South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	77/20

Name of meeting	Quality and Patient Safety Committee
Date	Thursday 17 September 2020
Name of paper	Patient Experience Annual Report 2019/2020
Responsible Executive	Bethan Haskins, Executive Director of Nursing and Quality
Author	Graham Parrish, Patient Experience Manager Tam Moorcroft, Head of Patient Safety
Synopsis	The attached report highlights the activity in patient experience during 2019/2020; it includes the challenges and successes with complaints, compliments and the wider patient experience work. The report also highlights any lessons that have been learned. The report has been reviewed by the Clinical Governance Group.
Recommendations, decisions or actions sought	The Committee is asked to: • Note to contents of the report; • Acknowledge the progress made during 2019/2020; • Make any recommendations.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	No

Patient Experience
Annual Report 2019/2020

Contents

Introduction

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) endeavours to always ensure patients, staff and the public are safe when in our care, and that the quality of the care they receive is consistently at the highest possible standard. However, even with the best of intentions, inevitably sometimes things go wrong, and this can lead to complaints about our service. SECAmb is committed to investigating complaints when they are received to ensure causes can be identified and learned from to improve practice and reduce the likelihood of a recurrence.

The purpose of this report is to provide an overview of all compliments and complaints that were received during the period of 1st April 2019 to 31st March 2020. The report will explain the route that complaints can take to be investigated, depending on their severity, and the processes that underpin this, it will also highlight any notable themes and explain any actions that were taken to mitigate risks relating to them. In addition, the report will highlight key learning that has been identified from complaint investigations.

Key Achievements

- The Patient and Family / Carer Experience Strategy has been now been approved; the Trust Board approval was delayed by Covid 19.
- Improved processing of compliments resulting in staff receiving recognition within a week of receipt.

Patient and Family / Carer Experience Strategy

Our Patient and Family / Carer Strategy was co-designed with stakeholders following three events, one each in Surrey, Sussex and Kent, and a consultation workshop with NHS Improvement / England (NHS I/E). The four events provided us with the opportunity to speak with our patients, their families and carers as well as our staff, and external partners, including Health Watch across the region, to co-develop this strategy. As a Trust we were delighted with the engagement, as it was fundamental in the development of the strategy.

Our vision is that our strategy will also be co-delivered with our partners and we anticipate that over the next five years we will see an increasing influence from patients and their families / carers in the care that we provide. We are also grateful to the support from NHS I/E with the development of this strategy.

Developing of our strategy helped us to identify areas that we currently do well in addition to those where we need to change how we do things and we will build on our existing good practice. We recognised that we needed to be ambitious in order to truly improve the experience of our patients and their families / carers. To this end we intend taking a Trust wide approach to examining our culture, leadership, patient and staff engagement and how we measure experience.

We also recognise that the format of our full strategy document is not helpful to patients who want a quick and easy reference. We have had to obtain a balance between the governance requirements of the Trust and the information which is accessible to patients. Therefore, we will be developing a shorter one page, more accessible format which clearly defines the elements of our strategy. This will also be made readily available throughout our Trust.

The Board approved the first Patient and Family / Carer Experience Strategy for South East Coast Ambulance NHS Foundation Trust in May 2020.

The first planned workstream arising from the strategy is to review how we collect, collate and triangulate all our data relating to patient experience. It is recognised that whilst we have systems in place currently, they are likely to become more sophisticated over the next year. We will be able to understand more of the experience of our patients and use quality improvement methodology to make changes arising from that feedback.

Compliments

Each year the compliments received by the Trust, thanking our staff for the work they do, far outnumber complaints. Compliments are recorded on the Trust's Datix system (electronic patient safety and risk management software system), alongside complaints, so both the positive and negative feedback is captured and reported back to operational staff. The staff concerned receive a letter from the Chief Executive in recognition of the dedication and care they provide to our patients. During 2019/2020 the Trust received 1,884 compliments, slightly more than the 1,846 received during 2018/19.

Compliments are shared with crews and the leadership team; staff appreciate being recognised and feel valued when they receive compliments, this validates the good work they are delivering and makes them feel part of a successful team. The Trust believes, as with complaints not being recognised or investigated, the same approach should be taken with compliments.

Compliments are often published in the Bee Line, allowing staff to see the good work their colleagues are doing. Compliments received influence morale overall and make a big difference to the overall behaviours of the staff.

Table 1 Compliments by service/operating (OU) area and month:

Op area / Month	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Ashford OU	5	6	4	11	13	10	9	8	6	16	6	12	106
Brighton and Mid Sussex OU	7	3	1	13	17	20	8	21	17	20	8	19	154
Chertsey OU	6	8	6	18	19	13	10	28	18	10	24	27	187
Gatwick and Redhill OU	13	5	6	36	30	18	24	27	17	38	29	28	271
Guildford OU	5	5	8	13	25	8	15	18	12	21	22	12	164
HART	0	0	0	0	0	0	0	0	0	0	0	1	1
Medway and Dartford OU	10	2	10	34	21	20	17	29	24	37	31	19	254
Paddock Wood OU	7	6	3	25	15	8	13	7	14	12	13	18	141
Polegate and Hastings OU	8	4	7	8	26	16	22	28	8	19	19	7	172
Tangmere and Worthing OU	8	3	9	24	30	23	16	23	14	13	9	25	197
Thanet OU	12	3	3	12	20	10	9	26	15	24	20	21	175
East EOC	0	1	0	1	1	1	1	3	1	2	0	2	13
West EOC	2	2	0	1	2	1	2	4	1	2	4	2	23
NHS111	0	0	2	0	1	1	1	5	1	0	0	3	14
Patient Experience	0	0	3	2	0	0	2	1	0	1	2	1	12
Total	83	48	62	198	220	149	149	228	148	215	187	197	1884

Direct feedback and compliments resulting from 999 calls to the Trust's Emergency Operations Centres are more difficult to obtain as calls tend to be very concise and focused. However, examples have been included below where life-saving advice has been provided.

