

# Weekly News

Keeping you informed about the latest developments in healthcare



## NHS Staff Given Guidance on Admitting to Clinical Errors



The guidelines from the NMC and GMC will enforce face-to-face apologies from NHS employees when a patient has suffered harm whilst receiving treatment or care from healthcare professionals.

The guidelines, produced by the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC), help implement the statutory Duty of Candour, introduced in October 2014. The Duty of Candour made it unlawful for healthcare professionals to conceal medical or nursing mishaps from patients.

The NMC and GMC have also highlighted the need for apologies to be personal, rather than an organisational written response; a face-to-face apology needs to be made.

Calls for a Duty of Candour law were first made by Patients

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### About Us

The Patients Association's motto is 'Listening to Patients, Speaking up for Change'. This motto is the basis on which we build all our campaigns. Via our Helpline, we capture stories about Healthcare from over thousands of patients, family members and carers every year. We use this knowledge to campaign for real improvements to health and social care services across the UK. In addition, our Helpline provides valuable signposting and information for patients and supports them as they navigate the Healthcare service.

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### Our Helpline

The Patients Association Helpline is here to help.



[helpline@patients-association.com](mailto:helpline@patients-association.com)



0845 608 44 55.

This is a local rate number and if a phone provider charges, we are happy to return calls. The Helpline both informs patients and gathers their views.

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Association president, Sir Robert Francis QC, in his report on the failings of Mid Staffs hospital. The Patients Association welcomes these guidelines and hopes that they can go further to ensure closure for patients who have suffered from errors.

Katherine Murphy, Chief Executive of the Patients Association, said:

*“A face-to-face, heartfelt apology for a patient who has suffered harm, in a healthcare setting, is a crucial step towards their emotional recovery.”*

*“We are well aware of how hard it is for people to be told that an error has caused their suffering. These guidelines should ensure that all patients, in the future, will receive a full explanation of why the error happened and also the apology that they deserve.”*

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### Link Between Nurse Staffing and Patient Safety Proven



A leaked study from NHS England has revealed a statistically significant relationship between 40 indicators of patient safety and the number of on-duty nurses.

The research, conducted at University Hospitals Coventry and Warwickshire NHS Trust, looked at how nurse staffing affected various aspects of patient safety, such as “slips, trips and falls, sickness, blood pressure, respiratory rate and temperature.” The results were conclusive; the number of qualified nurses does affect the welfare of patients.

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### Tweet of the week



Patients Association @PatientsAssoc · 23h

Black and minority ethnic people are short-changed by mental health services - [ow.ly/IOM5R9](https://ow.ly/IOM5R9)

\*\*\*\*\* Health

### & Social Awareness

We support all health and social care awareness campaigns!

This Month

Sickle Cell Awareness

Ethnic Minority Cancer Awareness Group B Strep Awareness

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The news comes in the wake of NHS England taking over from NICE's work on safe staffing- a decision that was criticised by Patients Association president, Sir Robert Francis, who had specifically recommended NICE for this task in his report on the failings at Mid Staffordshire Hospital.

These findings give further weight to the calls for improved staffing in the NHS, and it remains to be seen whether or not NHS England will be able to fulfil this task.

Katherine Murphy, Chief Executive of the Patients Association, said:

*"Understaffing in NHS hospitals is saturating healthcare news columns. But rigorous, statistical analyses such as these are vital for giving specific guidelines about when understaffing starts to harm patients."*

*"Hopefully NHS England will continue this evidence-based and analytical approach and provide guidelines to uphold patient safety."*

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## EXPERTS CALL FOR GREATER ACCESS TO TEST THAT COULD SAVE THE NHS MILLIONS



New report details the most effective and efficient ways to implement point of care (POC) C-reactive protein (CRP) testing to reduce antibiotic prescriptions and to save the NHS millions.

A multidisciplinary panel of leading of experts have today called for an effective and efficient means to implement point of care (POC) C-

reactive protein (CRP) testing in the NHS. This call to action was encompassed in the 'Straight to the Point - Ensuring the Rational Use of Antibiotics in Primary Care A Consensus Report', which makes suggestions on how testing will help the NHS meet the challenges posed by antimicrobial resistance (AMR).

Today's report concludes that POC CRP testing can reduce antibiotic prescriptions by up to 10 million each year, saving the NHS £56 million a year in prescription and dispensing costs alone. These conclusions were formulated from previous research which revealed that POC CRP testing can reduce antibiotic prescribing for respiratory tract infection (RTI) in primary care by up to 41.5%. Despite the findings that POC CRP testing reduces inappropriate and unnecessary antibiotic prescribing in primary care, an important driver of AMR and that POC CRP testing is widely used within a variety of European Countries such as Sweden and the Netherlands who have lower rates of antibiotic usage than the UK, the UK continues to limit its use of the testing method.

Katherine Murphy, Chief Executive of the Patients Association said today:

*"The Patients Association welcomes these new findings. POC CRP testing is a cost effective method which reduces the level of antibiotic prescribing. The report from these findings will provide clinicians with additional diagnostic information to help them make crucial antibiotic prescribing decisions, especially where there are high levels of diagnostic and prognostic doubt. The Patients Association will continue to support the implementing of this testing method, a treatment process which can save the NHS £56 million a year, reduce the number of antibiotic prescriptions by up to 10 million each year and enhance patient safety can only be a positive step for our NHS."*

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## **Black and Minority Ethnic People Given Inadequate Mental Health Care**



A body of research, from the Race Equality Foundation, the Care Quality Commission (CQC) and the Guardian, suggests that Black and Minority Ethnic (BME) people are often being sold short by mental health services.

