THE CONSULTANT

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HOT DEBATE
DO WE CARE FOR OUR ELDERLY?

NHS ON THE BRINK OF FINANCIAL COLLAPSE

THE NEED FOR RESILIENT CULTURES
PARTICULARLY IN TIMES OF UNCERTAINTY FOR HEALTH SERVICES

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Editor's Introduction

Welcome to this eleventh edition of The Consultant. I do hope that you are continuing to find the content stimulating and thought-provoking. We love to get direct feedback and when we do it is always shared across the editorial and production team.

This edition features a diverse range of articles designed to inform and stimulate discussion. For example, this month's Hot Debate focuses on a topic which perhaps does not receive the attention it truly warrants: the care of the elderly, particularly those suffering with dementia. We are aware of a vast amount of conflicting opinion out there around this topic and therefore I am particularly keen to receive direct feedback,comment and opinions,some of which will be published in next month's edition.

Elsewhere, we showcase the importance to organisations of having resilient workplace cultures during a time of great uncertainty for healthcare services, new acne treatment techniques for treating inflammatory and non-inflammatory are put under the microscope, and improvements to stroke pathways is the latest article from our regular contributor, Dr Steve Allder.

We hope you enjoy looking through this edition.

Yours faithfully

Dr Sara L Watkin
Editor-in-Chief

In This Issue...

FEEDBACK

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Plan to cap elderly care costs set to be announced by Cameron

A plan to help thousands of elderly people who struggle to pay for care bills is soon to be announced by David Cameron.

The plan - a cap on care home costs to prevent older people from having to sell their homes to pay for care bills - will cost the Government £1.7 billion a year.

The move to introduce an upper limit on care home costs is in response to the 2011 Dilnot Commission which recommended that care bills should be capped at £35,000, with the Government providing costs in excess of that level.

Despite Health Secretary Andrew Lansleyand Chancellor George Osborne previously saying that money may not be available to pay for the reforms, Mr Cameron has confirmed that funding will be found.

Michelle Mitchell, Charity Director General of Age UK, said: "This is really encouraging news.

"If the Government puts a £35,000 cap on lifetime care costs, it would be a real leap forward for many older people, lifting them and their families out of the fear caused by spiralling care costs.

"It would be a courageous and compassionate legacy that could help transform our social care system."

Jo Webber, NHS Confederation deputy policy director, added:"We are extremely encouraged by reports that the Government is taking action to tackle the issue of social care funding.

"Our current model of social care is broken and we desperately need a long-term, sustainable resolution if we are to avoid further detrimental impact on local government and NHS services. As part of this we need firm, affordable and coherent decisions about funding.

"We need to address this issue now or risk paying the price further down the line."

A cap on care home costs would come into effect after the next election in 2015.

Diabetes prescriptions rise 50% in six years

The increasing cost of diabetes drugs to the NHS has been highlighted once again with the release of new figures this week which show that prescriptions for diabetics have topped 40 million in year - a rise of nearly 50%compared to six years ago.

The net cost of diabetes drugs also rose by just under 50% in the same period, according to the Health and Social Care Information Centre (HSCIC) report - Prescribing for Diabetes in England: 2005/06 to 2011/12.

The report, which focuses on primary care, shows that while the overall cost of all drugs to the NHS fell last year by just over 1%, the diabetes drugs bill increased by nearly 5%.

HSCIC Chief Executive Tim Straughan said: "Our figures show diabetes is having a growing impact on prescribing in a very obvious way – from the amount of prescriptions dispensed to patients in primary care to the annual drugs bill costs to the NHS."

Barbara Young, Chief Executive of Diabetes UK, said:"This report shows that spending on diabetes-related medicines is rising and one of the main reasons for this increase is that there are now more people with diabetes. About 2.5 million people in England have been diagnosed with the condition and the number of people with diabetes is expected to reach 4.2 million in England by 2025. We face the real possibility of diabetes bankrupting the NHS within a generation."

The report can be accessed at: http://www.ic.nhs.uk/pubs/prescribingdiabetes0512

Three candidates for Deputy Chair announced by BMA

Fay Wilson

Kailash Chand

Tom Dolphin

Three candidates have thrown their hats into the ring in a bid to become the Deputy Chair of the BMA Council.

The candidates are Cheshire retired GP Kailash Chand, London specialty trainee 6 in anaesthesia Tom Dolphin, and Birmingham GP Fay Wilson.

Dr Chand said: "The NHS and the BMA are both in for an unprecedented change in the coming years. I have a strong understanding of the challenges facing the NHS in the next decade, and I am able to devote my time to promoting policies agreed by UK council, both within the BMA but also externally."

Dr Dolphin said: "I believe that the chair of council needs a strong deputy who can provide support and advice, and stand in when required on any issue.The deputy chair role requires energy, imagination, calm and tact, and I have all of these to offer in the service of the BMA, and more."

Dr Wilson said: "I'm hard-working, flexible and have decks cleared for action. I will fill gaps and bridge divides, stand in and stand up, chair meetings and table papers, speak up and speak out.My vision is for the BMA to work better, be stronger and achieve more."

BMA Council members have until 12 noon on 31 August to vote for their preferred candidate.

The use of fixed-combination acne treatments for inflammatory and noninflammatory lesions

John Notabartolo, MPAS,PA-C
Woodson Dermatology, Inc, Las Vegas, NV

Abstract
Fixed-combination therapy in acne is standard of care. Complementary mechanisms of action provide maximum efficacy against both inflammatory and noninflammatory acne lesions leading to greater lesion reduction and a faster response rate. Topical retinoids are commonly used as monotherapy for mild acne and as part of a combination regimen for moderate to severe acne. Their use is limited by the potential for cutaneous irritation: skin dryness, erythema, stinging, and pruritus.

Topical retinoids are recommended in combination with antimicrobials for moderate to severe acne. Both clindamycin and erythromycin are commonly used in fixed combination with benzoyl peroxide (BPO) to reduce the risk of antibiotic resistance. BPO has the added benefit of being comedolytic, but like topical retinoids, BPO may cause skin irritation, burning, erythema, and peeling.

While combination therapy is the most effective way to treat acne, managing side effects when active ingredients cause irritation and dryness can be a challenge. Optimizing outcomes whilst minimizing side effects can be achieved through careful product selection, dose titration, and tailoring an application regimen to the patient.

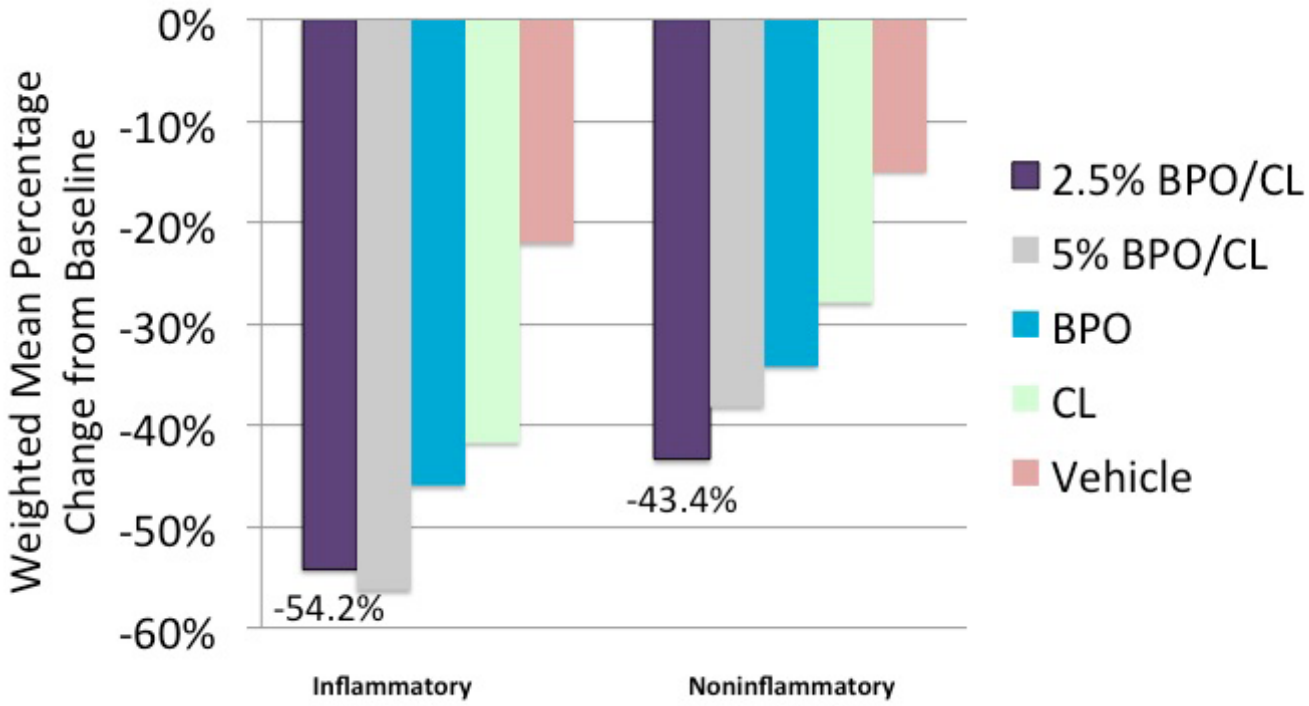
This review compares the data on three widely used fixed combination products to assess their relative efficacy in inflammatory and noninflammatory lesions and their irritancy potential.

Fixed-combination products containing benzoyl peroxide (BPO) are the most widely used treatments of acne vulgaris in clinical practice today.1-2BPO-containing products are rapidly bactericidal and reduce development of antibiotic-resistant bacteria.4 However, BPOis limited by its concentration-dependent dryness and irritation that may impact patient compliance and limit product use.5These side effects can be particularly bothersome, causing patients to reduce use or even stop the medication altogether.6 Given that adherence to topical therapy is consistently poor, particularly in teenage acne patients, and frequent 'call backs' with complaints of dryness, the selection of less irritating treatments or treatment regimens aimed at minimizing side effects is a desirable option.6

One possible option is to use a BPO fixed-combination with a lower concentration of BPO. It is widely reported thata significantly greater frequency and severity of burning, erythema, and peeling occurs in patients who used topical formulations containing 10% BPO compared with those who used a 2.5% BPO.7

Fixed-combination clindamycin-BPO products with 5% BPO have been shown to be moderately irritating in a cumulative irritation study.5In an Internet survey of subjects, aged 15-40 years who had used a clindamycin-5% BPO fixed-combination product in the last six months some degree of dryness and irritation occurred in nearly all the subject.6 These side effects were considered bothersome in the majority of subjects, with a third (34%) reporting severe dry skin.

There may be concern among clinicians that using a lower concentration of BPO might reduce efficacy, however, it has been previously reported that 2.5% BPO may be as effective as 5% or 10% BPO in reducing the number of inflammatory lesions of acne.7An in vitro percutaneous-penetration study showed that clindamycin phosphate 1.2%-BPO 2.5% achieved comparable skin penetration of BPO to clindamycin-BPO fixed-combinations containing 5% BPO following a single application, although the clinical significance was unknown.8
A more recent study compared the BPO skin penetration of clindamycin phosphate 1.2%-BPO 2.5% (Acanya® Gel) to clindamycin-BPO 5% (Duac®) and an alternative fixed-combination containing a low dose of BPO

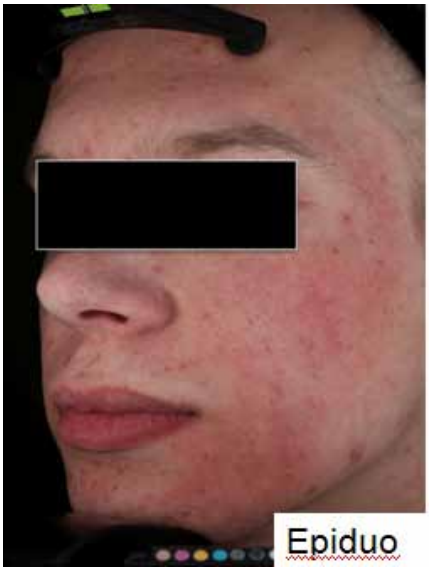


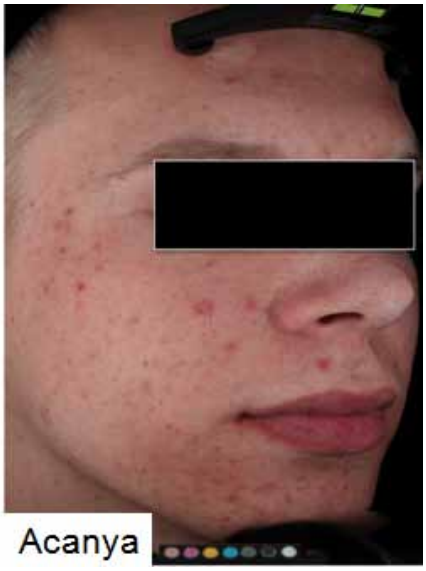
(adapalene 0.1% – BPO 2.5% [Epiduo®]) and found all three products achieved comparable skin penetration over 24 hours, although clindamycin phosphate 1.2%-BPO 2.5% was more efficient (Jason Olin, personal communication).