In previous years there were no guidelines regarding the time taken for the Trust to process compliments. This led to crews not receiving their much-deserved recognition in a timely manner. Although there is no statutory requirement for compliments to be processed within a defined period, the importance of processing these as quickly as possible was recognised, and the system was reviewed and revised. This has led to compliments being currently processed and completed within a week of receipt. The 1,884 compliments received during 2019/20 represent one compliment for every 1,205 interactions, meaning that 0.082% of all calls / journeys attracted a compliment.

Some examples of the compliments the Trust received during 2019/2020 are below:

"Mother wished to thank the call operator for saving her two-day old sons life. They kept her calm whilst in blind panic and helped her administer CPR which eventually worked before the crews arrived and she cannot express the appreciation and thanks as now he is a healthy five-week-old baby."

"Patient called to say thank you to the crew who assisted them, they were extremely empathetic, reassuring and helpful. They were professional throughout and are a credit to SECAmb."

"Mother called our office to say thank you to the crew who assisted her son. They were incredible, reassuring, compassionate and their good humour calmed and helped everybody. They kept both her and her son informed and went above and beyond the call of duty. She is very grateful that they kept her smiling during such a stressful time."

"Patient's sister called to express her gratitude to the team who assisted her terminally ill sister. She explained that the crew were with her sister for hours and made sure that she received the most appropriate care. The crew listened to the sister and family's concerns and made sure that she was taken to a hospice which was the right thing to do at the time. Patient's sister would like them to know they were absolutely brilliant and that they are all very grateful for everything they did on the day."

"A Supported Housing Officer wanted to thank the Emergency Medical Advisor (EMA) for the way they handled their 999 Call. They went on to say that the EMA talked everything through with him in such a cool and way that made it very easy for him and they were very reassuring throughout."

"Wife says that the crew were very helpful, caring and brilliant. They liaised with other services and since then her husband is getting the support he needs. She explained that she is 89 years old herself and she really appreciated all the help they received since our crew's attendance."

Complaints

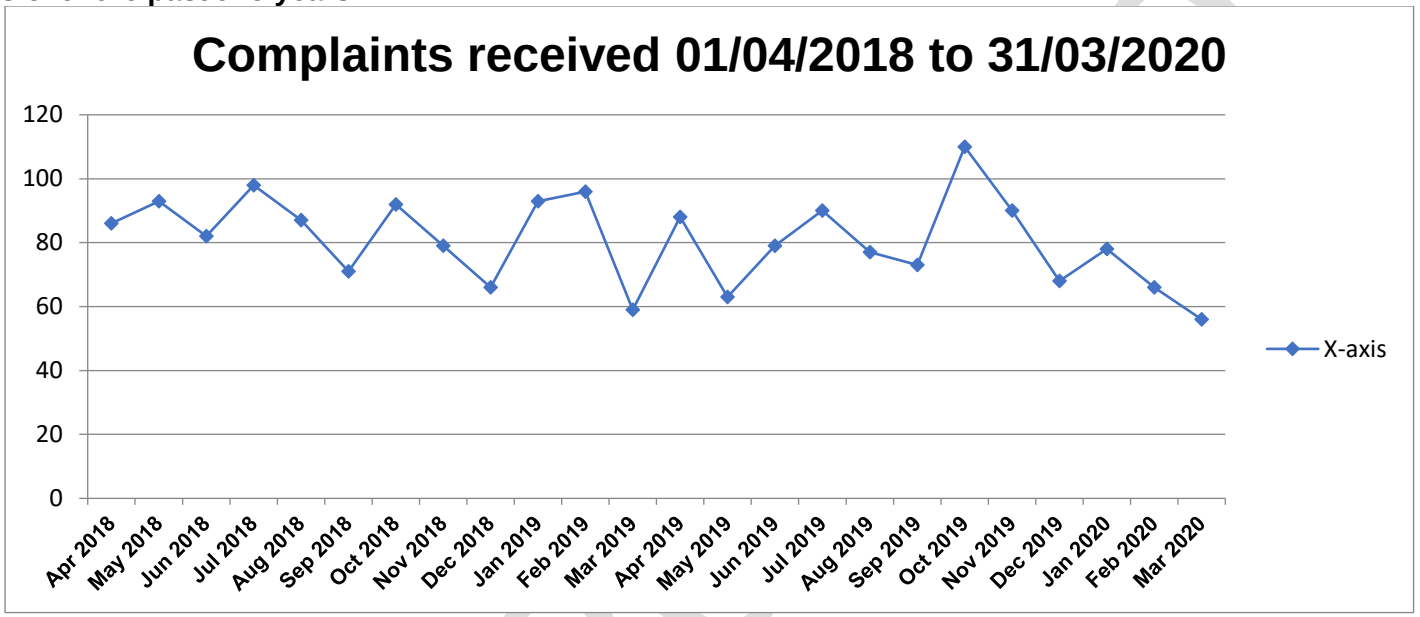
Statistics:

During 2019/20:

- Our Emergency Operations Centre staff answered 777,662 calls.
- Our A&E road staff made 713,052 responses to patients.
- Our NHS 111 staff took 780,902 calls.
- SECAmb received 938 complaints.

