THE CONSULTANT

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BULLYING IN HEALTHCARE – THE EXTENT, THE IMPACT, THE SOLUTION?

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Editor's Introduction

Welcome to edition 20 of The Consultant.

Bullying is an unacceptable practice in any vocation but in healthcare it seems even more unsavoury given the nature of the profession.

In this edition of The Consultant we examine the difficult question as to what constitutes bullying, how widespread the problem is in healthcare scenarios, and ultimately, what can be done to tackle an issue that is genuinely corrosive for staff morale and patient safety.

And, a year after its introduction, we take a look at how the medical revalidation process is progressing and speak to a member of the Revalidation Support Team about some of the issues that have arisen whilst they work to keep the process on track.

We know there is a vast amount of opinion out there concerning this topic and I am keen to receive direct feedback, comment and opinions, a selection of which will be published in next month's edition.

Elsewhere, our Quality, Governance & Experience Zone focuses on how services can up their game and Improve Quality at the Front Line.

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 hope you enjoy looking through this edition.

Dr Sara L Watkin,
Editor-in-Chief
The Consultant

In this issue...

FEEDBACK

Send us your feedback on The Consultant, ideas, suggestions or comments to:
fraser@theconsultantjournal.co.uk

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Revalidation's on track but there's room for improvement says RST

Since its introduction in December 2012, the medical revalidation process has progressed steadily with the majority of doctors (95.1%) now linked to organisations that are able to support their revalidation. However, according to a report published last month by the NHS Revalidation Support Team (RST), more work is needed to improve appraisal rates in hospitals. The Organisational Readiness Self-Assessment (ORSA) Report 2012-13 states that whilst overall appraisal rates have increased significantly over the past two years, reported appraisal rates for consultants and staff and associate specialists doctors in the acute hospital sector are of an 'unacceptable' standard and require 'urgent attention.'

Following the publication of the ORSA Report, The Consultant quizzed Dr Martin Shelly, Director of Implementation at the Revalidation Support Team.

The Consultant: What is the present role of the RST?

DMS: The RST works in partnership with the Department of Health, the GMC and designated bodies to deliver an effective system of revalidation for doctors in England. This includes: supporting healthcare organisations and responsible officers in preparing for medical revalidation; producing clear and effective guidance for annual medical appraisal: and providing evidence of the costs, benefits and practicalities of implementation, to ensure that revalidation supports high quality care and is cost-effective and efficient. The RST is funded by the Department of Health (England) and hosted by Guy's and St Thomas' NHS Foundation Trust. Since its formation in 2008, the RST has delivered a wide range of projects that have contributed towards a successful readiness assessment and helped pave the way towards the implementation of medical revalidation.

The Consultant: What is the ORSA and what are the key messages?

DMS: The Organisational Readiness Self-Assessment (ORSA) exercise is an annual self-assessment exercise designed to help designated bodies in England develop their systems and processes for the implementation of revalidation. Overall, substantial progress was made during 2012-13, with improvements in all measured key indicators. 95.1% of doctors covered by the survey were linked to organisations that were ready for revalidation. This increased from 82.1% as at 31 March 2012. Although, the overall picture was good, primary care organisations had fallen back slightly against some indicators and there were lower than expected appraisal rates in some sectors, most notably in the acute hospital sector.

The Consultant: We note that the number of doctors in acute trusts having appraisals has fallen. Why do you think this might be?

DMS: The proportion of doctors in the acute sector having completed their appraisal in 2012/13 has risen from 63.2% to 66.8%. The rate for acute hospital consultants has risen from 73.1% to 75.1%. This is of concern as it means one in four consultants has not had an appraisal in 2012/13 and these rates have fallen behind the rates in mental health trusts and primary care. The ORSA exercise did not investigate the reasons for this but appraisal may be given a lower priority by both trusts and doctors in the acute sector than in other NHS organisations. Professor

Sir Bruce Keogh, Medical Director for NHS England has written to hospital trusts asking them to urgently tackle low appraisal rates. NHS England's Deputy Medical Director, Mike Bewick has also written to all responsible officers via the regional responsible officers regarding this issue. Every designated body is expected to produce an action plan addressing any weaknesses and development needs identified through the ORSA exercise.

The Consultant: Whose responsibility is it to ensure an appraisal - the Trust or the doctor?

DMS: Both the trust and the doctor have obligations to ensure appraisals are completed. The doctor has contractual and professional obligations; the trust has obligations as an employer and under the responsible officer regulations.

Dr Martin Shelly

The Consultant: What will be the role of RST beyond March 2014?

DMS: The RST will be decommissioned in March 2014 and will not have a role beyond this date. Since 24 October, NHS England has had overall responsibility for the implementation of revalidation in all designated bodies in England. Funded by the Department of Health, the RST is gradually transferring its revalidation support functions to NHS England as it prepares for closure.

The Consultant: Regarding Trust doctors on 1 to 2 year contracts (that is non SAS, non-trainee doctors), who is making sure they have an appropriate appraisal with a MAG form?

DMS: The trust has a statutory obligation under the responsible officer regulations to ensure every doctor connected to them under the regulations has an annual appraisal. This includes doctors who are employed on temporary or short term contracts

The Consultant: What specific difficulties have been encountered with the implementation of revalidation?

DMS: Revalidation is the biggest shake up in medical regulation since 1858. It is also the biggest change in professional accountability, medical leadership/ management and the accountability of organisations for their medical wrkforce. The main challenge has beenensuring doctors in all types of organisations (both inside and outside the NHS) are being managed and supported effectively, and ensuring there is consistency in the decision making of responsible officers and appraisers. Designated bodies in England have made great strides in improving support for doctors over the past three years, as shown by our recent ORSA report, which reported that over 95% of doctors are now connected to organisations with the right systems and processes in place to support them. There are also solid mechanisms in place to facilitate consistent decision making, including regional networks of responsible officers.

Organisational Readiness Self-Assessment (ORSA) Report 2012-13, key findings:

- Almost 100% of doctors covered by this exercise had a responsible officer who had received appropriate training
- 97.8% of doctors covered by this exercise were connected to designated bodies with an appraisal policy which was compliant with the requirements of revalidation
- 93.6% of doctors covered by this exercise were connected to designated bodies with sufficient numbers of trained appraisers
- Overall 76.1% of doctors covered by this exercise completed an appraisal in 2012-13, compared with 72.7% in 2011-12
- Appraisal rates for consultants and staff grade and associate specialist doctors in the acute hospital sector were 75.1% and 60.7% respectively. These rates remained significantly behind those of their NHS counterparts in primary care and mental health (90.3% for GPs, 84.3% for mental health consultants and 80.7% for staff grade and associate specialist doctors in mental health)
- 98.5% of doctors were linked to designated bodies with a process for investigation of capability, conduct, health and fitness to practise concerns
- The proportion of doctors covered by designated bodies with a policy for re-skilling, rehabilitation, remediation and targeted support which is compliant with the responsible officer regulations, increased substantially from 58.4% to 83.3%

*621 bodies completed the ORSA, providing a 96.7% response rate.

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// Introduction

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Our Journal is Changing

Dr Sara Watkin

The original aim of The Consultant was to fill a void that existed – a non-clinical publication that could focus on the issues of the day that were most pertinent to us, consultants. The journal has remained free from the beginning and our intention is to continue in that approach. Our journal is changing though.

Enhanced Content

This edition has significantly enhanced content, with specific features on pertinent issues and an increase in external content – a trend we aim to continue. If the journal is going to serve your needs it needs to be valuable. With this in mind, you will notice an increase in articles that are designed to deliver a functional value i.e. the content is practical and useful, not just interesting. We will build this approach over future editions. You will also notice a distinct internal structure developing, allowing you to skip to whole sections of interest.

Please tell us what areas of practical use you would like to see articles or advice in

- Pension changes and how to approach them?
- Getting concerns heard in a safe manner?
- Please make suggestions to me, Dr Sara Watkin to sara@theconsultantjournal.co.uk

Move to Formal Subscription

This edition, we have moved to formal subscription but with a lifetime free subscription. Please do sign up. There are good reasons to. Historically, we have simply made the journal freely downloadable to anyone that wishes to and then circulated it to 'everyone'. This approach has resulted in really significant readership but in an uncontrolled manner. Here's why we want you to register.

- Having a registered set of readers allows us to develop a small advertising component (because we can quote a fixed and growing readership in actual numbers), which we want to invest in strengthen still further the content, especially in the area of valuable advice
- The registration site allows you to discuss pertinent articles with fellow consultants in a forum
- The site allows you to download individual articles and keep up to date with news as it emerges – another area we wish to enhance
- We intend to call for paid submissions and research through the readership

As you can see, we have strong aims to invest in, strengthen and grow The Consultant into a journal we can be proud of as a profession. It's one that doesn't have a political agenda. It reports with a sense of 'underlying reality' rather than trying to persuade you of a point of view. It seeks to tackle thorny issues. It encourages debate. It aims to become a focal point for consultant discussion and dialogue, something that has been missing for some time.

I look forward to telling you more in future editions.

Sara

Dr Sara L Watkin
Editor-in-Chief

The Impact of Bullying in Healthcare

Workplace bullying is unpleasant in any profession but in the healthcare world it seems even more so. Bullying impacts not only an individual victim's health, but it affects workplace morale and can undermine productivity.

Bullying can occur at any level of an organisation and given its pervasiveness, the chances are that if you have not directly experienced it yourself, you are likely to know someone who has.

The impact that such a culture can have on an organisation was recently exemplified at Colchester Hospital University NHS Foundation Trust which found itself accused of being rife with a bullying culture and was ultimately placed into special measures by the healthcare regulator.

The following articles examine the difficult question as to what may constitute bullying, how widespread the problem is in healthcare scenarios, and ultimately, what can be done to tackle an issue that has such a profound effect on staff morale and patient safety.

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THINK DIFFERENTLY

Workplace bullying within the NHS

The extent of the problem, the impact on individuals and organisations and suggestions on how to improve the situation

By Dr Madeleine Macdonald, ST7 Obstetrics and Gynaecology, and Dr Diana Fothergill, Consultant Obstetrician and Gynaecologist, Department of Obstetrics and Gynaecology, JessopHospital Wing, Sheffield Teaching Hospitals NHS Foundation Trust

Nearly half of all UK employees suffer from workplace bullying at some time during theirlives1with higher levels reported in the public sector especially in healthcare 2, [3]. In the 2012 NHS staff survey 24% of respondents' felt that they had experienced bullying, harassment or abuse from colleagues during the previous twelve months. [4]

Although accepted by a minority as 'an inevitable part of work' [5], the impact of such behaviour is considerable. For an individual; bullying may affect every part of life from health, self-esteem, self-confidence, and reputation within the organisation or department in which they work[6]. For the organisation,workplace bullying is thought to cost the NHS approximately £325 million a year [7]. A bullying culture leads to low staff morale, poor employee retention, loss of respect amongst colleagues, reduced productivity and poor performance [8].

In healthcare these factors have a significant negative impact on patient safety [9, 10]. Low morale and poor teamworking were implicated in The Healthcare Commission's investigations into concerns over safety at three NHS Trusts in 2005 [10] and the recent Mid Staffordshire Public Enquiry Final Report echoed these findings suggesting a wider problem within the NHS [11].

Good working relationships are a key aspect of good team-working and require a high degree of trust between team members. When this is not present a healthcare professional may not feel confident enough to discuss difficulties they are having in managing a patient with colleagues further jeopardising patient safety[12].

As much as 50% of workplace bullying is not reported [13] although the reasons behind this remainunclear. Significant factors contributing to this include 'fear of reprisals' from close colleagues of the bully or fear that by taking action career progression may be halted[14, 15]. Female doctors and those coming from outside of the UK are significantly less likely to report such behaviour [16].

What constitutes workplace bullying?

Many different definitions attempt to clarify what is meant by bullying in the workplace; the Andrea Adams Trust perhaps sums it up best:

"no simple definition (exists) because of the variety of forms that it can take and the situations in which it can arise…but it involves a gradual wearing down process that makes individuals feel demeaned and inadequate and that they can never get anaything right..." [17]

What is clear is that it is the perception of the person experiencing the behaviour that determines if it constitutes bullying or not and is therefore subjective [18]. Organisations such as UNISON and Postgraduate Deaneries [2, 19] list unacceptable behaviours rather than providing formal definitions which can be more helpful bymaking it explicit what type of actions may be defined as bullying.

Workplace bullying is most commonly subtle or 'covert', perceived only by the individual who receives it [20]. This is more

difficult for those working with the recipient to observe with isolated actions or comments seen as trivial and not worth reporting by others, if repetitive however,they can significantly undermine self-esteem or confidence.

Some debate exists regarding whether bullying can occur as a single isolated incident or if behaviour needs to be persistent [21, 22]. Although in most cases repetitive behaviour is the hallmark of bullying, a single episode such as shouting at someone in front of colleagues may have the same effect, causing the recipient to feel humiliated or intimidated. This action may impact on how the recipient approaches that person in the future and again may leave patients at risk of harm.

"I don't want to need her (the supervisor) but I need her. And unfortunately sometimes I will, maybe, wait a little bit longer because I just cannot, I just don't want to go and ask for her for anything and my client suffers for that"

(A nurse describing the impact on patient safety that can occur even after a single incidence of shouting, belittling or humiliating behaviour towards her[23]).

Who is affected and why?

Bullying in medicine is usually unintentional 9often due to inequalities in power between the parties 21 with some arguing that bullying represents a perceived 'legitimate exercise of power' 5. Traditional hierarchies within healthcare may be part of the reason why a bullying culture can prevail 9 with a 'survival of the fittest' mentality [15]. However, senior managers also report high levels of bullying [24] and 'horizontal bullying' (between colleagues at the same grade or level) is well documented in midwifery[25] where it has been found to be a major cause for staff leaving the profession [26].

Power over an individual can take many forms and in the context of bullying may be more subtle than the traditional hierarchy structure of consultant, senior registrar, junior registrar, foundation doctor and medical student. Knowledge of an 'incident' that occurred whilst on a work night out for example could be used by a 'junior' to intimidate or threaten a senior colleague. Social media such as Facebook could be used to spread malicious gossip or falsehoods about a senior that can spread rapidly across an organisation destroying their reputation and ability to perform their job.

Bullying and undermining of junior doctors has been studied bythe General Medical Council trainees surveys since 2006 [27]. In the latest survey [27,]27% of trainees reported they had experienced bullying in their current post and 37% reported they had been undermined by a consultant or GP. Pressures on rotas and tensions between balancing service and training opportunities have led to suggestions from some senior staff that junior doctors may perceive that they have been subjected to bullying if they feel aggrieved by their rota or issues surrounding the completion of workplace based assessments, for example if an assessment is not completed to their satisfaction.This issue was investigated in a recent survey of obstetrics and gynaecology trainees in one deanery who were asked about issues surrounding training

and workplace bullying [28]. Almost all respondents felt constructive feedback or criticism following work based assessments did not constitute bullying and a change in training opportunities part of the way through a placement was acceptable as long as a valid reason was provided.

Interesting very little is known about consultants' experience of workplace bullying. More general studies investigating business professionals in managerial or 'expert positions' have found that they were as likely to have experienced unacceptable behaviours as their more junior colleagues [24]. Employees at higher levels who experience workplace bullying were more likely to be female. Commonly cited unacceptable behaviours included being set unrealistic deadlines, having their opinions and views ignored or feeling information has been withheld from them [24]. A small pilot survey of consultants' experience of workplace bullying in our unit (unpublished) found at least half felt they had been subject to such behaviour whilst working as a consultant and most commonly instigated by another consultant from their own department. There were no differences in the seniority of the consultants, their gender or ethnicity.

Other professionals such as midwives are also known to suffer from high levels of bullying. The Royal College of Midwives found 43% of students and fully qualified midwives reported they had experienced such behaviour from a colleague [29]. Some authors suggest the lack, or perceived lack of control over decision making by nursing or midwifery staff due to the hierarchies within hospitals, leads to a 'conflict over territory' increasing inter and intra professional bullying [30]. A lack of 'shared goals' between different professionals prevents effective teamworking so crucial for the safety of patients [10, 31].

How to improve the situation

It should be remembered that most cases of workplace bullying in healthcare are unintentional and therefore stereotyping 'bullies' and 'victims' is not helpful when it comes to tackling the problem [22, 25]. Instead, strategies should be aimed at all employees with particular emphasis on increasing understanding between different professionals groups and improving teamwork31.

From the survey of obstetrics and gynaecology trainees' experiences of bullying, suggestions were made on how to reduce the problem [28]. The main themes were;

- multidisciplinary training that involves team working, respect and improved communication between professionals.
- training on how to give constructive feedback
- improving self-awareness
- mentoring
- raising awareness and improving education/training on the issue
- cultural change from 'blame' to 'openness and learning from mistakes'

Cultural change is very difficult and those attempting it need to take a long-term view as the results from such interventionstake time. It is important to ensure staff are ready and prepared for making the transition[32]. The prerequisites for making changes within organisations include education, communication, participation and involvement, facilitation and support, and negotiation and agreement. Those leading change should be 'credible, trustworthy, sincere and have the necessary expertise'[33].

Multidisciplinary training already takes place in many NHS departments in the formof maintenance of practical skills and knowledge. Learning about 'human factors' and communication within teams 31 is just as important and should become a regular part of multidisciplinary departmental training sessions. The Agency for Healthcare Research and Quality (AHRQ) has developed team training programmes such as Comprehensive Unit-based Safety Program (CUSP) and TeamSTEPPS designed to improve the safety culture within hospitals [34].

CUSP has been used by teams to support a culture of patient safety by integrating training in communication, teamwork and leadership and has been shown to reduce death rates on Intensive Care Units across the United States. Work environment is also known to have a significant impact on how well a team functions even after extensive 'team training'. Without an environment or climate that allows training to be translated into staff's everyday working life, the chances of effective changes in behaviour and sustained improvement is reduced[35].

Developing self-awareness is one of the core elements of leadership 36, a previously neglected aspect of medical training, now rising to prominence especially in the aftermath of the Francis Report 11.From the point of view of workplace bullying, it should aim to improve our understanding of how we are perceived by others and so reduce the incidence of unintended workplace bullying. The Johari window is one example of a method for increasing self-awareness [37] (Figure 1).

Asking for feedback and improving communication expands box 1 and reduces box 2 - our 'blind spot' (how others perceive what we say and how we act)- and this may reduce unintended bullying. (Figure 2).

Improving communication requires trust and openness within a department. Beginning to understand others' beliefs can help to create trust in within the work place [31] and increase the likelihood of 'opening up'. Asking for feedback, now a prerequisite for appraisal and revalidation, can be difficult when there is a lack of trust between colleagues and although feedback should be honest it must be constructive, otherwise trust is further eroded 38. Constructive feedback involves discussion of facts, actions and behaviours, with explanations of what took place; what was good and what could be improved, personal references and judgemental comments must be avoided
. Ideally individuals should have a mentor or trusted supervisor when undertaking any exercise aimed at increasing self-awareness to guide and support them during the process.

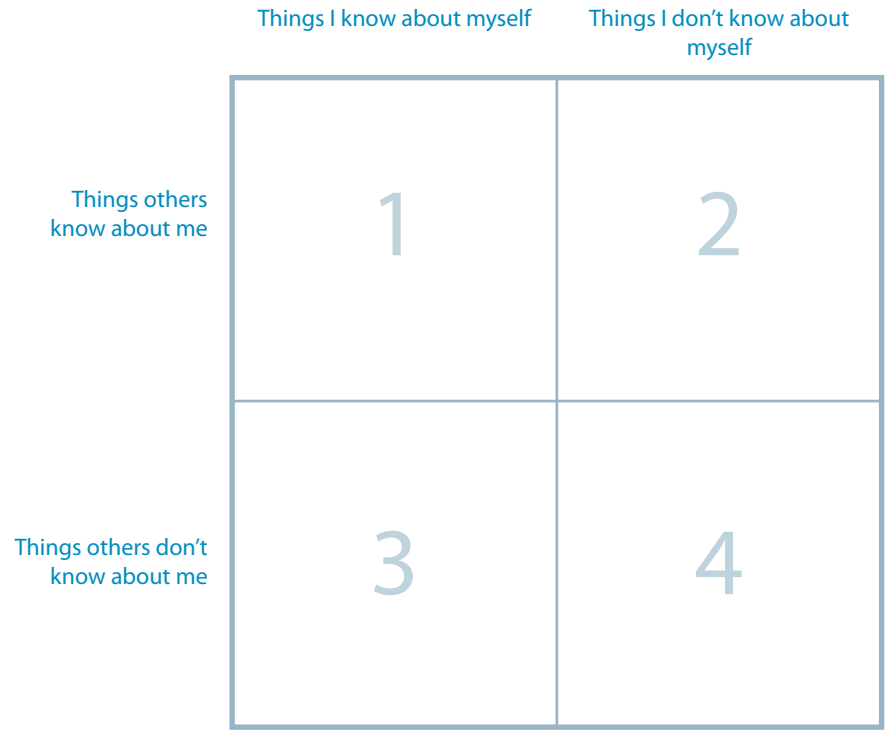

Figure 1. The Johari Window

Conclusion

Sadly within the NHS, an organisation whose primary function is to care for individuals, how we treat one another is often neglected. The structure of the organisation and environment in which we work may also contribute to the significant levels of workplace bullying found in the NHS. For the situation to improve, attitudes need to change from stereotyping 'bullies' and 'victims' towards greater understanding between healthcare professionals at all levels. Focusing on more effective team working and on creating a better work environment can ultimately lead to higher quality and safer patient care.

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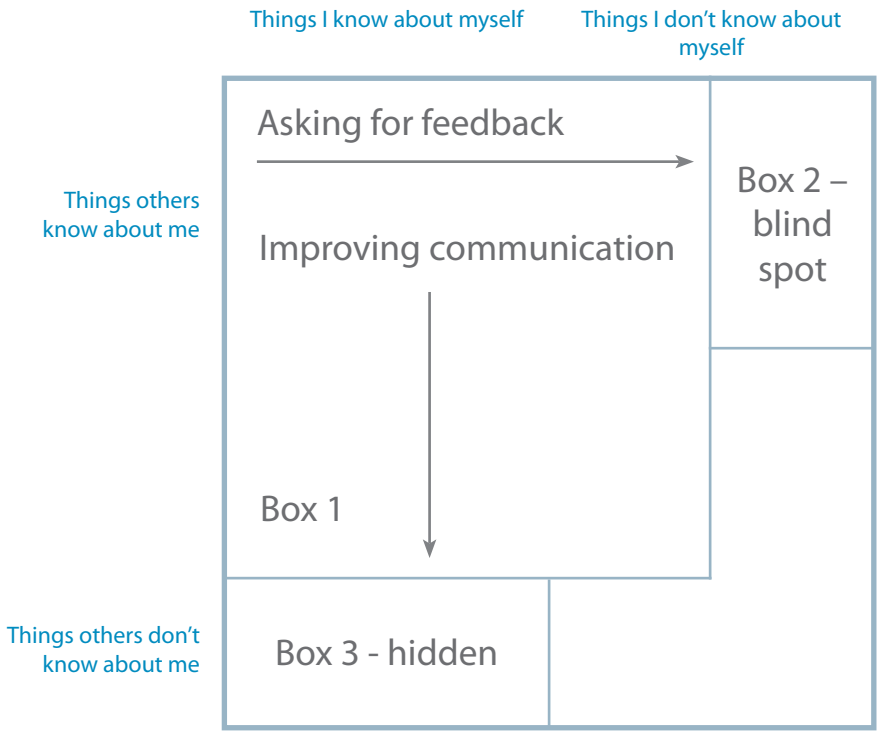

Figure 2. Enlarging Box 1 of the Johari Window

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ACADEMYST EVENTS - CHANGING CONFERENCES & SEMINARS, RESTORING ACCESSIBILITY, MASSIVELY REDUCING COSTS, IMPROVING QUALITY, IMPACT & USEFULNESS

// Introduction

Commissioning has been changed for a reason in the post Health & Social Care Act 2012 era. It has a specific set of jobs to do and a new way of doing them. The commissioning job to be done represents a plethora of risks, threats and opportunities for all types of services and it's important to understand just what these are. Perhaps the greatest risk is that the very people who really need to understand commissioning in its modern form are the same people that find it mystifying. This day is designed to thoroughly demystify it for consultants, matrons, managers and other service leaders, along with anyone who recognises the importance of understanding how things work today. It will provide clear guidance on how to approach it to maximise opportunity and safety whilst minimising or mitigating its risks & threats.

