Patient Experience
Annual Report
2022-23

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1. Reflections on 2022/23

The last year has been challenging and rewarding for both the Patient Experience Team as well as the wider North East Ambulance Service NHS Foundation Trust.

We were humbled to receive 850 appreciations from members of the public, thanking us for the service we had provided.

The support from the public during such a challenging year was appreciated by all our colleagues across the Trust. Some examples of the heart-warming feedback we received is included throughout the report.

During 2022-23 life continued to return to a new normal for patients and their families in the North East. Despite the lift of restrictions, Covid-19 was very much still present and continued to contribute to increased contacts to our service, and ultimately increased ambulance attendances.

We also saw a surge in demand for our services generally. This was compacted by lengthy handover delays at the region's Emergency Departments. These delays were longer than anything we had encountered before. Naturally this impacted on our ability to dispatch ambulances quickly in many cases.

Our patients were often waiting longer than they should have for help to arrive. Patients and their families raised concerns with us about this.

The complaint management process had to be adjusted to respond to the increased volume of complaints raised during the surges in service demand. The most notable surge in complaints was during Quarter 3, and this meant it took longer to acknowledge complaints.

2022-23 was the first year where we could not consistently meet the national requirement to acknowledge a complaint within 3 working days. Whilst this was disappointing for us, as well as our complainants, it is reassuring that the changes to complaint management from December 2022 were effective. This meant that during Quarter 4 we were able to meet the 3-day acknowledgement timeframe for complaints once again.

2022-23 Appreciation - Carlin How emergency crew

"Two paramedics arrived and they were such warm, lovely people. Me and my partner were both very worried and the girls made us feel so at ease and were really caring in their way of looking after my partner. We had around a two hour wait at A&E to be seen and the two women chatted to me while my partner slept.

They constantly asked if either of us needed anything or if there was anything extra they could do for us. They even came back to visit us in the hospital after they'd brought another patient in to see how we were getting on. They were so professional and just did a fantastic job of caring for my partner and also easing my stress and worries. They are a real credit to the service and deserve special recognition for the way they care for their patients and ensure they are doing everything they possibly can for them."

2. Overview of Complaints and Appreciations 2022/23

Appreciations

850 ⬆

Complaints

398 ⬆

Informal concerns raised

123

Enquiries via the Patient Advice and Liaison Service (PALS)

500 ⬇

Average days to respond to a complaint

54 ⬆

Complaints were linked to a patient safety incident

39.2% ⬆

Complaints as a percentage of total calls received

0.03% ⬌

Complaints as a percentage of all patients seen face-to-face

0.11% ⬌

3. Appreciations

850 appreciations received

Our colleagues are always touched by the time and effort that patients and their families spend to show their appreciation for our service.

In 2022-23 we received 850 appreciations thanking our colleagues for a positive experience.

This was an average of 71 appreciations per month, which is an increase on 67 per month the previous year.

Further appreciation data is included in Appendices A-C.

2022-23 Appreciation - Health Advisor, Emergency Operations Centre

‘My gran lost consciousness and we phoned 999. The lady who answered the phone was exceptional and calming.

I don't have the lady’s name, but I wanted to say a huge thank you for her support and help. Such a tough job when people are panicking. She got us an ambulance straight away and talked me through the steps I needed to take.

Thankfully my gran is ok but I am truly grateful for the support from the ambulance service. Thank you very much again.’ -

4. Complaints

398 complaints raised

The Patient Experience Team continued to meet with members of the public to discuss their concerns throughout 2022-23. They also communicated with complainants on video calls or via telephone, or via email or post if that was the complainant's preference.

Complaint responses were altered to suit the needs of the complainant where necessary. This included different coloured paper, different font size and formatting, or hand delivery of a complaint response to allow the response to be discussed at that time if necessary.

How many complaints did NEAS receive?

During 2022/23 we received 398 complaints, an average of 33 per month. This was an increase of 4% on the previous year, and a return to pre-Covid complaint levels.

The full details of complaints received, along with previous year data for comparison, is included in Appendices D-M.

Geographical spread of complaints

DH8 had the most complaints (11)

We have analysed the location of the incident related to the complaint, as well as the complainant's postcode, to understand if there is anything to be learned from patterns of concern within a certain area.

The highest number of complaints were in the NE central postcode area (Gateshead, Newcastle, South Shields, North Tyneside). This is unsurprising as a densely populated area with a high proportion of patient contacts.

We also saw high levels of complaints and concerns in Teesside and the Durham and Darlington area. The individual postcode prefix with the highest volume of complainants was DH8 (Consett) with 11 complaints. The common theme identified was dissatisfaction with the behaviours or attitude of the crew that attended. The further details of complainant postcodes are included in Appendix L.