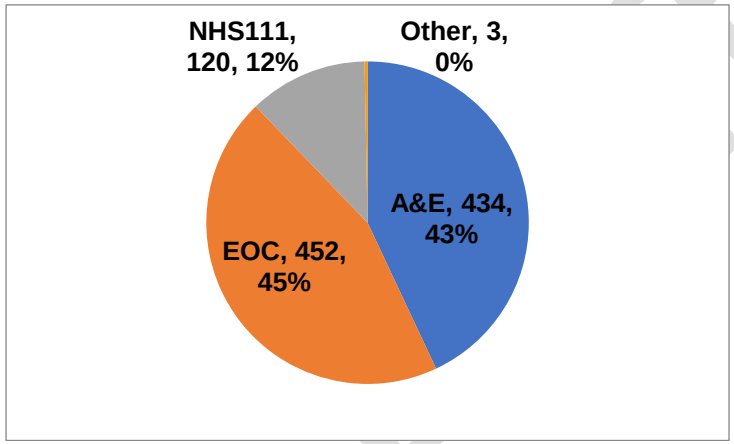
This equates to one complaint for every 2,422 patient interactions, meaning that 0.041% of all calls / journeys attracted a complaint. Detailed below is a comparison between the complaints received in the past two years which shows a slight reduction in 2019/20 against 2018/19.

SECAmb complaints over the past two years:

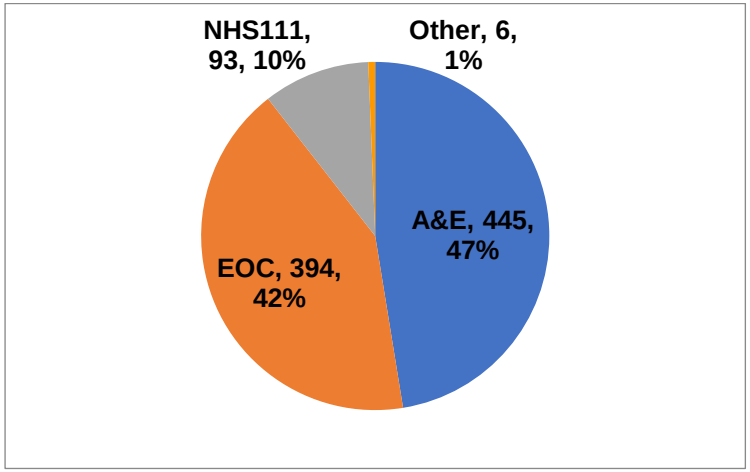


The peak during October 2019 correlates with an increased level of activity experienced across the Trust, with only 34% of the month being in Surge Management Plan Level 1.

2018/19: 1009



2019/20: 938



Complaints by service/operating (OU) area and month:

Service / OU / Month	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Ashford OU	2	4	5	8	7	4	8	4	5	3	3	3	56
Brighton and Mid Sussex OU	6	6	5	4	6	5	3	6	4	8	3	1	57
Chertsey OU	7	5	3	6	4	7	6	3	4	2	4	5	56
Community First Responder	0	0	0	0	0	0	0	0	0	1	0	0	1
Gatwick and Redhill OU	5	6	10	9	8	3	8	7	4	8	8	3	79
Guildford OU	3	3	6	4	1	5	6	7	3	9	2	2	51
Medway and Dartford OU	10	6	10	11	3	6	8	6	4	9	4	6	83
Paddock Wood OU	4	3	5	3	6	3	6	5	3	4	3	3	48
Polegate and Hastings OU	8	2	4	7	2	5	10	4	4	3	3	4	56
Tangmere and Worthing OU	9	7	9	6	9	6	6	11	8	5	9	8	93
Thanet OU	5	5	3	4	6	4	6	3	4	4	4	4	52
HART	0	0	0	0	0	0	1	0	0	0	0	0	1
East EOC	7	3	7	8	4	5	11	9	5	7	6	5	77
West EOC	7	8	7	12	11	10	23	16	10	9	9	5	127

Service / OU / Month	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
EOC Clinical	0	0	0	0	0	0	0	0	0	0	0	1	1
EOC information Team No Area	0	0	0	1	0	0	0	0	0	0	0	0	1
NHS111	14	5	4	7	10	10	7	9	9	6	7	6	94
Communications	0	0	0	0	0	0	0	0	0	0	1	0	1
Patient Experience	0	0	0	0	0	0	0	0	1	0	0	0	1
Information Governance	1	0	0	0	0	0	0	0	0	0	0	0	1
PALS / Complaints	0	0	1	0	0	1	0	0	0	0	0	0	1
Total	88	63	79	90	77	74	109	90	68	78	66	56	938

Complaints are allocated by the Patient Experience Team to the service / operational unit upon receipt, all complaints regarding timeliness are allocated to and investigated by the Emergency Operations Centres.

Complaints are reviewed and graded according to their apparent seriousness; this ensures they are investigated proportionately. These are:

- Level 1 - complaints that can be dealt with by the Patient Experience Team as they already hold the information necessary to respond to the complaint or can easily obtain it without sending the complaint to anyone else for investigation. These are normally registered as concerns; would be considered as PALS issues in other Trusts.
- Level 2 – a complaint that appears to be straightforward, with no serious consequences for the patient / complainant, but needs to be sent to a manager for the service area concerned to investigate.
- Level 3 – a complaint which is considered to be serious, having had clinical implications or a physical or distressing impact on the patient / complainant, or to be of a very complex nature.
- Level 4 - any complaint which is later classified as a Serious Incident (SI). Once a decision has been taken by the Serious Incident Group to declare a serious incident, the complaint is passed to the SI Team for a root cause analysis investigation to be carried out. The SI Team will liaise with the complainant confirming the process to be followed and responding to any queries.

