THE CONSULTANT

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HOT DEBATE
LIFE-EXTENDING DRUGS:
COST EFFECTIVENESS VS. PUBLIC OPINION

BATTLING THE
'SILENT EPIDEMIC'

CLINICAL COMMISSIONING
ARE THE CHALLENGES BEING MET?

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Editor's Introduction

Welcome to the tenth edition of The Consultant.

I sincerely 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.

We do hope that you enjoy this edition as it features a diverse range of articles designed to inform and stimulate debate. For example, this month's Hot Debate focuses on the controversy which surrounds the use of life-extending drugs. We know there's 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 report on newly published research which will hopefully aid the global fight against escalating levels of diabetes, the latest thinking is showcased on the introduction of Clinical Commissioning (as well as a review of the recent Commissioning Show 2012), and our regular Amazing Medicine section focuses on a major breakthrough in heart surgery.

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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Debt-ridden South London Trust has Special Administrator appointed

Health Secretary Andrew Lansley has announced that a Trust Special Administrator has been appointed to deal with the case of South London Healthcare NHS Trust.

The Administrator has been confirmed as Matthew Kershaw who will immediately assume full control of the Trust, replacing the functions of the Trust board and assuming the role of the Accountable Officer.

He will also be responsible for maintaining patient services as well as developing recommendations to secure a sustainable future for services provided by the Trust.

Secretary of State for Health, Andrew Lansley said:"Past efforts have not succeeded in putting the South London Healthcare Trust on a sustainable path. This will be a big challenge and my key objective for all NHS Trusts is to ensure they deliver high-quality services to patients that are clinically and financially sustainable for the long term. The purpose of the Trust Special Administrator is to ensure that services are high quality and to ensure a lasting clinical and financial solution.

"Matthew, working with clinicians, all other staff, commissioners, patients, the public and other stakeholders, must now drive the changes and shape a sustainable solution for South London Healthcare NHS Trust and the local health economy."

Matthew Kershaw

Trust Special Administrator at South London Healthcare NHS Trust, Matthew Kershaw, said:"My priority is to work with staff, patients, the public and all those involved in healthcare services in the south east London area to maintain high quality, effective services during the running of the Unsustainable Provider Regime.

"There have been some recent improvements in clinical standards at the Trust but these are not being delivered within budget. The Trust is overspending by £1.3 million each week, meaning vital resources are being diverted away from other services and communities – this is not acceptable or fair. Patients and taxpayers deserve more than this. I am committed to the NHS and committed to ensuring patients and tax-payers both get a good deal in south east London."

A final report by Mr Kershaw will be submitted to the Secretary of State for Health by 8 January 2013.

MP task force sets its sights on tackling cardiovascular disease

Diabetes and obesity epidemic threatens to undo progress so far

The NHS restructure, financial pressures, increasing life expectancy, and rising levels of diabetes and obesity levels means the Department of Health must do more to improve progress preventing cardiovascular disease, according to a cross-party group of MPs.

The group, which contained key experts in heart disease, diabetes, stroke and kidney disease, has spent the last three months examining the key priorities for tackling cardiovascular disease – which costs £14.4 billion a year to treat and is the UK's biggest killer.

Their findings are likely to form a large part of the Government's major new Cardiovascular Disease Outcomes Strategy which will be published later this year.

Betty McBride

Simon Burns MP

The group's main findings:

- 157,000 people die from cardiovascular diseases each year
- One in every 133 babies are born with congenital heart disease
- There are 140,000 new diagnosis of diabetes each year. It's estimated that more than five million people will have diabetes by 2015
- 300,000 are living with moderate or severe disability because of a stroke
- 10 per cent have significant kidney impairment

Betty McBride, Chair of the CVC and Policy and Communications Director at the British Heart Foundation, said:"The Outcomes Strategy will need to recognise that today's heart patient could be tomorrow's stroke victim.

"Cardiovascular diseases don't wait in line – all too often people are living with more than one condition and this can have a devastating impact on people's lives."

The Minister of State for Health, Simon Burns MP, added:"We're very grateful to the APPGs and the BHF for producing this report, and to all the individuals and organisations who have contributed their time and expertise.

"As we develop the Cardiovascular Disease Outcomes Strategy, these recommendations will be considered fully and carefully, alongside the feedback we are receiving from our engagement across the country.

"By all working together, we can improve outcomes for people with, or at risk of, cardiovascular disease and make a huge difference to people's lives."

Hopson is new Foundation Trust Network Chief Executive

Taking over as head of a high profile organisation such as the Foundation Trust Network (FTN) during a time of great upheaval in healthcare requires a talented individual, an individual such as Chris Hopson.

Joining the FTN from HM Revenue and Customs, Mr Hopson has had numerous strategic communications and corporate affairs roles as well as experience in large public sector businesses.

He succeeds Sue Slipman and will take up his appointment in September.

He said: "I am delighted to have been appointed as the FTN's new chief executive. Working in such a vibrant and innovative part of the public sector is a very exciting prospect.

"There are huge opportunities to be grasped, and I look forward to working with the FTN membership, board and team to realise that potential."

Chairman of the Foundation Trust Network, Peter Griffiths, said: "I am delighted that Chris will be joining us, and that he will bring his leadership skills and wealth of experience in the public, private and voluntary sectors to ensure the FTN continues to go from strength to strength.

"In particular we welcome Chris's hands-on experience of working across Government and his strategic communications background, both of which are absolutely essential to influence effectively on behalf of all healthcare providers in the NHS.

"With the radical changes to the NHS landscape and the far-reaching financial constraints, these are challenging times for all our members; we need to ensure that their voice is heard at the highest levels."

In welcoming Chris, NHS Confederation Chief Executive Mike Farrar said:"I would like to congratulate Chris on his new appointment."I look forward to working with him and continuing our relationship with the Foundation Trust Network, so we can mutually support the NHS by bringing together leaders from across the healthcare system when we need to address system-wide issues.

Chris Hopson

"I would personally like to wish Sue Slipman all the best for her future endeavours. She has provided strong leadership for foundation trusts on the issues that matter to them over the past eight years."

"Right action to take" says Stout as administrator appointed at South London Healthcare NHS Trust

The announcement by Health Secretary Andrew Lansley that South London Healthcare NHS trust was to be placed into administration sent shock waves throughout the healthcare system but was undoubtedly the right course of action to take in response to the troubles at the Trust, says David Stout from the NHS Confederation.

The Trust is the first to ever enter administration – a devastating testament as to the extent of the debts accrued.

Mr Stout, the Confederation's Deputy Chief Executive, believes that such a move was the only way to address the Trust's "fundamental problems."

Responding to the news this week that a special administrator, Matthew Kershaw, has been appointed to oversee South London Healthcare NHS Trust, Mr Stout said: "The Government is taking the right action to respond to the troubles this trust is facing.

"Propping up struggling trusts with short term solutions is not the answer. These organisations need to be allowed to sort out their fundamental problems.

The Trust, which runs Queen Mary's Hospital in Sidcup, the Queen Elizabeth Hospital in Woolwich and the Princess Royal University Hospital in Bromley, is thought to be losing in the region of £1 million a week and cuts to jobs and services are seen as likely.

Mr Stout continued: "We need more decisive action if the NHS is going to maintain the highest quality service and stay on a stable financial footing during these financially challenging times. This will mean many NHS organisations making radical changes to way services are provided.

"When taking over a trust, it is important that the administrator looks beyond hospital care to consider primary, community care and social care to make sure services are placed back on a financially sustainable footing."

"It is important to reassure patients and the public that the hospital will continue to provide the full range of services while the administrator develops proposals."

‘Not fit for purpose’ Victorian hospital to get Department of Health makeover

Paul Burstow

A hospital branded ‘not fit for purpose’ – Broadmoor Hospital in Berkshire - is to get a £298 million upgrade for patients and staff with old buildings replaced with fit-for-purpose and secure facilities.

The high securityhospital, which dates back to 1860,treats people with mental illness and personality disorders who represent a high degree of risk to themselves or to others.

Facilities at the hospital, which treats patients with some of the most challenging cases of psychiatric and mental health problems in the country, will be improved to make sure that patients have access to the right treatment in a secure and safe environment.

The investment follows a report by the Commission for Health in 2003 which concluded that “the accommodation at Broadmoor Hospital is no longer fit for the delivery of modern mental health services”.

Care Services Minister, Paul Burstow said: “It is clear that the facilities at Broadmoor are no longer fit for purpose. This investment is vital if we are to maintain security at the site and provide patients with treatment in the most appropriate conditions.

“The redevelopment will ensure that the hospital can provide facilities where patients can be treated and recover in a safe and restricted environment. We cannot let this hospital continue to crumble.”

Edinburgh Legionnaires’ outbreak hits 100 cases

The latest reports on the Edinburgh Legionnaires’ outbreak show that a further person has been confirmed with the illness taking the overall number of cases to 100.

Of the 100 cases, the total number of confirmed cases is 52 and the number of suspected cases is 48.

A total of 20 cases are being treated in the community, 59 have been discharged from hospital and three people havedied.Ten cases are being treated outwith the NHS Lothian area. The ages of the confirmed cases ranges between 32 and 85, with more males than females affected.

Health Secretary Nicola Sturgeon said:“The latest case of Legionnaires’ has been ill for some time, and has now been identified as a confirmed case.