// Key Topics

- Understanding commissioning & its new structure
- Commissioning Agendas
- How commissioning works & how to work with commissioning
- Optimising your commissioning strategy

The Corrosive Effects of Bullying & How to Stop Them

By Patricia Iyer MSN RN LNCC, President of Med League Support Services, a legal nurse consulting firm, www.medleague.com, Flemington, New Jersey, U.S.A. and Alessandro Stievano PhD-MSN-RN, Centre of Excellence for Nursing Scholarship,Ipasvi Rome, Italy

- A child is taunted and berated in the school yard, and becomes afraid to go to school.
- A nurse is deliberately excluded when her colleagues plan a social event;she feels socially ostracized and withdraws from her peers.
- A cardiothoracic surgeon storms into an operating theatre in his street clothes to criticize a junior doctor who is assisting in open heart surgery. The surgical team stops the operation to deal with the behavior of the surgeon.
- A neurologist gruffly interacts with the nurses, who become fearful of speaking up and reporting significant changes in his patients' medical conditions.

All of these behaviors are components of bullying, which is defined as malicious, insulting behavior that is directed to others. It results in feeling humiliated, outcast and criticized.

Corrosive Effects of Bullying

The NHS focus on equality applies to the issue of bullying. Bullies do not treat others as equals and create damage to the individual and organizations. The first step to address this problem is to recognize that bullying occurs in all walks of life irrespective of age. Bullying causes far-reaching effects resulting in a reduction in individual morale and institutional productivity. Healthcare providers trying to manage the emotions stirred up by being bullied may withdraw, at least temporarily, while they recover from a physical or verbal attack. Bullying increases absenteeism, the inability to complete all work within the assigned time, and turnover. Individuals who feel they have no recourse but to leave an institution after being subjected to repeated bullying episodes, create a gap in the healthcare staff - a hole which requires precious money to recruit and train a replacement.

In today's workplace, many victims of bullying feel they cannot leave their position. They feel trapped and thus may react with anxiety and depression, frequently developing physical and mental problems, feelings of worthlessness, and having trouble sleeping and eating. Thus bullying is detrimental to an individual's sense of self-worth, work satisfaction, professional engagement, physical and psychological well-being - all of which conspire to diminish the quality of patient care.

Patrica Iyer

When healthcare providers are disrespected, humiliated, or degraded, their ability to provide good team support and generate good relationships (fundamental to the healthcare environment) diminishes the appropriate care of patients. There is a fundamental need for all those working in health care to be comfortable in their work environment in order to provide a high standard of patient care.

Bullying erodes the team spirit that is so necessary to deliver excellent healthcare in today's complex world. There is a decline

in creativity, willingness to help others, to talk to others, and to be part of a highly functional team. Patient safety is affected when healthcare providers are reluctant to report information to others for fear of being chastised. Healthcare professionals who are in fear of losing their jobs or not being able to work at all may accept an unsatisfactory hostile work environment. If this is to be avoided, leadership must come from the senior management group to eradicate bullying because it is the right thing to do rather than the view that if people leave, they can be replaced.

Bullying as a Global Issue

Bullying is a phenomenon that affects the performance of healthcare systems worldwide.Bullying crosses all boundaries. Documents released by different institutions highlight that workplace violence has gone global, is widespread in all countries, and among all healthcare occupations. The authors of this article met at the International Council of Nurses Conference in Melbourne, Australia in May 2013 when Pat Iyer presented a talk on bullying as a global issue. The multinational audience of nurses shared their concerns with the bullying occurring in their countries.

A recent review of healthcare literature showed that bullying or "mobbing" (a term used in some European countries) is reported in articles written in Australia, Italy, Jamaica, Japan, New Zealand, Portugal, Slovenia, South Africa, Spain, Switzerland, Taiwan, Thailand, Turkey, and the United States.Bullying is extensively addressed in nursing literature because of the historic role of nurses as an oppressed group – as targets of fellow nurses, nursing managers, medical staff and other healthcare professionals.

Alessandro Stievano

In some countries the situation is exacerbated by the deprivation of workers' rights or by poor economic conditions. However, even in developed countries the situation is difficult. In the Mediterranean countries a culture permeated by a medical dominance has resulted in large numbers of physicians compared to the needs of population. The culture is profoundly influenced by the traditional power of this group of professionals.

Nurses are at risk of being bullied by patients, which is predominantly in the form of physical assaults, compared to verbal abuse from a variety of sources. However, more commonly bullying of nurses is largely through verbal abuse between peers on the same level within the organization's hierarchy, although bullying by physicians is certainly not uncommon.

Nowadays, this situation of nurse's powerlessness is worsened by economic factors. One of the central pressures within healthcare systems is not the retention of valuable people but cost containment. When nurses are seen by hospital administration as disposable, healthcare standards and

patient safety are compromised.

The increased attention to workplace bullying reflects the huge cutbacks in health systems all over the world, particularly in a context affected by the global shortage of nurses. In fact, the World Health Organization estimates that there are about 60 million health workers worldwide, and 31.6% of them are situated in the American continent, with United States possessing the majority of them. About 60 countries in the world have a great shortage of healthcare professionals. Summed up they are about 2,400,000 among nurses, physicians and physiotherapists.The reality is that it is not easy to replace healthcare professionals who leave because of an intolerable work environment. It is particularly hard to replace experienced people who take away years of experience.

Reversing the Damage

Some healthcare senior management teams are looking at the costs of bullying and saying: "No more, we will not tolerate disruptive behaviors." Physicians are being held accountable for "bullying" behavior which, if demonstrated after review, may result in job loss. The cardiothoracic surgeon who stormed into the operating room found himself stricken from the hospital staff when it was time to renew his position. Frequently, American healthcare systems give one warning to a bully. The next infraction results in removal from the staff.

What to do with the physician bully?

Healthcare providers may be caught up in one of three roles: being the bully, being the victim, or observing someone else being a bully. All three roles require action. Alan Rosenstein, an American physician who has extensively studied bullying, sorts physician bullies into three groups. The first group consists of physicians who do not realize they are bullying. Once they become aware of their behavior, they self-correct.

The second group of physicians has a deep-seated problem with self-worth and anger management. They are arrogant. Under the stress within the healthcare environment, they may treat people with disrespect and bullying behaviors. This group may benefit from education, coaching, and counseling on stress, sensitivity, conflict and anger management. In addition, they need a warning that bullying behavior recurrence may jeopardize their job or institutional affiliation.

Physicians in the third group have a God-like mentality, and no insight into the damaging effects of their behavior or about the need for a team approach to healthcare. They are unwilling to change. They may have a personality disorder or substance abuse issues and need psychiatric interventions, sanctions, or possible revocation of their institution position/affiliation or referral to professional licensing authorities.

How can you stop being a victim of a bully?

Let's say a colleague is berating you in public. Present the rationale for your actions. Avoid becoming argumentative. If the other person does not withdraw, one approach is to say, "I see you are upset about this. Perhaps when we have both had some time to think about what has just happened, we can have a more reasonable conversation." Then walk away. It is not possible to continue an argument when the other person leaves. When you are calm, approach the person in private and say, "I felt belittled when you yelled at me in front of everyone." Engage in a discussion about what occurred and how you prefer the communication to occur. Be firm in offering your comments.

Also recognize that this is a complicated issue. Not every complaint of bullying is valid. Some people in the healthcare arena do not like to be told what to do. Managing differences of opinion can escalate into bullying behavior which, although understandable, is not an appropriate response. There may be legitimate differences of opinion between, for example, a physician on the one hand and a nurse on the other. If the nurse feels the physician's decision making is incorrect, the nurse has a responsibility to use his or her own hierarchical structure. More senior nursing staff may evaluate the situation and, if necessary, discuss matters with the physician. One of the authors (PI) has reviewed many medical malpractice cases that could have been avoided if the nurse had used the hierarchical structure to challenge a physician's order or refusal to come see a patient.

What should you do if you have good evidence that a professional is being bullied?

Let's assume you are a consultant and see a trainee doctor bullying a nurse. Mr. Peter Fielding, a British-educated general surgeon and departmental Chair, uses this approach: Sit down with the trainee doctor and ask a

series of questions to draw out the trainee doctor about what transpired between him and the nurse. Once he admits to what he did, ask how he plans to rectify the damage. Hold the doctor accountable for having a meaningful, apologetic conversation with the nurse. Follow up with the nurse to ensure the conversation took place, and then talk to the trainee doctor again. Did he understand the lessons learned from this conversation? In addition, make a statement that any further episodes will be formally reviewed and the results recorded. Repeated episodes will be sanctioned.

What do you do if the bully says, "In my native culture, we treat others lower in the hierarchy like this, and I have the right to behave according to my culture" ?Acknowledging diversity does not mean allowing the bully to act in a disruptive way. It requires educating the bully about the appropriate, respectful way to behave within the healthcare system.

What should you do if you have good evidence that people in leadership positions turn a blind eye to legitimate complaints? Firstly, proceed with care! More often than not, whistleblowers are badly treated in institutions that do not have or enforce their enunciated value statements intended to support employees. There are people in leadership positions who are aware of the problem and do not stop it. This reluctance to enforce the espoused values of equality results in widespread cynicism, depression, and increased feelings of powerlessness by the healthcare professionals aware of the behavior. People in leadership positions who turn a blind eye to bullying allow the damage to continue. They are often motivated by fear, because of the power of the bully, because of ignorance to the corrosive effects, or because of perceived economic dependence on the bully. All of the efforts to eliminate bullying will fail unless the organizational culture and leadership recognize the importance of addressing this behavior and are committed to doing something about it.

Conclusions

The organizations that have most effectively dealt with bullying use a combination of education, support, and action. When senior management decides that institutional corrective action is required, several phases need to be implemented:

- Make a clear statement (or restatement) of the culture in regard to unacceptable disruptive behavior
- Identify people who have skills in interpersonal relationship development/mediation
- Recognize that all healthcare professionals need high levels of sensitivity training, knowledge and experience in negotiation with others
- Provide education about the costs of bullying and the effective ways to terminate bullying
- Followup on problems to make sure any corrective actions have achieved their results and are sustained
- Establish regular reporting at unit, departmental and organizational levels to prevent reversion to the former behaviors

Those who stand up to bullies need support as well as those who do the right thing by reporting it. As a consequence of the culture changing to no longer permit bullying, the leadership team must be willing to take action to not tolerate those who are unwilling to let go of their bullying behavior. This is a frightening position for many in power in health care, yet it is the only way to create a culture of safety, equality, respect, and healthy teamwork.

Inspecting the Inspectors

Exploring bullying and harassment at the CQC

By Professor Derek Mowbray, Chairman and Director,
The WellBeing and Performance Group

The Report by People Opportunities Limited into the Care Quality Commission (CQC), published in June 2013, identified a widespread culture of fear, bullying, harassment, and manager inadequacies. It, also, identified widespread commitment by staff to the purpose of the CQC and to its values.

The significance of the findings is the consequential under performance of the CQC which results from bullying and harassment. Performance arises from the ability of the workforce to be able to concentrate on the tasks they are expected to undertake, within a wider framework of shared responsibility for the success of the organisation.

Concentration requires the workforce to feel well, to feel safe and secure; to feel capable of exposing their skills, knowledge and experience and apply these to the jobs they are expected to undertake, and in any way possible, to the success of the organisation as a whole. The impediments to concentration include motivation, distractions and feeling psychologically unwell.

Under performance is expensive. People who come to work but have their concentration involuntarily diverted by events and the behaviour of people around them, fall into a pool of workers experiencing psychological presenteeism (psychpresenteeism), people being present, but unable to perform effectively. The conservative estimate of cost is 1.5 times the combined costs of sickness absence and attrition attributable to psychological distress. Nationally, this is estimated to cost the country £1000 per man, woman and child – over £60billion. Much, if not most psychpresenteeism, is preventable.

The cost to the CQC of bullying and harassment is not estimated in the report. The costs will be associated with repeating tasks, longer time required to complete activities, adding extra staff to undertake tasks, errors, manager time, as well as the more obviously measureable sickness absence attributable to psychological distress. Other, less tangible costs are associated with lack of energy, motivation, innovation and a zest for getting things done, a form of corporate depression making the organisation as a whole vulnerable to further decline.

Professor Derek Mowbray

The Report by People Opportunities Limited describes an unhealthy organisation, one that probably lacks resilience – the capacity

to respond faster and more effectively to internal and external pressures for change than its rivals, without any diminution in performance. The CQC has had to adapt to enormous change over a relatively short period with the amalgamation of several organisations into a single new organisation. This has been achieved in the public eye. In the public sector such changes appear to be common, yet the way in which change management is undertaken suggests there is little concern about the enormous negative fallout that always occurs when such change is poorly managed.

The damage is done by the time reviews are undertaken and proposals made to improve the management of the new organisation. The opportunity to transform the pre-existing organisations into a healthy, resilient and vibrant new organisation is lost. The task now is much more challenging.

The challenge of transformation

Transformation is the process of taking raw ingredients, mixing them together in a relevant manner, and producing something quite different to the original raw ingredients. Where an organisation already exists, it is often necessary to disentangle it to discover its raw ingredients and to start again.

The report tells us that there are some good raw ingredients. There is enthusiasm for the purpose of the CQC and its values. There are some highly skilled and professional staff, some of whom, it is reported, have left more highly paid work elsewhere to join the CQC because of interest.

The report also tells us of some raw ingredients being present that may become inappropriate for a new organisation.

Organisations are controlled communities, controlled by people we call managers. This draws the distinction between organisations and social communities, which are not controlled by managers. It is, therefore, within the gift of individuals to make organisations fantastic places to work. The workplace should be fantastic. It should provide the inputs into personal success and happiness, such as social relationships, challenges, stimulating personal growth intellectually as well as technically, pride in success, a communal sense of achievement, a purpose in life. These are all ingredients for psychological wellbeing. Psychologically well people do not experience intrusive anxiety. Intrusive anxiety interferes with concentration and results in under performance. Fantastic places to work are mainly anxiety free. Bullying and harassment does not exist in fantastic places to work.

They are places under controlled pressure – pressure being a stimulant to concentration as long as the pressure is under personal control. High performance comes from controlled pressure, interspersed with periods of no pressure. Although there is no consensus on how long any individual can sustain concentration under controlled pressure, an example is concentrated periods under pressure for up to 50 minutes

- *a clear, unambiguous purpose, expressed as a simple 'big idea', an idea which all the staff relate to closely, and are proud to discuss with friends and colleagues.*
- *an atmosphere of confidence, where all the staff are interested in each other, support each other, and project this confidence towards clients and customers.*
- *staff who behave respectfully towards each other, value each other's views and opinions, work in teams which are places of mutual support, where anything is debated without a hint of humiliation, where the critique of individual and team work is welcomed, discussed and where lessons are learnt and implemented.*
- *staff who 'go the extra mile' by providing unsolicited ideas, thoughts, stimulus to each other, and where their interest in their customers offers something more than is expected, beyond courtesy, and beyond service, offering attentiveness and personal interest.*
- *challenges for their staff, that provide opportunities for personal development through new experiences, and which treat everyone with fairness and understanding.*
- *staff who are personally driven towards organisation and personal success – intellectually, financially, socially and emotionally.*

in the hour, with ten minutes complete break (reading emails, perhaps?), produces high performance.

Transforming the CQC from the description in the report to a high performing organisation requires certain steps to be taken, some of which are helpfully laid out in the People Opportunities Limited report.

Transforming the CQC

A starting point for any new organisation is for its leaders and managers to decide what kind of culture it wants. The example below is a culture that reflects strong psychological wellbeing and performance.

This example has been used to create a Charter for WellBeing and Performance. A Charter is a device that enables a new organisation to follow a common hymn sheet, so that everyone knows what the organisation expects its culture to be like. So, a Charter may be used as the aim for training and development purposes, the agenda for every manager meeting, and a display of values for clients and customers to appreciate.

This example has been taken from studies of the most successful organisations around the world. The key elements that provide the foundations on which the illustrated culture is based are commitment, trust and engagement.

Commitment, trust and engagement, in combination,are a principal antidote to psychological distress and psychpresenteeism. They are, also,basic ingredients for peak performance. No highly successful organisation, with low sickness absence and attrition attributable to psychological distress, exists without commitment, trust and engagement being strong.

Commitment, by some staff in the CQC, already exists.

Trust, which is the absence of second guessing the motivation of others, may not. Therefore engagement, otherwise known as social engagement – the type of engagement individuals feel when they derive their energy, buzz and excitement from their work and their organisation,akin to psychological flow – may not yet be present in the whole CQC, although there must be pockets of commitment, trust and engagement in parts for the organisation to continue to produce results.

Producing a high performing organisation based on commitment, trust and engagement, requires a systemic approach to transformational change.

The starting point is the description of the culture above. The next steps are all

critical to success and none should be left out. There is no short cut, nor is there the opportunity for cherry picking 'the easy to do' items and expect the rest to fall into place. Transformational change doesn't work like that. It works when the whole is transformed.

The WellBeing and Performance Agenda

A framework for introducing and sustaining commitment, trust and engagement into organisations is to follow The WellBeing and Performance Agenda.

The overall purpose of The WellBeing and Performance Agenda is to eradicate psychpresenteeism, (including the eradication of bullying and harassment thoughts and deeds) and, at the same time, provide the culture, management, working environment and personal resilience that provokes concentration at work, thereby providing the best possible opportunity for the organisation and its workforce to achieve peak performance.

The framework is shown below.
The Agenda is divided into three parts.

Part 1 – Discovery; Part 2 – Corporate Resilience against psychpresenteeism; and Part 3 – Personal resilience against adverse events and poor behaviour of others. Corporate resilience provides the context within which people work. The processes of attaining strong corporate resilience eliminate the risks of adverse events and poor behaviour for which personal resilience is required. Conversely, individuals may have extremely well developed personal resilience, but if the context isn't supportive there is only so much resilience that an individual can use before the individual becomes affected by events and poor behaviour and under performs. Personal resilience is not the solution for corporate incompetence.

Discovery -is the process of discovering the impediments to wellbeing and performance.

The report by People Opportunities Limited has discovered the impediments to performance, namely bullying and harassment.

The culture–to attain a high performing organisation requires the organisation to focus on the following specific items –

Each of the items should be addressed with commitment, trust and engagement of the workforce as the focus. The test, therefore, is whether each item achieves commitment, trust and engagement in the workforce.

The Management Standards for WellBeing and Performance (www.orghealth.co.uk) provides the detailed standards to be achieved under each of the items above. They, also, appear in Derek Mowbray's Guide to Corporate Resilience (www.mas.org.uk) .

The Management- has ethical leadership at its core, with a range of inputs that attain ethical leadership, commitment, trust and engagement. The rationale for ethical leadership and management is that no organisation should be established to underperform; the reasons for under performance can cause misery to individuals, and where this is known, the causes of the misery should be eliminated.

The approach to leadership and management is based on adaptive leadership principles. These principles draw a distinction between power invested in a few (an oligarchy) and power invested in everyone (a polyarchy). The manifestation of this difference is found in the basic approach to adaptive leadership which is shared responsibility for the success of the organisation. The prime responsibility of staff is to the organisation and its success, not to its managers.

Therefore, some of the key features of adaptive leadership include:

- Elephants in the room are routinely exposed and dealt with
- Independent judgment is expected and encouraged
- Reflection and continuous learning is institutionalised
- Responsibility for the organisation is shared
- Leadership capacity is developed

More detail about the behaviours and other aspects of leadership and management may be found in The Manager's Code for WellBeing and Performance (www.mas.org.uk) , which has been adapted by the Institute for Healthcare Management as The Managers' Code for Health and Social Care (www.ihm.org.uk) .

The Working Environment is about the various contributions to facilitating concentration at work. These include:

- The ability to take exercise
- The provision of appropriate nutrition to sustain energy
- The provision of ergonomically sound offices and equipment that facilitate concentration
- The application of technology that enhances concentration
- The application of information technology that enhances concentration
- The application of management practices that enhance concentration

The test for each of these items is whether the working environment facilitates concentration, or do they divert attention away from focusing on the tasks and activities that are expected to be completed effectively.

The Resilient Person is about strengthening the capacity for individuals to maintain personal control over themselves so that they may form robust and positive attitudes towards adverse events and poor behaviour in others. In a resilient organisation there will be less need for individuals to draw on their personal resilience, as the adverse events and poor behaviour in others will be largely extinct. However, all organisations experience degrees of adverse events, and all members of every workforce need to have degrees of resilience. Resilience is about attitude, and attitude is heavily influenced by the cultural context in which people work, and the attitude of managers towards their staff.

Conclusion

The report into bullying and harassment at the CQC found a number of features that suggest the CQC is currently an unhealthy organisation that is under performing due to the high perceived levels of bullying and harassment.

The report helpfully presents proposals for change. In this paper those proposals for change have been placed into The WellBeing and Performance Agenda which sets out the steps to be taken to transform the CQC to a high performing organisation.

Job Planning without Drama

For individuals undertaking job planning for their fellow consultants

Effective services have sensible consultant job plans that are closely matched to attainment of important organisational objectives. However, those responsible for establishing job plans and holding discussions with their consultant colleagues find agreeing job plans one of the most stressful activities they have to engage in. This reflects the high potential for discourse in the job planning process, especially as we transition from a largely clinically-driven to a more balanced clinical-business-driven environment.

Upcoming Dates:

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- Understanding the roots of discourse in job planning
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- Looking at & analysing demand, capacity & activity
- Comparable consultant effectiveness
- Where patterns & formulas are helpful and where they are not
- Achieving maximum benefits to all through Job Planning
- Commencing with a clear benefits statement
- Key questions to ask
- Resolving common scenarios for maximum benefit
- Job planning conversations
- Planning the discussion for the highest likelihood of success
- Getting discussions off on the right foot
- Holding structured discussions to improve collaborative objectivity
- Impact of human needs or psychological difference & how to control for this
- Effective influencing process - from art to science
- Ensuring that stones are not left unturned - avoiding the unpalatable or difficult
- Cementing agreement to ensure action without backsliding
- Negotiation Skills for Job Planning
- Approach negotiations to achieve win-win
- How to overcome historical agreements and precedents
- Special considerations for discussions you feel have the potential for discourse

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Cultural Damage and a Loss of Stewardship

The bigger cost of bullying

By Andrew Vincent, Partner & Head of Clinical Business Excellence, Academyst LLP

To be bullied as an individual is of a severity that can lead to breakdown and even suicide in certain individuals. However, terrible the individual impact, the system focus tends to be just that – individual – ignoring the longer term, large scale damage occurring in organisational culture, resilience and adaptability. That's a blindness that we'd do well to overcome, as these collective losses go to the heart of organisational survival in a climate that treats the strugglers very badly indeed.

Bullying takes many forms. Our traditional notion is one of a rather robust, vindictive individual picking on a milder, less assertive one not because he has a reason but because he can. This school-boy model belies the true systemic nature of bullying in the NHS, which is frequently a complex set of organisational and individual behavioural influences resulting in many people behaving in a manner that is uncharacteristic and undesirable, not to mention unacceptable. What is less clear though is ultimately who is to blame.

To consider this at the highest level is to appreciate that a system in which financial austerity exists must consider the undue pressure applied to senior individuals held responsible for financial performance. An individual that will lose their job and possibly career livelihood for not balancing the books has an enormous behavioural pressure applied that could tip the balance between open collaborative working and an approach to underlings that constitutes bullying – do this or else. The question remains as to whether the individual is criticisable for bullying or the system for creating an intolerable pressure resulting in departure from acceptable behaviour.

