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Winter 2013

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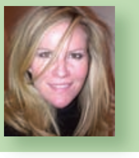

National tariff aims to push more care out of hospitals

Monitor and NHS England's draft national tariff could reduce the growth in emergency admissions to hospitals and result in more patients being managed in the community

By Norma Beavers

Monitor and NHS England have proposed a new national tariff to promote integrated and innovative services with more care delivered in primary and community settings. The tariff also looks set to focus more attention on disease prevention. Monitor and NHS England say the national tariff should help commissioners to work with providers to innovate so the NHS treats illness but also looks more closely at how to prevent it.

Monitor is due to finalise proposals for the national tariff in December and the tariff will come into effect next April. Working with NHS England, Monitor said it "will set out a development programme for a payment system that seeks to encourage innovative approaches to health care that promote well-being as well as treating illness."

Adrian Masters, Managing Director of Sector Development at Monitor, said, "Our proposals for the payment system in 2014/15 are designed to help commissioners and providers address the key challenges facing NHS care in their localities. We are offering them more freedom to encourage the development of new service models, maintaining incentives to provide care more efficiently and providing greater financial certainty to underpin effective planning for patients."

The draft national tariff includes two key changes relating to the rule under which providers are paid 30% of the tariff price for each emergency admission over an agreed baseline, with the remaining 70% retained by commissioners to invest in keeping patients out of hospital. The first proposed change is that where there have been significant local increases in emergency admissions outside the control of providers, "commissioners will be required to agree a revised baseline before the marginal rate kicks in." The second proposed change would mean NHS England would "ensure that the money retained by commissioners through the application of the rule will be spent transparently and effectively to enable more patients to be treated in community settings."

> **"They will set out a development programme for a payment system that seeks to encourage innovative approaches to health care that promote well-being as well as treating illness"**

The draft, indicates commissioners should bank on providers making annual efficiency savings of about 4%. The tariff of prices and rules for 2014 to 2015 takes account of rising NHS costs of 2.1%. This should mean the prices commissioners will pay their providers for services next year should fall 1.9%.

The proposed new payment system will put pressure on acute providers to "be more responsible members of the healthcare community" said Dr Stewart Findlay, Chief Clinical Officer, NHS Durham Dales, Easington and Sedgefield CCG. "They are going to have to make the services they provide more efficient. They will have to work with commissioners to move more services out into community and primary care," he said. As this happens the pressure will mount on General practice to fulfil heavier demands. The Royal College of General Practitioners (RCGP) estimates that up to 10,000 more GPs will be needed to manage the workload that is shifting from the acute sector into primary and community settings. This comes at a time when the Government is pushing General practice towards a 24-hour service with GPs seeing more patients between 8am and 8pm plus working out of hours, seven days a week. This emerging new model is being piloted, and may force GPs to form federations or larger partnerships, said Dr Findlay.

Pharmacists can relieve pressure on NHS services

Pharmacists and their employers must make an unprecedented effort to re-engineer what they do and incorporate more patient care services rather than just dispensing, finds a just published report. Pharmacists who succeed as care-givers will reduce demand on GPs, out-of-hours and hospital services, improve access and care for patients and free up capacity within NHS services, says the report from the Royal Pharmaceutical Society's Commission on Future Models of Care.

The report titled *"Now or Never: Shaping Pharmacy for the Future,"* finds pharmacists have "a marginalised position in the NHS and in health policy" a situation the NHS quickly needs to change. Dr Judith Smith, co-author and Chair of the Commission said, "With care for the frail elderly and emergency out-of-hours treatment at the top of the agenda, the door is open for pharmacists to secure a wider and important role in caring for patients. It won't be open for long, though, and only concerted and determined action from the profession itself can make sure that they don't find themselves shut out."

The report argues that by widening services, pharmacists will claim a role that will allow the health service to better cope with the financial squeeze, while still providing care free at the point of use, and improving access and dignity for patients.

The report calls on NHS England and the Department of Health to include pharmacy in plans for the future of out-of-hours and urgent care, public health and the management of long-term conditions. They must also allow pharmacists to contract individually or as groups rather than through employers, and funding must also shift from dispensing and supply to include provision of new services.