“Over recent days as expected, we have not seen as many cases of Legionnaires’ as we did at the peak of the outbreak, and this continues to offer reassurance that the outbreak remains under control.

“NHS Lothian are maintaining high quality care for patients who remain unwell and investigations continue to identify and deal with the source of the outbreak.”

Dr Richard Othieno, Consultant in Public Health Medicine, NHS Lothian, added:“While this is the first new case in more than a week, it is not unexpected.As the outbreak draws to a close we can expect to see a small number of cases coming forward who have experienced mild symptoms initially and have sought medical attention later in their illness.”


Nicola Sturgeon

Investigations into the source and cause of the outbreak continue with Lothian and Borders Police and the Health and Safety Executive jointly undertaking an investigation into the circumstances of the deaths.

Clinical Commissioning - are the challenges being met?

By Stephen Foster,
Non-Executive Director, Commissioning4health

So – Clinical Commissioning Groups (CCGs) are set to "go live" in just over nine months' time, and we don't seem to be any nearer to answering some of the key questions.

How are the challenges being met so far? How is the process proceeding? What safeguards are in place in case CCGs can't adhere to the strict timetables set them by the NHS Commissioning Board?

The answer to most of these questions is a rather vague "who knows"….!

There are currently 212 CCGs in transitional form and working towards authorisation, the size of which varies greatly depending upon which part of the country you look at.

In some areas, there are CCGs of well over 750,000 patients in size (surely far too large to be able to do anything "local"?) whose boards have developed sub-structures below them as "Locality Commissioning Groups" or LCGs.

In other areas, CCGs are much smaller (better suited to local decision making) but too small to manage some of the financial risks associated with their levels of responsibility. In these cases, the CCGs have clustered together in collaboratives with more centralised controls in place (which feels to me a bit too much like a return to PCTs and SHAs, to be honest).

CCGs are also at very different levels of development, and tend to be focusing their efforts on the "form" rather than the "function" – their members are spending their time working out the composition of their boards before they work on the strategic plans to deliver better patient care in their localities.

They seem to be doing this the wrong way around in my opinion, and I will explain why in a bit more detail.

One of the key messages of this transformational change in the NHS (the biggest in my lifetime) is the need for multi-professional clinical engagement at every level.

Unless we work very differently from how we did things in the past, this process will result in a very expensive and time consuming renaming of Practice Based Commissioning (PBC), which with a few notable exceptions was an abject failure.

The old saying "you don't know what you don't know" has never been more apparent, and GPs need to work very closely with their fellow health professionals in both primary and secondary care to design innovative new clinical services for the benefit of their patients and the public.

The Department of Health has recognised this as a key priority for emerging CCGs, and the need for multi-professional engagement in commissioning and provision forms a pre-requisite part of Domain 1 in the authorisation process.

This does not mean a group of GPs inviting one of their practice nurses along to their board meeting (which has been the way of things in the past) but true engagement with a whole range of clinicians from primary and secondary care, social care, public health and local government from as early a stage in the process as possible.

This engagement also needs to involve the contractor professions of pharmacy, dentistry and optometry as well as practice and community nursing, midwifery, and a variety of other allied health professionals such as speech and language therapists, physiotherapists, podiatrists and any others that you could name!

Early intervention and primary prevention also needs to come to the fore, with emphasis being placed on "keeping patients well" as opposed to "treating illness". This public health agenda is set to be led by local

authorities and local government, which is why CCGs need to engage with them as well.

When I spoke with the Business Manager at my local CCG recently about exactly this point, he explained to me that the board was in the process of putting together their strategic plans (a critical stage in the process of transition to CCGs) and that as soon as this work was complete, they would come and speak to me about the help we could give them.

Unfortunately, he was missing the point…. If CCGs leave clinical engagement to that stage, then it is already too late! This agenda is simply too big for GPs to "go it alone" and we are all there to help as part of one big team. For example, who better to help redesign a more efficient, effective speech and language therapy service than the local speech and language therapists?

It is also important to remember that different parts of the health system engage with different groups of patients. Although a GP might see around 30% of the patients on their practice register, they don't generally see the other 70%. However, these patients DO see their local dentist for a dental check-up, their local optician for an eye appointment, or their local community pharmacist for 101 different reasons! This is what I like to refer to as the "Heineken Factor" – reaching the parts that other (GPs) can't reach….

I would urge GPs and their colleagues in the emerging CCGs to engage NOW with as many clinicians as possible – not as members of the board, but in some sort of collective local clinical network. Intelligence from the coal face is critical, and there are networks of willing health professionals who are waiting to be asked.

One key example of this is the Clinical Commissioning Community. Led by Dr. James Kingsland, the community consists of a network of GPs and other clinicians interested and involved in commissioning at every level. While Dr. Kingsland leads the National Clinical Commissioning Network (NCCN) I myself lead the Healthcare Professionals' Commissioning Network (HCPCN), which represents pharmacists, dentists, nurses, optometrists and a whole host of allied health professionals.

Both networks are hosted on NHS Networks, and the details are easy to find. There are hundreds of participants within the community which means that we can support CCGs in every part of the country. Not only that, but with a broad range of clinical and commissioning expertise across the entire clinical spectrum, we can find someone to solve every conceivable problem!

From 1st October 2012, the National Commissioning Board is set to become fully functional, so I have no doubt that the picture will become a lot clearer at that stage. However, in the meantime, we cannot afford to sit back and wait for something to happen. We are all in this together; the GP's problems are everybody's problems; and the £20bn challenge is everybody's challenge.

Working together, I am confident that we CAN deliver this, and would like to offer the collective support to CCG boards of all those within the clinical commissioning community to make this happen.

Stephen Foster is the national clinical leader for pharmacy and Pharmacy Superintendent of Pierremont Pharmacy in Broadstairs. He leads the Healthcare Professionals' Commissioning Network (HCPCN) nationally as well as sitting on the NAPC Council. He is also a Non-Executive Director for Commissioning4health, a commissioning support organisation which provides bespoke training solutions for emerging CCGs as well as a bank of clinical and non-clinical associates to support the work of CCGs, the NHS and the pharmaceutical industry.

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 July Debate

Life-extending drugs: cost effectiveness vs. public opinion

Life-extending drugs can prolong life for months and in some cases, years, but their use not only places an intolerable strain on NHS financial resources, but also throws up a serious moral debate as to whether a patient is 'worth' an expenditure which on average is close to £10,000 per patient and which often results in just a few months grace.So just where should our priorities be? At a time of considerable financial austerity for the NHS when younger patients are being denied treatments and proper social care for the elderly is at a desperate low, who should pay for expensive drugs that prolong life only for a matter of months? Should it be the patient? Should it be the family? Or should it be the NHS?

Sara Watkin
Editor-in-Chief

Next Debate

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

Upholding the Sanctity of Life or a Drug Too Far?

Where should the cut-off be in the use of life-extending drugs?

Controversial and outspoken, Dr Karol Sikora is a cancer specialist well known for his forthright views on the use of life-extending drugs and the huge costs they incur for the NHS. Often referred to erroneously as the 'Lockerbie bomber's doctor', he was in fact one of a number of specialists requested to give an opinion on the life expectancy of the now deceased Abdelbaset al-Megrahi. Dr Sikora is, without doubt, a major voice in the moral debate surrounding the use of life-extending drugs and is generally scathing of the way the NHS operates overall. One of the most recent developments in the life-extending drug debate has been the U-turn performed by the National Institute of Health and Clinical Excellence (NICE) regarding the use of the advanced prostate cancer drug Abiraterone in the UK, a controversial move which Dr Sikora views with some suspicion as he relates to The Consultant's Fraser Tennant…

KS: One never knows how much political pressure NICE is under. They say that they are under political pressure but I very much doubt it. On initial calculation, NICE said that Abiraterone was too expensive to be worthwhile. It's about three thousand pounds a month. The Scottish Government, the Scottish equivalent of NICE, said it was too expensive. NICE then changed its mind. I can't help feeling it's because the drug was actually discovered in the UK. So it's a British drug and in every other country in Europe it's easy to get hold for patients, even on the equivalent of their NHS, so I think it would have been a political embarrassment. The company that make it, Johnson & Johnson, said that they reduced their price but the details are commercially secret so the answer is as transparent as mud, like a lot of things that go on in drug pricing.

You have a reputation for being outspoken on these kinds of issues. Does the NHS need to talk about this more often?

KS: It does. I think the real problem we've got at the moment is that all healthcare systems are in a perfect storm because of aging populations and the high cost of new technology. And everybody knows about it through the internet and through other media. When I was a student you could hide things. Now you can't pull the wool over people's eyes, they know about these drugs. They know about Abiraterone. So I think we've got to have much more transparent systems to deal with it and what I find very difficult is that the NHS is one of the most political services in the world because politicians get votes out of it. The real problem is that because of that, the actual decisions are obscure. My speciality, cancer, is a great example of obscurity. It's controlled by each of the ten strategic health authorities and each has different policies for different drugs. Different parts of the country have different policies in place and it's not transparent. This is not a national health service.

If we get away from this and think about how the NHS has to operate it's like an insurance company. You would complain if different

car insurers were giving different customers different levels of benefit, even though they've paid the same amount. That's exactly what the NHS is doing. And although I only know about cancer, because that's all I do, I suspect it's the same about other things.

If you've got a patient whose life could be extended by a particular drug, such as Abiraterone, but it can't be given because of cost, how do you explain that to your patient? How do you explain to their family?

