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**Public Board Meeting**

**25 November 2020**

**Item No 09**

**THIS PAPER IS FOR DISCUSSION**

**PERSON CENTRED CARE UPDATE**

<b>Lead Director</b>	Professor Frances Dodd, Director of Care Quality and Professional Development
<b>Author</b>	Mark Hannan, Head of Corporate Affairs and Engagement Alan Martin, Patient Experience Manager
<b>Action required</b>	The Board is asked to discuss the paper and provide feedback.
<b>Key points</b>	<p>This paper provides an update of our patient experience activity.</p> <p>The paper highlights our latest data on compliments, our Patient Focus Public Involvement work as well as complaints, their themes and actions to address them.</p> <p>An update is also provided on cases with the Scottish Public Services Ombudsman (SPSO).</p>
<b>Timing</b>	An update is presented bi-monthly to the Board.
<b>Link to Corporate Objectives</b>	1.1 – Engage with partners, patients and the public to design and co-produce future service. 1.2 - Engaging with patients, carers and other providers of health and care services to deliver outcomes that matter to people.
<b>Contribution to the 2020 vision for Health and Social Care</b>	Person centred care is delivered when health and social care professionals work together with people who use services, tailoring them to the needs of the individual and what matters to them. The Service's Person Centred Health and Care Plan promotes patient and staff participation in the development of services and continuous improvement of the experience of patients and of staff.
<b>Benefit to Patients</b>	Patient and carer feedback involvement in service development helps ensure services meet patient needs. Feedback helps drive continuous improvements to services and evidence that service developments are driving anticipated improvements.
<b>Equality and Diversity</b>	The Service works with a wide range of patient and community groups to help ensure that the feedback gathered is representative of communities across Scotland. Patient feedback is closely linked to the Service's Equality Outcomes work.



**Scottish  
Ambulance  
Service**  
*Taking Care to the Patient*



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**SCOTTISH AMBULANCE SERVICE BOARD**

**PATIENT EXPERIENCE UPDATE**

**PROFESSOR FRANCES DODD, DIRECTOR OF CARE QUALITY &  
PROFESSIONAL DEVELOPMENT**

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## **SECTION 1: PURPOSE**

This paper covers the period between 1 April 2020 and 1 November 2020. It provides an update on trends, themes and mitigating actions from patient and carer feedback.

The paper also provides data on our performance against the complaints handling standard, cases which are being considered by the Scottish Public Service Ombudsman (SPSO) and the outcome of these cases.

## **SECTION 2: RECOMMENDATIONS**

The Board is asked to discuss this report and provide feedback.

## **SECTION 3: EXECUTIVE SUMMARY**

The Service actively seeks feedback on its services so that it can continue to make improvements. We have many ways of gathering feedback – face to face, patient forums, online portals, complaints and concerns channels.

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## Feedback analysis

### Care Opinion

The online platform, Care Opinion, continues to provide the public with the opportunity to share their experiences of health and care. The Service is dedicated to reviewing and responding to every post to support patients and their families. The Service is also keen to identify learning from the feedback we receive.

Between 1 April 2020 and 10 September 2020, 70 stories were posted on Care Opinion relating to the Service. These have been viewed 17,604 times. NHS Greater Glasgow and Clyde and NHS Lanarkshire board areas currently make up around 37% of the stories posted.

Of the 70 posts, 80% were uncritical in tone. It should be noted that whilst the remaining 20% will have some form of criticality, this is not necessarily directed towards the Service, with the feedback often involving multiple NHS boards.

\*There was 1 Strongly Critical story within these stories that was directed solely to the Service. The Deputy Regional Director made contact through the channel of Care Opinion and the author replied. This feedback has now been taken through the NHS Complaints Handling procedure and the matter is now closed with the learning taken on board.

### Compliments

#### Social media

In addition to Care Opinion, we receive a large volume of feedback via our digital channels - Facebook, Twitter and the Service's website.

The communications team promotes these compliments through our social media channels and through internal communications channels to our staff. With the agreement of the patients involved, some of the stories told are targeted at national media outlets and feature pieces involving patients being reunited with the crews or Ambulance Control Centre staff who have assisted them.

