units - PRU).

**D: How long do ParaDoc consultations last?**

**Response:** The time required for ParaDoc to see patients in their own home varies, but on average is one to two hours, but can vary hugely.

**E: Does ParaDoc provide its services to homeless people and asylum seekers?**

**Response:** Yes, to both. ParaDoc concentrates on the needs of complex groups of patients including asylum seekers and people who ae homeless.

**F: How many calls do you receive monthly?**

**Response**: 180-200 and 60-70 of these are prevented from admission to hospital.

**G: How does ParaDoc respond to patient demand, e.g. pressures on the LAS**

 **and general practice? GPs feel swamped as a result of high demand on their**

 **services and consequently access to GP care can be difficult.**

**Response:** ParaDoc accepts referrals from GPs instead of them calling 999. ParaDoc is a finite service based on one vehicle/team, so on rare occasions may not have 'capacity' to accept further referrals. We can signpost and offer advice in these circumstances. We also triage all calls at the point of contact by the doctor.

**OUR PUBLIC MEETING ON ‘PARITY OF ESTEEM’**

**WITH NORMAN LAMB, CHAIR OF SLAM**

Chair of the South London and Maudsley Trust, Sir Norman Lamb was invited to speak at a meeting of the Patients’ Forum about the impact of the duty to exercise Parity of Esteem on the care provided by the NHS to patients’ mental health problems. We were particularly interested to know how Parity of Esteem has affected the care of patients detained under s135/136 of the Mental Health Act (MHA). Norman Lamb championed the introduction of Parity of Esteem when he was a Health Minister in 2012.

Parity of Esteem is the principle by which patients requiring mental health care must be given equal priority to patients with physical health problems. It was enshrined in law through the Health and Social Care Act 2012. The Government requires NHS England to work for Parity of Esteem between mental and physical health through the NHS Mandate. There are many areas of service provision where Parity of Esteem has not been realised, e.g., mental health care, which accounts for 28% of the burden of disease in the UK, but received only 13% of NHS spending.

[**https://tinyurl.com/bdday77r**](https://tinyurl.com/bdday77r)

Norman said that he often hears stories of patients in a mental crisis waiting in police cars and ambulances for very long periods outside mental health ‘Places of Safety’ (s136 suites in hospitals) and is very concerned that patients who are severely ill are detained in vehicles, when they should be receiving specialist care inside hospital. Many patients also wait for very long periods in grossly unsatisfactory conditions in A&E departments. Ref: Mental Health Emergency (2022)

**https://tinyurl.com/2p9xrbm7**

Early intervention is crucial for patients showing symptoms and signs of mental health problems to prevent psychosis developing. Norman Lamb said that the current situation at SLAM is that patients are waiting six weeks to see a therapist for IAPT and two weeks for patients showing signs of psychosis. There are longer delays for patients with eating disorders and other conditions.

He described the situation in A&E departments where patients in a mental health crisis can wait in excess of 12hrs for a mental health bed and in some cases more than 24hrs. He said that it is common for patients to be sent far away from their home, because there are no local beds and, in some cases, may be sent 100s of miles to the nearest bed. He said that this is a situation where Parity of Esteem is clearly not being exercised, because people with physical illness would not be subject to the same long waits or be transported long distances for treatment. To make matters worse, Norman said that patients are sometimes transported in vans with an internal cage, in which they are locked during transportation to a hospital. He described this situation as a scandal because patients may not know where they are being transported to and are put at a higher risk of suicide. He said this approach to finding beds for patients doesn’t work, is harmful and must be challenged.

Referring to s136 detentions, Norman said that at one time over 50% of people detained by the police under s136, were taken to police stations and locked in a cell, but now people who are detained are rarely taken to a police station – instead, they are taken by the police to a Place of Safety, or to an acute hospitals A&E department. But these departments are often full and have no space or appropriate clinical teams to care for severely ill s136 patients - the police are thus put in the caring role for patients who are acutely ill, rather than being cared for by mental health professionals or specially trained paramedics.

Norman referred to the work of the Crisis Care Concordant, which strongly objected to use of police vehicles and cages to transport patients, because they undermine dignity and respect for the patient. [**www.crisiscareconcordat.org.uk/about/**](http://www.crisiscareconcordat.org.uk/about/)

He said that people with mental health problems face a historic injustice and may die 15-20 years earlier than people without mental health problems. This is partly due to the failure of the NHS to deliver parity in the treatment of physical and mental health.

 **Courtney Grant** described a situation where a young black student was in

 great distress. His parents called the police for help, but the police pinned him

 to the floor, and he died of injuries caused by rough handling by the police. The

 police had exacerbated the situation.

 **Norman Lamb** said he was completely with CG and that it is essential to

 confront the use of force. He said that reducing the use of restraint is essential,

 and recognised that prone restraint has been heavily used in acute mental

 health services, but is now used much less and that the use of force should be

 completely eradicated from mental health services.

