Lancashire and South Cumbria Integrated Care Board

ICB Public Involvement and Engagement Advisory Committee

Date of meeting	25 September 2024
Title of paper	Complaints and Patient Experience
Presented by	David Brewin, Head of Patient Experience
Author	David Brewin, Head of Patient Experience
Agenda item	7c
Confidential	No

Executive summary

This report sets out Patient Experience and Complaints activity for the period June 2024 – July 2024.

Advise, Assure or Alert

Assure the committee**:**

- That the ICB is investigating and responding to formal complaints and MP correspondence appropriately.

Advise the committee:

- That the Patient Experience Team has produced three thematic reports to highlight the experience of patients in our health and care system.

Recommendations

The Public Involvement and Engagement Advisory Committee (PIEAC) is asked to:

- Note the activity, volumes and learning reported for the period June and July 2024.
- Note the three thematic reports produced by the team during this period.

Which Strategic Objective/s does the report contribute to		Tick
1	Improve quality, including safety, clinical outcomes, and patient experience	✓
2	To equalise opportunities and clinical outcomes across the area	
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	
4	Meet financial targets and deliver improved productivity	
5	Meet national and locally determined performance standards and targets	
6	To develop and implement ambitious, deliverable strategies	

Implications

	Yes	No	N/A	Comments
Associated risks			✓	

Are associated risks detailed on the ICB Risk Register?			✓	
Financial Implications		✓		

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**

Conflicts of interest associated with this report
Not applicable

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Data privacy impact assessment completed			✓	

Report authorised by:	Sarah O'Brien, Chief Nursing Officer

ICB Public Involvement and Engagement Advisory Committee- September 2024

Patient Experience and Complaints

1. Introduction

1.1 This report sets out the activity of the Lancashire and South Cumbria (LSC) ICB Patient Experience Service for the period 1 June 2024 to 31 July 2024. The information for this report was extracted on 10 September 2024.

1.2 Patient Experience activity has been reported to PIEAC from the outset and includes:

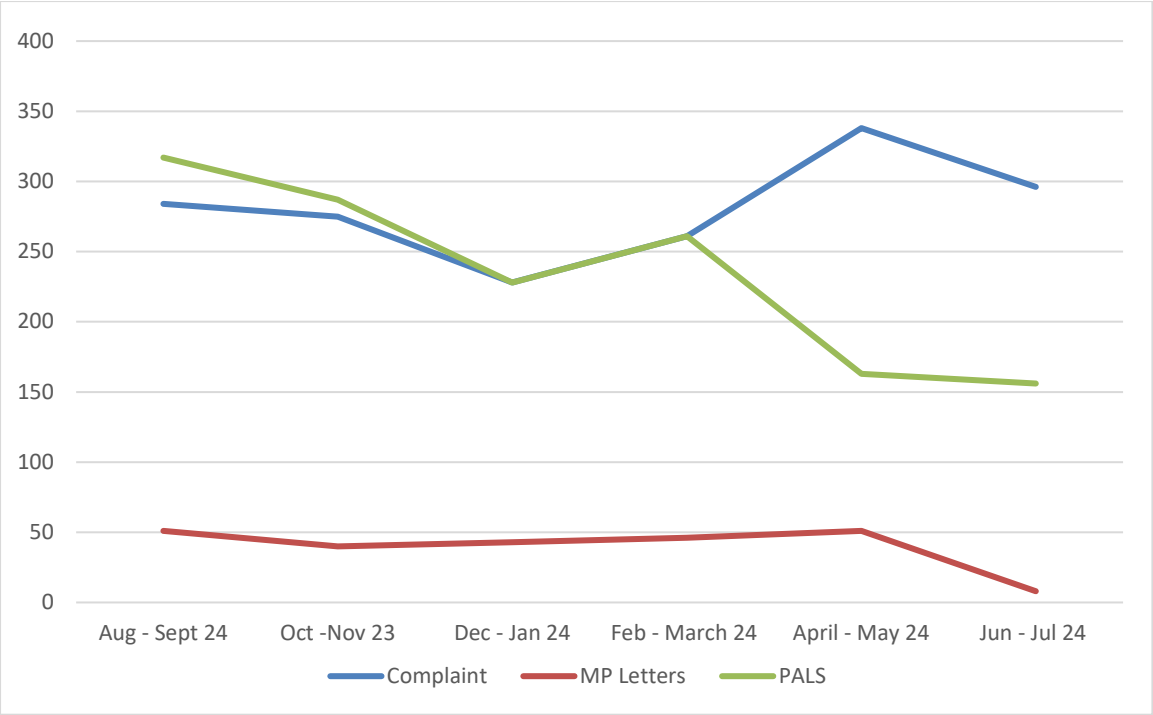
- The numbers of new contacts by type and comparisons to previous months.
- A summary of the type of complaints received and details of MP activity.
- Analysis of trends and themes emerging where identified.
- Examples of learning

1.3 The complaints included in this report are those handled in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 where the ICB is treated as the 'Responsible Body'. They are a combination of complaints about the actions and omissions of the ICB itself and our commissioned providers. Letters from MPs are made up of complaints from constituents, other queries raised by constituents but not handled as complaints and correspondence from MPs themselves typically about funding or strategy or other local health and care topics. The PALS totals reported here are those concerns we were able to resolve quickly and informally and requests for advice and information.