Most complaints received during 2019/20 were graded as level 2, 863 (92%), with the remaining 75 (8%) as level 3.

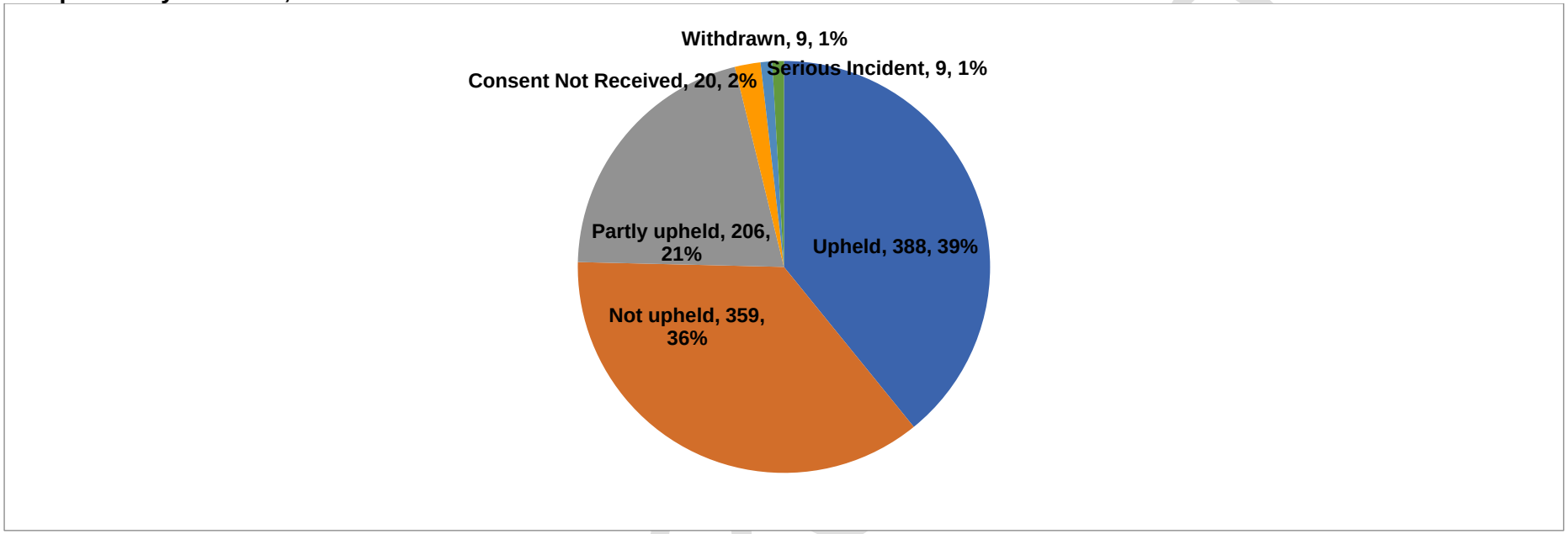
Complaints are categorised into subjects and can be further distinguished by sub-subject if required.

Complaints received during 2019/20 by subject and service area:

Directorate / Subject	A&E	EOC	NHS111	Other	Total
Administration	**1**	**1**	**2**	**2**	**6**
Communication issues	**15**	**12**	**2**	**2**	**31**
Concern about staff	**280**	**30**	**14**	**2**	**326 (35%)**
Information request	**1**	**0**	**0**	**1**	**2**
Miscellaneous	**6**	**1**	**1**	**0**	**8**
Patient care	**138**	**145**	**68**	**0**	**351 (37%)**
Timeliness	**1**	**205**	**6**	**0**	**212 (22%)**
Transport	**2**	**0**	**0**	**0**	**2**
Total	**444 (47%)**	**394 (42%)**	**93 (1%)**	**7**	**938**

When a complaint is concluded, the investigating manager, with input from the Patient Experience Team where necessary, assesses whether the complaint should be upheld, partly upheld or not upheld based on the findings of their investigation. During 2019/20 991 complaints were responded to; of these 60% were found to be upheld or partly upheld. Where a complaint is received which relates to one specific issue, and substantive evidence is found to support the allegation made, the complaint is recorded as 'upheld'; however, where a complaint is made regarding more than one issue, and one or more of these issues are upheld, the complaint is recorded as 'partially upheld'. The outcome from complaints is shown in the figure below:

Complaints by outcome, 2019/20



To enable the Trust to release details of an investigation, consent must be received from the patient or their representative. If this is not received by completion of the investigation the complaint is closed and marked as 'Consent Not Received' and a letter sent to the complainant confirming this, however, any learning resulting from the investigation is still put in place. 1% of complaints received by the Trust are withdrawn by complainants who specifically request an investigation does not take place. 1% of complaints are, after review from the Serious Incident Group, declared a Serious Incident and investigated accordingly, the complainant is kept informed in such circumstances.