5. Patient Advice and Liaison Service (PALS)

500 enquiries for NEAS

PALS work on behalf of NHS Trusts to take enquiries from members of the public and resolve some more straightforward concerns. North of Tyne PALS manage contacts from members of the public on behalf of NEAS.

In total, PALS managed 500 enquiries for NEAS throughout 2022/23, which was a 28% decrease on the previous year.

The most popular method for the public to contact PALS is via the freephone number. The average timeframe for PALS to close an issue was 13.3 days, which was a reduction from 15.5 days in the previous year.

All PALS contacts are shared with the Patient Experience Team at NEAS on a weekly basis. Where there are clinical concerns, NEAS will request a referral from PALS to allow these concerns to be investigated directly by the Trust. Full PALS data is included in this report as Appendix R.

6. Joint investigations with other NHS Trusts

62 joint investigations

Sometimes a complaint is received into an NHS Trust and there are concerns raised which involve other NHS organisations.

It will be agreed with the complainant that one of the NHS Trusts will act as the lead, liaising with the other Trusts to provide one complete response to all the concerns.

During 2022/23 we responded to 62 complaints where another local NHS Trust or local authority was the lead organisation. This was the same volume as the previous year. Further details are available at Appendix M.

7. Patient safety issues associated with complaints

> 156 complaints were linked to patient safety incidents.

All new concerns received are reviewed to determine if there are any patient safety concerns or concerns about clinical care which require investigation.

If this is the case, a patient safety incident is submitted and the incident investigated. There are also occasions where a complaint is received and there is already a patient safety incident logged about the incident. The complainant will receive one response to their complaint, which will also include findings from the patient safety investigation.

This year, 156 complaints had associated patient safety incidents associated with them; an increase from 91 in the previous year.

Sadly, in 37 of these incidents our service may have contributed moderate or severe harm to the patient. This is a significant increase from 11 incidents in the previous year. The details of the levels of harms from the incidents associated with complaints are included in Appendix N.

During 2022/23, the 37 incidents where the service may have contributed harm displayed some common features:

- The ambulance response was delayed in 51.4% of cases. The majority of these ambulance delays were category 2 responses (the emergency response assigned to patients who may be having chest pain, stroke symptoms, or major blood loss, for example).
- 48.6% of the incidents where serious harm is likely to have resulted were in the Durham and Darlington postcode areas, 32.4% from NE postcodes, and the remainder from other postcodes across the region.
- Of the 37 incidents, 10 went on to be declared as serious incidents (SIs).

2022-23 Appreciation - Ashington Scheduled Care crew

'I just want to say a huge thank you to the two ambulance crews who looked after me. I was collected at 12 noon and brought home at 1.30pm. I live in a high-rise block of flats and was a bit apprehensive about how I would manage but I need not have worried as the

crews were so very kind (the first collected me from my flat and the second brought me home and saw me safely into my flat. Each one of them were cheerful and kind and it was a real pleasure to meet them.

Thank you for the work all the Ambulance crews do, often in very difficult circumstances and I have certainly appreciated their help today.'

Being open with patients and families

If we identify that it is likely that something the Trust did (or did not do) has contributed harm to a patient, we will notify the patient and/or their next of kin. This is known as Duty of Candour, though we apply the principles of being open with all complainants.

As part of Duty of Candour, the patient (or their next of kin/relative/carer) would be informed of all the information we know at that point, advised about the next steps of the investigation, and asked for their questions and input. This is then followed with a written summary of the conversation.

Duty of Candour is a vital part of being open, honest and transparent when things go wrong and harm to a patient is likely to have resulted. The Patient Experience Team works closely with the Patient Safety Team to ensure that the Duty of Candour is met for harms which are linked to a complaint.

They ensure that the complainant has a named contact that they can liaise with who keeps them up to date with the progress of the complaint and the associated incident investigation.

8. Complaints with claims associated

7 complaints were linked to claims

The volume of claims with complaints linked reduced from 19 the previous year to seven in 2022/23. The claims relating to clinical negligence reduced from three in the previous year to just two in 2022/23. Further details are included in Appendix P.

9. What did the public raise concerns about in 2022/23?

Of the 398 complaints received, there were some recurring themes:

- **Ambulance delay:** complainants felt that the ambulance took too long to arrive with the patient.
- **Late patient transport:** patients were late for their hospital appointments, or sometimes missed their scheduled appointment.
- **Mobilisation/lack of support to walk:** concerns that patients were asked to walk or assisted downstairs themselves rather than being carried or wheeled in a chair.
- **Self-conveyance:** patients had to be taken by family/friends to hospital, or make their own way as they felt the wait for an ambulance was too long.
- **Patients being discharged at home and not taken to hospital:** patients or their family members felt they should have been taken to hospital rather than being discharged at their location by our ambulance crews.
- **Lack of compassion:** complainants felt the staff member they spoke to on the call or at the scene lacked empathy or compassion for the patient or family.

