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**Minutes of the Meeting held at**

**Monday DECEMBER 15th 2014, 5.30pm-7.30pm**

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| **Attendance : Forum Members** |
| Angela Cross-Durrant – Vice Chair - Kingston  Clarissa Rocke-Caton –Hackney  Janet Marriott - Richmond/Hounslow  John Larkin- Company Secretary  Kathy West - Southwark  Kay Winn-Cannon - Waltham Forest  Leslie Robertson – Merton  Louisa Roberts - Tower Hamlets  Inez Taylor – Southwark  Malcolm Alexander – Chair – Hackney  Michael English – Lambeth  Natalie Teich - Islington  Pat Duke - Southwark  Robin Kenworthy - Kent  Christine Kenworthy - Kent  Sister Josephine – Vice Chair – Croydon |
| **LAS** |
| Margaret Luce - Head of Patient & Public Involvement and Public Education |
| **Guest Speaker** |
| JANE MOORE - NICE |
| **Apologies** |
| Alhajie Alhussaine – Lambeth  Anthony John - Tower Hamlets  Barry Silverman – Southwark  C. Gustaffe - Southwark  David Payne - Southwark  Joseph Healy – Southwark  Lynne Strother – Richmond  Maria Nash – Barnet and carer  Rashid Laher – Kingston  Val Fulcher – Lewisham  Vishi Harihara - Camden/Barnet |
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**2.0 MINUTES**

2.1 Minutes of the meeting held November 10th 2014 were agreed a correct record.

**3.0 MATTERS ARISING FROM THE MINUTES**

3.1 Defibrillators – Malcolm reported that costings had been received from the LAS: Agreed to:

a) ask the Hackney Health and Wellbeing Board if a joint presentation can be made with the LAS and the Local Pharmaceutical Committee to get their support for a defib in every Hackney pharmacy.

b) Contact Wendy Mead, Chair of Health Committee, City of London.

c) Propose a further similar development in schools

d) Members agreed to promote similar developments in their own boroughs.

3.2 PTS Quality Standards. Noted that the PTS document has been updated and republished.

**Agreed to distribute to London hospital CEs and service providers.**

http://www.patientsforumlas.net/uploads/6/6/0/6/6606397/hapia-pts\_standards-october\_26-2014-final-\_copy.pdf

3.3 Foundation Trust status.

**Agreed to arrange meeting with Sandra Adams to discuss latest position.**

3.4 Trust Development Authority

**Agreed to invite Sean Overett to the March 11th meeting to discuss their role in the development of the LAS.** Their role relates to governance, quality and performance were areas of key interest to the TDA

<http://www.ntda.nhs.uk/wp-content/uploads/2014/10/Paper-B-Chief-Executive-report.pdf>

**3.5 Safety In Mind.**

**Agreed to show the mental health film at the end of the February 11th meeting.**

**3.6 CQC Inspection of the LAS.** Noted that an inspection of the LAS was likely to take place early in the New Year.Prior to the West Midlands inspection a listening event was held.

**Agreed to:**

1. **Discuss with the CQC what process would be used to invite members of the public and patients to this event. Noted that FT members, Forum members and HW should be invited.**
2. **Ascertain how the CQC appoints lay members for these visits – Angela to investigate (Experts by Experience).**
3. **Highlight the relationship within the hierarchy of the LAS and the extent to which it is a learning organisation.**

**3.7 Monitoring of Private Ambulances Use by the LAS**

Noted that Jason Killens had written to the Forum providing details of the monitoring arrangements re vehicles and staff contracted to provide a top-up to front line LAS service.

