Community Engagement

London Ambulance Service – Organisational Strategy 2023/28

Public Consultation by Healthwatch Havering

January 2023

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Community Interest Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your voice, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

Community engagement

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has a statutory duty to ascertain the views of health and social care services and to make them known to the commissioners and providers of those services so that they can be taken into account in the development, commissioning and delivery of services.

We do this in a variety of ways, such as surveys, interviews and focus groups.

We also participate, with other Healthwatch organisations across North East London, in the Community Insights System, which gathers views and comments on health and social care from people across the area. Intelligence gained from Community Insights is used directly in, or to inform, many of the surveys and other public engagement events that we carry out.

The results of our community engagement are shared with Havering Council, NHS North East London, NHS and other provider organisations and Healthwatch England.

Introduction

In October 2022, the London Ambulance Service (LAS) asked Healthwatch organisations across London to help with a public consultation exercise to identify priorities for the LAS for its development of an Organisational Strategy for the years 2023/28.

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Healthwatch Havering agreed to participate in the exercise. This note explains the methodologies adopted and their outcomes.

The LAS was particularly interested in finding out how the public responded to five questions:

1. **What is the LAS getting right?**
2. **How can the LAS improve emergency care?**
3. **How can the LAS enhance urgent care?**
4. **How should the LAS work with other parts of the healthcare system to improve care?**
5. **How can the LAS do more to contribute to life in London?**

This report consists of:

- A description of Havering
- Comments on the methodology used
- The findings, in detail
- Conclusions
- Acknowledgements

About Havering

The demography of Havering is different from that of the remainder of North East London, and indeed from significant parts of London as a whole.

According to the 2021 census, of the current population of 262,052, 81% were born in the UK. Of the remainder, around 10% were born elsewhere in Europe, 5% in the Middle East and Asia,

4% in Africa, and 1% in the Americas and the Caribbean. 88% of the population is of white ethnicity (white British and European, mainly Eastern).

Havering has a large percentage of people aged over 65 – some 18% - with 19% under 15 and 64% aged 15-64.

The principal hospital serving Havering is Queen's Hospital, Romford, which is one of the largest general hospitals – and certainly the busiest - in London (and possibly England). Recent data suggests that it has one of the worst performing Ambulance handovers to A&E services in England [1]. The LAS's Romford Ambulance Station is currently located near to Queen's Hospital but is under threat of closure to enable the area around to be redeveloped. Plans to relocate the station are under consideration. Queen's Hospital is provided by Barking, Havering and Redbridge University Hospitals Trust, which also provides King George Hospital, Goodmayes.

Most patients from Havering requiring LAS transportation are likely to go to Queen's Hospital although some may be taken to King George Hospital or other hospitals nearby including Newham General and Whipps Cross Hospitals. Those requiring highly specialised care, such as cardiac arrest or stroke sufferers, are often taken to more central London hospitals such as the Royal London or St Bartholomew's Hospitals.

The NHS 111 service in Havering is provided by the LAS.

[1] NHS England Ambulance Collection: Hospital arrivals and ambulance handover delays, 26 January 2023 -

Methodology

Healthwatch Havering approached the brief in three ways.

First, in company with most Healthwatch organisations that participated, we invited a wide range of local contacts – individuals and organisations – to complete a survey to ascertain their views as both recent patients of the LAS and as possible future users of the service. We joined several Healthwatch in North East London in a survey managed by our colleagues at Healthwatch Waltham Forest.

The survey was also publicised by newspaper advertisement, referenced in NHS North East London and Healthwatch mailings and advertisements placed in Havering libraries.

Secondly, we organised focus group-style sessions to discuss the five questions set out above.

In arranging both the survey and sessions, we particularly invited the participation of individuals and groups representing blind people, deaf people, people with autism and learning disabilities and carers. In addition to open events for the public, we spoke to individuals and visited a service-user group. We also visited Queen's Hospital, Romford and spoke to patients who had been brought to the hospital by LAS vehicles.

Finally, in September 2022 – before this work was commissioned – we had carried out an Enter & View visit to Accident & Emergency services at Queen's Hospital, including the Ambulance Receiving Centre there. Although not directly part of the current work we have included extracts from our report of that visit as they provide relevant, informed observations.

The findings

Discussions with individuals and groups

Participants in these sessions made a range of comments about the LAS.

The first thing to note was that most participants were overwhelmingly supportive and appreciative of the service. The conduct and expertise of crew members were highly regarded, and response times were generally thought of as reasonable in all the circumstances of the NHS as it currently reacts to winter and other pressures.

People who were blind, deaf or living with autism or learning disabilities did, however, tell us that they sometimes found it difficult to communicate with crew members. This was felt particularly by people whose first language is British Sign Language (BSL) but also by learning-disabled users of Makaton (a communication tool for individuals for have cognitive impairments) and people who relied on lip-reading.

Given that reassurance and calming is a key element in the first response to injury or illness, they felt it would be useful if all crew members received training in the basics of BSL and/or Makaton so that they could have at least a limited dialogue in the event of needing to treat a BSL or Makaton user, and understood the needs of those who were reliant on lip reading.

One session was attended by some St John Ambulance Community First Responders, who told us that they had the impression that Ambulance Control staff were not always fully aware of the specialist units available within the Service and

sometimes deployed a standard vehicle where a more specialist unit might have been more appropriate or failed to use the GoodSAM app to alert passing responders to the need for assistance.

Representatives of several care homes also attended the sessions. They told us that the Service was responsive to their calls, that crew members attended within reasonable timescales (bearing in mind that their patients were already in a care setting) and that crews were thorough in assessing the patients.

The following comments and observations are taken from what people told us during these sessions. They are not set out in any particular order:

- We spoke to five patients in the ARC at Queen's Hospital (see below) who were awaiting treatment; they told us that they were very happy with service the LAS provided but did not want to take survey. We also spoke very briefly to a patient waiting in the corridor who was very happy with her treatment in the ambulance.