10. Learning from complaints in 2022/23

Every complaint provides a valuable opportunity to learn in order to improve the service in future.

Each complaint is investigated and any learning identified is embedded to reduce the likelihood of recurrence of a similar incident in future. Actions and learning are tracked on our integrated risk management system to ensure timely completion.

Individual staff learning that is identified from complaints is addressed as soon as possible with the relevant staff member(s). There can also be wider learning which is beneficial to other staff.

Learning for all staff is included in the monthly Patient Experience Learning Bulletin which is distributed to all staff using the Trust's intranet and the Workplace forum. Operational managers are also encouraged to display the bulletins on Trust premises where possible.

Some key learning from 2022/23 includes:

- **Renewed guidance on moving and handling:** several complaints related to concerns that patients were not moved using safe or appropriate techniques. There was renewed learning reminding all staff to use approved techniques only. Staff were also reminded that should any incident occur whilst moving a patient, an incident needed to be submitted without delay.
- **Driving standards:** all staff were reminded of the importance of driving to the agreed standard, displaying professionalism when in Trust vehicles, and the responsibility to drive in accordance with all laws and local procedures.
- **Documentation:** complaint investigations found that some documentation was not completed as thoroughly as it should have been. There were also occasions where patients were not left with complete written information when they were being discharged at scene. Trust-wide learning was circulated to highlight the importance of accurate clinical record-keeping.

11. Complaint demographics during 2022/23

The majority demographic in each category for complaints is as follows:

- White - British
- Female
- Aged 70 and over
- Heterosexual/Straight
- Christian
- No disability declared

It is important that we understand the demographics of our complainants so that we can understand if there are barriers to any particular group of people in raising concerns. We also capture the location of incidents so that we can understand whether there are areas of the North East where there are more complaints raised, suggesting poorer care or poorer experiences for people who live there.

During 2022/23 there was a surge in demand for ambulances, coupled with extreme delays at hospitals to handover patients. This meant patients in the community were often waiting far longer than they should have for ambulances. To allow complaints to still be acknowledged and answered in reasonable time, the Patient Experience Team had to adapt and change processes. Unfortunately, there was a period where the demographic capture was affected by this change and this is likely to have reduced the amount of demographics that were captured overall.

We captured 551 elements of demographic information during 2022/23, which is a reduction from 562 elements the previous year.

Further demographic detail is shown in Appendix Q. From the demographic information provided,

We do also record where complaints relate to certain cohorts of patients to enable us to understand if any cohort of patient has a poorer experience of our service. These cohorts are explored below.

Children (aged under 18)

We received 28 complaints relating to children (on par with 30 the previous year). We did not receive any complaints made directly by a child themselves. Some themes from these complaints included:

- Children waiting too long for an ambulance.
- Issues with the 111 service arranging help for a child.
- Callers being asked to take the child to hospital themselves, rather than an ambulance attending.

We have information in both our Complaints Management Policy and the Trust website to ensure that children are aware they can complain directly and information on how to do this. Where we receive a complaint from a child's caregiver and the child is older than 12 we will speak with the child and confirm that they are happy for us to look into the care we provided and provide information to the caregiver.

Mental Health

36 concerns related to patients who identified that they had mental health issues, felt suicidal, or were in crisis (and increase of 19% on the previous year). Note, this data was captured from the information provided in the complaint rather than just the demographic dataset asked of the complainants (Appendix Q).

A common theme was that the attending crew lacked empathy or understanding about their mental health condition.

Other themes

- **Autism**: the same volume of concerns involving people with autism spectrum disorder were received as in the previous year (9 in total). Several of the complaints related to the manner of the staff involved.
- **End of Life:** Concerns involving patients at the end of their lives reduced slightly from 9 in the previous year to 8 in 2022/23. The theme in these complaints was the delay in ambulance arrival for the patients. We appreciate how precious time is when someone is at the end of life, and how important it is to them and their family to be in their preferred location for death. Any complaints involving end of life patients have been shared with our Macmillan End of Life Coordinator to ensure any learning is taken forward.
- **Learning Disability:** 5 concerns related to patients with a stated learning disability. There were no common themes within these concerns, though two involved significant delays in ambulance attendance.
- **Pregnancy and Maternity:** There was one complaint raised relating to pregnancy or maternity in 2022/23. This was a significant reduction from 8 concerns in the previous year.
- **LGBTQ+:** this year there were 2 complaints relating to this cohort of patients. This was a reduction from 6 in the previous year.
- **Disability:** there were 29 concerns raised relating to patients with a stated disability. 24% of these concerns related to delay in emergency ambulance or patient transport arriving. 48% also referenced poor behaviours or lack of compassion from attending staff. 41% of these complaints also had an associated patient safety incident.