**3.8 Ride-Out**

Louisa Roberts agreed to go on a ride-out in Tower Hamlets

**4.0 JANE MOORE – NICE - PRESENTATION**

**4.1 Jane made the following points:**

1. NICE is a non-department public body funded by the Department of Health. NICE employs 600 staff, all data is in the public domain, NICE is an international resource, there are 7 types of NICE guidance and NICE works closely with the MHRA (the Medicines and Healthcare Products Advisory Agency). NICE is not a regulator.
2. Guidance produced by NICE covers ambulance services and is embedded in the AMPDS (Advanced Medical Priority Despatch System), Fionna Moore the Medical Director of the LAS collaborates with NICE on this shared approach to ensuring that NICE guidelines are operational with the LAS.
3. When NICE carries out review of services to improve protocols, 2 lay people are always included, and they can significantly challenge the ideas of the NICE teams. NICE also works with Collaborating Centres:

NICE has established four National Collaborating Centres (NCCs). The centres harness expertise of the royal medical colleges, professional bodies and patient/carer organisations when developing clinical guidelines. Each centre is a professionally-led group with the experience and resources to develop guidance for the NHS on behalf of NICE. The collaborating centres work to an agenda specified by NICE to deliver national projects.

1. All service development committees are open to the public

NICE's advisory committee meetings, technology appraisal appeal hearings, public board meetings and a range of other meetings are open to the public and press to observe. Holding these meetings in public supports NICE's commitment to rigour, openness and transparency. <http://www.nice.org.uk/Get-Involved/Meetings-in-public>

1. **NICE Clinical Guidelines are produced in the following areas:**

NICE guidelines make evidence‑based recommendations on topics ranging from preventing and managing specific conditions; improving health; managing medicines in different settings; providing social care and support to adults and children; safe staffing and planning broader services and interventions to improve the health of communities. They aim to promote individualised care and integrated care (for example, by covering transitions between children's and adult services and between health and social care). Guideline recommendations set out:

* care and services suitable for most people with a specific condition or need
* care and services suitable for particular populations, groups or people in particular circumstances or settings, e.g. discharge from hospital)
* ways to promote and protect good health or prevent ill health
* the configuration, staffing and provision of health and social care services,
* how national and local public sector organisations and partnerships can improve the quality of care and services, e.g. how the NHS and social care services work together).

http://www.nice.org.uk/article/PMG20/chapter/1%20Introduction%20and%20overview#/nice-guidelines

1. When NICE recommends a drug for a particular purpose the NHS must make that drug available to patients.
2. NICE is considering making guidelines available for the use of ambulance services. The South Western Ambulance Service, won the 2013 Shared Learning Award for its work in improving clinical practice. The Trust aimed to harmonise clinical practice from using NICE guidance to set a standard for care. Notices were used to disseminate NICE guidelines to staff. The volume of updates given, and the amount of detail needed to be memorised, meant that it was difficult to keep track of many of the guidelines. To apply the guidelines in a fast-moving ambulance setting, and ensure frontline staff had quick access to key clinical information, the Trust took a radically new approach towards guidance dissemination. It developed a clinical guidelines folder developed by senior clinical teams working together to review guidance. This provided a standard, concise and easily accessible resource written by ambulance clinicians, for ambulance clinicians.
3. NICE Quality Standards defines clinical best practice within a topic area. They provide specific, concise quality statements, measures and audience descriptors to provide the public, health and social care professionals, commissioners and service providers with definitions of high-quality care: e.g. end of life care, dementia, caesarian and self –harm.
4. NICE Pathways offer an easy-to-use, intuitive way of accessing a range of clinical, public health and social care information from NICE. They include up to date NICE guidance, quality standards and related information. They are a resource for users of NICE guidance as they allow users to navigate the breadth and depth of NICE recommendations on any subject. They bring together guidance and supporting information on the topic from all of our work programmes.
5. Technology appraisals are recommendations on the use of new and existing medicines and treatments within the NHS. These can be:
6. Medicines; medical devices, such as hearing aids or inhalers; diagnostic techniques - tests used to identify diseases; surgical procedures, such as repairing hernias; health promotion activities such as ways of helping people with diabetes manage their condition.
7. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals.This is reflected in the NHS Constitution, which states that patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if their doctor believes they are clinically appropriate. Failure to provide a NICE recommended drug against medical advice that it should be used can lead to legal action being taken by the patient against a hospital or medical practitioner.