- One of the patients told us that he had called an ambulance that day for emergency healthcare, for physical health symptoms such as a possible heart attack or a stroke. He had received advice/treatment for the same condition less than a week ago. He thought the call was handled very well; the call handler had been calm, had listened to him and knew exactly what was going on.

He had waited 10 minutes for an ambulance, which he thought was entirely reasonable. His experience with the crew on arrival was excellent.

He felt he had definitely been treated with respect and privacy, that he could trust the crew, who had spoken to him in a way that was easy to understand. He received pain relief, which was effective, and had been given an ECG, his blood pressure was taken, and the crew had made sure he was all right. He could not think of any ideas for improvement.

He was taken to Queen's Hospital after the initial assessment, arriving there within five minutes. His ride had been comfortable. The ambulance was clean and tidy. He had been taken straight into the Resuscitation area.

He thought the ambulance service worked well with all the other services that he had dealt with since starting to experience symptoms. However, he thought that the NHS 111 needed help as the previous week it had taken them 14 hours to get back to him after an initial call.

- Another patient said that he strongly agreed that the LAS staff were competent, caring and dedicated, but he had the impression that the service was not run efficiently as there were "too many bosses" and ambulances could not get back on the road. He felt that the service was under-resourced, inadequately funded and that staff were under-paid.

He was very worried about ambulance and A&E waiting times in the local area, the availability of GP appointments and the state of the NHS in general. He was also very worried about the availability of dentist appointments in the area as it is impossible to get an appointment.

That said, he could not think of anything that could be improved and he had received an excellent service on the day. He considered himself and although he had access to IT equipment and the internet, he did not consider himself confident in using the internet to access services.

- A third patient had called an ambulance on the day because of physical health symptoms such as a possible heart attack or stroke symptoms. They had used the ambulance service less than a year ago. They had received healthcare advice from a hospital-based consultant.

  They had called 111, which then called an ambulance. The ambulance arrived in about 45 minutes, which they thought was reasonable. Their experience with the crew was very good; they felt treated with respect and privacy, that they could trust the crew and that they had been spoken to in a way that was easy to understand.

  They had received pain relief, which was effective.

  They were very happy with the assessment and treatment they received from the paramedics upon arrival and felt there was nothing that could be improved.

After initial assessment, they were taken to Queen's Hospital. The journey took 15 minutes. They were very comfortable during the ambulance ride. The ambulance was clean and tidy.

They were seen in Resus immediately. They thought the waiting time was entirely reasonable.

They thought that the ambulance service including 999 and 111 definitely worked well with all the other services that they had dealt with since they started experiencing symptoms.

They strongly agreed that the LAS staff were competent, caring and dedicated, the service is run efficiently, but felt it was under-resourced and inadequately funded. They thought the ambulance service could be improved by having more ambulances and more staff.

They also were very worried about ambulance and A&E waiting times in their local area, the availability of GP appointments in their local area and the state of the NHS in general. They were somewhat worried about the availability of dentist appointments in their local area.

They considered themselves disabled with a physical or mobility related disability. They had access to IT equipment and the internet and were somewhat confident in accessing the internet.

- We spoke to an eclectic group of people were experiencing mild to severe mental health issues, some of whom had complex disabilities.

Among the attendees was one who had previously worked for the ambulance service.

A number had used ambulances in the last year.

One participant thought that there should be separate access to hospitals for patients with mental health issues.

- We spoke to a supported living group for people living with learning disabilities and/or autism.

  They told us that paramedics on ambulances were brilliant, very professional, and thorough. They had no complaints, but one did ask why there were sometimes three crew members in attendance [an explanation offered by another participant in the session was that it was possible that the third person was assessing or training the other two].

  They told us that they had met a key member of staff from Queen's Hospital who dealt with people with learning disabilities and autism and they had found having a person they knew on hand if they had to go to hospital reassuring and calming.

  There was also concern that crews sometimes had difficulty communicating with people with learning disabilities or autism, who might be non-verbal users of BSL or Makaton.

  They expressed concern that hospital passports were sometimes misplaced in transit between the patient's home and hospital. Obviously, it was important that such

documentation should not be lost so they asked that a place be provided in the ambulance where such documents could be kept for safekeeping until the arrival at the hospital.

They also told us that people with learning disabilities and/or autism were not all comfortable about being given visible indicators of their special needs, such as coloured wrist bands, since that might draw unwanted attention to them. They preferred staff to be more vigilant and attentive without singling them out for special attention. They thought that some form of "digital passport" would be helpful.

- In another discussion, one participant told us about her experience of a recent call for assistance. The crew of three included two female paramedics who had been recruited from Australia. During conversation, the crew told her that the third crew member was a senior paramedic who was with them solely to drive as the Australians (whose paramedic qualifications were fully accepted in the UK) were not yet qualified to drive in the UK. Our participant had been told that it would take three months for these Australians to be qualified to drive, which seemed an excessive time given that vehicles in Australia are driven on the same side as the road as in the UK.

- A care home manager told us the staff at her home were very happy with the service they received from the LAS and

that, because of the nature of their home, they had a good rapport with the service. The wait for an ambulance to attend was sometimes too long; although they appreciated that priority calls took precedence, they had to wait 6 – 7 hours once and had to call again back again to find out where the ambulance was. It would be helpful if homes could be told if there was likely to be a delay in ambulance attending. The home had had to call out more ambulances than usual recently as they had more residents with complex issues. They cited the case of one recent resident who had been placed in the home for respite over Christmas and had been receiving palliative care. Although the patient's family thought that they should be conveyed to hospital, the GP had visited several times, and a care plan had been put in place (including a Do Not Resuscitate order). Staff at the home that the resident should have been allowed to pass away at the home and not be taken by ambulance to hospital. It had been quite difficult for the ambulance crew to convey this view to the family and a lot of the ambulance crew's time had been taken up on this case when they could have been better used elsewhere. The home did not have many dementia patients but there were some who were non-verbal.

