Patient Experiences

Annual Report

2016/17

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1. Introduction

Our Patient Experiences Report aims to present a rounded picture of patient experiences providing a range of information on all aspects of involvement whether that is good or bad. Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered.

This report highlights the following:

- Complaints
- Patient Advice and Liaison Service (PALS)
- Patients with complex needs who make repeated 999 calls
- Solicitor and other requests for medical records and witness statements.

It provides an overview and analysis of activity about PALS and complaints, including cases investigated by the Health Service Ombudsman, lessons learned and the action taken by the Trust arising from service-user feedback and complaints. We want to make the best use of feedback from patient and carers and make sure that they have a positive experience every time they come into contact with our staff.

The volume of complaints this year has fallen for the second year in succession. Each complainant received a response that was personally reviewed and signed by the Chief Executive (or a deputising Director when the CEO was away from work).

We manage our complaints handling process in accordance with the Health Service Ombudsman's good practice guidance, *Principles of Remedy*. This includes:

- All complaint responses include information about the recourse opportunity to, and contact details for, the Health Service Ombudsman.
- Our website and all our staff can offer information about how to make a complaint about the service we provided.
- Activity and themes arising from complaints are regularly reported to the Trust Board
- Our Learning from Experience Group reviews the themes and issues emerging from complaints and the action taken to improve services and the experience of patients

PALS offer immediate assistance including liaising with other departments and agencies. During 2016/17 there were 4302 contacts from patients, carers, relatives and the public. This contrasts to the decrease in the numbers of complaints in the same period and highlights the importance of maintaining our PALS service in order to provide advice, support and information to patients, families and their carers.

2. Context

This year, the Trust has experienced call rates of 1,826,840 x 999 calls, approximately 1.4% higher than the previous year (1,801,104). This constitutes a daily average of 4991 x 999 calls. We attended 1,111,673 of these calls which results in a 0.09% average ratio complaints versus calls attended. Lessons learned and improvements are reported to the Board of Directors and shared with staff throughout the Trust through publication of clinical articles and the *Insight Newsletter* based on patient and staff feedback.

Our Learning from Experiences Group is an important part of this work. It reviews and brings together lessons learned from external sources, adverse incidents, litigation, comments, concerns, complaints, audits, major incidents, safeguarding an information governance issues.

We continue to build on patient engagement activities including presenting patient stories at Trust Board meetings and monitoring public websites such as Patient Opinion and NHS Choices. Our *'Talking with Us'* Complaints and Thanking our staff leaflets have been made available on all our vehicles and each complainant will receive a '*Feedback on Complaints'* form with every complaint response.
http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

3. Summary of complaints and PALS

May 2016

The Trust implemented the web version of our case management system. This includes a specific *Patient Experiences* module which will be used to record all PALS and complaints.

The total number of enquiries added to PALS and complaints received in 2016/17 was 5376. This comprised of 4360 PALS specific enquiries and 1016 complaints of which 64 involved treating the referring professional as acting on behalf of the patient[1]. This enables the patient a recourse opportunity and advocacy assistance.

Table 1 'Section 8' cases

		Recorded under PALS				*Recorded as complaints on behalf of the patient*			
Title	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
s.8	2	79	51	78	21	50	82	71	64

This section of the report will provide a comprehensive review of complaints activity over 2016/17 evidencing any trends or variation in activity. Where the complainant is unhappy with the response received from the Trust, they have the right to contact the Parliamentary Health Service Ombudsman (PHSO) to request an investigation. All PHSO requests during this period are outlined in this section of the report.

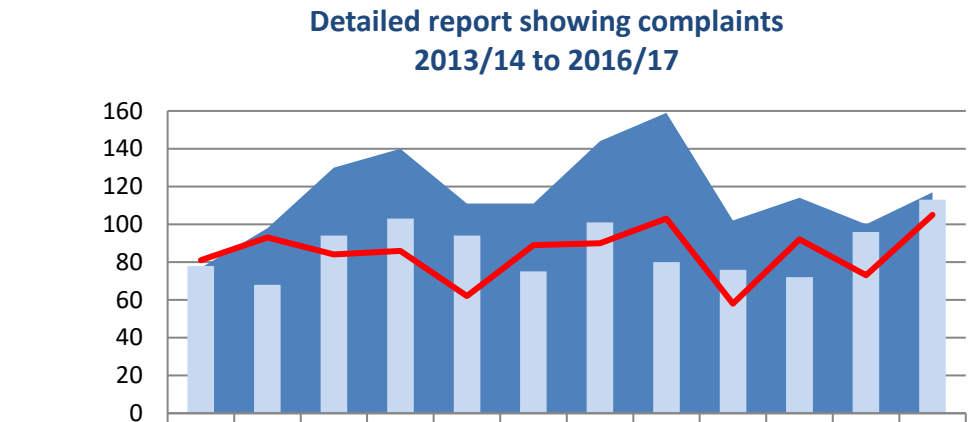
The Trust includes the 'Feedback from complaints' leaflet with every response, this asks for feedback on how the Trust managed their concerns. Across the Trust we take all complaints very seriously and wherever possible we use them to learn from and to make changes and improvements to our service. Examples of this are included in this report.

