North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 08/03/2011	**Enclosure:** 9
	Agenda Item No: 10.1

Title of Report: Health Service Ombudsman report on ten investigations into NHS care of older people

Aims:

To update the Board following publication on 15th February 2011 of the Health Service Ombudsman report on ten investigations into NHS care of older people " Care and Compassion?"

Summary:

The report presents findings following ten independent investigations into complaints received relating to the standard of care provided to older people by the NHS. Following the investigations it is recommended that urgent changes are required across the NHS to include listening to older people, to take account of feedback from families and learn from mistakes.

Throughout the report important issues are raised and all Trusts need to learn from its findings.

The report provides the Trust board with the Trust's position against the key findings in the report.

Specific implications for consideration (Financial/Workforce/Risk/Legal/Race Equality etc):

Financial	No specific implications.
Workforce	No specific implications.
Other	Trust Reputation Monitoring of standards of care.

Recommendations:
The Trust Board is asked to:

- note the report and
- agree that the actions referred to in section three are monitored by the Governance and Quality Committee

Document previously approved by:
N/A

Prepared by: Chris Platton Acting Director of Nursing, Quality and Governance.	**Presented by:** Chris Platton Acting Director of Nursing, Quality and Governance.

TRUST BOARD
HEALTH SERVICE OMBUDSMAN REPORT ON TEN INVESTIGATIONS INTO NHS CARE OF OLDER PEOPLE MARCH 2011

1. INTRODUCTION

The NHS Constitution 2009 sets out patient's rights and the quality of care they should expect to receive. All NHS staff have a role to play in making the commitments of the constitution a reality for patients.

The Health Service Ombudsman report *"Care and compassion?"* published on 15th February 2011 presents findings following ten independent investigations into complaints received relating to the standard of care provided to older people by the NHS. The report demonstrates the gap between the principles and values of the NHS Constitution to the reality of being an older person in the care of the NHS.

2. FINDINGS OF THE REPORT

The complaints investigated related to NHS Trusts and two GP practices. Following the independent investigations it was concluded that ten patients suffered unnecessary pain; indignity and distress whist under NHS care. The report states that the NHS is failing to treat older people with care, compassion dignity and respect.

The common failures featured throughout the investigations include:

- Pain control
- Discharge planning
- Communication with patients and relatives/carers
- Clean surroundings
- End of life care
- Adequate nutrition

The report concludes that urgent change is required across the NHS to include listening to older people and to take account of feedback from families and learning from mistakes.

3. TRUST POSITION

The value of listening to patients their relatives and carers cannot and should not be underestimated. It is the Trusts responsibility to listen to that feedback, so that we constantly improve the quality of care to patients and take the appropriate actions to reassure patients and their families that any mistakes will not be repeated.

The Trust already has in place a range of monitoring systems to review key areas such as the patient environment, patient nutrition and end of life care. However, to ensure the Trust learns any lessons it can from this important report, I have agreed with the Medical Director that the following specific areas will be reviewed as good practice:

3.1 Patient Experience & Communication

It is recommended that we further develop our current patient experience feedback audits which will include:

- Real time feedback from patients to include relatives/carers feedback.
- Monthly reporting to Trust Board through governance quality indicators on patient experience audits (to commence in April 2011).
- Increased Board to Ward Visits to be targeted on care given to older people.
- Increased spot check visits led by senior nursing team on the Essential Standards of Safety and Quality, specifically Regulation 17 / Outcome 1 *'Respecting and involving people who use services'.*
- Review of complaints the Trust has received regarding the care of older people to be undertaken to ensure action plans and lessons learned have been fully implemented.

3.2 PEAT Scores and Assessments

- To be reviewed with the Director of Estates and Facilities to agree whether additional environmental assessments need to be scheduled into the programme of work.

3.3 Nutrition audits

The Governance team have already reviewed the key evidence the Trust has against the CQC Regulation 14 / Outcome 5 – *'Nutrition Observation'*. The evidence against the requirements is robust, however it has been agreed that spot check assessments are carried out during March across both hospital sites to review how this is being delivered in practice.

3.4 End of Life Care

The Senior Nursing Team continues to be represented on the End of Life Care Collaborative. There are future audits to review on End of Life Care Pathway. As part of the CQUIN programme, audits will be reviewed which

focus on avoidance of inappropriate admission to hospital and to facilitate the patients who are able to die in the place of their choice.

3.5 Discharge

The Trust is in the process of reviewing the Electronic Discharge System across both sites. This is being led by Dr Chris Macdonald. The current delays and lack of information on patient discharge is a key part of looking how this can be improved for patients, staff and GPs in advance of the implementation of the 'ForWard' programme.

4. CONCLUSION

It is important to connect the information included in the Chief Executive's report on dignity in care to recognise the national importance that is clearly being placed on the care given to patients, especially older people.

Common themes found throughout the investigation linked to basic standards of care that were not delivered. The report demonstrated the gap between the NHS Constitution's promise of care and compassion and the injustice that many older people experience. The value of learning through patient experience feedback cannot be underestimated. Throughout the report important issues are raised and all Trusts need to learn from its findings.

5. RECOMMENDATION

The Trust Board is asked to:

- note the report and
- agree that the actions referred to in section three are monitored by the Governance and Quality Committee

Chris Platton
ACTING DIRECTOR OF NURSING, QUALITY AND GOVERNANCE