**4.2 QUESTIONS FROM MEMBERS**

* 1. Pat Duke asked how new themes are chosen by NICE for investigation. She asked if any work had been done on incontinence aids, e.g. pads?

ANSWER: a) New ideas are always welcome. See: https://www.nice.org.uk/about/nice-communities/public-involvement/develop-nice-guidance

b) There is no guidance on incontinence aids, but there is on: Lower urinary tract symptoms in men. <http://www.nice.org.uk/guidance/QS45/chapter/introduction>

* 1. Sister Josephine asked if guidance has been produced on medicine management in care homes?

ANSWER: Managing medicines in care homes guidelines were produced in 2014. <https://www.nice.org.uk/guidance/SC1>

In 2015 a Quality Standard on this subject will be produced.

* 1. Kay asked whether NICE had done work on reducing bedsores in less mobile patients?

ANSWER: Yes. Guidelines on ‘Pressure ulcers: prevention and management of pressure ulcers’ CG179 were published in 2014. <https://www.nice.org.uk/guidance/CG179>

D) Kathy West asked whether NICE observe the implementation of

Guidelines, e.g. those for people requiring dementia care? Quality

standard for supporting people to live well with dementia-

<https://www.nice.org.uk/guidance/QS30>.

What if an NHS body cannot afford to implement NICE guidelines?

ANSWER: NICE do not observe clinical practice when developing clinical

guidelines.

Guidelines not legally binding, but providers of NHS and social care are

obliged to provide care that meets NICE guidelines and it would be

inadequate for a body to claim they could not afford to treat in line with

NICE guidelines.

E) Are there guidelines regarding the provision of support for carers and young carers?

ANSWER: The are guidelines regarding the assessment and management

of bipolar disorder in adults, children and young people in primary and

secondary care. NICE guidelines [CG185] publishedin 2014

F) Louisa Roberts asked about guidelines re sickle cell disorders

ANSWER: There is a quality standard that covers the management of sickle

cell acutepainful episodes for people in hospital from time of presenting to

hospital until the time of discharge. NICE quality standards [QS58] 2014

[www.nice.org.uk/CG143](http://www.nice.org.uk/Guidance/CG143) .

**Key recommendations include:**

* Treat an acute painful sickle cell episode as an acute medical emergency, and follow locally agreed protocols for managing the episodes that are consistent with this guideline.
* Assess pain and use an age-appropriate pain scoring tool for all patients presenting at hospital with an acute painful sickle cell episode.
* Offer analgesia within 30 minutes of presentation to all patients presenting at hospital with an acute painful sickle cell episode.
* Throughout an acute painful sickle cell episode, regard the patient (and/or their carer) as an expert in their condition, listen to their views and discuss with them:

- the planned treatment regimen for the episode

- treatments received during previous episodes

- any concerns they may have about the current episode

- any psychological and/or social support they may need.

All healthcare professionals who care for patients with an acute painful sickle cell episode should receive regular training, with topics including:

- pain monitoring and relief

- the ability to identify potential acute complications

- attitudes towards and preconceptions about patients presenting with

an acute painful sickle cell episode.

**4.3 Jane Moore was thanked for hear excellent presentation.**

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| 5.0 Report from Margaret Luce – Head of Patient & Public Involvement  and Public Education |

5.1 LAS Performance of the London Ambulance Service

Margaret Luce said that the LAS were having a very difficult time

responding to patient’s calling 999 and current prioritisation of

callers has meant that many more people were receiving advice by

phone and people with less serious conditions are being asked to

use urgent care centres or to get to A&E themselves. Margaret said

there is a high level of stress amongst front line staff. This has

resulted in a large increase in complaints and may affect the reputation of

the LAS amongst patients. In addition staff were working a great deal of

overtime and over Christmas would be getting triple overtime rates.

Agreed to write to the Health Minister to emphasize importance of

supporting the LAS in this very difficult period

5.2 Public Education – Margaret said that despite high pressure on the front

line that paramedics were still providing in their own time, support for 60

events per month working with a wide variety of community groups and

organisations.

