

# The London Ambulance Service (LAS)





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## Introduction

Healthwatch Barking and Dagenham decided to look into the London Ambulance Service since service users have often fed back to us about their experiences of the service over the last few months. Also the LAS have received a lot of bad press recently and have frequently been in our local newspaper.

To complete this piece of work, Healthwatch Barking and Dagenham met with Margaret Luce (Head of Patient & Public Involvement and Public Education) and Steve Ford (Lead Duty Station Officer at the Romford Complex). We spent half a shift with an ambulance crew. We collected information from letters sent to The Rt Hon Earl Howe (Parliamentary Under Secretary of State for Quality) from Malcolm Alexander (Chair of the Patients' Forum for London Ambulance Service) and the London Ambulance Service (LAS) website. Finally we gathered patients' feedback on Streetlife, surveyed service users at the A&E departments of Queen's Hospital and King George's Hospital and received BHRUT patients' feedback on the ambulance service.

Healthwatch Barking and Dagenham are the voice of local people, groups and networks. We are independent and therefore do not have a pre-set agenda or a pre-determined interest in influencing the outcome of the results of a consultation.

This document represents a collective public response to the consultation and is a random sample. This has been conducted impartially - Healthwatch Barking and Dagenham have no organisational view.

Copies of this report are available by contacting Barking and Dagenham Healthwatch on 020 8596 8200 or by emailing us on [info@healthwatchbarkinganddagenham.co.uk](mailto:info@healthwatchbarkinganddagenham.co.uk).

If you would like a hard copy of this report or if you require it in an alternative format please contact us.



The London Ambulance Service (LAS) in the BHRUT area (Havering, Redbridge and Barking & Dagenham) currently has over 165 frontline staff across several shift patterns. Although the cover varies across days of the week (based on historical/planning data), as an average there are:

- 15 early (6am-4pm) ambulances and 5 fast response cars,
- 6 late (2pm-10pm) ambulances and 2 fast response cars and
- 8 night (10pm-6am) ambulances and 3 fast response cars.

### **Calls Categories**

A 999 call goes to Waterloo or Bow. Basic information including where the patient is and the nature of the problem is taken by a non medical member of staff asking questions from a complex system named 'the Advanced Medical Priority Dispatch System'. The information they obtain gets inputted so that another member of staff can effectively dispatch the closest and most appropriate help.

A clinical 'hub', who are medics, are at hand to help with more complex calls. Mental health and palliative nurses will soon become available too.