#### Facebook

- Posts reached on average 132,745 people between 5 October and 1 November (down by 6% from the previous 28 days)
- Videos reached 15,672 people over the same period (up by 190% on the previous month)
- An extra 357 followers during this period (37,398 followers)

#### Largest posts

The top five posts between 5 October – 1 November were:

- International Control Room Week – 44,600
- Additional Funding – 26,943
- Restart a Heart Day – 21,504
- World Health Day – 18,018
- Help us improve healthcare – 15,739

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## **Staff engagement session on feedback**

The Patient Experience Manager undertook an all staff engagement session on the importance of feedback and work underway to learn from the feedback the Service regularly receives. Our staff receive over 1,000 compliments every year through formal channels and social media praising their work and professionalism. Only 0.07% of the contacts made to the Service result in negative feedback and this demonstrates the quality of care being provided to our patients. It is important however that the Service learns from the feedback received and the presentation focused on the work we are doing to do just that across all levels of the Service.

Staff were briefed on the new Learning from Events group which has been established with broad representation from across the Service. They also heard about the move from a 'person's approach' to a 'systems approach' in relation to how we review feedback. A systems approach considers how the conditions under which our staff work can be optimised. The new group has been set up to ensure that learning gained from events is used to enhance system performance and aid staff wellbeing which should in turn lead to the best outcomes and experience for all.

A very constructive and positive discussion followed from staff on the call.

## **Learning from Events Group (LfEG)**

On 8 October 2020, the second meeting of LfEG was held. The meeting was again very positive with discussions around how the Service can learn from feedback, Advanced Practice, actions from Significant Adverse Event Reviews and detailed case studies. A number of actions were identified following the meeting. The group will also be looking to bring its first frontline members of staff on board for future meetings.

The group is looking to identify trends across the breadth of feedback the Service receives, not just from the public and external stakeholders, but also from our own staff. This group intends to action the learning from these trends by encouraging and supporting improvement activity. This will provide assurance to the Board that the Service is acting on its moral and ethical responsibilities to continually look at ways to improve patient care and outcomes whilst not losing focus on achieving as positive a staff experience as possible.

This group will not be looking at individual learning or making any efforts to take punitive action. Instead it will be embracing a learning culture with staff involvement at the very heart of its design. With partnership colleagues sitting on the group as well as regular front line staff in attendance, it is anticipated that this group will work with a bottom up approach, supporting local innovation and improvement.

This group will report to National Clinical Operational Governance Group (NCOGG).

## **Patient Focused Public Involvement (PFPI)**

### **Remobilisation Engagement**

We are running two pilots of our newly created Engagement Guide and Toolbox with the Clinical Services Transformation (CST) team. We are working to ensure our toolbox is robust and rigorous enough to be used by every project member within CST independently, without the need for ongoing support from engagement specialists.

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Our first pilot will be on our Falls pathway in Glasgow and will also take into account national work currently ongoing around falls. Working with Third-Sector organisations (Age Scotland, Alzheimer's Scotland, Glasgow Disability Alliance), we plan to canvas patient opinion using an online survey, focus-groups and our national PFPI group. With our Third-Sector partners, we will be seeking their expert opinion and exploring possible co-design, with follow-on actions to be picked up by CST after the trial concludes.

Our second pilot will focus on our COPD pathway in Tayside and our engagement toolbox will be tailored to focus on staff engagement. We want to ensure that our toolbox is not simply helpful when seeking, for example, the views and opinion of renal patients in Fife, but can be used to engage with anyone at any time. We will be using very similar methods of engagement for our staff that we use for patients. We will survey staff in the area, run local focus-groups and a National engagement session with staff – this will help us to gather opinion, but may also aid in the National rollout of the pathway.

As a follow-up action after our initial pilots conclude, we will swap the approaches around and ask the COPD team to focus on patient engagement and the Falls team to focus on staff.

We will present our data and case studies to the Recovery Group with a view to asking CST to make use of the toolbox in each work stream in every project that sits under their remit.

### **Volunteers**

We continue to recruit patient representatives, and have recruited 7 new representatives in the past two months. This brings our total of National patient representatives to 20.

### **Third-Sector Engagement**

We continue to maintain close contact with Third-Sector partners and associates. The current pandemic has taken a huge toll on Third-Sector funding, and due to so many organisations winding-up in the past few months, we find ourselves with 25 National organisations still able to offer us support in involving their members, service-users and patients.

### **Edinburgh College**

We continue our youth engagement work with colleagues in Education and we have four information sessions planned with Healthcare and Nursing students at Edinburgh College. We hope these sessions will not only increase public knowledge of our Service, increase goodwill and aid in recruitment, but help develop our relationship with a younger demographic to aid us in our improvement agenda.