They added that, although ambulance staff are highly skilled, their bedside manner may not always be suitable to the situation.

They concurred with the people for supported living that coloured wrist bands and the like were not necessarily

helpful and that better means of identifying people with special needs such as dementia should be sought.

- A representative of St Francis Hospice, Havering-atte-Bower (SFH) told us of their 24-hour advice line, on 01708 758643, which was available for all health professionals who were dealing with someone in need of end of life care. They also had senior nurses on call. The ambulance service could have used this with the instance cited above, where the care home was having issues with a family insisting a resident go to hospital even though they were receiving palliative care in the home. The care home confirmed they have used the line for another resident where the care home needed access to records of resident held by SFH.

- Several people commented that ambulances were called by people who do not really need them. The common view was that the service should prioritise calls and find other ways to help residents. This suggested that not everyone may understand why some calls are prioritised over others and that delays are not only due to people making improper 999 calls.

  This indicated that the public needed greater awareness of what constituted an "emergency", when the 999 and/or 111 call systems should be used and how ambulances responded to calls (including where ambulances are located when they receive calls).

- Members of St John Ambulance told us of a scheme currently being trialled whereby patients who were able to walk were taken to hospital by (LAS-operated) car rather than by ambulance; the hospital would be alerted in advance to expect that patient and thus able better to arrange for their treatment on arrival.

  They also told us about the Community First Responder scheme, and the GoodSAM app that together enabled qualified first aiders to respond to calls for emergency response in advance of a paramedic car or ambulance arriving and suggested that the exiting schemes could be expanded to assist more people in need of help.

  They felt that the use of volunteers generally by the LAS could be better coordinated, adding that the various traffic calming measures in place across London hampered volunteers responding to calls made by the LAS. They also suggested that highway and other authorities needed to be made more aware of the LAS's use of volunteer responders to emergency calls.

  They questioned whether the use of qualified paramedics to deliver basic life support training to the public was the best use of their time and skills given that less highly qualified people were available to do that training.

  They considered that a return to hospital-based Ambulance Managers to manage vehicles arriving at hospital would assist with speeding up turnaround times.

- A participant described to us a "Sit and Treat" service provided at North Middlesex Hospital where walk-in

patients arriving at the hospital were handed over to a nurse, who took observations prior to handing over the patient for full treatment. She told us that one team would look after two to four people.

- Staff from another care home told us that some residents could be in a critical condition, so rapid response times were essential. Sometimes the response was good and quick but at other times the home had to keep calling to ask when the ambulance would arrive.

  It would be helpful if call handlers could give a clear indication when the ambulance could be expected to arrive. The home usually tries the GP and 111 before calling 999 as a last resort.

  They told us that ambulance staff were able to communicate with residents; at one time they only spoke to staff but in recent times they talk to the residents themselves. Some of ambulance staff can communicate with sign language, but it is limited. It would be good if more ambulance staff had even just a basic knowledge of medical BSL.

  Some staff at the home are well trained medically and are qualified to know what is wrong with the residents. They did not always get the feeling the call handler they were talking to had fully understood the situation.

  They told us that the 111 was "OK but not fantastic", sometimes taking too long for return calls and failing to convey that they have a good knowledge of what you are

talking about. On one occasion, the home has called 111 at 11pm and again at 2.am to be told they are still on the system. They eventually got a call back at noon that day to ask if everything was OK.

The home's staff felt that call handlers at 111 were sometimes reluctant to alter their assessment (where it differed from that of the staff) and wondered whether those call handlers always had a clinical background. The service was getting better but still had a long way to go. If the home had to wait too long to hear back from 111, the home will call 999. They recounted that, on occasion, they had been told by 111 to call GP, and then told by the GP to call 111.

They told us that ambulance crews spent less time with patients now; it used to be about two hours for a call out. Now assessment takes most of the time, approximately 40 -45 minutes from arrival to leaving. The paramedics always make sure the residents are stable before leaving.

- A sight-impaired couple (one blind, the other with limited vision) told us about an incident involving them that had occurred in Hornchurch High Street outside the Sainsbury store.

  They were waiting to cross the road at the pedestrian crossing and were just about to cross as the "green man" sign started beeping when a member of the public stopped them. An ambulance was approaching on the wrong side of the road (as it was entitled to) with its blue

lights flashing but giving no audible warning of its approach. Neither of them had any way of knowing the ambulance was there and if they had not been alerted to its approach by the other person they might have been in a collision with the vehicle. It may well have been that the ambulance driver had assumed that the partially sighted person could see the ambulance coming but that was not the case. They thought that ambulances should always use audible warning sirens when nearing pedestrian crossings as not all pedestrians can see them approaching.

- A participant recounted their neighbours' experience. The neighbour had an ongoing cardiac condition: his family called an ambulance which took five minutes to arrive, which they thought was excellent. The paramedics gauged the situation, stabilised the man and took him to hospital. The crew were fantastic and lovely, and the participants had been really impressed with the service rendered.

- A woman with a learning disability told us of an incident when, following consultation with her GP and NHS 111, it took seven hours for the ambulance to arrive. When the ambulance arrived, the crew were good, but it was so late she did not want to go in the ambulance to hospital, so she went of her own accord the next day.

  She was not happy with 111 service or the GP, as neither could not hurry up the ambulance. She called at 5pm in afternoon the ambulance arrived at 2am.

The ambulance crew were polite and understanding, she had a pre-arranged phone call planned from her GP the next day and did not want to miss that, so did not want to be admitted to hospital. No medication was given.

There is a link on computer screen in hospital, on which patients with a learning disability are flagged up. It would be useful if ambulance crews cold similarly be advised if patients have special needs.

The survey

The survey was carried out by several North East London Healthwatch working together. It asked a number of questions about patients' and others' experiences of LAS services.