KS: It's very difficult. To know that there is a treatment, but for cost reasons you can't access it, is very difficult to accept and very difficult to explain. I think it's especially difficult if some people are getting it freely out of the NHS. If no-one's getting it, then

you say, well, that's the deal, that's the way the NHS has gone. But to have some postcode prescribing going on quite openly is something that is really unacceptable.

So should a drug be made available if it costs £10,000 over three months?

KS: I would say it depends on what the benefit is. If the benefit is months of good quality life with not many side effects, then I would say yes. NICE has a £30,000 cut-off point for a quality adjusted life. Any intervention above that is not given. Anything below is easily given. The trouble is a lot of things are in the middle, around £30,000 a year for a quality adjusted life. In the case of Abiraterone, Johnson & Johnson have lowered the price to make it nearer £30,000.

Now, NICE is a very good organisation, it's just that what happens is that the politicians play around because they don't like the decisions. They didn't like the idea that Abiraterone could be given to British patients, so they asked them to go and re-examine the whole thing. But even still, there is inequality in access to many cancer drugs.

How independent is NICE from government decision-making?

KS: I don't believe it is. The other problem we've got with NICE is that the £30,000 per quality adjusted life ruling has been in place since 1999 (when NICE was created) and medical inflation has gone at about 7% a year since then. So £30,000 should now be about £60,000 after 13 years yet it's not, it's still £30,000. So it is a strange business to have NICE and then to have a cancer drugs fund which can bypass NICE. It's very simple. A hospital has a list of drugs it gives to patients and if the drug is not on that list, it isn't given. That seems a reasonable approach and, obviously, what hospitals try and do is use generic drugs where possible, because that reduces cost and that's good training for the students and the younger doctors. The difficulty here is that we're in an era where there's going to be five or six high cost cancer drugs and we're faced with exactly the question you've asked: why tell them about these drugs?

So how transparent is availability information? Are patients really being deliberately kept in the dark to save costs?

KS: I always think that if you don't ask in our great NHS, you don't get. And although you can never find this out, even under Freedom of Information, I am convinced that people who are better educated and much more savvy are getting drugs on the cancer drugs fund through the special application process. They know how to work the system and how to persuade the consultant, 'look I need this drug, I want it, I've researched it, I've been on the computer and I'd really like to get it, I'll fill the forms in for you.' That's another example of inequality on the NHS. The retired old boy who's been a porter in a factory for forty years, he's not going to know how to do that, how to persuade people that it is justified. The other great argument about all this is, with drugs for cancer and other things, is ageism. Should you be ageist? I'm a great believer in ageism. The cut-off is above my age, you know.

What about quality of life?

KS: If you've got an 85 year old with dementia, would you seriously want to give them £100,000 worth of cancer drugs? People are crazy wanting to do that. They're a drain on everybody, including the relatives. They don't know where they are. I've got an 82 year old patient at the moment with prostate cancer and he's in a care home in West London and he does not know what day of the week it is. He comes to the hospital every month for his injection of Zoladex, which is a hormone drug, but he's now beginning to fail. So do we start him on a drug like Abiraterone when he's not asking for it and his family don't want him to have it?

They're very happy for him to just gradually go down. The ethics are very difficult. It's a very good example of ageism and seems a reasonable approach here. Now, there may be a man of a similar age who has fantastic quality of life and I would definitely recommend that they have an expensive drug. But clinical decision-making has been removed through algorithms and a level of bureaucracy that's very difficult to follow.

In the case of the Zoladex patient, aren't you leaving yourself open to accusations that you're leaving people to die?

KS: No. I was just looking about the thing in the news today about cardio pulmonary resuscitation. I think we're kidding ourselves if we think we have that much control over it. These drugs have a relatively small impact in some patients and a bigger impact in others. You can't necessarily predict it. I don't know what the impact's going to be on an individual but I don't think they have as much as people imagine. But there is the emotional blow if someone isn't getting a drug. Imagine the scenario. A patient has heard about a drug and you say yes, it would suit them. Tests are done and paperwork is completed for the new drugs panel. Then the patient waits, only to be told 'I'm terribly sorry, but they've decided not to give you the drug.' It's worse than telling someone they've got cancer. And there's no appeal and no reason for it. The only way around it at that point is to pay for the drug, which someone can do if they've got the resources. But it's £3,000 per month. You need at least two months to know if it's going to work, so you need to have £6,000 cash. For some people, that may be relatively easy. For others, it's actually quite difficult. People have gone down the route of selling their house and so on, which is very sad.

Who should pay? The patient? The patient's relatives? The NHS?

KS: Exactly. If the patient does pay, that's coming out of an inheritance. Nearly all these drugs, even the very high costing ones, prolong survival by months only. The good news is that if we could predict which patients would respond to these drugs, we would make them much more cost-effective because, instead of giving it to a hundred patients with a particular type of cancer, we would only give it to the ten that are really going to respond.

The Hippocratic oath advises against performing nihilistic medicine. Are doctors struggling to come to terms with this?

KS: In cancer medicine, it's easy to tell someone they've got cancer if you then say this is what we can do about it. It's much more difficult to say you've had cancer for a few years, the disease has spread, you've had everything we've got, and there's nothing more that we can do. That is the most difficult conversation to have. And different doctors have different ways of doing it.

Dr Karol Sikora

Going back to the NICE reversal, will their decision have a ripple effect as regards other conditions?

KS: Yes, I think we'll see that. But I can't understand why there is a need for this commercial sensitivity. There's stuff on patent for the next decade. We'll know what the price is anyway when it is published in the British National Formulary. It's just hiding the decision process from public view. Which seems almost childish because, if all the company's done is to reduce the price by 30%, that's fine, let's do it.

How would you react to those who say that all human life is sacred and should be fought for, regardless of cost?

KS: That's an unrealistic expectation. If there was a drug that would cure an infection for the cost of a pound, we could cure the infection and everyone would trip over themselves to pay a pound for someone to get better. If it was ten million pounds, nobody would be able to do that. The reality is we're dealing with significant sums of money. It's unrealistic to use a whole healthcare budget to save five or six patients, which would be an extreme example. With modern technology we're going to get more and more into this sort of debate because technology can be used with older people and has got another cost. If the patient survives longer, they're likely to get other illnesses and will consume other drugs, other interventions, so their total healthcare costs are going to go up. We have to be realistic.

What impact will the Health and Social Care Bill have on this scenario?

KS: It's difficult to know how it's going to change the landscape. There is a lot of noise but it's not clear that we're really changing anything. Sure, we're changing the names of PCTs to Clinical Commissioning Groups and so on, but it's going to be the same people and the fundamental underlying problem is exactly the same. Someone's got to say when we can't go on treating someone, when we can't go on spending a lot more money on something. There was no need for this radical change. So I'm sceptical whether it will really make much difference in the end. I suspect the next government will change it again just to make it worse.

Dr Karl Sikora was previously Joint Clinical Director of Cancer Services at Hammersmith Hospital and is currently Dean of the University of Buckingham Medical School. A founding member of Doctors for Reform, an organisation which seeks new ways of funding and delivering healthcare, Dr Sikora is also Medical Director of Cancer Partners UK, a network of private cancer treatment centres.

The Ethics of Doing Nothing

Can we reasonably consider 'doing nothing' as an alternative course of action?

By Sam Watson, University of Warwick

This may come down to an issue on the role of the health care system in general. One of the principle tenets of NICE and the NHS is justice (the others being beneficence, non-maleficence, and autonomy). This NHS justice, it seems, is a sense of justice as described by John Rawls – justice as fairness. Justice as fairness is founded on two points – liberty and equality, that everyone should have the same right to basic liberties and that inequalities should be arranged to benefit the worst off in society to ensure distributive justice. Both of these principles are satisfied by the idea of access to health care based on need and regardless of ability to pay.

We use cost-effectiveness analysis to best allocate resources, so that we all get the greatest gain for our limited resources, but that does not necessarily ensure that the worst off get priority.

In the end it comes down to a deontologism versus consequentialism debate. Deontologism dictates that there are certain moral rules that must be followed, or as Kant described them 'categorical imperatives', and these rules can be reached through logical reasoning and must be universal. In this case, for example, if doing nothing were universally permissible for health care professionals then it would be permissible for no-one to be treated which would negate the existence of the health care professional in the first place. So, if we say that all those with needs must be treated, this may be a deontological stance. However, we do not provide services for all those with needs, and it may be practically impossible to do so. Health care provision is proportional to need, but those with the least needs generally have to pay for their own services, unless they are sufficiently poor, for example, dentistry.

Now, if we consider health care provision to be philosophically consequentialist, can we allow a 'do nothing' option? Many thought experiments exist to exercise consequentialist ethics. Consider a runaway train, it's careering down the track towards a station in which there are ten people who will die if the train gets there, you are on the train and have the option to switch tracks to divert the train away from the station. However, there are three men working on the line on the other track who will die if you pull the lever. Do you pull the lever? One argument, the utilitarian one, would say yes. The total loss would be smaller on the other track, we would therefore be maximising the total utility from the situation.

Another argument may say though that not pulling the lever is the only option since, if you did, the deaths of the three men would be your responsibility but in doing nothing you would be morally neutral. This is a form of egoistic consequentialism. Under both these arguments a health care provider could do nothing, in the first case if utility was maximised by treating others and in the second case because the health care provider is not morally responsible for a person's health care state in the first place – although this then leads to a further debate about agency.

