

MEETING WITH ELIZABETH OGUNOYE– COMMISSIONER FOR THE LAS

ATTENDANCE: SISTER JOSEPHINE, KATHY WEST, ANGELA CROSS DARRANT, MALCOLM ALEXANDER

1) Complaints – Review of the Effectiveness of Complaints Investigations

E.O. said that the “deep dive” report into LAS complaints investigations, would be submitted to the Clinical Quality Review Group (CQRG). Anjalikaa Thaker would provide details of the date of the meeting and arrangement for the Forum to observe. We noted that there had been a considerable delay in this LAS report being submitted to the CQRG.

2) CQRG Attendance by the Forum – Anjalikaa Thaker will provide dates for these meetings and access to minutes documents produced for this joint LAS-Commissioners group.

3) Outcome of the CQC Inspection – The CQC will revisit the LAS in 18 months unless the LAS asks them to attend earlier. A corporate action plan has been produced by the LAS and submitted to the CQRG. The report is in the public arena – ‘Our Quality Improvement Plan – Moving Forward Together’.

4) Sickle Cell Disease – The LAS and Commissioners have agreed to a Service Development Plan. Stuart Ide is leading on the production of the plan and the Sickle Cell Society has asked for a meeting to agree priorities.

5) SC Care Plans – We asked a joint pilot project to link SC care plans to the LAS emergency operations system to ensure that patients in crisis go the right service and appropriate medication first time.

6) CQUINS – Noted that CQUINS are most attached to the CQC-LAS improvement programme. They will include mental health, palliative care, development of the clinical hub, 111/999 developments. The Forum’s comments and proposals for 2016/7 CQUINS are below. Our proposal for a CQUIN relating to Learning Disabilities is unlikely to be a priority for 16/17 but the LAS are working on service improvement in this area of care.

7) CQUIN Review of 2015-16 – Reports for quarters one and two are available and Quarter three will be available later in February from Stuart Ide.

- 8) AMBULANCE QUEUING OUTSIDE A&E** – We discussed the Forum’s commitment to stop ambulance queuing, because of the impact this has on patients, their care and the availability of ambulances for emergency responses. Elizabeth said that the TDA, NHSE, NHS Trusts and the London CCGs are working together to eradicate queuing. It is unclear who this group will report to, but Andrew Hines and Anne Rainsberry will be able to provide more information. The Forum have also invited Dr Andy Mitchell, the Medical Director for London to address the June 13th meeting of the Forum. Andrew Hines is Associate Director of Delivery and Development (London) at the NHS Trust Development Authority and Anne Rainsberry, Regional Director for London – NHSE.
- 9) EQUALITY AND INCLUSION** – We discussed continuing difficulties in the effectiveness of the LAS work with and support for staff and patients with protected characteristic. We asked if the contract for 2016/17 could reflect the Forum’s concerns. We also discussed the lack of diversity in the LAS Board and the need for the Board to be more assertive in leading on this issue and the need for the Board to have appropriate training, e.g. in relation to safeguarding.
EO said that the TDA appoints Board members.
- 10) GOVERNANCE IN THE LAS** - Sandra Adams and Peter Nicholson are responsible for governance and Lesley Stephens is responsible as Improvement Director for Trust Performance.
- 11) CLOCK START PILOT** - a controlled pilot project led by Professor Bengner of NHS England, with the aims of:
- Achieving faster dispatch to the most critical calls through the use of a pre-triage ‘Nature of Call’ series of questions
 - Having resources more available (through less multiple allocations) to respond to life threatening immediate calls
 - Utilising “Dispatch on Disposition” to allocate the most clinically appropriate resource to patients by taking a little more time to triage the call (from 60secs to 180 secs).
 - Increasing the use of ‘Hear & Treat’ and ‘See & Treat’
 - The LAS has participated in the clock start pilot but its data will not be included in the national study because it is in special measures.