Efficacy of fixed-combinations in acne

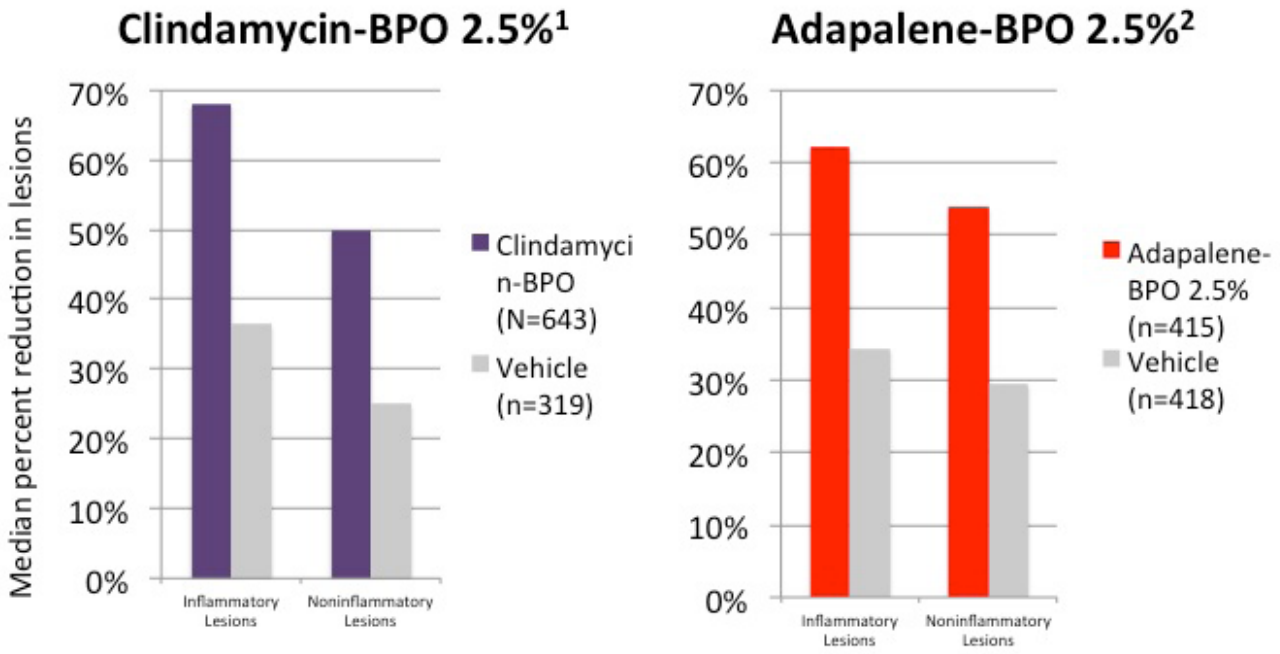
There being no randomized controlled trials comparing the most widely used fixed-combinations, a recent meta-analysis of 16 RCTs in 5737 subjects sort to compare the efficacy of fixed combinations containing clindamycin-BPO 5% with clindamycin phosphate 1.2%-BPO 2.5% gel (FIGURE 1).16The authors concluded that clindamycin phosphate 1.2%-BPO 2.5% gel was comparable to other topical products containing clindamycin-BPO 5% in reducing lesion counts and the percent reduction in noninflammatory lesions with clindamycin phosphate 1.2%-BPO 2.5% gel was statistically greater than with any of the other treatments.16 Indeed, it is worth noting that five clinical studies Duac®have not adequately demonstrated the effectiveness of Duac® versus BPO in the treatment of noninflammatory lesions.

Adapalene 0.1% – BPO 2.5% was studied in a large multi-center RCT in 1668 patients with moderate acne.9 Adapalene 0.1% – BPO 2.5% was significantly more effective than adapalene and BPO monotherapy and vehicle in reducing inflammatory and noninflammatory lesions (P≤.017). From baseline to week 12 subjects treated with adapalene 0.1% – BPO 2.5% showed a median reduction of 62.1% in inflammatory counts compared with 50.0%, 55.6%, and 34.3% with adapalenemonotherapy, BPO monotherapy, and vehicle, respectively. From baseline to week 12 subjects treated with adapalene 0.1% – BPO 2.5% showed a median reduction of 53.8% in noninflammatory lesion counts compared with 49.1%, 44.1%, and 29.5% with adapalenemonotherapy, BPO monotherapy, and vehicle, respectively.





While not directly comparable, a subpopulation analysis of clindamycin phosphate 1.2%-BPO 2.5% efficacy in 2282 subjects with moderate acne showed similar results (FIGURE 2).10Clindamycin phosphate 1.2%-BPO 2.5% was significantly more effective than clindamycin and BPO monotherapy and vehicle in reducing inflammatory and noninflammatory lesions (P≤.001). From baseline to week 12 subjects treated with clindamycin phosphate 1.2%-BPO 2.5% showed a median reduction of 68.0% in inflammatory counts compared with 55.6%, 57.7%, and 36.4% with clindamycinmonotherapy,BPOmonotherapy,



1.Efficacy and tolerability of a fixed combination of clindamycin phosphate (1.2%) and low concentration benzoyl peroxide (2.%) aqueous gel in moderate or severe acne subpopulations. Webster G et al JDD 2009; 8(8):736-743.
2. A North American Study of adapalene –benzoyl peroxide combination in the treatment of acne. Stein Gold L et al Cutis 2009;84:110-116

and vehicle, respectively. From baseline to week 12 subjects treated with clindamycin phosphate 1.2%-BPO 2.5% showed a median reduction of 50.0% in noninflammatory lesion counts compared with 41.3%, 43.6%, and 25.0% with clindamycinmonotherapy, BPO monotherapy, and vehicle, respectively.

Tolerability of fixed-combinations in acne

It can be a challenge to combine multiple therapies that are each potentiallyirritating. The concentration-dependent dryness and irritation of BPO, and potential solutions has already been discussed. Topical retinoids are also irritating to the skin with the most common adverse effects being dryness, erythema, stinging, and pruritis.11Irritation, especially over the first few weeks of treatment can be a limiting factor for treatment adherence in many patients.12 As a result, it is generally recommended to start at a low strength and increase as needed to minimize the potential for irritation.13This dose-titration is much harder to manage with a fixed-combination where you may expect the potential to cause dryness and irritation additive. Indeed, in the large RCT, Signs and symptoms of local tolerability were observed, mainly within the first 2 weeks of treatment, with greater incidence in the adapalene-BPO combination gel group compared with the adapalenemonotherapy, BPO monotherapy, or vehicle groups. However, most signs and symptoms were transient,occurred early in the treatment course, and were mild to moderate in severity.9

A comparative evaluation of irritation potential and the likelihood to continue use of clindamycin 1%-BPO 2.5% and adapalene 0.1% - BPO 2.5% once daily application was recently conducted in a split-face study over 14-day treatment period in 21 acne subjects ≥ 18 years old.14At study end 86% subjects treated with clindamycin 1% - BPO 2.5% reported no or only mild erythema compared to 62% with adapalene 0.1% - BPO 2.5% (FIGURE 3). No severe erythema was reported with clindamycin 1% - BPO 2.5%. Adapalene 0.1% - BPO 2.5% treatment was prematurely discontinued due to severe erythema in two subjects and two continuing subjects reported severe erythema on Day 14.Subjects' preference and likelihood of continued usage was greater withclindamycin 1% - BPO 2.5%.14

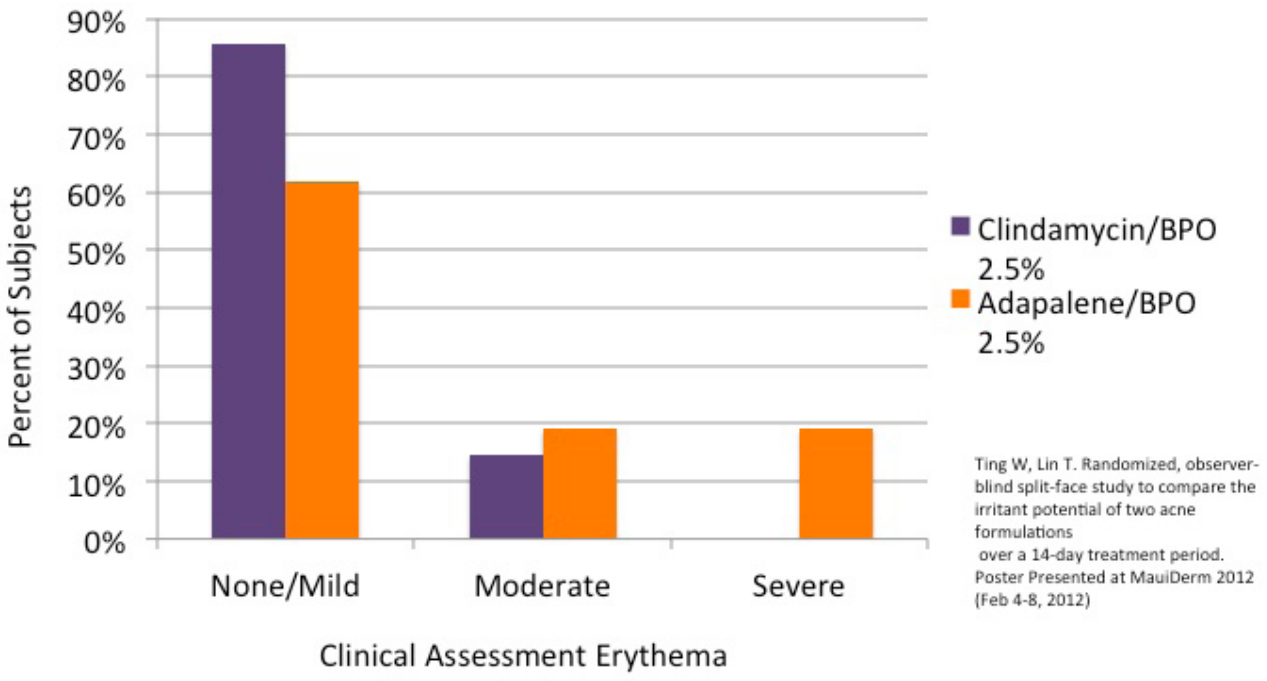
Use of fixed-combinations in acne

Fixed-combination therapy in acne is the standard of care, targeting the major pathogenic factors in its development.15,16

Currently, two fixed-combination products are available that combine a low concentration of BPO (2.5%) with either clindamycin or adapalene. Theirefficacy in treating acne has been demonstrated through large pivotal studies.9,10 In separate RCTs, clindamycin 1% - BPO 2.5% and adapalene 0.1% - BPO 2.5% showed similar efficacy in reducing both inflammatory and noninflammatory lesions in moderate acne sufferers.9,10

With treatment efficacy now well established, we must address a number of additional factors that will influence treatment success, the most critical being compliance. The characteristics of a selected treatment (e.g. tolerability profiles, dosing, and vehicle) can have a profound effect on a patients'adherence to a treatment plan. In addition, achieving continued good compliance in patientswith acne can be difficult both because of prolonged topical therapy and the primarydemographic.17,18

It is important that patients see improvements within the first two weeks of



treatment initiation and further, irritation, especially over these first few weeks, can be a limiting factor for treatment adherence in many patients.12 Simple once-daily dosing regimen, excellent tolerability and high levels of subject satisfaction willencourage treatment adherence and lead to more effective acne resolution.

ACKNOWLEDGEMENT

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THE HOT DEBATE

Stimulating open discussion

The Hot Debate is set to be just that – heated. Each month we'll pick a topic that warrants further open discussion because controversy remains.

We'll see to it that a variety of views are included in the interests of editorial openness and neutrality. We may provide comment, we may even get involved but ultimately, we think it's healthy that thoughts and feelings from all sides are shared and not hidden simply because they may or may not conflict with your own. However, it's also important to realise that just because we are publishing a viewpoint it doesn't mean we share it or indeed disagree with it either. We're simply putting it 'out there' for the benefit of debate.

In the interests of furthering debate, we're going to invite comment in two forms. Each debate will have a debate question or questions designed to gauge your feelings. We'll report the findings in the subsequent month. Additionally, we'd like you to submit comments in a 'Twitter-like' form of up to 50 words and we'll publish a selection of the best ones.

The August Debate

Do we care for our elderly?

It is said that one of the hallmarks of a civilised society is how we care for those in need, such as the disabled, the vulnerable, and the elderly.

With the costs of caring for the elderly continuing to soar, new strategies are desperately required to ease the burden on healthcare services and provide a more joined up approach to care between the NHS, local authorities, the voluntary sector, emergency services, and government organisations.

Providing an insight this month into the possible shape of things to come are two well respected voices in the field of elderly care: Dr Ian Donald, from the British Geriatrics Society, and Professor June Andrews, from the Dementia Services Development Centre.

At a time of considerable financial austerity for the NHS, we ask where the priorities should be for elderly care and just why it is so important to promote good practice – for both the patient and for healthcare services.

Sara Watkin
Editor-in-Chief

Next Debate

What topics would you like to see?
topics@theconsultantjournal.co.uk

"Older people are losing out"

Will constant failures over elderly care result in a reshaping of our healthcare systems?

The British Geriatrics Society is committed to improving the quality of care that is received by the UK's growing number of older people – an improvement in life experience as well as care experience. One of the Society's key spokespersons is Dr Ian Donald, an expert in older people's health and a man with strong views concerning the lack of interest officialdom appears to have in elderly care and the reasons for such apathy. In the second part of this month's Hot Debate, Dr Donald tells The Consultant in blunt fashion that the healthcare system, as it currently stands, is comprehensively failing to look after the needs of our elderly population.

Interview by Fraser Tennant

The Consultant: Are elderly people in the UK being failed by the healthcare system?

Dr Ian Donald: I think the healthcare system is doing the best it can, but we struggle, don't we, from one crisis to the next. The failure we're seeing as geriatricians across the country is that we haven't really reshaped healthcare for the needs of frail, older people. This is the message of the British Geriatrics Society. We get people coming in (to hospital) with relatively minor events, but they're not supported and haven't got anywhere else to turn at home. They're not being supported either because people don't perceive their needs as being critical at home, or they may already perceive their needs as important but the home help that goes in fails to be the sort of support that someone who's frail actually needs. A frail person has crises, and not necessarily at the time the home help happens to be calling. We haven't got a good system, we feel, for providing quite vulnerable people with more wraparound support, day and night.