Closed complaints by Subject and Outcome:

	Consent Not Received	Not upheld	Partly upheld	Serious Incident	Upheld	Withdrawn	Total
Administration error	0	3	1	0	0	1	**5**
Advice	0	0	1	0	0	0	**1**
Breach of confidentiality	0	4	2	0	3	1	**10**
Communication issues	1	16	4	0	11	1	**33**
condition / comfort of vehicle	0	0	1	0	0	0	**1**
Crew diagnosis	0	14	5	1	5	0	**25**
DOS issues	0	2	0	0	1	0	**3**
Equipment issues	0	0	1	0	2	0	**3**
GP call back delay	0	0	1	0	0	0	**1**
HCP failed to visit	0	0	0	0	1	0	**1**
Inappropriate treatment	0	31	15	1	12	0	**59**
Made to walk	0	2	3	0	1	0	**6**
Miscellaneous	0	2	1	0	3	0	**6**
Not transported to hospital	0	18	14	1	6	0	**39**
Pathways	5	83	35	2	95	2	**222**
Patient injury	0	2	5	0	2	0	**9**
Privacy and dignity	0	2	0	0	0	0	**2**
Request for documentation	0	1	0	0	0	0	**1**
SECAmb policy or procedure issue	0	0	0	0	1	0	**1**
Siren noise	0	1	0	0	0	0	**1**
Skill mix of crews	0	1	2	0	0	0	**3**
Staff conduct / attitude	3	137	79	0	53	1	**273**
Standard of driving	1	23	10	0	11	0	**45**
Timeliness - 111 Response	0	1	0	0	5	0	**6**
Timeliness	10	14	26	4	176	3	**233**
Transport arrangements	0	2	0	0	0	0	**1**
Total	**20**	**359 (36%)**	**206 (21%)**	**9**	**388 (39%)**	**9**	**991**

By far the highest category of complaint which are upheld or partly upheld is timeliness with 202, 20%, followed by staff conduct / attitude with 132, 13% and Pathways with 130, 13%. Timeliness complaints primarily occur when the Trust has implemented its Surge Management Plan Level 3 or 4 and is experiencing high levels of demand for its services. Of the complaints received regarding staff conduct / attitude 48% are upheld or partly upheld and result in significant learning for our staff, this is gained through reflective practice where crews complete a paper on how they would have dealt with a situation differently which is then discussed with their line manager. In some cases, it can also result in formal action via the Trust's Disciplinary Procedure. Any complaint received which relates to the use of NHS Pathways is referred for the call to be audited, the findings are then fed back to the call handler by the line manager, any additional learning identified is put in place.

During 2019/20 63% of complaints were responded to within the Trust's timescale, compared to 95% in 2018/19. The Trust's agreed timescale within the complaint's procedure is for 90% of complaints to be responded to within 25 working days. The reduction in response times was a direct result of the earlier highlighted issues experienced with investigating and responding to EOC complaints, 34%.

Directorate	Complaints closed	Number responded to within 25 working days	% number responded to within 25 working days
A&E	**456**	**382**	**84%**
EOC	**437**	**146**	**34%**
NHS111	**100**	**92**	**92%**
Other	**6**	**5**	**83%**
Overall	**999**	**625**	**63%**

Complaints by service area: A&E field ops

The table below shows the A&E field operation's complaints received by subject. The two main themes of complaints relating to emergency field operations are, as in previous years, 'concern about staff' (which includes complaints about staff conduct, attitude, breach of confidentiality and the standard of driving), 280 (63%), and 'patient care', 138 (31%). These figures correlate with those from 2018/19 which were 'concern about staff', 275 (63%), and 'Patient care', 144 (33%).

OU / Subject	Administration	Communication issues	Concern about staff	Information request	Miscellaneous	Patient care	Timeliness	Transport	Total
Ashford OU	**0**	**2**	**28**	**0**	**0**	**9**	**0**	**0**	**39**
Brighton and Mid Sussex OU	**0**	**1**	**31**	**0**	**1**	**12**	**0**	**0**	**45**
Chertsey OU	**0**	**1**	**17**	**0**	**2**	**17**	**0**	**0**	**37**
Gatwick and Redhill OU	**0**	**1**	**36**	**0**	**1**	**23**	**1**	**0**	**62**
Guildford OU	**0**	**1**	**26**	**1**	**1**	**6**	**0**	**0**	**35**
Medway and Dartford OU	**0**	**3**	**35**	**0**	**0**	**24**	**0**	**0**	**62**
Paddock Wood OU	**1**	**0**	**17**	**0**	**0**	**13**	**0**	**0**	**31**
Polegate and Hastings OU	**0**	**2**	**21**	**0**	**0**	**10**	**0**	**0**	**33**
Tangmere and Worthing OU	**0**	**3**	**37**	**0**	**1**	**16**	**0**	**0**	**57**
Thanet OU	**0**	**1**	**32**	**0**	**0**	**8**	**0**	**2**	**43**
Total	**1**	**15**	**280**	**1**	**6**	**138**	**1**	**2**	**444**

Concern about staff:

Concerns regarding staff feature as one of the top five themes of complaints within the NHS. For the Trust this includes the standard of driving for which there were 45, a slight increase on 2018/19 where 39 were received. In March 2020 the Trust recruited a Fleet Risk Reduction and Driving Standards Manager who reviews all complaints received regarding the standard of driving.

The overall 280 complaints the Trust received regarding concerns about A&E road staff during 2019/20 reflects a slight increase over 2018/19 when 275 were received. However, of those received during 2019/20, 45% (127) were upheld or partly upheld, compared to 54% (149) during 2018/19.