There are objections to this line of reasoning. Peter Singer describes a situation to illustrate an objection to this. Imagine you are walking home one day. As you walk you pass a pond in which a child is drowning. The pond is not very deep and you could walk in and save the child, bearing no tangible risk to your own life. In this case the choice of inaction would lead to the child's death, and you surely could be held responsible for that. The choice of doing nothing, then, does not negate responsibility. Moreover, if the budget holder is the government, there are certainly arguments which may attribute to them a certain responsibility for poor health in the population (consider the relationship between the macroeconomy and health).

The key issue that remains is opportunity

cost. The only reasonable argument for doing nothing is that the time and resources could be better spent elsewhere, and cost-effectiveness analysis provides us with the information to know where it is best spent. However, in reality, no patient would be left to die if they turned up to a hospital and could be saved, and many adult intensive care units intervene in ways that are not cost-effective as per the NICE definition. The end of life is the most difficult to deal with, research has shown that people value a change from 0.2-0.4 quality adjusted life years (QALYs) more than they value a change from 0.6-0.8 QALYs. Many expensive life prolonging cancer drugs are not funded by the NHS, but there are cases of successful lobbying to have these drugs reimbursed despite their lack of cost-effectiveness. This could lead us to conclude that doing nothing is fine as long as it does not kill the patient (or allow the patient to die, depending on your stance) in which case we should always intervene. It is unfair to ask a health care professional not to act, since, as detailed, it is their responsibility if their patient dies through inaction.

For the most part, everybody is provided with the necessary treatment when they are in need. It's really only at the end of life the problem of opportunity cost is apparent due to the high cost of interventions. Perhaps the answer lies in allowing NICE to negotiate the price of drugs, although this would not necessarily lead to price reductions since companies would be incentivised to pitch drugs at an even higher price knowing that they will be negotiated down to their acceptable price. To the contrary though it may be argued that this constitutes inaction on the part of NICE, and by negotiating (or at least trying to) they could allow more people to survive.

Another issue is that the few months that are gained by (usually expensive) end of life treatment are usually in very poor quality. From an Aristotelian perspective this would not be a virtuous choice, as we would not be achieving 'the good life', and what's more, Aristotle says, no-one would actually choose this state of suffering unless they were defending a philosophical position. In the end we may ask ourselves why an extra few months for a cancer patient would be desirable. To whose benefit is it? As John Donne rightfully pointed out, no man is an island – we are inextricably linked to all those around us; the benefit of life prolonging drugs may be minimal when considered at the individual level but at a broader societal level, from the perspective of family and friends, those extra months may be hugely beneficial. But cost-effectiveness studies rarely, if ever, account for this fact.

In the end we may defend 'doing nothing' as a choice as it may be necessary in the face of opportunity cost, and it is always better to know the outcomes from as many scenarios as possible when modelling it in simulation based studies. However, in practice 'doing nothing' may not be realisable, since the fear of death may prohibit people from accepting this option. It is furthermore unfair to ask physicians not to treat a dying patient if they require it. Perhaps there is a case for allocating more resources to health care from other areas of public spending, which there certainly is a case for. What would be ideal would be a quantifiable way of measuring the benefit from all government spending and then choosing the health care budget based on this. But this is definitely a long way from reality.

Recognising the Right to Life

Should the decision to treat be a matter of the heart or the head?

Despite the merchants of doom and gloom asserting that we currently live in an age of irreversible social and moral decline, it is fair to say that most of us in the UK believe that we do still live in a predominately caring and compassionate society – a care and compassion epitomised by the behemoth that is the NHS. But how far does this compassion extend to (cancer) patients facing a seemingly inevitable demise? Should doctors perform nihilistic medicine when the Hippocratic Oath expressly forbids them to do so? Moreover, how is treatment, which in some instances costs £10,000 per patient to prolong a life by three months, to be paid for? The Consultant's Fraser Tennant poses the questions to Heather Walker, Policy Manager at Cancer Research UK…

Can the use of drugs such as Abiraterone, which costs the NHS £10,000 per patient and which extends life by months, be justified?

HW: Any patient whose clinician believes they'll benefit we believe should get access to these drugs. Bodies like the National Institute for Health and Clinical Excellence (NICE) and the Scottish Medicines Consortium (SMC) have a difficult job to do in weighing up the clinical and cost effectiveness of a drug. We think it's really important that NICE uses the right kind of criteria and looks at the drug properly and that it's free to do that. So we do think that they should be looking at the clinical effectiveness and weighing that against cost. Also, it's up to the pharmaceutical companies to price responsibly. In the case of Abiraterone, it actually got approved for two reasons. The change in position by NICE was because they assessed it differently and the pharmaceutical company looked at the price again and were able to offer a better one. The time that Abiraterone gives is around four months on average, but it is an average. We've heard of some men who have been on this drug and lived for years after being on it. So it's difficult to just say. Even if it is just months, they are precious for patients and their families. So it may be the difference between seeing their son or daughter married or being able to see a grandchild.

Looking at the bigger picture, with NHS funding limited, should money be being spent elsewhere?

HW: That's obviously the big question as we know the NHS doesn't have unlimited resources. If you do spend money on, say, an expensive drug, you might not be able to spend it elsewhere and that may even be within cancer services. We want to see a balance across cancer services to ensure that other services which are cost-effective, such as surgery and radiotherapy, continue to be funded and that it's not just about drugs.

Are some patients in effect being written off because information about available drugs is not being passed on?

HW: I don't think so. We haven't seen evidence of this. Before NICE was set up there had been local arrangements but this had led to a kind of postcode lottery, prescribing differently in different areas of the country, which was what NICE was set up to avoid. But doctors who believe that their patients would benefit from a drug that isn't routinely available can go through exceptional case committees to get funding.

How long does such a process take given we are talking about someone's life in terms of months?

HW: It's really important that these decisions are made quickly and they will vary because they can be made locally. We are really keen that the processes are streamlined and we support NICE so that they have enough time to make the right decision which is really important. With Abiraterone, there was a number of months where NICE was deliberating and where the pharmaceutical company was being kind of to and fro about the price. So systematic

Heather Walker

processes, where these happen across the board, really need to happen quickly.

What is the public perception of the issue?

HW: I think the public do understand the issues. We put out a survey asking for patients' opinions about this new pricing mechanism that the government is hoping to bring in and it is clear that people do understand that the NHS doesn't have unlimited resources. It's not simply a case of we should have every drug available, no matter what the cost. People do understand the issues especially if they have them explained to them, it's not something they can't engage with. Patients are very interested in this issue and it's one that has been around for a long time. I don't think there are signs of it going away. The government has these plans for value based pricing and it's also looking at potentially being able to get drugs to patients earlier, before they have their licence. They're due to consult on this imminently. We're really keen to see these government plans because it might be that we can look at the drug development pathway in a different way now and start to see a more innovative way of getting these drugs to patients. At Cancer Research UK, we believe that patients should really be informed and the government should be involving them in these plans.

Ultimately, how is all this going to be paid for?

HW: Patients can take that decision for some treatments but we'd rather be seeing the NHS managing its resources in a way that means people can get access to the treatments that clinicians think will benefit them. Again, it comes down to that balance of NICE getting it right when assessing drugs and the pharmaceutical companies pricing responsibly. It could be that, in the plans the government is drawing up, that there are new ways of making sure. So if there was an early access scheme that got drugs to patients at an earlier stage, it could be that we don't know as much about the efficacy and safety of these drugs. It could be that they initially launched at a price that's more affordable and, as more information is gathered, the price might vary. We don't know exactly how it will work but that's one possibility. So I think we will need to see more innovative ways of thinking about how to price these drugs, because cancer is on the increase because of our aging population and the NHS is coming under more financial pressure to provide treatments.

Heather Walker is a member of the Policy Department at Cancer Research UK where she manages treatment issues. She has worked at the charity since 2009 and previously led on charity sector policy. Prior to this, she managed a project on face-to-face fundraising at donor advice charity Intelligent Giving. A high flyer on the Charity Works management development programme cohort in 2010-11, Heather also studied Social and Political Sciences at the University of Cambridge, where she achieved a First Class degree.

Battling the 'silent epidemic'

UK and US give global diabetes research a timely shot in the arm

By Fraser Tennant, Medicology Ltd

Often labelled as the 'silent epidemic' due to the insidious and chronic nature of the condition, diabetes is a life-changing affliction which, if uncontrolled, can cause death, incapacitation, and have a negative impact on quality of life. However, twonewly published studies - one in the US focusing on prediabetes and one in the UK concerned with Type 2 diabetes- haveprovideda fresh impetus in the global battle against the disease.

With diabetes (Types 1 and 2)and its associated complications currently costing the NHS an unsustainable 14 billion pounds every year and US costs sitting at an eye-watering $174 billion, the announcement of new methods for dealing/preventing the condition are increasingly being greeted by the global healthcare community in a fashion akin to that of a drowning man gasping for air.

At present, it is estimated that there are 850,000 cases of undiagnosed Type 2 diabetesin the UK with around one person in every 74 undiagnosed. In the U.S, the figures are thought to be a massive 79 million people, around 11% of which go on to develop full diabetes.