Is it possible to quantify the extent of the problem?

I think we can quantify it by the number of emergency admissions to hospitals, where the illness level really wasn't that high and some hospitals just turn these people round on admission, sometimes in the middle of the night. They come in for a few days and then go back home again. But all of these episodes are a disruption to such people. We can quantify how often those people come to hospital, but we probably don't capture those numbers as well as we should. Beyond that, how much are we failing the wider group that don't necessarily come into hospital but, at any one time, are just on the edge, are not really getting enough help and their families are saying help, they're really worried about mum. That's probably very large. I think we need to see an emphasis again on preventive care. So the squeeze of funding on social care has meant that the lower levels of need are not being met and the lower levels are often the

Dr Ian Donald

preventive stuff. Most social services officers that I speak to feel they have to ignore the preventives because they've only got the resources to deal with the urgents. So we need to somehow find a way of addressing the preventive lower level. Some Councils around the country believe that they can

do so by having an immediate response to every sort of need. I know the Minister for Social Care thinks it's all about how canny and well-organised a social services department is.

How have the recommendations made in the Dilnot Report* been received?

They've gone down with age charities and with social services very well indeed. There are some people who think it's too generous to the rich, but generally social services directors have supported it, and the British Geriatrics Society has been strongly supportive of Dilnot.

What impact are healthcare austerity measures going to have on elderly care given that provision for this kind of care doesn't get a great look-in anyway?

Yes. One of the main impacts is the need to try to shorten, if at all possible, the length of time people are in hospital, and that means that people are turned around without all their needs being met, just to come back in again three weeks later because they haven't really sorted out the fundamentals. I think that is happening increasingly and so that means increasing re-admissions. In other places, and it does vary across the country, geriatricians are saying that there are loads of people stuck in hospital. There is still this thing of bed blocking, if you like. If you've got a lot of people in hospital waiting for their home help to be organised, that then causes pressure on the whole system, and so impacts on other people. So there's kind of an inequity around. You could argue that it is, potentially, a problem trying to be equitable. But in some parts of the country, it's dominated by being discharged too quickly.

What would be your ideal scenario?

I think we're increasingly coming to a consensus that the ideal pathway is that a specialist in frail old people sees the person within six to twelve hours of them pitching up at the acute hospital - so that they're assessed for their needs and then you can determine, at that point, whether the person is best served by staying in hospital or by a community support programme. The other half we need, which is very patchy and slow to develop, is the medical healthcare of frail elderly people at home. At the moment we rely on the GP and various other therapists and re-ablement schemes. I think we have realised now that re-ablement schemes and GPs are not too keen on looking after frail old people. When older people have a crisis, they need something more. There are emerging a few places around the country where the really good assessment in casualties and assessing in hospital has another arm in the community. This means that, whether the person goes to a community assessment scheme or whether they pitch up at the hospital, the hospital

can say, actually, we don't need this person in hospital but we will link our community other half and enable these people to be supported, but not just in a social care way. But these people are old and frail, have a whole lot of diseases and, when they have a crisis, they aren't ill but their illness is best served probably by not being in hospital, but with a bit more medical care at home, with much less disruption to the routine.

What would be the preference? Presumably it's home care?

It's staying at home, definitely, yes. There are a few examples now, such as in Leicester and Leeds where this model is going really well. Birmingham has developed it in part and Gwent has made a huge investment developing this sort of style of care. So it is emerging. I think it's going to be the dominant force.

Despite these examples, is it fair to say that we are becoming an increasingly uncaring society?

Do I think that's fair? I think that there's not much sign that health and social care is prepared to redesign the whole shooting match around the needs of older people and yet they are the biggest consumers of health and social care. They are still thinking mainly around the heroics for cancer and heart. So I think older people are losing out. Does anyone care? They seem to care when they watch Panorama programmes, but it doesn't really translate. This care hasn't yet translated into money being spent by social care and health care authorities, specifically on old people and on dementia. People seem to have the gut feeling of wanting to support older people, but their purse is not following.

In addition to his role at the British Geriatrics Society (www.bgs.org.uk), Dr Ian Donald is also Consultant Physician for Older People at Gloucester Royal Hospital. His main research interests are the epidemiology of disability in older people, falling, and intermediate care.

*The Commission on Funding of Care and Support, chaired by Andrew Dilnot, published Fairer Care Funding (the Dilnot Report) on 4 July 2011. The independent commission was set up by the Government with a brief to recommend a fair and sustainable funding system for adult social care in England. The report can be accessed at:

http://www.dilnotcommission.dh.gov.uk/our-report/

Dealing with Dementia - the "perfect storm"

Systems change is the key to improving dementia care and providing support for carers

Interview by Fraser Tennant

A recognised leader in the world wide movement to improve services for people with Dementia and their carers, Professor June Andrews, Director of the Dementia Services Development Centre (DSDC) at the University of Stirling, has called for a revolution in the way we deal with dementia, an illness that cost the UK a mind boggling £28 billion over the last year alone. Working as part of Scotland's National Dementia Strategy which is committed to meeting the challenge of an ever increasing number of people with the illness, Professor Andrews strives to improve public awareness of dementia, bolster innovation, and influence policy and systems change.

As part of its focus on the standards of elderly care in the UK, The Consultant contacted Professor Andrews at the DSDC offices and asked her if she could contextualise the extent of the dementia issue…

Professor June Andrews (PJA): There are 800 thousand people with dementia in the UK which cost £28 billion pounds last year. Because of the devolved nature of the UK, there are four health departments, Scotland, England, Wales and Northern Ireland, and each of those countries has a dementia strategy which includes basic issues such as early diagnosis, increasing public awareness and improving the knowledge of health and social care staff of how to look after people with dementia. In both financial and policy terms, it's huge, but this is the same all across the developed world, because the number of people with dementia will double in the coming years. It's increasing more rapidly in the developing world because it's a disease of old age and, as the population has aged, the number of people affected by dementia has increased.

What impact will healthcare austerity measures have on the quality of dementia care we are likely to see in the future?

PJA: We have a perfect storm brewing which is an aging population, meaning an increasing number of people with dementia, a reduced public purse, a reduced value of people's individual savings plans for their old age, and an increased public and personal desire for people who want to stay at home for as long as possible. All of this is crashing together at the same time. The most important thing that can be done for dementia is that unacceptable or unnecessary expenditure should be cut. The commonest unnecessary expenditure is an unnecessary or extended hospital stay as a result of their medical condition being complicated by poor management of their dementia.

Professor June Andrews

How do the different strategies employed by the separate administrations compare?

PJA: The strategies are very similar, but the method of implementation varies between countries. In Scotland, a key point of the strategy for increasing the number of people with a diagnosis, which has been strategy that exists in all four countries, is that it was set as target for health boards. They had to increase by 30% over three years the number of people with a diagnosis. And, because all the health boards met those targets, Scotland is one of the parts of the UK where you are most likely to have your dementia diagnosed. On the other hand,

England is where you are least likely to have your dementia diagnosed. The number of people with dementia in each developed country is the same as a percentage of the population, but the difference is that some of the people who have dementia have been formally given a diagnosis and some haven't. In Scotland, you've got about a 50% chance of having your diagnosis. In England, you've got less than 50%.

How do you explain that?

PJA: The biggest significant difference between the two countries is that Scotland set diagnosis as a target that the health boards had to meet. Although there has been general encouragement in England, there has never actually been a target set. In all four administrations there is that quality and outcomes framework, financial benefit for GPs in putting people on the dementia register and so the financial thing has been sorted out by GPs. This provided an incentive to sort out their populations. However, research has shown that some GPs think that a diagnosis means that there is nothing you can do. Once you have a diagnosis, they're giving someone bad news for no benefit. Now that's wrong but, because they believe that, it means that the person with dementia is excluded from moving down the pathway towards a diagnosis.

What are the options?

PJA: The fact that general practitioners think there's nothing that can be done is a matter of ignorance on their part because there's a lot that can be done. There's medication, the person can be advised on health maintenance issues. There are support services in the community, both in the charitable sector and in other sectors, which can be offered to the person with dementia. Having a carer living with you at home gives you 24 hour protection against institutionalisation and special support can be offered to carers in order to reduce this likelihood. It can either be a personal cost to the family or a cost to the local authority. All of these things are possible. It's a human right to be given information about your health status if someone else has access to it.

Do we need a fresh approach to dementia care?

PJA: The most important thing that could happen would be that the public are aware of it, that the health care professionals who are in the front line, like GPs, know what to do about it, and also felt that there was some point in doing something about it. It is also important to increase the number of people who are able to facilitate a diagnosis of dementia. A lot of pathways require the person concerned to be seen by a psychiatrist for complex cases, which is really important, but in many instances, a huge amount of triage could be done by teams including dementia specialist nurses.

How high is public understanding of dementia?

PJA: Public awareness of dementia is very high but attitudes towards it are very negative. A recent survey showed that when people were asked whether they would prefer to be diagnosed with cancer or dementia, the preference was cancer. The rationale behind that is that people feel that although cancer is a very dangerous and difficult disease, there is something that can be done. With dementia, there is a sense that not much that can be done. In addition, there's a difference between age range of people and how they feel about it. Older people are more phlegmatic about it, younger people, particularly people in the 50 to 65 age group, have a horror of dementia and so these things are framing our understanding of dementia and are interesting sociological questions. But the only thing that is unforgivable is if you have healthcare staff who are the gatekeepers, who properly care for dementia but who pretend that it doesn't exist, or they ignore it, or they consider that it's only age, or they assume that there's no point in engaging with it, or don't know how to stop the early

stages of it. Because they're condemning the person with dementia to be subject to all sorts of accidents and adverse incidents that will stop their life or, at the very least, affect their lives in deeply unpleasant and unnecessary ways.

The media tends to represent the condition in emotive ways such as the case of the Aberdeen woman who complained that her husband had been seen by 106 carers in the year prior to his death. Presumably this is not typical?

PJA: When you consider that he, Mr Ken Maitland, was having two carers four times a day, seven days a week for 365 days of the year, you would need a fairly large team in order to be able to cover that amount of care. Given that there are very many people that are receiving that amount of care and when you consider time off for holidays, sickness, study leave and other absences, you will have very large teams of people being involved. In his case, it was unexpectedly high, but it's not been outlined because it is the most extreme story, it's out been outlined because it's the best recorded and described story. Mr Maitland's wife was very gracious about the quality of care that was received, she just was puzzled and felt able to express her puzzlement about healthcare systems not being organised well enough to allow a smaller number of people to be involved.

How does dementia care in the UK sit in a global context?

PJA: The World Health Organisation has just included it in their list of chronic conditions that they're paying particular attention to. The management of dementia is more advanced in the developed world than the developing world, because it's more prevalent in the developed world at the moment, because of the age of our population. The management of it in different countries is improving by leaps and bounds in a variety of areas. Unfortunately, this new global interest in dementia is coming at the same time as a global recession, so it's a bugger when a topic only becomes noticed at a time when we haven't got any money to spend on it. But the positive thing about it is that doing dementia care badly costs more than doing it well. You can save money by just having some education in this area.

Professor Andrews has considerable experience in the management of change in health services, having overseen the Centre for Change and Innovation in the Scottish Executive Health Department for three years. In her current role as Director of the DSDC, Professor Andrews applies these skills across a number of sectors in the care of people with dementia, including the health, social services, private and voluntary bodies who provide care. Professor Andrews is also a former trade union leader and NHS manager.

www.dementia.stir.ac.uk

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The best and most beautiful things of this world can't be seen or touched - they must be felt by the heart

When an old man died in the geriatric ward of a nursing home in an Australian country town, it was believed that he had nothing left of any value. But later, when nurses went through his meagre possessions, they found this poem. Its quality and content so impressed the staff that copies were made and distributed to every nurse in the hospital.

Cranky Old Man ….

Cranky Old Man ….
What do you see nurses? ….what do you see?
What are you thinking? .... when you're looking at me?
A cranky old man …. not very wise,
Uncertain of habit …. with faraway eyes?
Who dribbles his food …. and makes no reply.
When you say in a loud voice …. 'I do wish you'd try!'
Who seems not to notice …. the things that you do.
And forever is losing . . . . A sock or shoe?
Who, resisting or not …. lets you do as you will,
With bathing and feeding …. the long day to fill?
Is that what you're thinking? …. is that what you see?
Then open your eyes nurse …. you're not looking at me.
I'll tell you who I am …. as I sit here so still,
As I do at your bidding, …. as I eat at your will.
I'm a small child of Ten …. with a father and mother,
Brothers and sisters …. who love one another
A young boy of Sixteen …. with wings on his feet
Dreaming that soon now ….. a lover he'll meet.
A groom soon at Twenty …. my heart gives a leap.
Remembering, the vows …. that I promised to keep.
At Twenty-Five, now …. I have young of my own.
Who need me to guide …. and a secure happy home.
A man of Thirty …. my young now grown fast,
Bound to each other …. with ties that should last.
At Forty, my young sons …. have grown and are gone,
But my woman is beside me …. to see I don't mourn.
At Fifty, once more, …. babies play 'round my knee,
Again, we know children …. my loved one and me.
Dark days are upon me …. my wife is now dead.
I look at the future …. I shudder with dread.
For my young are all rearing …. young of their own.
And I think of the years …. and the love that I've known.
I'm now an old man …. and nature is cruel.
It's jest to make old age …. look like a fool.
The body, it crumbles …. grace and vigour, depart.
There is now a stone …. where I once had a heart.
But inside this old carcass …. a young man still dwells,
And now and again …. my battered heart swells
I remember the joys …. I remember the pain.
And I'm loving and living …. life over again.
I think of the years, all too few …. gone too fast.
And accept the stark fact …. that nothing can last.
So open your eyes, people …. open and see.
Not a cranky old man .
Look closer …. See …. ME!!