Of those surveyed, 41% had used an ambulance in the last 12 months: perhaps surprisingly, only 11% of their calls followed an accident or other traumatic event, the other calls mainly being for reasons connected with physical health symptoms. 68% of the latter category of caller told us that they had previously received medical treatment for the same symptoms.

Most people told us that they had had a fair or better experience of calling 999; about half waited less than an hour for the ambulance to arrive but a 20% had waited for more than four hours.

Most people had a good experience of paramedics and none reported a bad experience. All respondents told us that they trusted the paramedics. 33% told us they were not offered pain relief although they felt they needed it.

83% of respondents were taken to hospital. All felt the ambulance were clean and that the journey to hospital was comfortable.

87% of respondents considered the staff to be competent and 84% felt that they were caring and dedicated. Only 7% considered the service not to be run efficiently but over 50% did not feel it was well-resourced or adequately funded.

Appendix 1 sets out the full responses to the survey in infographic format.

Enter & View visit to A&E Services at Queen's Hospital

Given that, in commissioning this report, the LAS were keen to know what they could do to work with other parts of the healthcare system to improve services, we feel it is appropriate to include reference to earlier work we had undertaken that is relevant to the point.

In September 2022, we carried out an Enter & View visit to A&E Services at Queen's Hospital. As part of that visit, we went to the Ambulance Receiving Centre (ARC).

Appendix 2 sets out extracts from our report of that visit [2]. The ARC is unquestionably a worthwhile innovation that is helping to alleviate the pressures of enabling patients brought in by

[2] The full report is available at https://www.healthwatchhavering.co.uk/sites/healthwatchhavering.co.uk/files/Full%20report%20Queens%20A%2BE%20final.pdf

ambulance to be looked after until a place can be found for them in the Emergency Department at the hospital, releasing the ambulance to return to "the road" and help more patients.

Our report concluded:

> Ambulance Receiving Centre
> Although the ARC is said to be temporary, there is no doubt that it is a considerable improvement on the arrangements that applied before its introduction. Whilst ideally patients should be taken straight from ambulance to the ED, for the foreseeable future some sort of holding arrangement will be needed and the ARC is important in that.
>
> Closer liaison between the LAS staff in the ARC and BHRUT staff in the ED is welcome and to be encouraged.

We believe this development is an excellent example of the sort of collaboration and innovation that the LAS should purse with other health service providers to secure future improvements.

Conclusions

As noted earlier, there is no question that the LAS and its staff are well-respected and highly thought of. The general public are, however, not necessarily aware of how the LAS works in the wider context of the NHS or of the range of clinical services that its operational staff can provide. The LAS may therefore wish to consider how better to publicise its activities, both front line ambulance and "behind the scenes" such as NHS 111.

Those who responded to our focus group sessions offered a range of suggestions that should be considered as part of the Organisational Strategy.

Relating their comments to the questions the LAS asked us to find answers to produces the following:

1. What is the LAS getting right?

- Overall, respondents to our events and survey were at least satisfied with their experience of the LAS but felt that some fine tuning of its services along the lines in the following comments were desirable.
- Most people's experiences were positive (as the anecdotes in the main body of this report indicate). Some were critical of the lack of information about likely arrival times of ambulance where there were unavoidable delays but were not critical of the reasons for delays.

2. How can the LAS improve emergency care?

- Management action – including reversion to the former system of Ambulance Liaison Officers based in Hospital – to ensure the prompt turnaround of ambulances, supplementing initiatives such as the Ambulance Receiving Centre at Queen's Hospital
- Training patient-facing staff in basic British Sign Language and Makaton, and how to converse with people who use lip-reading

- Provide safe-keeping facilities for patients' documentation (such as hospital passports) in ambulances so that vulnerable patients such as those with dementia, a learning disability or autism can produce their documents to ensure informed, prompt and effective treatment on arrival at hospital
- Ensure that newly recruited staff from overseas can be deployed effectively as soon as practicable after commencing duty
- Ensure that those who have called 999 are proactively kept informed of the estimated time of arrival of assistance in order to ensure that patients and those attending them are not subjected to avoidable stress when delays occur
- Ensure that call handlers for 999 calls are aware of all available LAS resources and dispatch them accordingly (including use of the GoodSAM app)
- Ensure that crews responding to calls are alert that not every pedestrian may be aware of an ambulance relying on blue lights alone and that audible warnings should always be used when approaching pedestrian crossing points

3. How can the LAS enhance urgent care?

- Return calls from NHS 111 by clinicians should be made more promptly (our respondent had waited 14 hours for a call)

4. How should the LAS work with other parts of the healthcare system to improve care?

- Liaise more closely with organisations such as St Francis Hospice to deliver appropriate care to patients already on an End-of-Life Care pathway
- Consider how crew members can adapt their "bedside manner" to deal with patients who are elderly or living with dementia, autism, learning disabilities, deafness, sight loss and other disabilities
- Consider how to make better use of voluntary support – both formal through St John Ambulance and the LAS's own volunteer corps, and informal through local volunteer networks – for example, by making the GoodSAM app and Community First Responder scheme more widely known
- Support the Community First Responder scheme by ensuring that highways authorities are more aware of it and take it into consideration, for example, when drawing up traffic calming measures
- Collaborate with hospital trusts to introduce innovations with A&E Services such as the ARC at Romford referred to elsewhere in this report, and the REACH initiative [3]

[3] *Remote Emergency Access Coordination Hub (REACH) aims to reduce unnecessary hospital visits by giving paramedics direct access to expert advice from emergency clinicians.* - BHRUT News, 17 January 2023 - https://www.bhrhospitals.nhs.uk/news/reaching-out-to-more-patients-3955

5. How can the LAS do more to contribute to life in London?

- There was no particular comment about the LAS's contribution to London overall. As already noted, it enjoins a high level of public support but people do not necessarily understand the full range of its activities and capabilities. A greater public profile would help raise awareness of these characteristics.

