The Royal Wolverhampton NHS Trust	NHS

Trust Board Report

Meeting Date:	26 October 2015
Title:	Parliamentary & Health Service Ombudsman Report – Complaints about Acute Trusts 2014-15 (September 2015).
Executive Summary:	This report provides a summary of the findings and recommendations made in the Parliamentary & Health Service Ombudsman report into complaints about acute hospital trusts 2014-15. It highlights that the Trust has maintained or improved its position across a number of indicators when compared to the previous year's report. In response to the report the Trust continues to implement the integrated complaints management improvement plan and the agreed actions from the internal audit report on complaints management. The reported highlighted that 11% of all investigated complaints about acute trusts in 2014-15 involved complaints where the complainant felt the trust did not adequately acknowledge their issues. A third (34%) of complainants cited receiving an inadequate apology for their dissatisfaction. Poor communication is cited as a reason in 35% of the complaints investigated, though this is lower than the proportion in 2013-14, when it was present as a factor in 42% of complaints. **RWT:** The report acknowledges the transfer of some services from the Mid Staffordshire Hospitals NHS Foundation Trust and makes a comment on the possible impact on the figures for this trust. Across all the indicators the Trust has made improvements between the 2013-14 and 2014-15 (see table in 2.4). A decision was made by the Trust to combine action plans from the Clwyd Hart Review (2013), the Parliamentary and Health Service Ombudsman report, Designing Good Together: transforming hospital complaints handling (2013) and the internal audit report (Baker Tilly Report Feb 2015) to create a combined improvement action plan to reduce duplication of actions required by the Trust. In addition the Trust agreed a number of actions to be implemented following the publication of the into complaints management. The implementation of these actions is now almost complete. Given this and the scope of the Trust integrated complaints management improvement the issues identified in the Parliamentary & Health Service Ombudsman Report – Complaints about Acute Trusts 2014-15 will be addressed by the continued implementation of this action plans.
Action Requested:	To note the report and to continue to support the agreed improvement action plan.

Report of:	Cheryl Etches, Chief Nurse / Deputy Chief Executive
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Links to Trust Strategic Objectives	1, 2, 3, 4
Resource Implications:	Revenue: Capital: Workforce: Funding Source:
Risks: BAF/ TRR (describe risk and current risk score)	None identified
Public or Private: (with reasons if private)	Public
References: **(eg from/to other committees)**	
Appendices/ References/ Background Reading	Clwyd-Hart review (2013) Parliamentary and Health Service Ombudsman report, Designing Good Together: transforming hospital complaints handling (2013) Patients Association, Handling Complaints with a Compassionate Human Touch (2014) Baker Tilly Internal Audit Report – Complaints Management (Feb 2015)
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

1. Purpose

To provide a summary of the findings and recommendations made in the Parliamentary & Health Service Ombudsman report into complaints about Acute Trusts 2014-15.

2. Narrative

2.1 Background

This is the second annual report published by the Parliamentary & Health Service Ombudsman into complaints made against acute hospitals. The report provides details of the number of complaints received by the Ombudsman, the outcome of the complaint and the reason which led people to complain. In 2014 the Ombudsman upheld 44% of complaints investigated.

2.2 Report Findings

The Ombudsman investigated twice as many complaints in 2014-15 compared to the previous year and nearly half of these related to acute hospital trusts. The report concluded that some trusts are seven times more likely than others to have a clinical episode resulting in an investigated complaint.

The report considers the reasons why complaints are referred to the Ombudsman and these fall into two categories:

a) The complaints management process
b) Hospital care and experience

a) The complaints management process

The reported highlighted that 11% of all investigated complaints about acute trusts in 2014-15 involved complaints where the complainant felt the trust did not adequately acknowledge their issues. Although this was a decline when in 2013-14 this was a factor in 36% of complaints. A third (34%) of complainants cited receiving an inadequate apology for their dissatisfaction. The second most common reason for referral to the Ombudsman was that the complainant felt the hospital response contained factual errors.

b) Hospital care and experience

Non-medical aspects of patient care was a factor in just under half of those complaints made about acute trusts, this includes issues that do not involve medical treatment, such as communication issues and staff attitudes. Poor communication is cited as a reason in 35% of the complaints investigated, though this is lower than the proportion in 2013-14, when it was present as a factor in 42% of complaints. In those complaints involving communication, 71% refer to issues in communication between the hospital and the patient or their family and the remaining complaints refer to communication issues between staff within the same hospital or between different

hospitals. The attitude of staff is linked to complaints about communication. This was a factor in 21% of all complaints in 2014-15, similar to 2013-14. Failure to diagnose was cited in 31% of complaints; a slight decrease on 2013-14 when the proportion was 35%. Complaints about clinical care and treatment factor in 38% of all complaints we investigated in 2014-15 which is similar to 2013-14.

2.3 Data analysis

The report compared the number of complaints the Ombudsman accepted for investigation with the number of clinical episodes recorded. On average the Ombudsman investigated 6.2 complaints for every 100,000 clinical episodes in each trust during 2014-15. This compares with 5.9 complaints investigated per 100,000 clinical episodes in 2013-14.

The proportion of investigated complaints varied significantly, the 10% of trusts with the highest proportion of investigated complaints experience 12.6 investigations per 100,000 episodes. In contrast, the 10% of trusts with the lowest proportion of investigated complaints experience only 1.7 investigations per 100,000 episodes. Therefore, after taking into consideration the size of the trust, some trusts are seven times more likely than others to have a clinical episode result in an investigated complaint.

2.4 Royal Wolverhampton Hospital Data and Response

The report acknowledges the transfer of some services from the Mid Staffordshire Hospitals NHS Foundation Trust and makes a comment on the possible impact on the figures for this trust. The following information is provided in the report:

	2014-15	2013-14	Average
Number of enquiries received from RWT	62	69	
Number of enquiries accepted for investigation	10	14	
Number of investigations partially upheld	9	2	
Number of investigations not upheld	7	1	
Enquiries per 10,000 clinical episodes	2.30	2.85	2.94
Enquiries accepted per 100,000 clinical episodes	3.71	5.79	6.16

Across all the indicators the Trust has made improvements between the 2013-14 and 2014-15.

In June 2015 the Trust reviewed a number of national reports into complaints management within hospitals. These included the Clwyd-Hart review (2013), the Parliamentary and Health Service Ombudsman report, Designing Good Together: transforming hospital complaints handling (2013) and the report from the Patients Association, Handling Complaints with a Compassionate Human Touch (2014). A theme emerged with regards to the report findings and the recommendations being made in each of the reports. As a consequence the Trust decided to produce a combined improvement action plan which took account of each report recommendations and which aimed to reduce duplication of actions required by the Trust. In addition the Trust agreed a number of actions to be implemented following the publication of the internal audit report (Baker Tilly Report Feb 2015) into

complaints management. The implementation of these actions is now almost complete. Given this and the scope of the Trust integrated complaints management improvement plan the Trust has concluded that the issues identified in the Parliamentary & Health Service Ombudsman Report – Complaints about Acute Trusts 2014-15 will also be addressed by the continued implementation of this action plans.

3. Conclusion and Recommendations

This paper has provided a summary of the Parliamentary & Health Service Ombudsman Report – Complaints about Acute Trusts 2014-15. The report shows the Trust has maintained or improved its performance when compared to the previous report. It is recommended that the Trust continues to implement the integrated complaints management action plan and complete the agreed actions from the Baker Tilly report.