This has a cascade effect. The Board creates a bullying climate as it collectively fears for its own security whilst problems exist. This in turn results in managerial staff adopting a bullying approach to the management of services, which must be OK, mustn't it, as the Board are doing it to us? It has become the tacitly accepted way of working when things aren't working.

The behaviour elicited at a service level is that of putting your head down and trying to keep out of the firing line. The justification is that you've raised your concerns and it is now 'management's' fault but the ultimate effect is that the service has moved from stewardship to compliance and that doesn't bode well at all.

A Climate of Stewardship

The definition of stewardship is the propensity to act in a manner that protects the service in all domains as part of yours and others collective sense of responsibility, including the raising of difficult issues and concerns, regardless of whether the source of concern is internal or external. This climate is an important component of a check and balance system, as well as the early warning system for Trusts that safety issues may occur. We're saying that bullied people just don't act with stewardship, instead replacing it with self-preservation behaviours. However, it is more serious than that.

How leaders behave and the organisational culture and behavioural norms are the two strongest drivers of how someone feels about working for the organisation. The right leadership and behaviours result in strong emotional attachment and the propensity to do everything it takes to

help the organisation in times of trouble, often in spite of the discretionary effort this might take. This is the basis of organisational resilience – the propensity of a group to save their own organisation out of a sense of ownership and emotional attachment. If you bully, you undermine that attachment and it creates a whole host of behaviours inconsistent with survival, including:

- Protection of terms and conditions
- Rigorous adherence to boundaries such as leaving time
- Inflexibility in adapting to proposed solutions e.g. a new work pattern
- Simplistic problem solving – do the minimum

Essentially, what we're saying is that by striving to provide a safe and stimulating environment in which individuals feel secure, we develop a strong sense of ownership in people who will then innovate, solve and adapt to protect their beloved organisation. If the organisation is not loved because it allows individuals to adversely influence how others feel, then those people may well protect patients but they lose their propensity to protect the organisation.

The Caring Profession

Clinicians care deeply about their patient welfare. They have a clear sense of purpose that if this isn't right then the whole thing isn't working. Senior managers often overrate how much individuals care about the organisation, misjudging the apparent support for an institutional structure e.g. resisting a service moving to the community, for active care of the organisation itself, rather than the care it delivers. Many professionals don't care if organisations or Boards survive, as the long as the care they provide is preserved in a high quality form.

This isn't to say that individuals can't or don't care about their organisations. We're saying that this caring can be so easily lost when the leaders and organisation don't behave in a manner that preserves it. Bullying is certainly one of the fastest ways of eroding it – if you don't demonstrate that you care about me, why should I care about you?

Ultimately, organisations today will only survive and thrive today through the drive and efforts of their people. Bullying may lead to temporary compliance but it in no way engenders a spirit of collaboration, engagement or collective responsibility. The true irony remains that so much bullying is in response to individuals feeling pressured to achieve things that have personal consequences if they don't and yet the very act of bullying predisposes the organisation to further decline and failure as a result of those pressures.

What remains fascinating but distressing is that so few individuals engaged in bullying can actually see the convoluted outcome of their activity. This just goes to demonstrate that they are most likely emotionally hijacked in response to the bullying from above, whether it comes in a direct, personal form or that of an organisational culture that places individuals at severe personal risk when the figures don't stack up. If we are going to address this insidious rot inside of our NHS organisations, we need to start by creating a climate of concomitant personal safety and true accountability – stewardship and an environment that supports its open application.

Shock for doctors as spectre of £50,000 annual allowance tax bill looms

Doctors receiving details of their annual pension savings for the tax year 2011/2012 have been shocked to find they've saved substantially more than the agreed cap with the result that those in breach of the new lower annual allowance limits could be hit with a very large tax bill – in the region of £50,000 in some cases.

Figures collated by Cavendish Medical Ltd, specialists in retirement planning for doctors, will come as a surprise to many because the HMRC calculations for pensions contributions are based on the deemed growth of the pension in the year and bear little resemblance to the amount a doctor has actually paid into their pot.

Simon Bruce, Managing Director of Financial Experts at Cavendish Medical, said: "We have been helping new clients who have received letters showing pension savings in 2011/2012, with one as high as £150,000 – much more than the individual had actually put in. The doctors may have no 'carry forward' allowance available from the previous three years so as the annual allowance cap is £50,000 this particular doctor will have exceeded it by £100,000. This must be added to their other income in that tax year – when the top rate of income tax was 50 per cent – so a staggering tax bill of £50,000 could be anticipated.

"The very real problem for these doctors is that this is happening long after the event – the 11/12 tax year has closed and the tax returns already filed. They may also have made personal pension contributions in the year that cannot now be refunded. There is little that can be done retrospectively. This tax charge has to be paid via self-assessment by amending the previously filed tax return, perhaps even incurring an interest fee for late payment, or choosing to use 'Scheme Pays'.

"Now doctors are completing their 2012/2013 tax returns but the vital pension contributions figures needed will not be released until October 2014 so this expensive problem could be repeated unless you seek help now.

"It is imperative that doctors get their finances in order well ahead of time – particularly going forward as the annual allowance rate is being reduced further to just £40,000 in April 2014."

Doctors will be facing an extra tax charge if the yearly growth in their pension and lump sum benefits is greater than £50,000 and they do not have any unused allowance to carry forward from the previous three tax years. They have the option to pay the tax bill themselves – which could be tens of thousands of pounds – or elect for the NHS pension scheme to pay some or all under the 'Scheme Pays' rules.

If their pension scheme settles the charge, doctors will accrue interest on the amount paid at the rate of 3 per cent each year plus the relevant CPI (consumer price index).

Simon Bruce

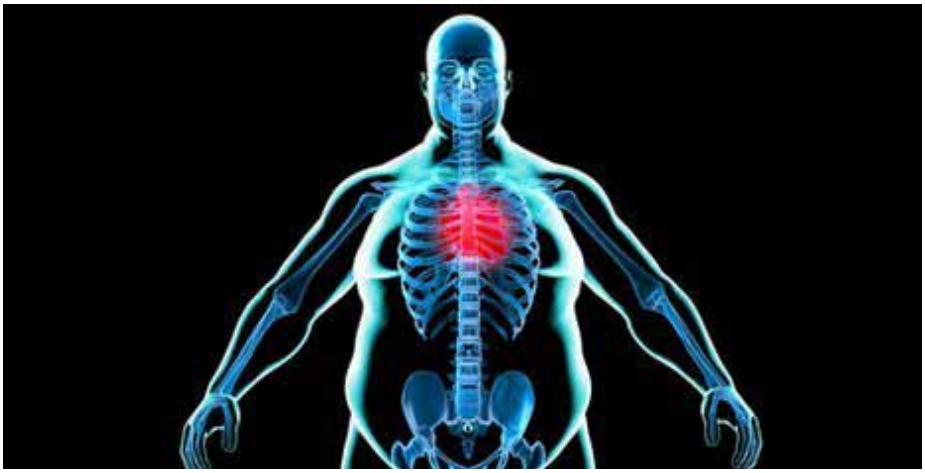
The amount then owing will be converted into a reduction of pension and lump sum benefits upon retirement.

For the tax year 2012/13 NHS Pensions must receive the application for Scheme Pays by 31 July 2014. The annual allowance will be reduced to £40,000 in April 2014.

Doctors who have exceeded the annual allowance for pensions' savings in 2011/2012 are being advised that they must apply now if they would like the NHS pension scheme to pay the resultant tax charge. Applications should be made to the NHS pension agency by 31 December 2013.

www.cavendishmedical.com

Rising obesity levels is a "grave concern" says BMA Scotland



BMA Scotland has responded to the publication of obesity indicators which show that 64.3% of adults are overweight or obese and 30.6% of children were at risk of being overweight or obese.

The indicators also reveal that cases of type 2 diabetes, which is closely linked with obesity, are also increasing.

Dr Sally Winning, Deputy Chair of BMA Scotland said: "The rise in obesity levels is of grave concern. Currently almost one third of children are either overweight or obese. We are in danger of raising a generation of children burdened with long term chronic health conditions. Doctors have a role to play in supporting overweight patients and talking about the dangers of obesity but there is a limit to what they can do."

To tackle the issue, BMA Scotland believes there needs to be a focus on:

- Healthy eating (extend the free fruit scheme in schools)
- Physical activity (increase funding and improve access to sport and recreation facilities within schools and communities)
- Protecting the social and built environment (Scotland's parks and play areas need to be maintained and improved to allow more children to access play spaces)
- Education (allowing children to make informed food decisions)

Dr Winning adds: "Prevention is much better than cure. It is better, healthier and safer if children are given the tools to manage their weight, eat healthily and take more exercise. But no-one is saying this is easy. It is crucial that we take the opportunity to halt the rise of obesity, and the host of illnesses that come with it – it is vital that the Scottish Government acts without delay."

NICE urges NHS to be smoke-free

The National Institute for Health and Care Excellence (NICE) is calling for NHS hospitals and clinics to adopt a completely smoke-free culture.

NICE advises that patients who smoke should be offered smoking cessation drugs, nicotine patches, and counselling as soon as they are admitted to an acute, maternity or mental health setting.

Professor Mike Kelly, Director of Public Health at NICE, said: "It is absurd that smoking is still being passively encouraged within hospitals.

"We need to end the terrible spectacle of people on drips in hospital gowns smoking outside hospital entrances. This new guidance can help make that contradiction a thing of the past by supporting hospital smoke-free policies to make NHS secondary care an exemplar for promoting healthy behaviour."

With smoking responsible for over 460,000 hospital admissions in England each year, Professor Kelly is also calling for stronger leadership among Trusts.

"Smoking has been thought to be a difficult nut to crack and so it is high time for this guidance. It recommends strong leadership and individual trusts have to own this. The professionals have to be willing to take this guidance on," said Dr Kelly.

Government's Francis response pledging a restoration of trust receives cautious welcome

Openness, compassion, and accountability to be cornerstones of NHS says Hunt

The Government's full response to the Mid Staffordshire hospital public inquiry (published last week) has been cautiously welcomed but much remains to be done warns the healthcare world.

Since the Government announced its initial response to the Francis Report in March 2013, several changes have been implemented. These include the appointment of three Chief Inspectors of hospitals by the Care Quality Commission; the publication of a guide to commissioners by NHS England; the introduction of a new hospital inspection of programme; and legislation for a duty of candour on NHS organisations.

The new plans build on this initial response and the Government, in total, has accepted 281 out of the 290 recommendations made by Robert Francis QC in his report.

Health Secretary Jeremy Hunt said: "I do not simply want to prevent another Mid Staffs. I want our NHS to be a beacon across the world not just for its equity, but its excellence. I want it to offer the safest, most compassionate and most effective care available anywhere - and I believe it can.

"These measures are a blueprint for restoring trust in the NHS, reinforcing professional pride in NHS frontline staff and above all giving confidence to patients. I want every patient in every hospital to have confidence that they will be given the best and safest care and the way to do that is to be completely open and transparent."

Some of the key measures in the Government's response include:
From April 2014, all hospitals will publish staffing levels on a ward-by-ward basis

- A new national safety website will publish all the information relevant to safety in every hospital in the country on a monthly basis
- A new national patient safety programme across England will spread best practice and build safety skills across the country from April 2014.
- Five thousand patient safety fellows will be trained and appointed by NHS England within five years, to be champions, experts, leaders and motivators in patient safety.
- Trusts will report quarterly on complaints data and lessons learned
- Experts will be asked to advise the Government on how to improve reporting of safety incidents
- A new criminal offence for wilful neglect will be introduced
- There will be a new Fit and Proper Person's Test which will enable the Care Quality Commission to bar unsuitable senior managers
- Every national NHS organisation has signed a compact to reduce bureaucracy
- Every hospital patient will have the names of a responsible consultant and nurse above their bed

Niall Dickson, Chief Executive of the General Medical Council, said: "We all need to step up to the challenge of the Francis report - patients should always be at the heart of

healthcare but we know this is not always the case. We welcome the Government's response and in particular the emphasis on greater consistency between healthcare regulators.

"Through our guidance, we have already done a great deal to encourage a duty of candour among doctors, but we are not complacent. We know there is more to do. We must strengthen the link between our guidance and doctors' practice on the frontline, the words on the page and actions on the ward. We look forward to working with doctors and others to make that happen."

Dr Johnny Marshall, Director of Policy at the NHS Confederation, said: "The Government's response to the Francis Inquiry report sends a clear message to leaders in the NHS to continue with vigour the work already started to promote improvements and innovation which ensures a transparent and open culture with patient safety and wellbeing at its heart."

Chief Executive of the Nuffield Trust Andy McKeon said: "The Francis inquiry report

was clear that a closed culture, which instinctively concealed poor care rather than confronting it, lay behind the harm done to patients at Mid Staffordshire hospital.

"This response focuses strongly on new legislation and guidance to hospital trusts and their employees. Yet the Mid Staffordshire public inquiry was clear that change must include central bodies, commissioners and regulators. Policymakers must ensure that these organisations understand their crucial roles in delivering safe and dignified care to patients, and create a culture that is open, supportive and patient-focused.

"Learning from and listening to patients and their communities will be crucial in helping the NHS to provide safer, better care. This response says little about engaging local people in conversations about quality of care. We hope the Government will make clear how it intends to support this in future."

"It is vital that organisations actively listen to their staff and take on their concerns"
British Medical Association
"Learning from and listening to patients and their communities will be crucial in helping the NHS to provide safer, better care"
Nuffield Trust

"We all need to step up to the challenge of the Francis report - patients should always be at the heart of healthcare"
General Medical Council

Editors Comments

Dr Sara Watkin

There is much in the Government response to improve transparency following Mid Staffs and the Francis Report. We should all welcome the increased scrutiny and publication of operational status around staffing and safety, as it will push poor or inappropriate resourcing into the public domain, making it easier to deal with in Trusts. It will make it more difficult for Trusts to cut in secret and then hold clinical teams accountable for failings arising from insufficient on the ground staffing. However, for all the positive points, there are a number of thorny issues that it hasn't tackled or considered.

It is introducing a changing landscape of accountability that could have adverse consequences. The introduction of Wilful Neglect – in effect culpability for not raising concerns or for a failure to deliver adequate care, in no way addresses the behavioural difficulty of such a requirement in the face of a threatening culture and behaviours. Whereas the legislation will undoubtedly stimulate more vigorous challenge to poor care, this appears to increase risk for an individual where an organisation refuses to provide adequate financial resourcing – who is ultimately culpable and is the clinician absolved of culpability for raising concerns that the Trust refuses to address? More questions than answers.

Equally, I am sure many welcome the Fit and Proper Person's Test for senior managers, as we have all no doubt seen individuals of questionable capability wreak havoc and then move on the next, poor, unsuspecting organisation. However, an organisation's financial or clinical performance is a collective affair, not a singular responsibility. I am interested to understand how this might change behaviour and whether those changes have been fully considered. How might this work where a specific individual is faced with a demand for additional resource on safety grounds in the face of a growing financial deficit? Intuitively, as clinicians, we would err on the side of safety but that senior manager faces a prospect of being held responsible for poor financial performance, resulting in loss of career, an equally catastrophic loss at a personal level. How will we rationalise this increasing likelihood? How will we protect managers who do the 'right' thing? How will we address poor Trust financial performance when part of the reason is the investment in safety. It is over-simplistic and romantic to think that investment in safety will automatically translate into improved financial performance too.

I suspect that we will discover that biological programming in response to personal risk trumps the idealism of making patients and public the heart of all our decisions and actions. I am not saying we shouldn't aspire to this ideal so much as highlighting that's all very well until you find yourself in a situation where your neck is exposed whichever way you turn. Time will tell.

NHS Trust breaks new ground with 'patient feedback app'

A new app for smartphones and tablets which breaks new ground for the NHS in the way it improves people's health and well-being is now available.

The free-to-download app – designed and developed by Derbyshire Healthcare NHS Foundation Trust – enables users to be just a touch away from rating services and giving feedback on their patient experience.

A key benefit of the app is that it can be personalised to meet the different health needs of users. It features an 'appointment tracker' which reminds people where they need to be and when; and provides advice on what to do in an emergency.

Derbyshire Healthcare NHS Foundation Trust Chief Executive Prof Steve Trenchard said: "As well as a caring organisation, we are a listening one too.

"This app not only gives the community we serve greater ownership and control over improving their own health, but it also adds a new dimension to the way we improve services by capturing their comments and experiences in an instant.

"This is an important step forward for us as we continue our journey to be at the forefront of healthcare technology and cement our position amongst the top performing Trusts in the NHS."

The app can be downloaded by searching for 'My CCS' on the Apple App Store, Google Play, or BlackBerry World.

Monitor urges Trusts to pursue efficiency savings

Health service regulator Monitor is urging NHS foundation trusts to make greater efficiency savings to avoid serious financial troubles in future.

In its latest quarterly report, the regulator states that despite the current economic challenges, trusts are delivering a good standard of care that patients expect but warns that much more needs to be done.

The report, which covers the three months ending 30 September 2013, shows:

- the sector's A&E performance improved over the summer period and the number of target breaches was more in line with historical levels
- trusts need to make better progress on achieving efficiency savings in order to meet the challenge they set themselves for the financial year and avoid more serious problems in future
- 11 foundation trusts failed the four hour A&E waiting time target, a reduction on 31 in the previous quarter. Seven trusts failed to meet this target in the same period last year

Jason Dorsett, Financial Reporting Director at Monitor, said: "We track the performance of foundation trusts to help them prevent operational issues becoming quality problems and adversely affecting patients' care.

"Overall the FT sector has been doing well in challenging economic circumstances, with clinicians and managers working hard to deliver quality of services patients expect and achieve a stable financial position. However, we will continue to scrutinise operational performance closely and step in where necessary to identify what can be done to improve services for patients."

Coinciding with the report's publication is the news that Monitor has launched an investigation into the financial conduct of Wirral University Teaching Hospital NHS Foundation Trust which may be in breach of its licence to provide healthcare services.

Robert Davidson, Regional Director for the North at Monitor said: "Through our routine financial monitoring process we

have identified that the trust's financial performance was significantly out of line with what income was expected, therefore we have decided to investigate further.

"No decision has been taken about whether regulatory action is required and an announcement about the outcome of the investigation will be made in due course."

Editors Comments

Dr Sara Watkin

Shocker… Monitor says save more. In actual fact, Monitor is highlighting an issue that has worried us at the Consultant, for some time. Are we really seeing genuine reform in Trusts and is it of a sufficient magnitude to address the enormous financial shortfall we see emerging. In reality, too many Trusts are simply cutting costs and not undertaking systematic and radical reform of how they deliver services. Cutting needs to be examined closely for its impact on our purpose and adverse effects on future performance and sustainability.

I say that Trusts don't need to 'save' more, rather they need to 'genuinely reform' by addressing the huge mismatch between care delivery model and patient need. This involves re-building from the ground up, not simply removing something because the budget value seems to fit the saving need. Ultimately, this stems from a lack of understanding of the true nature of reform, coupled to all of us being so involved daily on clinical delivery that we have no real time to innovate and re-design. After all, who is going to safely redesign our services? Someone with no operational clinical knowledge? It needs to be us and we need some space in which to undertake it.

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INSIGHTS – UNDERSTANDING THE EVOLVING HEALTHCARE LANDSCAPE

5 Really Important Questions

- Are you 100% confident that you fully understand current healthcare policy?
- Do you know the conditions and mechanism for competition entering your locality & the influence you have over this?
- Are you completely aware of everything that affects both tariff and your service funding?
- Do you fully understand the new choice agenda and just what information will be made available to patients (and how)?
- Are you fully conversant with the new commissioning agenda and how this will affect secondary/ tertiary care?

If you answered 'no' to some or all of these questions, it does raise some concern that you and your service may be vulnerable in the emerging landscape, especially if you are trying to influence or set strategy with an incomplete picture.

What's becoming clear is that the difference between a thriving service and one that struggles and lurches often comes down to depth of understanding and interpretation (leading to confidence to act appropriately). It's a whole new jungle out there and if you don't understand it then you are at a disadvantage, in an environment that has stopped looking after its prisoners.

It's now 2013, The Health & Social Care Act is enacted, the Commissioning Guidance released, the payment systems changing. Maybe it's time to really understand… View the Full Programme

www.NHSINSIGHTS.co.uk

CONSULTANT OPINIONS

The new Consultant Opinions section is designed to encourage a wider appreciation of the consultant viewpoints and it will do so by encouraging external contributions across a number of professional and personal domains.

In this edition:

- Mind the Safety Gap – the gulf between consultant opinion and Trust assertion over risk
- Call for participation in mini-research for publication in next edition
- Thoughts, Feelings, Fears and Funnies – call for contributions

Mind the Safety Gap

The gulf between consultant opinion and Trust assertion over risk

By Andrew Vincent, Partner & Head of Clinical Business Excellence, Academyst LLP

I have long held the opinion that reality and espoused reality are two different things – we believe one thing and yet the communicated 'position' is something very different – an elephant in the room. We decided to test this at a recent event we held and I would like to share the some anecdotal finding as an opener to a topic that deserves more editorial.

As consultants, you are encouraged to be open and raise concerns where you have them, more recently attracting adverse attention and possibly a charge of wilful neglect if you don't. However, do Trusts or senior managers within those Trusts adopt the same degree of candour they expect of us?

The event in question was that of Leadership & Culture in the Wake of Francis, attended by some 150 persons, the vast majority of which we consultants. As chair, I conducted a straw poll based on a single question:

> *Who is **actually worried** that quality, safety & delivery are threatened by current financial strategies in their Trust?*

Approximately 90% of the hands went up. That's almost everybody in the room believing that safety is being put at risk by the financial strategies (largely cutting) being adopted by their Trust. That's scary enough but what is perhaps more scary is that the Trusts themselves espouse something different.

I looked at Monitor's report on the number of Foundation Trusts forecasting red or amber-red Governance Risk Ratings and was surprised to find that it had reduced from 29% to 23% for 2012/13. Let's be clear, that's less Trusts forecasting problems whilst the frontline staff within them are saying we're really worried. Who's right? Are consultants of an overly pessimistic opinion or are Trusts deluded.

We do have a partial answer. In 2011/12, the previous year, only 3% of Foundation Trusts forecasted a red Governance Risk Rating but 13% closed the year in this most at risk category. So, four times as many Trusts end up in the wrong place as believe they will. That at least suggests that Trusts are overly bold and optimistic or that they don't listen to safety concerns from the coalface, or both.

This finding is supported by the trend identified in Monitor's own annual June infographic, in which it depicts the actual status of governance risk at that point.

You can see that there has been a steady slide of Governance Risk Ratings over the last 3 years. When I came to collect June 2013, I discovered that it hadn't been produced. I hold a personal opinion that when the data is damning politically or doesn't support the current approach, the system tends to stop collecting the data rather than revisit the strategy. Consequently, I counted, one by one, the number of Trusts with a GRR of RED and without surprise discovered it had climbed to 29. That's a significant slide and a very significant percentage of the whole cohort. I think we should be worried.

Although this report is anything but rigorous scientifically, it highlights an issue that warrants further attention and discussion. How can we create a safe system if we aren't willing to examine, openly, the underlying reality? How can we seek to charge consultants with wilful neglect when the system itself won't be open and honest about the true status?

CALL FOR PARTICIPANTS

Non-physical Bullying – What are you experiencing?

In the next edition, we are going to highlight consultant experiences and opinions on what we face that constitutes bullying. We want to surface the on-the-ground reality.

Please can you drop us a quick email with the following:

What actual bullying do you believe you have experienced or seen other consultants experience e.g. in response to concerns?

- Quick synopsis of circumstances
- The effects on you or the consultants concerned

What management tactics are you seeing become more prevalent that you think verge on bullying and harassment?

- What are they doing?
- When do you see it happening?

Please drop an email to myself, Andrew Vincent, on andrew@academyst.co.uk stating whether you wish to remain anonymous if we publish the synopsis. We will obviously respect faithfully requests for anonymity, given the sensitive nature of the topic.