2022-23 Appreciation – Ambulance Car Service

‘I had an outpatient appointment at Wansbeck Hospital on 13th June 2022, and used Patient Transport to and from. Both drivers were courteous and kind and put up with my chattering and clumsy ways. They, and all of your drivers I've encountered over the years, are wonderful people. Great-hearted, decent people, with great patience and a good sense of humour.

I'm indebted to all of them. They are a great credit to themselves and to the Patient Transport Service. I am really grateful to all of them, and to the lovely people who staff your booking service. This is an excellent service. I would mark it as top class.’

12. Feedback on the complaints process

All complainants receiving written responses are asked to provide feedback on the complaint management process within NEAS. Unfortunately, the response rate remains low, with only 10 surveys completed during 2022/23 (on par with 11 the previous year).

Complainants can also make direct contact with the Patient Experience Team or other staff members to comment on the Trust's response to their complaint. This is considered carefully by the Patient Experience Team and improvements made wherever necessary.

We have received some helpful positive feedback during 2022/23:

'I would like to thank you for being so efficient and replying to our complaint quickly and factually. We are now happy that due diligence has been done and are willing to accept the closure of our complaint.'

'Thank you so much, you have been a great help. I'm very appreciative of the main concerns you're going to answer. I'm very, very appreciative of it. Me and my mother both understand the wait time, we're both just very happy it's being addressed in the best appropriate way.'

'Thank you for your prompt reply and detailed reply to my complaint. I am very grateful to know that the high standards of the North East Ambulance Service NHS Foundation Trust are being upheld and that if I do need to use the service again in the future, that I will be very confident in calling upon your services.'

'I appreciate the pressures the NHS are under at the moment and thank you for taking the time to thoroughly answer my questions.'

We have also received feedback from people during 2022/23 who were not satisfied with how their complaint had been managed.

'It was obviously biased towards its own staff as historic experience shows still exists in this warped organization as to hiding the real truth.'

'What really caused upset was the feeling that the original investigation was looking for scapegoats, trying to blame the patient or the carer. It was defensive and not objective.'

'I feel the main point of my complaint has been skirted over the fact of the attitude of the staff on the phone and at the scene. I note you conclude by saying that your organisation is sorry about our situation however it would have meant more to me to say that all the staff involved send their apologies of how the situation played out.'

We do consider all feedback about the management of the process and we have ensured that we have made some changes to how we manage complaints to improve the process for complainants as a result of their feedback:

Feedback from complainants – how we have listened	
You said	**We did**
• It took too long for us to acknowledge your complaint after you first contacted the trust to raise concerns.	• Our acknowledgement timeframes became extended due to service pressures. The Patient Experience Team changed their processes to ensure that complaints were acknowledged quickly. By the end of 2022/23 we had returned to acknowledging all complaints within 3 working days.
• The timeframe to receive a response to your complaint was too long.	• Although we provided a maximum timeframe, we worked hard to deliver a complaint response as soon as possible. Our average complaint response rose to 53 days during 2022/23, therefore the management of complaints has changed to ensure that Early Resolution is a focus. New complaint documentation has been streamlined to support faster responses to complainants.
• You did not receive regular updates after making a complaint and were sometimes left feeling we had forgotten about your complaint.	• We changed our processes to ensure that all complaints requiring a closer look receive regular updates on the progress of the investigation.

PALS also requested feedback from members of the public who contacted them about our care. They received 44 forms (a reduction from 55 in the previous year).

Of these 89% stated that PALS were able to help with their query, and 93% said they would use the service again.

During 2023/24 NEAS will be aiming to increase the feedback from complainants to better understand what improvements we need to make.

13. Independent review of complaint investigations and reopened complaints

4 complaints were requested for review from the PHSO

Every complainant is notified of their right to seek independent review of their complaint investigation from the Parliamentary and Health Service Ombudsman (PHSO) whenever the Trust has sent a final response to a complaint. This information is also made available to complainants on the Trust website, as well as included in every response letter.

The PHSO assess whether they will review a complaint or not. Where they conduct a review, the Trust provides them with all associated documents and information relating to that complaint.

