Patient Experiences

Annual Report

2017/18

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1. Introduction

Listening to the patient and service-use experience enables the Trust to improve and develop our service. One of the major ways we do this is via our Patient Experiences team, who manage the following portfolios.

- Complaints
- Patient Advice and Liaison Service (PALS)
- Solicitor and other requests for medical records and witness statements.

This report provides an overview and analysis of activity including cases investigated by the Health Service Ombudsman; examples of lessons learned and the action taken by the Trust arising from service-user feedback and complaints.

2. Context

This year, the Trust received 1,892,659 calls to our Emergency Operations Centre, just under 4% higher than the previous year (1,826,840). This constitutes a daily average of 5185 x 999 calls. We attended 1,122,444 of these calls with a 0.08% ratio of complaints being made.

Managing demand

One of the most significant changes to service delivery this year has been the introduction of the National Ambulance Response Programme (ARP).
https://www.england.nhs.uk/urgent-emergency-care/arp/

Complaints handling features

- We manage our complaints handling process in accordance with the Health Service Ombudsman's good practice guidance, *Principles of Remedy*
- Each complainant received a response that was personally reviewed and signed by the Chief Executive (or a deputising Director).
- All complaint responses include information about the recourse opportunity to, and contact details for, the Health Service Ombudsman.
- Our website offers 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

Overview

3. Summary of complaints, PALS, Quality Alerts

The total number of enquiries to PALS and complaints received in 2017/18 was 5278. This comprised of 4278 PALS specific enquiries and 938 complaints; the latter represents an approximate 8% dip over the previous year (1016).

44 cases involved treating the referring professional as acting on behalf of the patient[1]. This enables the patient a recourse opportunity and advocacy assistance. The department also managed 44 Quality Alerts from Health Care Professionals.

From April 2018 we will assume full responsibility for external Quality Alerts and expect workload to increase substantially.

Table 1 'HCP referral' cases

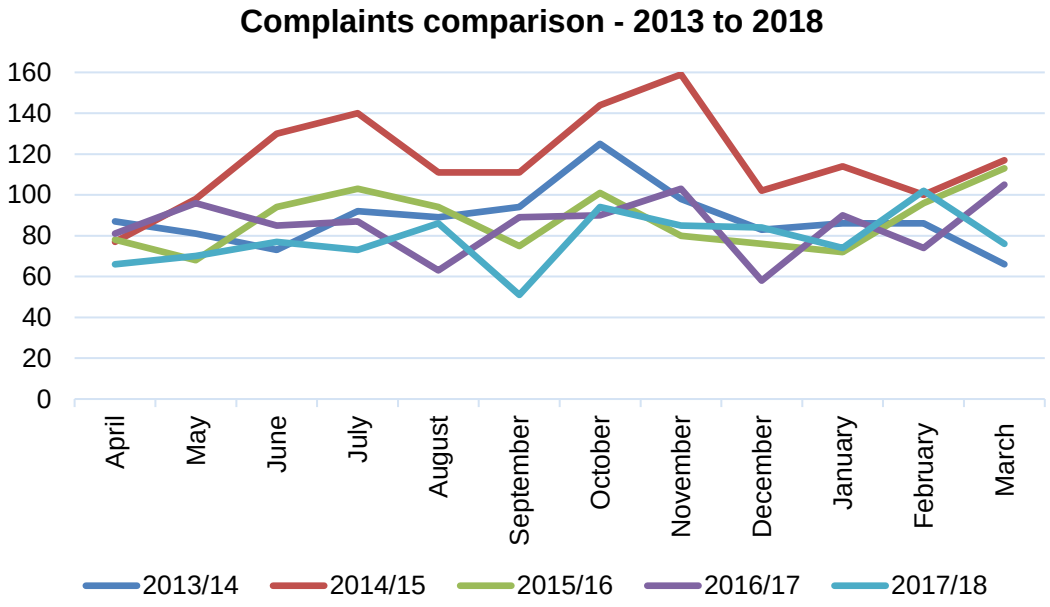
		Recorded under PALS				*Recorded as complaints on behalf of the patient*				
Title	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
HCPR	2	79	51	78	21	50	82	71	64	44