So this old man, with seemingly nothing left to give to the world, is now the author of this 'anonymous' poem, his sole bequest to posterity.

This article was previously distributed and is now being republished after numerous requests for it to be more widely circulated

NHS on the brink of financial collapse

Mr Andrew Vincent, Managing Director, Medicology Ltd & Head of Leadership & Clinical Business Excellence, Medicademy LLP

As South London Healthcare NHS Trust teeters on the brink of financial administration, with weekly losses of greater than £1 million, it has become abundantly clear that there is a systemic nature to the financial problems facing the NHS. Hard on the heels of the South London revelation came the news that a further 20 Trusts, responsible for more than 60 hospitals, are also facing serious difficulties which could ultimately see them in the same situation.

If this is frightening enough, a report by NHS London in February, discussing the FT status and circumstances of its 18 non-Foundation Trusts, said: "A maximum of six are in a viable long-term financial position in their present form in 2014-15."The report declared that only St George's Healthcare, The Royal Free Hampstead, Kingston Hospital, Croydon Health Services, Lewisham Healthcare and Barnet & Chase Farm Hospitals Trusts could keep out of the red, even if all the Trusts achieved 18-20% savings.The other 12 hospital trusts either needed longer to become viable or had no hope of doing so without changing form or getting outside support.

Just to paint a slightly darker picture still, the Department of Health also gave emergency funds to four Foundation Trusts and 17 other Trusts between 2006 and 2012, according to the National Audit Office. These bailouts were needed to help pay creditors and staff. The situation is clearly declining because between 2010 and 2011, struggling trusts had to be bailed out to the tune of £76m but this figure drastically increased last year to £253m, the NAO said.The report also revealed that 34 Trusts, including three PCTs, 10 Trusts and 21 Foundation Trusts, reported a deficit in 2011 and 2012.

Our concern is that rather than this being the extent of the issue it is in fact the tip of the iceberg in an era of complete cessation of real terms healthcare funding increases but without the same cessation of increasing healthcare demand, increasing and ageing population and higher than average inflationary costs. We see this as an emerging crisis, not the end result of an earlier one.

Mike Farrar's stark warning

Mike Farrar, Chief Executive of the NHS Confederation representing most of most NHS hospitals, primary care trusts, ambulance services and mental health trusts in England, said that the need to make £20billion of financial savings by 2015 "means our finances are under more strain than ever".

He specifically warned that few users of the NHS were prepared for the scale of the changes likely to be forced upon the service by financial pressures and went on to state "I am deeply concerned that the gravity of this problem for the NHS is not widely understood by patients and the public. There is a real risk we will sleepwalk into a financial crisis that patients will feel the full force of".

Mike painted a picture of 3 potential scenarios:

- The NHS maintains service standards but goes bust while doing so
- It sees standards slip but maintains financial balance
- It keeps improving and stays in the black

He highlights that everyone is hoping for scenario 3 but points out that "we will only get there if the NHS can resource to meet growing demand. That means radically reorienting services to reduce hospital stays and offering new forms of care. Put bluntly, this means fewer beds and fewer hospital-based jobs."

Our own experience, amassed from being deeply involved with the clinical coalface,

is that Mike's fears are very well-founded. It appears that there is a nihilistic view that financial collapse is inevitable emerging mostly as a result of continued failed efforts by Trusts to balance their books utilising very tough financial control measures and cuts that run the risk of undermining quality and safety of care. In fact, Mike himself paints that very picture – it's a choice – balance the books or maintain standards.

However, we'd like to introduce an alternative viewpoint, not for all but for those that recognise its inevitability. It makes difficult reading but the propensity to accept it might just mean the difference between survival and demise for many services. Faster readers will prevail over slower ones, as we will make clear.

The Stark Reality

We'll paint a very complex picture as simply as possible, not because you do not have the intellectual ability to adsorb it but because it is so easy to miss the point.

In just about every nation, healthcare expenditure as a proportion of Gross Domestic Product (GDP) has risen year-on-year, effectively indicating that year-on-year healthcare consumes more of our national disposable annual income than the previous year, displacing spend in other potential areas of need e.g. teaching.

Looking at the United Kingdom specifically, figure 1 illustrates that the growth in healthcare expenditure closely mimics the trends seen across the Organisation for Economic Co-operation and Development (OECD), albeit at a slightly below average rate until 2010.

At the current average rate of climb, which has been broadly stable across the last 60 years, by 2050 we will be spending 19.9% of our GDP on health and by 2100 an enormous 52.5%, both of which are wholly unaffordable without significant detriment to other areas of national, central expenditure.

What has fuelled this faster-than-inflation growth?

At a simplistic level, the core drivers of this emerging situation fall into 3 distinct areas, as illustrated by figure 2. More people, carrying more disease in an area of high innovation cost almost guarantees that society will continue to face this challenge unless it re-thinks its whole approach to health. The irony is that this is an innovation-created problem that demands fundamentally more innovation to solve it.

Population Changes

Based on Office of National Statistics 2008-based population projections, our population will rise to 71.6 million by 2033, from the 2008 level of 61.4 million, a percentage rise of 17% across 25 years. However, consider that 7.0 million of that

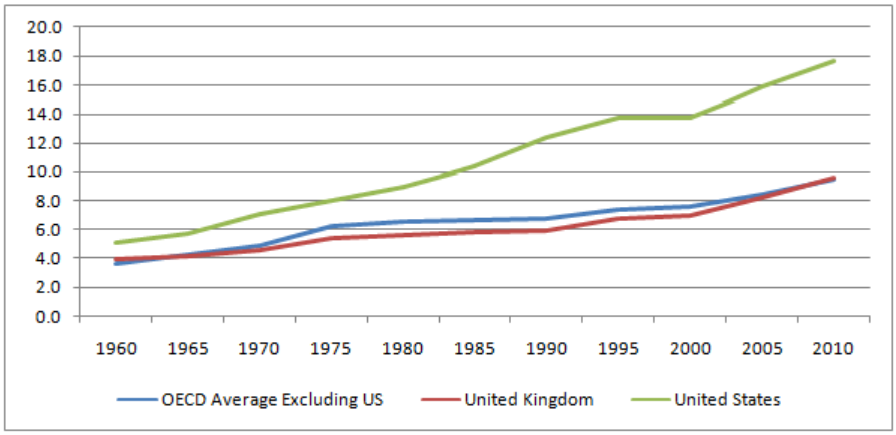

Figure 1 OECD Healthcare Expenditure as a Percentage of GDP 1960 - 2010

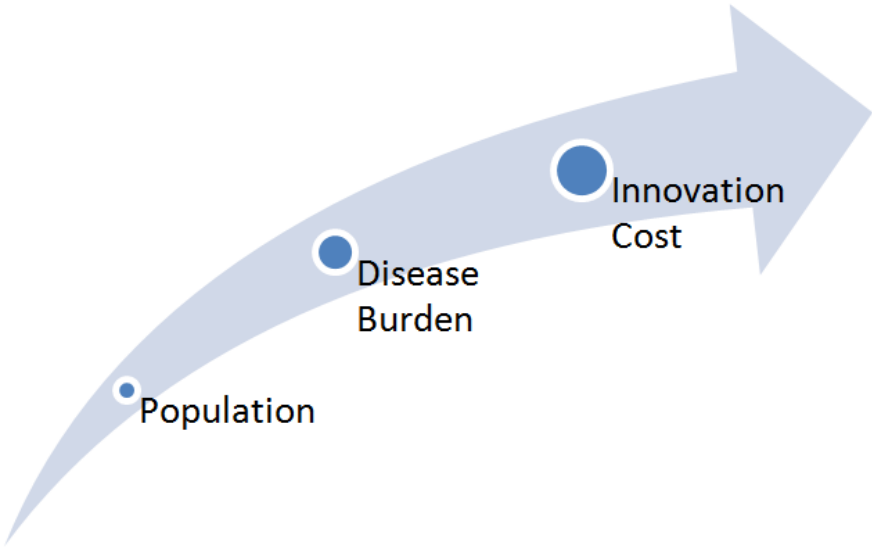

Figure 2: Factors contributing to faster than inflation healthcare growth

10.2 million occurs in the 60+ age bands, with a significant 3.9 million in the 75+ age band specifically, bands of maximum healthcare consumption.

Population changes occur primarily as a function of the birth rate, death rate and net migration rate, the latter being relatively stable or declining across this period. However, by examining the relationship between the birth rate and death rate, we can see that the population is growing primarily because of a declining death rate. Figure 3 demonstrates that the emerging gap between births and deaths is widening, reaching a level not dissimilar to the 'baby boomer' period of the late 60s and early 70s but with the driver on this occasion being the declining death rate, not a heightened birth rate.

The net effect of this declining death rate is to extend the older age bands faster than the younger ones, creating an increased healthcare demand but without

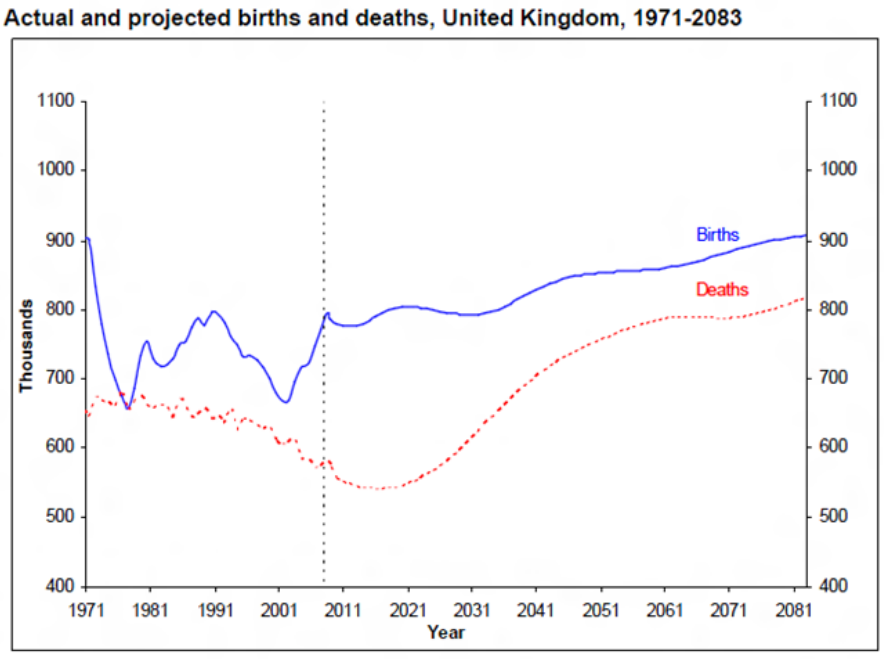

Figure 3: Office of National Statistics. Actual and projected births and deaths.

the developing working age (tax payer) population to support it. This obviously has significant implications for health system funding and social care provision that must be addressed if society is not to literally run out money to support its population's health and social care needs. This extending life expectancy is driven primarily by medical and scientific research and innovation, resolving or partially resolving medical challenges that would previously have resulted in earlier demise.

Disease Burden

The impact of medical research and innovation is illustrated profoundly by improvements in diabetes life expectancy over time. In 1897, the average life expectancy for a 10-year-old child with diabetes is about 1 year. Diagnosis at age 30 carries a life expectancy of about 4 years. A newly diagnosed 50-year-old might live 8 more years. In a cohort study evaluating 9066 deaths from type 2 diabetes, life expectancy was 9.9 ± 7.3 years in 1943-1965 period, followed by a significant ($p<0.001$) rise to 12.2 ± 8.2 years in 1966-1988, and 14 ± 8.1 years ($p < 0.001$) in 1989-2009 (Ioacara 2011). Across this period, there was a significant increase for coronary heart diseases and cancer and a significant decrease for infections and end-stage renal disease as causes of death, indicating that the progression of medical science in identifying and treating type 2 diabetes, as well as its ability to deal with complications, has not only extended life but also changed the profile of the disease itself.

The relevance of this to our picture of healthcare burden is that the addition of interventions devised through innovation and research have changed diabetes from an acute disease to an ever more chronic one, resulting in a burgeoning population of diabetics on life-long therapy and consuming ever more interventions for complications. The impact of this has been the creation of a singular condition with the potential to bankrupt the NHS within our lifetime.

The Impact Diabetes Report 2012, in the journal Diabetic Medicine, has projected that annual spending on diabetes in the

UK will increase from £9.8 billion to £16.9 billion over the next 25 years, resulting in the NHS spending 17% of its entire budget on the condition. The same report also suggests that the cost of treating diabetes complications (including kidney failure, nerve damage, stroke, blindness and amputation) is expected to almost double from the current total of £7.7 billion to £13.5 billion by 2035/6.

Diabetes is by no means unique, with a host of diseases following a similar path, including cardiovascular disease, respiratory disease, serious infections such as HIV, preterm birth, cancer and more.

The Frail Population

A further impact of our ageing population is that of increasing frailty and reduced mobility of larger numbers of patients. With many routine healthcare needs alongside their more complex ones, the elderly, as they age, will find it increasingly difficult to 'pop in' to their 'local' hospital for diagnostics, outpatients and follow up. There is a huge need to relocate services closer to these patients to ensure continued accessibility.

This conclusion is not ground-breaking and was firmly recognised in the Darzi-led contribution to healthcare reform, in which he openly discussed moving care from hospital locations to community ones where feasible. Additionally, the growing chronic disease burden of increasing age and frailty requires longer term support designed to prevent hospital admission, through delivery of 'different' support services in the community for people with complex needs.

