The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	23rd May 2011
Title:	Report of the Ombudsman *Care and Compassion?*
Executive Summary:	The above report serves as a significant reminder to Trust s like RWHT of the poor experiences that patients and families continue to suffer. In addition to the poor experience the way in which their concerns and complaints are handled adds to their levels of dissatisfaction resulting in referral to the Ombudsman.
Action Requested:	To raise awareness of the committee of the above report and the lessons needing to be learnt across this organisation.
Report of:	Director of Nursing & Midwifery
Author: **Contact Details:**	Director of Nursing & Midwifery Tel: 01902 695950 e mail c.etches@nhs.net
Resource Implications:	No direct costs identified to date but resource implication for training purposes.
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	www.ombudman.org.uk
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

Background Details

INTRODUCTION

In February 2011 the Health Service Ombudsman for England released a report, 'Care and Compassion?', regarding the results of 10 investigations into NHS care of older people. The report can be accessed at www.ombudsman.org.uk.

The purpose of the report is to raise the potential for issues throughout the NHS so that lessons may be learned to prevent other patients and families experiencing healthcare as cited in the 10 investigations. The report has specifically focused on the care of older people in either primary or secondary care. Approximately 18% of all complaints received by the Parliamentary and Health Service Ombudsman (PHSO) – 9,000 in 2009/10 – were related to care of the older person.

A copy of the report was sent to every Chief Executive for information and locally determined action.

DETAIL

The report contains 10 accounts from different families regarding a patients' experiences of healthcare within the NHS. Family members have approached the Ombudsman as they were dissatisfied with how their complaint had been dealt with at the local level within the relevant NHS Trust. The stories range from clinical care, e.g. medication prescribing and administration, misdiagnoses, nursing care standards and pain management to attitude of staff with both patients and families, ineffective communication and lack of protection of a patient's privacy and dignity.

The report has been circulated widely to clinical teams within the organisation. Every Matron has received a copy and has been mandated to read and share its findings within their areas of clinical responsibility. Many of the areas of concern are not unique to the 10 Trusts/GP practice cited within the report and could be found in the analysis of complaints within other organisations, including RWHT.

Specific themes identified within the report include:

- Communication with carers/relatives both when present and when not with the patient
- General care issues relating pain management, call bells being left out of reach, toileting needs not addressed, personal hygiene not attended to, lack of concern/sympathy by staff
- Ineffective management of a patient's personal belongings
- Nutritional care needs not identified or met
- Poor wound management
- Repeated falls in high risk patients
- Discharge planning and arrangements with associated effective discharge information to patients, families and GPs
- Management and care of patients with dementia
- Inappropriate/injudicious use of antipsychotics

In addition to the above, a common theme through each of the stories was the dissatisfaction of the complainant with how the organisation handled their ongoing concerns and the complaint itself.

The report has been considered by the Heads of Nursing in both Divisions with a preliminary action plan developed. Involvement of colleagues in community

settings will also be included within the plan.This action plan will be presented to the Quality & Safety Committee in June 2011 and ongoing monitoring will be through Divisional Governance meetings and the Quality & Safety Committee.

Other work streams will include reviewing and improving the compliant's process within RWHT.

SUMMARY

The 10 stories within the report make unpalatable reading, however unless organisations like RWHT learn lessons from these very tragic events, then the risk of such experiences happening within our own organisation remain a real possibility. Many of the actions required in response to this report will be integrated into existing action plans for quality improvement, and this will be demonstrated through the reports to Quality & Safety Committee.

Continual monitoring of complaints received within the Trust, including trends analysis, must continue to play an important part in the quality improvement cycle of the organisation.