2. Activity

2.1 The chart below records the number of contacts by type for each two-month period over the last year extracted from the 'Ulysses' case management system. Each PIEAC meeting will receive details of incoming volumes for a rolling 12-month period.

Total volumes received.



2.2 Numbers of complaints received remained high. They were broadly in line with averages over the last year. To cope with this demand, we have continued to pass some complaints to providers rather than handle them directly. This is a discretionary power afforded to NHS commissioning organisations.

2.3 We closed 292 cases during the period comprised of 263 complaints and 29 MP letters. This is in line with closures in recent months. When this data was extracted on 11 September 2024, there were 321 open cases which is an increase of 10 from the last PIEAC report.

3 Analysis

Complaints

3.1 The complaints we handle can be broken down into four categories. We first reported this to the June 2023 meeting of PIEAC and those numbers are included to allow comparison.

Reporting Period	ICB	All Age Continuing Care	Secondary Care Provider	Primary Care
June – July 2023	17	16	50	59
August – September 2023	23	12	62	187

October – November 2023	14	19	90	152
December 2023 – January 2024	15	25	55	133
February – March 2024	17	19	76	149
April – May 2024	13	18	105	202
June – July 2024	10	14	83	189

3.2 The proportion of complaints about primary care continue to rise and it represented 64% of the total handled in this period. There were 85 about general practice, 65 pharmacy and 33 dentistry. Six were recorded as 'primary care' without specifying which element. Dentistry complaints continue to be about access with general practice complaints showing more variation. The increase in pharmacy complaints is mostly about events in a particular community pharmacy rather than an emerging theme.

General Practice Complaints

3.3 Complaints about general practice remain high and account for a substantial proportion of the overall totals we receive. For this period, we have carried out some additional analysis.

3.4 For all formal complaints we capture a 'Domain of Patient Experience'. For general practice complaints they are recorded as:

Domain of Patient Experience	**Number of Mentions**
Access and Waiting	23
Better Information, More Choice	13
Building Closer Relationships	8
Safe, High Quality, Co-Ordinated Care	39
Other	2

3.5 There are no notable hot spots at any specific practice. The highest number recorded was five, with two other practices having four. PIEAC is scheduled to receive a more detailed report in December 2024 which will provide greater insight over a longer period. This will cover the number of complaints received directly by each practice in LSC. All complaints are attributed to our four places, and this is set out below.

Place	**Number of Complaints Received**
Lancashire	55
Blackburn with Darwen	12
Blackpool	12
South Cumbria	3
Out of Area	3

3.6 Through reviewing individual complaints and responses, it is possible to identify some additional themes running through the complaints about general practice the ICB handles. For this period, these can be summarised as:

3.7 Complaints about clinical care range from the seemingly trivial to three about missed diagnosis where there is identified harm or patients sadly died. At the time of writing, all three have been responded to and upheld and have resulted in a Significant Event Analysis to identify learning and prevent repetition. In all three, lack of continuity of care was referenced by the complainant.

3.8 There is an emerging theme in relation to prescribing and the interface between general practice and community pharmacy. At least eight complaints were about not receiving medication, wrong prescriptions, and communication failures. There are also a group of complaints about access to weight loss medications.

3.9 Previously, complaints about access were often about length of wait for an appointment. There is more variation here with dissatisfaction about use of technology, appointments with other clinicians who were not doctors and telephone appointments rather than face to face. There were also complaints from patients who had received letters about their behaviour, been removed from practice lists or were unhappy about complaint handling in practices where there had been previous conflict.

3.10 In section four of this report, we have highlighted and extensive piece of work about autism and ADHD and again, this can be seen as a theme in this data. The general practice element is centred on referrals and whether they can be expedited. Three complaints explicitly refer to patients exercising their right to choose and the role practices play in facilitating this.

Parliamentary and Health Service Ombudsman (PHSO)

4. There were no contacts from the Parliamentary and Health Service Ombudsman (PHSO) in the period and we have no cases open with them currently.

MP Correspondence

5. We received only eight letters. This is a substantial reduction from the average of 49 for the previous 12 months and is attributable to the general election. We anticipate an increase when Parliament returns in September. Of the eight letters, the most were from Tim Farron with three. We received three letters about our All-Age Continuing Care Service and two about NHS dentistry.

PALS Enquiries

6. PALS totals show a small reduction from the June 2024 PIEAC, and a significant reduction form the average. This is because we reduced the service provided to cope with the increase in formal complaints.

Learning from Complaints

7. When a complaint is fully or partially upheld, we identify learning and include it in our response. This could be additional actions to resolve individual complaints or broader service improvements. These examples could be about LSC ICB or a commissioned provider. Examples of learning from this period are:

You Said	We Did
I couldn't get an appointment when I needed one. The practice didn't listen to me. There were also delays in reviewing my X-ray report.	The practice should undertake a full team Significant Event Analysis, (SEA), into the care provided. This should include: - What is the practice policy of logging and responding to patients who attend in person asking for an urgent or more expeditious appointment? - The training of administrative team members regarding their approach to patients, relatives or carers requesting an appointment for an urgent GP review. The triage of eConsultation requests for urgent appointments, including contact with the patient/relative/carer if necessary to gather any further details and the recording of the triage decision in the patient's medical record.
My mum's care was not adequate, and the problems should have been escalated.	The Trust has identified that there may have been two occasions that the District Nurses could have escalated sooner to the District Nurse Team leaders or a manager. I am reassured to hear that the organisation has recognised this learning and have committed to reviewing process and embedding any changes required. They have also confirmed that this will be shared with the team at the next team meeting.