CALL FOR SUBMISSIONS

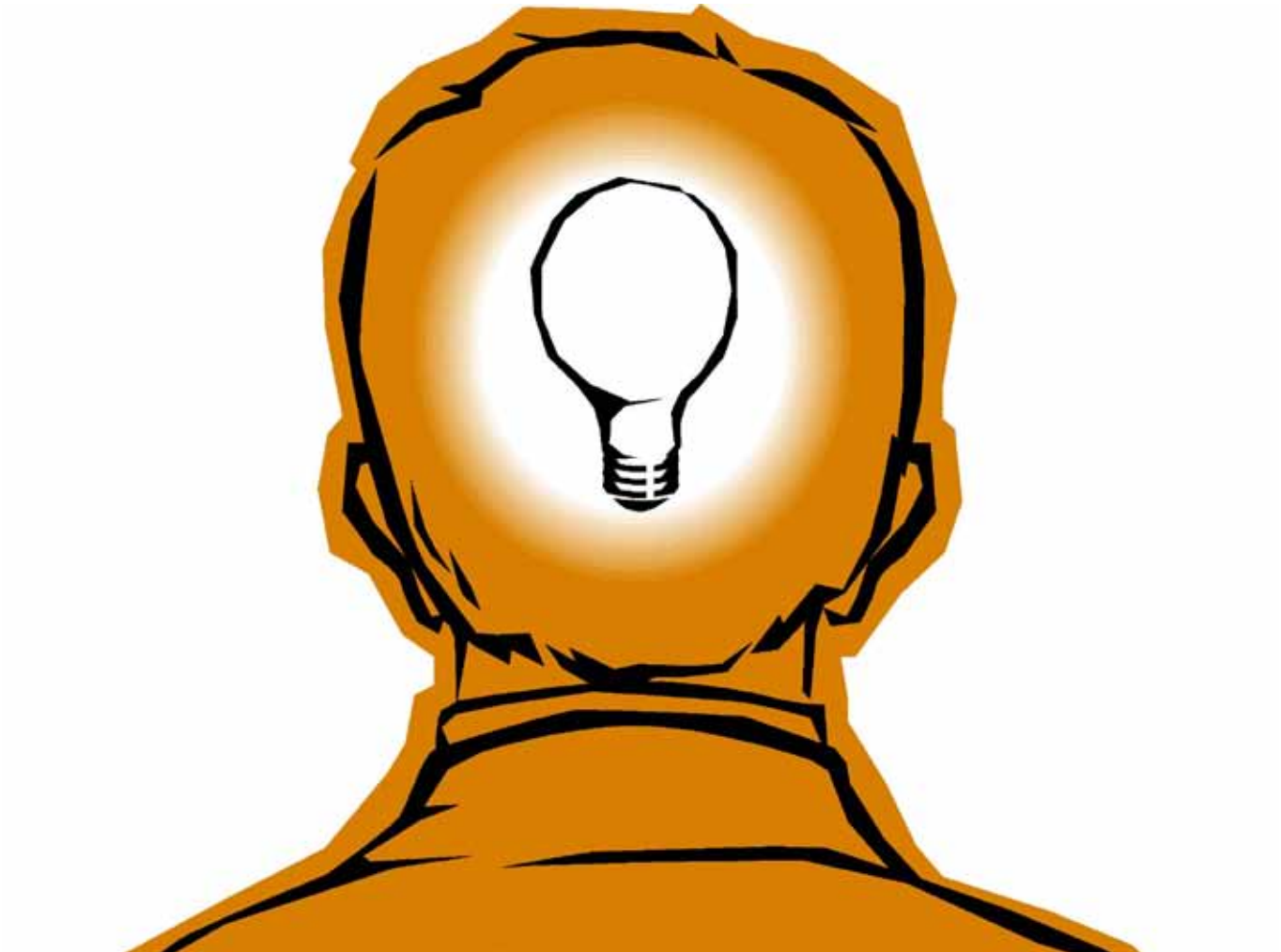
Thoughts, Feelings, Fears and Funnies

We're really keen to increase the amount of smaller contributions from individuals. In this somewhat general, free-for-all section, we'd love to hear from you about anything that has 'struck' you in some way recently as interesting, thought-provoking, amusing or down right scary:

- Any thoughts or feelings on what is going on today?
- Something that happened that was genuinely funny?
- What are you worried about?

It could be a simple one line such as "John Smith is worried about my pension task bill" or something more substantial. We don't mind – submit!

All submissions need to be sent by email to myself, Fraser Tennant, on fraser@theconsultantjournal.co.uk



Arrogance and the imposter: musings on the inherent conflicts of leadership

Do you ever feel secretly inadequate? I don't mean the confusion of not quite understanding what's going on in a busy and demanding world. I mean feeling out of your depth, bewildered and doubtful as to whether you can do what is asked of you in your leadership role? Or more accurately, a deep-seated, suppressed and secret feeling that really, you're not up to the job?

By Chris Lake, Head of Professional Development, NHS Leadership Academy

I have. My presenting behaviour - my 'brand' if you like - is confident, assertive, and assured. I'm sure some people might even turn the volume up on those words and call me over-confident and maybe sometimes even rude. These are behaviours I've been working on for years where I try and manage the thin boundary between genuine passion and unfortunate arrogance. However, my internal experience is different. Sometimes I look at the expectations people have of me, and think I'm just not up to the job in-hand.

I don't feel like this all the time, but when things are tough and my resources are low I can find myself rocked and uncertain.

If sometimes you feel like me, that you might not have what it takes - we're not alone. This feeling is called the Imposter Syndrome and it's completely normal. During my leadership development and coaching practice I've worked closely with numerous managers, leaders and fellow developers. Pretty much every one has at some point said 'I'm only one page ahead of the others,' or 'I feel that at any moment I'm going to get found out for the fraud I know myself to be.'

Despite apparent evidence of one's competence, when the Imposter Syndrome hits you'll remain convinced that you do not deserve the success you've achieved, dismissing this inwardly as luck or fortuitous timing. Psychologists would call it a phenomenon where successful people fail to internalise their accomplishments, unable to believe they are themselves responsible for, or deserving of, the position they've achieved.

I've met some truly brilliant people who experience this hindering internal pattern. One in particular comes to mind: a bright and brilliant talent who is by everyone's estimation a deserving young leader full of real promise. By everyone's estimation that is, other than her own.

Almost every leader I've worked with as a coach has expressed this personal doubt. I say 'almost' every leader – there have been a few that were justifiably nervous and rightly aware they were out of their depth – living examples of the Peter Principle where employees in a hierarchy will be successively promoted until they reach their level of incompetence. But these weren't the worrying ones – they were usually helped to find more fitting employment – sometimes uncomfortably, but normally appropriately and with compassion.

Chris Lake

No, the really disappointing leaders were the couple who had no qualms at all of their capability. Is it that they were so 'complete' and personally confident that they didn't need to doubt themselves? Quite the opposite – they were the real imposters who serendipitously found themselves in senior positions but lacked the humility and insight to work reflexively on their own practice, to seek genuine feedback and take a proper look in the leadership mirror.

I'd like to make an appeal to those of us who climb high enough in organisations to qualify for the label 'senior' - we have responsibilities that others don't carry, and we should be mindful of them and deploy them with sensitive aplomb. I'm not talking about complex strategy and big budgeting, nor contingency planning and the keen awareness of everything from politics to policy.

What I'm talking about is our responsibility to fulfil these senior positions in a way we would have wished when we ourselves were the juniors in the organisation.

Think back - when you were wandering the lowly foothills of the organisation, what were your private thoughts and feelings, your silent wishes and pleadings, even your shared and gossiped views, of the big beasts breathing the rarefied air at the organisational summit?

And if your memory is not so long – if casting your mind back to the rosy glow of your innocent youth is proving difficult – then how about recalling the middle years? Those times where you sat in the 'squished middle'; responding to the requests and demands of your seniors whilst sometimes protecting and sometimes pushing, but always relying on, those one level below.

So what did we wish for back then? And more importantly – are we delivering to those wishes now?

My musings on this subject have led me to a list of messages I hope will support my current practice a senior leader:

Juniors have the most accurate view. Research has proven that most often in 360 degree feedback processes, it is the direct reports, not the line manager nor the individual themselves, that have the most 'accurate' view. We might massage our profiles with our bosses, but our reports are rarely fooled. In essence, we are under their scrutiny all of the time.

How we act really matters. Leading on from the point above, we have a responsibility to act true to the values we should hold dear. I'm reminded of a scene in Silence of the Lambs (an awesome film in my view, though not for the fainthearted) when Agent Starling reminds her very senior FBI boss Crawford of his role-modelling responsibilities:

Crawford: Starling, when I told that sheriff we shouldn't talk in front of a woman, that really burned you, didn't it? It was just smoke, Starling. I had to get rid of him.
Starling: It matters, Mr Crawford. Cops look at you to see how to act. It matters.
Crawford:Point taken.

This is about us role modelling. We might think of one of our behaviours as an innocent act or a small pragmatic decision that blurs slightly the line of good practice

but does so in service of getting the job done. That behaviour though, whether actively scrutinised or just tacitly influential, sets the tone for how our colleagues work and sanctions their practice to follow suit.

Design and lead doable jobs. I was disturbed recently when I read a job description of six pages of closely typed heavyweight demands – and nestled hidden in the undergrowth of page three was a requirement that all these things be delivered in less than 50% of fulltime (the rest of the time should be hands-on clinical work)! At best this was unrealistic senior leaders designing an undoable job. At worst it's the bosses setting their middle managers up to fail.

Remember: what's yours – and what is not. Every time we interact with, or are thought about by, those less senior than ourselves we lay ourselves open to their projections. I'm a white, nearly middle-aged man in a suit occupying a role of relative seniority. That's what people see. They don't see the me which is wrestling with the Imposter Syndrome. But they might unconsciously see the pinstriped men that crashed the banking system, or their intimidating headmaster, or their dad. I can't stop this unconscious projection – but I can choose to acknowledge its potential existence and let it bounce off.

Care in – care out. At the Academy we are nearing the end of our research project to find an appropriate model of leadership for the emerging NHS. One of the strongest messages so far is the clear correlation between leadership style and patient/service user/customer experience. In short, a leadership style characterised by care for employees and internal customer service will manifest in frontline care for patients and a service we can be proud of. And the opposite is true – lead with a demanding focus on urgency and the service user experience 2-3 levels below is more likely one of efficient scant attention.

So, what will keep you honest as you climb? And keep you especially honest at the top?

A healthy dose of the Imposter Syndrome might just do the trick – to humble your ego and add a self-questioning step in your otherwise (sometimes maybe over) confident stride.

But the Imposter Syndrome also needs managing. Assuming you're one of the majority of leaders, of people, who experience (or suffer) the Imposter Syndrome. What can you do? All I can suggest is the same as I have suggested to clients, and the same as I suggest to myself when the feeling hits.

1. Believe that it's normal! Take a look around the office at those you admire, and know they'll experience this too.
2. Ask for feedback. Since the Imposter Syndrome is really a denial of the realities of your own efficacy, seek out others who can give you a more dispassionate view. They'll probably tell you you're not perfect – but that you deserve the success you've earned.
3. Save up positive feedback – and use it when you need it. Be it a patient's 'thank you', a colleague's 'well done', a manager's recognition or a good appraisal. Some people keep a 'my plaudits' file on their computeroffering a mine of restorative nuggets to be excavated in times of need.

Oh, and one entreaty. If we assume that most people at some time or other experience this feeling of doubt – let's help them out. Let'spass praise around our worlds freely and liberally. I'm not talking about adopting a leadership style of complacent acceptance of poor performance – quite the opposite – I'm all for challenging (fairly, compassionately and very directly) those that truly aren't up to the job. The majority of colleagues though are talented yet self-doubting people doing the best they can. An encouraging word and a positive stroke could be just the reinforcement they need to keep their imposter within at bay.

I can't promise to be the best senior leader my team have ever met; that I'll never fall foul of the mistakes I once saw from the foothills of yesteryear's organisations, or to occasionally believe with a little too much verve my own good press. However, I can promise I'll do my best. My sometimes inadequate, and oft imperfect, but genuinely heartfelt best. And I urge my fellow leaders to do the same.

www.leadershipacademy.nhs.uk

Chris Lake is Head of Professional Development at the NHS Leadership Academy where he leads the design and delivery of the Academy's core leadership development programmes. He also heads the learning and development elements of the Graduate Management Training Scheme and Academy Fellowships, and leads on innovation and industry links beyond the health sector.

Coming up in the Next Edition of The Consultant...

Each edition of The Consultant presents a range of insightful and informative articles for medical consultants and the wider healthcare community.

Our next edition includes:

- Whistleblowing, Gagging Orders and the NHS – taking on the system
- The face of plastic surgery expertise: an interview with Rozina Ali
- How the NHS is improving occupational health and safety
- NHS surgeons - leading the world in publishing outcomes data
- Are NHS harm statistics misleading?

We are also keen to collaborate with readers and would be interested to showcase the views of those who have something to say regarding healthcare as it exists today.

The Consultant edition 21 - available January 2014.

Amazing Medicine

"A future where Type 1 diabetes can be stopped in its tracks"

Vaccine could be available within 20 years says Diabetes UK

"A vaccine for Type 1 diabetes could be available within the next 20 years." That's the view of Dr Alasdair Rankin, Diabetes UK's Director of Research, who believes that such a vaccine is now a real possibility and would represent the most important breakthrough in diabetic research since insulin was first used to treat Type 1 diabetes over 90 years ago.

Dr Rankin said: "We tend to think of Type 1 diabetes as unavoidable but there is a huge sense of excitement in the research community that the work being done today is building towards a future where Type 1 diabetes can be stopped in its tracks."

Dr Alasdair Rankin

Decades of work by the research community have identified a long list of different parts of the immune system that could be potential targets for treatment. And although many of these have been tested in clinical trials, initial results proved to be disappointing.

But now, after following these studies for a number of years, scientists have realised that treatments that fall short of preventing development of Type 1 diabetes altogether could still potentially reduce health complications if they give patients even a slightly longer period before they have to take insulin or allow them to continue to make small amounts of their own insulin.

Together with an increased understanding about how the immune system works in diabetes, there is real excitement about the potential for new approaches and combinations of existing treatments to make a much bigger difference and lead to a Type 1 diabetes vaccine.

"This is not, of course, going to happen overnight, says Dr Rankin. " It is likely that the first vaccines we see will allow people to live longer before they develop Type 1 diabetes, rather than preventing it entirely. But we know that if people who do develop Type 1 diabetes are treated early with a vaccine then it could provide some benefits that make their condition easier to manage and improve their health in the long term. We would also expect treatments to get

gradually better as we understand more about how the immune system works in people with Type 1 diabetes.

"While there will be difficulties to overcome, I am really hopeful that within the next 20 years, we will have a vaccine that can stop Type 1 diabetes developing. When you think that there are 300,000 people in the UK with Type 1 diabetes and that all of them have the daily struggle of managing their condition and die up to 20 years younger than people without the condition, the benefit of a vaccine would be enormous.

"It has the potential to be one of the really big medical breakthroughs in the first half of the 21st Century."

Immortal Rodents

Researchers find diabetes drug extends lifespan in mice

An international team of researchers studying the nature of aging and how to extend the active years of life has discovered that male mice treated with the type 2 diabetes drug metformin have markedly improved levels of health and longevity.

The team led by Rafael de Cabo from the National Institute on Aging (NIA) tested mice with two amounts of metformin – a 0.1% dose and a 1% dose.

Researchers found that male mice on a 0.1% metformin treatment had a 5.83% increase in lifespan compared to control group mice on a standard diet with no metformin.

However, the higher 1% metformin treatment had the opposite effect. These mice had a 14.4%shorter lifespan compared to the control group, thought to be due to kidney failure. The lower metformin dose had no adverse effects on the renal systems of the mice.

Further tests with male mice taking 0.1%, 1%, or no metformin, revealed a clear health benefit of the 0.1% treatment. These mice had improved general fitness and weighed less than the control group mice, despite consuming more calories. Metformin increased their use of fat for energy.

Furthermore, the research team found that mice on metformin tended to preserve body weight with age, a characteristic associated with increased survival in other studies. They had a lower incidence of cataracts, a common health problem in the strain of mouse. Not surprisingly, metformin prevented the onset of metabolic syndrome.

It had similar effects as calorie restriction on genes in the liver and muscles, which induced longevity-associated activity in the mice. Metformin also appeared to have some antioxidant effects in the mice.

Prescribed since the 1960s to treat type 2 diabetes, metformin is known to enhance insulin sensitivity, prompt sugar to be converted to energy, and prevent sugar build up in the liver. It also reduces risk of health issues associated with metabolic syndrome, a condition characterized by an increased chance for heart disease and stroke, as well as type 2 diabetes.

Rafael de Cabo said: "Aging is a driving force behind metabolic syndrome and diabetes. Given that metformin is clinically proven to alleviate symptoms of these conditions, and reduce risk of cancer, we thought perhaps it was a good candidate to study for its broader effects on health and lifespan."

De Cabo's research primarily focuses on testing compounds that might mimic benefits of calorie restriction. A significant reduction in calories causes the body to adjust how it creates and processes energy, generating a mild biological stress, which contributes to the reported health benefits.

Metformin works, partly, by also controlling the body's energy use and production. The study offers evidence that metformin might provide some of the positive effects of calorie restriction.

Previous work by de Cabo found that the immunosuppressant rapamycin extended lifespan when fed to mice and this study is also being monitored to gauge possible health benefits. De Cabo believes that learning more about these and other compounds and the mechanisms underlying their effects on the body, may point the way to future aging therapies in humans.

However, De Cabo is quick to say that a great deal more research is still required before the implications of metformin for human aging are known.

Touch Surgery- A Mobile Platform for Surgical Decision Making

By Jean Nehme, Chief Executive Officer; Andre Chow, Chief Operating Officer; Advait Gandhe, Chief Product Officer; and Sanjay Purkayastha, Academic Director.

Surgical practice can be broadly divided into cognitive decision-making and technical expertise. This distinction is not equal and it is estimated that "a skillfully performed operation is 75% decision making and 25% dexterity" [Darzi et al. 1999]. The surgical safety guru and writer Atul Gawande best described this in a 2011 New Yorker piece that "…doing surgery is no more physically difficult than writing in cursive. Surgical mastery is about familiarity and judgment. You learn the problems that can occur during a particular procedure or with a particular condition, and you learn how to either prevent or respond to those problems." This can be further emphasized with the adage "decision comes before incision", explaining how it is a surgeons mind and not just his hands that are critical to performing an effective and safe operation. However, despite the importance of decision making within surgery it is not formally taught in many surgical training programs.

Problems with the Surgical Training Model

Traditionally the surgical training model was described as an apprenticeship. Surgeons acquired expertise through a process of repetitive observation and observed practice. However, expecting to attain all the subtleties and intricacies of the surrounding surgical process in this way is an inherently variable and inefficient process, and potentially dangerous to patient care. The limitations of working hours and budget constraints have reduced the amount of time spent in the operating theatre being able to observe and practice. In addition, studies have shown that expert surgeons are not necessarily the best at imparting surgical knowledge, omitting up to 70% of the required information to trainees when explaining complex tasks [Clark et al. 2012]. Finally, this model does not address continued surgical training and revalidation of expert practice.

It is evident that the surgical training model is facing multiple challenges. Solutions are required to improve the delivery and acquisition of surgical knowledge and experience. Requirements of an ideal system include: modularity, time-efficiency, cost-effectiveness, and safe training with the opportunity for objective feedback. The objective evaluation is key and forms the loop in a system that would otherwise be linear.

Advances in Surgical Simulation

Surgical simulation has been heralded as a solution, introducing a standardized and efficient means of delivering surgical training. Available simulators range from box trainers to expensive virtual reality simulation rigs with tactile feedback. The literature has supported this direction, with a Cochrane review finding reduced operative time and error rates associated with virtual reality training [Gurusamy et al. 2009]. However, healthcare systems have been slow to incorporate simulation into training curricula. Part of this is due to considerations of economy and scale. High-fidelity simulators are expensive and costs extend beyond purchasing hardware to include space, management and maintenance. Furthermore, simulators on the market focus primarily on technical training and offer a limited set of defined surgical procedures.

Touch Surgery Simulation and Assessment

Touch Surgery is a mobile surgical simulation platform that was created specifically to address the needs of surgical decision making. It builds on a process called Cognitive Task Analysis (CTA), a method for obtaining sophisticated performance expertise for areas where many covert decisions are linked with complex overt actions [Smink et al. 2012].

Touch Surgery hosts modules ranging from basic procedures to more complex tasks

aimed at junior and expert surgeons. Touch Surgery not only teaches intra-operative decision-making, but also has a means of quantitative analysis of decision-making pathways and skill. This allows personalised learning curves, and identification of areas that require development. The platform therefore has the potential to allow objective assessment and standardization of surgical decision-making training in curricula. Furthermore, being a software solution that is based upon readily available and accessible devices makes the Touch Surgery platform extremely scalable, and accessible to surgeons worldwide.

Work is underway to validate the Touch Surgery platform with respect to the gold standard face, content, construct validities. Interim reports from academic departments in the US and UK demonstrate strong face and content validity for the platform (unpublished data). Currently further academic collaborations are currently being agreed to allow continued development of this platform to the standards needed by surgical training curricula.

Touch Surgery- Patient Safety and Cognitive Rehearsal

Errors of surgical cognition can account for up to two thirds of surgical malpractice claims. Although, surgeons work to provide the best patient care, surgery remains a very human profession, meaning that mistakes will inevitably occur. This is a fact that was described in a report from the Institute of Medicine "To Err is Human" where it was stated that "…the real problem isn't how to stop bad doctors from harming… It's how to prevent good doctors from doing so".

Systems such as Touch Surgery can help make a difference, by providing surgeons with a means of simulated cognitive decision making in a safe environment. Furthermore, applying the platform as a means of operative rehearsal could significantly affect surgical performance. This was exactly the effect shown in studies that demonstrated how mental rehearsal prior to a task translated into superior performance in surgery [Arora et al. 2011].