The impact of this, of course, is to reduce the breadth and scope of local hospital services needed over time i.e. shrinkage of the local hospital sector. Given the complex interrelationships of different specialties, it is simply not feasible for all hospitals to shrink. The reality is that some will stay, with larger catchment areas and some will go. Some will cope by offering non-hospital services too.

Innovation & Healthcare Cost

Medical practitioners and scientists have continued to innovate since medicine was first defined as a scientific discipline. Besides the obvious scientific drive to push understanding and therefore boundaries, continued medical innovation is justified on the basis of a positive rate of return, based on utilising cost per life year saved balanced with the economic contribution of an individual. However, concern exists that this positive economic return does not consider the cost of treatment at today's rates. For instance, a patient not dying from renal failure in type 2 diabetes may well go on to have multiple cardiovascular events requiring acute intervention and ultimately develop cancer in later years.

A further concern is that the economic benefit does not contribute fully to the cost of care. A patient having years preserved in their working life will contribute taxes but consume healthcare resources, often at a faster rate, depending on the disease. Besides healthcare consumption, they often incur social care costs too, frequently not considered but significant in value.

The cost of medical interventions themselves comes at a significant price. Forbes estimates that the average drug developed by a major pharmaceutical company costs at least $4 billion, and it can be as much as $11 billion. This huge R & D cost must be reclaimed from the healthcare economy over the patent life of the medication, resulting in annualised treatment costs running to many tens of thousands for new drugs.

Regardless of the contributing economics, the effect has been to take the UK healthcare cost from £437 million at outset in 1948 to £122 billion in 2010/11, some 18% of national expenditure annually. Had that £437 million simply been extrapolated by inflation, it would currently stand at around £9 billion today. This is clearly not sustainable and the current government has already taken steps to arrest the rate of increased cost by simply ceasing to increase funding. The impact of this on the current system is to create a shortfall between funding and cost over the next 4 years of some £20 billion, even though inflation, innovation and increasing population are all driving an increase in healthcare spending demand. In effect, this takes an emerging health and social care crisis and simply turns it over the health profession to 'cope with'. It is this latter revelation that needs careful consideration in terms of what it means and what we must do.

In conclusion of this somewhat summarised version of the emerging social challenge, we have to accept that there is insufficient funding available even for current demand, as clearly illustrated by the earlier financial picture. When Mike Farrar highlights the need for a radical re-think, he is really saying that if we don't, all Trusts run the risk of bankruptcy. We think that that re-think needs to start at the level of how you see your position in healthcare. We'll explain.

Implications for Trusts and Services

Let's be very, very clear on what this means for Trusts and services, specifically hospital services. There are 2 critical environmental pressures on hospitals:

- Insufficient funding for healthcare as a whole, given increasing demand
- Insufficient funding to maintain our local hospital infrastructure, given the redistribution of care

However, and this is a BIG however, there is no reason why any single provider should not prevail or indeed thrive in this environment without any detriment to service quality or provision i.e. there is absolutely no reason why any single provider must choose between survival and quality.

However, and this is an even BIGGER however than that last one, in a system that does not have the funding to support all of the existing players, it is imperative that Trusts and services accept the inevitable state that there have to be winners and losers. Which category you are in is a function of adaptability, strategy and insight, along with how swiftly you mobilise your masses to put yourself in the winning category.

Health Warning

At this point we also want to point out perhaps one of the singular most damaging

aspects of the emerging challenge, something that Mike Farrar plainly sees but is undoubtedly caught between a rock and a hard place over, given his representation of 'all' providers. That aspect is this:

> If you are scrambling to save money here, there and everywhere, you almost certainly don't understand the emerging system sufficiently because it means you are cutting, not competing i.e. all failing together rather than accepting that the stronger, more adaptable must prevail over the weaker or less adaptable. It's not a race to the bottom.

We can say with significant confidence that in most Trusts we look at, the incessant drive for cost improvement is not only a distraction from the vital role of strategic reform and competitiveness but damages it further, leaving Trusts with an increased risk of demise in subsequent years. Furthermore, it is most frequently underpinned with a superficial understanding of why the imbalance has occurred at all i.e. a failure to understand the true nature of the problem you face. In effect, this cost cutting regime is a management solution to a strategic leadership problem – the failure to understand the changing environment and know what to do about it (or how).

We want to be explicitly clear that we are not suggesting that Trusts or services give up financial reform. Quite the opposite, in fact. We are saying that we need to replace reactive and damaging, panic-driven cost-cutting and downsizing with a sensible strategic reform agenda that addresses not only your financial footprint but also the core strategic issues that you face going forward.

I am sure we're making no friends at this point but we are telling it like it is. Why? Well, we hate to point it out but if you look around you there are comparatively few Trusts that are 'comfortable' and an increasing number in significant distress. Many, if not most, of those that are in balance are full of clinicians with genuine, well-founded concerns over safety and quality. These are not successful Trusts, they are Trusts that have chosen financial balance over quality, number 2 of Mike's scenarios.

We are constantly struck by the level of denial that is apparent in upper management levels and the naivety that exists below them. We can't say it more plainly than Kotter's words, "the iceberg is melting". Learn to make the right strategic choices and adapt in a timely fashion or perish. Those strategic choices are not a mystery to those that understand the new system or indeed competitive markets in general. However, they are poles apart from the behaviour we are currently

seeing and it is this concern that obviously prompted Mike Farrar to say "this could see the NHS forced to salami-slice its way out of financial trouble, cutting services and use of less effective treatments."

When Mike says "we're all hoping for scenario 3" [improving and staying in the black], we say don't hope – it's far better to take the right strategic steps and ensure you end up in scenario 3.

Who's a Survivor?

Throughout this article, we have raised the issues that need to be considered. However, in this last section we'd like to pull them together in an easily digestible form. There are 6 basic determinants of success going forward, along with a myriad of contributing factors (and a little luck too). Table 1 highlights these as we see them.

Quite clearly there are more issues that need considering. We hope that this article has helped focus the mind, uncomfortably or not, on the emerging challenge and has itself challenged some of the naivety, denial and misplaced bullishness that risks services and Trusts today.

The most likely survivors are those with the humility to accept that maybe they don't know enough, the open-mindedness to seek out different ways of thinking and doing and the drive to act sooner rather than later. These will be the leaders learning to think differently, adapting their business models, seeking innovative strategies and firmly placing themselves into a category of winners, regardless of the fact they feel a little more 'dirty' for doing so. In that regard, we share your concern. In some consolation we'd like to acknowledge your desire for it to be different but remind you that regardless of intent, nature has long taught us the lesson that the adaptable tend to prevail.

CRITICAL FACTOR	CRITICAL CONSIDERATIONS
Insight & Understanding	If you don't **really** understand the system, it's difficult to make good strategic choices. Poor strategic choices make life worse, even if they balance this year's books.
Adaptability	If you can see what to do but don't know how to do it, you are still extremely vulnerable. Contrary to popular believe, change in healthcare is simple, if you do it correctly! Yes, really.
Competing	Eat or be eaten, there isn't enough financial food to go round. Accept it and start hunting, sensibly. We also guarantee that your current financial state is competition-mediated, even if you can't see it.
Offering Better Value	This is a population and disease burden challenge. If you can offer better ways of doing things, you'll be welcomed with open arms by commissioners. Use innovation to compete and expand.
Collaborative Internal Working	Internal competition and clinical-managerial divide is a fast road to ruin. A few heads need knocking together on this one. Everyone in a room asking intelligent questions. What does this mean? What must we do?
Service-led Solutions & Strategies	Besides the near-perfect predisposition of a clinician for complex problem solving, management teams just do not have the authority to impose their will on the custodian of the patient. Accept it and learn to lead differently.

The need for resilient cultures - particularly in times of uncertainty for health services

By Derek Mowbray,
The Wellbeing and Performance Group

Change is an essential aspect of survival. The ability to adapt effectively to internal and external pressures for change marks the difference between a successful organisation and one that is at risk of collapse.

The number and combination of pressures facing organisations may have the effect of tipping the organisation over from being sufficiently resilient to survive and prosper to a situation of helplessness. The impact of helplessness, at its simplest, is to tap into the resilience of individuals and to cause individuals to call into question their own determination of face up to and overcome challenges to their own survival.

The National Health Service appears to be facing a combination of pressures that are real threats to survival of individual organisations within the overall service.

There is the general context of the NHS that all employees' experience – a breakdown in trust with the major institutions of trust, such as banks, police, politicians, combined with the erosion of faith in forms of religion. These have a major impact on individual feelings of uncertainty; uncertainty is a major stressor. Stress causes anxiety, and anxiety interferes with concentration and, therefore, performance.

The NHS itself is exposed to pressures that play straight into the trigger points of stress for many of its leaders and professional staff. The promotion of general practitioners as leading commissioning, in the context of economic constraints, compounded by financial commitments inherited from earlier political decisions such as the private finance initiative, plays straight to the conflicting ideologies between professionals and the bureaucracy – namely the focus on individuals and what is best for them conflicting with the focus on the services as a whole and what's best for the services. The structure plays to the command and control regime that erodes individual discretion, and the continued emphasis on process as opposed to outcome, and using processes as a proxy for quality and effect, each of which run counter to the interests of clinicians and their ability to perform effectively. Some of these matters, combined with others, may have had an impact on the public perception of the NHS, which is generally lower than desired, but hasn't interfered with individual satisfaction with personal experiences of care and treatment which is high.

Derek Mowbray

The political intensions for the NHS may, also, play to the anxieties of clinicians and others. The re-arrangements currently being introduced require clinicians to shift their ideology towards managing the wider services, which requires a change in thinking and feelings that requires time. On top of this is the need to acquire skills in commissioning and management that are not in abundance. The leadership style in a command and control context is likely to stifle employee

engagement, itself an inhibitor to high performance. There may be a sense that failure to make the new arrangements effective will lead to an intention to fragment the health services between public and privately funded arrangements, and draw into the mix more commercially focused services, with the consequences being a market led health service exposing the vulnerable to greater risk than already exists. Whilst this isn't in the interests of patients, it may be in the interests of politicians.

All of these features conspire to produce an effect known as psychological presenteeism, where individuals are at work but their performance is impaired because their concentration is eroded due to them thinking about all these issues and many others as well.

A conclusion might be drawn that the NHS isn't in a very resilient position.

Corporate resilience

There are certain characteristics of a resilient organisation that make them successful. They include being healthy – having the capacity and ability to respond rapidly to pressures for change, faster than their competitors; they have a buzz about them that accompanies high level performance; they can renew themselves rapidly and effectively; they have the capacity to determine their own future and destiny, and the ability to simultaneously plan strategically and deliver services operationally.

Corporate resilience is achieved by developing a corporate attitude towards adverse events or pressures for change – such a changing demand, technology, and workforce skills, knowledge and experience. A corporate attitude implies an engaged workforce.

A central feature of corporate resilience is commitment, trust and engagement between staff, their work and their leaders. Engagement, in this context, is characterised by 'a positive, fulfilling, work related sense of attachment that is characterised by vigour, dedication and absorption'. Such an attachment is engineered as much by context as by the work itself. The context would need to be a positive working environment that provokes a strong sense of personal satisfaction in staff.

The headline features that can do this are: having a clear, unambiguous purpose, that can be expressed as a 'big idea' , that can be succinctly described so that staff can talk about the purpose with pride with their friends, and their friends will feel infected by the pride being displayed; a vision that is realistic and shared amongst staff; values that are the values of staff translated into corporate speak – core values that reflect the self-interest of staff and are, therefore, their core drivers; a culture that is based on adaptive principles – sharing responsibility for the organisation, encouraging independent contributions, tackling 'elephants in the room', encouraging leadership, and institutionalising learning (a process of always seeking to learn from experiences and sharing the learning with others); a corporate strategy that places the psychological wellbeing of the workforce at the centre (and not as an add on under the auspices of HR or Occupational Health);

an organisational structure that is as flat as possible; a capacity to problem solve – drawing together those with the appropriate skills to resolve the specific problem (and not leaving problems to be solved by the least skilled people); and confidence – the tackling of corporate anxiety as it arises.

The challenge is deciding to implement these headline features and deciding who should ignite the change.

Adaptive leadership

The onus is always going to be placed on leaders to take a lead. Finding leaders that inspire commitment, trust and engagement is key to this development. Such leaders will need to be able to apply Adaptive Leadership skills that mirror the adaptive cultural principles – sharing responsibility, encouraging independent thinking; tackling the 'elephants in the room' and encouraging everyone to take a lead in aspects of everyday working life.

Consistency of approach combined with constantly explaining what is happening, and why, will gradually reduce corporate anxiety and build confidence in the future.

Manager behaviours

However, this will only happen if the behaviours of leaders and managers exhibit the features that provoke commitment, trust and engagement, within a resilient culture that supports the promotion of these behaviours. This is in marked contrast to the behaviours that are being adopted in many places, which seem to focus on quick fix solutions to complex and difficult problems, supported by a check list attitude towards management. The opposite is needed to ensure that all staff experience the encouragement and nurturing that provides the motivation for staff to act with personal discretion and take reasonable risks.

All behaviours are preceded by thoughts and feelings. The attributes or thinking that produces the behaviours required to provoke commitment, trust and engagement fall into five categories – attentiveness, intellectual flexibility, encouragement, reliability and conflict resolution. All these require leaders and managers to focus on the individual; to concentrate on demonstrative behaviours that facilitate interaction leading to engagement; to respond positively, if assertively, to others, and to consistently explain what is going on and why. Leaders and managers will require training in this area, and they will, also, require the cultural context to constantly reinforce these forms of behaviour for the culture to be adopted throughout the organisation.