My father's Continuing Healthcare annual review was conducted poorly. It was done on Teams and the meeting was too long, so he wasn't able to contribute.	Where possible, we try to conclude a review in a single meeting. We will reflect on this and as a learning point for the service, review the time we allow for meetings so that we don't set unrealistic timeframes. As a result of your complaint and other feedback received, reviews are now conducted in person rather than on Microsoft Teams with only limited exceptions.
The practice isn't getting my prescriptions on time, and I've been given medication meant for other patients.	As a result of your complaint, we've identified further learning. We are conducting an audit of how we have handled queries from patients about their prescriptions. We will contact anyone where errors have been made to explain, apologise, and rectify mistakes.

8. Additional Patient Experience Reports

8.1 The ICB Patient Experience Team hold a wealth of insight about being a patient LSC. We have been keen to collate and share this across the organisation so in can inform change and improvement. During this period, we produced a series of three thematic reports where we reviewed complaints and responses to amplify the voices of our patients. The three areas covered were:

- Urgent and Emergency Care (UEC).
- Autism and ADHD assessments and post diagnosis support.
- Blackburn and Darwen (BwD) Place with a focus on care homes.

8.2 There were different reasons for selecting these three areas. The ICB is currently developing a UEC strategy (as discussed at the June PIEAC) and the experience of patients is pivotal in developing this. The document has been shared with the Programme Team and senior leaders and will help refine the strategy and ensure it is focussed on patient experiences. As this is pertinent to the work of this committee, a copy is appended.

8.3 The autism and ADHD report was produced as we were aware that we had substantial numbers of contacts and they had identified delays, the difficulties faced when local organisations closed and poor communication and coordination. This report has been shared and will inform future commissioning of our pathway

8.4 The Blackburn with Darwen work arose from a discussion with clinical leads who were looking for evidence to direct their future priorities. We were able to combine patient experience, patient safety, and soft intelligence for the first time which provided a more comprehensive picture.

8.5 The documents for the latter two pieces of work are available to Committee members on request from the ICB Head of Patient Experience.

9 Recommendations

9.1 PIEAC is asked to:

- Note the activity, volumes and learning reported for the period June 2024 and July 2024.
- Note the three thematic reports produced and shared.

Appendix 1.

Patient Experience of Urgent and Emergency Care

Background

The Lancashire and South Cumbria ICB Patient Experience Team receive complaints, concerns, and MP correspondence about the full range of Urgent and Emergency Care services across our geography. We have examined records from our case management system covering a 15-month period comprised of the entirety of 2023/24 and Quarter One of 2024/25. Theis report is in two parts. Firstly, the numbers of cases of each type, services involved and any significant themes. Secondly, extracts from correspondence we received during this time.

Case Volumes.

In the period we received 128 cases. This will be an underestimate due to the way cases are categorised. For example, some cases will be coded as ‘mental health’ or ‘secondary care’ but will have involved attendance at an urgent or emergency care service. Also, cases that involve more than one provider are only captured against the principal organisation complained about. By way of comparison, the Patient Experience team dealt with 3,289 contacts in total during these 15 months, so this represents a small proportion.

Type of Case	Number
Complaint	90
MP Letters	5
PALS enquiry	33

These contacts can also be broken down by type of service with the overall scope of UEC provision:

Service	Number
NHS 111	32

A&E	48
Ambulance	5
Emergency Assessment	2
Minor Injuries	2
Out of Hours	9
'Urgent Care'	19
Walk In Centres	10

All our contacts are ascribed a 'domain of patient experience'. These were:

Domain of Patient Experience	Number
Access and Waiting	27
Better Information, More Choice	14
Building Closer Relationships	13
Clean, Friendly, Comfortable Place to be.	3
Safe, High Quality, Co-ordinated Care	63
Other Issue	8

Named organisations and/or specific services were identified with some exceptions. The report does not extract a provider for each record. This requires examining individual cases. We have done this for A&E services at each of our acute provider trusts and can identify the provider in 43 of the 48 records. Results are:

Organisation	Number
Blackpool Teaching Hospitals	12
East Lancashire Hospital Trust	17
Lancashire Teaching Hospitals	9
University Hospitals Morecambe Bay Trust	5

Further scrutiny of the data reveals some clear themes. These are set out below and each are illustrated with examples extracted from the original contact to us from patients and families. Additions by the ICB are in italics. Some comments have been edited for brevity and accuracy.

Wait Times

'Currently around 4-5 patients are sat in the emergency room after they all got admitted yesterday. Each one was told that no beds are available and then kicked out of the waiting room and told to sit in A&E. This is where they have spent the night. They are

refusing treatment to these patients until they have a bed. But have kept them at the hospital all night. How do you expect patients to get better when they've spent the night in an emergency room with no treatments?'

'My 86-year-old dad with a suspected heart attack had to wait for 36hrs in a corridor on a wheelchair before admitted to a ward. Ridiculous service. God help anyone who needs to use this place.'

'My dad was admitted to A&E after seeing his doctor. So far, he has been waiting for 26hrs. He was admitted due to excess fluid around his heart, he has still not been seen by a doctor! I and others have tried to call A&E today, mostly the calls where unanswered and when they were, we were on hold for 30 mins. I am currently on hold after waiting for 48 mins. This is not acceptable'.