Patient Care:

Complaints about patient care are divided into sub-subjects, which include:

- Crew diagnosis
- Equipment issues
- Inappropriate treatment
- Patient injury
- Patient made to walk to the ambulance
- Patient not conveyed to hospital
- Privacy and dignity
- Skill mix of crew

During 2019/20 we received 138 complaints specifically about the care provided by our road staff and an additional 28 complaints where 'patient care' was a secondary concern i.e. initial complaint regarding timeliness and concerns raised regarding care provided by the crew once on scene, a total of 172 complaints, of which 92 (53%) were upheld or partly upheld, compared to 108 during 2018/19 where 58% were upheld or partly upheld.

64 complaints were received in relation to inappropriate treatment with 32 (50%) of those upheld or partly upheld.

44 complaints were received about patients not having been conveyed to hospital, of these 20 (45%) were upheld or partly upheld.

Crew diagnosis, which is occasionally used interchangeably with non-conveyance (not all misdiagnoses resulted in non-conveyance) accounted for 26 complaints of which 11 (42%) were either upheld or partly upheld.

Complaints by service area: Emergency Operations Centres (EOCs)

Historically, the responsibility to investigate complaints relating to the Trust's Emergency Operations Centres (EOC) sat within the EOC. However, in March 2019, due to a recognised backlog and lack of support for the staff member responsible for these complaints, the decision was taken to move the function and the resource within the Patient Experience Team (PET) to improve the support provided. It became apparent very quickly that only one person being able to undertake this work was a single point of failure for the organisation, and unfortunately shortly after this move occurred the risk was realised when the staff member had an unplanned absence away from the Trust. As an interim measure the Trust secured temporary assistance from colleagues within the Nursing and Quality Directorate and the EOC to help work through the backlog. Subsequently, the Patient Experience Team have secured the services of a permanent member of staff with extensive experience within EOC and full investigation training; they are due to start in June 2020. In the meantime, the back log of complaints within EOC has been cleared.

Complaints received regarding the Trust's EOCs have reduced dramatically over the last two years from 577 during 2017/18 to 452 during 2018/19 and to 394 during 2019/20 representing a reduction of 125 (21%) during 2018/19 and a further reduction of 58 (13%) during 2019/20.

The figure below shows the EOC complaints by subject. The two main themes of complaints about the EOCs is, as in previous years, 'timeliness' 205 (52%) and 'patient care' 145 (37%).

	Administration	Communication issues	Concern about staff	Miscellaneous	Call triage	Timeliness	Total
West EOC	**1**	**9**	**11**	**1**	**92**	**137**	**251**
East EOC	**0**	**3**	**19**	**0**	**53**	**68**	**143**
Total	**1**	**12**	**30**	**1**	**145**	**205**	**394**

Timeliness:

By far the highest number of complaints that were received regarding the EOCs were timeliness, 205, although this year has shown a reduction of 47 complaints, just under 19%; 90% of these complaints were found to be upheld or partly upheld. Timeliness complaints are when the Trust does not achieve its target response time; when this is confirmed the complaint is always found to be upheld. The Trust regularly reviews its operational establishment to try to ensure there are enough staff to meet the predicted operational demand, however, often the demand outstrips the number of resources; this work is ongoing as the demand is ever increasing. Significant work has also been undertaken in the EOCs to again, try to ensure patients are safeguarded whilst awaiting a resource; the number of staff made available to complete welfare calls has increased allowing those with worsening symptons to be identified and re-triaged in a more timely manner.

Call triage:

Call triage (NHS Pathways) formed the next highest number of complaints with 174 complaints received where an element of the triage was questioned, with 108 (62%) being upheld in some part. These complaints were often found to be as a result of human error, with staff not correctly following the triage process, some examples of errors made are below:

- selecting the wrong pathway
- insufficient probing of symptoms
- insufficient explanation
- EMA not deferring to clinician
- Clinical Supervisor not using NHS Pathways to reinforce their clinical decision
- not following policy correctly
- issue with NHS Pathways itself

All 999 calls which are the subject of a complaint are audited and feedback is provided to the call taker from the audit by their line manager, all identified learning is put in place via action plans.

Complaints by service area: NHS111

During 2019/20 the Trust received 93 complaints about its NHS111 service, compared to 120 during 2018/19 and 166 during 2017/2018; a decrease of 29% and 28% respectively.

	Administration	Communication issues	Concern about staff	Miscellaneous	Call triage	Timeliness	Total
NHS111	**2**	**2**	**14**	**1**	**68**	**6**	**93**
Total	**2**	**2**	**14**	**1**	**68**	**6**	**93**

Of the complaints received 93, (58%) were upheld in some way.

As with the Trust's EOCs, the highest number of complaints related to call triage; 68 (73%); of those 43, (63%) were upheld in some way. As with complaints about the Trust's EOCs, audits are completed on all calls subject to a complaint and feedback provided to the call taker by their line manager.

Learning from complaints

Lessons identified from complaints throughout 2019/20 have been wide ranging.

741 actions were identified from complaints during the period 01/04/2019 to 31/03/2020. Actions from A&E complaints include feedback provided to the crew both formally and informally, reflective practice, additional training and 'ride outs', when an Operational Team Leader spends the day with a crew reviewing their working practice. Actions from complaints for EOC and NHS111 are equally wide ranging and include feedback provided to the EOC and NHS111 staff both formally and informally, additional training or mentoring, clinical instruction and policy / procedural reviews.