**LAS STILL HIDING THEIR PERFORMANCE DATA**

The LAS has consistently failed to provide detailed and up to date performance data since September 2021.

The Forum has made repeated requests for this data and raised the matter through the London Assembly, LAS Commissioners and the ICS (Integrated Care System) for North East London. None of these bodies have been able to persuade the LAS to share their detailed performance data. It is our view that hiding the data is an attempt to conceal from the public the LAS’s very poor performance.

We asked the London Assembly Health Committee to support our reasonable request for monthly performance data produced by the LAS and provided to CCGs/ICS, to be provided to the Patients’ Forum and Healthwatches.

**We wrote to Caroline Russell, Chair of the London Assembly Health Committee on March 21st, 2022, as follows:**

Dear Ms Russell, I am writing to you to raise a matter of concern about the London Ambulance Service.

We have been trying for six months to obtain information from them about the performance of the LAS, which they have refused to provide. We have received this information from the LAS for many years, but the last full data set we have been able to get was from the Commissioners of the LAS (North West London CCG) is dated September 2121. Both the LAS and their Commissioners are refusing to share with us the data pack which is sent to all London CCGs on a monthly basis. Thus, we do not have the full data set for October, November and December 2021 and January and February 2022.

We believe that the data is being refused because it paints a very concerning picture of the performance of the LAS. The LAS do publish a performance report in their Board papers, but this is deficient of data that demonstrates poor performance by the LAS.

The missing data is as follows (I attach the September 2021 data set):

1. Performance by each London CCG area and locality - therefore we cannot compare C1 mean breaches or C2, C3 or C4 breaches by locality or by

CCG/borough/area across London.

1. The hospital conveyance lost hours report published by the LAS is missing the

 following data:

                          - Handovers exceeding 15 minutes - LAS **contractual breaches**
**-**Arrival to handover: % over 15 minutes and the overrun per 15

 minute breach

       -Total time lost over 15 minutes (in hours)
                          - **Handovers exceeding 60 mins**

Over the past few months, we have repeatedly asked both the LAS and the Commissioners for this data, but the LAS has refused to provide their monthly data pack and the Commissioners have told us that they have been told by the LAS not to provide it. They told us to get the data from the NHSE, but the data listed above is not on the NHSE website. We also attempted to get this information through Healthwatch, which does not need to use the FOI to collect data. Healthwatch should have reasonable access to all data they require under s224 of the Local Government and Public Involvement in Health Act, 2007 (amended by section 186 of the Health and Social Care Act 2012). “Duties of responsible persons to respond to Local Healthwatch organisations or contractors”. As an example of good practice, the Homerton Hospital provides data every day on their A&E performance and compliance with targets.

**The London Assembly Health Committee** used this letter and ‘Our Statement for the Mayor’s Health Team’ (https://tinyurl.com/yph6cjen) in their investigation of the LAS and produced the following response and recommendation:

**Involving patient voice in LAS decision-making**

Evidence presented to the London Assembly Health Committee through our call for evidence, suggests that the LAS could do more to involve patient groups in policy development and decision-making processes. In particular, responses mentioned the desire for patient groups to have greater access to LAS performance data. High levels of engagement and transparency should be the norm, in order to allow patients to constructively feed into decisions on how services are delivered.

One of the development principles of the LAS Strategy 2023-2028 is that it should be co-developed and co-produced with partners including patients and the public. The Health Committee believes that this should be an overarching principle for the LAS and should guide their operations throughout the lifespan of the strategy, not just in its development. By better involving the patient voice, in particular those experiencing health inequalities, the LAS can become a more responsive organisation better placed to serve London’s diverse communities.

**Recommendation 1***:* ***The LAS should include in its new strategy commitments to increase levels of patient engagement, in order to give patients a greater say in how services are delivered.***

**BREACH OF THE NHS CONSTITUTION BY LAS AND THEIR COMMISSIONERS**

1) The NHS is accountable to the public, communities and patients that it serves.

2) The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.

3) The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

4) The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

5) Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS.

6) We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

**SICKLE CELL DISORDERS IN THE TIME OF COVID**

**John James, Chief Executive, Sickle Cell Society - SCS**

John James opened his presentation by referring to the publication by the All-Party Parliamentary Group (APPG)/Sickle Cell Society of a report called **‘No One’s Listening’,** in which MPs called for urgent changes to the quality of care for patients suffering a sickle cell crisis. 31 recommendations were made in the report. The inquiry found “serious failings” in care provided by the NHS.

The Report published on 15th November 2021, followed an inquiry into avoidable deaths due to inadequate care provided to sickle cell patients. John said that the APPG inquiry highlighted shocking failures in acute service provision, and racist attitudes by some services providing care to patients with sickle cell disorders.