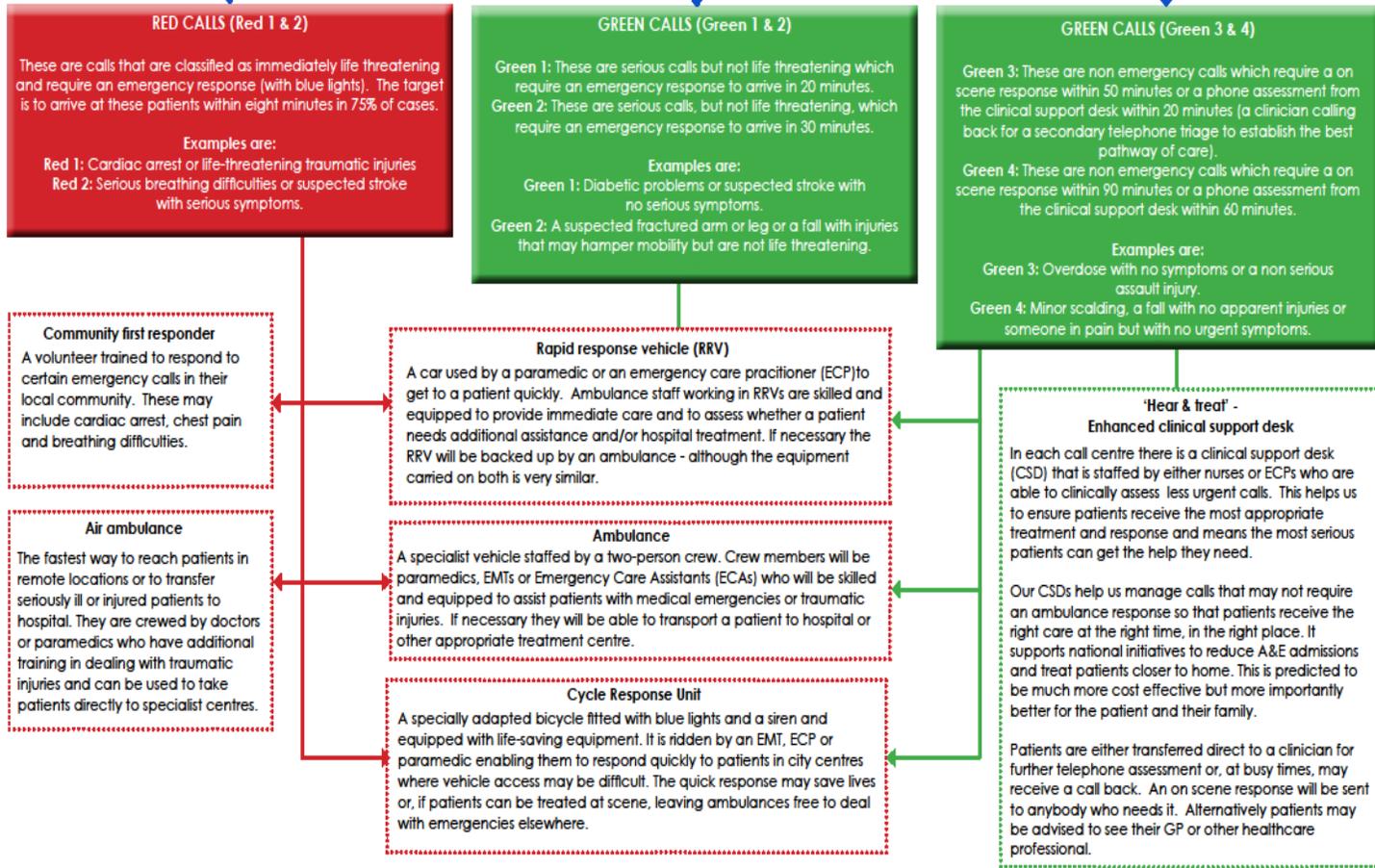
Since April 2011, following the removal of Category B (serious but not immediately life-threatening), calls are handled as either Category A (RED: immediately life-threatening) or Category C (GREEN: not serious or life-threatening) only.  
See diagram below.

# What happens when you call 999 for an ambulance?

A call handler answers and checks the caller's telephone number, address of the incident and reason for calling.

Depending on the nature of the call, the call handler will either advise the caller about the assistance they will receive and end the call, or stay on the line, offering practical help and advice where necessary.

Following a thorough clinical assessment using an internationally accredited system each call is given a prioritisation category based on the information given by the caller.



*The Advanced Medical Priority Dispatch System (AMPDS), is an Emergency Medical Dispatch (EMD) system developed and marketed by Priority Dispatch Corporation. AMPDS is primarily used in the United Kingdom and Ireland, where it is medically approved. The developer has similar products for police and fire.*

*AMPDS provides a unified system used to dispatch appropriate aid to medical emergencies. It includes systematized caller interrogation and pre-arrival instructions. The caller responses are used as inputs to gain a main response output category - A (Immediately Life Threatening), B (Urgent Call), or C (Routine Call). This can link to a performance targeting system such as ORCON to match call metrics to their targets, such as category response time. For example, in the United Kingdom, calls rated as 'A' on AMPDS have an 8 minute responder-on-scene target.*

*Each call is also assigned a sub-category or code, often used as a means of gathering further statistics about performance. It also helps when analysing the calls for how the call was described by the informant, compared to the injury or illness found when the crew attend. This can then be used to help improve the questioning system which gives the AMPDS classification. Each category is numbered from 1 (abdominal pain) through 32 (unknown). This is usually used for brevity and privacy over the radio. In some areas instead of the A, B, C categories, A (alpha) through E (echo) are used. (Wikipedia)*

**Response Time**

At the moment the BHRUT LAS’s response time is 2 minutes over the 8 minutes and 45 seconds response time guideline at 10 minutes and 45 seconds.