- During 2022/23 the PHSO requested four complaints for review.
- One of the complaint reviews recommended a further letter of apology to the complainant for failings in care.
- The PHSO confirmed there was no further action required in the remaining three cases.

Complainants are asked to make contact with the Trust directly if they feel their concerns have not been answered adequately, or perhaps they have new concerns following receipt of the response prior to approaching the PHSO. In these circumstances the complaint is reopened and investigated further.

Details on reopened complaints are in Appendix J. There were 17 complaints were reopened throughout the year (4.3% of the 363 complaints closed in the year).

This is a slight reduction on 20 reopened complaints in the previous year (5.3% of the total closed complaints).

2022-23 Appreciation – 999 call handling and Emergency Care

‘We went to check on my father-in-law as we hadn't heard from him. We arrived to find him collapsed on the floor. We immediately dialed 999 and spoke to the most helpful, calming, and sympathetic lady who explained exactly what we needed to do. Please pass on my thanks to her.

The paramedics arrived within 5-10 minutes… they were just amazing, clear instructions, fabulous communication between them I knew my father-in-law was in great hands. We quickly transferred to hospital, and they expertly looked after my father-in-law in the ambulance…I was so impressed, reassured and confident in their abilities.

From start to hospital hand over, my father-in-law was cared for fabulously.’

14. Priorities for 2023/24

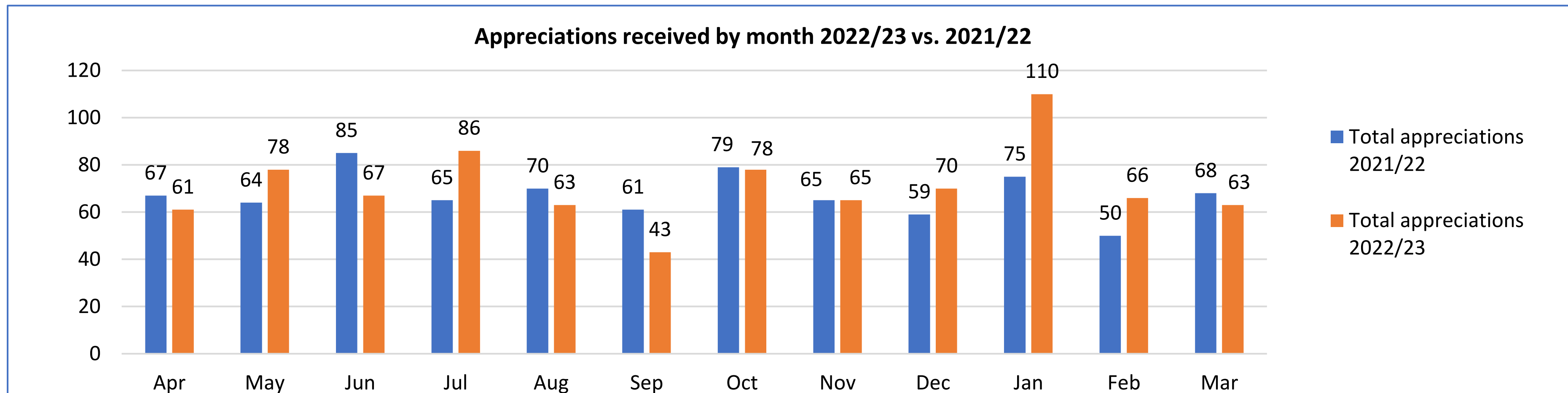
The Patient Experience Team has a workplan for 2023/24 to continue to improve the overall patient experience, as well as the process of making a complaint at NEAS.

Some of the key priorities for the team in the year ahead are:

- **Reduce the average timeframe for complaint response** – changes to processes in complaint management should support quicker resolution of complaints.
- **Improve engagement with staff involved in complaints** – staff should have improved engagement on all stages of a complaint, including the opportunity to comment on the investigation report and final response letter.
- **Development of a web version of the complaints management system (Ulysses) –** this would allow complaints that are submitted online to be linked straight into the complaint management system and streamline investigation processes.
- **Embed new PHSO complaints standards**– continue to embed the revised PHSO Complaints Standards to ensure our processes align to the requirements which were introduced in April 2023.
- **Support complaints investigation training** – ensure that managers investigating complaints have the relevant training to conduct an investigation which is balanced, open and objective.
- **Embedding a revised approach to managing complaints with an associated patient safety incident** – the revised approach will ultimately support quicker responses to complainants, with improved engagement whilst the investigation is ongoing.
- **Review internal mechanisms to improve the use of patient feedback and experience data** to inform service improvements, priorities, and strategies.
- **Improve capture of complainant feedback** – increase uptake of surveys about the complaint process.
- **Improve demographic capture** – better understand who is complaining and what barriers may exist to raising a complaint.