The new diabetic research is the latest in a number of studies to have been undertaken in the last year; breakthroughs which include the clinical trials (funded by Diabetes UK) conducted at Newcastle University which saw a group of Type 2 diabeticsreverse their diabetes by drastically cutting their food intake to just 600 calories a day.

The UK study, an analysis by Diabetes UK, found that one in 70 people in the UK are living with undiagnosed Type 2 diabetes and so are missing out on vital health checks – a scenario that, if it should continue indefinitely, greatly increases the chances of complications such as amputation, blindness, kidney failure and stroke.

"When you consider the potentially devastating health consequences of Type 2 diabetes, it is shocking that so many people have the condition and do not know it," said Barbara Young, Chief Executive of Diabetes UK. "These figures show that every time we walk down our local high street, we are likely to be walking past people who have undiagnosed Type 2 diabetes.

"This is a real concern, because it is only by getting the condition diagnosed early that people can start getting the treatment they need to prevent serious health complications, including blindness, amputation, kidney failure and stroke. Getting these people diagnosed is a race against time, and unfortunately it is a race we are all too often losing.

Dr Leigh Perreault

"We are also encouraging people to talk to their friends and family about Type 2 diabetes. Making them aware that someone can have the condition for a number of years, without realising, could be the vital first step towards someone being diagnosed and

getting the healthcare that can give them the best chance of a long and healthy life."

In a study which complements its UK counterpart, the US research, undertaken by the US Diabetes Prevention Program Research Group and involving 1,990 people with pre-diabetes (the precursor to Type 2 diabetes), suggests that an"early and aggressive" approach should be taken with people on the cusp of developing Type 2 diabetes.

The study showed that patients who reduced their blood sugar levels to normal, even briefly, were 56% less likely to develop Type 2 diabetes during the six years of the study.

Lead researcher Dr Leigh Perreault, an associate professor of medicine at the University of Colorado-Denver, said: "The biggest risk for people with prediabetes is that about 70% of them will develop Type 2 diabetes over their lifetime and this is singlehandedly fuelling the diabetes epidemic.
This analysis draws attention to the significant long-term reduction in diabetes risk when someone with pre-diabetes returns to normal glucose regulation, supporting a shift in the standard of care to early and aggressive glucose-lowering treatment in patients at highest risk."

Fellow US diabetes expert, Dr Joel Zonszein, Professor of Clinical Medicine at Albert Einstein College of Medicine, added: "The analysis stresses the significant long-term reduction in diabetes risk when someone with prediabetes returns to normal blood-sugar levels, supporting a shift in the standard of care to early and aggressive glucose-lowering treatment in patients at highest risk.

"My recommendation for my patients with early diabetes is therapeutic lifestyle changes plus aggressive anti-diabetic agents."

Giving a UK view of the US study, Matthew Hobbs, Diabetes UK Head of Research, commented:"This research investigated a group of people who had some, but not all, of the symptoms of Type 2 diabetes. The results show that the percentage of these people who went on to develop Type 2 diabetes was significantly reduced if they managed to regain control of their blood glucose at any point before the study began. It is interesting that the method used to achieve this improvement (diet, exercise and education or the drug metformin) was not important. The important thing was to regain normal glucose handling in some way.

"This research does not definitively prove that regaining control of blood glucose reduces the risk of developing Type 2 diabetes but does provide further evidence that those at high risk of developing Type 2 diabetes should be tested early and often to establish their glucose control. Poor glucose control, even at levels below the threshold used to diagnose Type 2 diabetes, should be treated as an early warning sign and treatment should be prescribed to maximise the chances of regaining control. This is why we are currently funding a range different studies which look at different ways of achieving this."

Big names and big advice at Commissioning Show 2012

"I've heard things vocalised today that we just didn't know about and it's excellent to have some degree of certainty"

The above is typical of the feedback given by primary care movers and shakers who were in London a couple of weeks ago for perhaps the biggest healthcare event of the year - the Commissioning Show 2012.

Complementing major primary care associations and over 200 healthcare exhibitors and suppliers was a mouth-watering collection of the biggest names in healthcare including: Andrew Lansley, the Secretary of State for Health; Dame Barbara Hakin, National Managing Director of Commissioning Development; Stephen Dorrell MP; and Dr Charles Alessi, Chairman of the National Association of Primary Care. All were keen contributors to the discussion and debate around the key issues concerning the introduction of clinical commissioning.

Certainly oneof the UK's most thriving healthcare events, the two-day Commissioning Show (27- 28 June) was promoted as being a veritable hotbed of influential policy makers and a mecca for inspiration and advice. Indeed, the Show's website states that over 2700 GPs and healthcare managers were in attendance, experiencing 40+ workshops and expert Q&A sessions.

Show attendee Dr Rashira Buranjupaysaid: "There are very few opportunities for clinical leaders to learn. We're already holding down a day job and trying to do this as well. So I think this is something that's very time efficient, valuable, and brings the key speakers into one place at one time so that GPs can maximise the value of their time and learn. It's certainly been worth coming to."

Echoing Dr Buranjupay's sentiments was Mark Jennings from the RGCP Centre for Commissioning. He said: "It's a good event because we've got an emerging world of landscape commissioning and it's helpful for people to be able to see what's on offer and I've certainly spoke to a whole range of people here."

The Show was awash with big opinions, none more so than that given by the Health Secretary during a plenary session on the first day of the Show when he stated that the transition (to commissioning) would be "tough" and that commissioners needed to be willing to mine every opportunity to increased standards of care in the NHS.

Alluding tothe financial meltdown at the South London NHS Trust which hit the headlines earlier that week, Mr Lansley said: "Rarely will care settings close down but some may see their role changed. Hospitals with long standing problems can no longer kick the can down the road. We can't endlessly prop up organisations that can no longer stand on their own two feet."

Keen to cut through some of the wealth of dis-information which exists around commissioning, Mr Lansley also announced that there would be no top slicing of CCG budgets by the National Commissioning Board and that CCGs would not have to be constantly applying for re-authorisation - an urban myth was how he described this latter point.

Reflecting on the success of the show and its increasing appeal, Mike Ramsden, Chief Executive of the National Association of Primary Care, said: "Events like this are probably the best way for people to get leading edge information about what is happening and what the opportunities are."

Buoyed by its success, organisers have announced that the Commissioning Show will be returning in 2013 and will be held on the 12th and 13th June at the London ExCel.

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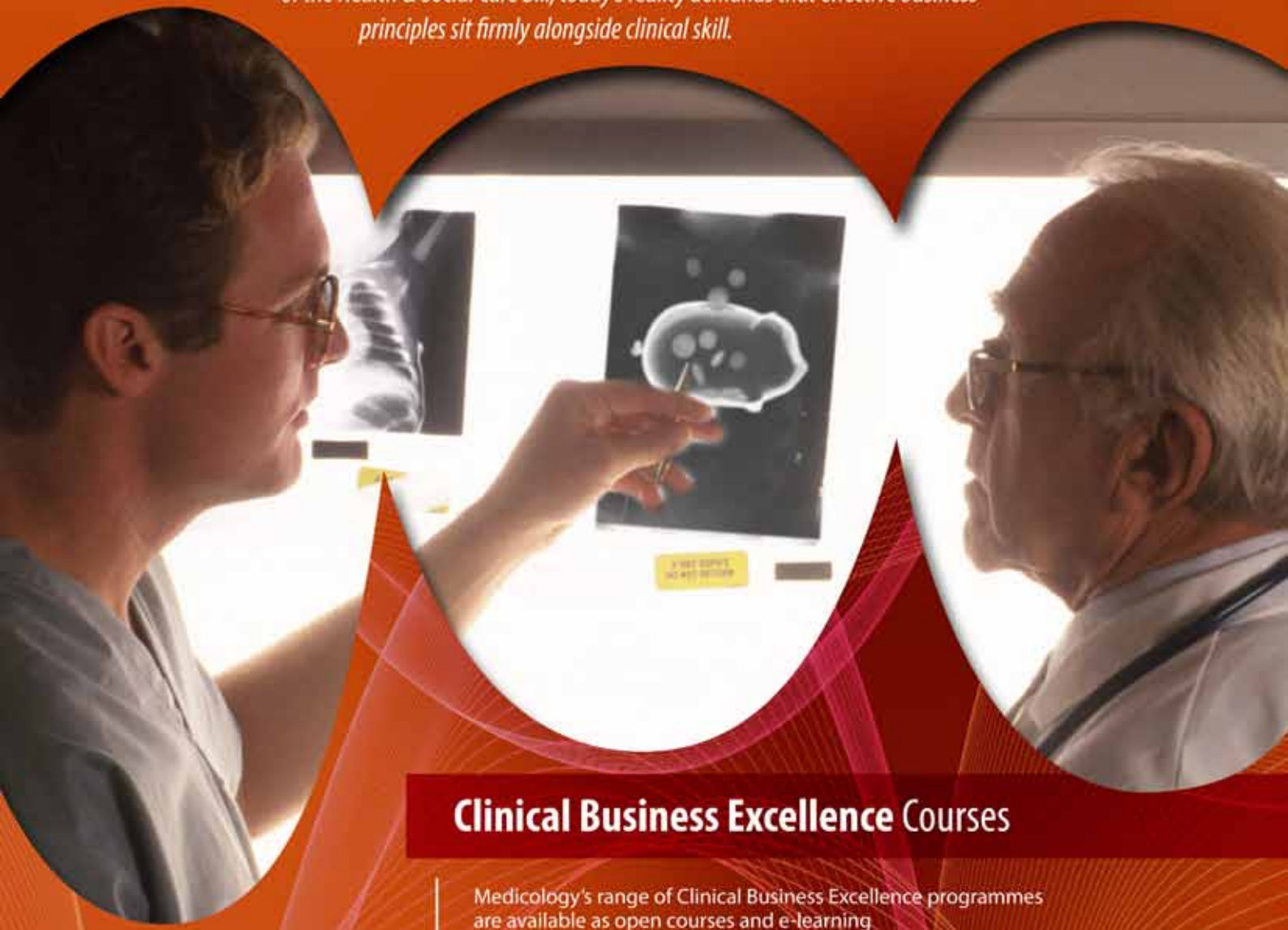

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Applying the Framework: Thriving in the Changing External Environment

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

This article provides a summary of the framework that I have been describing in the previous articles in this series. The first article was designed to illustrate the authentic improvement in the cost and quality of a clinical service that can be achieved from the application of the framework. The subsequent articles have given the details that underlie the different elements of the framework. Beyond providing a summary, this article will describe why this particular framework is powerful. In addition I will introduce why providers that employ this framework will be well suited to thrive in the changing external environment that they will find themselves working in the next decade.