Personal resilience

Dovetailing with corporate resilience is personal resilience. Resilience is a process not a personality trait and is about forming robust attitudes towards events. The purpose of personal resilience is to prevent events from causing psychological distress, as stress impairs performance, and is a major consumer of resources as a result.

Strengthening attitudes is about maintaining personal control over oneself in different situations. This can be achieved by enhancing self-awareness about the kind of events that pose threats to personal survival or self-interest; enhancing the capacity to respond effectively to events by developing the ability to problem solve and organise oneself in the context of chaos; and enhancing the capacity to respond effectively to other people in ways that promote self-interest and exclude stress in oneself and others.

Personal attitude is based on thoughts and feelings. These are, normally, heavily influenced by context. So, if the context of the individual is a resilient and healthy organisation, the elasticity of the individual is expanded to stretch their own tolerance of adverse events, in the knowledge that standing up to events and overcoming them contribute to the maintenance of a healthy and resilient organisation, a context that reinforces individual sense of satisfaction. This inter-connection between context and the individual is often not addressed by managers, who may consider that personal resilience enables individuals to cope with excessive stressors. It doesn't. It is the combination of corporate resilience with personal resilience that enables organisations and individuals cope with and thrive in challenging circumstances.

Conclusion

The NHS is undergoing changes in a wider context of national distrust in institutions and services. The NHS changes, themselves, play directly to some of the triggers of distress. The combination produces challenges that may topple the NHS over the edge between surviving and becoming helpless, resulting in a de-motivated and underperforming workforce.

An approach to prevent this is to start creating a resilient culture now by identifying leaders who inspire commitment, trust and engagement. They will then need to introduce the features that generate a resilient culture, through consistency in approach and continuous explanation of what is happening and why.

Derek Mowbray is founder and director of The Wellbeing and Performance Group. He is also director of The National Centre for Applied Psychology and visiting Professor in Psychology at Northumbria University. He is the author of The Manager's Code for Health and Social Care launched on behalf of the Institute of Healthcare Management by Dame Carol Black in February 2012 for application into the NHS.

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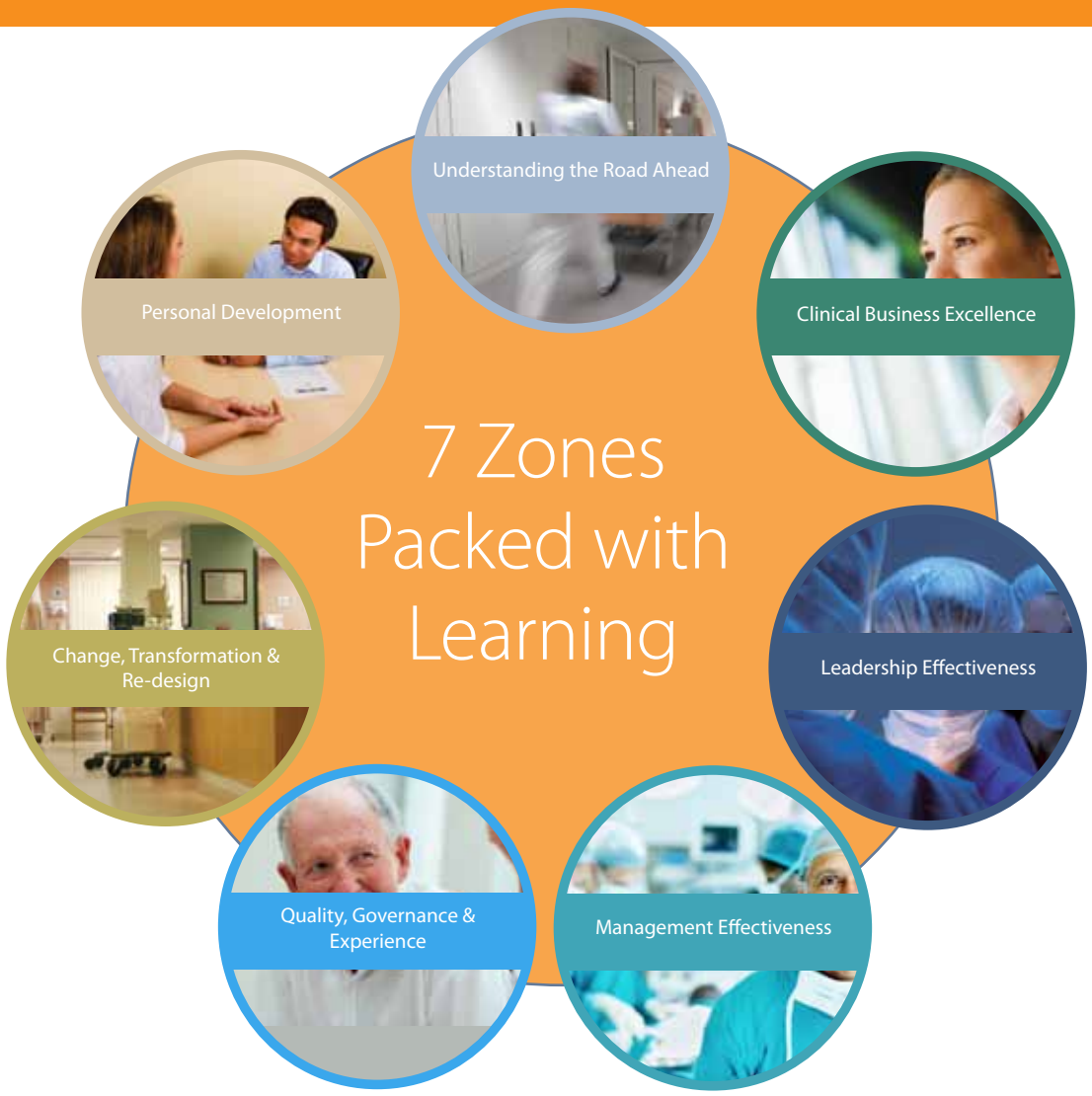

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Are those consultants opposed to the Health & Social Care Act 2012 at greater vulnerability than those in favour?

Mr Andrew Vincent, Managing Director, Medicology Ltd & Head of Leadership & Clinical Business Excellence, Medicademy LLP

In the normal passage of change, we all find ourselves challenged by strategies or re-organisations that we may feel are at odds with our viewpoint, values or beliefs and never more so when considering the move from a 'National' Health Service to a more devolved, provider-based, market economy i.e. competition. Under such circumstances, where clinicians, managers and senior leaders all would consider themselves custodians over the service as a whole and where clinicians particularly see themselves as the moral and ethical balance for patient welfare over business performance, it would be unhealthy not to have significant debate about the implications of any changes. However, we'd like to raise the ethical dilemma that entering this debate voraciously against these changes has also placed those very 'defenders' of the current system at greater vulnerability than early acceptors of the change.

The answer to this interesting question lies in what those defenders do whilst they voraciously defend.

A core principal of a competitive market is 'first mover advantage' which is best demonstrated by the example of a treatment centre opening in a small-to-medium sized town. Let's say that this town has a reasonably significant local population, sits on a motorway and is roughly equidistant from two larger towns, each of which having an acute hospital. The concept of first mover advantage suggests that the Trust recognising the opportunity for a successful treatment centre in the small town and acting early effectively changes the parameters for the second Trust by making a similar move more risky or completely unviable i.e. there is room for only one and the first locks out the second.

Why does this disadvantage the conscientious objectors?

Objectors, conscientiously debating whether or not we should allow competition, commercially-focused treatment centres etc, are much less likely to act in favour of evaluating the business case for one whilst the debate continues, either out of possibility that the legislation may get changed or moral standpoint that you can't both oppose and do the very thing you are opposing at the same time. Consequently, whilst both 'for' and 'against' camps may enter the debate, the 'for' camp are also more likely to be moving towards a robust business case whilst the debate continues, providing them with a substantial time advantage in a system that favours first movers.

Another example is an objection that certain treatment and triage services move from hospitals into the community. If you are 'for' such a move, or even simply neutral, recognising that a competitive market requires you to seek out opportunities and proactively pursue them means that you are more likely to fully understand the new legislation, how it works and what it takes to seize business in such a move. The objector may be far more concerned with why the legislation or direction of travel is 'wrong' than how the legislation is designed to work. This leads to false security, such as expecting a tender to be organised for such a care change when in fact it can be implemented through Any Qualified Provider without any such tender at all.

What's clear is that whether 'for' or 'against', fully understanding the implications of the Health & Social Care Act 2012 and its underpinning White Papers is critical for all camps. However, with those in favour more likely to understand the working mechanisms more deeply and more likely to have the propensity to act in line with it earlier, it does indeed appear that the conscientious objector is at a considerable disadvantage.

We can see two possible answers. The first would be to have a consultation and debate where no actual moves were permissible, followed by a distinct 'cooling off' period, in which all camps could prepare for the new era before each engages in the new environment for real. However, that is not only unlikely but historically has not a shred of evidence in support of it future likelihood. The second answer is a difficult moral and ethical one for the 'no' camp. It suggests that an even playing field is only created if you debate and prepare concurrently i.e. say 'no' but act 'yes' just in case it happens. If that feels somewhat like being against euthanasia but quietly putting people to sleep whilst the jury is still out then we can certainly see why.

The alternative is not a particularly palatable situation. The very people fighting so hard to protect the system, its values and the patients it serves, positively motivated and morally accountable, may just find their services in the greatest trouble as more eager competitors take patients and funding away from these slower movers. We realise this doesn't provide an answer but answers are rarely forthcoming until we raise the right question. What should we do?

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Improving the Stroke Pathway

By Steve Allder, Assistant Medical Director &
Consultant Neurologist, Plymouth Hospitals NHS Trust

This article will describe the work relating to the improvement of the Stroke pathway. This is the first prospective application of the framework I have been describing in the preceding articles. The first phase of the improvement in Stroke happened from 2005. This work was aided by my involvement in a course facilitated by the Royal College of Physicians and the Institute for Improvement and Innovation.

This phase of work allowed the Acute Stroke Unit to be opened. This was associated with some changes in working practice that certainly improved the care of patients with stroke. However, most of this work was unfortunately halted when the financial crisis of 2006 within the Trust meant the Stroke Unit had to be temporarily suspended.

External context

By mid-2008 the National Stroke Strategy had been published and our SHA incorporated the aspiration of the strategy in the local improvement plan. This was important because it meant there was a network with resource developed, and there was an imperative within the trust for Stroke to become a strategic priority. Our local team seized this opportunity and created significant improvements up until May 2010. This timepoint marked the General Election and shift in approach from Andrew Lansley, the new Secretary of State for Health. This shift significantly altered the external context. It coincided with a freeze in NHS allocation, but it also marked a scaling back of regional and central support for priority-setting. Both of these shifted improvement from a supportive context to quite a hostile one for ongoing improvement.

Directing

It was my explicit intention to use this improvement opportunity to test and hopefully validate the approach described in the framework.

Analysis of demand

This analysis revealed that for as long as we had been collecting demand figures, demand was extremely stable. The average number of stroke patients was 1.5 per day, and this varied from 0-5.

Value-proposition concept

Our starting point was to determine what patients really wanted from the Stroke pathway. Using the value-added steps methodology we focused on diagnosis, acute treatment, secondary prevention, avoiding medical complications, and obtaining optimal functional stability. From this it was clear that, while there were improvement opportunities for each element, the element with greatest uncertainty was the obtaining optimal functional stability step. Fortunately, we had been collecting data relating to this over the previous 3-4 years and we were now able to specifically dissect what this was telling us. Our audits had shown that there was great variability in the length of stay of patients relating to this step. Careful review of this data illustrated that most of the variability was coming from patients who were frail prior to their stroke, and that they had had a severe new stroke.

This showed very clearly which group of patients we had not designed an appropriate pathway of care for. In turn this group was also consuming a large, highly variable number of beds day-to-day, which was making running the unit complex, and also contributing to the poor financial position.

Value-proposition delivery

The team reviewed a consecutive batch of patient notes relating to this type of patient. They concluded it would not be possible to develop a clear-cut protocol for each and every patient, but by identifying this group

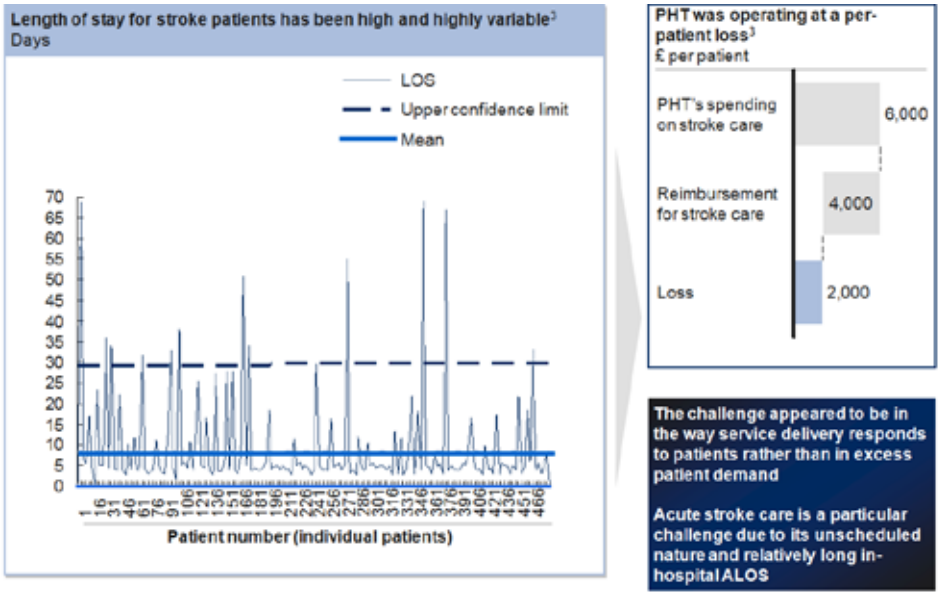

Figure 1

of patients and collecting a pre-defined set of data, it should be possible to manage the patients along what was later termed the expectant pathway

For the remainder of the patients the team simply reviewed established guidelines and protocols. These appeared evidence-based and fit for purpose.