The Government aim for 75% of Category A (cardiac arrest / life-threatening traumatic injuries or serious breathing difficulties / suspected stroke with serious symptoms) calls to receive appropriate help within 8 minutes. Barking and Dagenham response time is as follow:

	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14
Barking & Dagenham	61%	56%	60%	52%	47%	55%

The response time is longer than it should be because of:

**1. A lack of staff**

Until 2 years ago staff stayed on for a very long time but with the change of leadership, the education process (paramedics now need a degree in Paramedic Science as well as a full manual UK driving licence) and the fact that staff are encouraged to use their skills in other areas of the NHS, there is a lack of frontline staff. LAS has therefore had to recruit in Australia and New Zealand (they recently recruited 157 new paramedics).

In a letter addressed to The Rt Hon Earl Howe, Parliamentary Under Secretary of State for Quality, Malcolm Alexander, Chair for Patients’ Forum for London Ambulance Service, wrote: ‘Ambulance staff are under intolerable 100% pressure at the moment. Long shifts, staff shortages, no lunch breaks and relentless pressure to keep people out of A&E. They are at the edge of a precipice, and although staff are being recruited from Australia, this is a short term solution. We urgently need active recruitment of

*paramedics from our inner cities - we can't rely upon recently graduated Australian paramedics in the long term.'*

Long term, there is a need to recruit in the UK but the need for a degree seems to be putting people off the training.

At the moment there are 400 vacancies in the London Ambulance Service according to Malcolm Alexander, Chair of the Patients' Forum for the London Ambulance Service.

## 2. An increase in the demand

This table shows the increase in Category A (cardiac arrest / life-threatening traumatic injuries or serious breathing difficulties / suspected stroke with serious symptoms) calls in various locations in 2014:

Cat. A Increase in Demand (2014)	London	BHRUT	B&D	Havering	Redbridge
	7%	13%	12.4%	14.8%	13.2%

According to the managers we talked to, the reasons for the increase are multiple but they suggested that:

- the largest call group is the 24-31 age bracket. This is the Generation Y. They are young people with high expectations, the 'now generation'.
- cuts have created gaps in the provision of other services for vulnerable people such as mental health, social services and drugs and alcohol users.

However, we were told that:

- there is little to no Chinese service users (who prefer to use their own remedies)
- Jewish people also have their own ambulance services in some parts of London and would not use any services on Sabbath days.
- a significant number of war refugees are not aware that 999 is a free service and therefore do not use it.

## 3. Handover wait / long transfer time to A&E

In his letter addressed to The Rt Hon Earl Howe, Parliamentary Under Secretary of State for Quality, Malcolm Alexander, Chair for Patients' Forum for London Ambulance Service, wrote: *'Queuing of ambulance outside of A&E departments is not only intolerable for patient waiting in ambulance and trolley queues to be transferred to a cubicle, but as a result of these queues thousands of sick people are waiting even longer for emergency care. The data that follows is obtained from the commissioners for ambulance services in London and shows that each month thousands of people are queuing to get into A&E.'*

LAS crew are legally required to stay with the patients they are taking into A&E until the latter are officially transferred to A&E. If A&E have no beds available, the crew have to wait until one becomes available.

Patients waiting between 30-59 minutes to be transferred to an A&E cubicle (December 2014):

Barnet Hospital	197
Ealing Hospital	322
Hillingdon Hospital	251
Northwick Park Hospital	475
Princess Royal University Hospital	391
Royal Free Hospital	217
Queens Hospital	636
Queen Elizabeth Hospital (Woolwich)	151
St George's Hospital	531
Whipps Cross University Hospital	302
West Middlesex University Hospital	207
North Middlesex University Hospital	454
St Mary's Hospital, Paddington	273

Queens Hospital had the highest number of patients having to wait to be transferred in the London area in December 2014.



I attended a meeting with Margaret Luce (Head of Patient & Public Involvement and Public Education) and Steve Ford (Lead Duty Station Officer at the Romford Complex) where they expressed that Government targets are not always necessarily achievable and are just figures. They expressed they feel happy the feedback they receive from patients is generally positive and does not reflect the negative press they regularly receive.

The LAS management is always looking at ways to better their performance and meet Government targets.

