PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

ANNUAL REPORT AND FINANCIAL STATEMENT 2025

PATIENTS' FORUM AMBULANCE SERVICES (LONDON) LTD

THE DUTY TO WHICH THE LAS MUST ASPIRE

Complying with the NHS Constitution for England

"The Patient will be at the heart of everything the NHS does.

NHS services must reflect - and should be co-ordinated around and tailored to the needs and preferences of patients, their families and their carers. The NHS (LAS) will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services". ***NHS Constitution***

Patients' Forum Ambulance Services (London) Ltd. Registered in England.
Registered office: 30 Portland Rise, N4 2PP
Company limited by guarantee. Company number: 6013086

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FORUM OFFICERS

POSITION	NAME AND CONTACT	COMMENT
Company Secretary Director/Trustee	John Larkin, Fornham Lodge, 4 Verna Street, Marham Park, near Fornham All Saints, Bury St Edmunds, Suffolk, IP32 6FU	
Chair Director/Trustee	Malcolm Alexander patientsforumlas@aol.com Tel: 07817 505193	
Director/Trustee	Louisa Roberts Tel: 0208 986 8972	Resigned November 2025
Vice Chair Director/Trustee	Sister Josephine Udie sisterjossi@hotmail.com	
Communications Lead	Polly Healy patientsforumlas@aol.com	
Registered Office	**Patients' Forum Ambulance Services (London) Ltd, 30c Portland Rise, N4 2PP**	

Our four Directors/Trustees have remained in office for the period since the 2006 launch of the Company, including the year 2025. Louisa Roberts resigned in November 2025.

SPECIAL THANKS TO …

- Our **fantastic members** for their high level of involvement and engagement in our activities, and for helping to make the Forum so effective.
- Our wonderful Vice Chair, **Sister Josephine Udie.**
- **John Larkin**, Company Secretary, for his outstanding governance work and support for the Forum.
- **Polly Healy** for her outstanding work in maintaining our website and ensuring that our publications are well produced and distributed, and copy editing to the highest standard.

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PATIENTS' FORUM FOR THE LONDON AMBULANCE SERVICE

Patients' Forum Newsletters:
https://www.patientsforumlas.net/newsletters.html

https://www.patientsforumlas.net/

INTRODUCTION

The Patients' Forum promotes the provision of effective emergency and urgent care that meets the needs of people in London. This Annual Report outlines our aims and achievements in relation to our charitable objectives during 2025. Central to our work is the place of patients, their relatives and carers in our campaigning activities. A key role of the Forum is to monitor the LAS in relation to its effectiveness, safety and responsiveness to patients needing urgent and emergency care. We encourage the LAS and Commissioners to listen to service users and we promote improvements in clinical care. The LAS is an organisation that struggles to listen to the voice of patients and use their experiences to improve patient care.

The Forum wants the patient's voice to be heard loud and clear, valued and respected during the planning and design of services, and in the development of new clinical, quality and performance strategies. We have used this model with respect to services for people from LGBTQ communities, those with sickle cell disorders, epilepsy, acute mental health problems, stroke, and women who have experienced poor service during pregnancy. We now want to explore the impact and effectiveness of emergency care provided by the LAS on health inequalities of people living in London.

It is essential that the diverse voices of service users are continuously heard and valued as a catalyst to the evolution of more effective care, provided in collaboration with health and social care services in every London Borough.

Many service improvements are needed, including much enhanced responsiveness to emergency calls. The performance of the LAS in relation to meeting their targets for getting to patients within specified target times and handover at A&E is often disappointingly poor, especially in relation to Category 2 calls which include patients who have suffered a stroke. Other improvements are needed in relation to mental health care, responding effectively to patients' complaints within a shorter time frame, and the transformation of the LAS in relation to equality, diversity and inclusion. We co-produced an excellent 'Complaints Charter' with the LAS to improve their handling of complaints, but they have since withdrawn from promoting this Charter to those with complaints against the LAS. **https://tinyurl.com/26v7vrdm**

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WHAT IS THE PATIENTS' FORUM?

The Patients' Forum has monitored the LAS and other urgent and emergency care services across London for 20 years. Its members are patients and local people who examine services both as users and active lay people. It obtains the information it needs to monitor health services from many sources, including service users, the LAS, the Commissioners and NHS service providers across London.

The Forum raises awareness of the needs and views of patients and the public and attempts to place them at the centre of health service decision-making.

Telephone: 07817 505193 Email: patientsforumlas@aol.com
www.patientsforumlas.net

A person loses 2 million nerve cells for every minute they don't receive medical treatment during a Stroke, so getting to hospital early really is a lifesaver.

Improving the Diagnosis of Stroke in Emergency Care

VERY POSITIVE RESPONSE FROM DR FENELLA WRIGLEY

Response From Dr Fenella Wrigley to Dr Nick Mann 9-6-2025

Dear Dr Mann, I have, I hope good news for you, in that both NHS Pathways and MPDS, as the two approved 999 triage tools have now made changes.

NHS Pathways

- In NHS Pathways there is comprehensive training around the "Declared Stroke" route. This is for anyone who reports anything like, "I think they're having a stroke." Where this is declared, but the symptoms are not FAST +ve, and not otherwise identified in the pathway, these go to a senior clinician for an emergency call back for further assessment (Dx11).

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- The triage product does not specifically enquire after a new inability to **read** in the (Declared) Stroke pathway. However, the question wording is intentionally broader, and asks "**...suddenly unable to see properly in the last 24 hours?**"

- The supporting information for that question reads:

"This means being completely or partially unable to see. It may be described as a loss of vision in one eye or on one side. This means a new problem that has come on very suddenly in the last 24 hours. The eyesight may or may not have returned to normal at the time of the contact."

- In the event that someone who was newly unable to read (due to a stroke related visual disturbance) answered "no" to that question, the minimum end-point they could reach is Dx11 - i.e. urgent continuation of triage by a medical expert (usually a GP).

- Other routes that one could reasonably take, where "Stroke" wasn't the declared reason for the call but someone's sole presenting complaint was a new inability to read might include Eye, Visual Loss or Disturbance or Behaviour Change. The lowest dispositions possible in these pathways are Dx02 - attend ED - or Dx05 - an emergency GP - respectively. However, it is unlikely that they would reach the bottom of these pathways.

- So, a change in vision, such as being unable to read, would be captured by the question on visual disturbance in the stroke pathway. If they were triaged via Eye, Visual Loss or Disturbance - the other most likely route - the minimum endpoint would be to advise to attend the ED.

- In addition, and in direct response to the feedback from the LAS Medical Director, NHS Pathways have inserted a new line into the 'Hot Topic' on Stroke to reflect the scenario raised (see screenshot below with red wording highlighting the new text).

- Hot Topics are an important part of ongoing training and also a recent 'relaunch' of 'Illness vs Injury' in terms of health advisor pathway selection has emphasised the need to discuss with a clinician for any clinical scenarios that may sound unusual.

In addition, NHS Pathways acknowledged that Stroke is a difficult condition whereby symptoms can be so varied that it is difficult to capture them all in

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the various places and they have done some extensive work to encompass Posterior Stroke Symptoms described below:

- In terms of the pathways themselves visual disturbances are very well covered within the posterior stroke build and this has been reviewed by National Clinical Assurance Group (NCAG) colleagues.

- A sudden visual disturbance + becoming too unsteady to stand without support=PT213 which is the stroke closure build where if symptoms were present within the last 4 or 10 hours a Cat 2 ambulance Dx is reached.

- If there is no unsteadiness generally we ask about confusion which in a high risk stroke PW such as headache is Dx05 being the lowest disposition reached if there is NO functional impairment.

- In Behaviour Change, following the stroke, then posterior stroke build we ask about 'responding normally' which is a further catch where the lowest disposition reached is again Dx05 but more than likely would have come off on a higher disposition.

- The stroke and posterior stroke builds are present in the 'Eye Visual Loss or Disturbance' Pathway where the lowest disposition reached for sudden visual loss/disturbance is Dx02.