We also use benchmarking data to understand how the Trust performs against other similar Ambulance Trusts to provide greater assurance in relation to performance against key indicators. Improvement work on the way complaint outcomes are identified and actions are implemented will continue into 2017/18.

Complaint volumes have continued to level out since the exceptional demand in 2014/15. Henceforth we will be using the data for 2015/16 (1051) as our benchmark for future complaint numbers. The following graph demonstrates complaint numbers received from April 2014 to March 2017.

[1] This is considered best practice in the light of Section 8 of *The Local Authority Social Services and NHS Complaints (England) Regulations (2009*) as one *responsible body* (health and social care providers) cannot use the complaints procedure to 'complain' about another.

Graph 1 The following graph demonstrates complaint comparisons April – March 2014, 2015, 2016 and 2017

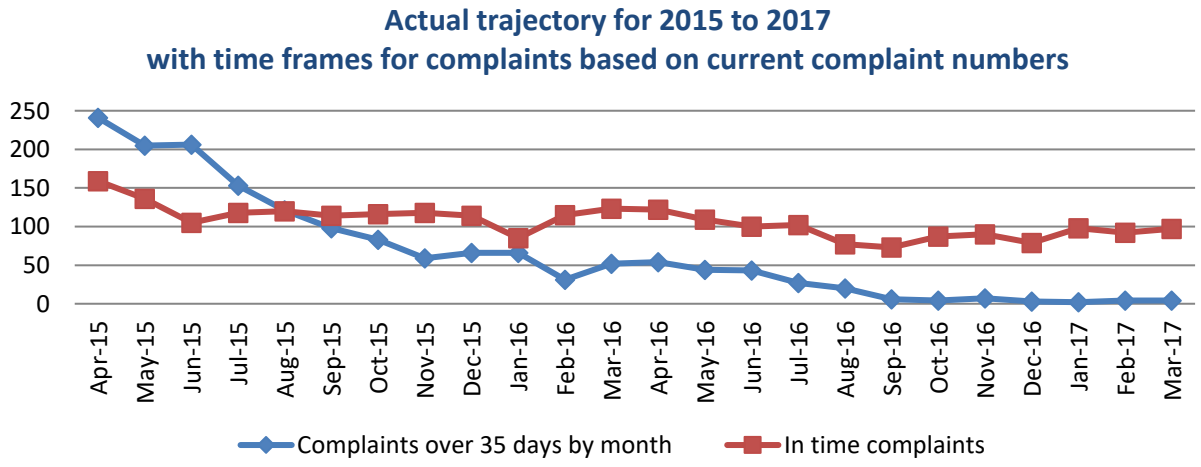


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	77	98	130	140	111	111	144	159	102	114	100	117
2015/16	78	68	94	103	94	75	101	80	76	72	96	113
2016/17	81	93	84	86	62	89	90	103	58	92	73	105

Response timeframes

The Trust works to a locally set target of responding to complaints within 35 working days (or with an extension agreed with the complainant if appropriate). The following graph illustrates compliance with our target trajectory from April 2015 to March 2017:

Graph 2 The following graph illustrates compliance with target trajectory



4. Summary of agency referrals

There has been a steady decrease in the numbers of external agency referrals from Acute Trusts, midwives, GPs, CCGs and local authorities.

The Trust does not have an agreed centralised mechanism to receive and action *incident reports* from external stakeholders. A further consideration is the need to achieve consistency of approach in how the Trust actions internal incident reports involving health and social care agencies.

As matters stand, many of these come to Patient Experiences by default although many agencies either use personal networks with CCGS often approaching local complexes.

Interface with the complaints procedure

One *responsible body* cannot use the NHS complaints procedure to 'complain' about another – Reg 8(1) (a) *The Local Authority Social services and NHS complaints Regulations (2009*) - http://www.legislation.gov.uk/uksi/2009/309/regulation/8/made

All health and social care professionals are captured by this provision, although this is largely applied where they are acting in a professional capacity on behalf of the organisation they work for.

The usual alternative is to raise an *incident report*, although this should not be confused with a *Serious Incident*

http://www.londonambulance.nhs.uk/health_professionals/reporting_incidents_to_us.aspx

There is discretion to treat any approach as having been made on behalf of the patient involved, which brings the matter back within the complaints procedure and thus enables the patient access to free and independent advocacy and a recourse opportunity to the Health Service Ombudsman - http://www.ombudsman.org.uk/

In these circumstances, we ask the referring professional to alert the patient that they have approached us, which is in keeping with the principles of the *duty of candour* - http://www.cqc.org.uk/content/regulation-20-duty-candour

5. Complaints

Managing demand

The London Ambulance Service (LAS) receives on average in excess of 1.9 million emergency calls per year, which makes us the busiest ambulance service in the UK. This equates to approximately 4 calls per minute being answered in our Emergency Operations Centre. In this situation, it is naturally important to prioritise calls so that vehicles may be dispatched according to the urgency of the patient's clinical need. During 2016/17 - 1016 complaints were received which represents an approximate 3% dip over the previous year (1051).