John James said that Implementation of the 31 APPG recommendations would radically improve the care of patients with SCD. The SCS has met the Secretary of State for Health to get his support for implementation of the 31 recommendations, and the SCS is now seeking the support of the GMC, NMC, and the NHS Race and Health Observatory. He said that the NMC has not been adequately supportive. [**www.sicklecellsociety.org/no-ones-listening/**](http://www.sicklecellsociety.org/no-ones-listening/)

Survey results relating to people with sickle cell disorders, showed that 97% survived the epidemic, and 66% of people in a sickle cell crisis dealt with the crisis in their own homes. Deaths that did occur related to comorbidities. Very few people with sickle cell disorders were infected with Covid, and there was no need for high level respiratory support for either adults or children who were infected. There was no evidence of resistance to vaccination from those with sickle cell disorders. Those who were shielding felt its impact affected their mental health and general wellbeing more than Covid did on their physical health. Very few children with SCD were infected. Those with SCD who were admitted to hospital were mostly unvaccinated.

John described some of the findings of the ‘No One’s Listening’ report, which included the impact of racism on patients attending EDs or who were admitted to hospital wards. Appalling treatment was provided to some patients, especially young men and women. The death of Evan Nathan Smith was one of the most tragic cases - he was admitted to a general ward at North Middlesex Hospital while in crisis and was abandoned by care staff. In desperation he dialled 999 from the ward to get help. The failure of care led to his death. He was described by staff as troublesome because of his behaviour when in a painful crisis and security guards were called.

The Sickle Cell Society is campaigning for a Health and Social Care Select Committee Inquiry into failures of care in this case, and the sub-standard care for patients with SCDs; despite clear NICE Guidelines.

**Their investigation priorities for the inquiry are:**

A) Failure of compliance with the NICE Guidelines, in relation to coordination of care.

B) Treatment in general hospital wards and EDs being inadequate due to poor training and failure of staff to understand the needs of patients in a SC crisis.

C) Racial bias impacting on care, disrespect of patients and not listening to them. This includes false allegations that people in a crisis are ‘troublemakers’, who are noisy and aggressive after taking drugs for treatment of their SC crisis.

D) Limited investment into the treatment of patients with SCD and inadequate research into how the needs of patients can best be met.

E) Ensure that patients in a SC crisis are taken to a hospital with the necessary expertise and skills to provide the expert treatment for patients in a crisis.

**https://tinyurl.com/zhzzz2n8**

[**https://www.sicklecellsociety.org/evannathansmith-update**](https://www.sicklecellsociety.org/evannathansmith-update/)

**QUESTIONS TO JOHN JAMES**

1. **There are many sickle cell groups across London, do they have an**

**important role in challenging hospital services when the care provided is poor?**

**Response**: JJ said there are 40 groups across London who work with local hospitals, but they do not have the capacity and resources to challenge hospitals on the standard of care provided. JJ said the groups need capacity and resources to become effective in influencing services.

**2) Joseph Healy: Would the Sickle Cell Society support the Covid Action**

**campaign to increase awareness of Covid, because it is still rampant, e.g.**

**through a return to wearing masks as is the case in France.**

**Response:** JJ would be pleased to hear from Joseph Healy about the campaign.

**3) Logie: How many people with SCD died due to Covid, and whether there is a national campaign to inform people about SCDs and associated risks.**

**Response:** 6 deaths from Covid are known about. The SCS is talking to Amanda Pritchard, CE of NHS England about implementation of recommendations from the APPG, and how NHS staff can be trained to provide the best treatment for patients with SCDs.

**4)Sister Josephine: Was the APPG inquiry held because standards of care for people with SCD are deteriorating?**

**Response:** Lola Oni, a Specialist Nurse Consultant and Service Director at Brent Sickle Cell/Thalassaemia Centre, said that the issues raised in the ‘No One’s Listening’ report are not new and have been causing major concern for many years. She said it is essential to hold the NHS to account for the provision of high-quality SC services in EDs and hospital wards. She added that training and development of staff providing care to people with SC needed to be dealt with urgently.

JJ added that holding the NHS to account was essential to ensure access to high quality standards of care, which are compliant with contractual response times and NICE guidelines.

**Inez Taylor asked whether Evan Nathan Smith had received any SC treatment in hospital prior to his death.**

**JJ replied that when Evan was admitted to the hospital nobody was listening to him. NICE guidelines should have been followed. He should have had a specialist package of continuing care. Some people in crisis are treated at home, but if patients are admitted to hospital, they need specific care related to their symptoms.**

**SICKLE CELL DATA**

**FORUM’S QUESTIONS TO LAS MEDICAL DIRECTOR,**

**DR FENELLA WRIGLEY**

Dear Fenella, as you know we have been working with the Sickle Cell Society and other sickle cell groups for many years, and through our joint work with the LAS achieved significant service improvements for patients suffering from a sickle cell crisis. We have received a number of questions from Kye Gangola who is the Chair of the Sickle Cell Society and Chair of the Public and Patient Voice Group, of the West London Specialist Centre for Sickle Cell Disease. As you know the Patient and Public Voice Group, works with the steering group of the Sickle Cell Network (HCN) to establish priority working.