For MPDS

After liaison with the President of the International Academies of Emergency Dispatch agreed to include it in updated release of the Stroke Protocol – I have shared the information below as assurance.

The changes for the call handlers are as below:

Determinant descriptions have been updated from "Speech Problems" to "Sudden speech, reading, or writing problems" where applicable.

All of these changes have been shared with all ambulance services in England and also the Medical Directors and asked to report any further cases – no other cases have been raised. We continue to work closely with the National Stroke team to improve the care for our stroke patients. I am afraid I am not able to do any more than we have achieved so hope this provides the necessary assurance that we took your feedback extremely seriously.

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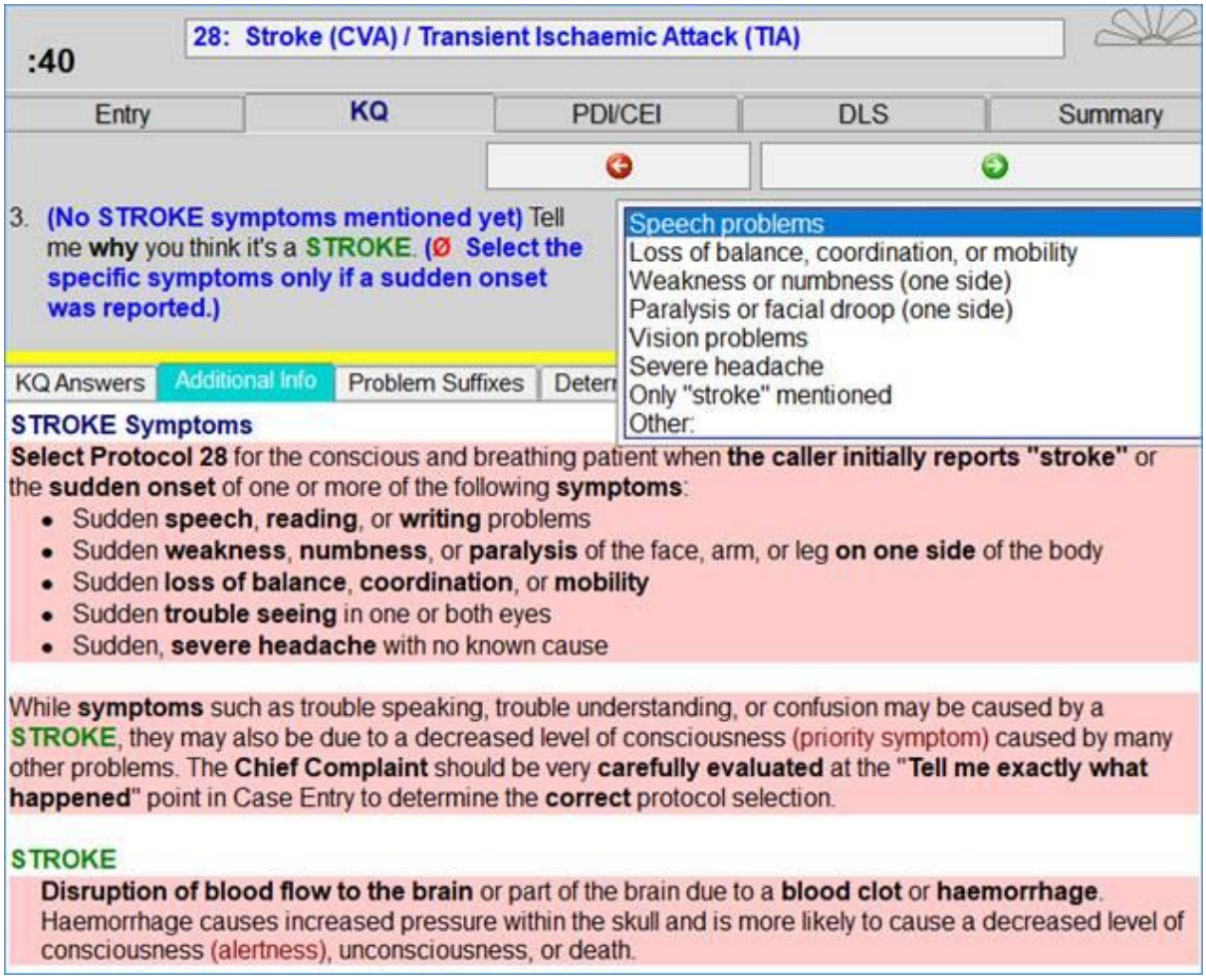

Questions & Issues raised with Fenella Wrigley, Chief Medical Officer and Deputy Chief Executive of the LAS (raised in 2024).

Dr Nick Mann's Stroke symptoms were not picked up by LAS 999 using the MPDS algorithm (USA owned software). MPDS (Medical Priority Dispatch System) does not include: "sudden inability to read", as a stroke symptom.

- It was agreed by participants in the Patients' Forum meeting that "sudden inability to read" is a 999-symptom and should prompt immediate suspicion and recognition of a stroke diagnosis.

- The 999 call-handler did not seek further advice from available Paramedics and Nurses within the Clinical Hub (Emergency Operations Centre).

- An LAS video assessment would have assisted diagnosis, but would have required a Paramedic to attend the patient on-scene.

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- It was confirmed by the Senior Lead for the Clinical Hub (EOC), Mike Ward, that “sudden inability to read” is recognised by the LAS 111 NHS-Pathways algorithm as a symptom of stroke, but not by 999 MPDS.

LAS Response: Alexia is NOT recognised by NHSP, but acute visual disturbance is (Alexia is acquired deficit inability to interpret written language).

- Dr Fenella Wrigley stated that information from the International Academies of Emergency Dispatch website is that the FAST algorithm is more effective than on-scene ambulance crews at detecting strokes. It is accepted that this stands in contradiction to 2014 research.
https://pubmed.ncbi.nlm.nih.gov/24576912/

LAS Response: This is information from the International Academies of Emergency Dispatch website relayed by Dr Wrigley. It is acknowledged that there is alternative evidence from research published in 2014.

- The 2014 research suggests that dependence on the FAST algorithm is poorly predictive of stroke diagnosis overall, and substantial numbers of strokes are consequently missed through use of the FAST algorithm.

- Use of the BE-FAST algorithm reduces strokes missed by FAST from 14% to 4.4%. BE-FAST is not currently used by the LAS.
https://pubmed.ncbi.nlm.nih.gov/28082668/

- Courtney Grant highlighted evidence that use of algorithms can lead to an ‘over-dependence’ and that Clinicians and Call Handlers may become over-reliant on such algorithms, causing important symptoms and diagnoses to be missed.

LAS response: The algorithms being referred to here (MPDS) are being utilised by non-clinicians. They are an assistive tool for non-clinicians who use them to support their assessment to determine the most appropriate response for the patient.

- Multiple organisations must collaborate and agree to any alterations or updating of algorithms. It is not clear whether these remote organisations operate within a clear, effective and efficient chain of command and communication system, to quickly enable necessary changes to occur.

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OUR RECOMMENDATIONS TO THE LONDON AMBULANCE SERVICE

1) **As a matter of urgency the MPDS algorithm should be amended to include "Sudden inability to read" as a Stroke symptom.**

2) **Action must be taken to ensure that MPDS and 111 NHS Pathways recognise the same symptoms in the diagnosis of Stroke.**

3) **Sudden Inability to read must be regarded as a Stroke symptom equal in status to other symptoms included in FAST and BE-FAST.**

4) **The LAS must adopt the BE-FAST algorithm for standard use, in view of the evidence that it reduces Strokes missed by FAST from 14% to 4.4%.** https://pubmed.ncbi.nlm.nih.gov/28082668/

5) **Call Handlers in LAS Emergency Operations Centres must receive additional training regarding their response to Stroke symptoms, including 'sudden inability to read', and this training should be carried out together with other staff in the Clinical Hub.**

6) **Front line LAS staff should be trained in the use of video assessment techniques to assist diagnosis of Stroke.**

7) **Training of all clinical staff in the LAS must ensure that face to face clinical assessment is seen as the most effective way of diagnosing a Stroke, and that the FAST test is no longer seen as the highest level of diagnostic practice in Stroke diagnosis.** https://pubmed.ncbi.nlm.nih.gov/24576912/

8) **Front line staff and their managers must be trained in Human Factors to enhance their awareness that algorithms can lead to 'over-dependence' on them as a diagnostic tool, and that Clinicians may become over-reliant on such algorithms, causing important symptoms and diagnoses to be missed.**

9) **Multiple organisations must collaborate and agree to alterations or updating of algorithms. These remote organisations must operate within a clear and efficient chain of command and communication system, to quickly enable necessary changes to occur.**

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LAS BME PARAMEDIC WORKFORCE STATISTICS

The Forum has been collecting this data from the LAS since 2003. Significant progress has been made in recent years, but the % of BME paramedics (13.6%) is still low compared with the BME population of London which is 46%.