[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.*

Historical benchmarking

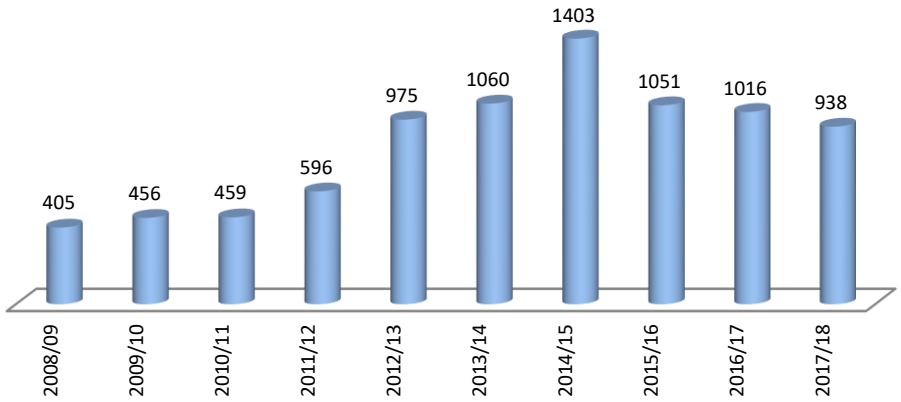
Complaint volumes have continued to level out since the exceptional demand in 2014/15. We therefore use the data for 2015/16 (1051) as our benchmark. The following graph demonstrates complaint numbers received from April 2014 to March 2018.

Graph 1 The following graph demonstrates complaint comparisons - April – March 2013 to 2018



Graph 2 shows complaints received by year indicating the fluctuation in volumes since 2008. 2017/18 is more comparative to 2012/13.

Graph 2 Complaints comparison 2008/09 to 2017/18



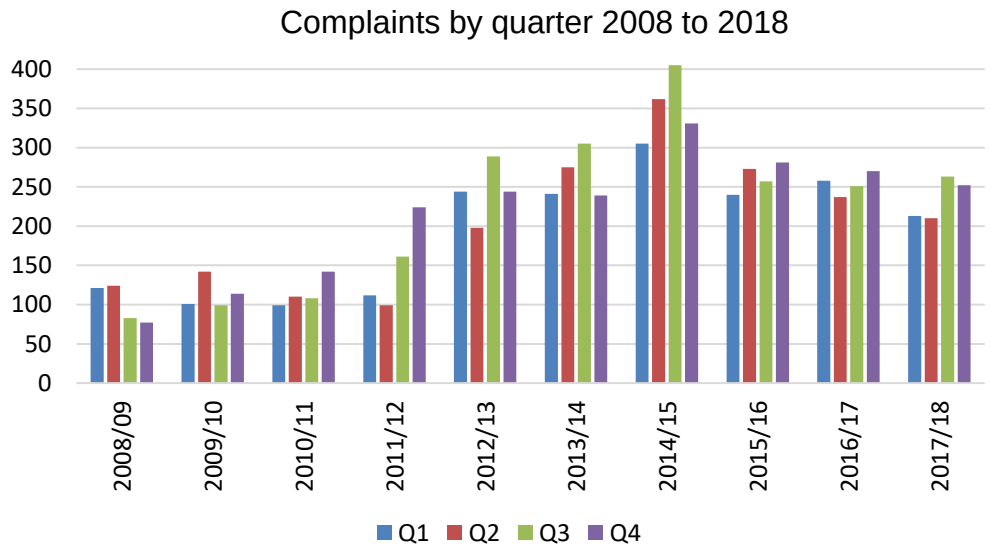
When the complaint volume is matched with the rise in demand, this indicates a fairly constant rate at 0.08%. This is illustrated in Table 2 below:

Table 2: Complaints 999 incident ratio against demand

Month	Face to face incidents	Complaints received	Percentage of complaints against calls attended (rounded)
Apr-17	89420	66	0.07
May-17	96581	70	0.07
Jun-17	92661	77	0.08
Jul-17	94855	73	0.08
Aug-17	91828	86	0.09
Sep-17	90327	51	0.06
Oct-17	96364	94	0.10
Nov-17	93535	85	0.09
Dec-17	97780	84	0.09
Jan-18	97258	74	0.07
Feb-18	86261	102	0.12
Mar-18	95574	76	0.08
Totals	**1122444**	**938**	**0.08%**
		Average	0.08%

Graph 3 Complaints by quarter 2008 to 2018.