The other explored pathways for the BHRUT area are:

- treating people in their homes
- GP surgeries (LAS can make appointments with GPs for people whilst with them)
- Walk-in centres (Upney is the only one in B&D and is only for minor injuries. It also has restricted access for ambulances / Harold Wood polyclinic / UCC at King Georges Hospital (like GPs) and at Queens Hospital (but with a reduced service since the recent changes)

A new Community Treatment Team (CTT) has emerged to give service users access to:

- A fallers team
- Social services
- Mental health (geriatrics mainly)
- All therapies

The CTT refers patients directly to those services in order to take workload off the LAS. The CCGs and LAS are funding together a CTT car with a paramedic and community nurse (similar thing in Hackney called Paradoc). The LAS has always been centralised but under the new commissioning, the CCGs have agreed to fund specific things in different areas: care homes services in Croydon, the CTT car in BHRUT for example.

### **Discharge**

The LAS are also looking more broadly at issues such as discharge as they realise that these problems affect them too. They recently secured a seat on the Urgent Healthcare Board and are appointing a Stakeholders Engagement Manager as a stand-alone job to be the local contact and LAS representative.

### **Engagement with the public**

LAS took part in over 60 public events every month in 2014. These are done by staff in their own time. Staff are reported to have low morale but are in reality most are highly motivated.

Events include face to face engagement such as school events, joint ventures with the police and fire brigade and Transport For London.

## 111

LAS send ambulances to respond to 111 calls. The Partnership of East London Cooperatives Ltd (PELC) are the providers of the NHS 111 service for residents in BHRUT (Outer North East London). The 111 service is staffed by a team of fully trained advisers and experienced clinicians. On dialling 111 a member of the team will assess your condition and direct you straightaway to the local service that can help you best, when you need it. That could be your GP surgery, an out-of-hours GP, A & E, a local urgent care centre, emergency dentist or a late opening pharmacist. If it is an emergency, an ambulance will be dispatched immediately without the need for any further assessment.



It was arranged I could spend half a shift (8am-2pm) with a LAS crew. The medical technician and the paramedic have worked for the LAS for quite a few years.

I was introduced to them by one of the station managers at Queens Hospital whilst they were parked up at Queens, waiting for their next call.

A 'Category A' (immediately life-threatening) call arrived within a few minutes to attend to a young lady who had been vomiting after a gastroscopy a couple of weeks previously. The system showed the call had been placed on 111. The 111 phone number, which replaces NHS Direct, is meant to be the first port of call for patients with urgent **not life-threatening** symptoms.

The crew immediately expressed their frustration at the fact that 111 has doubled their workload since it started in April 2013. They claimed that 98% of calls they go to don't require an ambulance to attend to them. They feel medically trained people should answer the calls with much broader questions than the ones they currently use. For example, they should ask 'Where does it hurt?' rather than the closed question '*Does your chest hurt?*' (as this is immediately referred to the ambulance service). The 111 is staffed by call centre handlers with only a few weeks' training. The ambulance crew felt that this has resulted in ambulances being sent to patients who could have gone to their GP or taken themselves to a walk-in centre. To err on the side of caution, ambulances are sent to people but this generally wastes resources and especially for critically-ill patients who in the meantime potentially have to wait who in the meantime have to wait.

As predicted by crew, when we arrived at the home, we found as predicted that the patients' mother had phoned 111 for advice, since she could not get a GP appointment and had even refused the ambulance but it had been sent to her anyway. After the routine checks, we left and the young lady made her own way to A&E as, as the patient put it 'we won't get seen any sooner if we get there in an ambulance and in the meantime we are wasting your time'.

According to NHS 111, the ambulance service is only mentioned as a last resort solution but this ambulance crew's experience did not seem to be in keeping with this.

The next two calls were 999 calls that took us to 2 elderly people who had aches and pains following a fall. The crew told me they try to keep people at home as much as possible unless of course it is a real necessity to take them to A&E. In these instances they administered pain relief tablets to one patient and tried to organize a physiotherapist home visit for the other. They let me know that not all crews work in the same way. Some automatically take patients to Accident & Emergency.

The final call during my time with the crew was a Category A Red1 for pregnancy/miscarriage/delivery. We arrived at the address within the 8 minutes

response time along with an emergency car. We took the lady to the Maternity unit at Queens Hospital.