Year	*Total No. Paramedics*	*Total No. of Paramedics of BME heritage*	*Actual Annual Increase BME Paramedics*	*% BME*	*BME Paras As % staff on front line (direct patient contact)*	*BME Paras As % of total workforce*
2003/04	685	22		3.21	Not known	0.5
2004/05	734	26	+4	3.54	1.07	0.65
2005/06	832	26	0	3.13	0.99	0.62
2006/07	816	27	+1	3.31	1.00	0.61
2007/08	836	32	+5	3.83	1.19	0.74
2008/09	881	31	-1	3.52	1.04	0.7
2009/10	917	34	+3	3.71	1.01	0.68
2010/11	1,025	41	+7	4.0	1.22	0.83
2011/12	1,385	64	+23	4.62	1.98	1.38
2012/13	1,648	93	+29	5.64	2.97	2.01
2013/14	1,611	95	+2	5.9	3.09	2.04
2014/15	1,707	106	+11	6.2	3.49	2.3
2015/16	1,991	139	+33	7.0	4.6	2.8
2016/17	1,969	134	-5	7.0	4.2	2.6
2017/18	2,050	133	-1	6.4	3.9	2.5
2018/19	2,104	158	+25	7.5	4.8	2.7
2019/20	2,274	204	+46	9.0	6.1	3.5
2020/21	2,278	225	+21	10.0	5.6	3.5
2021/22	2,370	261	+36	11.0	6.4	3.9
2022/23	2,573	312	+51	12.1	7.2	4.2
2023/24	2,878	385	+73	13.4	8.2.	4.7
2024/25	3,194	434	+49	13.6	8.8	5.0

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The 2025 ANNUAL GENERAL MEETING of the Company PATIENTS' FORUM AMBULANCE SERVICES (LONDON)Ltd was held via Zoom Conference Call Link with the registered office of the Company on: NOVEMBER 20th 2025

Zoom Meeting:

The following Resolution was submitted to the AGM and passed unanimously:

1. It was RESOLVED that the Annual Report and Financial Statement of the Company for the year ended 31st December 2024 be and are hereby received and adopted by the meeting.

GUEST SPEAKER: JOSEPH HEALY – THE COVID INQUIRY AND COVID PANDEMIC.

THE COVID WINTER WAVE - PROTECTING PATIENTS AND PUBLIC

PRESENTATION ON PUBLIC INVOLVEMENT IN THE NHS

ATTENDEES

Malcolm Alexander, Dr Joseph Healy, Sister Josephine, Elsie Gayle,

Felicity Dowling, Anna Roscher, Beulah East, Sandra Wyman.

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DESCRIPTION OF THE FORUM FROM THE LAS WEBSITE …

What is the Patients' Forum?
The Forum is an independent body that monitors the LAS for the benefit of the public.

Who makes up the Patients' Forum?
It is made up of members of the public who are involved in LAS monitoring, audit, research and policy-making committees.

Officially, Patients' Forums were abolished in March 2008 and are no longer statutory bodies.
However, we have continued to have an effective relationship with our Forum and work with them in the following ways:

- Our Senior Managers attend Forum Meetings to present information and invite
- discussion on a range of topics. This gives Forum members the chance to have a say on key issues and decisions.
- Ad-hoc meetings are held, and action taken, to take forward issues of particular interest to Forum members.
- More recently, we have run a series of visits to the Control Rooms for Forum members and have also run a basic Life Support Session for them.

The Forum has been running for 20 years and throughout that time has continuously campaigned to bring about improvement to urgent and emergency care, for patients suffering from serious medical conditions.

The Patients' Forum suffered a drop in activities during the Covid period, but has since revived, and is running very successful public meetings, together with leaders of health and social care services.

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REPORT AND FINANCIAL STATEMENT FOR THE YEAR ENDED 31 DECEMBER 2025

The Trustees have pleasure in presenting their Report and Financial Statement for the year ended 31st December 2025.

INCORPORATION

The Company (No 6013086), which was incorporated on 29 November 2006 under the Companies Act 1985, is a not-for-profit private Company Limited by Guarantee, with no share capital, and is registered with the name of Patients' Forum Ambulance Services (London) Ltd.

Its Memorandum and Articles of Association are in the model format for a charitable company as issued by the Charity Commission. Its objectives and activities are those of a small un-registered Charity, as described more fully in this Report.

The *nature of the company's business is covered by the classification code categories: 86900* - Other human health activities, and 94990 - Other membership organizations.

DIRECTORS AND TRUSTEES

The Directors of the company are its Trustees for the purpose of Charity Law. As provided in the Articles of Association, the Directors have the power to appoint additional directors. The Trustees who have served during the year and since are:

- Malcolm Alexander (re-elected 11 November 2024)
- John Larkin
- Louisa Roberts (resigned 5 November 2025
- Rev Sister Josephine Udie

Patients' Forum Ambulance Services (London) Ltd comprises members of the public, including patients and carers.

The office of the Patients' Forum is located in London.

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ACTIVITIES AND ACHIEVEMENTS

Since 1st April 2008, the Patients' Forum has established itself as a corporate body in the voluntary sector.

The Forum has continued to work with the London Ambulance Service and other health bodies in London and beyond, ensuring that a body of experienced people exists who can be highly effective at monitoring services provided by the London Ambulance Service and other providers, and commissioners of urgent and emergency care. The Company has worked closely with Local Healthwatch since their establishment on 1st April 2013.

The Forum has successfully monitored services provided by the London Ambulance Service and worked successfully with the voluntary sector and the commissioners of the LAS, as well as forming links with patients, patients' groups and the public.

The Forum has successfully carried on its commitment to supporting and influencing the development of high quality urgent and emergency health care.

From the outset, the Company invited and received a constructive letter of mutual recognition and understanding from the Chief Executive of the London Ambulance Service, in confirmation and furtherance of the good working arrangements that have long characterised the relationship between the London Ambulance Service and the Patients' Forum. The Forum has consistently relied upon this document as affirming its positive relationship with the LAS.

The range of issues within the independent purview of the Company is frequently updated as necessary, and participation is readily accessible to members and the public by attending the Forum's meetings and/or visiting the Company's website – *www.Patientsforumlas.net.*

Members from across London, and Affiliates from all parts of the UK, are very welcome to join us.

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MEMBERS AND AFFILIATES

All the Trustees are members of the Company. During the year ended 31 December 2025, the Company also enrolled other membership of the Company.

Each member guarantees, in accordance with the Company's Memorandum of Association, to contribute up to £10.00 to the assets of the Company in the event of a winding up.

Membership is open to individuals who are London based at the time of joining. Members are entitled to attend meetings of the Company, and to vote thereat. The Annual Membership fee for individuals is £10.00. New members are welcome to join.

AFFILIATION

- Affiliation is open to groups, organisations and to individuals, both local and national.
- Affiliates are fully entitled to attend meetings of the Company, but not to vote thereat.
- The Annual Affiliation fee for groups and organisations is £20.00.
- The Annual Affiliation fee for individuals is £10.00. New Affiliates are welcome to join.