ADDENDUM:

CQUINS for 2016-7 FORM COMMENTS ON CQUINS

Dear Stuart Ide, these are our comments on the CQUINS and a proposal for an additional one on sickle cell disease. All the best. Malcolm

1) E-PRF and DOS – Promoting Use of ACPs

- a) E-PRF – this is an essential project, but we wonder if it is suitable for a CQUIN in view of the development time for implementation of the E-PRF? Surely, E-PRF needs to exist as a working system before it can be subject to the CQUIN process.
- b) We would like to know more about issues of consent in relation to the sharing of clinical information through the E-PRF. Is there a policy on how the patients consent is obtained in relation to the sharing of information between different clinical organisations?
- c) Regarding the development of the DOS system we feel that this is very suitable for the CQUIN approach, but that the system is not controlled but the LAS and neither is access to ACPs (alternative care pathways).
- d) We believe for this CQUIN to be successful, that effective governance is required of the DOS system and ACPs, by the CCGs and where appropriate hospital trusts. Pressure on CCG is essential to ensure they are providing local services that meet LAS's ACP requirements. At this time governance is very weak, e.g. Mental Health – only 2 of 9 MH Trusts in London can provide 24/7 ACPs.
- e) We also feel that the use of Urgent Care Centres as ACP to be used by the LAS, needs to be evaluated to see if this model works for patients and is clinically sound. Are patients who are taken through this route asked to assess effectiveness of the 'patient journey'?
- f) In relation to DOS, are 111 services sharing feedback to a common spine on relating to the evidence they have of effective access to services?
- g) Have you considered role out of K466 across every London borough as the most rational means of establishing effective alternative care pathways.

2) Clinical Impact Based Performance Standards.

We strongly support the development of this approach

- a) We would like to know apart from stroke, cardiac and trauma what other conditions might be amenable to this approach. We believe that the following conditions should be considered: sickle cell, asthma, COPD, falls, bariatric care.
- b) We would like to see how clinical impact will be measured in the illnesses/conditions chosen.
- c) We would like to see patients and carers experience included in the model alongside clinical impact.
- d) The system is rightly moving towards the use of objective clinical criteria, but seems to be forgetting about patient experience, pain, long waits, trauma and distress.

3) Clinical Hub

- a) We agree this would be an excellent CQUIN as the approach being used is fundamental to the clinical development of LAS services and staff.
- b) We would like to see some degree of outreach included, e.g. for mental health patients who are suicidal or in crisis?

4) Development and Implementation of a 2 Way Gate for Transferring Calls between 999 and 111

- a) We do agree that this is a system that needs fixing, because of the inappropriate transfers that sometimes take place.
- b) We need more detail to assess the suitability of the system for a CQUIN.
- c) We are concerned that having several 111 services in London will make this a system that is too complex to make a CQUIN workable

5) Proposed Sickle Cell CQUIN

Experience from the effectiveness of the MH CQUIN suggests that this would be an excellent approach for sickle cell disease. Recent work between the Sickle Cell Society, LAS and the Forum provides a great opportunity for a CQUIN that literally brings patients, voluntary and statutory partners together with common purpose. The elements of the CQUIN would be as follows:

- a) The development of care plans between people living with SC and their clinicians that can be linked to GPs and acute services and flagged on the LAS system to enable the patient to get the right care, first time.
- b) More effective and appropriate pain management control for people in crisis.
- c) Greater sensitivity to the needs of people in sickle cell crisis when they are transferred from their home to an ambulance and then to Accident and Emergency.
- d) Developing an understanding of the intensity of pain that can be experienced during a sickle cell crisis and providing appropriate care.
- e) Greater understanding of the associated pathologies/complications that can be life threatening to people in crisis, e.g. lung and stroke.
- f) Challenging the stigma that can affect the way people living with sickle cell and their families relate to care providers and ask for help from the emergency services – e.g. delays in seeking treatment.
- g) Attitudes amongst some clinical staff that can lead to people with sickle cell in crisis being labelled as 'drug users'. Changing attitudes is essential.