Summary of framework

Figure 1. provides a diagrammatic representation of the different elements of what I am calling the 'Framework for organisational effectiveness: Embracing a systems perspective'. It includes the three components (directing, leading and managing) and the diagram shows that these elements exist in interaction with one another. Beneath each element there is clearly a large amount of fine detail and there is no doubt that embracing much of this is essential for organisational effectiveness. However, before getting lost in the detail it is crucial to understand why this framework is important and how it should be utilised.

Why the framework should be used and how

As I said in article two the basis of the framework, i.e. the three different elements, emerged from my reading of Steven Bungay's book The Art of Action. In order to fully comprehend the power of the framework, it is essential to understand where the framework emerged from and why its specific design is so important.

The framework is derived from the actions of a notable German General, Clauswitz. His experience informed him that there was always a difference between what was planned to happen and what did happen in the theatre of war. Clauswitz recognised intuitively that how this gap was managed appeared to determine the fate of the army in the war it was involved in. He concluded that armies find executing strategy difficulty because of a concept he termed friction.

Clauswitz concluded friction always occurs when human beings, who have independent will, try to achieve a collective goal. Friction is made worse when the environment in which the goal is being pursued is complex, fast-changing and unpredictable. Friction is a universal phenomenon; it arises from the fact that individuals have independent wills, and is applicable to all aspects of life, in particular running an organisation. It can never be escaped but, at best, can be reduced and harnessed. The ability of an individual or organisation to reduce or harness friction provides a competitive advantage.

Clauswitz determined friction is generated as a consequence of three very specific issues:

1. We always have imperfect information because we cannot know everything, and unpredictable events occur continuously;
2. No matter how carefully information is communicated between individual people, there is always the difficulty of differential perception by individuals of exactly the same facts. This means there is a challenge in agreeing a shared understanding, which in turn inhibits alignment; and
3. Any actions that we do take always create unpredictable and unforeseen outcomes.

Therefore, there is necessary to track and understand what has happened in reality, instead of what was hoped for.

Each of these three issues interact with one another continually This means that if the organisation has not got the ability to effectively adapt to the emerging reality, it can start to become very ineffective. Clauswitz observed that our natural tendency with this dilemma is to demand more and more information. Unfortunately this often makes the situation worse not better. It was from this finding, drawn from careful studies of real wars, that this framework was designed.

Clearly, the first step is to recognise the fact that friction exists and must be effectively managed. The next step is to question whether it is really that important. I argue: absolutely. I base this position on my own experience and analysis, as well as on the growing body of knowledge that is demonstrating there are huge limitations in our current approach to managing and leading organisations across all sectors. In subsequent articles, I will describe my own experience but, by way of introduction, I have included below relevant excerpts from several key texts:

• Gary Hamel – Professor of Management, London School of Economics – What Matters Now: How to Win in a World of Relentless Change, Ferocious Competition, and Unstoppable Innovation
This is not a book about one thing. It' s not a 250–page dissertation on leadership, teams or motivation. Instead, it' s an agenda for building organizations that can flourish in a world of diminished hopes, relentless change and ferocious competition.
This is not a book about doing better. It' s not a manual for people who want to tinker at the margins. Instead, it' s an impassioned plea to reinvent management as we know it—to rethink the fundamental assumptions we have about capitalism, organizational life, and the meaning of work.
Leaders today confront a world where the unprecedented is the norm. Wherever one looks, one sees the exceptional and the extraordinary. Business newspapers decrying the state of capitalism. Once–innovative companies struggling to save off senescence.

Dr Steve Allder

Next gen employees shunning blue chips for social start–ups. Corporate miscreants getting pilloried in the blogosphere. Entry barriers tumbling in what were once oligopolistic strongholds.

Obviously, there are lots of things that matter now. But in a world of fractured certainties and battered trust, some things matter more than others. While the challenges facing organizations are limitless; leadership bandwidth isn' t. That' s why you have to be clear about what really matters now. What are the fundamental, make–or–break issues that will determine whether your organization thrives or dives in the years ahead? Hamel identifies five issues are that are paramount: values, innovation, adaptability, passion and ideology. In doing so he presents an essential agenda for leaders everywhere who are eager to...

• reverse the tide of commoditization
• defeat bureaucracy
• foster extraordinary contribution
• capture the moral high ground
• outrun change

• Price and Keller, Senior Partners at McKinsey & Company – Beyond Performance: The secret of achieving and sustaining organizational excellence revealed

In an ever–changing world where only a third of excellent organizations stay that way over the long term, and where even fewer are able to implement successful change programs, leaders are in need of big ideas and new tools to thrive. In Beyond Performance, McKinsey & Company's Scott Keller and Colin Price give you everything you need to build an organization that can execute in the short run and has the vitality to prosper over the long term.

Drawing on the most exhaustive research effort of its kind on organizational effectiveness and change management, Keller and Price put hard science behind their big idea: that the health of an organization is equally as important as its performance. In the books foreword, management guru Gary Hamel refers to this notion as "a new manifesto for thinking about organizations."

Ultimately, building a healthy organization is an intangible asset that competitors copy at their peril and that enables you to skillfully adapt to and shape your environment faster than others—giving you the ultimate competitive advantage.

Tim Harford, Economist and author – Adapt: Everything we know about solving the world's problems is wrong
Out: Plans, experts and above all, leaders. In: Adapting - improvise rather than plan; fail, learn, and try again.

In this groundbreaking new book, Tim Harford shows how the world's most complex and important problems - including terrorism, climate change, poverty, innovation, and the financial crisis - can only be solved from the bottom up by rapid experimenting and adapting. From a spaceport in the Mojave Desert to the street battles of Iraq, from a blazing offshore drilling rig to everyday decisions in our business and personal lives, this is a handbook for surviving - and prospering - in our complex and ever-shifting world.

Jo Owen, Author and management consultant – Death of modern management
We are at the start of a new wave of management. The recent financial crisis highlighted problems not just in the economic

system, but also in the way that many companies are governed and managed. Now modern management has reached its end game and we approach a new era in leadership. Rather than the certainties of command and control, this new epoch will be based on co–operation and commitment. There has been a strategic revolution – instead of following the rules, we now have to make them. For some this represents great risk; for others it is an enormous opportunity.

So what is going on here? In-between the development of the framework described above and these more recent, scientifically driven findings, 'Taylorism' emerged. Frederick Taylor is often referred to as the father of modern management and his teachings were very successful in organisations that employed his approach for most of the 20th Century. However, the style of management advocated by Taylor was developed in a very controlled, stable environment; one of production lines and single provider dominated markets. This led to seeing organisations as machines that needed close 'command and control'.

Although this is a far cry from the reality of management in any sector in the world today, unfortunately, the machine dominated metaphor associated with Taylorism still permeates business and management thinking. All the authors listed above argue that this implicit approach to management and leadership contributes to the fact that, despite huge volumes of articles being written about execution and change management, performance in execution and change management remains completely unchanged.

What has this to do with healthcare? Well, the reality of healthcare context is simple: we are facing the need to create unprecedented change at a time of increasing uncertainty about what is required for patients and for payors. An excellent example of this was illustrated in the recent Health Service Journal article that captured the views of Mike Farrar, the Chief Executive of the NHS Confederation:

The health service "looks like a supertanker heading for an iceberg", the head of the NHS Confederation has warned, after a survey reveals that almost half of its leaders think cost

cutting will reduce quality of care for patients over the next year.

Research, carried out before the confederation's annual conference in Manchester, shows that NHS leaders fear that growing financial pressures will damage patients' quality of care.

Of the 252 chief executives and chairs of NHS organisations questioned, almost half believe the financial burden on the health service is "very serious" and 47 per cent say this means quality of care will reduce over the next 12 months.

Mike Farrar, chief executive of the confederation which represents organisations providing NHS services, said: "Despite huge efforts to maintain standards of patient care in the current financial year, healthcare leaders are deeply concerned about the storm clouds that are gathering around the NHS".