This Report was approved by the Directors/Trustees on 2026
and is signed on their behalf by:

_____

Malcolm Alexander
Director/Chair

John Larkin
Director/Company Secretary

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PATIENTS' FORUM AMBULANCE SERVICES (LONDON) LTD
INCOME AND EXPENDITURE ACCOUNT

For the Year Ended 31 December 2025

	Unrestricted Funds 2025	Total 2025	Total 2024
	£	£	£
Incoming Resources			
Donations	-	-	-
Membership fees	10	10	25
Affiliation fees	-	-	-
Other	-	-	-
Total Incoming Resources	10	10	45
Resources Expended			
Companies House fees expenses claims	62	62	62
Website administrative expenses claims	134	134	-
Bank charges	72	72	71
Total Resources Expended	268	268	133
Net Incoming/(Outgoing) resources for year	(258)	(258)	(88)
Total funds brought forward	3587	3587	3675
Total funds carried forward	3329	3329	3587

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BALANCE SHEET - 31 December 2025

	TOTAL 2025 £	TOTAL 2024 £
- Fixed Assets	-	-
- Debtors	-	-
- Cash in hand	10	-
- Cash in bank	3319	3587
- Gross current assets	3329	3587
CREDITORS		
- Amounts falling due within one year	-	-
NET CURRENT ASSETS	3329	3587
TOTAL ASSETS LESS CURRENT LIABILITIES	3329	3587
RESERVES		
- Restricted funds	-	-
- Unrestricted funds	3329	3587
TOTAL FUNDS	**3329**	**3587**

NOTES

1. These accounts have been prepared in accordance with the provisions applicable to companies subject to the small companies' regime.
2. For the year ended 31 December 2025 the Company was entitled to exemption under Section 477 of the Companies Act 2006.
3. No notice from members requiring an audit of the accounts has been deposited under Section 476 of the Companies Act 2006.
4. The Directors acknowledge their responsibility under the Companies Act 2006 for:

(i) Ensuring the Company keeps accounting records which comply with the Act; and

(ii) Preparing accounts which give a true and fair view of the state of affairs of the Company as at the end of its financial year, and of its income and expenditure for the financial year in accordance with the Companies Act 2006, and which otherwise comply with the requirements of the Companies Act relating to accounts, so far as applicable to the Company.

5. Patients' Forum Ambulance Services (London) Limited is a registered Company limited by guarantee and not having a share capital; it is governed by its Memorandum and Articles of Association. It is an un-registered Charity whose income is currently insufficient to fulfil the criteria for compulsory registration with the Charity Commission.

This Financial Statement was approved by the Trustees on 2026 and is signed on their behalf by:

Malcolm Alexander- Director/Chair John Larkin - Director/Company Secretary

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OBJECTS OF PATIENTS' FORUM AMBULANCE SERVICES (LONDON) LTD

Members of the statutory Patients' Forum, which was abolished on 31 March 2008, originally formed the Company alongside the London Ambulance Service, as a not-for-profit body with exclusively Charitable Objects.

The Company was duly encouraged to progress in the voluntary health sector as an independent catalyst for more than a decade of fruitful co-operation, whilst promoting a mutual observance of pan-NHS legislation as well as pan-NHS constitution and guidelines, actively achieving constructive public benefit through patient and public healthcare and involvement across London and beyond.

The Company remains committed to act for the public benefit through its pursuit of wholly charitable initiatives, comprising:

(i) The advancement of health or the saving of lives, including the prevention or relief of sickness, disease, or human suffering; and

(ii) The promotion of the efficiency and effectiveness of ambulance services.

The Company is dedicated to the pursuit of its Objects as a small, unregistered Charity.

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APPENDICES

APPENDIX 1 – GLOSSARY

ACP … … …	Advanced Care Plan/Alternative Care Pathway
AACE … … …	Association of Ambulance Chief Executives
A&E … … …	Accident and Emergency Department
AI … … …	Artificial Intelligence
AMHP … … …	Approved Mental Health Professional
APPG … … …	All Party Parliamentary Group
ARP … … …	Ambulance Response Programme
BAME… … …	Black, Asian, Minority Ethnic Groups
BME… … …	Black and Minority Ethnic
BEFAST … … …	Balance-Eyes-Face-Arm-Speech-Time
CAD … … …	Computer Aided Dispatch
CARU … … …	Clinical Audit Research Unit
Cat 1 … … …	Target - life threatening conditions – 7 minutes
Cat 2 … … …	Target - urgent/emergency conditions - 18-40 mins
CC … … …	Corpus Callosum
CCG … … …	Clinical Commissioning Group
CH … … …	Call Handler
CHUB… … …	Clinical Hub (EOC)
CoRe … … …	Covid Rehabilitation Service
CPN … …	Community Psychiatric Nurse
CPR … …	Cardiopulmonary Resuscitation
CSR … … …	Corporate Social Responsibility
CQC … … …	Care Quality Commission
CQRG … … …	Clinical Quality Review Group
CQUIN … … …	Commissioning for Quality and Innovation
CmC … … …	Co-ordinate my Care
COBRA … …	Cabinet Office Briefing Room
COP 26 … …	26th Conference of the Parties (UN Climate Change Conf)
CTA … … …	Clinical Telephone Advice
DKA … … …	Diabetic Ketoacidosis
DNAR … … …	Do Not Resuscitate Notice
DoC … … …	Duty of Candour
DoS … … …	Directory of Services
DTA … … …	Decision to Admit
EBS … … …	Emergency Bed Service
ECD … … …	Emergency Care Department
ECPAG … … …	Emergency Call Prioritisation Advisory Group

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ED … … …	Emergency Department (A&E)
EDM … … …	Early Day Motion
EEG … … …	Electroencephalogram
EI … … …	Equality and Inclusion
EHRC … … …	Equality and Human Rights Commission
ELFT … … …	East London Foundation Trust
EOC … … …	Emergency Operations Centre
ePCR	Electronic Patient Care Records
EoLC … … …	End of Life Care
FAST … …	FACE – ARM – SPEECH – TIME (TO CALL LAS)
FBU … … …	Fire Brigades Union
FRCEM… … …	Fellow of the Royal College of Emergency Medicine
FOI … … …	Freedom of Information Act 2000
FT … … …	Foundation Trust
GDPR … … …	General Data Protection Regulation
GMC … … …	General Medical Council
HASU… … …	Hyper Acute Stroke Unit
HAZMAT … …	Hazardous Materials
HCA … … …	Health Care Assistant
HCP… … …	Healthcare Professional
HCPC … … …	Healthcare Professions Council
HUH … … …	Homerton University Hospital
IAED… … …	International Academies of Emergency Dispatch
IAPT … … …	Improving Access to Psychological Therapies
ICB … … …	Integrated Care Board
ICS … … …	Integrated Care System
IUC … … …	Integrated Urgent Care
KPI … … …	Key Performance Indicators
LAS … … …	London Ambulance Service
LGBTQ … …	Lesbian, Gay, Bisexual, Transgender, Queer
LTC … … …	Long Term Condition
MAR … … …	Multi Attendance Ratio
MCA … … …	Middle Cerebral Artery
MDTs… … …	Mobile Date terminals
MPDS… … …	Medical Priority Dispatch System
NASMeD … …	National Ambulance Service Medical Directors' Group
NEL … … …	North East London
NETS … … …	Non-Emergency Transport Service
NHSE … … …	NHS England
NHSI … … …	NHS Improvement
NHSP… … …	NHS Professionals

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NMC … … …	Nursing and Midwifery Council
NRLS … … …	National Reporting and Learning Service
OOH … … …	Out of Hours
PIP … … …	Personal Independence Payment
PLACE… … …	Patient-Led Assessments of the Care Environment
PPI … … …	Patient and Public Involvement
PRF … … …	Patient Report Forms
RCEM… … …	Royal College of Emergency Medicine
SCA … … …	Sudden Cardiac Arrest
SCI … … …	Spinal Cord Injury
SCS … … …	Sickle Cell Society
SCD … … …	Sickle Cell Disorders
SDEC … … …	Same Day Emergency Care
SECAMB … …	South East Coast Ambulance Service
SI … … …	Serious Incident
SMI … … …	Serious Medical Illness
STP … … …	Strategic Transformation Plan
TBI … … …	Traumatic Brain Injury
TIA … … …	Transient Ischaemic Attack
UCH … … …	University College Hospital
UEC … … …	Urgent and Emergency Care
WRES … …	Workforce Race Equality Scheme

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APPENDIX 2 - PROTECTED CHARACTERISTICS

AGE

Where this is referred to, it refers to a person belonging to a particular age (e.g. 32-year-olds) or range of ages (e.g. 18 - 30-year-olds).