Value-proposition monitoring and adaptation
In order to facilitate this step the team developed a dashboard of relevant operational metrics that was updated daily by a dedicated data analyst. This data was reviewed to begin with in a weekly meeting and areas where we were failing to achieve our pre-defined goals were further examined, and potential solutions proposed and trialled. This approach enabled significant improvements in multiple measures to be achieved.

It is important to emphasise at this point that the national strategy and SHA had developed their own set of targets and measures. Our approach recognised the importance of reporting on these measures; however, the development of the local metrics were developed from the analysis of our work in reality. This approach was successful, as we improved our service-base and local data by default we achieved all of the national targets that we were expected to report 0n. This emphasises an important distinction between different types of measure (Warwick Business School Classification).

The improvements within the Stroke unit were driven through this weekly 'within-unit' meeting. Obviously the patient pathways extends beyond the Acute Stroke Unit element; improvements across the broader pathways were managed through a 'Pathway Provider' meeting, that had developed a complimentary set of operational measures. Through this process it was possible to create improvement in discrete elements of the pathway, and coordinate improvement between elements where the data suggested joined-up improvement work was possible.

The final point of note is how the change was embedded in the day-to-day running of the Pathway. The changes were informed by analysis of the existing pathway, by the existing teams. Changes were tested and monitored by the teams within and across the pathway. This not only produced significant measurable improvement, it also created a supportive and exciting environment in which to provide care and service improvement.

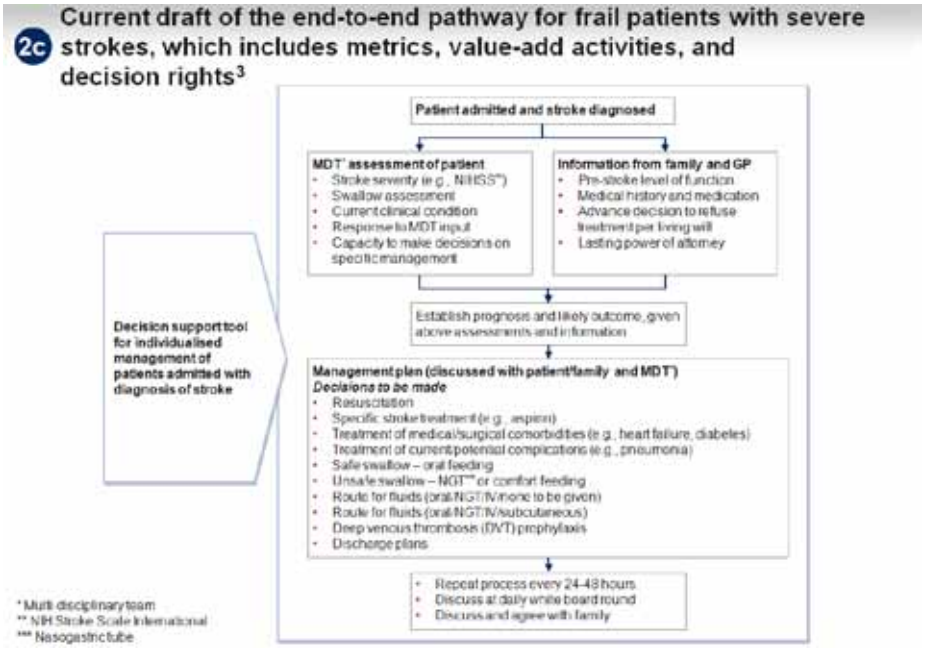

Figure 2

Dr Steve Allder

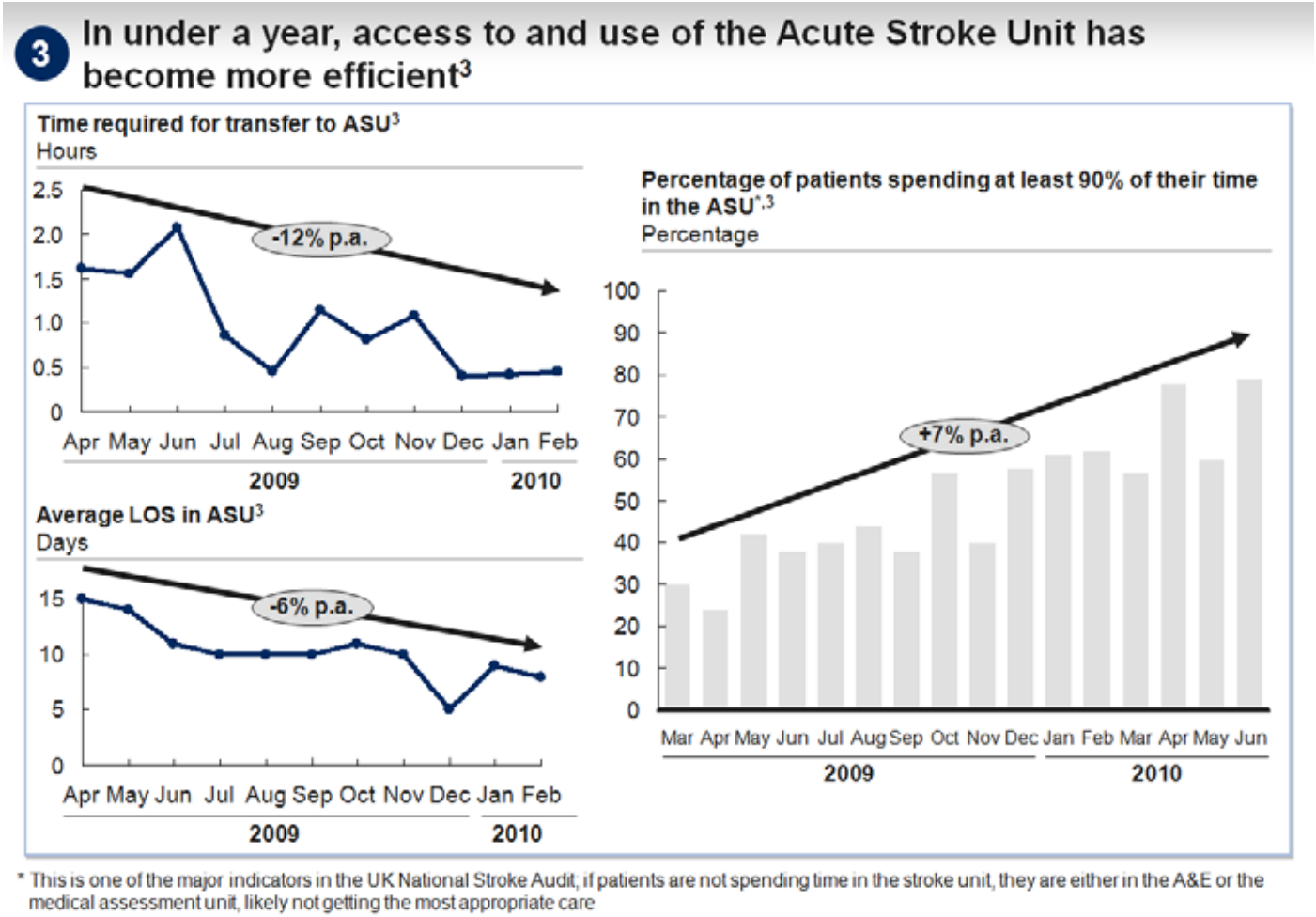

Figure 3

High-level change journey

At the beginning of this phase of the Stroke improvement there were 7 workstreams with multiple existing projects contained therein, and individual teams were very passionate about their existing pieces of work. The high-level approach up to this point has been very simple:

1. Provide absolute clarity about accountability and responsibility for the day-to-day operation of the pathway and its change.
2. Ask each local team to review its own existing policies and protocols, and to develop local measures to test themselves against delivery of their own targets.
3. Encourage each local team to develop a weekly operational review meeting that will use current performance and trial multiple small improvement experiments.
4. Coordinate activity across the pathway through the pathway provider group. This pathway group does two things: provides oversight of the improvement within each of the local teams; facilitates one key improvement between provider groups.
5. When improvement either within the local teams or between teams has been sustained for several months, new areas for improvement are asked for, and new improvement measures added to the dashboards.

Leading Self and team

This project was greatly enhanced as the provider pathway group leadership team emerged from an existing team within the acute trust. Where the team evolved from was far less important that the composition of the team members. Each of them had a good grounding in different elements being brought to bear, e.g. the need for careful empirical analysis (directing), the need for great care in understanding how to motivate local teams and pathway cooperation (leading), and the importance of on-the-ground delivery from the existing teams (managing).

Motivating others

At the start of the process there was significant distrust and explicit hostility from different teams within the patient pathway. However, because the mandate was securely established from the executive teams across the health economy, local teams engaged with the process. As it turned out, as the process was intended to be empowering, bottom-up and empirically based, achieving and maintaining clinical buy-in has not been a problem at any point during the project. In fact the Commissioner accountable for the Stroke pathway commented after 6 months that she couldn't believe, given the hostility at the beginning of the process, that the changes achieved had been so significant with so little audible dissent.

Managing Basics

Establishing the mandate relating to who would

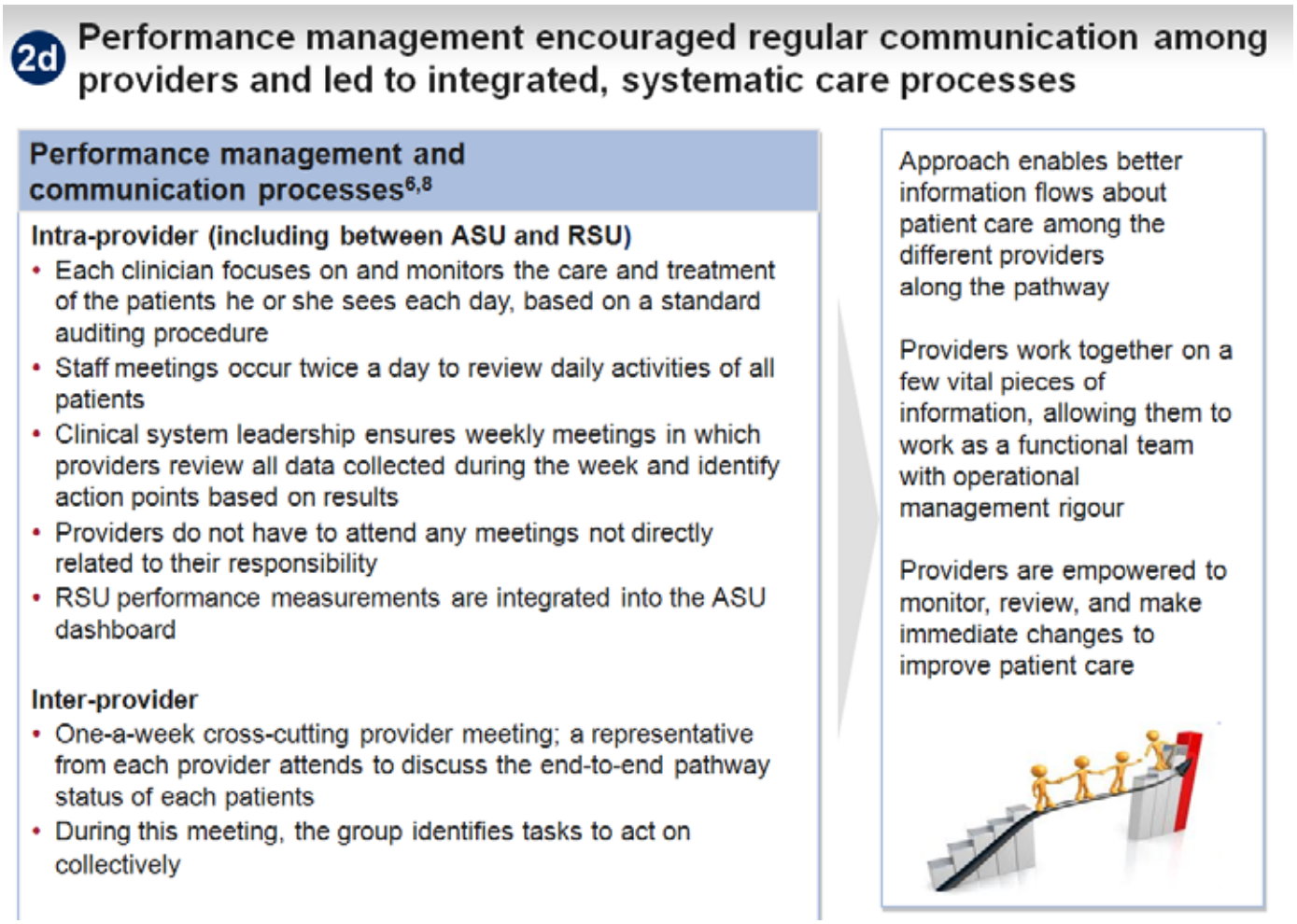

Figure 4

be accountable and responsible for the pathway performance was a very stressful process. As the pathway involved several different providers the mandate needed executive sign-off from the Acute Trust and the PCT provider arm. Within these organisations, to start with, there were divergent views within their clinical members regarding how to approach the change.

Given the reality of the financial position of both organisation, substantive further investment was not viable, so my proposal to achieve the improvements in care at the same or less cost was finally decided to be the one of choice. With this mandate, I was able to introduce a simple, clear structure, and as a leadership team we spent considerable effort ensuring everyone was clear about it.