NHS Digital now request complaints data on a quarterly basis:



4. Performance and response timeframes 2017/18

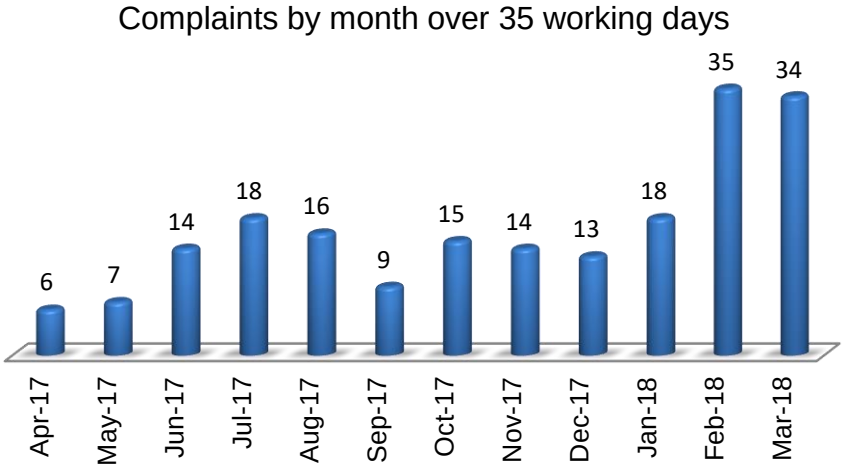
We achieved 100% acknowledgement of complaints within 3 days, in accordance with Reg 13(3) of the NHS complaints regulations.

The NHS works to a locally determined set of targets; in our case, the base line target is 35 working days (an extension is agreed with the complainant if appropriate, see below).

In those cases where the 35 day target was assigned, we have achieved a turnaround of approximately 75%.

The following graph illustrates compliance with our target trajectory, this data is compiled for the Quality Report each month, this is a dynamic figure. The drop in performance throughput towards the end of the year was prompted by winter pressures to the Trust which meant that staff were not available to offer statements, evaluate 999 call management and provide clinical appraisals.

Graph 4 The following graph illustrates compliance within 35 day target



In accordance with accepted practice and agreement with the complainant, in a number of cases the target response time was increased (see below). As indicated, this was usually because of complexities arising as more information became available or times of significant pressure to the Trust. A further consideration is where a the matter that is the subject of a complaint is also declared as a Serious incident, a governance mechanism used across the NHS which attracts a target completion within 60 days, with a further 20 days period for approval and sign off by Clinical Commissioning Groups.

Table 3 Complaint response times – 2017/18

Complaint response times 2017/18 – including where the target date was increased		Number achieved
35 working days	807	608 (75%)
40 working days	26	17 (65%)
45 working days	47	24 (51%)
60 working days	28	12 (41%) includes 8 serious incidents
Concerns (no time frame)	30	30
Total	**938**	**691 (75%)**

Table 4 Complaints by Department Area

Area	Numbers of complaints
Sector Services	456
Control Services[2]	336
Not LAS / Other organisation	92
Central Operations	29
Patient Transport Service (PTS)	11
HR & Workforce	5
Finance and Performance	4
Clinical Education and Standards	2
Quality and Nursing	2
Strategy and Transformation	1
Total	**938**

Table 5 Complaints by the top 5 subjects 2017/18

Complaints by subject 2017/18	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Delay	21	17	16	14	26	9	22	33	19	17	40	21	255
Conduct	16	19	24	19	19	16	17	25	20	22	23	20	240
Road handling	12	11	13	14	10	7	14	9	7	6	10	6	119
Treatment	1	2	5	1	7	5	16	8	9	8	14	4	80
Non-conveyance	3	0	4	12	0	1	6	1	7	6	3	4	47
Totals (above)	53	49	62	60	62	38	75	76	62	59	90	55	741
Annual totals	**66**	**70**	**77**	**73**	**86**	**51**	**94**	**85**	**84**	**74**	**102**	**76**	**938**