In order to achieve this prioritisation of calls the LAS, like many ambulance services worldwide, operates the Medical Priority Dispatch System. This involves a system of structured questions which identifies priority symptoms and thereby the clinical need of the patient. From that, an assigned level of priority is made, in turn historically determining the type of resource that will be allocated to manage the incident. Thus all emergency calls are prioritised according to a scale of 'Red' (immediately life threatening); C1 and C2 (serious but not immediately life threatening) and C3 and C4 (not deemed life threatening).

Calls assigned at a C1 - C4 priority may be reviewed by our Clinical Hub, clinicians based in the Emergency Operations Centre who may call back to undertake an enhanced assessment. The purpose of this is to determine whether an ambulance is required or the patient's symptoms can be managed at home or they can be referred to an alternative care pathway. For some C4 calls, 999 call handlers may advise the caller to contact the local NHS 111 service.

999 calls made by a healthcare professional are managed slightly differently as it is assumed that the referring clinician is able to assess the clinical urgency for the patient to be treated at hospital and thus the target time for an ambulance response, including or extending the response targets indicated below.

Whilst we do not under-estimate the distress caused by pain, this is a subjective consideration and as such the triage system cannot take that into account.

Although generally aware of the demand we are experiencing at any time, 999 call handlers cannot speculate on the likely time of arrival of an ambulance as this function is arranged elsewhere in the control room. They are similarly not aware of the whereabouts of resources that may be dispatched to the particular emergency or predict how long an ambulance crew will need to spend with a patient. Finally, ambulances can be redirected whilst en-route to another 999 patient triaged as being of a higher clinical priority. This is again routine practice given the dynamic nature of emergency care. However, at times when the Surge Plan (see below) is implemented, call handlers will advise of the length of time it may take before an ambulance may be sent. This was introduced having arisen from service-users feedback, although it simply represents a snapshot of the position which can change very rapidly.

Repeat 999 calls about the same patient are re-triaged in recognition that a patient's condition can deteriorate whilst an ambulance is being arranged; in this way, the priority level can be changed as may be necessary.

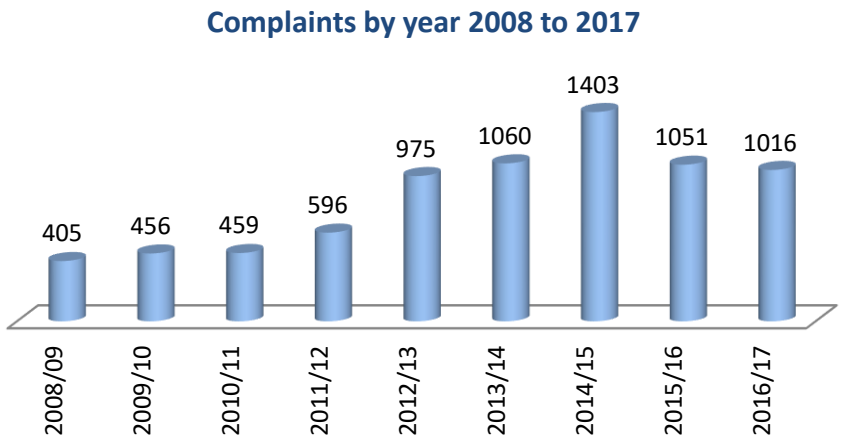
Surge Plan

To help us manage capacity, we have a Surge Plan which is implemented at times of high demand when there is evidence of significant pressure across the London health system. It is used to ensure we can continue to provide a rapid response to the sickest and most seriously injured patients whilst ensuring other patients receive advice about where to access help. Our call takers will either advise the caller to ring NHS 111 or the call will be reviewed and potentially assessed by clinicians in our Clinical Hub – this enables a more detailed clinical assessment to be undertaken and then either an ambulance can be arranged or the caller can be advised about the most appropriate place to seek further help. This may be an urgent care centre, a GP or A&E.

For more information, please see:

http://www.londonambulance.nhs.uk/about_us/what_we_do/providing_an_emergency_respons.aspx

Graph 3 Complaints comparison 2008/09 to 2016/17



Graph 3 above shows complaints received by year indicating the fluctuation in volumes since 2008/92014/15 was an unprecedented year in terms of demand to the service. 2016/17 is more comparative to 2015/16 with regards to the numbers of complaints received.

