

A DIGNIFIED REVOLUTION NEWSLETTER: February 2014

"Never doubt that a small group of thoughtful committed citizens can change the world - indeed it is the only thing that ever does" (Margaret Meade)

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HEADLINE NEWS

It is a year this month since the publication of the [Francis report](#) on the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Following its publication few have been held to account for the failures that occurred. Jan Harry, former Director of Nursing for the Trust (now retired), who was recently given a 5 year caution by the NMC has agreed to be [struck off the nursing register](#). The Professional Standards Authority had launched a High Court appeal against the NMC's original decision on the grounds it was "too lenient" The Fitness to Practise case of Helen Moss, the Director of Nursing who succeeded Jan Harry, was returned as '[no case to answer](#)'. Weaknesses have also been found in the [General Medical Council's](#) handling of one in five of the fitness to practise cases that it closed early without doctors facing a disciplinary panel. And, calls for [Sir David Nicholson](#) to step down were ignored. He will be retiring next month.

The NMC has been struggling since 2008 when an [inquiry](#) was undertaken into how the organisation was being run. In its latest report (2013) the Health Select Committee (HSC) [continues to be disappointed](#) with the progress that NMC is making to improve its performance. Despite this the NMC is proposing to introduce [revalidation and plans to update the nurses code](#). MPs however, are warning that the NMC should first show it is capable of [clearing an existing backlog](#) of hundreds of accusations of poor and dangerous practice.

In 2011 the NMC told the Health Select Committee that it [did not audit](#) registrants' continuing professional development (CPD) portfolios because it had neither the capacity nor the resources available. In light of the recent HSC review one wonders why it now believes it can effectively implement such a process?

After [reviewing of the complaints system](#) in England MP Ann Clwyd has said that the culture of delay and denial over NHS complaints in England must come to an end. And, Chair of the Care Quality Commission, David Prior has said that the safety of the most vulnerable patients is being jeopardised by a "dysfunctional" rift between NHS managers and clinical staff. He calls for radical change to drive up standards and rid hospitals of a [toxic bullying culture](#) that damages patient care.

The Health & Safety Executive is [Investigating the death of Gillian Astbury](#), a patient who died at Mid Staffordshire Foundation Trust after falling into a diabetic coma.

Discussion continues about the need for [minimum staffing levels](#). In Wales, Assembly Member Kirsty Williams is calling for minimum nursing staff levels to be enforced by law.

Following various damning reports last year there is now acknowledgement that the NHS in Wales has similar problems to those exposed in Mid Staffordshire and other hospitals in England.

In October the Health Minister ordered an [independent review](#) of hospitals in Abertawe Bro Morgannwg Health Board (ABMU) following the death of an elderly patient in 2012. The [Police](#) are also conducting their own separate inquiry.

This month there has been [criticism](#) that the independent review is not investigating the time that this particular patient was in hospital but will be focusing on the position at Abertawe Bro Morgannwg University Health Board now.

One of our founder members met with executive nurses at the Princess of Wales hospital in 2005 to discuss the [neglect](#) that her mother had endured whilst a patient there. Assurances were given then that action was being taken to rectify the problems. However, ADR has since met executive nurses from ABMU on a number of occasions to make them aware of further cases of neglect, and each time the same assurances have been given. Nine years on and the neglect continues.

At a public meeting in Bridgend on 30 January it was made clear that there was only interest in current cases.. As someone who attended the meeting pointed out "*those who ignore the lessons of history are doomed to repeat them*". *You need to look back to see the patterns of behaviour more clearly and you cannot say to one person sorry your relative died too long ago for us to bother, whilst seeking a solution for someone who died a few weeks/months later. The fact that ABMU could publish a report last May (2013) saying that things had improved whilst we found precisely the same things happening two months later both on wards and in the way the complaints were treated casts grave doubts in our minds on what ABMU thought was bad practice.*

At the public meeting there were calls for a [public inquiry](#) and the [resignation](#) of the Chief Executive at ABMU. There have been serious failures in patient care for a number of years within ABMU hospitals – under the leadership of previous Chief Executives Sir Paul Williams and David Sissling, both of whom went on to head up the NHS in Wales. In January this year it was reported that [David Sissling](#), who is currently Chief Executive of NHS Wales is standing down and will be moving to a role with the health service in the East Midlands

OVERSEAS LINKS

During the last month we have extended our network to the Royal Adelaide Hospital in Australia. We sent senior nurses copies of some of our resources e.g. Dignity & Respect Matters article and Dignity Ward, which were well received. And, we directed them to the [webpage](#) where they could find more of our information.

They told us ‘we implemented 14 Fundamentals of Nursing Care here at the Royal Adelaide Hospital. The vision for patient care is to ensure that patients and families will feel cared for with kindness and compassion, feel free from worry and feel they are partners in care in an environment that is calm, safe, professional, evidenced based yet innovative and where the fundamentals of nursing care are deeply embedded into the care while the patient’s uniqueness is understood to create wellness and healing.’