Acknowledgements

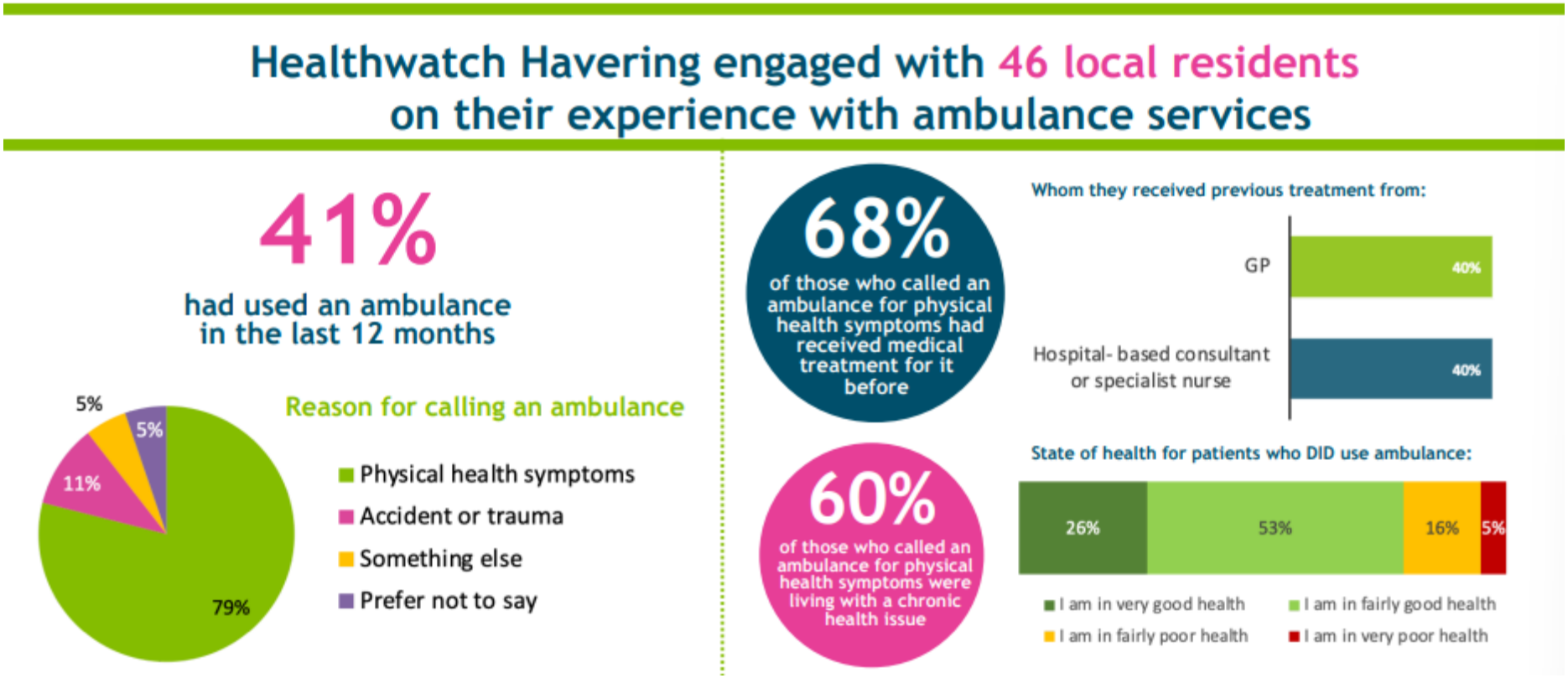
We are grateful to everyone who participated in our various events for sharing their thoughts and stories and to those who completed the survey. We are also grateful to the staff of Havering Libraries who facilities both some of the events and the survey.

Particular thanks go to our colleagues at Healthwatch Waltham Forest who analysed the survey results and produced the infographics.

Finally, thanks go to the London Ambulance Service for commissioning this opportunity to find out what people think of the LAS.

Appendix 1

Infographics derived from the survey data



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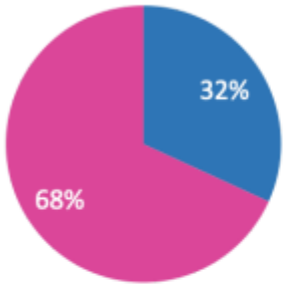
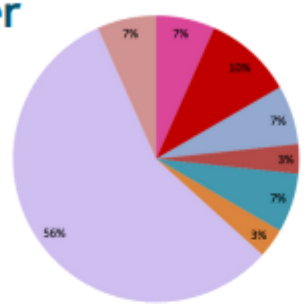
Who our respondents were

Gender





Ethnicity

- Asian: Indian
- Black: African
- Black: Caribbean
- Mixed: White and Black African
- Other White ethnicities
- White: Baltic (Estonian, Latvian or Lithuanian)
- White: British (incl. English, Scottish, Welsh, Northern Irish)
- White: Romanian

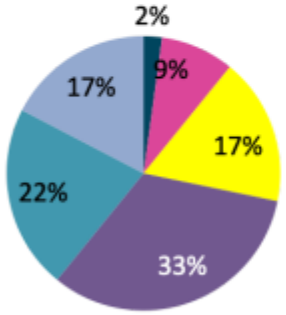
8% were LGBT

15% were parents

43% of them were single parents

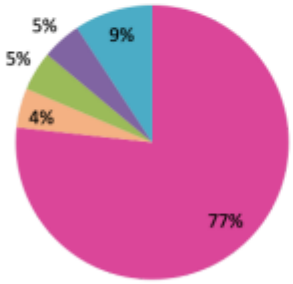
44% were digitally excluded

Age



- 18 to 24
- 25 to 34
- 35 to 49
- 50 to 64
- 65 to 79
- 80+

Religion



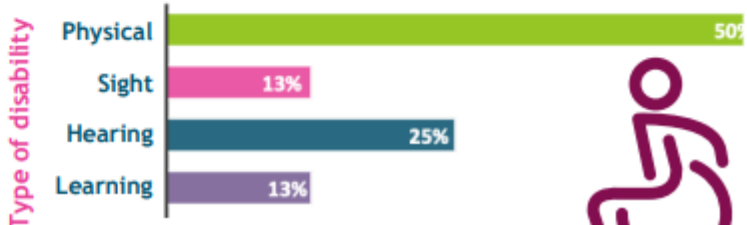
- Christian
- Hindu
- Jewish
- Muslim
- None (incl. atheist)