'I'm 85. I went to A&E as a varicose vein was bleeding. I got there at 9am. By 4pm I'd had nothing to eat and I'm diabetic. I asked the nurse she said, 'that's not unusual' and walked on. 20 minutes later a doctor came out and said if I don't read out your name, tell me. I told him he hadn't said mine. He went to the desk, and I hadn't been booked in. I then saw the doctor at 5.15pm. He said I needed a specialist, but I couldn't see one until tomorrow, so I was on a trolley in a corridor all night. It was frightening'.

'We spent just under eight hours in A&E and even though we had rung 111 and they sent him with suspected sepsis he didn't see a doctor for seven and a half hours'.

Coordination between different elements of the UEC system

'I am writing to bring to your attention the waiting times at Blackpool Victoria Hospital. My nana was told by her doctor to go straight to A&E she was 'in organ failure'. She has been sat on a chair for over 24 hours because there are no beds, we've been told a further waiting time of 60 hours now lies ahead of her and my family. A much loved 83-year-old who has paid her stamp all her life with a bad heart, osteoporosis and organ failure must sit in A&E for over 60 hours before she receives lifesaving treatment (assuming she lasts this long). Our NHS is failing my nana and countless other seriously ill people waiting for treatment. Why aren't there enough beds? Why are people waiting so long? Why is Victoria Hospital continually stretched beyond its capacity!? I'm not sure if I'm contacting the correct department, if not please point me in the right direction to help give my nana the respect she deserves and the chance to see another Christmas'.

'I rang my GP at 4.45pm as I needed antibiotics. I knew what I needed as I understand my condition. They refused and told me to ring 111 who sent me to A&E. I'm still here at 3.40am with a raging temperature, sat on a plastic chair and shivering. Nobody has seen or spoken to me since 10.40pm. Surely people shouldn't be treated like this?'

'I enclose two screenshots one from HCRG which says at the bottom you could book an appointment with 111 but in the email from 111 say they don't book appointments for Ormskirk walk in centre. Who is right?'

'My daughter was in a coach crash in Turkey. The Turkish hospital x-rayed her and said she had broken her elbow. When she got home, I took her discharge notes to her GP, who told me to go to the MIU as she needed another x-ray. They said, 'I am not x-raying her arm as it's been x-rayed already'. I questioned this and the nurse abruptly said 'no, all can do is send her to fracture clinic'. The doctor there said he had no documentation on the elbow, I explained it had happened in Turkey and that I took her to minor injuries and they had made the appointment here. The doctor told us we would

have to go to A&E as he needed an x-ray. The doctor in A&E wasn't happy that the MIU hadn't done an x-ray and advised me to complain. At this point her arm had been in a sling for four weeks and he said this had made things worse'.

'I called 111 at 8.02am as my partner's condition deteriorated. They suspected sepsis so rung an ambulance. 50 minutes later they rang back to say it had been cancelled and asked me to drive him to A&E. On arrival, he couldn't stand or walk.

He was initially assessed by a nurse. I checked in several times with the nurses as he seemed to be getting worse and was becoming sensitive to the lights, I was reassured he would be seen. At approximately 10:45am he started to vomit then his body stiffened, and he lost consciousness. I called a nurse who ignored me on my first call but when she saw him, she rushed over. At this point he was taken to a treatment bay, given an ECG and a doctor called. Blood was taken and while this was being done, they told me his notes should have been in the RAT pile, but she had found them in triage and that someone had put them in the wrong place. After bloods were taken another nurse came and administered fluids and antibiotics stating that they were treating him for sepsis. This was stated at 11.10am, which was three hours after the 111 clinician had already provisionally diagnosed sepsis. The nurses were advised that his sensitivity to light was getting worse'.

'I attended RBH at approximately 9pm with a suspected broken collar bone. I waited in the waiting room to be seen by the triage nurse. I asked staff if I could get some pain relief, but none was provided, four hours later after pestering I was seen by the triage nurse who gave me codeine and a triangular bandage as a sling.

During that four wait the triage nurse was only seeing three or four patients an hour, he certainly wasn't acting as triage who should be in assessing people's needs quickly and prioritising their needs.

The next interaction I had with any staff was at 4am when a senior nurse came into the waiting room asking who would like to go home now and get an appointment to come back later that day. About half of the waiting room took up this offer and went home. After this time nobody in the waiting room was seen until approximately 8am.

I was eventually seen by a doctor at about 9am after chasing up reception and any other staff I could find. I was sent for an X ray which confirmed I had broken my right clavicle; it was a full break and was now overlapping itself. Whilst sat in the treatment room I heard the doctor on the phone say it looks like a nasty break could orthopaedics look at it. I was eventually discharged after another 45-minute wait at pharmacy being told I didn't need surgery and was told I would be contacted to arrange an appointment at the fracture clinic.

I was in a lot of pain, not asked anything about what my job entailed or my lifestyle and given very little advice. Fortunately, I had private health care. After contacting them I got an appointment and saw a consultant who immediately said I had been given the wrong type of sling and that the only way to fix the fracture with a good outcome was for surgery. A few days later I had surgery, a plate was screwed in place putting my clavicle back to its correct position. I was told after the surgery that a shard of bone from one end of my broken clavicle was stuck into a muscle causing the pain.

I can only thank my lucky stars I had private healthcare otherwise my recovery and future use of my shoulder and arm would have been very different'.

Care Provided – including corridor care.