The crew both expressed that they strongly feel the LAS is abused and they are not enjoying their job anymore. They suggested people need further education regarding what a real emergency is. The current social media, newspapers and websites presence should be increased to national TV and include shocking adverts for example for people to remember what 999 is really there for.



## Patients' Feedback

Healthwatch gathered feedback on Streetlife. We also surveyed service users at the A&E departments of Queen's Hospital and King George's Hospital. Finally we received BHRUT patients' feedback on the ambulance service. Altogether we received feedback from 61 service users.

Overall the feedback is very positive and most patients are very satisfied with the service they receive.

Feedback	Numbers	Percentages
Positive	43	70.5%
Negative	18	29.5%
<b>TOTAL</b>	<b>61</b>	<b>100%</b>
Waited more than 1 hour	16	26%
Ambulance arrived very quickly or took less than 1 hour	45	74%
<b>TOTAL</b>	<b>61</b>	<b>100%</b>

Please see the Appendix on page 17 for specific comments from service users.



It is now widely accepted that health depends most strongly on social, economic and environmental factors. In 'The Marmot Review', Sir Michael Marmot reviewed this: the areas of deprivation, where there is high unemployment, poor housing, low incomes and low educational attainment, will also have poor health.

The 'B&D Census 2011 key Information tells us that Barking and Dagenham is amongst the four poorest London boroughs as far as:

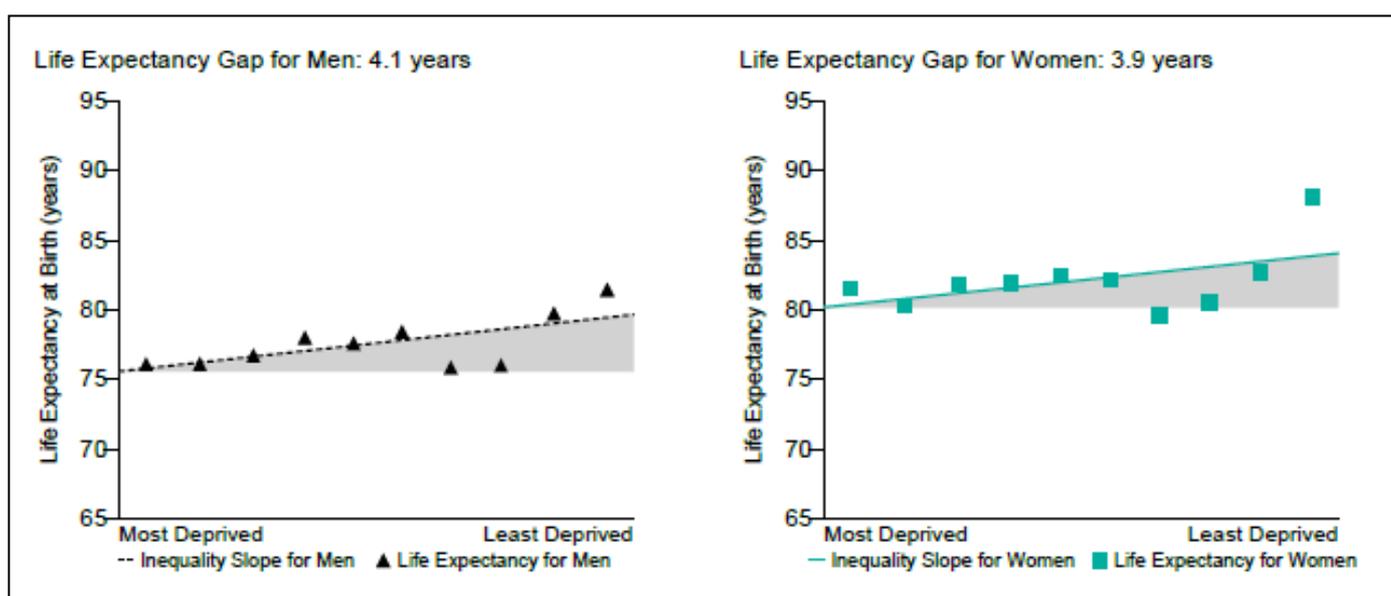
- unemployment
- out-of-work benefits
- mortgage repossession orders
- affordable housing in social renting

This in turn will inevitably affect the health of the residents.