Touch Surgery Development

Touch Surgery was founded by four surgeons, aiming to raise the standards of surgical care

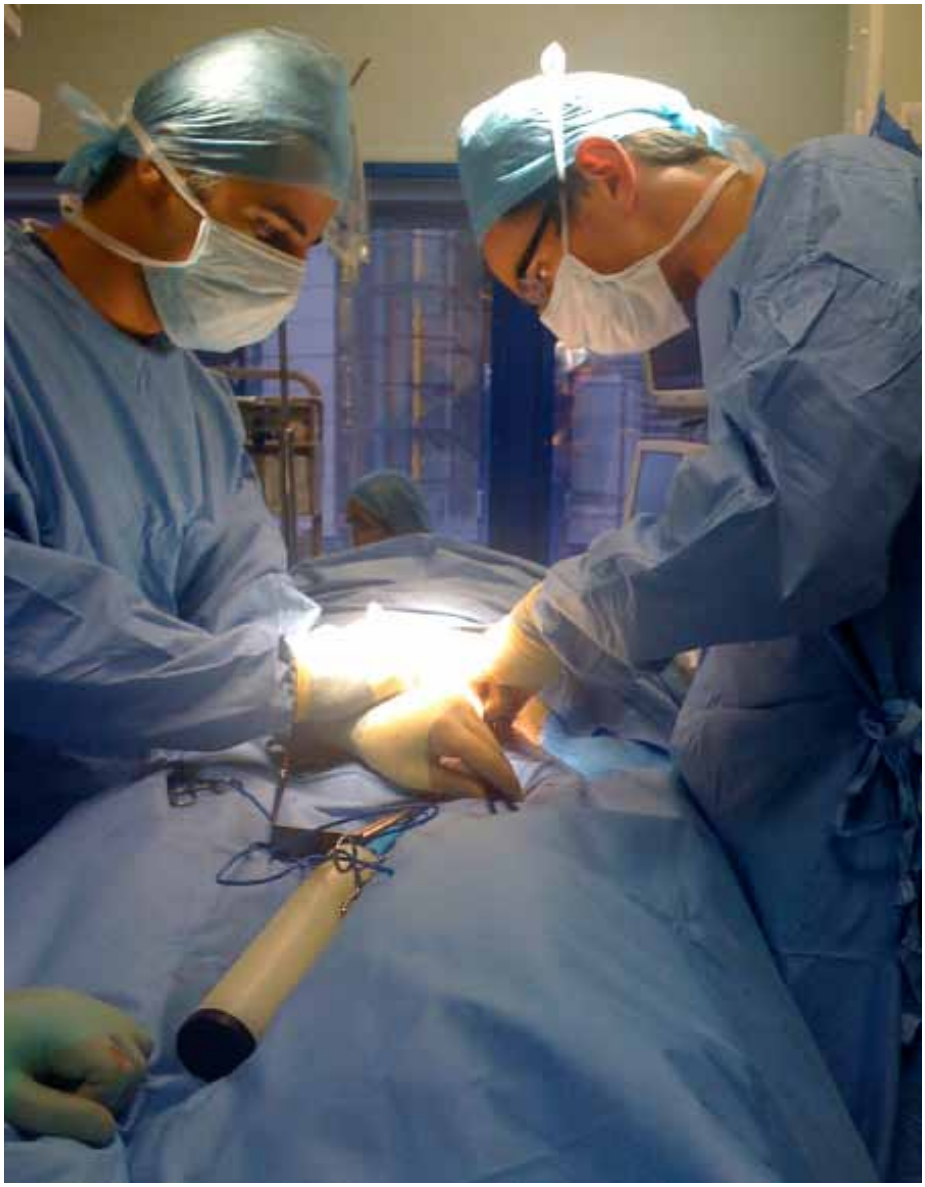
globally, utilizing cutting edge, affordable, and accessible technology.

The team is currently involved with building an academically validated curriculum of surgery and interventional medicine that will be able to be used worldwide, so that physicians from around the globe will have access to the expertise and training from leaders within their fields. To this end, Touch Surgery is reaching out to academic institutions and hospital groups to collaborate in developing content for an open surgical education platform.

The medical device industry will also be involved heavily with this process, as surgical education now is incomplete without learning about current tools and devices which are used in operating rooms every single day. Furthermore, Touch Surgery provides a cost effective means of safe introduction of devices and real time evaluation of surgeon education.

Surgeons will be able to use validated Touch Surgery assessment tools to receive real-time feedback, identify areas for attention, and develop their own personalized surgical training pathway to shorten their learning curve to expertise. Surgical training systems will be able to have an overview of a surgeon's development, and ensure that proficiency is reached and maintained in a quantifiable and standardized manner. Hospitals will be able to use this system to understand surgical performance, and mitigate risk with early identification of problem areas and actionable data, which will become even more critical as systems move towards pay-by-performance reimbursement strategies. Although there is a lot of work to be done before such a situation exists, the marriage of new technologies and attention to cognitive performance in surgery will allow the rapid development of new surgical training solutions that can transform surgical training and care as we know it.

Touch Surgery was founded by four surgeons Jean Nehme, Andre Chow, Advait Gandhe and Sanjay Purkayastha. Jean Nehme is chief executive officer, Andre Chow chief operating officer, Advait Gandhe chief product officer and Sanjay Purkayastha is the academic director. Touch Surgery Labs is based in Clerkenwell and is home to academic, creative, data, development and research scientists- making a difference to surgical practice worldwide.



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// Introduction

As the NHS is placed under ever greater financial pressure, the likelihood of a crisis developing in any organisation increases, whether a crisis of financial failure, quality & safety concerns, major workforce issues or all of these together. It is imperative that today's leader equips themselves with the knowledge necessary to ensure that an emerging crisis does not evolve into a disaster, along with the trail of destruction that goes alongside it. Although with a solid academic underpinning, this programme is designed to be a highly practical look at just what you need to do if you find yourself in the uncomfortable position of leading in a crisis. Although prevention is better than cure, preparation is the real insurance that a crisis is dealt with sensibly and with the long game in mind.

// Main Sessions

- Understanding crises NHS-style
- People & behaviour in a crisis
- Leading people in a crisis
- From crisis to consistent stability

Surgeons set to use 3D printing technology to rebuild patient's face

Surgeons at Morriston Hospital in Swansea are restoring the looks of a patient who suffered serious facial injuries using 3D printing technology to create titanium implants.

Led by consultant maxillofacial surgeon Adrian Sugar, the innovative surgery is currently being showcased at an exhibition at London's Science Museum – before the operation itself is performed.

Mr Sugar and his team have used images from a CT scan to design bespoke devices that are being created in titanium using Additive Manufacturing – commonly known as 3D printing.

ABMU's Maxillofacial Laboratory Services Manager, reconstructive scientist Peter Evans, said: "The patient suffered trauma and had multiple injuries across his body, including some quite severe facial injuries.

"He underwent emergency surgery at the time and we are now at the stage where we can do a proper reconstruction of his face."

The project is the work of the Centre of Applied Reconstructive Technologies in Surgery (CARTIS), established in 2006 as a partnership between Morriston Hospital's Maxillofacial Unit and the National Centre for Product Design and Development Research (PDR) based at Cardiff Metropolitan University.

CARTIS aims to make Wales a world leader in the research, development and application of advanced medical technologies in surgery.

Mr Sugar and Mr Evans worked with PDR's Sean Peel and Ffion O'Malley to virtually plan the complex surgery, which will involve repositioning the patient's facial bones.

They worked from a CT scan that allowed them to create a mirror image of the unaffected side of the patient's face.

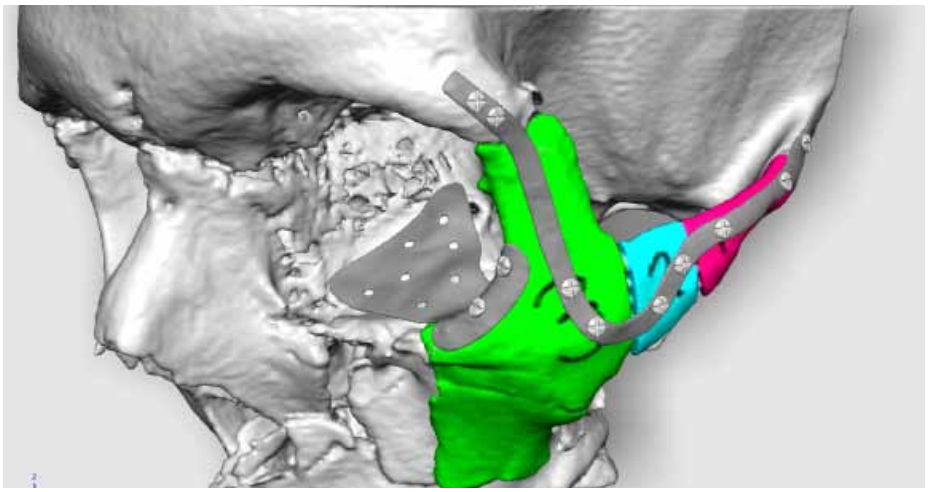
From this they designed guides to cut and position the bones with pinpoint accuracy, as well as implants tailor-made for the patient.

Adrian Sugar

The guides and implants are being produced in medical-grade titanium in Belgium, at one of the world's few specialist 3D printing facilities.

Mr Evans said: "We have done everything up the point of surgery. The concept of the operation has been virtually designed and we hope to do the work very soon. The patient's facial symmetry will be restored so he should be back to normal as far as his facial looks are concerned."

*The exhibition at the London Science Museum is called 3D: Printing The Future and is due to run until 1 July 2014. "The exhibition is all about cutting-edge activities in this area of work so to have this case appear there is amazing," said Mr Evans.



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How to unlock tax relief for your practice: Capital allowances demystified

I believe that practice managers could be missing substantial sums in tax relief. The low profile of capital allowances and the complexity of the rules have resulted in tens of billions of pounds of tax relief being unused. It will take many practice managers by surprise to know that they may be sitting on substantial unused tax relief, perhaps worth hundreds of thousands of pounds.

By Andrew Stanley, Managing Director, STax

What are capital allowances?

Capital allowances are a form of tax relief on items (or assets) bought for use within a practice. They allow commercial property owners and many leaseholders to write off the cost of assets against taxable profit. Since they are a form of tax relief on profits, they are only applicable to private practices which pay corporation tax on profits, and are not therefore applicable to the NHS.

Phone systems, computers and medical equipment in a private practice may all qualify for capital allowances. Any accountant worth their salt should pick up on these, but certain fixtures and integral building features may also qualify. These could include electrical wiring, cold water systems, heating and air conditioning systems and lifts.

Claiming capital allowances on fixtures and building features requires a level of specialist expertise beyond that which a general accountant could be expected to possess, so less obvious items are often left unclaimed. Consequently, most property owners and leaseholders are only claiming the tip of the iceberg while most of the value remains hidden from them. This means they pay more tax than they need to i.e. they are losing money needlessly.

Capital allowances rules state that only one owner is able to take full advantage of the available tax relief during the lifetime of the building, so if the previous owner did not claim the current practice owner could be in line for a windfall.

Since 1st January 2013 HMRC allows a 100 per cent 'annual investment allowance' (AIA) on £250,000 of capital expenditure on all of the above. This lets commercial property owners and some leaseholders deduct up to £250,000 from their taxable profit. Any capital allowances over this £250,000 qualify at a standard rate, depending on the item.

What are the benefits?

Accurately assessing qualifying items and processing an effective claim will in many cases form the basis of a substantial write off against the profits of a practice, resulting in a lower tax charge or in some cases a cash rebate for previous years. Individual claims can sometimes amount to as much as 35% of the value of a freehold i.e. £350K of tax relief for a building bought for £1m. It is estimated that 96% of businesses are under claiming their rightful capital allowance tax relief - to the tune of tens of billions of pounds.

Capital allowances can also add to the monetary value of a premise. This is great news for sellers and, it has to be said, practices that encounter hard times and go into receivership.

Andrew Stanley

Why the urgency?

The Finance Bill 2012 has changed the way capital allowances work at the point of sale however the central reform is yet to be enacted. The principal rule, which comes into effect in April 2014, is the introduction of mandatory pooling of capital allowances. From this date all commercial properties must be fully assessed and capital allowances pooled, recorded and transferred to the new owner.

If this does not happen by the book then the opportunity to claim simply disappears. Practices wishing to unlock tax relief need to act now or risk losing this major tax benefit.

How do I claim?

When it comes to fittings and building features a full survey of the property is necessary. The actual claim is determined by the property and its usage. The key test is if the item is used for the practice (therefore claimable) or forms part of the setting where treatments or consultations are carried out (un-claimable). This distinction is not as clear cut as you might think and can vary greatly from business to business e.g. a hotel can claim for a chandelier as it is intrinsic to the ambience of the hotel, whereas a medical practice cannot!

The rules governing which items are eligible to be pooled for this form of tax relief are complex and vary significantly from building to building and across different industries.

Due to the variable nature of what is claimable and the fact that a substantial amount of case law needs to be brought into consideration, it is vital to take professional advice to ensure every eligible item is included in the pool in order to get a claim agreed with HMRC.

Case study

STax has completed three capital allowance claims for a care home business for the owner, Robin Roopun. The first building had been surveyed by a competitor company who spent many months trying to assess the eligible capital allowances only to eventually give up due to the complexity of the case. STax were then brought in to survey the building and took the time to fully understand the difficulties of the case and worked through the barriers one by one. The owner's claim on this care home was just under £300k.

Mr Roopun then informed STax he was in the process of buying two more care homes and requested a review of the transactions. The vendor had issued an election to fix the capital allowance value at £1 in the new buildings. Mr Roopun's solicitors were unable to advise him and apparently the vendor was not going to budge from their position.

A capital allowance value of £1 would have meant that Mr Roopun would simply have lost all of the tax benefit of the plant in the buildings. STax negotiated with the vendor and their solicitors on Mr Roopun's behalf and finally reached an outcome. Mr Roopun retained the right to claim on the plant and machiner, which included many items which would normally have been overlooked, such as kitchen equipment, extractors, thermostatic mixing valves and pipework.

STax surveyed the buildings and calculated an apportionment of the purchase consideration. Across the two properties Mr Roopun's claims were £336,017, an improvement from the position he started at and a net cash saving of £77,283 for his business.

Furthermore, both care homes needed to be renovated. Mr Roopun has now been able to invest funds in improving the residents' accommodation, including the internal decoration and gardens. Without the capital allowances Mr Roopun would almost certainly have had to abandon the project not only to the detriment of his business but also the residents of the homes.

Andrew Stanley is the managing director of STax, a firm of tax advisers specialising in capital allowances and real estate related tax matters.

For further information visit:
http://www.staxuk.com/

CONSULTANT CLINIC

Addressing your challenges, one by one

In a challenging world, where we find ourselves facing all sorts of difficulties, especially within our own Trusts, it is sometimes difficult to see the wood for the trees. Consequently, we wanted to introduce a section and indeed a service of providing advice on sticky issues.

Each edition, we'll pick one or two subjects submitted by you to provide advice and guidance on how to approach it. The team behind that advice will be myself, Sara Watkin, Editor-in-Chief and an experienced consultant, clinical lead and educator in leadership, management, finance and governance, as well as my co-contributor, Andrew Vincent, Partner at Academyst and a specialist in leadership and behaviour.

What sorts of issues?

- Job planning problems
- Bullying & harassment
- Failing to getting heard over quality and safety issues
- Problems with colleagues
- Conflict issues & resolving difference

Please drop an email to myself, Sara Watkin, on sara@theconsultantjournal.co.uk stating whether you wish to remain anonymous if we publish your challenge. We will obviously respect faithfully requests for anonymity, given that some of the subjects are likely to be sensitive in nature.

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THE ROYAL CRESCENT

Author: Dr Sara L Watkin, Consultant Neonatologist & Clinical Service Lead, University College London Hospitals NHS Foundation Trust, Partner & Medical Director, Academyst LLP

A longstanding love affair

I wanted to share a decade long love affair with a very special place, in case anyone else was looking for something really special to do. For me, this affair started in January 2001, when my (now) husband whisked me away to the Royal Crescent Hotel in Bath. Then as now he clearly knew the way to a women's heart, as this special place delivered (for me) the perfect combination of romance, amazing experiences, beautiful food and wine, along with wonderful.

Since that first stay, we have had many a romantic weekend away a deux but sometimes trois, quatre, cinq or even six, depending on the number of children who sought to indulge in some rare opulence. Its place in my heart though was finally cemented permanently in place, when, quite naturally, it proved the perfect place to get married too.

However, before I go any further; a word of warning. Please do not heed my advice if you must have uber-modern efficiency, tea making facilities, large flat screen TVs, or a dinner with speedy passage from starter to dessert. This is not that kind of place. With the grace, goes a pace of personal, relaxed professionalism. Lastly, theirs a wealth warning too. If you are going to wonder how much they charge every two minutes or before ordering your tea in bed then this is not the place for you. However, if you're happy to gulp, put the credit cards in the safe and remember that experiences last a life time (and it's probably only one more private patient to cover it…), then this is a magical place for those prepared to absorb it.

Occupying the two central buildings of the Royal Crescent, arguably the finest Georgian Crescent in the world, the size and beauty within the hotel (Grade 1 Listed Building), are masked despite the stately, grand facade. The hotel comprises the centre of the crescent, a beautiful landscaped garden stretching to an acre and several coach houses too, housing a spa, restaurant and

some of the loveliest bedrooms the hotel has to offer.

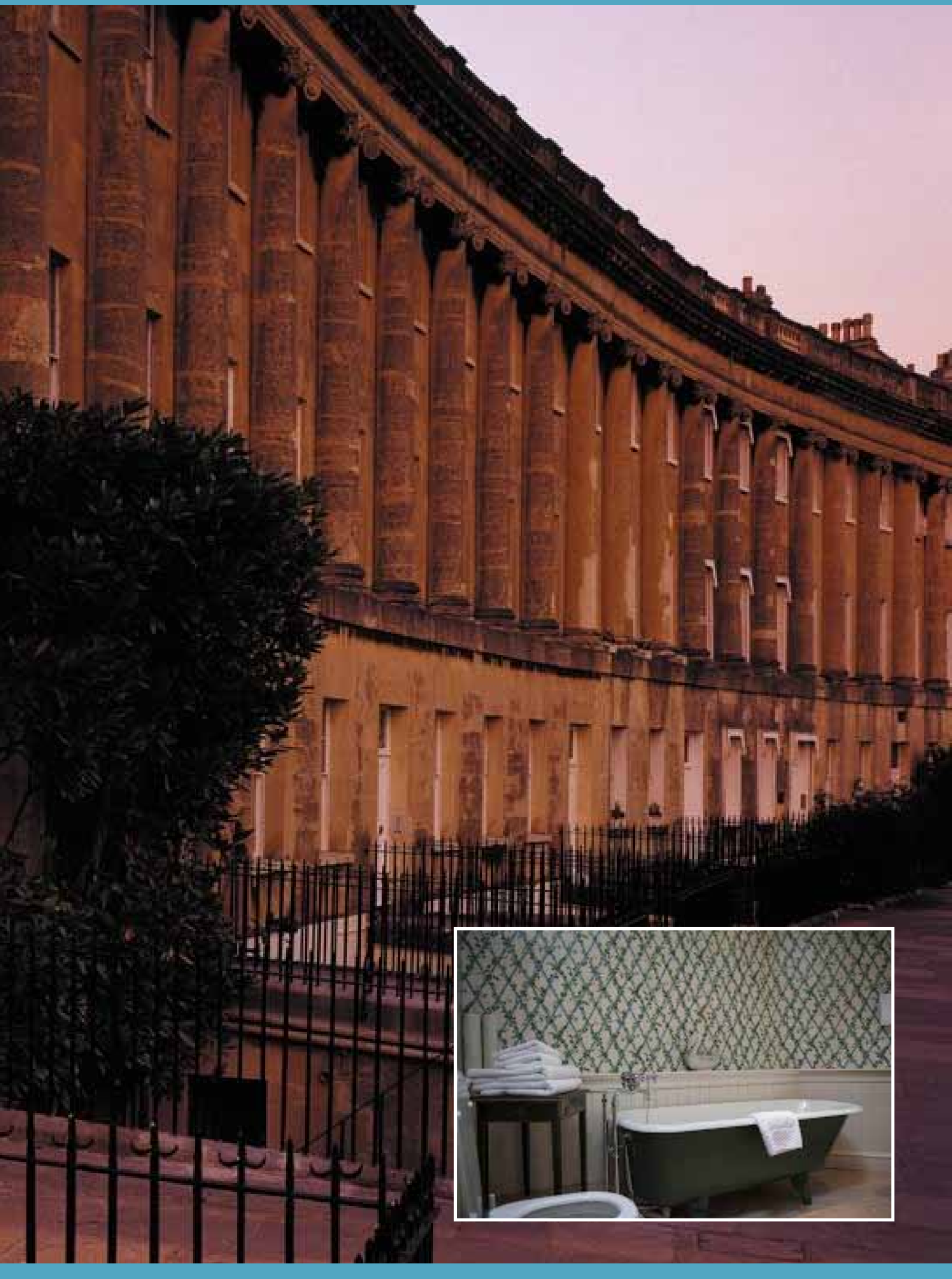
The hotel's own brochure describes that it offers the opportunity to experience a style of gracious living from the age when Bath was the very centre of the civilized world. However, for me, some of the best things are simple:

Tea (made from real leaves) and biscuits served (hopefully by a dashing young man) in bed accompanied by the weekend papers.
Staying in a suite – it is already expensive so why not go the extra mile? I have stayed in many of them and enjoy the uniqueness of each. I particularly love the ones overlooking the garden and if you are on the ground floor or basement you can walk straight out in the garden – fantastic when our little boy was young.

The gardens - they are magical at all times of year and whatever the season. I love the opportunity to just sit, possibly reading, sipping a nice crisp sauvignon blanc and taking in the peace and quiet.

A very special part of the hotel is the Spa. The first time we visited we nearly didn't find it. This amazing place is not your standard hotel spa and if you want to bash out lengths of an Olympic pool then it

EXPERIENCES WORTH SHARING



is probably not the place for you. Nor is it open to children under the age of 14, being designed as a place of relaxation and tranquillity. My personal favourite is to go after dark when, it is lit by candle light and wonderfully magical. The pool, described as a relaxation pool, is heated to 32oC. It is really too hot to swim but perfecting for lazing, relaxing and being romantic. There are no noisy Jacuzzis but there are 2 smaller dipping pools made of wood (read 'large barrels'), one even hotter than the main pool and the other cooler when things are just getting too hot to handle.

The position of the hotel, towards the Northern end of the older part of Bath, is great for walking out. Bath has great shops, wonderful galleries, fantastic restaurants, hot air balloons taking off from Victoria Park on a summers evening to watch the sunset, the river, the locks on the Kennett and Avon Canal as it leaves Bath, the most amazing architecture and so much history. It actually took us 8 years to go to the Roman Baths, it was definitely was worth it. We have yet to go to the new (controversial if you are a Bath resident) Thermae Bath Spa but the reviews suggest it is also a great experience if booked in advance.

Every time we go back, and I have to admit I've been a few times, I love it more (and there is always something to celebrate or something a girl needs to buy, as an excuse) and discover more about the hotel and Bath. Anyway, I wanted to share it because it has brought me so much pleasure.

Favourite restaurants
(besides the hotel one)

- Green Park Brasserie
- Martini Restaurant
- Olives' Restaurant *(Queensbury Hotel)*

Favourite art gallery

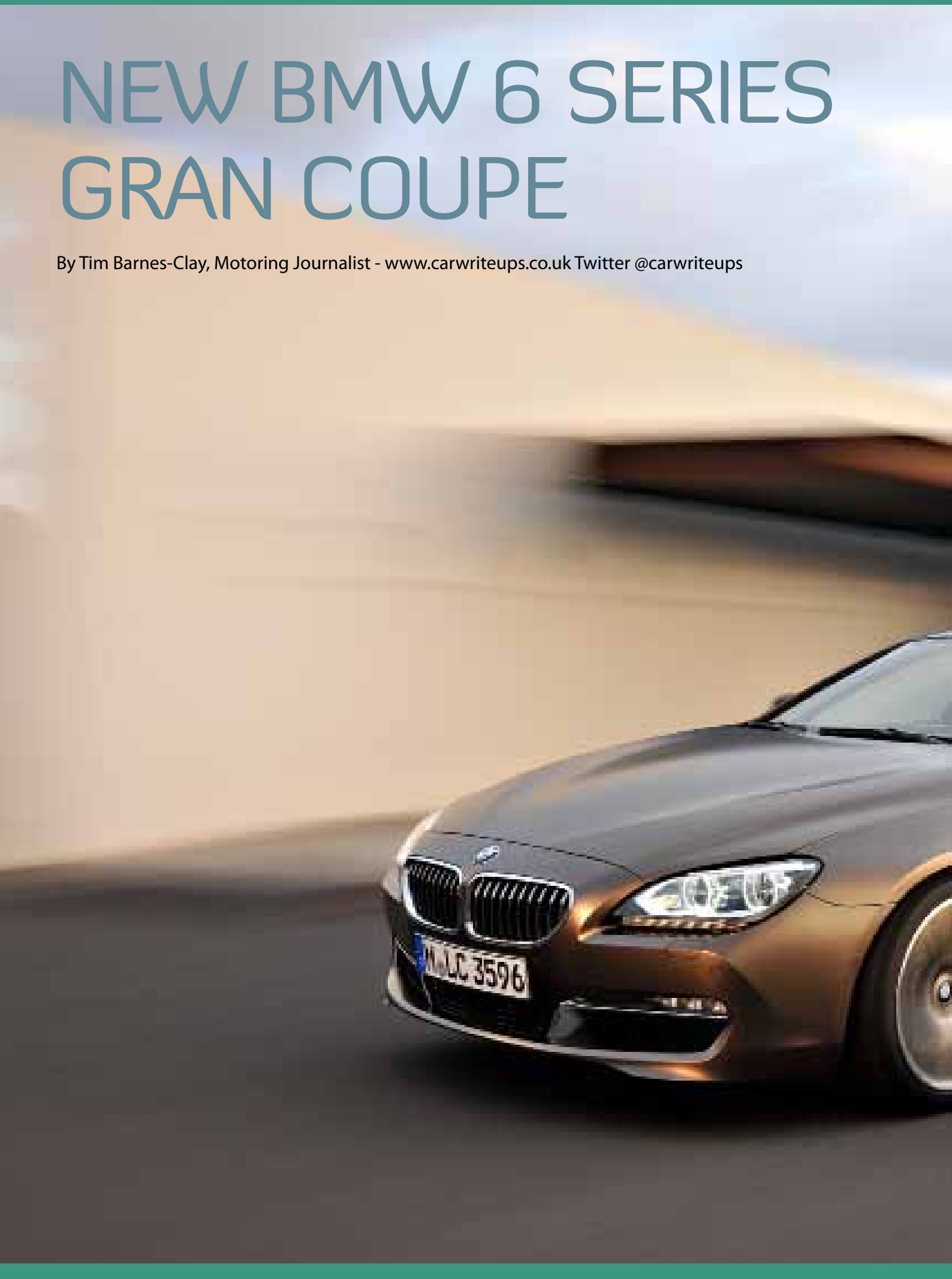
- Gallery LeFort
  always an interesting exhibition

Favourite clothes shops

- This year it is The Loft
  (but there are so many great shops in Bath)

NEW BMW 6 SERIES GRAN COUPE

By Tim Barnes-Clay, Motoring Journalist - www.carwriteups.co.uk Twitter @carwriteups



FOLLOWING THE convertible and the Coupe in the BMW 6 Series, the Gran Coupe is the bona fide incarnation of aesthetics, sportiness, comfort and luxury.