The PPVG commend the LAS for the excellent data received by the joint Renal and Haematology Unit (RHTU) at Hammersmith Hospital. We would now like to access to the following LAS data. Would you please be kind enough to make this data available? The questions are:

1) Does the LAS hold any records on the administration of analgesia given by LAS staff to patients in their homes, other locations and in ambulances? i.e. is there data on the type of analgesia given to patients and the length of time taken to administer it, post contact between the LAS and the patient in a sickle cell crisis?

2) Does the LAS hold data on the length of time it takes the LAS to respond to patients in a sickle cell crisis, in each ICS sector in London?

If this data does exist, is it comparable to other reasons for ambulance call-out in Cat 2 cases (i.e. stroke, heart attack, injury, respiratory issues)?

3) Is there information available on the category of LAS ambulance response to patients in a sickle cell crisis? We assume it is always Cat 2, but is this always the case? How does the response category effect the type of treatment/analgesia available to patients?

4) Is there a standardised protocol that ambulance crews have access to for the treatment of Sickle Cell patients in crisis?

5) Is data available on the use by LAS crews of personalised protocols that have been created by the Specialised Haemoglobinopathy Units, CMC or other advanced clinical treatment plans?

6) Does the LAS have data on how many occasions personalised protocols have been used to guide staff in the treatment of patients with SCDs over the past year?

**Sickle Cell Data – Example of Data Provided by Tim Edwards, LAS Consultant Paramedic – 1/1/2020 – 22/9/2022.**

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| --- | --- | --- | --- | --- | --- | --- |
| **Post Code** | **Age****Years** | **Hospital**  | **AMPDS****Code** | **DH-Cat** | **Response** **Time** | **Drug admin** |
| W9 3 | 48 | Hammersmith | 36C5A | C3 | 00:14:00 | MOR |
| W9 3 | 48 | Hammersmith | 26C3 | C2 | 00:04:53 | MOR |
| SW1P 2 | 36 | St Thomas’  | 26C3 | C2 | 00:09:46 | NOO |
| E5 9 | 52 | Royal London | 21D5M | C1 | 00:09:17 | MOR |
| 1G8 9 | 45 | Homerton | 26C3 | C2 | 00:19:51 | MOR |
| SW4 6 | 21 | King’s  | 36C5A | C3 | 00:11:20 | NOO |
| SW1 2 | 27 | St Thomas’  | 26C3 | C2 | 00:31:20 | MOR |
| SE1 4 | 23 | Declined against advice | Dx012 | C3 | 01:12:32 | NULL |
| SE15 5 | 23 | St Thomas’  | 26C3 | C2 | 00:10:58 | MOR |
| NW9 0 | 31 | No trace | 21D5M | C1 | 00:03:44 | OXG |
|  |  |  |  |  |  |  |

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**REPORT AND FINANCIAL STATEMENT FOR THE YEAR ENDED**

**31 DECEMBER 2022**

The Trustees have pleasure in presenting their Report and Financial Statement for the year ended 31st December 2021.

 **INCORPORATION**

The Company (No 6013086), which was incorporated on 29 November 2006 under the Companies Act 1985, is a not-for-profit private Company Limited by Guarantee, with no share capital, and is registered with the name of Patients’ Forum Ambulance Services (London) Ltd.

Its Memorandum and Articles of Association are in the model format for a charitable company as issued by the Charity Commission. Its objectives and activities are those of a small un-registered Charity, as described more fully in this Report.

The ***nature of the company’s business is covered by the classification code categories:***

***86900*** - Other human health activities, and 94990 - Other membership organizations.

**DIRECTORS AND TRUSTEES**

The Directors of the company are its Trustees for the purpose of Charity Law. As provided in the Articles of Association, the Directors have the power to appoint additional directors. The Trustees who have served during the year and since are:

* Malcolm Alexander
* John Larkin
* Louisa Roberts
* Rev Sister Josephine Udie

Patients’ Forum Ambulance Services (London) Ltd comprises members of the public, including patients and carers.

The office of the Patients’ Forum is located in London.

**ACTIVITIES AND ACHIEVEMENTS**

Since 1st April 2008, the Patients' Forum has established itself as a corporate body in the voluntary sector.

The Forum has continued to work with the London Ambulance Service and other health bodies in London and beyond, ensuring that a body of experienced people exists who can be highly effective at monitoring services provided by the London Ambulance Service and other providers, and commissioners of urgent and emergency care. The Company has worked closely with Local Healthwatch since their establishment on 1st April 2013.

The Forum has successfully monitored services provided by the London Ambulance Service and worked successfully with the voluntary sector and the Northwest London

Commissioning Support Unit which commissioned the LAS, as well as forming links with patients, patients' groups and the public.

The Forum has successfully carried on its commitment to supporting and influencing the development of high quality urgent and emergency health care.

From the outset, the Company invited and received a constructive letter of mutual recognition and understanding from the Chief Executive of the London Ambulance Service, in confirmation and furtherance of the good working arrangements that have long characterised the relationship between the London Ambulance Service and the Patients' Forum. The Forum has long continued consistently to rely on this document as affirming and reinforcing its relationship with the LAS.