It is therefore essential that health services in BHRUT including ambulances and the A&E department run very efficiently as the demand on them is greater than in most other parts of England.

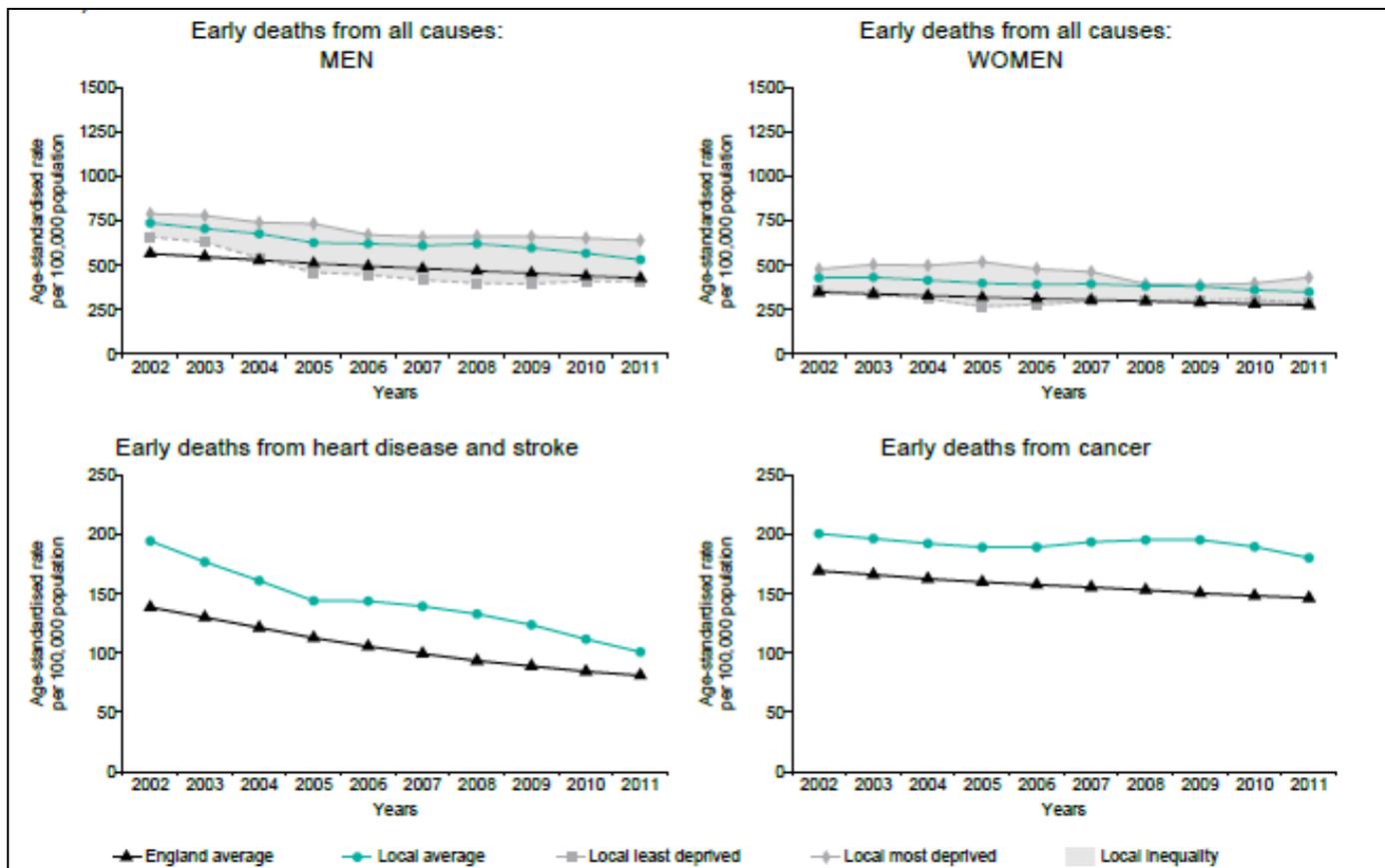
### Life Expectancy and Healthy Life Expectancy at Birth

According to the Public Health England Health Profile 2014, life expectancy in Barking & Dagenham for both men and women is lower than the England average. It also is 4.1 years lower for men in the most deprived areas of Barking & Dagenham than in the least deprived areas.