The slender grace of this vehicle, the very first four-door Coupe in the history of the renowned German automaker, is an outstanding phenomenon.

The low and beautiful lines are striking, but especially so when looking at the car's side profile. The recessed passenger compartment appears near to the ground and effortlessly stretched because the window silhouette extends deep into the C pillar. The frameless door windows are also a design ingredient indicative of a muscular Coupe.

Indeed, the BMW 6 Series Gran Coupe represents an unusual synergy of astonishing aesthetics; the dynamics typical of a Coupe and the functional flexibility of a four-door motor. The car measures 5,007 millimetres in length and 1,894 millimetres in width, with a height of 1,392 millimetres. Its proportions are unquestionably BMW, from the elongated bonnet with its bold contours to the classiness of the extended wheelbase (2,968 millimetres) and the set-back passenger area.

At the front, chrome elements, unique to the Gran Coupe, divide the air intake from the fog lights, underlining the firm tenacity expressed in the look of the car. The standard dual Xenon round headlights (for high and low beams) feature three-dimensional LED rings that are characteristically BMW in appearance and which create a unique and functional light architecture for the night-time driving experience. With the optional Adaptive LED Headlights, the light spheres are faintly flat at the top and bottom. High and low beams are generated with the LED units that are positioned on horizontal ribs across each of the light circles, casting their light on the reflectors facing them.

The visually low centre of gravity, along with the horizontal and V-shaped lines at the rear, suggests authoritative and vibrant chic. Another individual creative element of the BMW 6 Series Gran Coupe is the third brake light that stretches out along the full width of the rear window, consequently forming the top edge.

FAST FACTS:

- Max speed: 155 mph
- 0-62 mph: 5.4 secs
- Combined mpg: 50.4
- Engine: 2993 cc, 6 cylinder, 24 valve petrol
- Max. power (bhp): 313 at 4400 rpm
- Max. torque (lb/ft): 464 at 1500-2500 rpm
- CO2: 148 g/km
- Price: £64,130 on the road

PROS 'N' CONS:

- Good looking √
- Luxurious √
- Economical √
- Fast √
- Safe √
- Spacious √
- On the pricey side X

Inside, the typical spirit of BMW is unmistakable. The cabin is refined and well-appointed with leather upholstery and electrically operated seats. Roominess for rear passenger contentment is considerable and folding rear seatbacks, as well as an auxiliary third seat are among the design attributes that contribute to the car's versatility. The wheelbase is 113 millimetres longer than that of the BMW 6 Series Coupe and accounts for the increased legroom enjoyed by rear passengers. The boot has a volume of 460 litres, which can be expanded up to 1,265 litres due to the through-loading system and the folding rear seatbacks.

Driving dynamics, unforced performance and efficiency are the hallmarks of the TwinPower Turbo engines available for the big BMW. The 640d I drove delivered impressive shove. Zero to 62 mph comes in just 5.4 seconds, thanks to its six-cylinder power unit. Mated to this lump is a creamy smooth eight-speed Sport automatic transmission and proven BMW EfficientDynamics technology. The remarkable ratio of driving fulfilment, yet frugal fuel consumption stems from the outstanding competence of the engines and the flawless automatic transmission, not to mention the benefits delivered by the motor manufacturer's EfficientDynamics gadgetry.

Safety aids include front airbags, side airbags integrated into the seatbacks, head airbags for front and rear seats, three-point automatic seatbelts for all seats, belt force limiters and seatbelt tensioners at the front, as well as ISOFIX child seat fasteners at the rear. What's more, intelligent lightweight construction reduces the vehicle weight, and the doors and bonnet are made of aluminium. The front side walls consist of thermoplastic material, while the boot lid is made of fibreglass composites.

The wide range of premium standard equipment in the BMW 6 Series Gran Coupe is startling: the eight-speed Sport automatic transmission, a choice of leather upholstery and trim, electric seat adjustment with memory function for the front seats, automatic air conditioning with 2-zone regulation, Xenon headlights and the BMW radio Professional with hi-fi speaker system.

Additional exclusive options can be selected to give the car a personal touch. Among the highlights in the range of elective equipment are Adaptive LED Headlights and a Bang & Olufsen High-End Surround Sound System. And then, of course, there is always the legendary M Sports package to add in.

Optional extras on a BMW look and feel great, but there's always a downside – they tend to make the total price of the car eye-wateringly high. But, if you are a Bimmer addict, and you have the cash to splash, then this won't put you off the 6 Series Gran Coupe – it is one of the best four door coupes on the market today.

Guiding consultants through the private practice tax minefield

Every year, I am pleased to say, I get a phone call or three from Physicians and Surgeons that begin with 'I'm just starting in Private Practice and wonder if you could give me some advice?'

By John McFarlan, Proprietor of Medical Finance and Managing Director, UK Will and Trust Ltd

Without new clients looking for help, my own business would diminish as the clients I've known for up to 30 years retire to their boats or to villas in Spain. So over the years I've put together a 'Starter Pack' for consultants that are new to private practice. It's a list of points to consider along with the HMRC forms you have to complete and the points that anyone embarking on private practice should address. I've never met anyone who enjoys form filling, but there are still some consultants who I would rather complete their own tax returns and keep their own accounts.

So for anyone considering private practice or who has just started out, here is a summary of what needs to be done from outset:

1. Decide whether you want to be self-employed, a Partnership or a Ltd Company. Most clients start as self-employed as first year earnings tend to be relatively low.

2. Tell HMRC that you have embarked on self-employment. The form is available by googling 'HMRC Self Employed Getting Started'. This should be filled in and sent to them within three months of starting Private Practice. Even if you subsequently declare the income but haven't notified HMRC of your new business, they can fine you for not letting them know earlier.

3. Tell National Insurance what you expect to earn and that you are also earning a salary with the NHS or University. If you don't, when you come to submit your tax return, you'll be charged additional national insurance that you don't owe. Most consultants pay the maximum NI on their PAYE and so will only be liable to a further 2% on their profits.

4. Open a separate bank account for your business. Make sure all and only your practice income and none other goes into the account. This way you'll have an accurate record of your earnings. Most banks offer the facility to download your statements as spreadsheets and these can form the basis of your accounts.

5. If you are going to pay a secretary, spouse or any other member of your family, register for 'real-time' PAYE. Under recent changes, if you pay more than a certain amount a month to any one employee you must be registered for PAYE and submit a monthly report on line along with the tax and NI due. No more 'ascribing' a sum to your spouse at the end of the year unless you want a fine.

6. Summarise any existing computers, office furniture, phones etc that you will be using for the business. Value them as they will essentially be transferred to the business as business assets and can be used as Annual Investment Allowance which reduces your profit.

7. Decide where you are going to keep you receipts. A box under the bed is fine as long as you place all your receipts in the one place. It will save you hours of rummaging through summer jackets in the middle of winter in search of the receipt for your new phone.

8. Start keeping a note of your car mileage. There are strict rules about what you can claim. You cannot usually claim to and from home to a private hospital, but if you work in an NHS hospital and travel back and forward between NHS and Private hospital, keep a note of the journeys and any trips to printers, post office etc for a month or two to get an idea of the mileage expended on business. HMRC will allow you 45p a mile without having to keep receipts for all car expenses. They will disallow anything they see as home to place of work.

9. Keep a note of all your expenses.

As a brief guide you can claim:

- A proportion of all your car expenses; maintenance, repairs, fuel, insurance, and road fund licence. (Or 45p a mile!)
- Interest and charges on a car loan. (But not if you are claiming 45p a mile)
- Transport such as rail and air fares. The cost of overnight stays for conferences and meetings.
- All office disposables; stationary, postage, inks and computer maintenance.
- Professional fees; MDU, Royal Colleges, BMA, GMC, other registered organisations.
- Journals and replacements of text books.
- Premises costs; room hire at a hospital and the use of your home office. The taxman allows about £4 a week but you can claim a proportion of your home costs provided you have a separate office and are aware this could involve capital taxes when you sell your home.
- Wages to staff: your secretary, registrar and book-keeper. If your spouse does not work and helps you run your practice, you can pay them or any child who assists. Remember to register for PA YE with HMRC if you are paying staff.
- Life Insurance and pension contribution for you or your staff can be tax deductible. It's a specialised area but many consultants have life cover in excess of £1m to cover mortgages etc and 42% tax relief on the premiums could be substantial.
- Charitable giving. If you give money to charity through gift aid, the charity claims the tax you paid on that donation. However, higher rate tax payers can claim back the higher rate tax paid.

Capital Allowances

Once you have deducted your expenses from your income, you can then deduct the cost of depreciation on your business equipment. The allowance depends on the item and as it's based on the depreciating value of your business equipment you need to track that reducing value. You therefore need to keep a balance sheet, showing the value of your business equipment.

When you sell or dispose of an item on your balance sheet you may need to declare a 'balancing charge.' Once you are organised you need to produce a 'profit and loss account' in order to work out what your profit is. To declare that profit, you must submit a tax return by 31st January each year. To do this, I'd recommend you register with HMRC on line and complete the tax man's form using their software. It will ask you all the relevant questions and work out how much you owe before you submit it... and it's free to use.

Be aware that when you are self employed, once the tax on your profit exceeds 20% of your total tax annual tax including tax on your PAYE and investment income, you will be asked to make payments on account as well as the tax you owe at the year end. This means that if you owe tax of £20,000 on profit from 6th April 2012 to 5th April 2013 you'll have to pay this by January 2014 but you'll also pay £10,000 towards 6th April 2013 to 5th April 2014 and a further £10,000 by July 31st 2014. So that when January 2015 rolls round, you'll already have paid £20,000 towards that year's bill.

Simples? Only the taxman says tax isn't taxing! So always ensure you put aside your tax as you go along. Keep a third back and you won't be far out.

At the end of the day, most of my clients can make enough in an afternoon to pay what we charge them to collate their income and expenses, produce a set of accounts, keep them right with PAYE and submit their tax returns. In most cases we can find ways to reduce their tax bill as well.

All professions like to think they offer value for their fees and Accountants are no different. But if you choose to use an accountant, make sure it's someone who you feel you can rely on to return your calls. Tax is the same no matter how big an operation your accountants run. But most Doctors work during the day so try and find someone who is happy to take your calls in the evening and weekends. There are a few of us around.

The biggest complaint we hear from clients migrating to us is that the previous accountant was very knowledgeable but never available. I actively encourage clients to text me with any questions I may not be able to answer in full right away but I can usually acknowledge the same day with a timescale for a full answer.

If you are contemplating setting up in private practice and would like the starter pack, just e-mail me at: johnmcfarlan@talktalk.net

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CAN USA SURGICAL ERROR STATISTICS AND INSIGHTS INTO INTERPERSONAL DYNAMICS HELP UK OPERATING ROOM STAFF UNDERSTAND AND REDUCE ERRORS?

By Beth Boynton, organizational development consultant

This article is written to demonstrate similarities between the incidence of surgical mistakes in the USA and UK and to show how human relationship patterns involving communication, collaboration, and emotional intelligence are implicated as primary root causes of major surgical errors in the USA. Combining these two points with experiential data obtained from consulting work for improving related skills in the USA may have useful application for improvements in the UK.

In May 2013, the BBC's Nicola Beckford reported that 750 patients were victims of serious and preventable mistakes in England's hospitals during the previous four years . Their investigation, Freedom of Information requests to various NHS trusts, found that the majority of these errors fell into four categories:

- 322 cases of foreign objects left inside patients during operation
- 214 cases of surgery on the wrong body part
- 73 cases of tubes used for feeding patients or for medication being inserted into patients' lungs
- 58 cases of wrong implants or prostheses being fitted

In the USA, the Joint Commission (TJC), an organization that accredits hospitals and reports data involving "sentinel events" - unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof - provides statistics that suggest some similar issues.

The top four most frequently reviewed sentinel event categories reviewed by TJC in 2010 were:

- Unintended retention of a foreign body
- Delay in treatment
- Wrong-patient, wrong-site, wrong procedure
- Op/post-op complication

Then in 2011 :

- Unintended retention of a foreign body
- Wrong-patient, wrong-site, wrong procedure
- Delay in treatment
- Op/post-op complication

And in 2012 :

- Unintended retention of a foreign body
- Wrong-patient, wrong-site, wrong procedure
- Delay in treatment
- Suicide

The TJC investigates errors and

generates reports on the root causes of sentinel events and as allows for the viewing of trends over time. In the TJC report, Sentinel Event Data Root Causes by Event Type 2004-20012 , there is a list of 18 commonly identified root cause categories and subcategories. In this report one can study a particular type of sentinel event with information gathered from all reporting agencies and see what root causes were involved from 2004-2012.

Given that the sentinel event type 'unintended retention of a foreign body' was the most frequent type of event in 2010, 2011, and 2012 in the USA it is worth looking further into the categories and subcategories of root causes of this type of event during the 2004-2012 period. Interestingly, the top three categories of root causes were leadership, human factors, and communication. In fact, leadership, human factors, and communication show up as the overall leading root cause categories involving all types of events in 2010, 2011, 2012!

A closer look at these three categories and their subcategories reveals some fluid, unpredictable, and tough-to-measure components of interpersonal relationships, communication, and human behavior. The report lists these categories and subcategories as follows:

- Leadership as a category contains these subcategories:
- organizational planning, organizational culture, community relations, service availability, priority setting, resource allocation, complaint resolution, leadership collaboration, standardization (e.g. clinical practice guidelines), directing department/ services, integration of services, inadequate policies and procedures, non-compliance with policies and procedures, performance improvement, medical staff eng organization, and nursing leadership.
-
- Human Factors as a category contains these subcategories: staffing levels, staffing skill mix, staff orientation, in-service education, competency, assessment, staff supervision, resident supervision, medical staff credentialing/privileging, medical staff peer review, and other (e.g. rushing, fatigue, distraction, complacency, and bias).

Communication as a category contains these subcategories: oral, written, electronic, among staff, with/among

physicians, with administration, and with patient or family.

Many of these terms involve communication, relationships, and/or behavioral components. For example, in the Leadership category, the subcategory leadership collaboration may involve relationships among nurse managers, operating room staff, and surgeons. Are they working together as highly functional teams or are there some dysfunctional underlying dynamics going on that may interfere with safety? Is there trust, mutual respect, and effective communication between team members and the surgeon? Do nurses feel safe to speak up to a surgeon about an impending error? Are surgeons effective as leaders and managers? Are all players trained in giving and receiving constructive feedback and are there opportunities to practice and develop these skills in a supportive environment? Is time built into busy operating schedules to address conflict in a productive and respectful way?

Despite questions that can be raised about the exact translation of this data from one country to another, in terms of the language used in describing errors and/or research methods used in obtaining and reporting on data there are some provocative coincidences. Catastrophic errors in both countries have a high incidence with surgical interventions!

What is Going On in the Operating Room?

More clues to the answer can be found in sharing some consulting work provided for a chapter of the American Organization of PeriOperative Registered Nurses (AORN). In preparation for assertiveness training, I asked their educational committee to share most common communication challenges that nurses faced. There answers, as follows, are quite revealing:

1. Your teammate purposefully holds back information about a surgery to make you look bad in front of the surgeon
2. The surgeon yelling that s/he "wants somebody in here that knows what they are doing"
3. Other team members saying negative things about you in front of you and not including you in the conversation
4. Surgeon refuses to wait for "time-outs" or "count" at the end of a procedure, (especially when counts are incorrect), and ignores or becomes angry when the nurse requests the surgeon consider the information presented

These scenarios reveal layers of interwoven relationship patterns that help explain the data on root causes and types of sentinel events. Add to that, more innocent unawareness

about individual behaviors and their impact on others along with lack of skills in self-reflection and expression and the complexity of interactions and ramifications begins to emerge.

Team members vying for approval and leaders who are somehow gratified by giving or withholding approval are participating in relationship patterns that contribute to adverse events. Withholding information, setting up a colleague to work in a position without appropriate training and experience, or using humiliating language and tone are not in the patient's best interests.

Human beings want and deserve to feel respected and have a sense of power. Yet in many healthcare systems, some members and professions are valued more than others. This imbalance chips away at everyone's self-esteem and contributes to complex feelings and behaviors involving frustration and resentment.

Even under pressure, a mistake requiring an immediate substitution of staff can be handled with respect. A statement such as: "I need trained OR assistance, now!" is quite different from, "Get someone in here who knows what they are doing!" They both get the same problem addressed, but first statement brings up an organizational responsibility re: training, while the second is more blaming of and humiliating for the individual. Making sure that such a situation is followed up as soon as possible after surgery by debriefing with surgeon, nurse manager and staff will identify training problems, seek solutions and provides opportunities to practice giving and receiving constructive feedback in a respectful manner.

Solutions that consider both individual and organizational or systems factors are less blaming and more likely to lead to long-term, meaningful change. Administrative leaders have a responsibility to advocate for resources required to focus on communication training, opportunities to practice skills and recognizing learning curves. Individuals have a responsibility to seek help, acknowledge limitations and develop their skills. Not everyone is cut out to work in the OR, and career coaching and/or discipline may also be necessary.

Process consultants can use facilitated discussion, individual coaching, and communication training that invites input about the following questions provides rich experiential learning and engaged problem-solving:

1. What does respectful communication look like in the OR?
2. What makes it challenging or different here?
3. What do we need in terms of support and/or training in order to practice it?

Positive outcomes including safer surgery, creating new norms, increased collaboration, personal and professional growth and improved morale are all possible!

Beth Boynton, RN, MS is an organizational development consultant, medical improvement trainer, and author of "Confident Voices: The Nurses' Guide to Improving Communication & Creating Positive Workplaces". More information is available at www.confidentvoices.com.

NHS65: HOW DOES THE NHS DEFINITION OF QUALITY MEASURE-UP RELATIVE TO GERMANY, AUSTRALIA AND THE USA?

By Patrick Keady, Independent Consultant and Interim NHS Manager

In this article, I give suggestions as to how NHS England can refresh it's definition of quality, in the interests of patients, providers, commissioners and in time for the NHS65 celebrations taking place early next month.

I am often reminded that I am a non-clinician. That said, it seems strange to me that while the purpose of healthcare in western Countries is very similar – treating cardio-vascular disease, cancer, long-term conditions etc – that there continues to be differing views about what quality in healthcare is all about.

Does this matter?

In risk management terms, it matters a lot. The effect of differing definitions of quality introduces uncertainty which in turn means that providers, clinicians and commissioners are less likely to know when they are delivering quality healthcare.

For example, are Clinical Commissioning Groups more interested in the number of patient episodes or do they know how they can use their massive purchasing-power to motivate providers and clinicians to deliver clinically effective care that fully satisfies the expectations of patients ?

The current definition of quality in the NHS in England comes from Lord Darzi and his findings that were first published in the NHS Next Stage Review Leading Local Change (2008).

Lord Darzi simplified quality into three elements which are separate and at the same time, they are part of the same thing – clinical effectiveness, patient safety and patient experience. It continues to interest me that patient experience comes last rather than first, and this is something that I might write about at another time.

Clinical Effectiveness

We are told that clinical effectiveness is measured by clinical outcomes and patient-related outcomes. While there could be more agreement on what clinical outcomes and patient-related outcomes look like, feel like and sound like, there is growing evidence of wide variation in the clinical effectiveness of healthcare delivered in England. My view is that the NHS definition of clinical effectiveness would benefit from five ideas raised by our colleagues in Germany and the USA:

German National Institute (BQS)

- minimizing the impact and effects of illness, and freedom from its symptoms
- re-establishing normal physical and psychosocial function
- healing and improving the quality of life
- Institute of Medicine (USA)
- avoiding waste, including

equipment, supplies, ideas, and energy
- delivering care so that the use resources is maximised and waste is minimised

Patient Safety

While much has been written and said about the paramount importance of patient safety, I believe that we still have some way to go in getting a common understanding of what good patient safety looks like, sounds like and feels like.

There seems to be too much emphasis on what clinicians must avoid and not enough on what clinicians should achieve – perhaps we need to think much less about the 'never's and more about 'always's ?

While there is general agreement that the NHS definition of patient safety is more helpful than the USA Institute of Medicine definition – "avoiding injuries to patients from the care that is intended to help them" and "minimising risks and harm to service users" – this is probably due in part, to the relative timings of the definitions – 2008 (NHS) and 2001 (USA).

In my view, the NHS definition of patient safety can benefit from considering these two ideas:

German National Institute (BQS)
- avoiding preventable complications (patient safety)

Australian Commission
- reducing the risk of unnecessary harm associated with healthcare to an acceptable minimum

Patient Experience

The experience that people have on their journey through healthcare can be even more important to individual patients than how clinically effective their care has been.

In my view, the NHS definition of patient experience can be enriched by considering five ideas from our colleagues in Germany and the USA:

German National Institute (BQS)
- level of patient experience
- level of patient satisfaction.

Institute of Medicine (USA)

- Patient-centredness – providing care that is respectful and responsive to individual patient preferences, needs, and values taking into account the preferences and aspirations of individual service users and the cultures of their communities
- Timeliness & accessibility – reducing waits and sometimes harmful delays for both those who receive and those who give care health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical nee
- Equity – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status delivering care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status

While many of these ideas already exist and are being implemented in the NHS in England – what I continue to see as I move from NHS provider to NHS provider and CCG to CCG is that they are not always seen as part the Quality agenda.

With just a month to go until we celebrate the 65th anniversary of the NHS, this seems like the perfect time to incorporate these ideas into a shared understanding of what quality is in 2013 and beyond.

MORE ON THE QUINTESSENTIAL EMPOWERED PATIENT

By Michael A. S. Guth, Ph.D., J.D.,
Senior Director, Health Economics and Outcomes Research
Risk Management Consulting, Oak Ridge, Tennessee, USA

In a prior article that appeared in the Quality, Governance & Experience journal, I described the efficiency gains when empowered patients, as opposed to the typical passive patients, interact with their health care providers. The dynamic changes brought about by patient empowerment lead to elimination of unnecessary appointments with doctors, better doctor-patient exchanges of information, better and more appropriate lab testing, better patient compliance with the mutually agreed upon treatment plan, and much higher satisfaction rates with the doctor-patient relationship.