[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.*

Other common themes include:

- Call management errors
- The patient being referred to an Alternative Care Pathway rather than being taken to hospital
- NHS 111 call management

5. Analysis/Themes

Current volumes involve relatively new areas of service delivery, for example calls managed by our NHS 111 team who provide this service in the South East London area; our use of community responders; and the effects on response times to lower priority emergencies when the Surge Plan (the Trust's escalating demand management plan) is implemented.

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.

5. Governance and Learning mechanisms

We provided regular monthly summary activity reports to the Quality Oversight Group and the Control Services Governance Group. The Patient Experiences & Feedback Group receives bi-monthly updates. This is an important part of our work. The Group reviews and brings together lessons learned from external sources, adverse incidents, litigation, comments, concerns, complaints, audits, major incidents, safeguarding and information governance issues.

Patient stories also continue to be a powerful tool to describe patients' experiences and these and the learning that has resulted are presented to the Trust Board.

From a national perspective, we also report on quarterly basis to NHS Digital.

We continue to monitor 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 receives a '*Feedback on Complaints'* form with every complaint response.
http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

We include examples of learning on the Trust website and disseminate these across the Trust via in our *Insight* magazine, *Clinical Update Bulletins and Control Services Bulletins.* To widen the learning in appropriate cases, we also share these with the National Ambulance Patient Experiences Group.

6. Examples of learning 2017/18

Staff attitude

Example 1

Complaint that the attending staff did not appear to understand how the patient's mental health problems affected her and she heard them inform the hospital she had threatened them with scissors, which she denied; they also used abusive language.

We concluded that the crew felt threatened, even if this had not been intended. Whilst we do not condone derogatory language, especially as this risk can cause an unpredictable situation to escalate, this was a reaction to a potentially volatile situation and the need to immediately be assertive in order to disarm the patient. The member of staff concerned was quite clear that she did not mean to seem unkind and had the welfare of the patient in mind, even though the sudden incident with the scissors understandably scared her.

Example 2
Complaint that the attending staff were dismissive of the patient's sickle cell crisis symptoms.

We explained that the patient should have been offered a carry chair and/or trolley bed to the ambulance and taken to their usual treatment centre. It was also unclear whether the extent of the patient's symptoms had been explored. The staff undertook a reflective practice exercise on the treatment of sickle cell patients.

Example 3
Complaint that an ambulance was declined despite the gravity of the patient's symptoms.

The Quality Assurance evaluation identified that the call handler made a technical error when applying the triage protocol which would have otherwise achieved a higher priority from the outset. Priority would still have been given to patients determined at a higher categorisation but in keeping with our learning approach, feedback was given to the call handler concerned.

Example 4
Complaint hosted by Acute Trust that the attending ambulance staff appeared to question why an ambulance had been called

The paramedic acknowledged that he came to a view based on the fact the patient was not in acute distress and accepted that although he did not mean to be derogatory, this was inappropriate.

Example 5
Complaint that the attending ambulance staff did not help the patient into her property despite her being hardly able to walk.

We concluded that it would have been more compassionate and safer practice to have ensured the patient was able to safely get into her home. In addition, the assessment record did not make any reference to any assessment of the patient's hip, which should have been completed. Feedback was offered accordingly.

Example 6
Complaint at the aggressive attitude of the call handler.

The call handler did not adhere to protocols which may have prevented the conflicting answers provided and the triage assessment to be conducted more quickly. She also deviated from the prescribed questioning, omitted to use the breathing detector tool and failed to verify the location. She did not display appropriate customer service skills and should not have given precise details of the responding ambulance resource, as it is possible they could have been re-directed to another 999 call so this was misleading. An apology was offered and reflective practice arranged.