## Mortality Rates for Common Causes of Death

These charts provide a comparison of the changes in early death rates (in people under 75) between Barking & Dagenham and all of England. They show that the Barking and Dagenham mortality rate is consistently above the England's ones for both heart disease and stroke and cancer.



## Selected Public Health Indicators

The chart below shows how the health of people in B&D compares with the rest of England.

The grey areas are above England's rates.

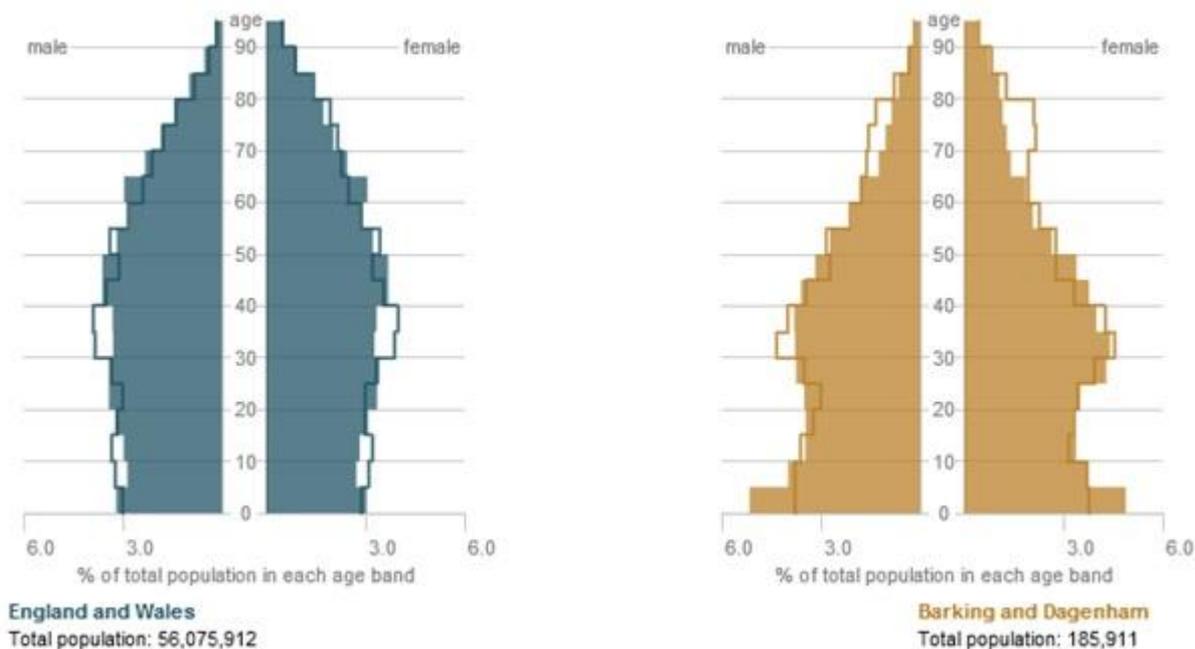
	Note	B&D	B&D value	England value		
				Worst	Average	Best
Hospital stays for alcohol-related harm	1.	843	552	1,121	637	365
Drug misuse	2.	994	8.4	26.3	8.6	0.8
People diagnosed with diabetes	3.	11,418	6.8	8.7	6.0	3.5
New cases of tuberculosis	4.	66	35.0	112.3	15.1	0.0
Acute sexually transmitted diseases	5.	1,996	1,067	3,210	804	162
Obese children (year 6)	6.	568	24.4	27.3	18.9	10.1
Infant Mortality	7.	15	4.0	7.5	4.1	0.7

1. The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13
2. Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11
3. % people on GP registers with a recorded diagnosis of diabetes in 2012/13
4. rude rate per 100,000 population, 2010/12
5. Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate)
6. % school children in Year 6 (age 10-11), 2012/13
7. Rate per 1,000 live births, 2010-2012

## Population Projections for Barking & Dagenham

The population of B&D is one of the fastest growing in England and its population of under 4s is the highest in England.