With all these positive benefits that occur with patient empowerment, it is not surprising that the web page for the NHS, http://nhs.uk, shows a logo at the top that reads, "CHOICES: your health, your choices." That logo implies patients will become informed of relevant health information and then decide what is best for their immediate care, continuing care, and preventive health. Becoming an informed patient is a necessary first step in the process of becoming an empowered patient, who is capable and willing to decide between alternative courses of treatment. An open question remains as to how the proverbial empowered patient will operate within the somewhat chaotic environment of the NHS or the evolving health care system in America.

Individual autonomy and the non-paternalistic approach

Empowered patients exercise a greater degree of autonomy in managing their own health than typical patients. Indeed, the concept of individuals taking personal responsibility for their own health and becoming empowered is an announced goal of the newly implemented Patient Protection and Affordable Care Act in the United States. Similarly, in the UK, an article in the Health Services Journal indicated that patient empowerment is one of the six foundational blocks for integrated care. "Educated and empowered patients become active participants in their care and the decisions affecting their health and healthcare. The process of informed choice enables patients to understand the benefits and risks associated with treatment options and allows them to choose the option best suited to their goals, needs and circumstances. Patients can actively contribute to their health management if they know and agree what plans are in place and the goals." [1]

In moving from broad goals of health care policy to concrete examples of how patient empowerment works, new trends have began to emerge in the doctor-patient relationship. The old fashioned model of health care delivery services followed a paternalistic approach best typified by the phrase, "The doctor knows best." In this paternalistic model, the doctor makes all the important decisions concerning the patient's health, and the patient passively accepts the doctor's preferences. In a non-paternalistic, patient-centered approach to medicine, the doctor serves as a health advisor to the patient but does not try to impose

his or her own views on the patient. The quintessential empowered patient is prepared to use nutrition, supplements, and prescription drugs aggressively – even more aggressively than most (allopathic) physicians – to combat medical conditions such as atherosclerosis, hyperlipidemia, osteopenia, diabetes/prediabetes, hypertension, and sarcopenia.

Medical schools took notice of the increasing level of knowledge that patients possess about their own health and treatment options and began to instill a different approach to medical practice in their students. "[Y]ounger practitioners have been educated in a patient-centred climate, rather than the traditional paternalistic approach to medical practice, which has also brought with it the idea of 'defensive medicine'." [2] It is certainly true in America that health care systems that practice a non-paternalistic approach to patient treatments experience a much lower incidence of medical malpractice lawsuits. That fact alone should encourage any rational health care organization to migrate towards a non-paternalistic model.

Barriers to patients becoming empowered

Given the desirable health outcomes with patient empowerment, why are the vast majority of patients still passive and have not become empowered? In order to become empowered, patients must be willing to educate themselves on anatomy and physiology, medical conditions, and treatment options (including both prescription and non-prescription drugs). Most patients are unwilling to devote sufficient time required to educate themselves about health matters, in general, and preventive medicine, in particular.

For example, virtually all people need to avoid eating foods high in starch, which would include white potatoes, white rice, pasta, and white bread. As soon as some patients hear that improving health requires them to give up some of their favorite foods, they tune out and will not listen to the information. These patients comment such as, "We all have to die sometime, so I am going to eat whatever I want." That attitude illustrates the antithesis to an informed patient making intelligent decisions about what is best for that person's health. Therefore, a lack of means to self-educate and a lack of willingness to take action to optimize health are two barriers to patients becoming empowered.

A third barrier is lack of access to resources. While the Internet provides extensive information on medicine and health-related topics, most of that information is non-technical and intended for the general public. An empowered patient needs to have a means of searching medical journal articles electronically, because these medical journals provide information on smaller clinical trials and doses used in those trials that never get published in the popular press. Without access to those medical journals, an ardent patient-researcher would see what appear to

be hyped up claims for the efficacy of one product or another, but the researcher would have no way of distinguishing hype from fact.

In addition to medical journals, the quintessential empowered patient will also have access to doctors who specialize in integrating prescription drugs with non-prescription drugs in the treatment of medical conditions. In the United States, there are organizations that provide free health advice to their members, where the health advisors have been specially trained in integrative medicine. I belong to one of those organizations, which provides me with a toll free number where I can reach medical doctors and other medically trained physicians (naturopaths, chiropractors, osteopaths). I have learned more in the past three years about optimizing health from telemedicine calls with the organization's doctors than from all my local primary care physicians combined! These organizations are open to anyone, and the cost of membership is relatively cheap, e.g., $69/year. Perhaps the time has come for the United Kingdom and other countries to contact these organizations about the possibility of opening field offices in their countries.

Another obstacle patients will encounter is medical doctors who are set in their ways and have not kept abreast of the latest developments in their field. These doctors actively discourage patients from looking into any new treatment methods and scorn the possibility that a non-doctor (patient) might discover something they do not already know. This resistance to change is illustrated in the following case study.

Case study: Ford Motor Company, Inc.

Last year I sent Ford Motor Company, Inc., one of the big three American-based automobile manufacturers with a large unionized workforce, a short proposal entitled "A State-of-the-Art Corporate Wellness Program for Ford Motor Company." Ford responded within a week by scheduling a phone conference call with me. On the other end of the conversation were a senior director in the human resources department, the manager for negotiations with Ford's health insurance carrier, a person with job title "Senior Manager, Corporate Wellness," and the global Medical Director. Ford provides health insurance coverage for its current employees as well as non-union retirees. At first, I was impressed that Ford ponied up money to pay for many (70% – 80%) of the blood tests that I advocate as a health economics and outcomes researcher.

However, during the conversation, the medical director said Ford manages employee cholesterol levels using total cholesterol. I was shocked with his admonition and told the group, no competent medical doctor, in my opinion, would manage cholesterol using the total cholesterol level by itself. Heart attack risk depends crucially on the relative share of good cholesterol, HDL. Thus competent primary care physicians would use either the Total Chol/HDL ratio or the bad/good (LDL/HDL) ratio is assessing cardiovascular disease risk and setting a treatment plan. Empowered patients are aware that various medical and research organizations recommended the optimal Total Chol/HDL ratio values should be 3.5 or below. [3, 4, 5] However, the quintessential empowered patient would set a goal of Total Chol/HDL < 3.2 for men and Total Chol/HDL < 3.1 for women, based on research and recommendations from Life Extension Foundation. [6]

An empowered patient knows the vast clinical guidance literature on use of cholesterol ratios in managing lipids disorders, yet Ford's medical director said Ford gets by using total cholesterol < 200 as its measure for lipids control and had no plans to change that. An empowered patient would have confronted Ford by saying, "If you are going to practice medicine the way it was done in 1980 instead of 2012, then you are not serious about preventing cardiovascular disease in your workforce."

Similarly, diabetes is determined clinically by the 3-month average serum glucose levels (HbA1C). The empowered patient would insist on getting that test, which costs about $20, to determine precisely his or her risk of diabetes. Ford Motor Company pays instead for the cheaper "fasting glucose" test, which costs only $2. Empowered patients know that fasting glucose reflects the amount of sugar in the last meal consumed prior to the blood draw: whatever sugar content was in the patient's dinner and any snack the night before the blood draw. Fasting glucose is a highly unreliable marker for diabetes risk yielding both false negatives and false positives. A person could have fasting glucose of 95 and yet be diabetic or fasting glucose of 130 and yet be nondiabetic. Again, Ford said it had no plans to change relying on its fasting glucose < 100 test, because that is the standard of care for doctors in the state of Michigan.

How would an empowered patient react? If using fasting glucose to determine diabetes risk indeed reflects the conventional medical wisdom or standard of care in Michigan, then that state is exacerbating the national diabetes epidemic with doctors who use inappropriate measures for diabetes risk. The Center for Disease Control estimates 90% of American patients who are prediabetic do not even know their status, because the patients are completely unaware of the appropriate laboratory test, and their doctors have never once tested their HbA1C levels. [7] Empowered patients would insist on getting their HbA1C levels tested, memorize their HbA1C status, and keep track of changes up or down.

So at first an empowered patient-employee might be impressed that Ford Motor Company is one of the few corporate employers willing to pay for extensive blood tests to check its employees' health. But the empowered patient would be completely disillusioned that Ford tested many things the wrong way and also omitted useful, important tests for C-reactive protein (the most reliable measure of heart attack risk), homocysteine (another measure of systemic inflammation correlated with stroke risk), and hormones (Ford does not care about menopause or andropause or metabolism — thyroid function, and does not check the associated hormone levels in its workforce).

Doctor benefits from seeing empowered patients

Most doctors would prefer to have patients who take responsibility for their own health, rather than place that burden on the doctor. They describe a partnership in which the patient understands his or her roles and responsibilities. Empowered patients bring with them a wealth of knowledge. For example, the empowered patient will bring copies of medical articles to show his or her physician during an office appointment. Doctors who have a full patient load have very limited time to pursue external reading, and it is helpful if a patient finds an interesting article and shares it, rather than requiring the doctor to look for such articles on his own. If a doctor had 1,000 empowered patients in his practice, he or she would essentially have the benefit of 1,000 graduate research assistants all focused on topics of concern to his or her practice.

Conversations with empowered patients are conducted with a higher degree of sophistication than with typical patients. For the quintessential empowered patient, the conversation will be peer-to-peer, on a first-name basis, as if the doctor were treating another doctor as his patient. The doctor must be on his "A-game" when answering the empowered patients' questions, and these conversations push the doctor to learn more about topics and treatments beyond his immediate expertise, which in turn makes the doctor a better

clinician. For example, empowered patients will be aware that the pharmaceutical industry has spent billions of dollars attempting to produce a HDL-boosting drug. They may know more than their doctors about the pipeline drugs in the new class of cholesterol ester transfer protein (CETP) inhibitors. Two of the drugs in that class, torcetrapib and dalcetrapib, would have boosted HDL levels by 50%, but both of those drugs failed safety clinical trials.

Empowered patients are likely to discover non-Niacin supplements that when combined can raise HDL similarly by 50%. One of these supplements is concentrated Omega 3 fish oils that contain 500 mg of Docosahexaenoic acid (DHA) per gelcap. Virtually all of the doctors' patients – whether empowered or passive – would benefit from raising their HDL levels. Doctors can pool their empowered patients' knowledge and improve the quality of care they offer all patients. Empowered patients have a vested interest in helping doctors expand their knowledge base, because empowered need physicians who can advise them on relatively sophisticated health topics. Thus with empowered patient-doctor relationships, a true partnership arises in which both parties work together to optimize the patient's health, and the doctors learn new information about off-label uses for prescription drugs and treatments outside the universe of Medicines and Healthcare products Regulatory Agency (MHRA)-approved drugs in the UK or Food and Drug Administration (FDA)-approved drugs in the USA.

If you are interested in this discussion of the empowered patient, please join our LinkedIn.com group on Life Extension Integrative Medicine, Age Management Medicine, and Eicosanoid Research using the link, http://www.linkedin.com/groups/Life-Extension-Integrative-Medicine-Age-4771999 That group has ongoing discussion threads on patient empowerment and various topics in preventive medicine.

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3. http://www.webmd.com/cholesterol-management/finding-the-ideal-cholesterol-ratio?page=2

4.http://www.mayoclinic.com/health/cholesterol-ratio/AN01761

5.http://www.health.harvard.edu/fhg/updates/update0205c.shtml

6.http://www.lef.org/protocols/appendix/blood_testing_04.htm Author's note: The web page indicates optimal Total Chol/HDL ratios of less than 3.4 for men and 3.3 for women. Those recommendations have now been updated to 3.2 for men and 3.1 for women, although the revised optimal ratios do not appear yet on LEF's web site.

7. The CDC has removed the 90% unaware estimate from its website, but not before that percentage estimate was picked up by scores of other websites. See, e.g., http://lifespa.com/2012/03/pre-diabetes-part-2-home-screen-your-risk-for-pre-diabetes/ ("Today, close to [79] million people have pre-diabetes and 90% of them do not know it, according to the CDC."); http://notme.com/dpca/prediabetes.html ("According to the Centers for Disease Control and Prevention, . . . 90% of those with prediabetes do not even realize they have the disease." (emphasis in the original); http://drhyman.com/blog/conditions-category/pre-diabetes/ ("ONE OF EVERY TWO of you have a deadly disease that's making you fat, sick, and will kill you, and 90% of you don't even know you have it.")

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ACADEMYST EVENTS - CHANGING CONFERENCES & SEMINARS, RESTORING ACCESSIBILITY, MASSIVELY REDUCING COSTS, IMPROVING QUALITY, IMPACT & USEFULNESS

// Introduction

We operate in a competitive market, whether it is patient-by-patient or for a fair share of a limited financial resource. Enhanced choice represents dynamic demand, making it increasingly difficult to plan capacity at a time when an increased RTT (Referral to Treatment Time) brings Monitor to the door. Services and Trusts must learn to influence their flow of patients at both ends of the pathway. Reputation is key, along with understanding that when reputation fails, often the organisation does too. This powerful programme is designed to provide service leaders with a deep understanding of the core principles and a practical tool set from which to plan and execute an appropriate reputation strategy for their service.

// Key Topics

- The NHS Promotional Context & Bigger Picture
- The Strategic Component - Creating a Plan
- From Planning to Operations - Designing Reputation
- Building the Reputation - Communication, PR & Promotion

IMPROVING QUALITY AT THE FRONT LINE – THE VALUE OF FRESH EYES

By Professor Susan Fairlie, MSc, BSC (Hons), RGN,
Managing Director, Mindset Matters Ltd

Since the initial investigation by the CQC into the care provided at Mid Staffs was made public in 2009, the quality agenda has been figural throughout the NHS. The subsequent Reviews and Inquiries and, most recently, the publication of the Francis Report in February has sent shockwaves throughout the system.

Quality assurance is being sought at every level and no longer is it acceptable to limit the quality agenda discussions to Board and Senior Management Team meetings; it should now be the pre-occupation for all staff. And yes that includes non-clinicians too – those in both front line and back-office roles. For those of us who are passionate about Quality and Quality Improvement, we need to be opportunists; we are knocking on an open door - this is our chance to really up the ante. There is a danger however, that quality assurance will become an industry in itself – creating a tick box mentality to provide evidence to an external assessor.

Within healthcare, the terms Quality and Quality Improvement are frequently conflated and used interchangeably. They are typically considered to be about providing safe and compassionate care. I think it is helpful to make the distinction. All NHS Trusts have a Quality Committee (a sub-committee of the Board) and yet very many Trusts choose to call this the 'Safety and Quality Committee'. It may seem pedantic, but I think this misses the point that high quality care, as defined by Lord Darzi, comprises all three domains of Quality: Safety, Experience and Effectiveness – all three being of equal importance. In short, whilst safety is vitally important, it is only one part of the bigger quality picture.

Quality Improvement however, is an enabler for achieving high quality care – it is about a mind-set and is a far cry from a tick box demonstrating compliance. That is not to say that targets are not useful - they are but if we only focus on hitting the target, we are in danger of missing the point. We need to avoid the tyranny of mediocrity, where organisations are happy to be in the 'middle of the pack' and so unlikely to be scrutinised as an 'outlier'. A Quality Improvement approach requires a relentless quest to continuously improve the quality of services. There are a raft of tools, techniques and approaches to enable this. That said, making an improvement requires a change and yet we need to consider the wise words of Ely Goldratt who reminds us that not every change is always an improvement. We need to measure the impact of our change efforts and be vigilant for unintended consequences.

In recent years, to effect change within the NHS, we have used the Model for Improvement, developed

by Langley et al. The model is a useful way to clearly identify the aims and measures of improvement and uses small tests of change known as PDSA cycles (Plan, Do, Study, Act) to test a hypothesis. Using the model on its own however, is unlikely to lead to sustained improvement and so underpinning any Quality Improvement approach is the need to consider the human dimensions of change.

Indeed, evidence from McKinsey shows that 70%of change efforts fail and 70% of those failures are to do with organisational factors. These are pretty sobering statistics and by and large, it comes down to people and culture; behaviours and beliefs.Even great improvement ideas will not be realised if staff are not engaged from the outset. We need to recognise that leaders of a system will seldom have all the answers to a problem and that if we want the best ideas, we need to co-design improvement interventions with the relevant stakeholders (staff, patients and carers).

In order to facilitate front line staff to make improvements, and building on what is known collectively about Quality Improvement; the NHS Change Model has recently been developed. Although championed by NHS England, it was developed with NHS staff at all levels of the system and is the culmination of what is known to make the biggest difference for implementing change. The model provides a framework of eight components, each of which are aligned to avoid an over reliance on one. There is an expectation that, within NHS England, everyone will have a basic understanding of it. For more information please visit: www.changemodel.nhs.uk

The scope of this article doesn't permit extensive discussion of all the fantastic work that is being done each and every day by individuals, teams and whole organisations across the NHS. Suffice to say that there are plenty of role models and good practice that we can, and should, emulate. Indeed, all organisations concerned with providing high quality care need to be on the front foot in identifying good practice and considering how to equip front line staff with the knowledge and skills to lead a culture of quality improvement. In addition to learning about tools and models, staff at all levels should be encouraged and, if necessary, taught how to create a compelling case for change, how to challenge the status quo and even how to have a difficult conversation. This is essentially leadership development and academic institutions, who are training the NHS workforce of the future, have a key role to play here.

So where do we start?

There are numerous things that we can do but holding up a mirror and

The NHS Change Model

having a good hard look is a useful place to start when seeking out opportunities to improve. There will be some organisations and staff, who will be thinking that they are nothing like Mid Staffs and what happened there wouldn't happen in their organisation. That sort of thinking is hubris. As leaders of Quality Improvement we should ask ourselves how do we really know? How do we know that patients receive the same high quality care that you would expect at 3pm as at 3am? How often do we turn a blind eye to something that would require some effort to change? For example, we know the importance of training and education, reflective practice, appraisal and clinical supervision. Some organisations however, continue to use permanent night staff who, typically, do not receive the same degree of support in such matters.

In some instances, these staff have worked together for many years, have few learning and development opportunities and little critique of their working practices. By default, they often develop their own culture, customs and practices -I have had reports of staff filling in the observation sheets at 2am for the entire night!

This isn't necessarily about bad apples but about the culture that makes this behaviour acceptable. The answer is that we won't know if we don't look and so as well as identifying good practice and celebrating our achievements, we need to shine a light in dark places too. That may mean having some difficult conversations – if we don't challenge poor practice, systems and processes, then in effect we are colluding with them.

Hand washing is a key element of patient safety practice and yet when doing some leadership development with junior doctors recently, they reported that they frequently witness their consultant colleagues not washing their hands. When asked whether they felt able to challenge this behaviour, the overwhelming response was that this would be career limiting. As leaders of Quality Improvement we need to find ways to create a culture where we can have courageous conversations and break through the deference threshold. A culture where hierarchy doesn't get in the way and where staff are treated as heroes for speaking up rather than as villains for exposing poor practice. Creating a staff compact; an expectation that all staff will speak up and in return, senior staff will listen, is an important first step.

The simple concept and benefit of using fresh eyes is often overlooked. For example, the process of induction whilst important and necessary can be perilous. We rapidly seek to show new staff 'the way things are done around here' but in doing so, we often miss a trick. By encouraging all new staff within their first few weeks to look out for things that surprise, delight and concern them on a daily basis, we can benefit from some 'free' consultancy. Giving them a journal in which to document their findings and thoughts and explicitly asking them to feedback to their manager is a powerful way to benefit from new insights. Further, such feedback then becomes the norm and encourages a culture of speaking up when there are concerns. By embracing the feedback, the manager is demonstrating real

leadership – a desire to learn and improve; a mind-set that as well as amplifying what is working well, asks what have I overlooked and where are my blind spots?

A Quality Improvement culture requires innovation - being prepared to try new things that might look and feel weird at first. We can learn lessons from other sectors that have radically altered their techniques to gain significant improvements. For example in athletics, it wasn't that long ago that the Fosbury Flop replaced the 'scissors' in the high jump. At the time, it looked really odd but is currently the accepted Gold Standard. Within healthcare, we also have seen radical changes to our tried and tested practices; it is only fairly recently that key hole surgery has been introduced which has had a significant impact on the quality of care.

By learning from others, both within and outside of healthcare, our vision of what is possible is altered. This again is about our mind-set as demonstrated by Sir Roger Bannister and his contemporaries in 1954. At that time the prevailing belief was that it was physically impossible for a human to run a mile in less than four minutes. When Bannister became the first man to do so, both he and the rest of the world were amazed. Amazement soon turned into ambition for others to achieve the same and ultimately this became accepted practice - the standard to aspire to.

And so it is with healthcare improvements. For example, many healthcare organisations are concerned with eliminating avoidable Pressure Ulcers. By identifying those organisations who have had great success in doing so, we can change the culture of accepting that Pressure Ulcers happen, to one where Pressure Ulcers do not happen here! Within the Abertawe Bro Morgannwg University Health Board in Wales, they did just that. In 2009 their Pressure Ulcer incident rate was 10%. By challenging their assumptions and using improvement methodologies, they reduced this to 0.09% by September 2012. This is one example of those who have paved the way for others to follow. When we know something can be done, we are more likely to follow suit. This in turn affects culture which is essentially the shared assumptions that underpin behaviours or more simply, the way we do things around here. So at the risk of stating the obvious, our beliefs affect our behaviour which in turn, affects patient outcomes.

Using fresh eyes is also a useful tool to help us overcome intransigent problems. By using the lens of different industries, we can identify new systems and processes beyond our usual reference points. This is increasingly being done within healthcare and is what Professor Martin Elliot and colleagues from Great Ormond Street Hospital did. Martin is the head of cardiac surgery at GOSH and explains how they have improved their processes by learning from Formula 1. He describes the perilous journey from theatre to intensive care which was always where the untoward incidents and near misses happened –a time of particular risk for the tiny babies.

On one particular occasion, they returned to the common room after a difficult transfer and Formula 1 racing was on the TV. They were so impressed with the impressive pit stop routine and imagined there were many applicable lessons for them. They immediately made contact with the F1 team and in short, there began a collaboration between F1 and the GOSH team. They learned a significant amount about process and human factors – constantly anticipating what could go wrong, not waiting

Image from: www. formula1.com

until things had gone wrong. They also brought in dancers to help them choreograph their moves – how and where to stand when transporting the patient and during the handover period. As a result of this work, they have reduced the number of multiple errors fourfold. They are now looking at Premier Inn processes to help them with bed occupancy and the Red Arrows to learn about debriefing.

We know the importance of communication and documentation to improve patient safety. The increasing use of the SBAR tool (Situation, Background, Assessment, and Recommendation) is another example of using fresh eyes to learn from others. Originally used in the military and aviation industries, SBAR was developed for healthcare by staff from Kaiser Permanente. Even the most conscientious healthcare professionals are fallible human beings, and prone to making mistakes. The use of the SBAR tool within healthcare has had a positive impact, with reports of theincidence of harm to patients falling by 50 per cent. The tool comprises standardised prompt questions, helping staff to frame conversations and capture the salient information to be communicated between team members. The tool lends itself to any stage of the patient journey from referral, to discharge and staff are finding it particularly beneficial during handover and when managing the deteriorating patient. In short, it prevents the hit and miss process of 'hinting and hoping' that key messages have been heard.

Experience based design and Co-design are relatively new approaches to Quality Improvement and both are related to the principles of fresh eyes. Both are concerned with using the experience of patients, carers and staff to inform and improve service provision. The former is about identifying key emotional 'touch points' and then working with patients, carers and frontline staff to improve these experiences rather than just the systems and processes. Similarly, the latter uses the insights of a variety of stakeholders to make improvements ranging from the more functional elements of healthcare services to fundamental and transformational redesign. When seeking to make improvement, we often overlook non-clinical front line staff, patients and carers and yet they often can see some very obvious solutions to everyday problems. For example, using this approach, one NHS Trust discovered from a patient who had had a stroke, that when using the toilet they felt unsafe and at risk of falling when reaching for the toilet roll which was on the same side as their weakness. The simple solution was to install toilet roll holders on both sides of the toilet. There are numerous examples of such empowering approaches being used to improve patient care.