The below shows examples of the more common themes and lessons learnt:

A&E complaints:

Complaint	Investigation Findings
We had an ambulance out to my Grandad in the early hours of Sunday 16th June, we called as he was end of life and was in severe pain with chest pain. We were told the ambulance was on the way with lights and sirens and we should wait outside as the house was hard to find. My partner waited outside for 2 hours in total waiting for them to arrive. We had to call them back as they seemed to not be showing up. When the paramedics did arrive, they did not even come on blue lights. When they walked in, they did not apologise at all for the wait. My grandad was end of life with terminal cancer and all treatment had been stopped recently by his cancer doctor but a DNR had not yet been put in place. When we mentioned this, she repeatedly told us she would be resuscitating him if he were to pass away. We made it very clear this was against his wishes and she did not have to as he was end of life. She continued to tell us we were wrong. This was obviously very distressing for us. We wanted end of life treatment for him at home and asked her advice with what to do. She said he could not have any treatment without going to hospital and this was best for him. We reluctantly agreed for him to go as she was going to leave him with absolutely nothing in place if we refused hospital. He later passed away in hospital, totally against his wishes.	The investigation found that although the crew had the patient's best interest at heart there were obvious communication issues as the family felt they were not being listened to and some of the rationale for decisions were not clearly communicated with them: • EOC were not correct in confirming an ambulance was on route. • Staff came across as forceful and unsympathetic. • No check was carried undertaken to find out if a 'Do Not Attempt Resuscitation' order (DNAR) was in place, family confirmed in place but not on IBIS. • Crew did not explain that patient could stay at home only telling them that they had to go to hospital. Learning: • Crew uncertain about leaving patient at home. • Clearly explaining what is happening and why. Action taken: • Crew met with SECAmb End of Life Care Lead in order to expand their understanding of care pathways in such circumstances.

EOC complaints:

Complaint	Investigation Findings
I received a verbal complaint from a relative of a patient whilst in attendance at an incident. They were incredibly angry with the experience they had whilst on the phone to EOC. I tried to explain to them how our triage process works and why they were asked so many questions. However, in the end we agreed that they would like their concerns investigated. I told them that I would investigate this myself and write back to them via our PALs dept.	As with all complaints about the Emergency Operations Centres an audit of the calls was completed. Following audit, the auditor raised concerns that Pathways questions did not safeguard patients suffering from severe tremor, copies were sent to NHS Pathways who reviewed and confirmed: *"Thank you for submitting the issue regarding severe tremor. This has been reviewed by members of the authoring and training team. Changes were made to the key points of Tremor PW for 18.5 and then work completed for 19.3 to transfer those with tremor symptoms for less than a week to Other Symptoms PW, therefore those with 'acute' symptoms will be interrogated for 'high end' conditions including critical illness. We agreed that these changes would enhance the triage for the symptoms described by the caller, acknowledging the difficulty that the call handler had with these calls, of which we felt were managed well. We will be closing this issue as changes have been applied, many thanks for taking the time to upload these calls for review."*
XX called to say that her 10-year-old son was out cycling with his friend in the woods behind a street of houses, when he fell off and landed in a ditch tangled up with his bike on 26 May between 19:45 and 20:15. His friend phoned for an ambulance. A couple who were in the wood were asked by the call taker to move her son as the ambulance couldn't find him - although they weren't comfortable doing this, they did so. XX says that at this point the ambulance hadn't even arrived. At one point he was unable to feel his legs. He is alright, but very bruised. XX complains that the call taker should not have asked the couple to move her son, as the ambulance crew should always go to the patient.	The investigation found that the Emergency Medical Advisor should have sought clinical involvement before advising the movement of the patient to ensure no further injury was caused as per advice of NHS Pathways. A shared learning document was sent out to all staff inclusive of the dispatch function to ensure that learning has come from this incident and the importance of resource dispatchers and dispatch team leaders knowing that they need to seek clinical advice before moving any patients post injury to ambulance response. The Trust also implemented a new method of working in relation to obtaining remote rural locations utilising "What3Words" ops 298. This was implemented in July 2019. What3Words provides a precise and simple way to talk about locations. The world has been divided into a grid or 3 metre x 3 metre squares each one assigned a unique

Complaint	Investigation Findings
	three-word address. This allows it to be used on a mobile device to quickly determine a user's location.

NHS111 complaints:

Complaint	Investigation Findings
Could you kindly review the following incident that came through as a 111 call Cat 5 C, referred to GP and 4 hours later was dealt by 999 Cat 2 A, as a stroke and the patient died yesterday morning within 2 days of the 111 call. Could you kindly evaluate the original 111 call where she was referred to her GP and 4 hours later the 999 call was made and assigned as Cat 2 with A Priority. The patient was my best friend and ex-partner's mother. She passed away yesterday morning (28/04/2019) at about 1.30 am. The only sad part is the time difference of 4 hours between 111 and 999 calls, because my 'brother in law' who is the full time carer of both his parents, felt reassured enough after the 111 call, to leave his mom alone at home to take his dad for an appointment at Worthing Hospital. If there is an opportunity to use this call as a learning curve, that would be amazing. There are no negative feelings towards the call handler, and I wish only that you evaluate the call to identify whether there is the possibility to learn from this.	Following investigation, the audit found that a more urgent disposition could have been reached had the Health Advisor (HA): • Followed the "New confusion" route through NHS Pathways. • Sought clinical support regarding the combination of symptoms which were not all covered by the NHS Pathway that was followed. The HA received one-to-one feedback from the audit to ensure they understood that clinical support should be sought when the patient has multiple symptoms and the caller is concerned and is not accepting the disposition that has been reached.
I contacted 111 at about 8.30am on 14.12.2019, that morning I had had a purpuric rash for 36 hours which had started on my upper thighs, spreading to lower legs then whole body, with bloody blisters on the gums and front of tongue and bleeding from the mouth overnight. I can't remember exactly what I said but, I am sure I mentioned the purple skin rash as well as the mouth symptoms. The algorithm used by 111 took the operative to recommend I consult a dentist in the next few days.	Following investigation, the Health Advisor accessed the patient as per training which requires ABC's to be accessed as the priority, however due to this a purpuric rash was missed by pathways and an unsuitable disposition was reached. Taken to pathways user testing, pathways issue rejected. Health Advisor received staff feedback regarding the purpuric rash being missed. The hot