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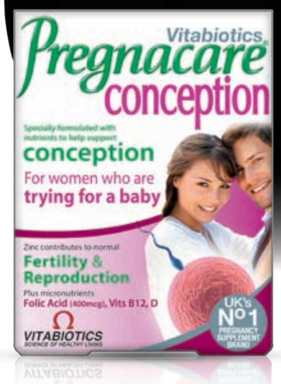

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1 L Brough, GA Rees, MA Crawford, RH Morton, EK Dorman (2010) Br J Nutr. 2010 Aug;104(3):437-45
† Professor Beckett is not cited in the capacity of a health professional, but as a product inventor and former Chairman of Vitabiotics.
††Based on a survey of 1000 midwives. For more information on this research, please visit www.pregnacare.com/mostrecommended
* UK independent sales value data (IRI 52 w/e 13 Jul 13)

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From the editor

No longer the humble pharmacist …

A report from the Royal Pharmaceutical Society's Commission on Future Models of Care has called on the NHS to enable pharmacists to expand their role to include "care-giving" *(see front page)*. Well, it's about time.

In the late 1990s when I worked in New York on *American Druggist* and *Drug Topics*, two leading pharmaceutical magazines, American pharmacists had already established careers working with patients to manage long-term conditions. American pharmacists delivered pharmaceutical care which meant working with patients to help them to better manage asthma, diabetes, being overweight and other challenging health conditions that had led to out of control health spending for the American health system. Pharmacists were paid for doing pharmaceutical care and the outcomes they achieved kept their patients out of hospital and enabled them to go to work and enjoy their lives because their health improved. For the employer-sponsored health plans, who paid the bill, another benefit was that commissioning pharmacists to provide pharmaceutical care reduced their drug and overall health spend.

So, why shouldn't that happen here? What's to prevent commissioners from commissioning pharmaceutical care from pharmacists and pharmacies? In some areas of the country there are already isolated examples of pharmacists extending their role to work with other health professionals. Some visit frail elderly people after they are discharged from hospital, helping them to manage their conditions without having to go back into hospital. Pharmacists are also providing a range of services including vaccination, management of anticoagulation for people at risk of stroke, and quit smoking programmes. But as the Commission's report points out, these examples of pharmaceutical care need to be more widespread and extended in scope.

Commissioners who are innovative – that should be everybody – need to look at the benefits of recruiting and paying pharmacists to do a lot more than dispensing pharmaceuticals. Dispensing is a vital role but let's also learn lessons from the Americans. They have gone beyond dispensing and have been commissioning pharmaceutical care from pharmacists for decades. Isn't it time for us to catch up?

Norma Beavers
Editor, *Primary Care Today*

> **"We know we need to put the patient at the heart of the healthcare journey, rather than our historic processes dictating the course of that journey"**
> **See page 14**

> **"The new proposals are a part of the Government's wide approach to fixing the health care system, with the stated aim to help end patients suffering disjointed health care and social support services"**
> **See page 24**

> **"We don't know whether this diet will put Type 2 diabetes into remission in the long term. Even more fundamentally, this kind of diet is certainly not an easy option or a quick fix"**
> **See page 26**

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Skype consultations could miss the mark on confidentiality

Plans announced by the Prime Minister and the Health Secretary for GPs to pilot the use of Skype and other technologies may hit legal problems

Using Skype to get face time consultations with patients may not be a viable option for GPs, said Dr Shane Gordon, Chief Officer, North East Essex Clinical Commissioning Group. A better option may simply be to use the telephone, he said.

GP surgeries have already pioneered several types of telepresence but Skype has the potential to lead to court battles, said Dr Gordon. "Skype has particular information governance challenges because the servers for Skype are hosted in the States. The information that is transmitted is not secure within the boundaries of the sovereign jurisdiction of the United Kingdom and therefore our information governance advice is that Skype is not suitably secure for the transmission of confidential data," Dr Gordon told *Primary Care Today*.

"Telephone consultation has a well established evidence base and telephones are pretty universally accessible, cheap and easy to use. I'm not sure Skype is a magic bullet but having done email consultations myself they have a place, and a role. It's relatively limited and it's limited to relatively binary requests such as repeat prescription requests," he said.

Using Skype could put GPs in danger of breaching patient confidentiality and that could lead to legal challenges about information governance issues, he said. While a move towards experimenting with how Skype can be used may be "in principle the right thing to do" there are some issues that need to be overcome to make Skype a real solution at scale. A further issue with using Skype for contacts with patients is whether the technology will actually allow GPs to see more patients or whether it will actually save GPs' time, he said.