The range of issues within the independent purview of the Company is frequently updated as necessary, and participation is readily accessible to members and the public by attending the Forum’s regular meetings and/or visiting the Company’s website – *www.Patientsforumlas.net.*

The plan for the Forum is to expand and to seek to raise funds to support its charitable activities, and to continue to meet in public to support and to influence the development of patient centred ambulance and other health services that meet public need.

Members from across London, and Affiliates from all parts of the UK, are very welcome to join us.

**MEMBERS AND AFFILIATES**

All the Trustees are members of the Company. During the year ended 31 December 2021, the Company also enrolled several other members of the Company.

Each member guarantees, in accordance with the Company's Memorandum of Association, to contribute up to £10.00 to the assets of the Company in the event of a winding up.

Membership is open to individuals who are London based at the time of joining.

Members are entitled to attend meetings of the Company, and to vote thereat. The Annu

al Membership fee for individuals is £10.00. New members are welcome to join.

**AFFILIATION**

* Affiliation is open to groups, organisations and to individuals, both local and national.

* Affiliates are fully entitled to attend meetings of the Company, but not to vote thereat.
* The Annual Affiliation fee for groups and organisations is £20.00.
* The Annual Affiliation fee for individuals is £10.00. New Affiliates are welcome to join.

This Report was approved by the Directors/Trustees on 2022 and is signed on their behalf by:

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Malcolm Alexander John Larkin

Director/Chair Director/Company Secretary

**PATIENTS’ FORUM AMBULANCE SERVICES**

**(LONDON) LTD**

**INCOME AND EXPENDITURE ACCOUNT**

For the Year Ended 31 December 2022

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Unrestricted** **Funds****2022** | **Total** **2022** | **Total** **2021** |
|  |  £ |  £ |  £ |
| Incoming Resources |  |  |  |
| Grants |  - |  - |  - |
| Donations |  200 |  200 |  -  |
| Membership fees |  140 |  140 |  50 |
| Affiliation fees |  40 |  40 |  30 |
| Investment income |  2 |  2  |  3 |
| Other |  34 |  34 |  - |
| Total Incoming Resources |  416 | 416 |  73 |
|  |  |  |  |
| Resources Expended |  |  |  |
| Renewal of website |  51 |  51 |  24  |
| Incidental administrative expenses claim |  - |  - |  - |
| Companies House fees expenses |  40 |  40 |  80 |
| Bank charges |  31 |  31 |  - |
| Total Resources Expended |  122 |  122 |  104 |
| Net Incoming/(Outgoing) resources for year |  294 |  294 |  (31) |
| Total funds brought forward |  3193 |  3193 |  3224 |
| Total funds carried forward |  3487 |  3487 |  3193 |

**BALANCE SHEET - 31 December 2022**

|  |  |  |
| --- | --- | --- |
|  | **TOTAL 2022****£** | **TOTAL 2021****£** |
| FIXED ASSETS |  - |  - |
| - Debtors |  - |  - |
| - Cash in hand |  - |  - |
| - Cash in bank |  3487 |  3193 |
| - Gross current assets |  3487 |  3193 |
| CREDITORS |  |  |
| - Amounts falling due within one year  | - |  - |
| NET CURRENT ASSETS | 3487 |  3193 |
| TOTAL ASSETS LESS CURRENT LIABILITIES | 3487 |  3193 |
| RESERVES |  |  |
| - Restricted funds | - | - |
| - Unrestricted funds | 3487 |  3193 |
| **TOTAL FUNDS** | **3487** |  **3193** |

**NOTES**

1. These accounts have been prepared in accordance with the provisions applicable to companies subject to the small companies’ regime.
2. For the year ended 31 December 2022 the Company was entitled to exemption under Section 477 of the Companies Act 2006.
3. No notice from members requiring an audit of the accounts has been deposited under Section 476 of the Companies Act 2006.
4. The Directors acknowledge their responsibility under the Companies Act 2006 for:
	1. Ensuring the Company keeps accounting records which comply with the Act; and
	2. Preparing accounts which give a true and fair view of the state of affairs of the Company as at the end of its financial year, and of its income and expenditure for the financial year in accordance with the Companies Act 2006, and which otherwise comply with the requirements of the Companies Act relating to accounts, so far as applicable to the Company.
5. Patients’ Forum Ambulance Services (London) Limited is a registered Company limited by guarantee and not having a share capital; it is governed by its Memorandum and Articles of Association. It is an un-registered Charity whose income is currently insufficient to fulfil the criteria for compulsory registration with the Charity Commission.

 This Financial Statement was approved by the Trustees on 2023 and is

 signed on their behalf by:

Malcolm Alexander- Director/Chair John Larkin - Director/Company Secretary

**OBJECTS OF PATIENTS’ FORUM AMBULANCE SERVICES (LONDON) LTD**

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

The Company was duly encouraged to progress in the voluntary health sector as an independent catalyst for more than a decade of fruitful co-operation, whilst promoting a mutual observance of pan-NHS legislation as well as pan-NHS constitution and guidelines, actively achieving constructive public benefit through patient and public healthcare and involvement across London and beyond.