50% had a long-term condition

0% had a mental health condition

7% were neurodivergent

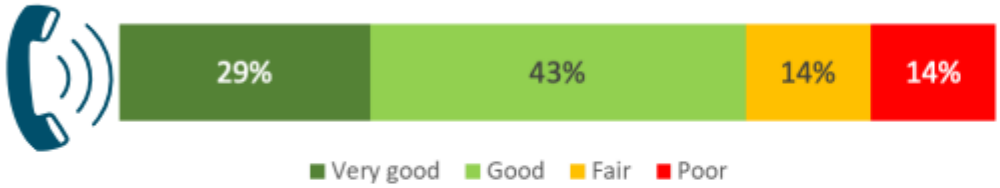
20% were disabled



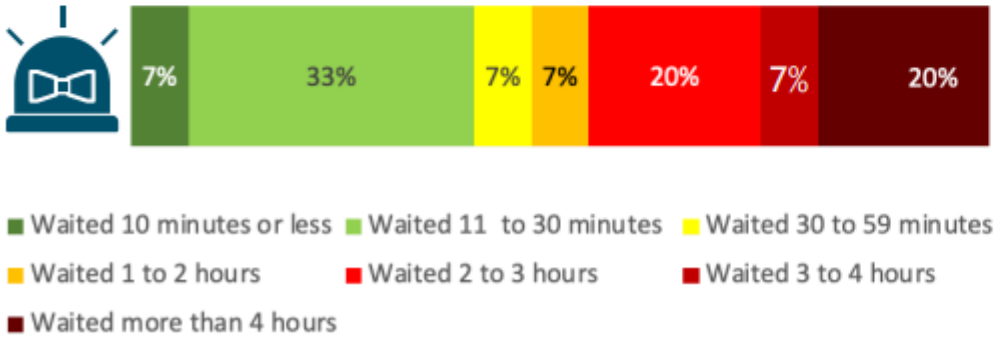
Level of English

Accessing an ambulance

7 people gave feedback on their experience calling 999

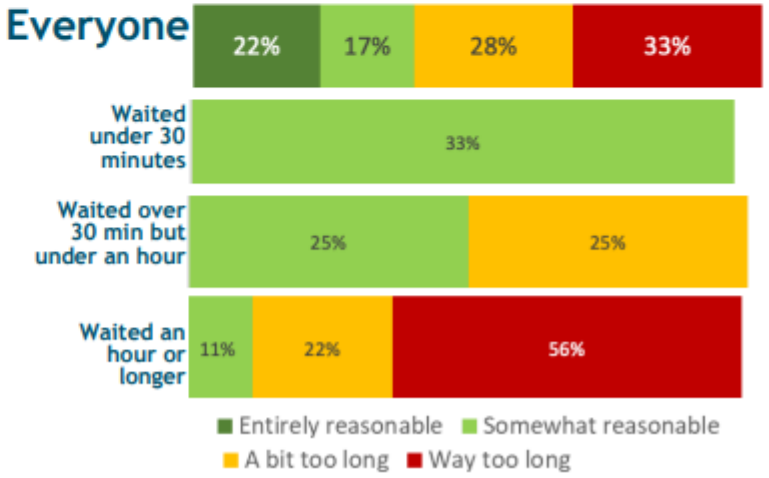


12 people gave feedback on waiting for an ambulance



The average waiting time for an ambulance was **2 hours and 18 minutes**

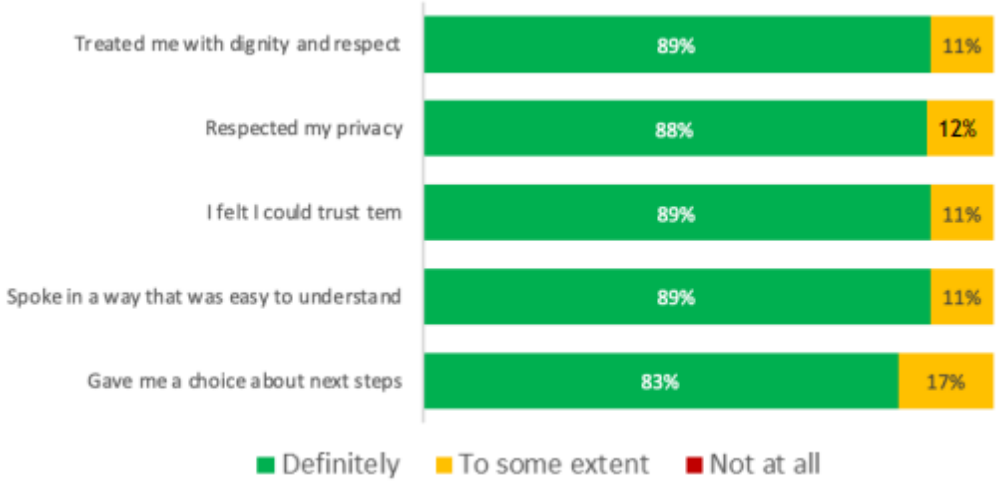
Opinion of ambulance waiting times



Experience of paramedics

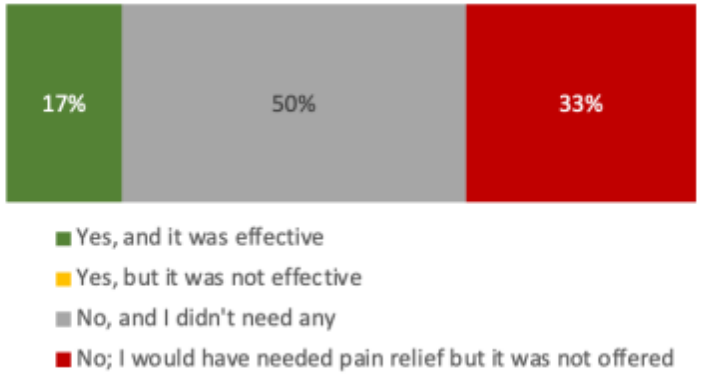
Most people had a very good experience of paramedics