When the complaint volume is matched with the rise in demand, this indicates a fairly constant rate at 0.09%. This is illustrated in Table 2 below:

Table 2: Complaints ratio against demand

Month	Calls attended	Complaints received	Percentage of complaints against calls attended (rounded)
Apr-16	87658	81	0.09
May-16	94567	93	0.11
Jun-16	92151	84	0.09
Jul-16	95275	86	0.09
Aug-16	91862	62	0.07
Sep-16	89468	89	0.10
Oct-16	94156	90	0.10
Nov-16	92061	103	0.11
Dec-16	99290	58	0.06
Jan-17	96109	92	0.09
Feb-17	84188	73	0.08
Mar-17	94888	105	0.11
Totals	**1111673**	**1016**	1.1
		Average	0.09%

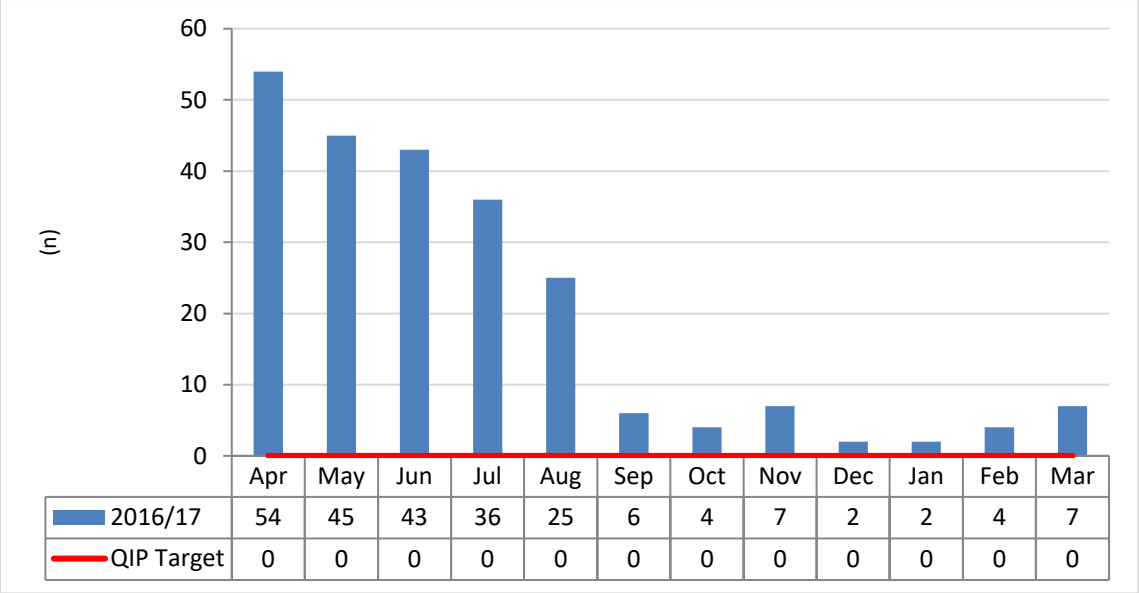
The highest volume of complaints were about delays in an ambulance response; these are administratively attributed to the Emergency Operations Centre under the existing case management practice although clearly much depends on the available resourcing, an operational responsibility.

The department was also greatly affected by a number of IT issues and challenges with the case management system during the latter part of the year. It is likely that this impacted on complaint numbers as the system was running very slowly impacting on the ability of duty staff to enter information in a timely manner. As a result of this, it is possible that calls to the duty phone were missed and that potential complainants did not call back.

6. Performance

Overall performance has improved month on month. In line with the Quality Improvement Programme for 2016/17, overdue complaints have reduced considerably. The following graph is evidential of the improvements made within the department to reduce the turnaround time frame of complaints.

Graph 4 Overdue open complaints April – March 2017



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	54	45	43	36	25	6	4	7	2	2	4	7
QIP Target	0	0	0	0	0	0	0	0	0	0	0	0

Of the total complaints, where the 35 day target was assigned, we have achieved a turnaround of 74%. However, this is partly due to the high number of overdue complaints carried over from 2015/16 and has improved in recent months. In accordance with accepted practice and collaboration with the complainant, in a number of cases the target response time has been increased (see table {}) below.

Table 3 Complaint response times – 2016/17

Complaint response times 2016/17 – including where the target date was increased		Number achieved
35 working days	891*	656 (74%)
40 working days	24	24
45 working days	40	40
60 working days	21	21 (includes 11 declared Serious Incidents)
Total	**1016**	**85**
*includes concerns		

Examples of learning from Complaints linked to Serious Incidents

We include examples of learning from complaints which have been declared as a Serious Incident in our Insight magazine and Clinical Update Bulletins

Table 4 Complaints by Department Area

Complaints by Area 2016/17	Number of complaints
Emergency Operations Centre	342[2]
South East Sector	99
Not LAS / Other organisation	80
North Central Sector	75
South West Sector	71
East Central Sector (old)	56
West Sector (old)	49
Central Ops Management	31
North West Sector (old)	38
North East Sector (old)	34
North East Sector	27
Patient Transport Service (PTS/NETS)	28
North West Sector	23
NHS111	22
Emergency Preparedness Resilience & Response (EPRR)	12
Insufficient info	8
Communications	5
Fleet and Logistics	4

[2] All complaints regarding a delay are attributed to Control Services. However, the cause is not due to processes within control they are mainly due to resourcing across all areas.