### 2011 Census Population Estimates (outlines show 2001)



Source: ONS 2001 mid-year population estimates, 2011 Census. ONS Data Visualisation Centre

The steady increase in population with high health needs create a very high demand on local services.



## Conclusions

1. There is a difference in views between the managers and staff within the London Ambulance Service.
2. The effectiveness of NHS 111 is disputed by staff. However Healthwatch is not in a place to comment on the service as we were not given any official figures from the PELC.
3. The general feeling is that the LAS service is good. A minority of people complain and when so, service users are generally displeased with the waiting time. However there seems to be a misunderstanding about what a life-threatening emergency really is.
4. The LAS are experiencing a significant lack of staff. This is partly thought by crew to be a result of the training being too much for the job.
5. Barking and Dagenham has a growing population with high health needs.
6. Transfer times from an ambulance to A&E are problematic in BHRUT and a cause of frustration for the staff.



## Recommendations

1. There needs to be an increase in publicity to define the proper use of the ambulance services.
2. It is difficult for Healthwatch to comment on the effectiveness of the 111 service. However it remains the firm conviction of staff that NHS 111 has contributed to the inefficient use of the LAS service.  
It would be helpful if this mismatched of perceptions could be addressed by managements of both LAS and 111.
3. Transfer times at the A&E department at Queens Hospital remain high and should be addressed by both the LAS and the A&E department.  
In his letter addressed to The Rt Hon Earl Howe, Parliamentary Under Secretary of State for Quality, Malcolm Alexander, Chair for Patients' Forum for London Ambulance Service, wrote: *'Queuing of ambulance outside of A&E departments is not only intolerable for patient waiting in ambulance and trolley queues to be transferred to a cubicle, but as a result of these queues thousands of sick people are waiting even longer for emergency care'*.

This report was sent to Margaret Luce (Head of Patient & Public Involvement and Public Education), to Steve Ford (Lead Duty Station Officer at the Romford Complex) and to the Local Authority Commissioner, Monica Needs. No response has been received from the providers. This is now a public document.



*'Ambulance took an hour and a half to come but they were helpful when they arrived.'*  
*'Today the ambulance paramedic who came to see my daughter was extremely nice and never had anyone so funny and child friendly. Big thank you to paramedic team.'*  
*'Had to call ambulance 1st time ever they were excellent quick friendly and efficient.'*  
*'Extremely pleased with response of ambulance team and doctors.'*  
*'The only problem was that due to ambulance shortage it took approximately an hour for the ambulance to arrive the team who meet me were professional and inspired confidence.'*  
*'I cannot fault my treatment and all doctors/nurses and staff have been extremely kind and helpful especially the LAS crew. '*  
*'The ambulance was prompt and the men very caring.'*  
*'Phoned for ambulance about 12.30am and the paramedic arrived very quickly followed by the ambulance.'*  
*'I was satisfied with the professionalism of my paramedics.'*  
*'Excellent care by ambulance staff. Staff obviously overworked but still have time to treat you with professionalism and care.'*  
*'I was treated very well by all the members of staff quickly and efficiently. Many thanks to the ambulance staff taking care of me.'*  
*'The ambulance staff were absolutely brilliant - kind and considerate and all the nurse are most kind and helpful as was the wonderful doctor. Bless em all!!'*  
*'Hello! Treated promptly from ambulance to ante coag taken straight to A+E (heart pain) ECG very thorough, considerate and thoughtful.'*

*'Paramedic staff seem very busy so they can't concentrate properly and don't take interest unfortunately. Thanks.'*  
*'The UCC in the hospital were really good however getting to the hospital was a absolute joke my son was waiting an hour for an ambulance and the paramedic turned up in a car we was advised to take him to hospital ourselves as there were no ambulances available.'*  
*'Assuming the ambulance service part of emergency response. The overall care received from paramedic staff was below par. The feeling given - go away - there is nothing wrong with you - is not only defying the GP's concern but not acknowledging.'*

*'Appalling service. Had a fall at 11.15 am and waited an hour for an ambulance.'*  
*'GP requested ambulance not emergency for patient after waiting 3hours patient made own way to A&E.'*  
*'On admission via ambulance despite a long wait of 3.5 hours at home.'*