‘On the Friday we called 111 at 10am. Following a discussion with a doctor an ambulance was called who took us to Blackburn. We arrived at approximately 12pm. He was extremely sensitive to light and noise and was vomiting a lot. The doctors were more concerned about the blisters on his hands than his headache, sickness, and light sensitivity. I had to keep pushing them on the matter and requesting pain relief which he didn’t receive until about 9pm. It was then suggested that he may have meningitis and he was moved into a bay. His headache was getting much worse and his eye started to droop, he still had no pain relief. Eventually they took him for a CT scan. At 8pm a consultant delivered the news he had suffered a subdural hematoma and urgently needed some medicine. It took a further three hours for him to receive this. His eye was now fully closed, he was in a lot of pain and was very confused. I overheard a phone call with Preston Hospital arguing they shouldn’t have to take him. Blackburn decided to send him anyway and called an ambulance. He arrived at Preston at 1am the following morning where we were told he would be monitored over the weekend as the department doesn’t have a full service at weekends.

If he had been seen sooner or transferred sooner the outcome could have been different’.

‘I am writing to let you know of our appalling experience of A&E Corridor Care at RBH.

An emergency doctor visited us at home and said my husband needed to go to hospital. We arrived in A&E, and they got him a chair as they could see how unwell he was. The waiting area was far too small to accommodate the number of patients waiting to be seen. It was completely overcrowded. All chairs were full, so patients had to sit outside, on the floor and at times on the toilets as there was nowhere else. We have no complaints about staff — we felt that they were trying their best.

Then came ‘Corridor Care’ which was an unbelievable experience. For approximately nine hours, my husband remained in a chair before he was eventually allocated a trolley. For most of the time my husband was in position 26 on the corridor and was referred to more than once as number 26. We felt his diagnosis was delayed by being cared for on the corridor. Once he was admitted to a single room due to his infection of unknown origin, an x-ray of his leg and a CT lower abdomen was arranged. Other checks were undertaken which were not completed in the corridor such as skin swabs. He was also administered an anticoagulant and fitted with stockings to prevent deep vein thrombosis.

My husband was cared for in the corridor in close proximity to other patients when he was suffering with an infection of unknown origin. At this point no one had any idea of his diagnosis.

There was absolutely no confidentiality/privacy in the corridor other patients knew of my husband’s condition and we knew all about theirs. It was impossible for staff to discuss confidential information without other patients hearing what was going on.

There was very little nursing care — by this I mean no washing or changing facilities or any attention to oral hygiene. My husband was dressed in the same clothes that he was admitted in for almost three days. He had all the equipment to wash and clean his teeth but there was nowhere for this to take place. During his time on Corridor Care, he did not wash (we were told that there were no facilities for this). When we were coming up to three days, I insisted that he should have a shower and that I was happy to help him. The member of care staff contacted a ward and was told that my husband could have a shower when they had a bathroom which was not in use. Two hours later,

he went to a ward when he had a shower. He suffered with oral thrush whilst he was on the corridor due to his ill health and also due to poor care.

My husband was suffering from diarrhoea and unsteadiness on his feet — he had to walk to the toilet as best as he could. If he was away from his stretcher when food or drink was delivered, he had to wait until the next round for a warm drink or food. There were no checks on input versus output. No one had any idea about how much he was drinking or how much urine he was passing.

Food consisted of sandwiches and soup. He couldn't eat them. Curtains were not used in the corridor when personal care was delivered to patients. Drinks were limited and there was nowhere to put drinks down — occasionally my husband was given a bottle of water but no ready access to water. There were no call bells which led to other relatives finding water and seeking help for patients.

My husband's nurse did not know anything about him. When I asked for an update, she said that she thought he was her patient and then referred to the computer to say that he was on antibiotics which I knew. My husband was so ill that I wanted a proper update — the night nurse checked the computer for me and said that my husband had sepsis.

I cannot believe that all the principles of good, safe care are put to one side as a result of Corridor Care. It was an awful situation as I knew that he was not in safe hands on that corridor where he was labelled 'number 26'. We were told that, yet another corridor was being opened up for patients during my husband's stay. Your staff know that this is a poor-quality service, they know that the corridors are not properly set up to provide safe care to patients and so do you'.

'When I returned, I found Mr A on a corridor, no fluids, no blanket and directly under a bright light. I was unable to find out what was going on, I was advised that he was fine and had not had any antibiotics. I had to explain this was incorrect. A doctor came to assess Mr A but he wouldn't listen. He was visibly deteriorating. I later spoke to a nurse who listened and was fantastic but as no one was able to access the new system no pain relief or information was available to the nurses.

When the doctor came round, he had no information about why Mr A went to A&E. It was many hours before the doctor could access the system and provide the medication. It was four hours late. They asked for a urine ample but never checked it. Two other doctors saw him but didn't know why he was there. He spent 26 hours without sleep'.

'My dad returned to A&E yesterday morning early hours, and he has been waiting almost 48 hours for a bed to come up on a ward. He should have never been discharged in my opinion as he's massively gone downhill. My dad is 81 years old, has dementia, blind, cannot walk, now has pneumonia again and a further UTI, yet he's still laid up in A&E waiting for a bed. I attended to see him yesterday and the smelt of urine. It's unacceptable'.

'I rang 111 and they sent me to A&E. They couldn't get blood so abandoned this. Then I was sent for a CT scan. When I got back to A&E nobody told the staff. The nurse was patronising which made it worse. I was then advised that a specialist doctor would see me that evening'.