HR / Workforce	3
First Responders (CFR/VFR)	2
Incident and Delivery (Incident Response)	2
Patient Experiences (PED)	2
Clinical Education & Standards	1
Safety	1
Specialist Care	1
Total	**1016**

7. Complaints: Analysis & Themes

Volumes

The number of complaints has decreased compared to the previous year.

Themes

There were 15 broad themes arising from complaints. Table [] illustrates the number of complaints by subject using the top five of these themes since 2011. They are ordered from left to right with the most common themes this year being first.

Table 5 Complaints by the top 5 subjects 2011/12 – 2015/16

Top 5 complaint subjects	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Delay	193	411	421	756	434	325
Conduct and behaviour	152	267	250	303	325	279
Road handling	10	15	119	98	96	95*
Treatment	62	65	91	85	59	63
Non-conveyance	64	69	86	91	57	43
Totals	**481**	**827**	**967**	**1333**	**971**	**805**
Total complaints that year	596	975	1060	1403	1051	1016

*where vehicle was part of LAS fleet

Other common themes include

- Staff challenging the validity of the 999 call
- Sequential call management errors at times of significant demand
- Failure to re-triage repeat 999 calls about the same patient
- Increase in non-conveyance where the patient has been referred to an Alternative Care Pathway
- Interface with NHS111 providers

8. Changes to Service Provision/case examples

Case Examples 2016/17

Example one:

The patient was not taken to the correct treatment centre. We identified that the crew should have contacted the Clinical Hub for advice about optimum destination and that the clinical information relevant to this case is contained within three separate cardiac care circulars, all of which contain different information.

Outcome: The Medical Director to combine this guidance into a single document or creating a separate document

Example two:

Complaint that a patient with dementia was not taken to hospital by an ambulance crew only to be conveyed by a second crew the following day when the patient was found to have a fractured vertebra. Clinical opinion suggested that the assessment and management by both crews was appropriate given the clinical information they were presented with. However, a balance has to be achieved to take into account the extent of a possible injury against the distress that can be caused by taking a patient with dementia to a busy and unfamiliar A&E environment. Furthermore the capacity of a dementia patient to make an informed decision can fluctuate.

Outcome: An article in a Clinical Update published by the Medical Directorate to widen awareness of managing patients with dementia across the Trust.

Example three:

Complaint from a patient who was upset at the attitude of the 999 call handler and that after calling her GP she waited a considerable time for an ambulance, which exacerbated her condition.

Outcome: the medication the patient required should have indicated that it was not appropriate to assign a Non-Emergency Transport Service (NETS) crew from the outset. Currently, an automated system operates in that emergency calls of a pre-determined nature are automatically routed to NETS staff for allocation of a resource. EOC reminded of the suitability of NETS staff against the call criteria when dispatching resources.

Example four:

Complaint from the patient's daughter that the paramedics failed to act on the advice from a nurse to convey the patient to a specific treatment centre, instead taking the patient to a local hospital. This hospital did not have the surgical staff to treat the patient and the patient further deteriorated before being transferred for surgery.

Outcome: We concluded that the decision to take the patient to the nearest emergency department was reasonable so that his pain and vomiting could be relieved and any bleed stabilised before transfer to specialist care. The patient was offered a Patient Specific Protocol for future contacts.

Example five:

Complaint from the patient that despite being given the impression that an ambulance had been cancelled, the police forced entry to her property which left her but with a bill to repair the damage.

Outcome: Compensation has been agreed as the call handler could have verified whether the ambulance was being cancelled. In addition, the Registered Mental Health Nurse should have made it clear that the Clinical HUB (CHUB) paramedic would call the patient back rather than leaving the patient thinking they were being transferred immediately; the CHUB paramedic should also have called the patient back rather than simply applying an upgrade to the priority level. Feedback given to the staff concerned and all CHUB staff reminded of the importance of a clear handover when undertaking telephone assessments.

Example six:

That the 999 call handler could not verify the address of the incident.

Outcome: This a common occurrence but in addition to feedback to the call handler about the options open to them, this very often results in improved information being inputted to the gazetteer system.

Example seven:

Taxis being arranged to take patients to hospital

Outcome: An explanation is offered that during periods of continuing high levels of demand to the ambulance service, it is now routine practice to arrange a taxi to take patients to hospital who have been assessed as being suitable to convey in this way. Feedback has however been provided to the

taxi provider about ensuring patients are taken the correct A&E entrance and that EOC should be alerted if the patient deteriorates whilst en route to hospital.

Challenges to patients entered on the Locality Alert Register

Outcome: Work continues to improve compliance with Trust policy to arrange a care plan approach where a patient's behaviour may be linked to their condition.

Example eight:

Patient raised concerns that a taxi was sent to convey her to hospital and that she had difficulty in getting to the vehicle.

Outcome: Although the call was managed according to procedures, confusion may have arisen by the call handler referring to the vehicle being dispatched as a 'car '(i.e. interpreted as meaning an ambulance resource). Feedback was given about ensuring the patient fully understands what is being arranged.

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Example nine:

There was a significant delay in property being reunited with the patient.