Behavior of paramedics:



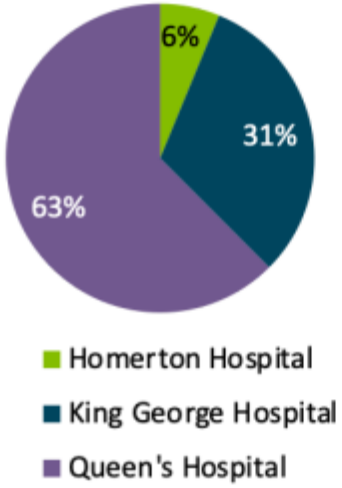
78% recall paramedics introducing themselves

17% of patients received pain relief:

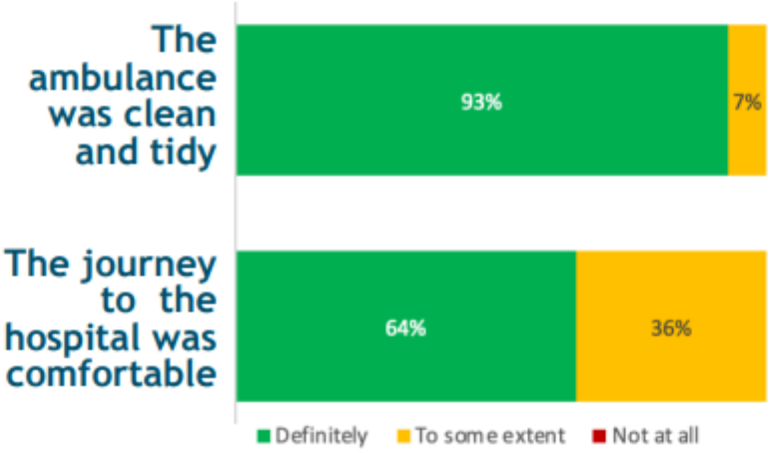


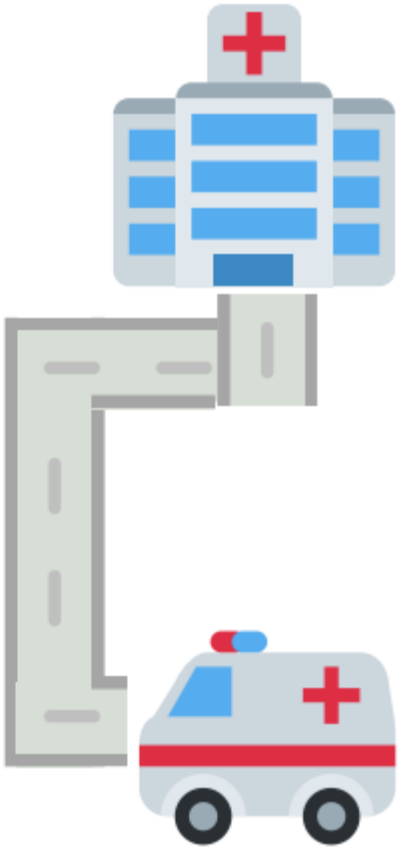
Journey to the hospital

83% of those seen by paramedics were taken to a hospital



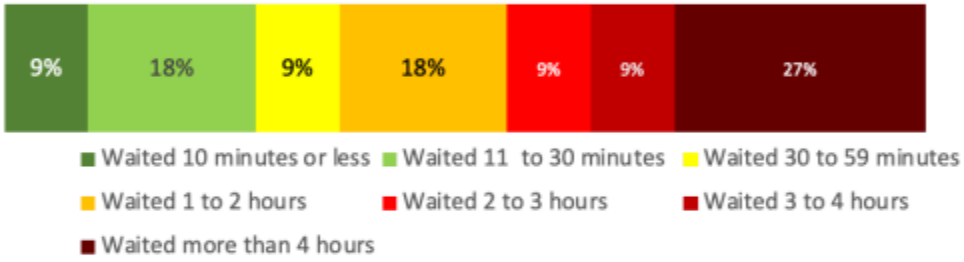
The average journey to a hospital took **22 minutes**