For information about the Australian Dignity in Care [click here](#)

ACTIVITY

During the last month we have:

- written to the Older People’s Commissioner to ask how the working group that is looking at how professionals speak out when they have concerns is progressing We were promised a response but have not, to date, received one
- contacted AVMA for information about the public meeting in Bridgend. We were surprised at the response which seemed to assume that it was not relevant to ADR. The Chief Executive responded that *“It is really for individuals/families who have experienced poor care or complaints handling”*.

- written to Llyr Gruffydd, North Wales AM to ask whether any progress has been made on his call for a police inquiry into last year's outbreak of [CDiff](#) in North Wales
- been contacted by BBC Wales regarding the Government inquiry into the work of Healthcare Inspectorate Wales
- written to the NMC and received no response
- been contacted by MP Ann Clwyd's office with a request to meet with her
- attended the NHS Confederation Wales conference
- responded to NMC consultation on revalidation
- received correspondence from Professional Standards Authority (PSA). Although we were not making a complaint PSA told us *"the particular section of our governing legislation that would allow us to deal with complaints about the regulatory bodies has not been enacted and we have no power to investigate the complaints that we receive"*. It seems therefore that there is no-one to turn to if members of the public are not satisfied with the outcome of their complaint to a regulator? If anyone has any information on this issue please get in touch.

FEEDBACK

- *Well done for the crucial job you do here in highlighting all these issues. I signpost this briefing to a wide range of member groups and to our HQ*
- *Thank you so much these resources are fantastic!*
- *Thank you very much for sending these newsletters to our (Janki) Foundation, they are helpful and appreciated by many of our friends in the UK.*
- *I would like to subscribe to a monthly copy of your email. Fascinating and damning.*
- *Just wanted to say a very big thank you for your regular updates*

PETITION

Sign Age UK's [petition](#) to protect older people's human rights

RESOURCES

The triangle of care - carers included: a guide to best practice for dementia care

The [triangle of care](#) is a model for dementia care that supports a partnership approach between the person with dementia (the patient), the staff member and carer. It is designed to ensure that carers are appropriately included and involved in the care of people with dementia, particularly in hospital settings.

How to guide will support improvements in general hospital care for people with a learning disability

A 1000 Lives Improvement [How to guide has been launched](#) to ensure people with learning disabilities receive the right level of care in hospital in Wales.

Further updates on My Local Health Service website

The My Local Health Service [website](#) in Wales, which contains easily accessible information on NHS performance has been updated giving patients even more information on their local hospitals, GP practices and health boards.

Challenging poor practice

North West Dignity Leads have developed a [resource](#) for staff who witness poor practice in health and social care.

Life after death: six steps to improve support in bereavement

This Dying Matters [report](#) outlines benefits for improving support for people who are recently bereaved

NEWS

Dignity Action day

Dignity Action Day took place on 1 February and efforts to promote dignity in care settings continues throughout the year are encouraged. [Click here](#) for more information

20% of NHS work does no good, says Welsh minister

Up to a fifth of the [NHS's work does not benefit patients](#) and could cause harm, the health minister for Wales has said. Source: BBC News

Barrow hospital's nursing chief's pledge to learn from past

A new boss at the NHS trust which runs [Furness General Hospital](#) has described the pain of watching the organisation where she started her career face a series of high-profile problems. Source: NW Evening Mail

Kettering Hospital withholds death inquiry findings

A hospital where a girl bled to death has [refused to publish the findings of its inquiry](#) for fear of "endangering the mental health" of staff. Source: BBC News

High risk activity revealed at Alder Hey hospital

One of the country's leading children's hospitals has been [issued with a safety warning](#) by one of its own trust executives after an internal review into its operating theatres. Source: Channel 4 news

Nepotism tribunal: NHS trust suppressed report

South Devon Healthcare NHS Foundation Trust ["dishonestly" suppressed a report](#) into accusations of nepotism, a tribunal has found. Source: BBC News

Doctor risks sack by going public over whistle-blowing

Whistle-blowing doctor Jane Hamilton is risking a six-figure settlement and possibly the sack because she is not prepared to stay silent over [serious concerns](#) she has raised about a specialist psychiatric mother and baby unit (MBU) at St John's Hospital in Livingston.