Complaint	Investigation Findings
If I had followed this advice, it would have put me at great risk of major morbidity even mortality. I had Idiopathic thrombocytopenic purpura with a platelet count of 1. I objected to the decision of the contact who then agreed to pass me on to someone clinical at 111. With a purple rash and bleeding gums- the algorithm should have been set to advice immediate attendance at an A&E, After being transferred by phone by 111 to the OOHs service, I received the correct advice and attended Tunbridge Wells Hospital; A&E. And then received the appropriate emergency in patient treatment.	topic for Meningitis was also recirculated to all staff. The case has also been discussed with senior clinicians and Operations Managers Clinical. All have the same opinion that Clinical support should have been obtained during the call for advice. There are differing views to whether this is a pathways or training issue as neither pathway would access both symptoms, however all have agreed that the mentioning of the purpuric rash should have been a red flag for the health advisor.

Parliamentary and Health Service Ombudsman

Any complainant dissatisfied with the outcome of a formal investigation into their complaint may take their concerns to the Parliamentary and Health Service Ombudsman (PHSO) for review. When the PHSO's office receives a complaint, they contact the Patient Experience Team to establish whether there is anything further the Trust feels it could do to resolve the issues. If we believe there is, the PHSO will pass the complaint back to the Trust for further work. However, if the Trust believes that local resolution has been exhausted, the PHSO will ask for copies of the complaint file correspondence to review and investigate themselves.

In the year 2019/20 the PHSO contacted the Trust and asked for copies of 11 complaint files, the cases are still with the PHSO being reviewed. There were three cases updated from 2018/19, two of which were not upheld and the third the Trust were asked to write an apology to a complainant as they felt we did not fully explain our findings or provide them with the appropriate reassurances.

Patient Advice and Liaison Service (PALS)

PALS is a confidential service to offer information or support and to answer questions or concerns about the services provided by SECAmb which do not require a formal investigation.

The table below details the number of PALS enquires received by the Trust during 2018/19 and 2019/20:

Type	2018/19	2019/20
Concern	**52**	**57**
Enquiry	**40**	**25**
Information request	**348**	**327**
Total	**440**	**409**

Most requests for information are Subject Access Requests under the Data Protection Act, where patients or their relatives require copies of the patient care record (PCR) completed by our crews when they attended them, or recordings of 999 or NHS111 calls, for a range of reasons. These requests are dealt with in accordance with the General Data Protection Regulations. The implementation of the new Electronic PCR has streamlined this process.

Other contacts are requests for advice and information regarding what to expect from the ambulance service, people wanting to know how they can provide us with information about their specific conditions to keep on file should they need an ambulance, calls about lost property, and on occasion, families wanting to know about their late relatives' last moments.

Monitoring Systems

The Trust has continued to improve the incorporation of the electronic reporting system (Datix) into the complaints process which has improved the ability to produce accurate reports and streamline the audit process. With the purchase of Datix Cloud, the latest most up to date version, it is hoped this will improve further once implemented.

In October 2018 the Trust embedded protocols for the weekly review of all open complaints; the report is sent each Monday to all investigating managers and copied to directors and senior managers, and sets out all open cases under investigation within their areas, this includes a reminder of the due dates for reports to be returned to the Patient Experience Team. This is continually being adapted and improved. This has helped to prevent complaints from becoming overdue and resulted in a current total number of open complaints for the Trust at the end of the year 2019/20 of 34.

Reporting Arrangements

Monthly compliance of internal complaints timescales is reported to the Trust Board within the Integrated Performance Report. Additional management assurance is also provided to the Quality and Patient Safety Committee. Patient stories are provided to each board meeting and available through the Trust website.

The national return for complaints with the NHS is the KO41a return. This data is submitted on a quarterly basis to the NHS Digital via their online portal.

The Patient Experience Team

The overarching responsibility for complaints, PALS and compliments sits with the Patient Experience Team. The work is diverse and brings the team into contact with many patients and their families, some of whom are struggling with mental illness, disorders or bereavement. Whilst many of these contacts are constructive, there have been occasions when team members have had to deal with highly complex and stressful or distressing situations. Supportive work began with the team in terms of resilience in 2018 and continues, including meeting with the Trust Mental Health Team.

Conclusion and future areas of development

The Trust continues to develop the rigour of complaints investigations. The Head of Patient Safety has developed training for Trust investigators ensuring that all complaints, incidents and serious incidents are investigated, using the appropriate level of investigation, to the same high standard which lead to more tailored and appropriate learning outcomes.

During the Covid-19 pandemic the Patient Experience Team have taken on a greater responsibility for investigating some Level 2 complaints in order to ease the necessity for operational staff to be taken off the road to complete investigations.