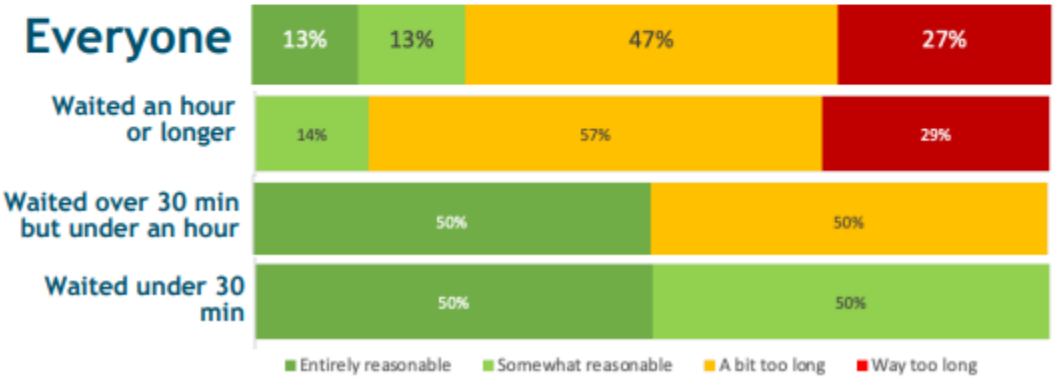


Experience of A&E 8 people gave feedback

The average waiting time in A&E was
Two hours and 37 minutes

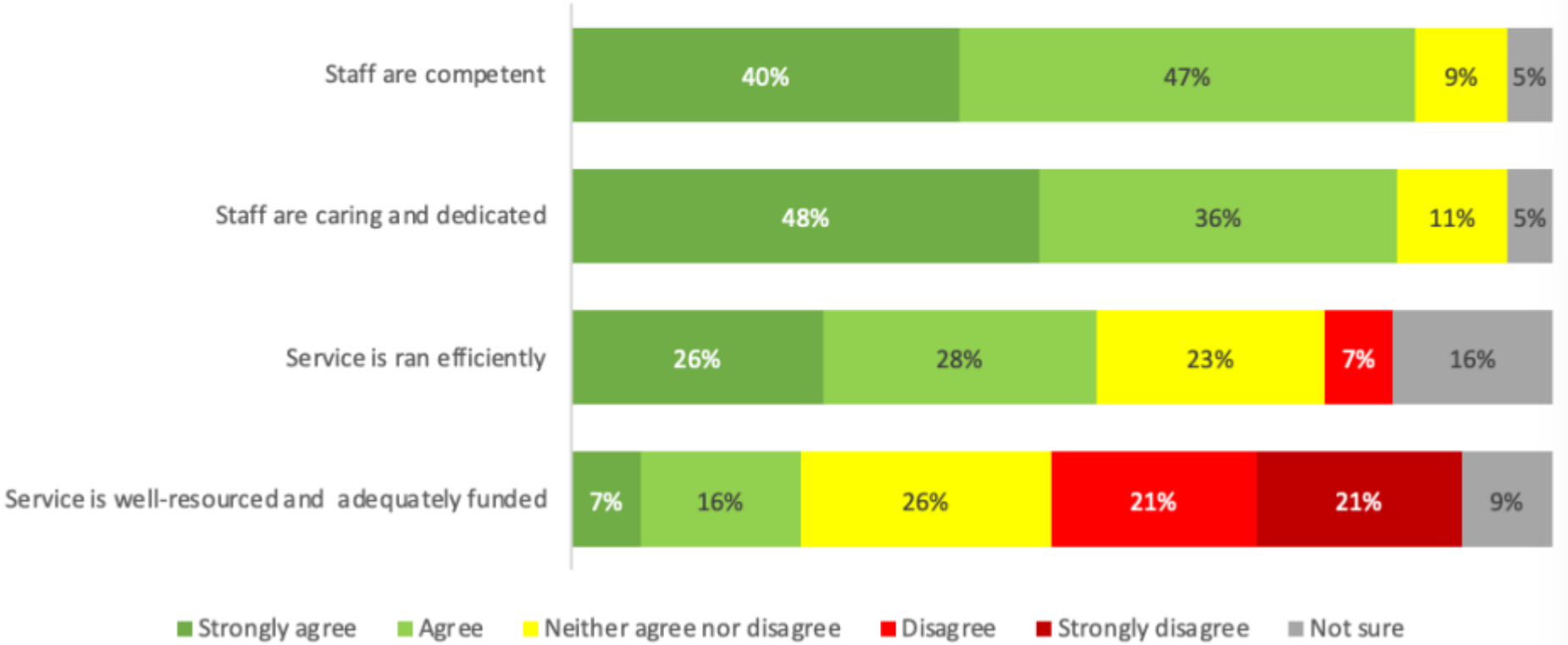


Opinion of A&E waiting times



Do services work well together?

Perception of the London Ambulance Service



Appendix 2

Extracts from

Enter & View – Queen's Hospital, Romford: Accident and Emergency Services

Ambulance Receiving Centre

Introduction

The Ambulance Receiving Centre (ARC – pronounced Ark) at Queen's Hospital is provided by the London Ambulance Service (LAS) as a supplement to their role of providing the general accident and emergency ambulance response for the whole of London. …

It is worth noting that the ARC at Queen's Hospital was the first to be set up in the UK and was a response to the very high demand experienced at the hospital for patients being brought in by ambulance (often the busiest in London and among the busiest in the whole of England). The services provided there are evolving as experience is gained to the point that, at the time of our visit, preliminary care is offered to patients, including initial treatment procedures, such blood testing, canula insertion and other tests. The LAS and BHRUT have collaborated extensively in these developments; the effect has been the prompt release of ambulances for re-deployment and to ease pressures on the ED; LAS and BHRUT staff are now working together far more than hitherto. Patient feedback has been wholly positive.

…

The aim ideally is to reduce the number of residents taken to ED that do not need to go there,

since if patients can be treated in the community, it is better for everyone.

…

Another initiative the LAS and BHRUT had introduced shortly before the visit was Cohorting. This involves BHRUT staff working closely together to attend to patients in the corridors.

A third of patients admitted have experienced this and in just six days use of this initiative had released 38 ambulance crews earlier, equating to a minimum of 3 hours saved per patient, releasing least a 100 hours of ambulance staff time back in the community.

…

Another Model BHRUT are using is the RAFT (Rapid Assessment and First Treatment). Blood tests and observations can be taken, cannulas can be inserted, staff can record details on patient records ready for treatment and patients are assessed for their clinical pathway to begin. This quickens and helps the flow through ED. Patients are transferred to a hospital trolley from an ambulance trolley which is more comfortable for them and reduces the risk of bed sores.

…

Summary

Although the ARC was clearly very busy, there was a calm atmosphere.

There has been a positive patient response to the ARC.

…

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Healthwatch Havering Friends' Network

Join our Friends' Network for regular updates and other information about health and social care in Havering and North East London. It cost nothing to join and there is no ongoing commitment.

To find out more, visit our website at https://www.healthwatchhavering.co.uk/advice-and-information/2022-06-06/our-friends-network-archive

Healthwatch Havering is the operating name of
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