### **Complaints Data**

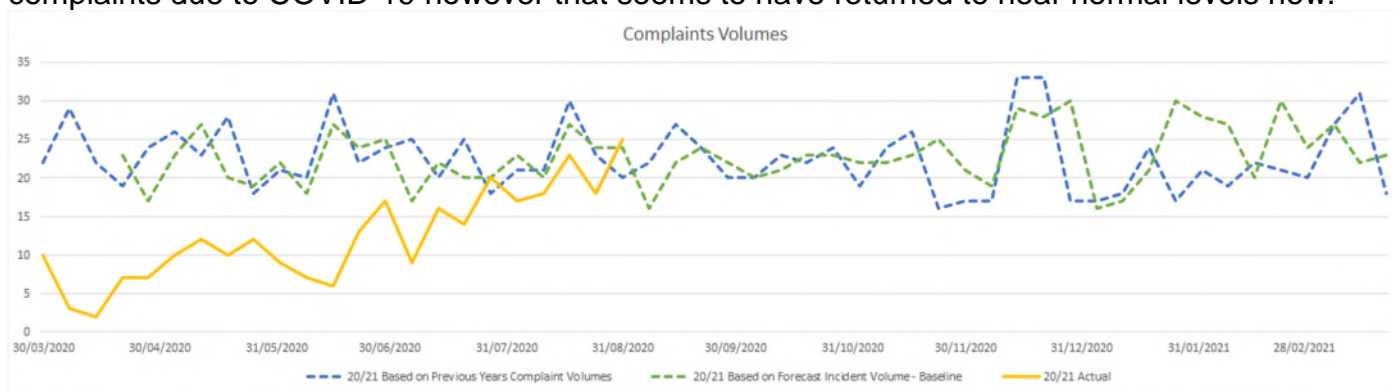
Between 1 April 2020 and 1 November 2020, a total of 446 complaints were received, with the Ambulance Control Centre (A&E) continuing to receive slightly under 38% of these. This shows a 34.6% decrease from the same period last year where we had received 682 complaints.

<b>Financial Year 1 April – 10 September</b>	<b>Total Contacts with Service (attended or not)</b>	<b>Total Complaints Received</b>	<b>% of Contacts to Complaints</b>
2019/20	355, 544	682	0.14
2020/21	330, 628	446	0.09

Work started in September 2020 to analyse the correlation between the number of complaints received and demand. A member of the Business Intelligence team has been provided with complaints data and asked to look for statistically relevant patterns in an effort to not only capture trends in what happened, but potentially forecast future complaints numbers.

The Business Intelligence team has now completed this work and modelled it in two different ways (see chart attached below). The first method is using the volumes of complaints seen over previous years (blue dashed line) the second method is based on the predicted volume of incidents (green dashed line) which makes the assumption that when we see higher demand there are longer waits for patients and therefore more complaints. When this was overlaid onto the charts there seemed to be a 3 week lag between the demand rising and the expected peak in complaints so this has been shifted by 3 weeks to reflect this.

The Business Intelligence Team member also overlaid the actual complaints we have seen for 2020/21, obviously in the early part of the year we saw an unseasonable decrease in the number of complaints due to COVID-19 however that seems to have returned to near normal levels now.



Another shift is within the 3 most common themes for complaints. Below is a table comparing the themes from last year to this year.

1 April 2019 - 1 November 2019	1 April 2020 - 1 November 2020
1. Delayed Response - 190 (27.9%)	1. Attitude and Behaviour - 106 (23.8%)
2. Attitude and Behaviour - 116 (17%)	2. Delayed Response - 98 (22%)
3. Triage/Referral to NHS24 - 78 (11.4%)	3. Clinical (other)* - 44 (9.9%)

(\*Clinical other is a theme that incorporates complaints that have a clinical aspect to them but do not necessarily relate to the initial or subsequent clinical assessment. Examples of these may be moving and handling or the hospital chosen for destination)