'There were three patients myself included left without beds at the end of A&E opening hours. The other two patients had their observations taken and given beds and I did

not. I went from 3pm Saturday to 6am Sunday without any observations being carried out which is absolutely disgusting. The doctor arrived to see me at 3:30am'.

'I was left without a bed until I asked to be discharged due to needing to lie down because of the pain. I then got a makeshift pillow filled with towels and a trolley from the corridor to lie on at about 1am. I was then turfed out of the bed at 7am after no sleep for the space to be made back into a waiting area'.

I then saw the consultant around lunchtime Sunday who advised he was admitting me and wanted me to have a lumbar puncture. None of this made any sense given the previous discussion with the doctor. This frightened me as I kept being told different information.

If I was supposed to be so poorly, I would not have been left without observations for 14 hours and I would not have been left without pain medication for nine hours surely?

I had told staff I needed sleep, food and quiet none of which I had to recover. This was ignored. I self-discharged after 26 hours. I recovered quickly as I had slept, eaten, had fluids and been able to rest'.

'M visited the vascular clinic at Accrington's Pals Centre. M is 84 has heart failure and the clinic quickly noticed his legs and abdomen were swollen with fluid retention.

The clinic advised him to go home, and they would contact a specialist team from Burnley General to visit him at home that day. The team visited him and advised him there was nothing that could be done at home, and he would have to go into hospital.

There were no beds available, but he was advised to go through A&E. Michael presented himself at about 16:00. He then spent the rest of Monday sleeping on a chair. A doctor assessed him and said that the problem could be treated at home, after being told that the team from Burnley said that it couldn't be treated at home.

Late Tuesday M was put up on a makeshift bed next to the nurses' station on a ward. He was moved onto various corridors, but no decision made about treatment or care at home. Is this the way we treat our frail elderly now?'

'I have rung a couple of times today to speak to staff and they have been rude and unhelpful on the phone. Have told my dad's got a bed so they don't understand my concern as to why he's not been moved to a ward! He is a dementia patient. A&E is not the best place for him to be. It's a fast-paced environment, noisy, which is not ideal for my dad at all, he needs quiet and continuity!'

Staff attitude

'Staff were regularly stating they were exhausted, had stayed hours over their shift ending, didn't know what they were doing, didn't know the ward, they didn't usually work there, were only bank staff, negative and dismissive towards doctors and would forget or ignore patient requests for help'.

'I received a phone call from SDEC, who told me that the community team was refusing to come out to me, and that I needed to go to SDEC that evening to have IV antibiotics. He told me that I would then be sent home with a plan. I was also told that the staff at SDEC would know of my case, so that I wouldn't have to wait around.

I arrived at SDEC at 18:45, and I wasn't seen until 20:15. My bloods were taken, my blood pressure recorded, and an ECG performed, and I was told to wait out in the

waiting room. I was then ignored for the next three hours. Other people were even given tea/coffee and sandwiches, but I was bypassed completely.

At 23:30, I was told that SDEC would close within half an hour, and that because I hadn't been seen, I would have to return the next day. This, as I'm sure you can understand, rather angered me - I was told that my case would be a quick one, that they were expecting me, and yet they did not even treat me. I returned home, and after the weekend had passed, I called my local GP and spoke to the advanced nurse practitioner. She arranged for me to return to SDEC.

I arrived at SDEC just after midday. I was seen after 40 minutes by a nurse who had no idea why I was there, despite me being told that everything had been pre-arranged yet again. Eventually, she brought the sister of the department over, who proceeded to tell me that everything which the advanced nurse practitioner had told me was wrong. When I told her how I felt about being told conflicting stories by different members of staff, and also about my first visit to SDEC, she told me that she did not care about how her staff treated me, and that I should stop talking. She also suggested that I was lying about how I was treated during my first visit.

I found this to be quite rude, and understandably, I was angry. Overall, the treatment I received in SDEC leaves a lot to be desired. Nurses should not be talking to patients in that way. As someone who suffers with a chronic illness, I have visited a number of hospitals over the years, and I have to say that this was the worst hospital experience I have ever had'.

'I went to A&E in excruciating pain after having surgery and a serious allergic reaction to antibiotics. After two hours I approached a nurse and just asked for some kind of pain relief. She was rude, dismissive, and unhelpful. She told me I wasn't an urgent case and just had to wait. I have been bed bound since Monday and attended A&E as I was in unbearable pain. I cannot physically sit in a chair for that long with no pain relief, so I had to leave without being seen'.

'I went A&E at Blackpool Vic. My experience was:

- I wasn't admitted to a ward for over 48 hours.
- I was left in a cold waiting room with no blanket when I had pneumonia and provided no sanitary products even though I had requested them.
- The attitude of staff towards me was very cold when I asked for help.
- I have MS and being left in a chair in a wating room with no sleep has caused a relapse into my condition. They didn't take my condition into account.
- The attitude of the doctor in A&E was appalling, he spoke down to me, and I felt like nothing.
- The nursing staff in A&E were terrible. I was being sick, and they did not care.
- The doctor who saw me on the ward shouted at me and upset me when I was trying to speak to him about my relevant medical history. He made a nasty comment to me that I 'turn on the waterworks'. He then tried to deflect this saying he was speaking to a student nurse, which clearly was not the case.