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

1. The advancement of health or the saving of lives, including the prevention or relief of sickness, disease, or human suffering; and
2. 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 if, and when, appropriate.

**APPENDIX 1 – GLOSSARY**

ACP … … … Advanced Care Plan

A&E … … … Accident and Emergency Department

AMPH … … … Approved Mental Health Professional

APPG … … … All Party Parliamentary Group

ARP … … … Ambulance Response Programme

BME … … … Black and Minority Ethnic

CARU … … … Clinical Audit Research Unit

Cat 1 … … … Target - life threatening conditions – 7 minutes

Cat 2 … … … Target - urgent/emergency conditions - 18-40 mins

CCG … … … Clinical Commissioning Group

CPN … … Community Psychiatric Nurse

CPR … … Cardiopulmonary Resuscitation

CSR … … … Corporate Social Responsibility

CQC … … … Care Quality Commission

CQRG … … … Clinical Quality Review Group

CQUIN … … … Commissioning for Quality and Innovation

CmC … … … Co-ordinate my Care

CTA … … … Clinical Telephone Advice

DKA … … … Diabetic Ketoacidosis

DNAR … … … Do Not Resuscitate Notice

DoS … … … Directory of Services

EBS … … … Emergency Bed Service

ED … … … Emergency Department (A&E)

EI … … … Equality and Inclusion

EHRC … … … Equality and Human Rights Commission

ELFT … … … East London Foundation Trust

EOC … … … Emergency Operations Centre

EoLC … … … End of Life Care

FOI … … … Freedom of Information Act 2000

FT … … … Foundation Trust

GDPR … … General Data Protection Regulation

HCA … … … Health Care Assistant

HCPC … … … Healthcare Professions Council

ICS … … … Integrated Care System

ICB … … … Integrated Care Board

KPI … … … Key Performance Indicators

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­LGBT … … … Lesbian, Gay, Bisexual and Transgender

MAR … … … Multi Attendance Ratio

NASMeD … … National Ambulance Service Medical Directors’ Group

NETS … … … Non-Emergency Transport Service

NHSE … … … NHS England

NHSI … … … NHS Improvement

NRLS … … … National Reporting and Learning Service

PPI … … … Patient and Public Involvement

PRF … … … Patient Report Forms

RCEM… … … Royal College of Emergency Medicine

SCA … … … Sudden Cardiac Arrest

SCS … … … Sickle Cell Society

SCD … … … Sickle Cell Disorders

SECAMB … … South East Coast Ambulance Service

SI … … … Serious Incident

STP … … … Strategic Transformation Plan

WMAS… … … West Midlands Ambulance Service

WRES … … Workforce Race Equality Scheme

**APPENDIX 2 - PROTECTED CHARACTERISTICS**

**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 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 3 – MENTAL HEALTH RECOMMENDATIONS**

**RECOMMENDATIONS TO THE ICS, ELFT AND HEALTHCARE HOMERTON**

**RECOMMENDATION 1 – ACCESS TO PERFORMANCE DATA**

a) Supply monthly data to Healthwatch Hackney (HWH) and the Patients’ Forum

 for the LAS (PFLAS), showing the number of patients waiting in excess of

 4 hours and in excess of 12 hours from decision to admit.

b) Send monthly bed occupancy data for the six Homerton MH wards to HWH and

 PFLAS.

c) ELFT to share their daily acute care performance reports with HWH and the

 PFLAS.

**RECOMMENDATION 2 - DECLARATION OF SERIOUS INCIDENTS**

Clarify when it is a duty on Homerton Healthcare to declare long stays in A&E as Serious Incidents requiring investigation, in view of the increased risk of harm to service users who remain within ED for over six hours.

Clarify when it is a duty on ELFT to declare long stays in the statutory Place of Safety as Serious Incidents requiring investigation, in view of the possible increased risk of harm to service users who remain within Places of Safety for long periods.

**RECOMMENDATION 3 - POLICIES ON PARITY OF ESTEEM**

1. Provide a copy of the Homerton Healthcare policy on compliance with the duty to exercise Parity of Esteem between patients who have a physical health problem, and those with a mental health problem.

 <https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/>

1. Provide a copy of the Homerton Healthcare policy on returning patients to

their home area mental health service, if this would in practice result in ‘spot purchasing of a bed in a private Hospital far from the patient’s home.

**RECOMMENDATION 4 - HIGH QUALITY CARE ALWAYS**

Ensure that high quality mental health care is always provided to patients who are waiting for admission to a mental health bed at Homerton or to their home area.

**RECOMMENDATION 5 - CONSENT FOR TRANSFER TO ALTERNATIVE MH UNIT**

1. If a patient is to be transferred from the Homerton ED to their home area,

 ensure that the patient has given consent for this transfer.