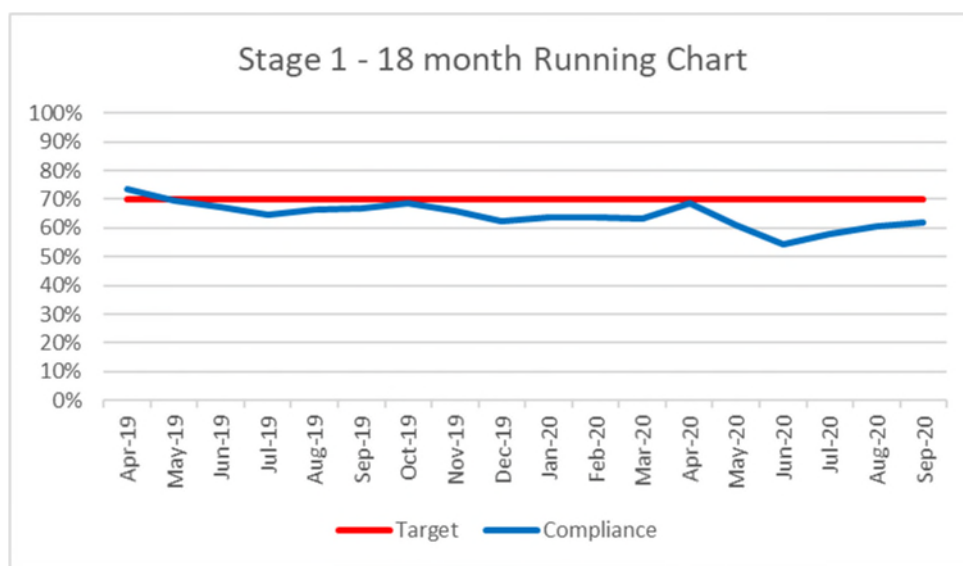
Data shows that 65.2% of the total complaints received this year are Stage 1 – Early Resolution Complaints (5-day target). This is an increase from last year where 54.8% of the total complaints received during this period were handled as Stage 1 Complaints.

**Stage 1** - (1 April 2020 – 23 October 2020)

Latest results indicate that Stage 1 complaints compliance is at 56.9%.



Stage 1				
	Closed within target			
	No	Yes	Total	Compliance
Ambulance Control Centre A&E	57	35	92	38.0%
Ambulance Control Centre PTS	12	48	60	80.0%
East Region	7	41	48	85.4%
North Region	7	7	14	50.0%
West Region	24	27	51	52.9%
Total	107	158	265	
Compliance	<b>59.6%</b>			

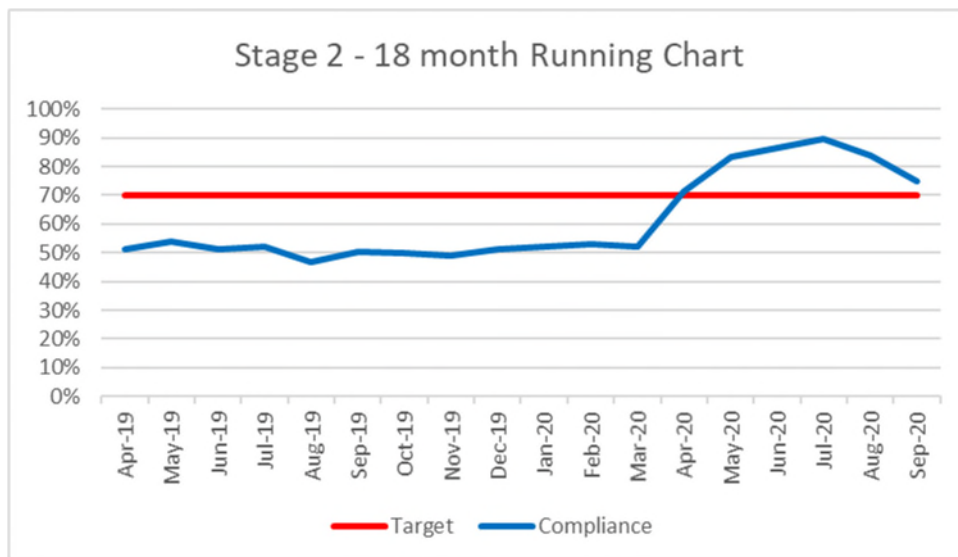


## Stage 2 – (1 April 2020 – 11 August 2020)

Latest results indicate that Stage 2 complaints compliance is currently 74.8%.

