

A DIGNIFIED REVOLUTION NEWSLETTER: December 2012

"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)

Follow us on [Facebook](#) and [Twitter](#)

HEADLINE NEWS

This month there has been a significant emphasis in the media on hospital care. A [Week In, Week Out](#) programme in Wales drew attention to poor diabetes care in hospitals.

[Panorama](#), which was broadcast on 3 December focused on the poor patient care that is putting thousands of people at risk of death or serious injury.

Newspapers have also continued to report significant failings in hospitals around the country. Scroll down to the news section to read some of the articles that have been published.

In response, there have been announcements about a number of initiatives designed to address the problems.

Health Minister Dan Poulter has announced that from April next year NHS hospitals and other providers of care will be [contractually obliged](#) to be open about when patient safety has been compromised.

Norman Lamb, the care minister, has announced a far-reaching independent [review of the Liverpool Care Pathway](#), saying it is unacceptable that people are being put on it without their relatives being informed.

The Chief Nursing Officer in England is launching a [three year vision and strategy](#) for nursing, midwifery and care staff that aims to build a culture of care in all areas of practice.

Julie Bailey, from Cure the NHS, continues to share her story with NHS managers. She visited Wales again in November and ran four sessions which were well received. Julie has published a book of her experience. [Click here](#) to purchase a copy.

CAUSE FOR CONCERN

During the last month issues have been raised with us about practices in some care homes in Wales.

There are concerns that, in the absence of relatives being available, residents are sent to unaccompanied. This is not only distressing for residents, particularly those suffering with dementia, but also for hospital staff who have little information to help them understand an individual's needs.

We have also received a complaint about Merton Place Care Home in Colwyn Bay, which was the subject of a recent unannounced inspection. The inspection [report](#) documents a number of issues, including inadequate nutrition and the poor quality of diabetes care.

As already mentioned above, the quality of diabetes care in hospital was recently under the spotlight in the BBC Week In, Week Out programme. It appears, therefore, that diabetes care is an issue that needs to be addressed in both hospitals and the wider community.

We raised the issue of diabetes care in hospital with Healthcare Inspectorate Wales (HIW) and they have responded to say that there are plans to review the methodology of Dignity and Essential Care visits to include diabetes care in future inspections.

HIW is also preparing an overview from the Dignity and Essential Care inspections that have already been undertaken, to draw out themes from this work and other activities, which will include concerns that have been raised with them. This will be ready in the New Year and HIW will be following this up with a range of organisations, such as education providers and professional regulators.

We are aware that poor diabetes care is not unique to Wales. There was a case reported at the Mid Staffordshire inquiry and some ADR members also have personal experiences.

We would like to hear from anyone who would like to share their experiences, comments or views on diabetes care in hospital and residential care settings. Email info@dignifiedrevolution.org.uk

Inspectorate welcomes contact from members of the public

Healthcare Inspectorate Wales is keen to encourage members of the public to contact them if they have any specific queries regarding any of its [reports](#). [Click here](#) for contact details.

GOOD NEWS STORY

Delilah Hesling is the first patient safety ombudsman in the country. She is employed by Brighton and Sussex University Hospital NHS Trust. Her role is to act as an impartial and independent intermediary for staff, patients and their carers if they have concerns about the safety or delivery of care in our wards and departments. Delilah says *“Meetings with staff and patients are informal and off the record. They won’t lead to blame or major investigation. I’m here to take the fear out of reporting concerns, and to act with individuals, or on their behalf, to bring their concerns to the right people’s attention.”* To find out more about Delilah’s role email Delilah.Hesling@bsuh.nhs.uk

ACTIVITY

In the last month we have:

- Been invited to speak to Robins volunteers from Age Cymru Gwent
- Written to the Patients Association about the reports of poor care that were published in the media – no response has been received
- Written to NMC about a Fitness to Practise case – no response has been received
- Written to Betsi Cadwalader LHB, Care and Social Services Inspectorate Wales, and the Older People’s Commissioner about the concerns raised in an unannounced spot check at [Merton Place](#) Care Home. The various organisations have reported that they are addressing the issues. We will be monitoring progress
- Written to Healthcare Inspectorate Wales (HIW) about including information on its website to show that it is monitoring LHBs to ensure that they act on recommendations made following Dignity and Essential Care spot checks. HIW has responded to say that *“We will require the Health Board to update their action plan at regular intervals to evidence that improvements have been made. While we have not routinely published updated plans in the past this is something we intend to do in the future. We have a joint secondee with the Board of Community Health Councils (CHCs) and part of this role is to develop an operating protocol between us. This will include how the CHCs might in the future be able to follow up our reports more formally and report on improvements.*