DISABILITY

A person has a disability if s/he has a physical or mental impairment that has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

GENDER AND REASSIGNMENT

The process of transitioning from one gender to another.

MARRIAGE AND CIVIL PARTNERSHIP

In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple. Same-sex couples can alternatively have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act 2010).

PREGNANCY AND MATERNITY

Pregnancy is the condition of expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

RACE

Refers to a group of people defined by their race, colour, and nationality (including citizenship), and ethnic or national origins.

RELIGION AND BELIEF

Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs including lack of belief (e.g. atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

SEX

A man or a woman.

SEXUAL ORIENTATION

Whether a person's sexual attraction is towards his or her own sex, the opposite sex or to both sexes.

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APPENDIX 3 – OUTCOME OF STROKE MEETING WITH DR FENELLA WRIGLEY, CHIEF MEDICAL OFFICER, LAS

Dr Nick Mann and Karen Kennedy Presentation to the Forum Meeting

Dr Nick Mann, who has been a GP for over 30 years, suffered two major heart attacks and was treated at the Bart's Coronary Unit. On the day following discharge from the Coronary Unit he suffered a Stroke.

His wife Karen Kennedy called 999 and described Nick's symptoms, but the 'call-handler' said that his symptoms – sudden loss of ability to read text - according to the FAST test and algorithm, failed to meet the diagnostic threshold for Stroke. Karen said that Nick as an experienced GP was sure he had suffered a Stroke, but the call-handler refused to send an ambulance and advised Karen to call 111 for a more detailed review of his symptoms, and the possibility of an ambulance being provided through an alternative route. Instead, they decided to call a taxi which got them to Homerton A&E at speed. An ambulance then took Nick to the Royal London Hospital (RLH) Specialist Stroke Centre, where he waited approximately 16 hrs in A+E for a bed. He has since made a good recovery.

Karen described her shock at this awful experience when Nick was in a very vulnerable state of health and an emergency response was refused by the LAS. Nick said that from his clinical experience, he could not suggest a diagnosis other than Stroke for his symptoms.

The LAS and 111 operate using two different diagnostic systems. The LAS uses the Medical Priority Dispatch System (MPDS), (sometimes referred to as the Advanced Medical Priority Dispatch System (AMPDS)), which is a unified system used to dispatch an appropriate response to medical emergencies, including detailed questions to the caller to ascertain the presumptive diagnosis. Pre-arrival instructions and advice are also given. 111 uses an alternative system called NHS Pathways. Nick said that the symptoms he had might not have been recognised by either system, and he asked who actually makes decisions regarding the diagnostic criteria for Stroke and other conditions, and whether these systems have been upgraded since his experience of Stroke in November 2023.

Nick experienced no Hemiplegia (paralysis that affects only one side of the body), no face droop or speech alterations, and no loss of function in his arms or legs.

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Although he had lost half his field of vision, he was not aware of that, but in practice he had only retained the left side of his field of vision. He was unable to recognise letters or numbers. The scan at the RLH showed that a large area of his brain was affected, and as a result had lost half his field of vision on the left side of his brain. He said that his medical knowledge and experience confirmed for him that he had suffered a stroke.

INITIAL RESPONSE FROM DR FENELLA WRIGLEY, LAS CHIEF MEDICAL OFFICER TO QUESTIONS FROM NICK MANN AND KAREN KENNEDY

1) WHY ISN'T 'SUDDEN INABILITY TO READ' A CATEGORY 2 ALERT?

The majority of acute Stroke patients present with signs that can be identified via the Face Arms Speech Time Test (FAST). Atypical presentations are inherently challenging to identify at the initial stage. Patients suffering strokes can present with a wide range of presenting symptoms including falls, fits, dizziness, headaches etc. These cases may not be picked up in the initial triage and so an additional clinical assessment helps us to identify these patients.

The additional clinical assessment is done by either our 999 Clinical Hub (by Paramedics or Nurses) or through LAS 111 (which has a multi-disciplinary team including advanced clinical practitioners and GPs). This enables us to provide a more individualised response, which might be an ambulance, a specialist response e.g. mental health car/urgent care car or it might enable us to make a referral to services closer to the patient's home. It is also important for us to ensure that patients with complex presentations or specific illnesses receive the right ambulance response.

If the patient or caller is asked to ring 111 and an ambulance is required, then the patient is immediately transferred back into the ambulance dispatch queue, at the priority level indicated by the additional clinical assessment.

Stroke patients are designated as category 2 (maximum 18 minutes to arrival time) where the symptoms are identified during the initial 999 call, and the symptoms started within the nationally agreed timeframe.

2) HOW ARE CHANGES TO DIAGNOSTIC ALGORITHMS MADE BY AMBULANCE SERVICES?

The London Ambulance Service 999 emergency triage tool is the Medical Priority Dispatch System (MPDS). This triage tool is built on having tested hundreds of

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millions of calls since 1979. MPDS includes 26 protocols (with hundreds of subcategories) that are continually updated based on recommendations and research. 999 calls triaged via this tool will generate a corresponding determinant code. Each of these codes has an associated ambulance response category which is agreed by NHS England based on the review of very large numbers of calls.

There are various national clinical leadership and steering groups tasked to oversee developments and changes within 999 emergency triage. These groups comprise of Subject Matter Experts and ambulance service representatives, who share learning from incidents, clinical audit and patient experience.

Where an ambulance service identifies, through learning, there may be a need to review a triage protocol or prioritisation, and this is raised through the following process:

- **Triage Protocol concern**

- A local ambulance service or Coroner or expert group identifies a concern with a triage protocol.

- The recommendation for review is raised to NHS Pathways and MPDS teams – they will decide about any changes to their triage tool. NHS England clinical coding groups are also informed.

- The request for change goes through expert clinical groups, governance groups, technical groups and when the change is made, it is changed for all users (for MPDS this would be shared internationally, and for NHS Pathways it would be shared in England).

- **Request for review of ambulance priority for a particular determinant code (patient group)**

- A request for a change to ambulance priority level for a particular determinant code (called re-categorisation) is made to the NHSE national coding group.

- The national coding group gathers information about the request from other ambulance services and discusses it with NHS Pathways and MPDS.

- If it is agreed there should be a change to the priority of a ‘determinant’ then the recommendation is made to the National Emergency Call Prioritisation Advisory Group (ECPAG).

- If approved, all ambulance services make the change by an agreed date.

The LAS has a close relationship with the International Academies of Emergency Dispatch and NHS Pathways and works collaboratively where evidence indicates a protocol/determinant change or where a further development may be required.

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Since Dr Mann's case came to light, the concern that this symptom of a Stroke is not being picked up through LAS triage has been raised to:

- MPDS
- NHS Pathways
- National Coding Group
- Stroke Clinical Network Co-Clinical Directors – London Region (response shared with Dr Mann)
- National Stroke Director

3) WHAT IS IN PLACE TO MONITOR THE NEED FOR ALGORITHMIC CHANGES TO THE CATEGORISING OF SYMPTOMS?

The LAS Clinical Audit and Research Unit (CARU) produces a Stroke Registry, which holds clinical information extracted from the LAS Patient Electronic Patient Care Records (ePCR), which are completed on-scene by the attending Clinicians. Data sets also include operational data collected from the Emergency Operations Centre (EOC), Call Logs and vehicle Mobile Data Terminals (MDTs).

Reports are shared internally and with national clinical audit and leadership groups for consideration. The learning is also shared internationally for product owners to review their triage tool and to make changes where required.