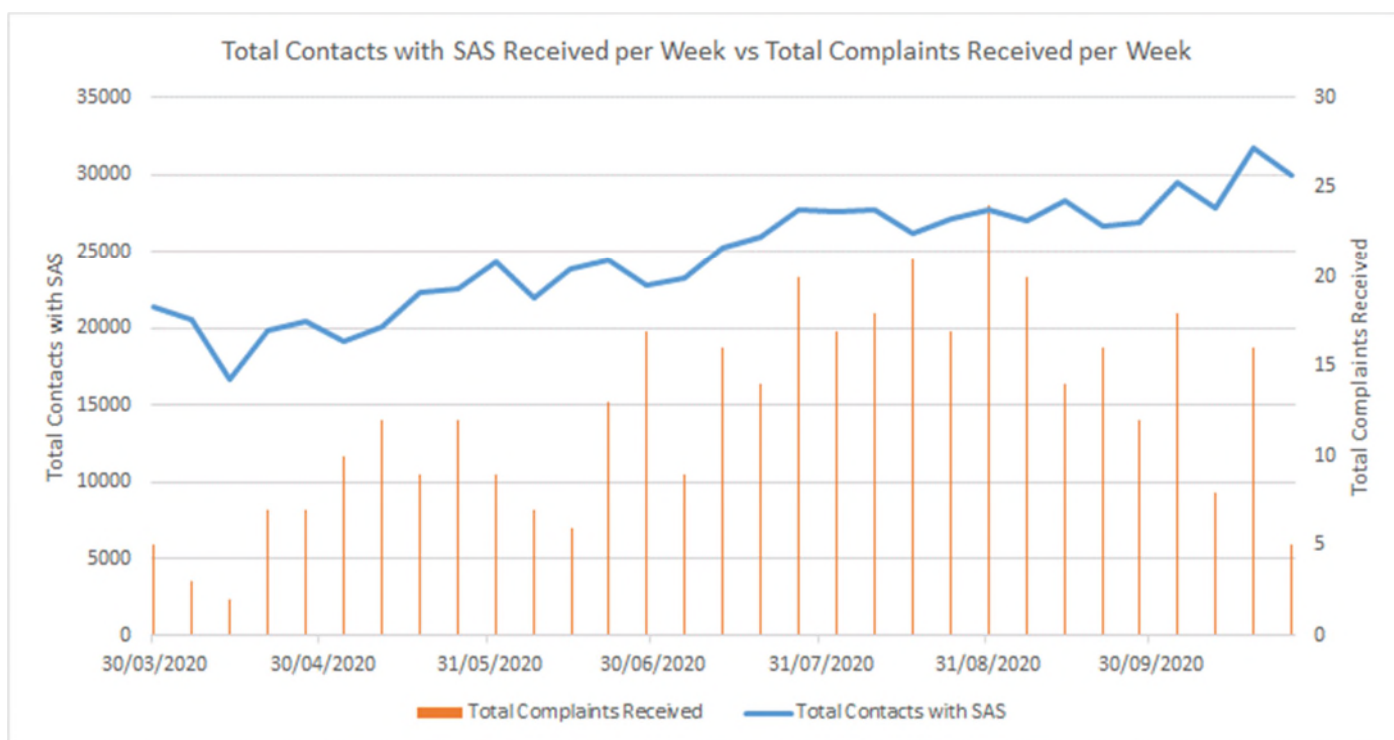
Stage 2				
	Closed within target			
	No	Yes	Total	Compliance
Ambulance Control Centre A&E	15	33	48	68.8%
Ambulance Control Centre PTS	4	3	7	42.9%
East Region	1	24	25	96.0%
North Region	1	7	8	87.5%
NHQ/Support Services	3	0	3	0.0%
Special Operations Response Division	1	0	1	0.0%
West Region	3	16	19	84.2%
Total	28	83	111	
Compliance	<b>74.8%</b>			





### Compliance Comments

Although we are still exceeding the 70% target for compliance, it is clear from the above dip that response turnaround times are beginning to dip slightly and this is likely due to the increase in complaints. Data below on the total number of contacts with the Service per week vs the number of complaints received per week show there has been a gradual increase since the start of the financial year in demand. There was also an increase in complaints with the peak occurring at the end of August and into September.



Anecdotally, there has been some feedback around challenges that suggest more complex reviews, multi-board approaches being required and staff abstractions have played a part in the dip in compliance. The Executive Team discussed resilience plans around the winter period for complaints handling and have begun conversations around utilising any available staff that are currently carrying out alternative duties to support colleagues in the management of complaints.