These are strong words. Change is clearly needed. This will involve adding more value for patients at less or constrained cost. For established providers the emerging empirical research on how to authentically achieve this is clear. In a 'thought paper' written for the Health Foundation in May 2012 , Professor Steven Spear, argues:

…the way to achieve great operational performance and value has often been misunderstood. In order to ensure that good people and good science are facilitated, rather than overwhelmed, by systems, leaders have to expand their attention from 'what individuals do' to 'how the pieces come together'. High quality care and great performance involves leaders making problem solving, improvement, and innovation part of the regular routine of daily practice.

How does this all fit with this framework? The key justification for proposing that this particular framework is appropriate is that it was developed from an empirical analysis of how to successfully navigate a fast-changing unpredictable environment. The framework was developed, adapted and applied over a 70 year period in many different specific settings, with measurable success. Given that all organisations now effectively function in a fast-changing dynamic environment, they will greatly benefit from understanding and adopting this operating model.

Article 10 Application to health generically

So what are the key takeaways for people interested in exploiting this methodology? The first step is the realization of the need to develop a management structure

characterised by independent thinking and initiative. Such a system is crucial to achieve simultaneously high levels of autonomy for the managers and high alignment towards the organisation's strategic intent.

To turn this realization into reality requires developing the skills to close the three key gaps described above. To close the knowledge gap it is necessary to limit direction to defining and expressing the essential intent. To close the alignment gap, allow each level to realise the intent. To close the effects gap give individuals freedom to adjust their actions in line with intent. The result is to make strategy and execution a distinction without a difference, as the organisation no longer plans and implements, but goes through a thinking-doing cycle of learning and adapting. For such a model people must be competent and share basic values.

Chapter 4. The Knowledge Gap – What and Why

A business strategy sets direction by considering both ends to be achieved and the means of achieving them in a competitive environment. Means include execution. Strategy development and strategy execution stand in a reciprocal relationship and co-determine each other.

A strategy is not in itself a plan, but prepares the organisation for the future by providing it with a framework for decision making, based on some basic choices about how to compete. It is "the evolution of an original guiding idea under constantly changing circumstances".

Depending on the nature of the uncertainties in the environment, a strategy can set direction by giving a compass heading or a destination or both. A robust strategy does not guarantee success, but shifts the odds in one's favour.

Thinking strategically involves "going around the loop" to establish coherence between aims, opportunities, and capabilities. It is a rational activity involving analysis, experience, and pattern recognition to generate insight on the basis of competition, the centre of gravity of the business. Good strategies involve risk, but they are realistic, not heroic.

A strategy is fundamentally an intent: a decision to achieve something now in order to realise an outcome; that is, a "what" and a "why". Even if our destination is unclear, we need some sense of the end-state to be achieved which gives our current actions a purpose.

And even if the current situation is volatile, we need to decide what to do next in order to get into a better position than we are in at present. Strategic thinking can therefore be laid out as a staircase: a logical sequence of steps which lead to an end-state, which is either the destination or a position which opens up future options.

The steps of the staircase define the organisation's "main effort" at a strategic level. The main effort is that single thing which will either in itself have the greatest impact or on which all other things depend. It has resourcing priority. Defining main effort creates focus and energy, helps people make trade-offs, and cuts through complexity.

Chapter 5. The Alignment Gap – Briefing and backbriefing

People at all levels can find themselves in situations where they have to exercise independent thinking obedience. They can only do so if the organisation has already prepared them by providing them with the information they need to make decisions.

That information can be formulated as a statement of intent, which distils the strategy for everyone. That statement can then be broken down into its component parts and used to start a process of briefing each level.

A briefing should cover the higher intent, up to two levels up, the tasks that this implies for the unit concerned, where their main effort should lie, and their freedoms and constraints.

Working this through in a structured way pays dividends in aligning the organisation both up and down levels and across functions.

The whole organisation can be aligned if briefing is done in a cascade, with each level adding more specificity to the tasks implied by the higher intent, and then presenting the results to the level above in a process called backbriefing. This checks mutual understanding, allows for adjustment of the original brief, and, when done collectively, helps alignment across functions.

A briefing cascade will only work properly if the organisational structure broadly reflects the task structure implied by the strategy. If it is in conflict with the strategy, it should be changed before anything else. It requires an appropriate level of hierarchy of entities that can be made wholly or largely accountable for critical tasks, led by people who are skilled and experienced enough to make autonomous decisions.

Chapter 6. The Effects Gap – Independent Thinking Obedience

There is a general requirement for individuals in a leadership position to adapt what they do in line with the organisation's intent, and to take responsibility for their decisions. Not everybody will be willing to do this. Equally, there will be others with an authoritarian personality who will be unwilling to give subordinates the space they require to be adaptive. Both groups are minorities in the management population, but they need to be detected in the recruitment and development process.

The bulk of the management population do not fall into either of these problem groups, but they need to be developed so that they master the appropriate briefing and decision-making skills. A common development program covering the behaviours which go along with these skills can begin to shape the culture, as long as it is reflected in day-to-day practice.

Even if they understand what part they are to play in executing a company's strategy, people do not always behave in the way required. However, they usually do behave rationally from the point of view of the subsystem of the organisation to which they belong. If we examine the goals, resources, and constraints of the subsystem, we can understand why they behave as they do and can take steps to change the subsystem itself in order to produce the behaviour we want.

Day-to-day practice is in part determined by organisational processes, most importantly budgeting and performance management. They should themselves by aligned with the strategy, and using a briefing cascade to link them all together is a practical way of achieving this. They should also enable rather than inhibit adaptation. A good first step toward making them flexible is to create an operating rhythm with quarterly reviews of progress, in which adjustment is expected and the budget is treated as a rolling forecast.

In order to know if the intent is being realised, we need a system of metrics. However, we should not allow metrics to be separated from what they are supposed to measure and substitute for it, or they become a fetish. A scorecard should be used to support strategy execution by monitoring the effects actions are realising, not to supplant strategy. Business leaders should supplement internal scorecards by taking a look outside through the commander's telescope.

The framework exploits 10 simple but rarely enacted principles:

1. We are finite beings with limited knowledge and independent wills
2. The external environment is unpredictable and uncertain, so we should expect the unexpected and should not plan beyond the circumstances we can foresee
3. Within the constraints of our limited knowledge we should strive to identify the essentials of the situation and make choices about what is most important to achieve
4. To allow people to take effective action we must make sure they understand what they are to achieve and why
5. They should then explain what they are going to do as a result, define the implied tasks and check back with us
6. They should then assign the tasks they have defined to individuals who are accountable for achieving them, and specify boundaries within which they are free to act
7. Everybody must have the skills and resources to do what is needed, and the space to take independent decisions and actions when the unexpected occurs, as it will
8. As the situation changes everyone should be expected to adapt their actions according their best judgement in order to achieve the expected outcomes
9. People only show the level of initiative required if they believe the organisation will support them
10. What has not been made simple cannot be made clear; what is not clear will not get done

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New valve in heart surgery procedure provides patients with more of the air that they breathe

Research trial at Leicester's Glenfield Hospital utilises latest medical technology

Surgeons at Glenfield Hospital in Leicestershire have used a new type of valve in their keyhole heart valve replacement procedure, as part of a research trial.

The new valveused in the Trans catheter aortic valve implants(TAVI) procedure is called PORTICO 23 and allows surgeons to reposition or even remove it to achieve the optimal placement, something that was not possible with earlier designs.

The TAVI procedure involves inserting a new valve inside the existing aortic valve using keyhole surgery to help patients with their breathing. It is less invasive than open heart surgery which means more patients can benefit from it.

Dr Jan Kovac, consultant cardiologist at Leicester's Hospitals and a pioneer of this type of procedure in the UK, has been performing the life changing procedure for five years. St Jude Medical, a company that develops medical technology, approached Dr Kovac to conduct this research trial.

Dr Kovac said: "Narrowing of the aortic valve is very common — it affects about 400,000 Britons and we are seeing it more and more. It's most common in elderly patients, and the population is ageing.

Dr Jan Kovac

"The aortic valve is the major valve in the heart. It has three triangular flaps which open and close to meet in the middle, pumping blood out of the heart to the rest of the body.

"While doctors do not fully understand why this valve can become narrowed as we get older, we know calcium is deposited in these flaps, so they stiffen and cannot open and close as efficiently.

"The heart has to work harder to pump blood round the body and ultimately can fail to do so."

"The traditional gold standard treatment, which has been around for more than 50 years, is open-heart surgery to replace the valve with one made from animal tissue or metal.

"This is major surgery which means a stay of up to ten days in hospital and up to three

months recovery. And since this is a disease of older people, around 30 per cent of patients are not fit enough for it.

"So in the past five years we've started using keyhole surgery, making a small incision in the thigh or the arm and then sliding the replacement valve up in a catheter, or thin tube, to the heart.The valve is anchored within the calcium of the patient's diseased valve and stays in position unaided.

"However, one of the issues of using keyhole techniques means we're more at risk of not placing the valve exactly in the right position.

"It's crucial that it is positioned precisely inside the damaged natural valve, otherwise it will leak and blood will not be pumped through efficiently.

"If this happens, the patient might have the same breathlessness and faintness after some time.

"The PORTICO 23 differs to the other two designs we've been using. This novel valve is designed to allow operators to slowly release it in a controlled manner, reposition, or even remove it completely and put in place again to make sure it fits perfectly.

"This should further increase the safety of implant for this technically challenging procedure."

The first patient on our research trial, and the first person in England to receive this new valve, was 89 year old Edna Watkins.