1. If a patient is to be transferred to a private facility outside their home area,

 ensure that the patient has given consent to be provided with care, away

 from their home area.

**RECOMMENDATION 6 - ADMIT TO A HOMERTON BED UNTIL A BED IS**

 **AVAILABLE IN THE HOME AREA**

Admit patients to a bed in ELFT if it would take more than 12 hours to locate a bed in the patient’s home area, i.e. with patients consent return to previous policy of taking patients to their home area only when a local bed is available.

**RECOMMENDATION 7 - AGENCY COLLABORATION TO STOP LONG WAITS**

Homerton Healthcare NHS Foundation Trust should work with ELFT and other partners in the City and Hackney Health and Care Partnership and the NEL ICS, to reduce and eventually eliminate very long waits, with the aim of bringing waiting times for patients in a mental health crisis back to no more than four hours from decision to admit to admission.

**RECOMMENDATION 8 - OPEN MORE BEDS AND DEAL WITH PUBLIC HEALTH**

 **ISSUES**

The ICS, HUH and ELFT should publish an assessment of the resources they would need to provide more mental health beds in Hackney, in order to return to maximum 4 hour waits in ED, from decision to admit to admission to a mental health bed, and ensure resources are used to meet the challenges of population need and health inequalities in relation to mental health.

**RECOMMENDATION 9 – DETERMINING REQUIRED NUMBER OF MH BEDS**

**IN NEL TO STOP EXCESSIVE WAITS FOR ADMISSION**

The NEL ICS should determine how many beds would be needed in North East London to stop MH ED waits in excess of 4 hours and publish a plan to open the required beds within the NHS – not the private sector.

**RECOMMENDATION 10 - ETHNICITY DATA**

Publish data each month on the ethnicity of patients who are held in ED in excess of 4 hours and in excess of 12 hours from decision to admit to admission to a bed or discharge.

**RECOMMENDATION 11 - CLOSER WORK WITH LOCAL AUTHORITY TO**

**SECURE ADEQUATE AND APPROPRIATE ACCOMMODATION**

Work better with local authorities to ensure that supported accommodation is available as required for patients discharged by ELFT who are homeless.

**Further Questions to Paul Gulliley – Medical Director, ICS NE London**

1. What action is now being taken by London’s Chief Medical Officers and the NE London, Urgent and Emergency Care Group, to reduce waits in ED for patients in a mental health crisis to no more than 4hrs?
2. Have London’s Medical Directors discussed setting up Mental Health Crisis Hubs across London, where patients in a mental health crisis can receive effective mental and physical health care to meet their needs in an effective and compassionate way?
3. What action is being taken by the ICS to build resilience and meet the mental health needs of children and young people post-Covid?
4. Will the ICS consider using the St Leonard’s Hospital site as a location for development of mental health services for older people, intermediate care, and step-down care for patients preparing for discharge? This would be consistent with the ICS focus on developing local services and ‘place.

**APPENDIX 4 – Complaint Charter Agreed with LAS**

**LAS COMPLAINTS CHARTER**

The LAS Complaints Charter was written by the Forum and agreed by the LAS Board. However, they were unwilling to share the Charter with people who made complaints e.g. by sending the Charter directly to complainants. They have now removed the Charter from their website. The commitments by the LAS were as follows:

**WHEN YOU ARE DISSATISFIED WITH HEALTH CARE SERVICES**

* Tell us, as soon as possible, if you are unhappy with our services so that we can investigate your concerns and quickly try to put things right for you.
* Tell us if you have any particular needs that we should be aware of, e.g. an interpreter or other ways of ensuring effective communication with you.

**OUR COMMITMENT TO YOU - WE SHALL …**

* Acknowledge your complaint within three working days and explain how we shall handle your complaint/s and what information we need.
* Give the contact details of the person or team that will investigate your complaint. • Keep you updated if it takes longer than we had hoped to respond and explain our progress in the investigation of your complaint.
* Pledge that making a complaint will not adversely affect your ongoing or future treatment in any way.

**WE WILL FOLLOW AN OPEN AND FAIR PROCESS BY**

* Listening to you carefully and fully understanding your complaint. • Requesting all the information we need from you.
* Explaining how we shall investigate all your specific concerns.
* Being open and honest throughout the investigation, by ensuring the Duty of Candour (DoC) is complied with and you receive copies of any relevant reports.
* Providing a comprehensive response to your complaint.
* Letting you know about local complaints advocacy services or other appropriate advocacy services to support and advise you during any complaint investigation.
* Explaining our decisions and recommendations, and how we reached them.
* Carefully evaluating all the information we’ve gathered to make a decision on your complaint and explaining how to contact and make recourse to the Health Service Ombudsman if you are dissatisfied with our findings.

**WE SHALL GIVE YOU AN EXCELLENT SERVICE BY**

* Treating you with courtesy and respect.
* Aiming to give you a final decision on your complaint within 35 working days – or explain the reason for any delay.
* Making sure our complaints service is easily accessible to you and giving you support and help if you need it.