SAS Reference	SPSO Reference	Date SPSO began their review	Complaint Overview	SAS Decision	SPSO Stage and Outcome	Date SPSO completed their review	Recommendations	Status of Recommendations
WEMDC/34/12576/18	201809644	01/05/2019	1. Scottish Ambulance Service failed to respond reasonably to the request for an emergency ambulance to attend patient. 2. Scottish Ambulance Service failed to respond reasonably to complaint of November 2018	Upheld	SPSO Have upheld part 1 and not upheld part 2	23/04/2020	1. SAS to send apology letter for issues identified  2. Feedback to Clinical Advisor the findings of this report and evidence adequate processes are in place to ensure CA callbacks are made  3. Feedback to crew the findings of this report	1. Complete and signed off by SPSO  2. Complete and signed off by SPSO  3. Complete and signed off by SPSO
SW/31/12956/19	201801934	02/05/2019	1. Scottish Ambulance Service's response to an emergency call on specific date was unreasonable	Upheld	SPSO have upheld	07/11/2019	1. SAS to send apology letter for issues identified  2. Further evidence of reflection from Call Handler  3. Update SPSO on system changes to mitigate risk of CFR's not being dispatched  4. Confirm a suitable protocol for when Satellite Navigation fails on vehicles  5. Evidence this review has been fed back to the crew involved  6. Consideration for aide memoirs for cease of resuscitation	1. Complete and signed off by SPSO  2. Complete and signed off by SPSO  3. This recommendation was due in April 2020 and is still outstanding. The demands of COVID have resulted in this delay and ACC Senior Management are looking to have this completed as soon as possible. System changes have already taken place and contact with SPSO updating them on the status of this recommendation has been carried out.  4. This recommendation was due in March 2020 and is still outstanding. The demands of COVID have resulted in this delay and ACC Senior Management are looking to have this completed as soon as possible. System changes have already taken place and contact with SPSO updating them on the status of this recommendation has been carried out.  5. Complete and signed off by SPSO  6. Complete and signed off by SPSO

DATIX 35926 (SAER)+J8B5:J9I4B5:J7B5:J11B5:J9B5:J11	201804510	30/10/2018	1. Scottish Ambulance Service 's response to the emergency call was unreasonable2. Scottish Ambulance Service failed to conduct a reasonable investigation around complaint of response	Upheld	1. SAS to send apology letter for issues identified2. Further evidence of reflection from Call Handler3. Update SPSO on system changes to mitigate risk of CFR's not being dispatched4. Confirm a suitable protocol for when Satellite Navigation fails on vehicles+B5:J115. Evidence this review has been fed back to the crew involved6. Consideration for aide memoirs for cease of resuscitation	28/07/2020	1. SAS to send apology letter for failing to keep reasonable contact with complainant and for failing to handle the complaint reasonably2. SAS to consider and where appropriate take action to improve identified areas of error	1. Complete and signed off by SPSO2. Complete and signed off by SPSO
DATIX 4952	202001395	03/07/2020	1. Scottish Ambulance Service failed to provide patient with a response within a reasonable timeframe.	Upheld	SPSO Sent information as requested - 06/07/2020  SPSO Have decided not to take this forward as nothing to add to SAS review - 07/07/2020	07/07/2020	SPSO not taking on	N/A
DATIX 3990	202000080	07/07/2020	1. Scottish Ambulance Service failed to provide patient with appropriate care and treatment on 20 March 2019  (Joint review where NHSD&G led)	Not Upheld	SPSO have not upheld	17/08/2020	Appropriate Care Given - High standard of Review carried out	N/A
DATIX 4331	201907499	29/06/2020	1. Scottish Ambulance Service failed to provide patient with appropriate care and treatment on 31 January 2018	Upheld	With SPSO Advisors	N/A	With SPSO advisors	N/A
DATIX 5016	201911093	31/08/2020	1. Scottish Ambulance Service failed to provide patient with reasonable care and treatment on 1 June 2019	Not Upheld	SPSO have not upheld	12/10/2020	Evidence in favour of appropriate care given and allegations unsubstantiated	N/A
DATIX 5146	202000072	25/08/2020	1. Scottish Ambulance Service failed to provide a reasonable response to the 999 call	Upheld	SPSO not taking any further as satisfied with SAS response and actions	02/09/2020	SPSO not taking any further as satisfied with SAS response and actions	N/A

DATIX 3629	201904012	13/11/2019	1. Scottish Ambulance Service unreasonably failed to respond to calls for ambulance in accordance with their procedures2. Scottish Ambulance Service unreasonably failed to properly investigate the complaint and provide an appropriate response	Upheld	SPSO have upheld part 1 but not part 2	01/10/2020	1. Letter of apology to be written to complainant for failing to confirm whether or not the patient's condition had worsened before continuing the call.2. Remind relevant staff to clarify whether or not a patient has deteriorated when making calls through the welfare call back process.	1. Complete and signed off by SPSO2. This recommendation is sitting with ACC senior Management with a due date of November 2020
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