We are currently developing the detail of our Forward Work Programme for 2013-14 and part of this is to determine generally what follow up visits we will be carrying out. As I am sure you will appreciate, this will be guided by a risk assessment of the findings of our earlier inspection visits and also the need to ensure that we achieve coverage of NHS services and settings. We also endeavour to gather information about our previous inspections whilst carrying out other types of inspection within Health Boards; for example, visits connected with the Mental Health Act are also used to gather information about more general organisation wide issues. We do need to include more follow up information so that people can see where improvements have been achieved (or not as the case may be) and HIW will be seeking to put this in place in the New Year”.

FEEDBACK

- *Great organisation. Sign up for their newsletters (Tweet)*
- *Well done for putting on the Preparing for Francis sessions. The experience of Tuesday morning and the evaluation evidence the willingness of staff in the LHB to make things better for patients*
- *I am retiring at Christmas and I'd like to take the opportunity to wish you every success in the future with A Dignified Revolution: the importance of a strong and challenging voice should never be underestimated (Chief Executive, HIW)*
- *Thank you so much for including The Last Six Months in your November newsletter. Many thanks for all the work you are doing to help, support, and bring awareness to so many people*
- *Keep up the good work*

RESOURCES

Advocacy on the Wards Blog

The Older People's Advocacy Alliance (OPAAL) has published a blog to keep people informed about its advocacy on the wards project that is being run in conjunction with Macmillan Cancer Support. [Click here](#) to find out more and to leave a comment.

Equalities Commission launches guide to home care and human rights

[Your rights to home care](#) aims to empower older people by making sure that they know they are entitled to a home care service which respects their human rights, however funded.

Personalisation rough guide goes digital

SCIE's [digital guide to personalisation](#) has been launched in digital format. It is aimed at a wide audience, such as social care workers and personal assistants, as well as trainers and occupational therapists.

Do No Harm

This [book](#) teaches nurses how to avoid becoming the target of a bully, how to address bullying behaviour in the workplace, and how to communicate effectively promoting a nurturing and supportive work environment.

Find your 1%: helping GPs to support people to live and die well

This National End of Life Care programme [resource pack](#) has been developed to be a practical tool to help GPs identify those patients who may be in their last year of life and talk to them about their preferences.

Consequences and Time for Action DVDs

This Action on Elder Abuse pack provides an introduction to the signs of elder abuse and what to do; a useful resource for the busy care home. For further information email enquiries@elderabuse.org.uk

Video aims to address the shocking care of older people

A film documenting the poor standards and care practices in [older people's hospital care](#) in Wales and England has been launched.

Guide to decision-making for people with dementia and their families

The University of Bradford has produced a guide to help people with dementia and their carers with decision making. There is also a short film to help the public and families understand how giving support to people with dementia can often enable them to make decisions. [Click here](#) for more information.

Exploring personal experience of ageing and dementia

Georgie Meadows, a Monmouth based artist and occupational therapist, recently exhibited her work at the Wellcome Trust. [Stitched drawings](#) brings together 20 textile artworks which explore personal experiences of ageing and dementia.

NEWS

Listening and learning: the Ombudsman review of complaint handling by the NHS in England

This Parliamentary & Health Service Ombudsman [report](#) reviews complaint handling in the NHS in the last year. It makes recommendations for strong leadership and embedding good complaint handling at the heart of the NHS as a way of improving patient experience.

Secret Scottish Incident Reports Released

More than [300 reports into the most serious incidents](#) in Scotland's hospitals last year have been published by BBC Scotland.

Quality of care suffering, says regulator

The [quality of services](#) provided to people across the health and care sectors In England is beginning to suffer according to the Care Quality Commission.

CQC takes action at Basildon & Thurrock NHS Foundation Trust

The Care Quality Commission has issued two [warnings demanding immediate improvement](#) at Basildon and Thurrock University Hospitals NHS Foundation Trust.

Addenbrooke's told to get back to basics

Cambridge University Hospitals NHS Foundation Trust is [failing to meet required standards](#) for cancer treatment, referrals from GPs, responding to patient complaints and controlling the deadly MRSA and Clostridium difficile superbugs. Source: Cambridge News.

Leaked report reveals hospital blunders

A leaked Healthcare Inspection Wales report shows that hospital patients are waiting more than 12 hours for beds, others are being left on trolleys for two days and some are being given devastating medical news in public. The [failings were uncovered](#) during a surprise inspection of the emergency care centre at Prince Charles Hospital, Merthyr Tydfil.