Delay/ambulance dispatch

Example 7

Complaint that there was a delay in an ambulance attending a patient after she had a seizure on a bus - resulting in the bus driver taking her to hospital

There were some technical shortcomings in the management of the initial 999 call, the call handler was rude at times, omitted to give the correct post-dispatch instructions and to explain that it may take up to 45 minutes for an ambulance to be dispatched. Extensive feedback was offered to the call handler concerned and their performance monitored for a period decided by their line manager.

Example 8

Complaint that despite his injuries post RTC, the patient was referred to NHS111.

The Quality Assurance evaluation identified that the call handler omitted to check whether the patient was still on the floor and that the information provided by the patient that there was an arm deformity should have prompted a higher priority outcome. The call handler will was given extensive feedback and their performance monitored for a period decided by their line manager

Example 9

Complaint that despite her symptoms, the caller's daughter was declined an ambulance.

The Quality Assurance evaluation identified that the call handler gave the incorrect referral information to the caller. The patient should have been referred to the CHUB as opposed to NHS 111.

Example 10

Complaint from patient to LAS 111 regarding the length of time awaited for a clinical call back.

We identified that the call was managed and assessed properly with a correct determinant of a call back within 6 hours being achieved. However, this was not communicated to the patient who was advised that she would receive a call within 2 hours

Example 11

Complaint from child's mother that she was declined an ambulance for her daughter despite her symptoms

The Quality Assurance evaluation concluded that the call handler made an error of judgement when applying the initial clinical triage protocol. Although call handlers do not have any clinical expertise, they are trained to ask a series of structured questions to progress through the triage process in order to assess the patient's condition and to determine the appropriate level of priority response. In this case, the 'Heart problems/AICD' protocol should have been applied which would have

indicated a Category 2 priority, although priority would still have been given to patients determined at a higher categorisation.

Example 12:
Complaint from patient's husband at the delay in providing a critical transfer ambulance for his wife, who was experiencing a placental abruption

The Quality Assurance evaluation confirmed that from the information provided all 999 calls were largely managed in accordance with our protocols, although some shortcomings have were identified and the Clinical Hub should have applied an upgrade after 60 minutes, as the operative misunderstood the new guidance in line the ARP. An exceptional bulletin was issued at all staff.

Patient Specific Protocol (psp)

Example 13
Complaint from parent about the delay in attending a child with a Patient Specific Protocol logged on the address.

Although the system highlighted the psp for the patient, the supervisor in EOC should have comprehensively reviewed that so that an upgrade could be made accordingly.

Example 14:
Complaint that the attending medic did not administer a nebuliser after she suffered an asthma attack

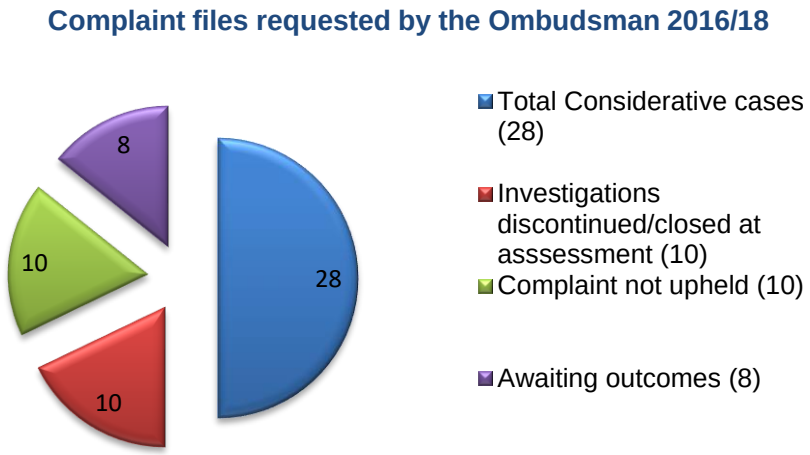
Extensive feedback was given to the Paramedic by the local management team, with an emphasis on the importance of recording the assessment record to an optimum level. They also jointly reviewed the treatment protocols in relation to patients with symptoms similar to the patient's presenting symptoms

7. Ombudsman case review

28 cases were considered by the Health Service Ombudsman. This includes complaints where the incidents in question occurred earlier but were considered by the Ombudsman during 2016/17.