15. Appendices

Appendix A: Appreciations received by month 2022/23 vs. 2021/22



Appendix B: Appreciations by service line

Nb: operational services were restructured during 2022/23, and a Central division added. This means data is not exactly comparable.

	2020/21	2021/22	2022/23
HART	5	3	2
Support Services	20	8	4
Unknown / general	13	24	17
Scheduled Care North	43	31	18
Scheduled Care South	6	22	15
Scheduled Care Central	N/A	N/A	16
Unscheduled Care North	360	320	267
Unscheduled Care South	243	267	176
Unscheduled Care Central	N/A	N/A	200
Other org/ volunteer	49	64	53
999	40	37	52
111	17	14	20
Unscheduled care dispatch	4	9	2
Scheduled care dispatch	9	5	4
Clinical hub	10	4	4
Total appreciations	**819**	**808**	**850**

Appendix C: Station with highest volume of appreciations

Station	Total appreciations 2022/23
Blucher	54
Coulby Newham	30
Hartlepool South	29
Cramlington	26
Hexham	24

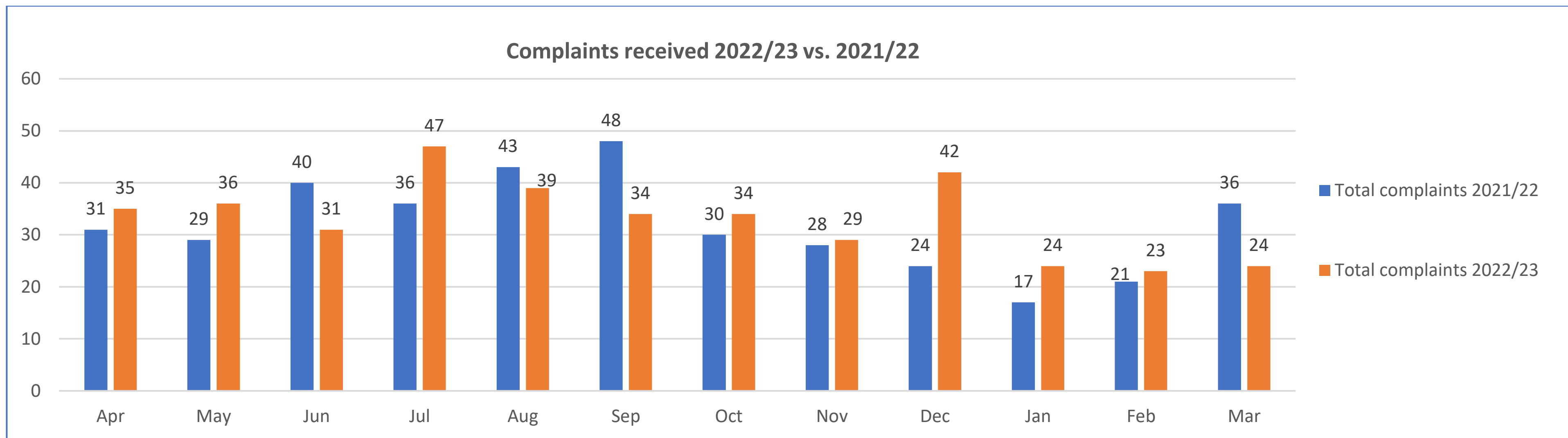
Appendix D: Complaints data overview 2022/23

Performance Indicator	2019/20	2020/21	2021/22	2022/23	Difference
Complaints received (including those which require consent)	436	271	383	398	+15
Overall volume of complaint elements (different main parts of a complaint)	641	372	503	625	+123
Acknowledged within 3 working days	98.9%	99.6%	99.5%	84.5%	-15%
Complaints closed*	486	266	378	363	-15
Closed within agreed timescale	91.9%	98.9%	96.3%	83.8%	-12.5%
Complaints Upheld	37.2%	28.6%	31.5%	28.1%	-3.4%
Not Upheld	39.9%	44%	38.9%	27.3%	-11.6%
Part Upheld	22.8%	27.4%	23%	33.9%	+10.9%
Queries dealt with by PALS	620	458	693	500	-193

Appendix E: Total complaints received and average days to respond

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Difference
Total Complaints	526	488	436	271	383	398	+15
Average days to respond	25	28	30	28	34	54	+20

Appendix F: Complaints received by month 2022/23 vs. 2021/22



Appendix G: Complaints by service line

Nb: operational services were restructured during 2022/23, and a Central division added. This means data is not exactly comparable.