Healthcare Inspectorate Wales inspection report on Bronglais General Hospital

Healthcare Inspectorate Wales has published a report following an unannounced Dignity and Essential Care inspection at Bronglais General Hospital. [Click here](#) to access the report.

Healthcare Inspectorate Wales Inspection Report on the University Hospital Llandough

Healthcare Inspectorate Wales has published a report following an unannounced Dignity and Essential Care inspection to Llandough Hospital, part of the Cardiff and Vale University Health Board. [Click here](#) to access the report.

Health Board criticised for the death of a woman at Royal Glamorgan Hospital

Cwm Taf health board, which [failed to act](#) following the results of a blood test from a woman who died of pulmonary embolism may have been able to prevent her death, a damning report has found. Source: Wales Online.

Hospital let Alzheimer's patient walk out to his death

A [man with Alzheimer's drowned](#) in a river after escaping three times from a secure NHS ward at Panteg County Hospital in Gwent. Source: Telegraph

Terminally ill mother left in agony

The daughter of a woman who died of cancer has [criticised the standards of care](#) given to her terminally-ill mum in the last few weeks of her life. Alison Holloway was admitted to the University Hospital of Wales, Cardiff, with severe back and leg pain in April. Source: Wales Online.

Hemel Hempstead nurse kicked 99-year-old patient

A Hertfordshire nurse who [called a 99-year-old patient "evil"](#), kicked him and told him she would spit in his face has been suspended. Source: BBC News.

Patient awoke to find nurse lying on floor in drunken slumber

A patient at a private hospital awoke after an operation to find a [nurse lying on the floor](#) having a drunken nap. Source: Daily Mail.

Woman, 93, left severely dehydrated in hospital

A 93-year-old woman died after she was [left severely dehydrated](#) in hospital for hours despite complaints from her medical lecturer daughter, a Nursing and Midwifery Council hearing heard. Source: Telegraph.

More than 50 hospitals sign up to improve dementia care

55 hospitals have committed to work towards [raising standards of care for patients with dementia](#). The Dementia Action Alliance (DAA) has launched a campaign to make all hospitals across the country dementia-friendly by March 2013.

Million 'dementia friends' wanted for training

The government wants to train a million people in England by 2015 to become [dementia friends](#) able to spot signs of the illness and help sufferers. It is part of plans to raise awareness of the condition, which affects nearly 700,000 people in England. Source: BBC News

1 in 3 diabetes inpatients suffer NHS error

Almost one in three diabetes patients in Wales [suffer NHS error](#), a new report from Diabetes UK Cymru shows. Source: BBC news.

Doctors and Nurses

This [Reform report](#) highlights examples of reforming healthcare workforces in order to improve the quality of care. The case studies demonstrate how to effectively manage and motivate clinicians to deliver better quality services.

Mid Staffordshire Hospital

Francis appoints health policy heavyweights to review recommendations

Robert Francis QC has appointed [four independent experts](#) to help him review the proposed final recommendations of his report following the Mid Staffordshire Foundation Trust Public Inquiry. Source: Health Service Journal.

Former boss of scandal hit Stafford hospital takes new job

[Martin Yeates](#), former chief executive of Mid Staffordshire hospital, who was too ill to give evidence at the Francis inquiry into hundreds of deaths has been given a new management position. Source: Telegraph

Residential Care

More than half care home residents denied basic care

More than half of elderly and disabled people in care homes are being [denied basic health services](#) while staff are failing to do enough to preserve their dignity, according to the Care Quality Commission. Source: Telegraph

EVENTS

RE-LIVE training

Re-Live has scheduled more dates for its training courses

- Introduction to Life Story Work (17-18 January)
- Life Story Work in End of Life Care (22 - 23 January)
- Experiencing Dementia (25 January)

[Click here](#) for more information and details of how to book.

Finally.....

If you have any information that you would like to share with others please let us know and we will be happy to circulate it in the next edition of the newsletter.

Join the mailing list

If you are reading a copy of this email forwarded to you by a colleague we may not have your contact details. If you would like to guarantee a regular monthly copy of the mailing send your details to info@dignifiedrevolution.org.uk

If you would like to unsubscribe email info@dignifiedrevolution.org.uk

A Dignified Revolution

Britannia House

High St

Cowbridge

CF71 7AD

Tel: 07811 159800

info@dignifiedrevolution.org.uk

www.dignifiedrevolution.org.uk