**MINUTES of the PATIENTS’ FORUM**

**MONDAY, March 21st, 2022 – 5.30pm**

**ATTENDANCE: FORUM MEMBERS AND ASSOCIATES**

Alan Alexander – Whitehaven, Cumbria

Anna Roscher - Bradford

Chris Hartley-Sharpe - LAS

Courtney Grant - Bromley

Derek Prentice – Royal College of Emergency

Elaina Arkangel – Hammersmith and Fulham

Georgina Taylor - Southwark

Jon Williams – Healthwatch Hackney - Host

Logie Lohendran – Chair, Healthwatch Merton

Lorraine Silver – Healthwatch Redbridge

Malcolm Alexander- Hackney-Chair of Patients’ Forum

Mike Roberts - Hampshire

Natalie Teich - Islington

Polly Healy – Surrey

Robin Kenworthy - Kent

Sister Josephine – Vice Chair of Patients’ Forum, Chislehurst

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**GUEST SPEAKERS:**

CHRIS HARTLEY-SHARPE–FIRST RESPONDER LEAD FOR THE LAS

DEREK PRENTICE – LAY MEMBER, ROYAL COLLEGE OF EMERGENCY MEDICINE

LONDON AMBULANCE SERVICE – Chris Hartley-Sharpe

LAS COMMISSIONER’S REPRESENTATIVE: Nil

**APOLOGIES**

Alexis Smith – Forum Lead on Acute Mental Illness

Carl Curtis - Lewisham

Maria Yianni – Outcome Volunteer

John Larkin- Company Secretary - Barnet

Louisa Roberts – Tower Hamlets – Board Member

1. **Chris Hartley-Sharpe – First Responder Lead for the LAS**

1.1 Chris is retiring from the LAS after 26 years of leading major projects on First Responders, CPR and Resuscitation.

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.

1.2 Chris 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 provide 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 presented a wide range of slides showing some of the interactions with well-known supporters of the community resuscitation and installation of defibrillators, e.g. former Health Minister, Tessa Jowel and actress Helen Mirren. He also presented details of work between the LAS and ambulance services in Kenya, Tanzania and Uganda.

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

* 30,000 people have a Cardiac Arrest each year in the UK whose lives could be saved with early CPR.
* 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 quality CPR and using a defibrillator.
* GoodSAM Responders are NHS (e.g. nurses, doctors, paramedics, therapists), Police and Fire Staff, First Aiders and others who are trained in CPR.
* GoodSAM is integrated with most UK Ambulance services, and when a call that is likely to be a cardiac arrest comes in, the system automatically alerts nearby responders.
* On average, responders receive only 1 to 2 alerts each year - but these basic skills save many lives.
* This is alerting, not dispatch - if you can't go, it's not a problem, the next nearest person is alerted, and an ambulance is enroute as normal.

**1.4 Chris Hartley-Sharpe’s slides accessible on website: WWW.patientsforumlas.net**

**2.0 DEREK PRENTICE** – LAY MEMBER OF THE ROYAL COLLEGE OF

 EMERGENCY MEDICINE - RCEM

2.1 Derek described his work with the RCEM where he sits on the Governance Committee and Lay Members Committee. He described his lifelong commitment to the NHS and his leading role in representing consumers’ interests. He has also been a lay member of the General Dental Council, Chair of the Board for the Dental Complaints Service, a member of the Governing Body for Kings College School for Medicine and Dentistry, and a Board Member of King’s College Hospital.

2.2 Referring to the current problems with ambulance queuing, (which is partly related to the current pandemic and other historical factors), Derek said he was concerned about the interaction between ambulance services and Emergency Departments, because of the pressures on both services and the chronic shortage of staff and beds, which 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.

2.3 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 has included 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 as a result of delay and the importance of looking at the mortality data to see 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 in order to stop ambulance queues and restore the 4-hour target. Unfortunately, the government want 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.

2.4 As a result of 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 not 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.

**2.5 Question for Derek Prentice**

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

**DP replied:** 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. other appropriate local services are 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 many of the 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 hospital, 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. In Scotland there are much stronger links between social care and hospital managers and that enables faster discharge of patients.

1. **Who are the community allies of the Royal College of Emergency Medicine? What can we do to help?**

**Response:** Healthwatch England and the Patients’ Association are very supportive. The data is powerful, the press is very helpful, but there is a risk of harm to patients if the situation continues to deteriorate. The cut in beds at Whipp’s Cross will make the situation worse. The RCEM is a small college that punches above its weight, but needs all the help it can get, e.g. through the briefing of MPs. RCEM data should be available for this purpose and reports on winter pressures. One of RCEM’s concerns related to the pressure not to go to ED is based on the assumption that there are better places to go – but for people needing emergency care ED is the right place.

1. **Are the CQC aware of the problems faced by EDs?**

Response: Yes, they know very well about the loss of beds and the consequential impact on EDs.

1. **Discharge –** 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 more deprived, and better end of life care for people in their own homes, rather than hospital wards. **Elaina**
2. **Pressures on services in Redbridge** – There are serious problems with delays and queues at King George Hospital (Barking, Havering and Redbridge University Hospitals), and the situation at Whipp’s Cross (part of Barts) is also serious especially in light of the plan to reduce beds when the hospital is rebuilt. Healthwatch Redbridge is always at meetings held about Whipp’s Cross, BHR and Barts, but the impact on service development and bed loss is not great enough. A new direction is needed to ensure that there are enough beds and effective discharge arrangements. **Lorraine**

Response: There is a focus on developing a major trauma centre in London and stroke services, but inadequate focus on mainstream emergency care and treatment in ED. Private hospitals are also of concern, e.g. the Cleveland Clinic and the Wellington Hospital are advertising their urgent care centres as an alternative to the NHS. GP at Hand is also attacking the NHS by draining money away from local NHS care and into distant GP services, which mostly provide minor services to a cohort of young people – but if their problem is more complex, they are advised to go to ED.

**2.6 Derek Prentice and Chris Hartley-Sharpe were thanked for their excellent**

 **presentations.**

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The meeting finished at 7.00pm