	2019/20	2020/21	2021/22	2022/23	Difference
HART	0	1	0	**0**	**-**
Support Services	4	3	5	2	-3
Scheduled Care North	14	2	8	2	-6
Scheduled Care South	17	8	5	6	+1
Scheduled Care Central	N/A	N/A	N/A	10	+10
Unscheduled Care North	77	68	85	41	-44
Unscheduled Care South	52	54	46	46	-
Unscheduled Care Central	N/A	N/A	N/A	44	+44
Other org/ volunteer	25	22	28	40	+12
999	47	44	61	56	-5
111	53	21	28	30	+2
Dencall	1	0	0	0	-
Unscheduled care dispatch	86	37	76	97	+21
Scheduled care dispatch	28	4	12	1	-11
Clinical hub	28	7	22	20	-2
Unknown/ unable to be attributed to service line	4	0	7	3	-4
Total Complaints	**436**	**271**	**383**	**398**	**+15**

Appendix H: Stations with highest volume of complaint elements 2022/23

Station	**Total complaint elements**
Blucher	15
South Shields	13
Hartlepool South	12
Gateshead	11
Middlesbrough / Ashington	10

Appendix I: Complaints by main element

	2019/20	2020/21	2021/22	2022/23	Difference %
Driving Incident	21	5	10	10	0%
Quality of Care	264	195	259	291	+11%
Quality of communication	63	30	46	73	+37%
Staff Attitude	140	82	87	123	+29%
Standards / Compliance	18	2	4	5	+20%
Timeliness of Response	135	58	101	123	+18%
Covid-19	N/A	4	1	0	-100%
Total	**641**	**372**	**507**	**625**	**+19%**

Appendix J: Reopened complaints and referrals to PHSO

Complaint Indicator	2019/20	2020/21	2021/22	2022/23	Difference
Number of closed complaints reopened	26	20	18	14	-4
Number of closed complaints reviewed by parliamentary ombudsman	3	4	5	4	-1

Reopened complaint status

Upheld status	Reopened complaints 2020/21	Reopened complaints 2022/23	Difference
Upheld	5	4	-1
Not upheld	9	6	-3
Part upheld	6	7	+1
Total	**20**	**17**	**-3**

Reopened complaint reasons

Reopened reason	2020/21	2021/22	2022/23	Difference
Disputes information	4	5	6	+1
Not all issues addressed in original response	4	1	1	-
New questions	7	0	3	+3
Requested local resolution meeting	2	4	4	-
Unresolved issues	3	5	3	-2

Appendix K: Complaints and appreciations by division 2022/23 vs. 2021/22

NB: during 2022/23 the operational services were split into 3 divisions, therefore there is no comparative data.

<table>
<tr><th></th><th>Appreciations 2021/22</th><th>Appreciations 2022/23</th><th>Appreciation difference from 2021/22</th><th>Complaints 2021/22</th><th>Complaints 2022/23</th><th>Complaint Difference</th></tr>
<tr><td>EOC</td><td>69</td><td>82</td><td>+13</td><td>199</td><td>204</td><td>+5</td></tr>
<tr><td>Unscheduled Care North</td><td rowspan="3">587</td><td>267</td><td rowspan="3">+56</td><td rowspan="3">131</td><td>41</td><td rowspan="3">0</td></tr>
<tr><td>Unscheduled Care South</td><td>176</td><td>46</td></tr>
<tr><td>Unscheduled Care Central</td><td>200</td><td>44</td></tr>
<tr><td>Scheduled Care North</td><td rowspan="3">53</td><td>18</td><td rowspan="3">-4</td><td rowspan="3">13</td><td>2</td><td rowspan="3">+5</td></tr>
<tr><td>Scheduled Care South</td><td>15</td><td>6</td></tr>
<tr><td>Scheduled Care Central</td><td>16</td><td>10</td></tr>
<tr><td>Other services</td><td>99</td><td>76</td><td>-23</td><td>40</td><td>45</td><td>+5</td></tr>
<tr><td>Total</td><td>808</td><td>850</td><td>+42</td><td>383</td><td>398</td><td>+15</td></tr>
</table>

Appendix L: Complaints by incident postcode

Postcode and example locations	Complaint volume 2021/22	Complaint volume 2021/22	Complaint volume 2022/23
DH (Durham)	29	53	51
DL (Darlington, South Durham, North Yorkshire)	25	40	55
SR (Sunderland, Peterlee, Seaham)	29	23	30
NE (Gateshead, Newcastle, South Shields, North Tyneside)	130	186	114
NE (Northumberland)*			60
TS (Teesside, South Durham)	43	67	66
Other/ unknown	15	14	22
Total	**271**	**383**	**398**

Nb: not all complaints related to a specific location – where no postcode could be established the complaint is not included in the data below.