We await notification on 8 cases, the remainder were closed following considerative assessment or the case not upheld following formal investigation.

Pie chart 1 Cases Requested by the Ombudsman2016/18



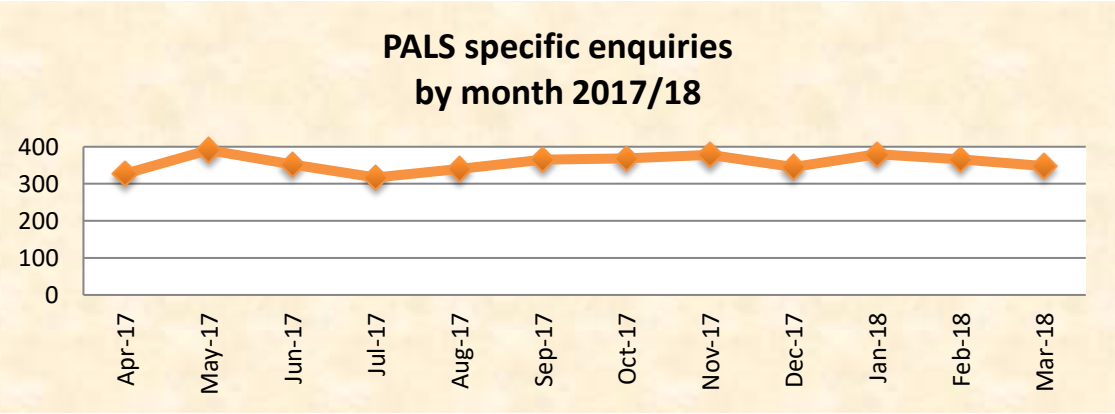
8. PALS

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.

The most common subjects of enquiry are hospital destination, 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. Bereavement related enquiries are a further consistent theme.

The following graph demonstrates a consistency in the monthly total of PALS enquiries.

Graph 5 PALS cases recorded by month 2017/18



9. 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. Additionally, we facilitate requests for witness statements, which are obtained via a face-to-face interview with staff.

This service attracts a fee. In 2017/18, 1568 requests were made by solicitors for medical records and requests to interview operational staff, generating a total of £65,641. However, this fee will no longer be applicable after the introduction of new legislation in May 2018.

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:

Table 7 Fees received in respect of Solicitors enquiries 2013/2018

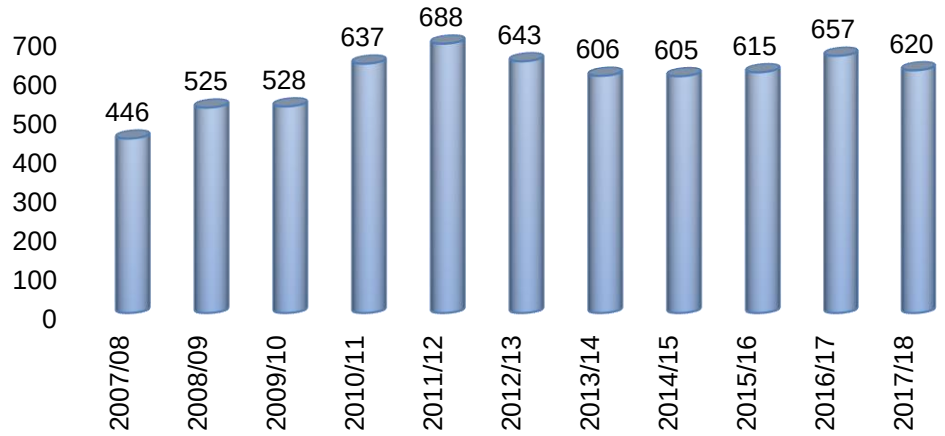
2013/14	£60,645
2014/15	£52,541
2015/16	£50,566
2016/17	£56,690
2017/18	£65,641

10. Lost Property

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

Graph [6] evidences the total lost property item enquiries received by year.

Graph 6 Lost Property.



Commonly reported items include mobile phones, spectacles, false teeth, keys, walking sticks and jewellery.