4) RESEARCH INTO THE USE OF THE 'FAST' TEST CALCULATED THAT ONE OF FIVE PATIENTS WITH STROKES ARE ROUTINELY MISSED

Evidence from telephone assessments from the International Academies of Medical Dispatch is that the Stroke diagnostic tool has been proven, through research, to identify more than twice as many strokes as medics on scene:

Note: The IAED link from Dr Wrigley links only to the front page of the IAED website. Research published in 2014 from a Randomised Control Trial at Karolinska Institute in Solna, Sweden. This indicates that the opposite is true: Emergency Ambulance staff are significantly more likely, not less likely, to correctly identify a Stroke:

https://pubmed.ncbi.nlm.nih.gov/24576912/
https://www.emergencydispatch.org/home

In London we have, and continue, to work with the stroke networks to ensure we identify as many Strokes as possible. This includes using additional clinical assessment:

- For ambulance crews on scene in some ICSs the use of video triage is available, which allows a crew to share symptoms with staff in the EOC

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clinical hub, if they suspect a new loss of function is possible; even if the patient is FAST negative.

- For all clinicians within the LAS (telephone and face-to-face): we have shared case examples with our clinicians to highlight less common presentations of stroke and emphasise the need to factor in the testimony of both the patient and/or their carer.

5) <u>EXTRA AMBULANCE CONVEYANCING – PATIENTS WITH STROKE SYMPTOMS MAY BE TAKEN TO HOMERTON A&E, THEN TO THE ROYAL LONDON HOSPITAL</u>

The LAS monitors the conveyance of Stroke patients directly to HyperAcute Stroke Units. The annual Stroke audit for 2022-23 showed 99.6% of patients were conveyed to the right destination first time. The data for 2023 -24 shows over 99% of patients have been conveyed to the correct destination.

If a patient requires transfer from an ED to a HASU, then this is a Category 2 transfer if they are within the timeframe for thrombolysis or thrombectomy.

Actions so far taken by DR FENELLA WRIGLEY, LAS Chief Medical Officer, to improve recognition of diagnostic criteria for stroke

Following the meeting between Dr Mann, Karen Kennedy and Dr Fenella Wrigley, Chief Medical Officer of the LAS on 18th January 2024, a significant amount of work has been undertaken to share learning and request changes. At the meeting on 18th January the LAS CMO committed to taking Dr Mann's concerns to national groups (re Stroke and triage tools). Some of the meetings are quarterly and Dr Wrigley has advised that these changes can take quite some time, but she has raised them with all the appropriate groups. There are national clinical reference groups for NHS Pathways and MPDS, each of which has an ambulance representative and the LAS is utilising this route. The actions which have been taken include:

- Request made via the National Clinical Coding Group
- Highlighting the case to the MPDS and NHS Pathways teams
- New processes in EOC for call handlers to highlight concerns to clinicians
- Co-locating clinicians with dispatchers to provide support
- Increasing capacity in the 999 Clinical Hub and 111 IUC, so if a patient requires a rapid clinical assessment this is done in a timely way
- Sharing the case with regional and national stroke leads
- Sharing the case with clinicians across urgent and emergency care
- Dr Wrigley has invited Dr Mann to share his story with the LAS Board
- Dr Mann has been invited to visit the LAS call centre and spend some time to see the changes so far made, when he feels well enough to do so

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CONCLUSION FROM KAREN KENNEDY

Karen Kennedy said: I will remain acutely aware that the LAS failed to provide an emergency ambulance when it was desperately needed, because of an adherence to a formulaic response, rather than empathetic listening to what I was telling them. Had I not taken Nick by taxi to A&E, the outcome could have been a disaster for us. It is deeply disturbing that such a disaster could happen to others at any time. I sincerely hope that the LAS learns from what happened to us and takes action to implement major changes to their diagnostic system. The LAS needs an engaged, intelligent, human response with call handlers actively listening, rather than following an algorithm that could lose many lives. We have been very fortunate that the development of Nick's symptoms at that time and his recovery since have left him relatively well and unscathed.

DUTY OF CANDOUR

Dr Wrigley would like to reiterate on behalf of the LAS her apologies for the failings Nick and Karen experienced at a time when they needed help from LAS. She recognises how difficult talking about the experience was and is very grateful to them both for sharing their story so that the LAS can continue to learn and improve.

FURTHER STROKE DATA REQUIRED FROM THE LAS

- Is rate of missed diagnosis increasing and would the LAS know if it was?
- How many Strokes and other serious diagnoses are predicted to have been missed in London and nationally, as a result of the use of algorithms?
- Eleven different ambulance services operate in England and may use algorithms which vary in the ways they respond to clinical input. How is national performance coherently evaluated?
- How are changes to algorithms by NHS-Pathways and MPDS recorded and reported to ambulance services?
- When will MPDS be updated nationally to reflect “sudden inability to read” as a stroke symptom?

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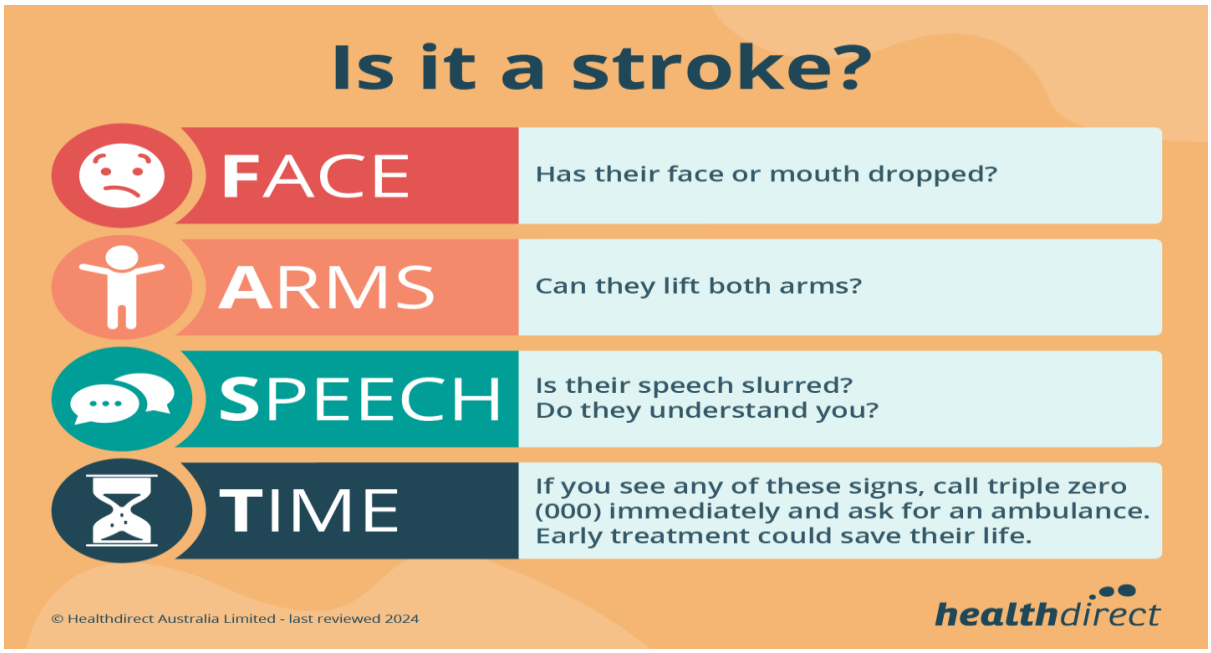
FAST TEST LEAFLET – AUSTRALIAN VERSION



APPENDIX 4 – MENTAL HEALTH EMERGENCY RECOMMENDATIONS ICS NORTH EAST LONDON - 2024

RECOMMENDATION 1 – ACCESS TO PERFORMANCE DATA

a) Supply monthly data to Healthwatch Hackney (HWH) and the Patients' Forum for the LAS (PFLAS), showing the number of patients waiting in excess of 4 hours and in excess of 12 hours from decision to admit.

b) Send monthly bed occupancy data for the six Homerton MH wards to HWH and PFLAS.

c) ELFT to share their daily acute care performance reports with HWH and the PFLAS.