People from some BME backgrounds are often reliant on emergency care, with mental health services focusing on short-term fixes, rather than long-term continuous care. Crisis care is an inadequate means to deal with mental health conditions and several services need to be working together to achieve effective treatment; as well as A&E services, social services to monitor a patient's health and benefit services to ensure that people with mental health disabilities stay in housing are essential.

The findings from the Guardian and the CQC also suggest that the patients feel unable to complain about their care as they do not believe that it would result in any change. Poor complaints handling is an issue that the Patients Association is currently dealing with and we will soon be publishing a report from The All Party Parliamentary Group for Patient and Public Involvement in Health and Social Care, an inquiry into complaints handling in the NHS and social care sector.

Katherine Murphy, Chief Executive of the Patients Association, said:

*“Any news of discrimination in care is unacceptable and it is a matter that the Patients Association greatly condemns.”*

*“Crisis care is merely a patch-up where the treatment of mental health is concerned and more needs to be done to ensure that all*

*people suffering from mental health conditions receive the continuous care that they require.”*

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## Patient Stories



This is a new section for our newsletter where we will be featuring real patient stories. If there is a story about you or your loved one's experiences with the health and social care system, which you would like featured, please contact us at [weeklynews@patients-association.com](mailto:weeklynews@patients-association.com)

**Ms L J in a personal capacity as former carer for my partner Alan who died on 29 June 2013**

Our story concerns

- Prescribing of opioids for older people with dementia without appropriate supervision and monitoring by GPs
- Inadequate record keeping and sharing between agencies and lack of a proper system for placing of alerts/warnings in medical notes
- No system to capture vitally important information for future learning/policies

My partner Alan was living well with dementia in 2012 (aged 87) until he developed severe back pain. I have no medical training and offer the following sequence of events as evidence for the points above:

Alan is prescribed Codydramol on 12 July 2012 and then Butrans patches which are quickly increased from 5mg to 10mg without close supervision and monitoring by the GPs (which I later discover should have been standard practice for someone of Alan's age and condition). I, as Alan's carer, am also not made aware of a) that these are opioids and b) what side effects to watch out for.

Within 2 weeks Alan has become first restless and agitated, then distressed and paranoid, literally running away in fear despite being physically exhausted through lack of sleep. I have to involve the police twice to bring him home.

By 26 July 2012 he is admitted to the local mental health assessment unit and sectioned at the weekend because, there being no consultant available to give the instruction to remove the Butrans patches until Monday, Alan continues in his psychotic state and tries to climb out of the unit to escape!

Alan never once exhibited this kind of behaviour before he was given opioids and returned to his 'normal' self/behaviour after these left his system and he returned home on 10 August. But the story does not end there – I discover after his death that the information regarding Alan's severe psychotic reaction to opioids is not relayed from the hospital to the GP surgery and no warning is placed in his medical notes.

This has catastrophic results for us since Alan's back pain reappears in December when he is again prescribed opioids, this time Dihydrocodeine, despite me questioning this with the GP and at that point still assuming a warning was put on his medical notes. Alan predictably develops psychotic symptoms and I walk with him to the GP surgery for help and query the lack of warning in the notes, imploring the GP to rectify this immediately. But the opioid has entered his system so Alan starts running away again. By now he is much frailer and has a serious fall, which results in a head injury.

6 miserable months later Alan is dead. Again, after his death I discover that no warning was placed in Alan's notes regarding his serious reaction to opioids even after I implored the GP to do so! I make a complaint to the surgery about the above issues to ensure they can learn from the experience, improve record keeping and pass on the issues about opioid sensitivity to the rest of the NHS but find I am stonewalled.

I take up the issues with the Senior Commissioning Manager for Medicines Management & Primary Care at the local CCG only to discover that the only 'system' there is for capturing the opioid

problem is via the 'yellow card' which is, as I understand it, a procedure for capturing side effects of drugs.

I, as a mere patient/carer, have no means of influencing decisions about when yellow cards are used or of even finding out whether there have been hundreds or thousands of yellow cards relating to opioid use with dementia patients (or none) – what I did find out was that no general monitoring of these potent and potentially dangerous drugs appears to exist for this patient group (whereas quite a lot of research and warnings exist for drug users).

Given that the increase in dementia is well anticipated, and reluctance to use opioids based on clinical experience was expressed to me by the consultant, isn't it time we developed a more reliable and effective system for monitoring whether opioids do induce psychotic states in dementia patients to prevent further experiences like ours?

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## Consultations

**The National Institute of Health and Care Excellence (NICE) are now consulting on: "Transition between inpatient hospital settings and community or care home settings for adults with social care needs: draft guideline consultation"**

[Link to the Consultation here.](#)

This guideline covers all adults with identified social care needs, including older people. It does not include children and young people. It covers transitions between general hospital and community or care home settings. It does not include inpatient mental health settings. A separate NICE guideline on transitions between inpatient mental health settings and community and care home settings is being developed.

The Patients Association are preparing a response and invite our readers to give their view. Please send your comments

to [dipen@patients-association.com](mailto:dipen@patients-association.com) by Monday 3<sup>rd</sup> August 2015.

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