The pilot scheme was announced last month by Prime Minister David Cameron and will see GPs in nine areas work a seven-day week including out of hours and weekends. The GPs will test the use of Skype, email and telephone consultations for some patients who find this type of access easier. Ministers want to use the pilots as the first step to rolling the scheme out across the country and they are encouraging hundreds of GP practices to adopt the new seven day a week schedule. Mr Cameron said, "Millions of people find it hard to get an appointment to see their GP at a time that fits in with their work and family life. We want to support GPs to modernise their services so they can see patients from 8am to 8pm, seven days a week. We also want greater flexibility, so people can speak to their family doctor on the phone, send them an email or even speak to them on Skype."

Telephone consultation and triage has been used effectively by GPs under The Stour Access System. GPs are able to deal with 50% of patient queries immediately on the telephone and triage appropriate face to face reviews, visits or surgery attendances for the remainder of cases. The Stour Access System enables GPs to use the telephone to manage a higher number of patients per partner without the use of Skype.

Nasal spray flu vaccine prepares to go national

The new flu vaccine for children has sparked parental concerns about the use of gelatine in pharmaceuticals but that will not halt a national rollout of the immunisation programme in 2014. Parents meantime remain free to decide whether the flu vaccine is right for their children

After some delays due to concerns about gelatine in its formulation, GPs, practice nurses and school nurses are administering Fluenz, Live Attenuated Influenza Vaccine, AstraZeneca's nasal flu vaccine. Targeted in pilots at children aged two to three and four to 10 years old the get ready for winter pilot scheme is being conducted across seven areas and is due to end mid-January. The aim is for the pilots to pave the way to offering the flu vaccine on a much wider scale nationally by September 2014 for children aged up to 17 years.

But some vegetarian and Muslim parents say the new vaccine is not right for their children because they do not approve of the use of animal products such as gelatine in the formulation. Some education is going to be necessary for parents, said Sharon White, Professional Officer at the School & Public Health Nurses Association. "It's going to be quite a public health challenge for health professionals and we still have some work to do with parents and carers because of the number of changes to the childhood vaccine programme," she said.

The immunisation pilots have been coordinated by Public Health England and NHS England and are testing different ways of implementing the immunisation programme nationally. White said, "In some of the pilots the vaccine is being delivered by school nurses, at others by pharmacists, or immunisation teams. The aim is to explore what works and what does not work. What is efficient and what is going to be safest."

Concerns about gelatine in the vaccine have been calmed in Muslim and Jewish communities, she said. "Parents have been assured that the porcine gelatine in the vaccine is highly purified and as with other vaccines it's used to stabilise the live viral vaccine. The Imams and Rabbis have said it is not of concern on the grounds of faith issues," she told *Primary Care Today*.

Rabbi Abraham Adler from the Kashrus and Medicines Information Service, said according to Jewish laws, there is no problem with porcine or other animal derived ingredients in non-oral products. This includes vaccines, including those administered via the nose, injections, suppositories, creams and ointments.

Dr Mary Ramsay, Head of Immunisation at Public Health England, said the advice to parents is to protect their children from flu by accepting the nasal vaccine. "We strongly recommend that anyone whose child is offered immunisation accepts this opportunity to give their child the best protection possible against the flu virus. This large programme has potential to protect children against the severe complications of flu and to reduce spread to more vulnerable people such as young infants, pregnant women, and those with underlying medical conditions," she said.

The influenza virus strains in Fluenz have been genetically altered so they are:

- Cold-adapted – the LAIV stimulates the immune system at the point where it enters the body; ie the nose, where cooler temperatures are found.
- Temperature-sensitive – the vaccine cannot infect the lungs or other areas where warmer temperatures exist.
- Attenuated – so it replicates to provoke a full immune response, but does not cause influenza to develop.

Children receive the vaccine as a divided dose in both nostrils. They can breathe normally while the vaccine is being administered – and there is no need to actively inhale or sniff. White said, "Because Fluenz is given as a nasal spray into the nasal mucosa it does not go down into the respiratory system so it cannot cause flu." Some children will have a slight reaction to the vaccine, others will have no reaction to it at all, she said.

Among the very common and common side effects of Fluenz LAIV are: runny or stuffy nose, reduced appetite, weakness, headaches, fever or muscle aches. LAIV is contraindicated in children who have hypersensitivity to eggs or egg proteins, gentamicin, or any of the excipients of the vaccine, such as gelatin.

The vaccine is also contraindicated in children who are immunocompromised and should not be given to children who have severe asthma or active wheezing, she said. Similarly it should not be given to children and adolescents under 18 years of age who are taking salicylates.