Mrs Watkins, from Spalding, said: "My consultant told me that I needed the procedure done quickly otherwise I may become too unwell to get through the procedure.

"When I was given the information sheet about this new valve trial I was happy to take part and by doing this I will hopefully help other people in the future."

Dr Kovac added: "We are really pleased to have been given the opportunity to use this new technology as it gives more choice and the ability to help a wider range of patients."

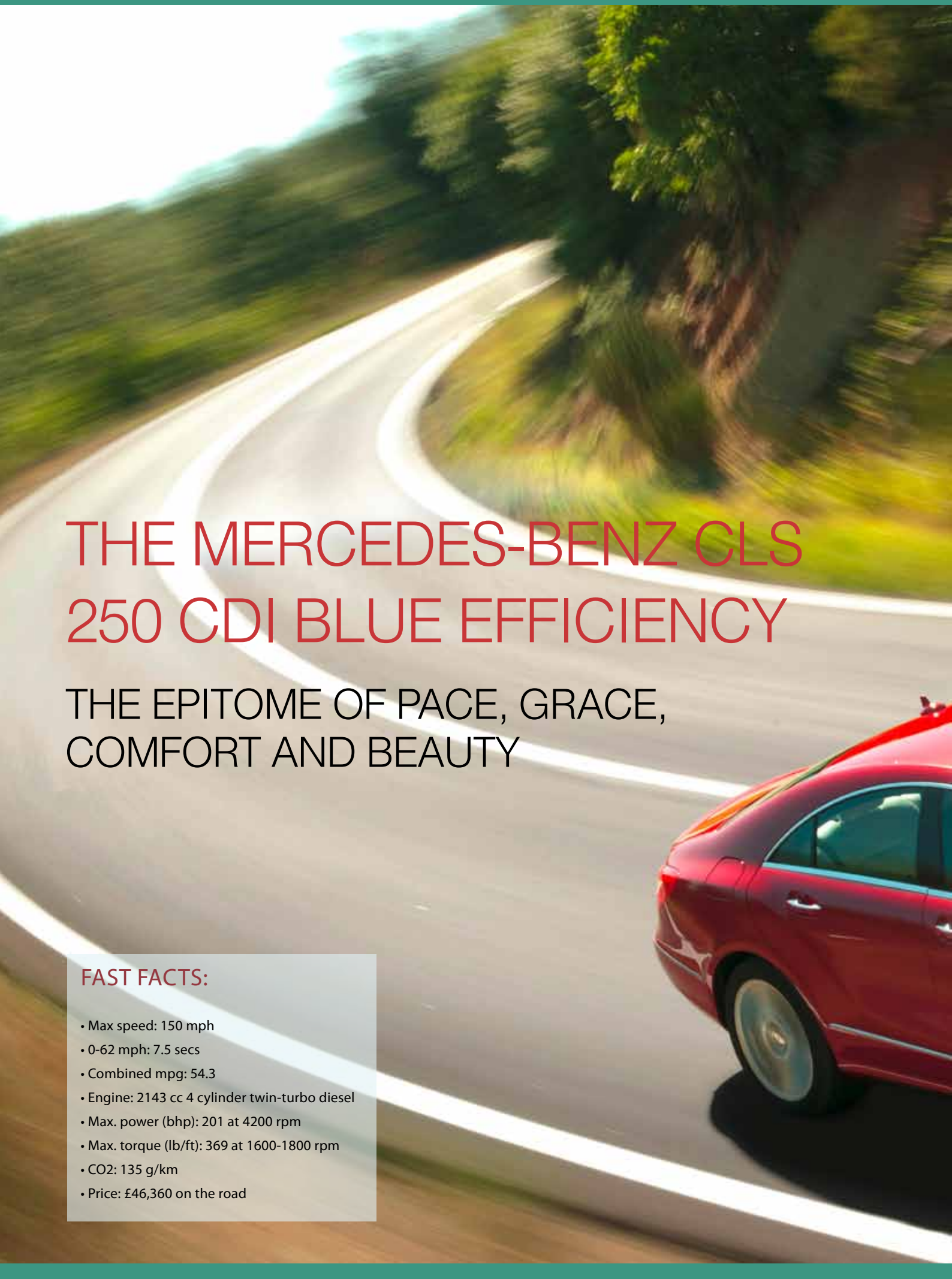
The fifth anniversary of the first TAVI procedure was in January this year when Dr Kovac undertook a procedure on behalf of Gladys Adams, aged 89,who is still leading an active and full life.

Malcolm Lowe-Lauri, Chief Executive at Leicester's Hospitals, said: "It is testament to the expertise of Dr Kovac's TAVI team and the rest of the staff in our cardiac services that St Jude Medical approached us to conduct their research here."

"Patients who might benefit from this type of valve are identified through a rigorous selection process. Once a patient has been identified and given the information about the trial, they are given time to decide if they would like to take part. Patient safety is paramount and the team follow strict guidelines as part of the trial to ensure that the right patients take part and benefit from this new valve."

Although the current valves cost the NHS about £15,000, should the trial be deemed a success, it is hoped that the procedure will be more widely available by the end of 2012.

Dr Jan Kovac is a consultant cardiologist – a nationally and internationally recognised innovator in the field of cardiology, specialising in cardiac interventions. One of the world pioneers and leaders in the field of structural and valvular interventions, Dr Kovac currently treats patients in Europe, Asia, US, and the Middle East.



THE MERCEDES-BENZ CLS 250 CDI BLUE EFFICIENCY

THE EPITOME OF PACE, GRACE, COMFORT AND BEAUTY

FAST FACTS:

- Max speed: 150 mph
- 0-62 mph: 7.5 secs
- Combined mpg: 54.3
- Engine: 2143 cc 4 cylinder twin-turbo diesel
- Max. power (bhp): 201 at 4200 rpm
- Max. torque (lb/ft): 369 at 1600-1800 rpm
- CO2: 135 g/km
- Price: £46,360 on the road

PACE, GRACE, comfort and beauty are the perfect words to describe this German machine.

After a 200 mile journey I felt as fresh when I got out of the Mercedes-Benz CLS as I had when I'd started the trip. The car is great at soaking up the UK's pothole ridden A and B roads and it has bags of smooth, seamless grunt for straight stretch sprints, thanks to its powerful 2143cc twin-turbo diesel engine.

With a 0-62 mph time of 7.5 seconds and a top speed of 150mph, the 250 CDI has a split personality: it's stimulating, yet, at the same time, relaxing to drive. The seats are ultra-supportive and the car is so quiet it's easy to forget that an oil-burner lurks under the bonnet. A sleek shifting G-Tronic Plus 7-speed auto 'box with steering column gear selector and gearshift paddles, along with Speedtronic cruise control, makes motorway commuting a breeze. The only niggle I found was getting used to the Mercedes' control layout. I kept turning the indicators on when I wanted the windscreen wipers to work!

You get as much of a thrill seeing the CLS parked up as you do driving it. What immediately strikes the eye is the front design, which is reminiscent of the Mercedes-Benz SLS AMG. Visually, the radiator grille is not integrated into the bonnet but is formed separately. This highlights the long, sporty bonnet even further. The large, elongated dark air inlets with black grilles also add to the vehicle's look. Another distinguishing feature comes in the form of the full LED headlamps. Inside they are divided into three arrow-shaped layers from top to bottom. A total of 71 LED's not only provide a 'string of pearls' appearance, but they also give you a really clear view of the road at night.

The CLS's outline, with its pleasingly long proportions, is the main attribute of the model's appearance. A distinctive and brawny shoulder line above the rear axle highlights the athletic character of the latest CLS. The flared wheel arches resemble the powerful thighs of a feline predator waiting to attack. The side view is rounded off with wide tail lights, again featuring LED technology, which are arranged in the form of a linking element to the rear of the vehicle.

Back inside, the Mercedes-Benz CLS 250 CDI is distinguished by an enduring design which combines straightforward sophistication with modern details and handcrafted perfection. Anattention-grabbing feature is the wrap-around effect of the cockpit: a high line sweeps from the driver's door over the instrument panel support and across to the front passenger door. The central display has also been nicely integrated into the upper part of the

instrument panel. At the same time, the downward sweeping side line on the doors continues the energetic dropping line of the exterior.

The model also lives up to its role as a design icon thanks to the nature of the materials used in the cabin. These consist of a mixture of satin and high-gloss finishes used on the metal surfaces. Highlights include matt galvanised air vents, for example, which form the ideal frame for a high-gloss-trimmed analogue clock - it's a lovely, classy touch. Handcrafted perfection is reflected in details such as the stitched leather seat covers, dashboard covering and wood trim. The particularly fine leather which is used has an especially warm and soft feel to it.

Looks, speed and luxury fittings aside, the Mercedes-Benz CLS 250 CDI BlueEFFICIENCY is pretty practical too. There is enough room to seat four adults and the large boot with remote release is convenient and easy to access. The German motor will also do

54.3mpg on the combined cycle and with CO2 emissions of just 135g/km, the car will be cost-effective to run.

So, in my opinion, if you want a stylish, fast, comfortable and safe car that also tells the world you've not done badly in business, then the CLS could well be the one for you.

PROS 'N' CONS:

- Sporty √
- Comfortable √
- Looks √
- Economical to run √
- Control layout X

The news about Bob's future wasn't good -
but he needed to know. After all he is the consultant.

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