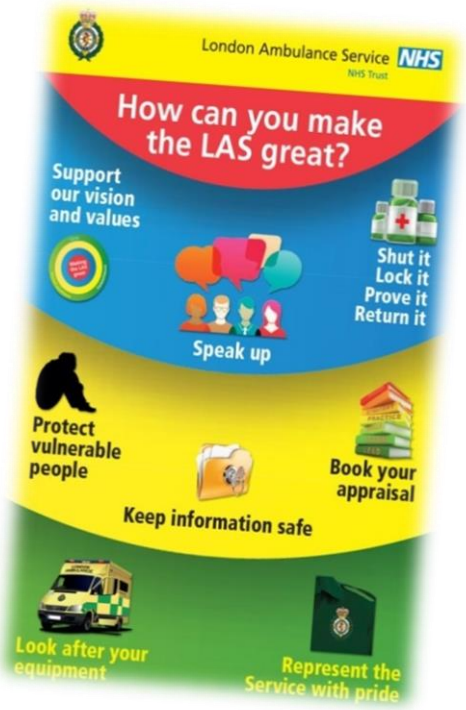
Outcome: In the light of this incident, and moreover the amount of time and effort the Trust is caused by patient property issues, we have asked the Director of Operations to develop an Action Plan to encourage staff to use patient property bags, with regular reporting on the number of episodes that occur and demonstrating compliance with policy. This should also set out to establish a process to enable items that are found on vehicles to be returned to the patient concerned in a timely manner, with clear lines of responsibility. Our intention is that this will then be piloted with the objective of establishing improved practice across the Trust.

Example ten:

Family complained that the attending staff did not appear to be aware of *Elhers Danlos Syndrome*.

Outcome: We advised that we would not expect staff to be familiar with every medical condition but of the sources of advice and support open to them, for example via the CHUB. We also suggested the clinicians responsible for the patient's care may wish to approach the Medical Directorate so we can consider arranging an emergency care component of any care plan. This information is held on our system against the patient's address/telephone number so it can be highlighted to the call handler and passed on to the attending ambulance staff.

Anyone making a call on the patient's behalf should be aware of this so they can let the call handler know.



Example eleven:

Complaint from patient's mother that the attending ambulance staff questioned her young daughter about what had occurred.

Outcome: The crew should not have questioned the child. To widen the learning, guidance about this issue is prepared by Safeguarding team and disseminated across the Trust.

Example twelve:

Complaint via advocate - patient's widow is concerned that despite having prepared a 'hospice at home' end of life care plan for her husband, the attending ambulance staff insisted on taking her husband to hospital.

We concluded that the crew could have done more to de-escalate the situation and contacted the Clinical Hub for advice, additional training and support for staff in relation to end of life care and difficult conversations to be a quality focus for 2017/18.

Example thirteen:

Complaint from patient's husband that the call taking system did not identify his location and the attending staff appeared to have problems finding the address which delayed the response to his wife who was pregnant and suffered a cord prolapse. The complaint specifically asked why we do not use Google Maps.

Outcome: We took advice from our Information Management & Technology specialist and offered a comprehensive response that whilst in theory we could utilise this type of technology, out of operational resilience and security reasons all our primary systems are self-contained. We were also able to amend the address on the system and were satisfied that the delay did not impact on the care provided.

Example fourteen:

Complaint from family that the crew questioned why a patient in labour had called an ambulance and then took a long time to get to hospital, the baby was still born.

Outcome: The staff involved have agreed a Learning Plan based on the findings of a clinical practice review. They have also contributed to a maternity training event with specific focus on placental abruption.

Example fifteen:

Complaint from patient that the attending Fast Response Unit (FRU) did not realise the significance of the patient's symptoms when the patient experienced an ante-natal bleed. The patient was taken to hospital by car and found to have suffered a placental abruption. Fortunately, mother and baby are well.

Outcome: The FRU undertook a reflective practice exercise and has also asked to attend the maternity skills refresher training.

Example sixteen:

Complaint from family that after the attending staff had arranged for the police to attend when the patient died in his garden, the crew treating the death as unexpected despite a DNAR being in place; the patient was left lying outside for almost 2 hours.

Outcome: We found that they might have sought advice from the on-call clinician or the CHUB; Medical Directorate to issue renewed guidance about end of life practice around DNAR being in place and what constitutes a *public place*.