5.3 Information for patients – Kathy West asked whether more information

would be provided to the public about making better use of urgent care, III

and other non-casualty services? Margaret responded that many younger

people were much more ill, admissions were much higher to A&E,

and research was needed discover why admissions were rising.

**6.0 Patient Reference Group**

6.1 Leslie and Kathy Reported on the Meeting held on December 9th by the

LAS. The following key points were made:

* Patient expectations were not currently being met
* Ann Radmore (Chief Executive) and Fionna Moore (Medical Director) attended and spoke to the meeting.
* They were very open about the severity of current problems
* Attempts were being made to substantially reduce the number of calls passed by the police to the LAS – a 50% reduction had been achieved.
* Staff were under huge pressure.
* Next meeting will be about how staff and public can communicate better
* Attempts will be made to encourage a greater attendance at the next reference group meeting.
* Presentations and flip chart feedback will be sent out by Ruth Lewis

**7.0 Ride-out Report – Leslie Robertson - St HelierAmbulance Station**

* Staff were outstanding
* The follow patients received care**:** Patients: 1) Phenergan Overdose in an asthmatic patient with altered heart rhythm, and chronic anxiety problems. 2) Patient with very painful dislocated shoulder following treatment 2 days earlier. 3) 89yr old patient with severe lower chest pain and bruising with altered heart rhythm after fall against corner of chest of drawers.4) Diabetic patient with renal failure, bleeding PR and severe constipation and pain. 5) 90yr old confused elderly person with altered heart rhythm following a fall in her flat in a Senior Citizen care home? TIA.
* All patients were relayed to Hospital - 4 to St George's and one to Kingston General. Handovers at ED were often within a multiple queue - receipt of patient information in ED varied. The 0700 – 1600hr shift finished one hour late due to the timing and transport arrangements for the last patient.
* This station has 180 staff and morale is good. Recruitment for LAS as a whole is seen as a priority and staff morale is said to be affected by the rotas and staff leaving to work in the 111 service.
* Complaints from patients are increasing - said to be due to pressures and tiredness, especially for those in post for several years. The gap between handover of patients is 14 minutes.
* Meal breaks are taken often between such handovers raising issues as to healthy diets and proper breaks in a shift.
* Need to advertise Patient’ Forum more effectively

**8.0 Recruitment of Paramedics –** Agreed to seek information from the

LAS about the actual costs of becoming a paramedic and the use of

bursaries to increase the number of recruits to the LAS from people

living in London who cannot afford the costs. Agreed also to

compare costs with those in South East Coast Ambulance Service.

**9.0 Forum Newsletter –** Noted that the Forum needs to advertise its

work better to patients who use the LAS, the wider community

and staff. Agreed to produce a newsletter describing what the Forum

is, the Forum’s work and ask the LAS to include articles from the

Forum in the LAS newsletter

**10.0 Safeguarding 13/11/2014 – Leslie Robertson**

* No. of safeguarding referrals has increased by 0.6% to 2.86%.
* Saville Enquiry recommends that policies must be patient centred. In order for this to now be so, it was agreed that any that impact on patients, will be raised with the Patient Forum.
* Ongoing need for database to be developed to ensure that all agencies become linked together and feedback can be given to staff on referrals.
* Literature for staff re religion, witchcraft; child sexual exploitation; alcohol ingestion in children and young people.
* Restraint policy undergoing legal review.
* Safeguarding/mental health conference is taking place April 28th 2015. The PF has 2 representative places.

**11.0 LAS Mental Health Awareness Form (LA383)-**

Noted this form is being used in a trial by paramedics in the

Hillingdon area.Agreed to invite Dr Daryl Mohammed, Asst.

Medical Director of the LAS to a future Forum meeting.

Noted that the LAS has produced LAS Clinical Update - Caring for

patients with a mentalhealth disorder (attached).

**12.0 Press** – Noted letter from Forum to the Evening Standard and

an ES article on the LAS crisis.

**The meeting closed at 7.30pm.**