If we really want high quality care, then we need to embrace a culture of Quality Improvement. A culture where we value fresh insights and where staff are encouraged to ask for feedback and express concerns. A culture where hierarchy doesn't get in the way and all staff are enabled to be 'leaderful'. In reality, despite the recent rhetoric around whistleblowing, unless we make it easy for people to speak up, they won't. There are a variety of tools and techniques to help us bring Quality Improvement to the frontline – let's use them! The metaphor of a burning platform may seem extreme, but we have certainly heard a compelling call to action from Robert Francis that drives to the heart of our NHS values. All of us who care about the NHS have a moral duty to answer this call.

UNDERSTANDING & WORKING EFFECTIVELY WITH COMMISSIONING

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ACADEMYST EVENTS - CHANGING CONFERENCES & SEMINARS, RESTORING ACCESSIBILITY, MASSIVELY REDUCING COSTS, IMPROVING QUALITY, IMPACT & USEFULNESS

// Introduction

Commissioning has been changed for a reason in the post Health & Social Care Act 2012 era. It has a specific set of jobs to do and a new way of doing them. The commissioning job to be done represents a plethora of risks, threats and opportunities for all types of services and it's important to understand just what these are. Perhaps the greatest risk is that the very people who really need to understand commissioning in its modern form are the same people that find it mystifying. This day is designed to thoroughly demystify it for consultants, matrons, managers and other service leaders, along with anyone who recognises the importance of understanding how things work today. It will provide clear guidance on how to approach it to maximise opportunity and safety whilst minimising or mitigating its risks & threats.

// Key Topics

- Understanding commissioning & its new structure
- Commissioning Agendas
- How commissioning works & how to work with commissioning
- Optimising your commissioning strategy

SPECIAL FEATURE - IMPROVING QUALITY AT THE FRONT LINE

NHS IQ: PROVIDING THE EXPERTISE TO MAKE BIG CHANGES

By Julian Hartley, Managing Director, NHS Improving Quality

The NHS is going through the most significant and wide-reaching changes since it was created in 1948. It must adapt to the needs of the people it serves, recognising that while we are living longer, we are doing so with increasingly complex health requirements.

With financial constraints and no growth in resources, the NHS needs to radically change and improve the way we do things. We need to deliver wholesale improvement and high quality services at a scale and pace to meet people's needs and exceed their expectations.

NHS Improving Quality will help achieve this by supporting health outcomes across England through improvement and change expertise.

Since our launch on 1 April 2013, we have beenworking to create a world class, sustainable improvement resource. This will enable frontline services to improve quality around clinical effectiveness, safety and people's experience of care.

Creating broader, faster change

We know that the ability to drive change in the NHS exists. What we now need to do is to coordinate, amplify and reinforce our change efforts in order to achieve significant benefits across the entire NHS. NHS Improving Quality is committed to making this happen.

As the driving force for improvement across the NHS, NHS Improving Quality brings together a wealth of knowledge, expertise and experience, while establishing a new vision and reshaping the healthcare improvement landscape. In forming NHS Improving Quality, we have taken onboard the lessons of history and the experience of previous national improvement teams.

However, the operating model of NHS Improving Quality is different to previous improvement organisations in a number of ways:

- We are fully aligned to and hosted by NHS England, and designed to identify and respond to its improvement requirements;
- We are a smaller, more streamlined organisation than previous improvement bodies, with a focus on designing improvement interventions and commissioning these through a range of delivery partners;
- We have a whole system responsibility, including offering improvement support to NHS organisations and networks;
- Our work brings together the key stages of the improvement cycle; creating a forward view, proof of concept and testing, designing for delivery, and delivery and deployment;
- We have geographical reach to support NHS England's regional and area teams and clinical commissioning groups (CCGs);
- We will support challenged NHS organisations through NHS Interim Management and Support (NHS IMAS), which forms part of NHS Improving Quality.

Our priority areas

For the first time the NHS has an improvement body that is fully aligned to its commissioning priorities as expressed through the five domains of the NHS Outcomes Framework:

Preventing people from dying prematurely;

1. Enhancing quality of life for people with long term conditions;
2. Helping people to recover from episodes of ill-health or following injury;
3. Ensuring that people have a positive experience of care;
4. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Ten key programmes of work have been identified, which map against these five domains. We are now establishing a range ofdelivery partners, including a delivery team comprised of experienced improvement staff, which we will commission to support NHS organisations in delivering improvement.

These may include academic health science networks, voluntary, policy, academic and commercial organisations, royal colleges and charities, as well as NHS organisations and alliances. We are also keen to hear about examples of service improvements you have been involved in locally or regionally that

could help inform our work.

How should we organise our key resources for improvement?

At NHS Improving Quality, we recognise that in order to successfully implement effective improvement programmes to support the NHS Outcomes Framework, we need to build improvement capacity and capability across the whole system.

A single improvement methodology includingthe NHS Change Model is being rolled out across NHS England, including senior leaders and regional area teams, clinical commissioning groups (CCGs) and primarymedical care. This ensures that improvements are sustainable and deliver real benefits, in line with the NHS Outcomes Framework and NHS England's strategic plan - Everyone Counts: Planning for Patients.

Over the next 12 months, every NHS England senior leader will be offered the opportunity to be a role model of transformational leadership by undertaking an accredited improvement capability building programme. As well as this, all NHS England area teams will be offered the opportunity to build capability for transformational change through coaching, master classes and action learning sets.

All NHS England staff will have access to a foundation level, e-learning programme to ensure everyone has basic capability in the NHS Change Model and improvement methodology for commissioners.

The time for change is now

Over the past decade, the NHS in England has seen much positive change, including reductions in waiting times for elective care, a fall in infection rates, and a significant reduction in hospital mortality – all as a result of a systematic approach to improvement.

With support and engagement from across the healthcare system, NHS Improving Quality will build on this work and act as a catalyst to drive transformational change across the NHS. In doing this, we will create innovative and new knowledge of how to achieve sustainable change.

We look forward to working collaboratively to ensure that our NHS continues providing top quality, affordable healthcare for all.

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Featured Course

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Achieving Resolution, Avoiding a Disaster

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As the NHS is placed under ever greater financial pressure, the likelihood of a crisis developing in any organisation increases, whether a crisis of financial failure, quality & safety concerns, major workforce issues or all of these together. It is imperative that today's leader equips themselves with the knowledge necessary to ensure that an emerging crisis does not evolve into a disaster, along with the trail of destruction that goes alongside it. Although with a solid academic underpinning, this programme is designed to be a highly practical look at just what you need to do if you find yourself in the uncomfortable position of leading in a crisis. Although prevention is better than cure, preparation is the real insurance that a crisis is dealt with sensibly and with the long game in mind.

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- The context of crises today - the emerging precipitators
- Crisis versus disaster - know the difference
- Recognising the danger signals of crisis escalation
- The distressed environment - understanding the reality
- The nature of emerging crises - clinical, financial & reputational
- Adopting a sensible crisis resolution model
- In it for the long game - not wrecking the future to save the day

People & behaviour in a crisis

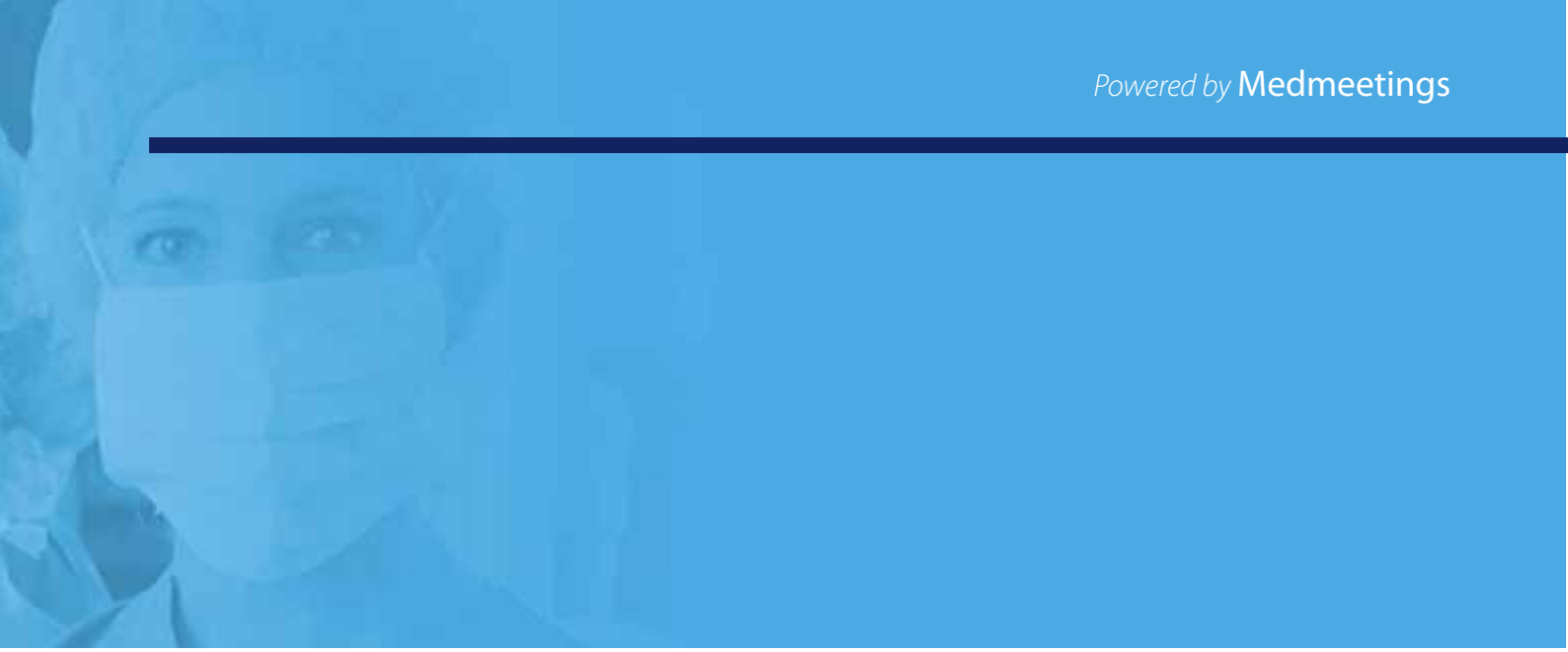
- Critical issues in emotions & behaviour
- Understanding human reactions using the Kubler-Ross Curve
- Panic & paralysis - understanding the mechanisms at play
- Segmenting crisis reactions - knowing who's likely to do what
- Limbic processing and the loss of emotional stability
- The adverse role of nihilism in disaster and how to avoid it

Leading people in a crisis

- Adopting a crises model of leadership
- What do people need from leaders in a crisis?
- Deploying people intelligently
- Ensuring that everyone knows what to do and how to do it
- Appropriate leadership communication in crisis situations
- Handling further set-backs to avoid further emotional damage
- How the organisation must behave to take people with it

From crisis to consistent stability

- Root true-cause analysis - deal with the cause not the symptoms
- Agreed solutions to commonly understood problems
- Assembling a crisis coalition to lead resolution
- How to facilitate consensus
- Agreeing crisis principles - behaviour, communication & solutions
- The design-implementation approach to crisis resolution
- Modelling - ensuring that you are doing the intelligent thing
- Examining a crisis through the ENABLEMENT lens



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Aimed at Clinical Directors, Clinical Service Leads, Senior Consultants, GP Principals, Service Directors & Matrons with a responsibility for leading their service successfully in today's challenging times.

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Cost: £390.00 + VAT Event Type: 2 day Course CPD Points: 23 Provider: Academyst LLP

The Applied Leadership Masterclass is for individuals who are determined to take their leadership ability to new heights with the intention of leading and catalysing the very highest levels of service or organisational success and change. Built on the principle that true leadership excellence is a journey of learning, discovery, self-insight and doing, it provides a tailored programme with all the backup you'll need along the way.

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Assertiveness without Aggression

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 8 Provider: Grow Medical LLP

Assertiveness without Aggression is probably the most comprehensive, practical programme available, designed to help consultants, other doctors and healthcare professionals adopt the right behaviour, communication and approach to have the right impact. The resulting effect is greater achievement, more self-control and a greater level of emotional self-mastery. All of this is achieved without ever trying to change the inner you whilst enhancing confidence, self-mastery, impact and interpersonal effectiveness.

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The Effective Clinical Director - is designed to ensure that the CD or Service Lead today fully understands the changing context of a service and consequently the true 'job to be done' by an effective lead today. It is not only perfect for aspiring Service or Divisional Leads but also for those with time in post who realise that a new framework is necessary for success today.

Find Out More
http://www.medmeetings.co.uk/training/all/clinical-director-acceleration-programme-1

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Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

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Find Out More
http://www.medmeetings.co.uk/training/all/clinical-director-acceleration-programme-2

Clinical Director Acceleration Programme 3 - Managing a Successful Service Today

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Managing a Successful Service Today - is designed to ensure that the CD or Service Lead can successfully keep a service on the straight and narrow, delivering the highest possible quality and experience at the lowest possible cost in a safe environment. This comprehensive day covers the 4 cornerstones of management effectiveness and how to apply them at the service level. It is geared towards managing people and performance in the context of today's tough environment, including how to rectify performance issues should they occur.

Find Out More
http://www.medmeetings.co.uk/training/all/clinical-director-acceleration-programme-3

Consultant Interview Skills Session 1 - Strategy, Skills & Techniques

Cost: £125.00 + VAT Event Type: Half day Course CPD Points: 3 Provider: Grow Medical LLP

With training becoming more standardised and competition for consultant posts getting ever greater, it is vital that you stand out from the crowd in order to secure the perfect post for you. That means getting the edge. The edge consists of having the right insights and demonstrating it, adopting the right overall strategy and how well you perform on the day.

Find Out More
http://www.medmeetings.co.uk/training/all/consultant-interview-skills-session-1-strategy-skills-techniques

Consultant Interview Skills Session 2 - Questions, Practice & Feedback

Cost: £125.00 + VAT Event Type: Half day Course CPD Points: 3 Provider: Grow Medical LLP

With training becoming more standardised and competition for consultant posts getting ever greater, it is vital that you stand out from the crowd in order to secure the perfect post for you. That means getting the edge. The edge consists of having the right insights and demonstrating it, adopting the right overall strategy and how well you perform on the day.

Find Out More
http://www.medmeetings.co.uk/training/all/consultant-interview-skills-session-2-questions-practice-feedback

Core Principles in Transformational Distributed Leadership

Cost: £190.00 + VAT Event Type: 2 day Course CPD Points: 12 Provider: Academyst LLP

Effective leadership is critically important at all levels in an organisation and particularly at the clinical coal face, where leadership failures come with a high price-tag to all concerned. However, the approach taken to leadership has a very strong influence over the success of that leadership and, critically, whether it makes Mid Staffs-type situations more or less likely.

Find Out More
http://www.medmeetings.co.uk/training/all/core-principles-in-transformational-distributed-leadership

Creating Monumental Improvement in Cost-efficiency, Quality, Safety & Experience

Cost: £195.00 + VAT Event Type: 1 day Conference CPD Points: 12 Provider: Academyst LLP

The massive requirement for reform is no secret to anyone but with multiple examples of reform meaning cutting costs at the expense of service quality and safety, it is not surprising that there is a growing concern that what we are being asked to do might be necessary but appears to be impossible. That's not true but we do need to approach it in the right manner. The recent article in the Daily Telegraph from Steve Allder, Stroke Service Lead in Plymouth Hospitals NHS Trust demonstrates just what can be achieved.

Find Out More
http://www.medmeetings.co.uk/training/all/leadership-for-senior-and-hyperbusy-leaders

Critical Principles in Getting the Best from People in Difficult Times

Cost: £195.00 + VAT Event Type: 1 day Conference CPD Points: 12 Provider: Academyst LLP

Healthcare is struggling to do what it needs to do, perhaps something that everyone agrees on. What needs to be done can be summarised as exceptional delivery, across all quality & experience domains, concurrently with significant, genuine reform, coupled to new levels of financial effectiveness, whilst coping with increasing confounders such as competition, in a system that few properly understand.

Find Out More
http://www.medmeetings.co.uk/training/all/critical-principles-in-getting-the-best-from-people-in-difficult-times

Excellence in Clinical Quality, Safety & Governance

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Designed for those leading the design and delivery of a truly patient-centric service across the domains of quality, safety and experience, this insightful course covers developing a patient-centric strategy and implementing it throughout a team, department or even a whole Trust. Practical & comprehensive, it will provide you with the essential knowledge and tools you need to drive forward service development , maximise quality across all 3 domains and ensure a culture of excellence emerges throughout your service.

Find Out More
http://www.medmeetings.co.uk/training/all/leading-managing-quality-safety-experience

Excellence, Safety & Cost Efficiency - Creating the Holy Grail Culture

Cost: £95.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Just about every healthcare organisation is currently wrestling with the need to improve cost-efficiency in light of extreme austerity. Many of us feel that the approach being taken puts some of our most important values and principles at risk, such as do no harm, and the evidence is starting to mount that this fear is well-founded. However, it is perfectly possible to improve cost-efficiency whilst enhancing safety and excellence but it must be organised and implemented the right way.

Find Out More
http://www.medmeetings.co.uk/training/all/excellence-safety-cost-efficiency

Finance & Financial Management for Consultants & Other Clinical Leaders

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Developed in conjunction with a Senior NHS Finance Director, this course is designed for the many consultants, senior nurses and PAMs who would like NHS finance and business planning demystified to the point of being both understandable and manageable. With particular emphasis on what it takes to be financially successful in today's NHS environment, the course balances a detailed understanding of the principles and process of NHS money flow with the practical skills to operate successfully to ensure services survive and thrive in...

Find Out More
http://www.medmeetings.co.uk/training/all/finance-and-business-planning-for-consultants-clinical-leaders

Insights - Understanding the Evolving Healthcare Landscape

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Our ground-breaking, renowned Insights programme is designed to take individuals from an inadvertent state of naive vulnerability to one of informed insight, allowing you to set a sensible strategic direction, seize opportunity and mitigate the myriad of risk in the emerging system. Going well beyond just information and facts, it provides a deep level of interpretation and insight as to how our new system is likely to play out in reality.

Find Out More
http://www.medmeetings.co.uk/training/all/insights-understanding-evolving-healthcare-landscape

Job Planning without Drama

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Effective services have sensible consultant job plans that are closely matched to attainment of important organisational objectives. However, those responsible for establishing job plans and holding discussions with their consultant colleagues find agreeing job plans one of the most stressful activities they have to engage in. This reflects the high potential for discourse in the job planning process, especially as we transition from a largely clinically-driven to a more balanced clinical-business-driven environment.

Find Out More
http://www.medmeetings.co.uk/training/all/core-skills-in-job-planning

Leadership & Management Masterclass for Latter Year Trainees & Newer Consultants

Cost: £585.00 + VAT Event Type: 3 day Course CPD Points: 29 Provider: Academyst LLP

Aimed primarily at those within sight of their CCT or recently into their first consultant post and specifically at those who recognise the unquestionable importance of true leadership and management effectiveness both in demonstration of your personal value to a prospective organisation and operationally in post.

Find Out More
http://www.medmeetings.co.uk/training/all/ultimate-leadership-management-programme

Leadership Fundamentals & Core Principles

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Our Leadership Fundamentals programme is aimed at taking those with no formal leadership training to the point of a thorough understanding of leadership, what really makes it work and how to start applying it in every day practise. It is designed to build very solid foundations on which individuals can build ever greater leadership expertise over time. It's thoroughly people-focused and designed to sit in the context of our very challenging times.

Find Out More
http://www.medmeetings.co.uk/training/all/leadership-fundamentals-1

Leadership in a Crisis - Achieving Resolution, Avoiding a Disaster

Cost: £95.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

As the NHS is placed under ever greater financial pressure, the likelihood of a crisis developing in any organisation increases, whether a crisis of financial failure, quality & safety concerns, major workforce issues or all of these together. It is imperative that today's leader equips themselves with the knowledge necessary to ensure that an emerging crisis does not evolve into a disaster, along with the trail of destruction that goes alongside it.

Find Out More
http://www.medmeetings.co.uk/training/all/leadership-in-a-crisis-achieving-resolution-avoiding-a-disaster

Leading Change, Transformation & Redesign

Cost: £390.00 + VAT Event Type: 2 day Course CPD Points: 12 Provider: Academyst LLP

Change is the one constant facing just about every service in the emerging landscape, whether it is new ways of working, financial reform or a major project. The easy way is to set it up right in the first place, ensure you get the right people on board, then plan and execute in a timely fashion with minimal resistance. This requires the right knowledge, insight and skills and that's exactly what this course is designed to deliver. Focused, practical and cutting to the heart of the real difficulties in change.

Find Out More
http://www.medmeetings.co.uk/training/all/change-management-masterclass-for-healthcare-professionals

Management Fundamentals & Core Principles

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

Clinical staff frequently find that the technical & medical knowledge they've worked hard to gain is only part of the story when managing people, projects and performance. This one-day comprehensive programme seeks to fully address that by covering all the essential topics in a very practical way, enabling you to really develop your management skills in the clinical context. It's built on robust principles and models to ensure that you develop a consistently successful approach.

Find Out More
http://www.medmeetings.co.uk/training/all/Management-Fundamentals

Management Masterclass for Consultants & Other Senior Professionals (2 days)

Cost: £390.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

There's a world of difference between managing patients and managing services and yet many clinical managers and leaders find themselves in charge of large numbers of people and huge budgets without formal training or development. Applied Management Masterclass is a hugely comprehensive and practical programme designed to help you excel in your role as manager in the context of today`s NHS.

Find Out More
http://www.medmeetings.co.uk/training/all/management-masterclass-for-consultants

Managing People for Maximum Morale, Performance, Quality & Productivity

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Academyst LLP

The imperative for top notch clinical and business performance has never been greater than today and yet this expectation sits in an environment filled with uncertainty, risk and decreasing morale, factors known to adversely affect performance. However, with the adoption of the correct approach, you can successfully align the people, the work and the results in a manner that not only enhances the results across all domains but leads to a happier, more secure team with a strong sense of mastery over its own destiny.

Find Out More
http://www.medmeetings.co.uk/training/all/managing-people-for-maximum-morale

Presentation Excellence for Clinical Professionals

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Grow Medical LLP

Effective presentation skills form one of the core backbone elements of a successful career in healthcare. Faced with a diverse range of scenarios, from teaching staff to interview presentations right through to a presentation of an international multi-centre trial or Trust board meeting, it is surprising that few have ever received any formal training in this vital area. This programme takes a single, intensive day approach to dealing with the core elements of effectiveness in presenting with poise and impact.

Find Out More
http://www.medmeetings.co.uk/training/all/presentation-excellence-for-clinical-professionals

Time Management & Personal Effectiveness for Consultants

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 9 Provider: Grow Medical LLP

Designed to make a lasting difference to people's lives, this course is practical, filled with insightful advice about managing load, regaining control, achieving goals more easily and working within today's healthcare. We understand the context of being a senior professional today and can help you achieve at a level you would not think possible. From pre-course assessment to post-course support, it's designed to deliver a transformation.

Find Out More
http://www.medmeetings.co.uk/training/all/insights-understanding-evolving-healthcare-landscape

Understanding & Preparing for Appraisals, Revalidation & Portfolios (appraisees)

Cost: £195.00 + VAT Event Type: 1 day Course CPD Points: 6 Provider: Grow Medical LLP

Even with revalidation upon us, most doctors have never received training in how to prepare effectively and get the most out of the appraisal process. This vitally important course covers the latest understanding of revalidation, the burden of evidence, developing meaningful portfolios and how to prepare for the appraisal itself. Furthermore, all participants will receive an ongoing Revalidation Update, to keep you fully informed.

Find Out More
http://www.medmeetings.co.uk/training/all/ultimate-leadership-management-programme

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