The health community already had large amounts of data relating to this pathway. This was collated and presented in more readily understandable formats, and we made it clear through the new structure that all of the ongoing management and change should be based on these new data dashboards. As these did show clear areas of opportunity, subsequently achieving buy-in was relatively simple.

The next key phase of the project was to ensure with the structure and information that we had set local teams clear expectation of how we wanted them to use the data and approach the change. After 4 weeks giving local teams space and autonomy it was evident that they were not able to achieve what we were hoping that they would. As a consequence we started to attend local team meetings, and role-model what we meant by what we were asking teams to do. Within 2 months the local teams had a better understanding of what we were saying and what that meant in reality, and they were more than capable of delivering this themselves after a relatively short period of guidance.

With this structure embedded we then went to great lengths to find areas of improvement and individuals who had particularly championed change, and praised them explicitly. We actively visited teams and identified people within them that were showing a particular aptitude for taking management and leadership positions, and we encouraged them to undertake small projects within their area. It is intended that these people will be invited to leadership development days we have organised with a view for creating a sustainable pipeline of leaders and managers within this clinical service.

We have not had to put in any additional resource or guidelines at a local team level. Simply asking and empowering local teams to manage to their own guidelines, using their own establishments, has delivered the improvements shown in the figures above.

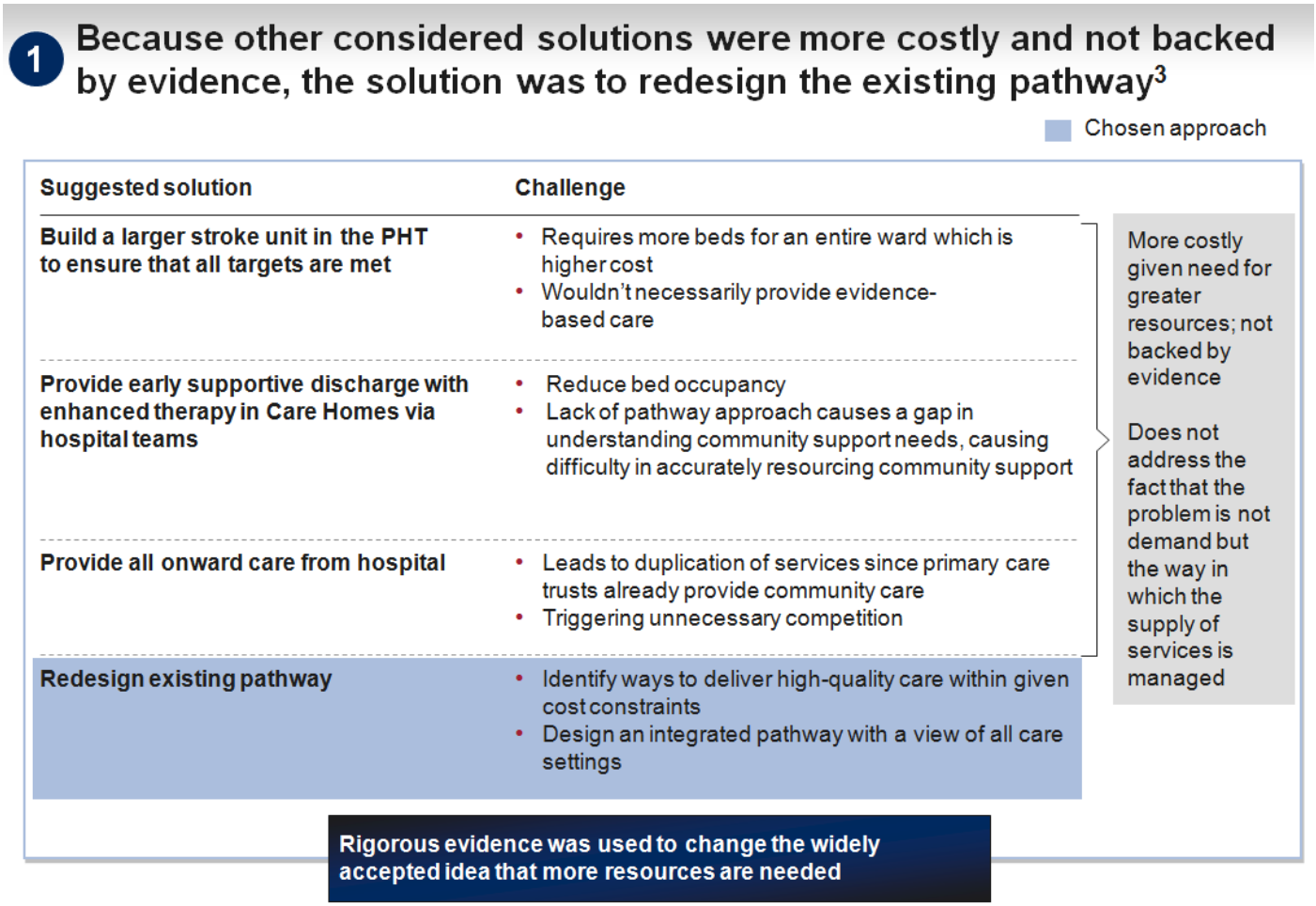

Figure 5

Conclusion

On the 18th of June 2010 the SHA team that had visited the Plymouth health community two years earlier came to make an evaluation. Their initial evaluation had been damning; they had found a clinical pathway that was disjointed, providing patchy, low-quality care. When they returned it was possible to present to them a joined-up clinical pathway articulated via 8 local teams, joined together with one single purpose: optimising the care of patients of stroke from the moment they had clinical symptoms, back into the community and beyond. It was the most satisfying experience I have in my career as a clinician and clinical manager.

However, from that point, although the improvements have been maintained, we have made small but significant improvements. The largest potential improvement possible has been halted; this relates largely to the change in approach following the General Election of 2010. The proposed changes to the SHAs and commissioning structure have provided a huge distraction to those individuals involved in these bodies. In addition, the Stroke networks and changing financial allocation to the NHS have created a context that is far more controlling and draconian, even for services like ours that are generating significant financial surpluses. We very much hope that we have now adjusted to the new environment and significant improvements can start again, based on the principles that have worked so far. The table below provides a summary of how the elements of this framework played out with respect to the Stroke project. Article 12 will draw the broader conclusions.

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lines which flow charmingly from the front wings to the rear. Uniquely designed 20-inch (and optional 21-inch) wheels reinforce the Mulsanne's commanding, sporting stance.

Inside, the aroma of leather and wood envelops you instantly. The scent is wonderful, yet almost overwhelming. And there's a reason for this: over 170 hours - that's almost half the entire build process – goes into crafting the interior of the Mulsanne. Each steering wheel can take 15 hours to hand-stitch while stainless steel brightware gleams so perfectly, thanks to an intensive 10 hour finishing process. The wood veneer takes five weeks to turn from a rough root ball into a full set of mirror-matched, fine-polished leaves – and a time-honoured tanning process is even employed for the leather; this is what gives off the rich, worn fragrance that is so evocative of vintage Bentleys. The entire cabin is also encased within a 'ring of wood' waist rail with an unbroken panel of wood gracing the Mulsanne's dashboard. Inverted dial needles within the instrument cluster are reminiscent of early Bentleys, while the whole dashboard and console design is a subtle reminder of the Bentley wings motif.

Naturally, sitting in the rear of the Bentley Mulsanne is the best place to comprehend the sheer graft that goes into creating the cabin. Amongst all the glossy wood and lavish leather, you also start to appreciate how the latest in-car technologies have been cleverly and unobtrusively placed within the lush interior. A multimedia system drives satellite navigation, audio/video, personal

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- 0-62 mph: 5.3 secs
- Combined mpg: 16.7
- Engine: 6752 cc Twin-turbocharged V8 petrol
- Max. power (bhp): 505 at 4200 rpm
- Max. torque (lb/ft): 752 at 1750 rpm
- CO2: 393 g/km
- Price: £225,900 on the road

data, telephone and Bluetooth® connectivity. The upper dashboard houses a multimedia screen, positioned discreetly behind an electrically operated veneered flap, while below sits a chic, leather-lined media player stowage drawer with connectors for iPod, USB and much more.

Whether sitting in the back or behind the wheel of the Mulsanne, you cannot ignore the pure punch of energy unleashed from the Bentley's 6¾-litre V8 engine. It guarantees huge power at low revs and self-possessed performance, while maintaining high levels of finesse at any speed. The powerplant, mated to an eight-speed automatic transmission with steering-wheel mounted paddles, delivers 505 bhp - and vast torque (752 lb ft) is delivered at 1750 rpm. This spectacular pulling power from just above idle and right across the rev range ensures that with a simple tap of the accelerator you're instantaneously rewarded with that distinctive, sonorous, V8 burble as well as exceptional acceleration.

Quite simply, the Mulsanne is as near to motoring perfection as you can get. The only thing that lets it down is a smaller than expected boot but, that aside, very few car manufacturers can offer such a concoction of performance and refinement in a single vehicle. So, if you can afford it – why wouldn't you want to experience Bentley's top model? Life's too short to keep it all in the bank.

By Tim Barnes-Clay, Motoring Writer
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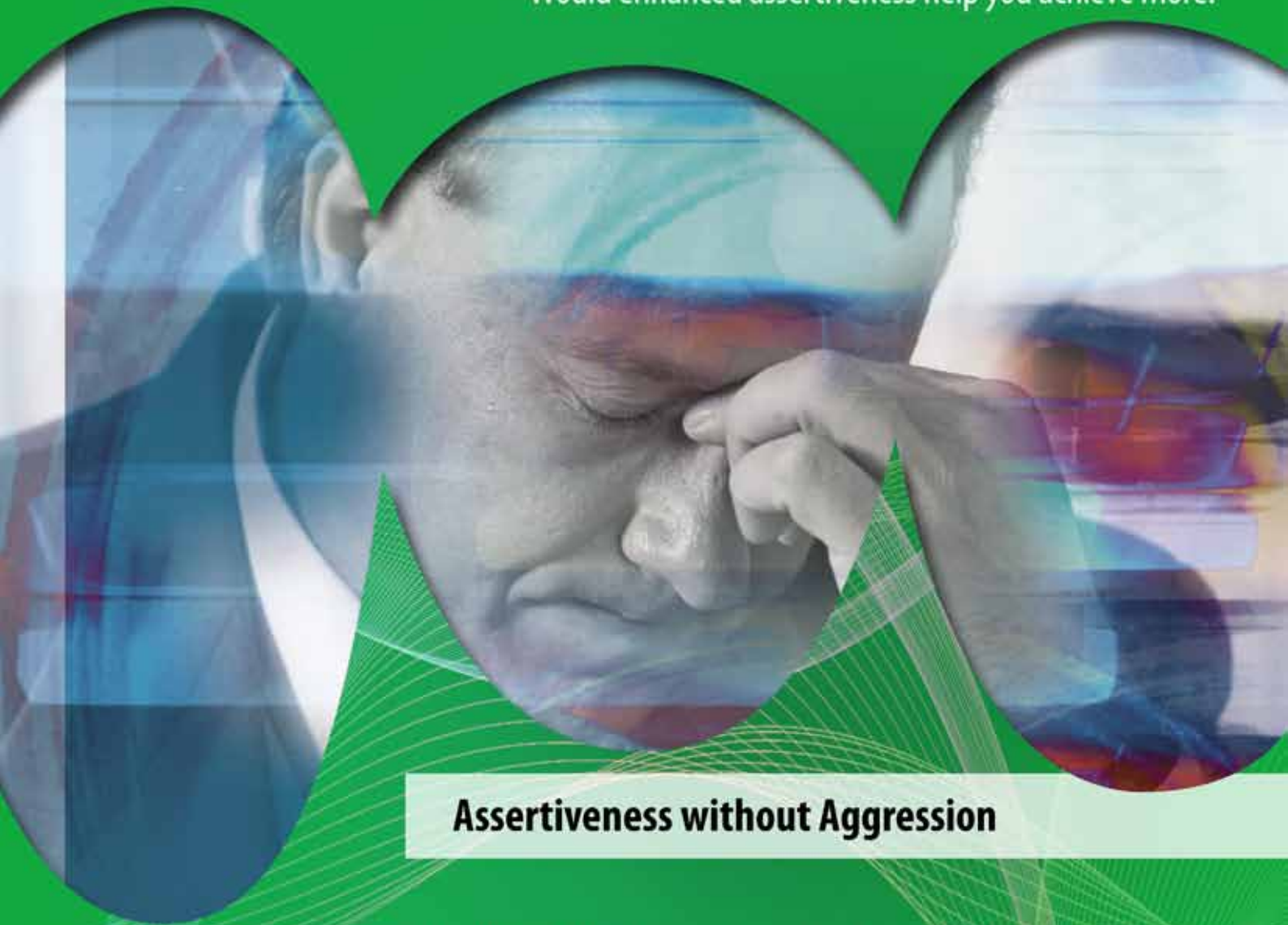
PROS 'N' CONS:

- Luxurious √
- Powerful √
- Iconic √
- Good looking √
- Small boot X

Assertiveness without Aggression

Do you feel you would benefit from more influence?
Would you like to improve your impact?
Would enhanced assertiveness help you achieve more?



Assertiveness without Aggression

The Medicology programme Assertiveness without Aggression is designed specifically to enable consultants and other doctors or healthcare professionals to have greater impact without adverse consequences

The course covers enormous ground from helping identify root causes of different behaviour to developing strategies to master your own emotions, so important in balanced, effective assertion. The course is built intelligently into 8 distinct modules, including:

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- Core Principles in Effective Communication & Influencing
- Improving Impact & Interaction Effectiveness
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