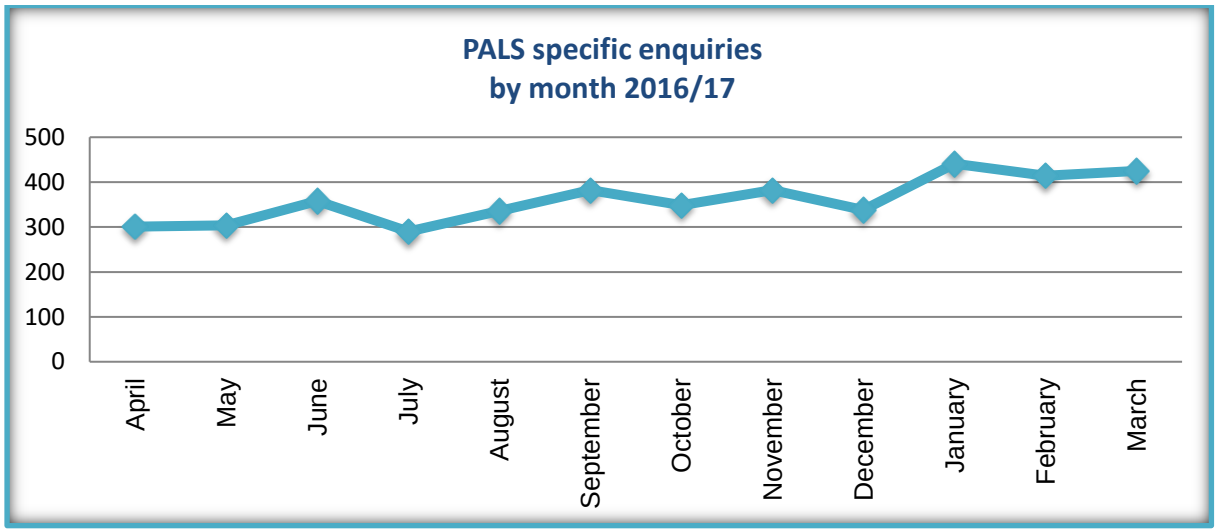
PALS

In May 2016 we moved our case management system to a web based version which has gradually been embedded in the Trust. PALS and complaints are now merged on a joint module called '*Patient Experiences'* which has a separate recoding function for enquiries and complaints.

The most common subjects of enquiry are the hospital destination of a relative, lost property and requests for medical records; policy and practice enquiries are also common from academics, students, other health and social care agencies and members of the public.

The following graph demonstrates that there has been a steady stream in the monthly total of PALS enquiries.

Graph 6 PALS cases recorded by month 2016/17



Solicitor enquiries

The team includes a specialist who process all requests for medical records, including those made by a solicitor acting on behalf of the patient or relatives, where legal action is not intended against the Trust. A charge of £50.00 is levied in keeping with the DPA (1998). Additionally, we facilitate requests for witness statements, which are obtained via a face-to-face interview with staff.

This service attracts an hourly charge. During 2016/17, 1322 requests were made by solicitors for medical records and requests to interview operational staff, generating a total of £56,690

Table 6 Solicitor summary

Solicitors request for medical records						
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
April	69	118	122	110	100	93
May	78	121	100	103	90	113

June	98	96	109	100	107	114
July	94	107	123	114	120	125
August	79	135	94	90	77	103
September	117	100	108	124	83	109
October	80	138	149	119	101	111
November	109	124	141	96	86	103
December	66	87	83	88	98	84
January	84	94	125	104	89	106
February	104	120	128	92	104	124
March	109	116	96	126	111	137
TOTAL	**1087**	**1356**	**1378**	**1266**	**1166**	**1322**

The following sums have been received since April 2013:

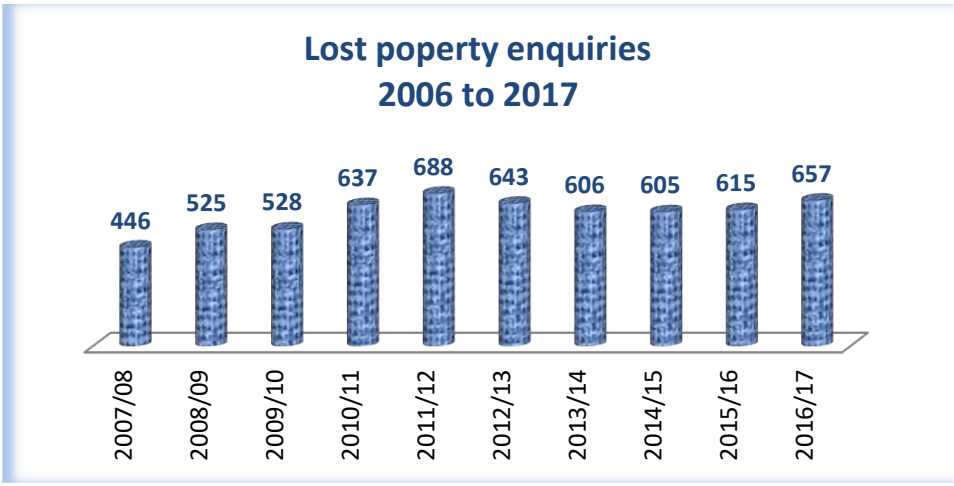
2013/14	£60,645
2014/15	£52,541
2015/16	£50,566
2016/17	£56,690

7. Lost Property

We continue to engage with the SMARTbags™ team and design improvements have been made to the property bags.

Graph [7] evidences the total lost property item enquiries received by year.

Graph 7 Lost Property.



An evaluation has shown that greater involvement of station administrators as a contact point has improved outcomes although it is not wholly possible to completely evaluate this as the database is not currently shared with local administrative staff. It is evident that the numbers of lost property enquiries continues to rise and we are planning to make the web version available to all complex admin staff which should improve audit and outcome analysis.