RECOMMENDATION 2 - DECLARATION OF SERIOUS INCIDENTS

Clarify when it is a duty on Homerton Healthcare to declare long stays in A&E as Serious Incidents requiring investigation, in view of the increased risk of harm to service users who remain within ED for over six hours.

Clarify when it is a duty on ELFT to declare long stays in the statutory Place of Safety as Serious Incidents requiring investigation, in view of the possible increased risk of harm to service users who remain within Places of Safety for long periods.

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RECOMMENDATION 3 - POLICIES ON PARITY OF ESTEEM

a) Provide a copy of the Homerton Healthcare policy on compliance with the duty to exercise Parity of Esteem between patients who have a physical health problem, and those with a mental health problem.

https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/

b) Provide a copy of the Homerton Healthcare policy on returning patients to their home area mental health service, if this would in practice result in 'spot purchasing' of a bed in a private Hospital far from the patient's home.

RECOMMENDATION 4 - HIGH QUALITY CARE ALWAYS

Ensure that high quality mental health care is always provided to patients who are waiting for admission to a mental health bed at Homerton or to their home area.

RECOMMENDATION 5 - CONSENT FOR TRANSFER TO ALTERNATIVE MH UNIT

a) If a patient is to be transferred from the Homerton ED to their home area, ensure that the patient has given consent for this transfer.

b) If a patient is to be transferred to a private facility outside their home area, ensure that the patient has given consent to be provided with care, away from their home area.

RECOMMENDATION 6 - ADMIT TO A HOMERTON BED UNTIL A BED BECOMES AVAILABLE IN THE HOME AREA

Admit patients to a bed in ELFT if it would take more than 12 hours to locate a bed in the patient's home area, i.e. with patients' consent return to previous policy of taking patients to their home area only when a local bed is available.

RECOMMENDATION 7 - AGENCY COLLABORATION TO STOP LONG WAITS

Homerton Healthcare NHS Foundation Trust should work with ELFT and other partners in the City and Hackney Health and Care Partnership and the NEL ICS, to reduce and eventually eliminate very long waits, with the aim of bringing waiting times for patients in a mental health crisis back to no more than four hours from decision to admit to admission.

RECOMMENDATION 8 - OPEN MORE BEDS AND DEAL WITH PUBLIC HEALTH ISSUES

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The ICS, Homerton Healthcare and ELFT should publish an assessment of the resources they would need to provide more mental health beds in Hackney, in order to return to maximum 4 hour waits in ED, from decision to admit to admission to a mental health bed, and ensure resources are used to meet the challenges of population need and health inequalities in relation to mental health.

RECOMMENDATION 9 – DETERMINING REQUIRED NUMBER OF MH BEDS IN NEL TO STOP EXCESSIVE WAITS FOR ADMISSION

The NEL ICS should determine how many beds would be needed in North East London to stop MH ED waits in excess of 4 hours and publish a plan to open the required beds within the NHS – not the private sector.

RECOMMENDATION 10 - ETHNICITY DATA

Publish data each month on the ethnicity of patients who are held in ED in excess of 4 hours and in excess of 12 hours from decision to admit to admission to a bed or discharge.

RECOMMENDATION 11 - CLOSER WORK WITH LOCAL AUTHORITY TO SECURE ADEQUATE AND APPROPRIATE ACCOMMODATION

Work better with local authorities to ensure that supported accommodation is available as required for patients discharged by ELFT who are homeless.

Further Questions to Paul Gilluley – Medical Director, ICS NE London

1) What action is now being taken by London's Chief Medical Officers and the NE London, Urgent and Emergency Care Group, to reduce waits in ED for patients in a mental health crisis to no more than 4hrs?

2) Have London's Medical Directors discussed setting up Mental Health Crisis Hubs across London, where patients in a mental health crisis can receive effective mental and physical health care to meet their needs in an effective and compassionate way?

3) What action is being taken by the ICS to build resilience and meet the mental health needs of children and young people post-Covid?

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4) Will the ICS consider using the St Leonard's Hospital site as a location for development of mental health services for older people, intermediate care, and step-down care for patients preparing for discharge? This would be consistent with the ICS focus on developing local services and PLACE.

APPENDIX 5 – Complaints Charter Agreed with the LAS

www.patientsforumlas.net/complaints-charter-and-complaints.html

LAS COMPLAINTS CHARTER

The LAS Complaints Charter was written by the Forum and agreed by the LAS Board. However, they were unwilling to share the Charter with people who made complaints e.g. by sending the Charter directly to complainants. They have now removed the Charter from their website. The commitments by the LAS were as follows:

WHEN YOU ARE DISSATISFIED WITH HEALTH CARE SERVICES

- Tell us, as soon as possible, if you are unhappy with our services so that we can investigate your concerns and quickly try to put things right for you.
- Tell us if you have any particular needs that we should be aware of, e.g. an interpreter or other ways of ensuring effective communication with you.

OUR COMMITMENT TO YOU - WE SHALL …

- Acknowledge your complaint within three working days and explain how we shall handle your complaint/s and what information we need.
- Give the contact details of the person or team that will investigate your complaint.
- Keep you updated if it takes longer than we had hoped to respond and explain our progress in the investigation of your complaint.
- Pledge that making a complaint will not adversely affect your ongoing or future treatment in any way.

WE WILL FOLLOW AN OPEN AND FAIR PROCESS BY

- Listening to you carefully and fully understanding your complaint.
- Requesting all the information we need from you.
- Explaining how we shall investigate all your specific concerns.
- Being open and honest throughout the investigation, by ensuring the Duty of Candour (DoC) is complied with and you receive copies of any relevant reports.

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- Providing a comprehensive response to your complaint.
- Letting you know about local complaints advocacy services or other appropriate advocacy services to support and advise you during any complaint investigation.
- Explaining our decisions and recommendations, and how we reached them.
- Carefully evaluating all the information we've gathered to make a decision on your complaint and explaining how to contact and make recourse to the Health Service Ombudsman if you are dissatisfied with our findings.

WE SHALL GIVE YOU AN EXCELLENT SERVICE BY

- Treating you with courtesy and respect.
- Aiming to give you a final decision on your complaint within 35 working days – or explain the reason for any delay.
- Making sure our complaints service is easily accessible to you and giving you support and help if you need it.

APPENDIX 6 – Co-Production Charter Agreed with LAS

FOR URGENT AND EMERGENCY AMBULANCE SERVICES IN LONDON

The Patients' Forum wrote the Co-Production Charter in 2019, in collaboration with Healthwatch Hackney. It provides a unique opportunity for enhancing and growing the production of patient-centred services in line with the duties imposed on the LAS by the NHS Constitution. The Charter provides dynamic advantages for further collaboration and co-production with patients and the public.

Trisha Bain, Chief LAS Quality Officer, formally agreed to accept the Charter at a meeting with the Forum President, Joseph Healy, and Chair, Malcolm Alexander, but the LAS have never implemented it. Some of the key aspirations of the Charter follow; the full contents of the Co-Production Charter can be seen at:

www.patientsforumlas.net/co-production-with-the-las.html

A. THE LONDON AMBULANCE SERVICE AND THE PATIENTS' FORUM AGREE THAT:

- Services are organised so that they meet people's needs.
- Patients will have a stronger voice in the LAS than ever before.
- The patient is at the centre of everything that the LAS does.
- The LAS will listen to staff and patients to determine priorities.

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- Patients and carers will be involved in all LAS improvement work.
- Integral to all LAS programmes must be robust patient and staff involvement.
- LAS will listen to patients, families and carers, and respond to their feedback.
- The LAS goal is to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently.
- LAS will widen and increase public involvement in the development of pioneer services and the monitoring of success.
- A co-designed and co-developed patient and staff engagement model will be used to drive quality improvement across the maternity care model.

(Statements from the 2018/19 LAS Quality Account)

B. THE LONDON AMBULANCE SERVICE (LAS) AND PATIENTS' FORUM FOR THE LAS (PFLAS) AGREE THAT THE CO-PRODUCTION CHARTER:

- Provides an effective means of designing, shaping and delivering services in a partnership between the LAS and people who have used the service or may use it in the future.
- Enables delivery of our shared objectives for the creation of better services and outcomes for patients.
- Sets out the potential outcomes that people can expect from the co-production of urgent and emergency care services and other LAS care services.
- Sets out responsibilities of people taking part in the co-production of services.
- Establishes principles which are intended to achieve a vision of service users as equal partners in the production of effective urgent and emergency care.
- Signals the direction of travel for integrated service development between the LAS, patients and the public.