‘My brother-in-law is around 90% bed bound but has short spells where he will stand and walk so he does not lose his mobility completely. Being in a sitting position increases his pain and we explained this to the nurses. They still sat him in a chair for over 12 hours with no offer of pain relief and no input from staff. Sometimes he got up to stretch and later when we explained his need to lie down a nurse said, ‘well I’ve seen him walk around A&E’.

He tried to lie on an empty bed in a corridor to relieve his pain only to be shouted at by a nurse to get off it. Eventually they gave him a recliner chair. My complaint isn’t about availability of beds as I understand the pressures of bed availability in the hospital, my concern and my families concern are the slow response to a deteriorating patient. The lack of compassion, medical response, lack of empathy and poor judgement of staff is in my professional opinion unacceptable. My brother in law’s condition has been caused by drug addiction and I suspect he was being judged but cannot prove this to be the reason for their poor treatment. I only hope lessons can be learned from this’.

‘I was taken by ambulance to BVH late in the evening suffering from chest pain and a fast pulse. I was sat in a chair all night and at 9 am I was told I shouldn’t be in A&E, and I was taken to SDEC.’

‘I was taken to BVH A&E at 0400h. I was advised by the doctor fairly soon after arrival that the bowel needed stimulation but to continue eating and drinking normally and to await laxatives. I was to stop the use of my blood thinner immediately. I was then moved to a trolley space on the corridor near bays 17-18.

When the shift changed at around 0800h I advised a nursing sister that I had already been waiting 45 minutes for a urine bottle or to be given assistance to access a toilet. At 0835h a passing HCA assisted me to an out of order WC (seat missing). A general excuse of ‘I am not dealing with this area, or I will tell the nurse’ prevailed and requests were either ignored, not passed on or subsequently disregarded.

Throughout the period from the initial doctor consultation until 1300hours no food or fluids were made available.

At 1300h a hospital volunteer provided a drink and sandwich, this being the first fluid I had been given access to for 9 hours. The nurse who was ‘caring’ for patients on the corridor since 0800h on her return from break was asked to relocate me. Whilst in pyjamas only I was deposited in the main reception area for A&E at 1445h. The failure of a nurse to make herself known to patients she is supposed to be caring for during a period in excess of 5 hours is deplorable’.

‘It was here when it went downhill, this doctor was clearly not happy about being there. Whether he was called in late I’m not sure, but I was greeted with him complaining about doing triage which in his words ‘is a nurse’s job’. He started answering all the health questions himself, answering no to them all and not asking me, saying they are silly questions. He was angry and speaking really fast so I could not understand’.

‘I have a problem with mobility, so I asked a staff member to let me through the door near her. She was extremely rude and had zero empathy. She told me that I'd have to walk round. When I explained again my reasons for using this door, she agreed to let me through, but this didn't go without her reducing me to tears. I was already anxious and worried, and her attitude was disgusting. I walked through the corridor in tears to

my appointment. I would never complain but I felt like I had to raise this to ensure no other person was made to feel like I felt last night'.

Children

Though we were not able to extract the numbers that were about children, from the individual cases we have examples that were about children and extracts of these are below.

'Last Saturday evening at 7pm I attended Chorley A&E with my 3-year-old son who had fallen off his bike and cut his chin. I looked on the website prior to setting off and thought that his injury fit the remit of Chorley. He was called into triage after only about 5 minutes of being in the waiting room. The nurse was lovely and agreed that my son needed some treatment, she thought that he would need the cut to be glued and steristripped. She left the room to run it by a doctor. When she returned, she apologised and informed me that she couldn't treat my son because he had had an 'accident'. She explained that the policy at Chorley was that they didn't see accidents in children, she explained that she would happily treat him but that she would need a doctor to discharge us. The doctor would not agree to the treatment and discharge us therefore she couldn't help us. I asked her to request the doctor to come and review us personally so that he could see the injury, but he refused. I requested to see the doctor again, but he wouldn't come. The nurse told me to take him to Preston A&E. I questioned whether this was really the best option for a 3-year-old to have to sit in an A&E department on a Saturday night, the nurse looked really apologetic and said there was nothing she could do.

My husband then took my son to Preston A&E. He arrived at approximately 8.40pm. My son was triaged again within about 10 minutes of attending. No observations were ever completed on him at either Preston or Chorley. The nurse at Preston did not even remove the plaster to check the injury. Just informed my husband that the wait was three hours and advised him to take a seat.

At midnight he brought my son back home having not been seen as the wait time had been increased to 7.5 hours. The next morning, I took my son to Bolton hospital, he was triaged and treated by the nurses, and we were discharged home within approximately 30 minutes. It was too late for his chin to be glued but it needed steristrips. I was informed that gluing of skin needs to be done within six hours of the injury.

I cannot understand why the nurses at Chorley were not able to use their judgment and skill to treat my son. Surely it would have been better to treat his injury than add to the already very strained workload of the department in Preston and ultimately not get the most effective treatment.'

We have a picture of the child's injury submitted by his mum.

'My 6-year-old son trapped his finger in a door at approximately 9.30pm and the top of his finger was hanging off. Took him to Burnley hospital straight away and was triaged and x-rayed within 15 mins of arrival. We then waited until around 2.30am when someone came out and told them that they have to go to Blackburn Hospital as the specialist team they need is there. When we arrived, the consultant asked why it had taken him so long if the accident occurred at 9.30pm. I explained we had been in Burnley hospital since 9.45 and the had only just told him at 2.30am to come here. The consultant was concerned about the amount of time he had been without

treatment. Why did Burnley only tell me to leave at 2.30 when they took an x-ray before 10?'