10. Ombudsman case review

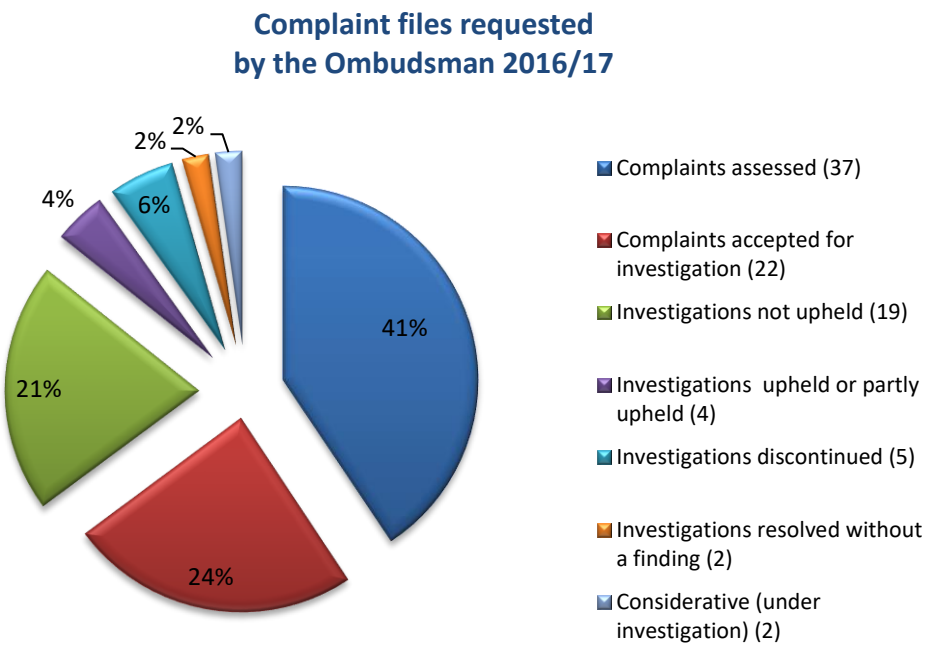
37 cases were considered by the Health Service Ombudsman. This includes complaints where the incidents in question that may have occurred earlier but were considered by the Ombudsman during 2016/17 – hence the disparity in the numbers in the following table:

2016/17	Enquiries received	Complaints assessed	Complaints accepted for investigation	Investigations upheld or partly upheld	Investigations not upheld	Investigations resolved without a finding	Investigations discontinued
London Ambulance Service NHS Trust	84	37	22	4	19	2	5
East of England Ambulance Service NHS Trust	80	35	22	3	18	0	1
North West Ambulance Service NHS Trust	48	21	16	2	8	1	1
Unknown Ambulance Trust	48	0	0	0	0	0	0
Yorkshire Ambulance Service NHS Trust	39	21	10	2	11	1	1
West Midlands Ambulance Service NHS Foundation Trust	35	17	9	0	10	0	1
South Central Ambulance Service NHS Foundation Trust	34	20	8	3	6	0	0
South East Coast Ambulance Service NHS Foundation Trust	25	14	11	3	10	0	2
North East Ambulance Service NHS Foundation Trust	22	8	3	2	5	0	0

South Western Ambulance Service NHS Foundation Trust	21	9	5	1	5	0	1
East Midlands Ambulance Service NHS Trust	20	4	1	2	3	0	0
Ambulance Trust	**456**	**186**	**107**	**22**	**95**	**4**	**12**

We await notification on 2 cases from 2016/17, 21 have been completed (19 not upheld). 2 have been partially upheld but there were no significant learning points.

Pie chart 1 Cases Requested by the Ombudsman



Ombudsman Case Examples

To summarise:

Datix	Complaint	Outcome PHSO	Actions
9955	Complaint from patient's sister that her sister was denied an ambulance and had to make her own way. Remains unwell	Upheld- failing in the triage and assessment of the 999 call / disagreement with QA findings	Action - Review existing framework to consider additional measure to verify sign off QA evaluations
10665	Complaint from patients MP who raises concerns about the delay in attending him when he had diabetic problems	Partly upheld - failure in the way calls were managed and use of Surge	Action - Reminder in Control Services Bulletin and revision of OP60 - call handling procedures

10671	Complaint from patient who is concerned that her 999 call was not treated seriously and she was referred to NHS111	Upheld - failing in the triage and assessment of the 999 call left the patient experiencing pain for longer	Action - apology to patient for failure to take account of all the information provided and an action plan detailing how these failings will be avoided in the future
10770	Complaint from patient who is concerned that he was advised there would be a long wait for an ambulance after he suffered breathing problems	Partly upheld - not called back for retriage and inadequate recording of patients known condition by the EMD	Action - apology offered and demonstrable feedback to the EMD

11. Governance

We provided summary activity reports to the Clinical Quality Safety & Effectiveness Committee, Safeguarding Group and Learning from Experience Group. The new Improving Patient Experiences Committee receives bi-monthly updates