[**www.patientsforumlas.net/complaints-charter-and-complaints.html**](http://www.patientsforumlas.net/complaints-charter-and-complaints.html)

**APPENDIX 5 – Co-Production Charter Agreed with LAS**

**CO-PRODUCTION CHARTER FOR URGENT AND EMERGENCY AMBULANCE SERVICES IN LONDON**

The Patients’ Forum wrote the Co-Production Charter in 2019, in collaboration with Healthwatch Hackney. It provides a unique opportunity for enhancing and growing the production of patient-centred services in line with the duties imposed on the LAS by the NHS Constitution. The Charter provides dynamic advantages for further collaboration and co-production with patients and the public.

Trisha Bain, Chief LAS Quality Officer, formally agreed to accept the Charter at a meeting with the Forum President, Joseph Healy, and Chair, Malcolm Alexander, but the LAS have never implemented it. Some of the key aspirations of the Charter follow; the full contents of the Co-Production Charter can be seen at:

[**www.patientsforumlas.net/co-production-with-the-las.html**](http://www.patientsforumlas.net/co-production-with-the-las.html)

1. THE LONDON AMBULANCE SERVICE AND THE PATIENTS’ FORUM AGREE THAT:
* Services are organised so that they meet people’s needs.
* Patients will have a stronger voice in the LAS than ever before.
* The patient is at the centre of everything that the LAS does.
* The LAS will listen to staff and patients to determine priorities.
* Patients and carers will be involved in all LAS improvement work.
* Integral to all LAS programmes must be robust patient and staff involvement.
* LAS will listen to patients, families and carers, and respond to their feedback.
* The LAS goal is to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently.
* LAS will widen and increase public involvement in the development of pioneer services and the monitoring of success.
* A co-designed and co-developed patient and staff engagement model will be used to drive quality improvement across the maternity care model.

***(Statements from the 2018/19 LAS Quality Account)***

1. THE LONDON AMBULANCE SERVICE (LAS) AND PATIENTS’ FORUM FOR THE LAS (PFLAS) AGREE THAT THE CO-PRODUCTION CHARTER:
* Provides an effective means of designing, shaping and delivering services in a partnership between the LAS and people who have used the service or may use it in the future.
* Enables delivery of our shared objectives for the creation of better services

and outcomes for patients.

* Sets out the potential outcomes that people can expect from the co-production of

 urgent and emergency care services and other LAS care services.

* Sets out responsibilities of people taking part in the co-production of services.
* Establishes principles which are intended to achieve a vision of service users as

 equal partners in the production of effective urgent and emergency care.

* Signals the direction of travel for integrated service development between the LAS, patients and the public.

C. PATIENTS AND THE PUBLIC WILL BE ENCOURAGED TO:

1. Participate at the earliest stages in design or redesign of services, where such

 changes may affect their care, treatment, or interaction with front- line staff.

1. Operate and function as equally valued voices, assets and partners.

D: EFFECTIVE COLLABORATION IS ESSENTIAL FOR EFFECTIVE

 CO-PRODUCTION:

1. LAS and the PFLAS agree to work collaboratively in the best interests of service

 users and the enhancement of their care.

1. The LAS and PFLAS agree to ensure that proposals for service changes and improvements will be the subject of joint work from initiation of the process to

completion, including feeding back to service users on the results and

outcomes of co-production.

E. PROMOTING EQUAL OPPORTUNITIES TO INFLUENCE CHANGE

 THE LAS AGREES TO:

1. Acknowledge differences in the capacity to effect change and in access to

resources between all those who participate in Co-Production of LAS services.

1. Ensure the differential in influence and resources will not hinder the design of enhanced care for users of urgent and emergency services.
2. Provide access to all information/ documentation relevant to achieving shared

goals of Co-Production in service design and creation.

1. Value equally all those who participate in and contribute to the joint process of Co-Production and decision making.

**APPENDIX 6 - THE FORUM’S MISSION STATEMENT**

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.

WE SHALL:

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

(2) Work with other service user networks that champion the needs of patients.

(3) Further develop campaigns for better and more effective emergency and urgent care services, and 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 LAS clinical staff and receive effective and timely responses.

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

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

(7) Work with partners to develop better solutions for the care, transport and disposition of people with severe mental health problems and their carers, that respects their wishes and meet their needs. The Forum promotes 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 better assessment, clinical effectiveness and care for people who suffer from cognitive impairment and dementia.

(9) Work with the LAS to develop effective systems and protocols, that ensure the wishes of patients with Advance Directives and Care Plans are respected, and that their care is provided completely in accordance with their prior decisions and wishes.

(10) Work with LAS equality, diversity and inclusion leads to promote effective training of all LAS front-line staff in provision of care for London’s diverse communities, in relation to all protected categories identified by 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 disorders and mental health c

**APPENDIX 7 - THE PATIENTS’ FORUM LEAFLET**