'My 8-month-old daughter went to RLI A&E after being stung in the mouth by a bee. The sting was stuck and I couldn't remove it at home. NHS advice is to seek urgent medical attention. My daughter was hysterical. I couldn't get through to 111 so went to A&E at around 7pm.

Upon arrival I was quickly taken to a paediatrics unit and a nurse took her details, sats and administered Calpol. I was told a doctor would be round to see her asap and look at taking the sting out of her mouth.

After an hour or so it was clear she was feeling a little better, I checked her mouth and the sting had dislodged itself. She has a dummy and her sucking on it must have removed the sting. I informed a nurse that the sting had disappeared, she must have swallowed it. She went to gain advice and came back to tell me a doctor would still need to see her due to her age.

By 11.30 she still hadn't been seen. I had no nappies or milk with me to keep her settled and I told the nurse on duty that I would be leaving the unit as I had not been seen and Esme looked as though she was feeling better. She apologised and stated she was not able to tell me when Esme would be seen as it was busy. She stressed her mouth would need still need to be checked and I could return at 8:30am to a drop-in clinic instead. The wait time of over four hours for an 8-month-old baby to be seen is unacceptable. All I wished for was a doctor to check my baby as promised and give me some advice on after care or signs to look out for at home. If she wasn't a priority this should have been communicated to me so I could have made my decision to leave sooner.'

Estates and Facilities

'I was sent to A&E by 111 as my seven-month-old baby was coughing up blood. The children's A&E department is absolutely unsatisfactory in every way, an utter disgrace, and I would go so far as to say that it poses a danger to the sick children who visit this department.

The 'waiting room', if it can even be classified as a waiting room, is a very small room, completely unventilated, and is packed to the brim full of very sick or injured children and parents/carers. We arrived with our seven month old at around 7pm and there were no seats left so we stood in a tightly packed corridor with sick people walking past us, paramedics trying to squeeze beds through, and hospital staff who are clearly overworked and overwhelmed looking completely overrun to the point where they did not seem to have the energy to be able to care for their patients well enough. We also overheard one of the staff telling someone that only one consultant was covering the whole department. Disgracefully, I must add that we were not the only ones waiting in the corridor, sick children were also forced to wait in the corridor with their parents, stood up with no offer of seating.

When a seat did become available, and we entered the waiting room we quickly discovered that the corridor was a much better option. The room was so small that there could be no space separating your child from other sick children, increasing the risk of your child picking up another illness on top of what they already have. It is a disgrace that a parent bringing their child to a hospital for medical care should be so

worried about being in this environment where they are in even more danger of becoming more ill and that taking them home might be a safer option.

Furthermore, the waiting room was almost entirely unventilated, with only a small open entrance door. You would think, in a hospital, that reducing the spread of illness would be paramount and that a waiting room full of sick children and babies would at least be ventilated. This surely is the most basic, simple way to even slightly reduce the spread of illness. Another result of the poor ventilation was that the room was stiflingly hot and was causing my baby to become sweaty.

There was a mother, with a child who looked around eight years old repeatedly throwing up, literally screaming out and writhing in pain, and I overheard her in tears begging a doctor to give the child some pain relief and to be seen as they had been in there since 11am. This happened at 8pm.

I refused to sit in the waiting room, exposing my seven-month-old baby to any more potentially dangerous illnesses. Thankfully, my husband was with us, so he was able to wait outside with our baby in the pram while I waited for a doctor.

I have so much sympathy for the medical staff. None of this is their fault in any way. We arrived just before a shift change, nurses and doctors looked totally overtired, overworked, and to be completely honest, past the point of being able to care anymore. I do not blame them, with the dire state that they are being forced to work in when they entered their career looking to be able to help people and are now forced to work in these conditions giving only the bare minimum of care that they possibly can do in this state. Desperate parents approached them with simple questions, worried about their children, and were met with cold, tired, scripted responses. When the shift changed and new nurses arrived, we could immediately see that they were also just as fatigued and overwhelmed as the nurses on the previous shift. Nurses, doctors, and other staff seemed to spend more than half their time either typing on computers or wandering round looking lost and helpless rather than seeing and caring for their patients. Again, not a complaint about them personally, a complaint against this broken system. The doctor we eventually were able to see was as reassuring and attentive as he could be in the little time we were able to have with him.

I am not exaggerating in the slightest when I say that this environment is a danger to the sick children that visit this department and honestly may pose more of a risk to some of them than if they were to wait to be seen by a doctor at home. The care provided was utterly unacceptable, to say this was an emergency department, for some it would have been quicker to wait at home over night and try to see a GP in the morning'.

Food and drinks

'I was there for 12 hours. One of the patients in the waiting room received a sandwich and a drink from one of the nurses, when I asked if I could get something I was told none was available, clearly a patient the nurse knew'.

'The doctor asked for the nurse to give food out to patients, and she refused stating she was too busy, so the doctor had to provide food for patients. The vending machines were broken. The refreshments machine provided in A&E was empty and despite it being acknowledged numerous times no one topped them up'.

‘One elderly patient who had diabetes hadn't eaten all day had been in hospital since mid-morning. The fact she was diabetic was only highlighted at around midnight. Another couldn't use her hands to eat or drink so was left hungry and thirsty. It is no wonder people go into hospitals and don't come out or come out worse’.

David Brewin

Head of Patient Experience

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