*NE postcodes were not split into Northumberland and other areas in previous years.

Appendix M: Complaints with another lead organisation

	2020/21	2021/22	2022/23
County Durham and Darlington NHS Foundation Trust	10	20	22
Northumbria Healthcare NHS Foundation Trust	10	20	12
NHS England	3	5	2
Sunderland and South Tyneside NHS Foundation Trust	6	4	6
North Tees and Hartlepool NHS Foundation Trust	3	3	6
Gateshead Health NHS Foundation Trust	4	3	5
Newcastle upon Tyne Hospitals NHS Foundation Trust	3	3	4
South Tees Hospitals NHS Foundation Trust	3	1	4
Other	1	3	1
Total	**43**	**62**	**62**

Appendix N: Patient safety incidents linked to complaints – Harm Levels

Harm level	Total complaints 2020/21	Total complaints 2021/22	Total complaints 2022/23	% of total
Harm not related to NEAS	2	3	5	3.2% (-)
Near miss	5	2	17	10.9% (up)
No harm	28	38	41	26.3% (Down)
Low harm	35	37	56	35.9% (Down)
Moderate harm	13	11	25	16.0% (up)
Severe harm	1	0	12	7.7% (up)
Death	0	0	0	N/A
Total	**84**	**91**	**156**	**100%**

Appendix P: Complaints with claims associated

	2020/21	2021/22	2022/23
Total complaints	**271**	**383**	**398**
Public liability claim linked to complaint	**1**	**1**	**0**
Employers' liability claim linked to complaint	**0**	**0**	**0**
Clinical negligence claim linked to complaint	**11**	**3**	**2**
Losses and compensation claim linked to complaint	**0**	**4**	**4**
Potential claim linked to complaint	**6**	**11**	**3**
Total	**18**	**19**	**9**

Appendix Q: Complainant demographics

Age (this is the known age of the patient, not the complainant)

Age (years)	2020/21	2021/22	2022/23	Difference
0-17	12	30	34	+4
18-30	32	36	43	+7
31-40	17	26	31	+5
41-50	40	34	61	+27
51-60	61	54	47	-7
61-70	44	42	63	+21
70+	82	121	155	+34
All	**288**	**343**	**434**	**+91**

Sexual orientation

Sexuality	2020/21	2021/22	2022/23	Difference
Gay/lesbian/bisexual	1	4	4	-
Heterosexual/Straight	34	56	59	+3
Other	2	1	3	+2
Prefer Not To Say	4	7	18	+11
Grand Total	**41**	**68**	**84**	**+16**

Ethnic Group

Ethnic Group	2020/21	2021/22	2022/23	Difference
Any Other Ethnic Group	2	16	6	-10
Prefer Not To Say	10	10	23	+13
White - British	57	94	146	+52
White - Irish	1	0	0	-
White and Asian	0	1	1	-
Grand Total	**70**	**121**	**176**	**+55**

Gender

Gender	2020/21	2021/22	2022/23	Difference
Female	128	197	234	+37
Male	93	171	132	-39
Other	1	7	1	-6
Grand Total	**222**	**375**	**367**	**+192**

Religion/Faith/Belief

Religion	2020/21	2021/22	2022/23	Difference
No religion	6	20	27	+7
Jewish	0	1	2	+1
Buddhist	2	0	0	-
Christian	22	29	30	+1
Muslim	0	1	0	-1
Other	1	8	5	-3
Prefer Not to Say	6	7	17	+10
Grand Total	**37**	**66**	**81**	**+15**

Disability

Disability	2020/21	2021/22	2022/23	Difference
Do not wish to disclose	2	5	16	+11
No	28	46	36	-10
Yes	14	34	50	+16
Grand Total	**44**	**85**	**102**	**+17**

Disability type disclosed	2020/21	2021/22	2022/23	Difference
Hearing Impairment	1	1	4	+3
Deaf	0	3	2	-1
Visual Impairment	2	0	2	+2
Learning Difficulty	3	6	5	-1
Mental Health Issue	2	5	16	+11
Other Disability	1	9	9	-
Other Mobility Issues	1	9	10	+1
Other Disability	2	1	1	-
Grand Total	**12**	**34**	**49**	**+15**

Appendix R: PALS data

Issues by Area	2019/20	2020/21	2021/22	2022/23	Difference
111	32	43	38	36	-2
999	21	29	45	32	-13
Dispatch	183	25	45	45	-
PTS	186	109	224	178	-46
Emergency Care	62	98	142	106	-36
General	136	153	199	103	-96
Total	**620**	**457**	**693**	**500**	**-193**