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C. PATIENTS AND THE PUBLIC WILL BE ENCOURAGED TO:

1) Participate at the earliest stages in design or redesign of services, where such changes may affect their care, treatment, or interaction with front- line staff.

2) Operate and function as equally valued voices, assets and partners.

D. EFFECTIVE COLLABORATION IS ESSENTIAL FOR EFFECTIVE CO-PRODUCTION:

1) LAS and the PFLAS agree to work collaboratively in the best interests of service users and the enhancement of their care.

2) The LAS and PFLAS agree to ensure that proposals for service changes and improvements will be the subject of joint work from initiation of the process to completion, including feeding back to service users on the results and outcomes of co-production.

E. PROMOTING EQUAL OPPORTUNITIES TO INFLUENCE CHANGE THE LAS AGREES TO:

1) Acknowledge differences in the capacity to effect change and in access to resources between all those who participate in Co-Production of LAS services.

2) Ensure the differential in influence and resources will not hinder the design of enhanced care for users of urgent and emergency services.

3) Provide access to all information/ documentation relevant to achieving shared goals of Co-Production in service design and creation.

4) Value equally all those who participate in and contribute to the joint process of Co-Production and decision making.

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APPENDIX 7 - THE FORUM'S MISSION STATEMENT

The Charity aims to influence the development of better emergency and urgent health care and improvements to patient transport services, by speaking up for patients and by promoting and encouraging excellence.

WE SHALL:

(1) Optimize working arrangements with the London Ambulance Service and other providers and commissioners of urgent and emergency care.

(2) Work with other service user networks that champion the needs of patients.

(3) Further develop campaigns for better and more effective emergency and urgent care services, and more effective and consistent approaches to service provision that reduce deaths and disability.

(4) Work towards better systems for all patients and carers to communicate their clinical conditions effectively to LAS clinical staff and receive effective and timely responses.

(5) Promote the development of compulsory patient focused quality standards for Patient Transport Services.

(6) Promote research to assess the clinical outcomes for the 25% of Category A (emergency) patients that do not get an ambulance response within eight minutes.

(7) Work with partners to develop better solutions for the care, transport and disposition of people with severe mental health problems and their carers, that respect their wishes and meet their needs. The Forum promotes sensitivity to their vulnerability, safety, culture and the gravity of their situation.

(8) Campaign to convince the Commissioners for the LAS and the LAS Board to develop better assessment, clinical effectiveness and care for people who suffer from cognitive impairment and dementia.

(9) Work with the LAS to develop effective systems and protocols, that ensure the wishes of patients with Advance Directives and Care Plans are respected, and that their care is provided completely in accordance with their prior decisions and wishes.

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(10) Work with LAS equality, diversity and inclusion leads to promote effective training of all LAS front-line staff in provision of care for London's diverse communities, in relation to all protected categories identified by Equality Act 2010.

(11) Work with the LAS Equality and Inclusion Committee to develop a workforce that reflects the diversity of communities across London, and provides care based on culturally and ethnically-based needs, when this is appropriate – for example, in relation to Sickle Cell disorders and mental healthcare

APPENDIX 8 - THE PATIENTS' FORUM LEAFLET

HOW IT WORKS

We hold monthly meetings that are open to Forum Members and to the public. These are usually held in the LAS Conference Room at 220 Waterloo Road, SE1 8SD, a few minutes from Waterloo Station. YOU ARE WELCOME TO ATTEND.

We invite service users and other influential speakers to discuss a wide range of issues connected to urgent and emergency care. They address the Forum and deal with questions and recommendations for service improvements. Each month we also meet with the Commissioner for the LAS who represents all London Clinical Commissioning Groups 9CCGs) to discuss ideas for service development.

We promote equality, inclusion and diversity in the LAS.

PATIENT EXPERIENCES DEPARTMENT
Tel: 0203 069 0240
ped@londonambulance.nhs.uk

CARE QUALITY COMMISSION
Tel: 0300 61 61 61
enquiries@cqc.org.uk

NHS ENGLAND
Tel: 0300 311 22 33

HEALTHWATCH ENGLAND
Tel: 03000 683 000

WHAT IS THE FORUM?

The Forum is an independent watchdog monitoring the London Ambulance Service (LAS). We advocate for patients by keeping a watch on emergency and urgent care in London, and we campaign for more effective services.

Patients, carers, community organisations and Healthwatch, can join the Forum and contribute to our work to achieve safer and more effective services.

Our Executive Committee regularly meets with senior LAS staff and the LAS Commissioners, to raise issues and to make proposals for better and more effective care.

We meet with health groups, e.g. mental health and sickle cell, to ensure that their experiences influence LAS services.

Most LAS services are excellent - our role is to promote public involvement and ensure that all patients receive care of the highest quality.

JOIN THE PATIENTS' FORUM
Receive monthly invitations to Forum meetings, and information about developments in urgent and emergency care.

Email or telephone your details to:
patientsforumlas@aol.com
0208 809 6551 or 07817 505193
www.patientsforumlas.net

JOIN the PATIENTS' FORUM for the LONDON AMBULANCE SERVICE

Tell us about your experience of Emergency and Urgent Care

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OUR ACHIEVEMENTS ...

The Forum has worked with the LAS and the Commissioners to improve care and practice in many areas, including:

* Prioritising training, care and treatment for patients with a mental health crisis and dementia care.
* Improving end-of-life care and transport for people who are terminally ill.
* Promoting the development of 'falls teams' for people who have fallen, but do not need hospital care.
* Developing joint work between the LAS and local services, to improve access to local care services.
* Encouraging a greater focus on the outcome of complaints and serious incident reports, as a means of improving services.
* Supporting and implementing Duty of Candour when optimal care has not been provided.
* Promoting equality, inclusion and diversity in the LAS.

FORUM'S EXECUTIVE COMMITTEE 2015/2016

Malcolm Alexander - Chair
Sister Josephine Udie - Vice Chair
Angela Cross-Durrant - Vice Chair
Lynn Strother
Kathy West
John Larkin - Company Secretary
Joseph Healy - President of the Forum

THE FORUM'S PRIORITIES FOR THE LAS

Emergency Care within 8 Minutes - Targets for emergency care are not being met for some patients. The LAS must be given sufficient resources to provide emergency care within 8 minutes - immediate care saves lives and substantially reduces disability.

Urgent, but not an Emergency (Category C) - LAS responses to Cat C calls are often poor. Patients who are very ill, but not life-threatened, sometimes wait hours for treatment, instead of 20 minutes. The LAS must have resources to meet Cat C targets (20 minutes for 90% of calls).

Home Care - Not Hospital Care - The LAS should develop agreements with local health and social care services in EVERY London Borough, so that immediate, effective and safe support and care is provided to patients who are frail and vulnerable, but need home care and not hospital care.

Dementia Care - Training in Dementia Care must continue to improve and to become more comprehensive - e.g: with pain control. We have recommended the film 'Barbara's Story about Dementia Care' is seen by every member of the LAS staff.

- See Barbara's Story on YouTube at http://www.youtube.com/watch?v=DtA2sMAjU_Y

FAST Test for Strokes - Refresher training is needed by all front-line staff to ensure that they are fully competent to identify strokes using the FAST test, and to rapidly transport patients to Stroke Units.

FAST ... ... FACE - ARMS - SPEECH - TIME to call 999

Mental Health Care - People with severe mental health problems who become ill on the street - or at home - and require emergency care, should be treated immediately by Paramedics and Nurses with specialist training in mental health care.

Ambulance Queueing Must be Stopped - Ambulance queueing outside A&E Departments is completely unacceptable and must be stopped. It results in very sick people waiting an hour or more for A&E care, and prevents Paramedics from treating other seriously ill patients.

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