Staff bullying concerns raised about largest NHS trust

Staff members at all levels and across all sites of at hospitals run in central and east London by the Barts Health NHS Trust England's largest hospital trust have expressed [concerns about being bullied](#), a report has shown. The Care Quality Commission (CQC) found "staff morale was low". Source: BBC News

Patients 'were locked up at criticised NHS hospital

Elderly patients and children at one of the country's largest hospitals have been [locked up and restrained against their will](#), a whistle blower has claimed. Source: Telegraph

Dying boy 'sucked moisture out of wet wipes

A four-year-old boy who [died on a "shambolic" hospital ward](#) was so neglected that he resorted to sucking moisture out of wet wipes, his parents told an inquest. Source: Telegraph

Police investigating Princess of Wales A&E wait death

[Police are investigating](#) the death of a 58-year-old man who waited four hours in an ambulance before being admitted to hospital. The man died at the Princess of Wales Hospital in Bridgend last Thursday. Source: BBC News

11,000 lost lives from heart attacks due to poor NHS care

More than 1,500 heart attack victims are [dying needlessly every year in Britain](#) due to substandard care and delays in treatment, a study in the Lancet has found. Source: Telegraph.

Older cancer patients in UK 'written off', charity warns

Some cancer patients are being ["written off" as too old for treatment](#), a charity has warned.. Source: BBC News

Thousands more elderly care home residents subject to restraints

Thousands of elderly patients have been [subject to restraint in care homes and hospitals](#) as the number of applications to deprive them of their freedom doubles in three years. Source: Telegraph

Safe staff levels 'should apply to NHS and care sector'

[Safe staffing levels](#) should be extended beyond nurse numbers in England to include midwives and doctors, especially in A&E units, MPs say. The Health Select Committee also suggested breaches should automatically trigger inspections by the regulator. Source: BBC News

Hospital staffing levels face scrutiny in major shake-up

Inspectors [will scrutinise staff levels in Scottish hospitals](#) for the first time in a major shake-up outlined by the nation's health service watchdog. Accident and emergency departments, maternity care and GP services would also be subjected to careful checks as part of new comprehensive quality and safety assessments proposed by inspection body Healthcare Improvement Scotland (HIS). Source: Herald Scotland

NHS safe staffing: not just a number

This Policy Analysis Centre [analysis](#) highlights the risks to patient care when hospital ward staffing falls short of the roster.

Nurses struggling under heavy workloads and decreasing staff numbers

The Royal College of Nursing's [employment survey for Wales](#) found that nurses across the country are struggling under heavy workloads and decreasing staff levels. Source: Wales Online

Professor Sir George Castledine struck off for misconduct

A professor knighted for services to healthcare has been [struck off the nursing register](#) for "sexually motivated" misconduct towards a widow. Source: BBC news

Most evil NHS staff have their pensions stripped

Eleven NHS workers have had their pensions taken away after committing offences including murdering and molesting patients, stealing their blood and corruption, the Department of Health has revealed. Almost all of the health workers stripped of their benefits are doctors and nurses, while only one is a health service administrator. Source: Telegraph.

NHS doctors and nurses must apologise for care failings

Doctors and nurses should be more open and honest when things go wrong and "say sorry" to patients to help win back trust in the NHS the health secretary has said.

Source: Telegraph

Nurses and midwives are becoming emotionally exhausted by the pressure to appear compassionate

Nurses and midwives are becoming emotionally exhausted by the pressure to appear compassionate at all times, new research suggests. A survey of 351 trainee nurses found that those who were required to show more compassion every day were significantly more likely to suffer stress outside of working hours. It also showed that when nurses are supported properly they have a healthier work-life balance. Source: Telegraph

Blaming care pathway 'like blaming Highway Code'

Dr Claud Regnard, a consultant in palliative care medicine in Newcastle-upon-Tyne, suggests the media, government and Neuberger panel were [wrong to blame the LCP](#) and questions whether the ban was justified and will benefit patients. Source: BBC News

Releasing Time to Care: making our priorities possible

This is Health Improvement Scotland's final [report](#) of the Releasing Time to Care programme which highlights the programme's achievements along with the critical success factors and challenges faced.

One in four hospitals records false waiting times

One in four hospitals is [recording false waiting list times](#), with patients waiting on average three weeks longer than NHS records show, the National Audit Office has found. Source: Telegraph News

NHS hospitals serve 69p meals to patients as spending cut

[Food bills have been reduced by more than two thirds](#) in certain NHS trusts, with some hospitals now spending as little as 69p on each meal, according to official figures. Source: Telegraph

Residential and Social Care

Scandal of elderly forced into A&E as faith lost in care outside hospitals

The number of vulnerable patients going to casualty is up 93 per cent in five years as senior doctors warn patients and health professionals are "losing faith" in care outside hospitals. Source: Telegraph

Care home whistle blower can't get a job

A [whistle blower who exposed a care home](#) where five residents died says she could lose her house because no one will employ her. Lisa Martin lifted the lid on Orchid View, which an inquest found was riddled with institutional abuse. Source: Daily Mail

Ministers treating middle class elderly like 'second class citizens'

Ministers accused of treating middle-class people who pay for their own care like "second class citizens" after blocking plans to protect them under human rights laws. People whose care is funded by the state can use the Human Rights Act to sue unscrupulous care homes if they are left in soiled sheets, poorly fed or treated without dignity. Source: Telegraph