Explaining the logic behind the immunisation programme White said, "It is absolutely vital for children to have this vaccine because then we will have the benefit of protecting the whole community. If we look at the evidence of our elderly and other at risk groups who get flu every year, we have a lot of fatalities still. Giving children the flu vaccine will not only protect them and also their at risk peers but will also give much wider protection, because there are children who don't blow their noses very well, don't wash their hands very well, and who will snuggle up to grandma or granddad when they are not very well. So it's a great vaccine in terms of being a protection for the whole of the population."

Disadvantaged to get online support with Tinder Foundation

By Norma Beavers

People who are digitally excluded and suffering from health inequalities are at the centre of Widening Digital Participation, a new programme set to go live by next April. The programme, which is funded by NHS England, aims to include people aged 65 to over 80 who are classified from a health inequality point of view as people who need to access health information and support online. NHS England believes half of all people who have little or no digital experience have a disability, and among those over age 65 years – who account for half of all NHS spending – 36% have never been online.

NHS England plans to help make online access universal by working with the Tinder Foundation, a Sheffield based digital technology social enterprise. Tinder Foundation has a proven track record – it has already used its UK online centres' network to work with Sheffield City Council, Jobcentre Plus, Citizens Advice and The Pensions Service on an innovative project in Sheffield that has increased awareness of the benefits of going online to connect with public services.

Working with NHS England the Tinder Foundation is now aiming to reach 100,000 or more people who don't usually have access to computers, giving them the chance to learn how to use a digital network to access information that can help them to improve their health and wellbeing. The target group includes the homeless, people over age 65, gypsy and traveller communities and sex workers.

The £1 million programme will see the Tinder Foundation use its existing UK online centres network to develop a Digital Health Information Network as well as coordinate over 200 events across the country to break down barriers to who goes online. Helen Milner, Chief Executive, Tinder Foundation, told *Primary Care Today*, "We are not reinventing the wheel. We are not making another health website but we are using NHS Choices and other not for profit health information sites as well … We will put in a course so the look and feel is similar for people who are learning about emailing, e-shopping or banking online. They will have as part of their user experience online, a course about how to stay healthy."

As part of the project, she said, "We'll be creating new learning content, including growing the learning portal at www.learnmyway.com/health and working with key groups including the Society for Chief Librarians on bespoke learning content. We have a three-tiered approach and we can hit the ground running and get moving very quickly because we have this network of 5,000 partners already in place."

The approach will see Tinder Foundation and its partners using its health information portal as well as a free online course about health and staying healthy. A group of about 500 partners will develop specific activities including 200 events geared towards getting people who are disadvantaged online. Milner said 15 or 16 flagships will also work with Tinder Foundation "to help us to reach particular target groups or test particular technologies".

One of the flagships is St Mungo's Recovery College, London. St Mungo's works with homeless and formerly homeless people, some of whom have multiple needs including physical, mental health and substance misuse support needs. St Mungo's offers them a chance to go to its own Recovery College to "learn, grow, inspire". St Mungo's courses range from personal development; health and wellbeing; to acquiring skills, creativity and learning IT. Milner said Tinder Foundation will work with St Mungo's so that more people use online resources and other health related services to achieve a holistic sense of how to improve their health.

Beyond St Mungo's and public libraries Tinder Foundation's 5,000 partners include development trust associations, social housing providers, village halls, places of worship, cafes, fish and chip shops, laundrettes – just about anywhere that people go to. Milner said, "Our project is about widening participation. The ambition is that digital can be an amazing force for good in the managing of one's health. There are 18 million people who have never used the internet and there are 11 million who don't have basic digital skills. NHS England is working with us to realise its responsibility to make sure people who are currently digitally excluded have a chance to access the real opportunities that digital brings."

Carers need more than 15 mins for elder care

> **"We simply cannot go on treating older people like this. There is no dignity"**

Commissioners and local authorities must revolutionise care services for the elderly but it may take "a catastrophe" to achieve it, said Gary Farrer, Managing Director of SureCare, a company which operates 27 care franchises with three branches across England. Farrer is critical of care contracts which try to restrict home visits to a maximum of just 15 minutes. He said, "In some areas, you are doing well if you receive a 15-minute visit. Budgets from central government are so tight that some local authorities follow a policy of minute by minute bookings in order to save as much money as possible."

One result is that carers work in their own time "to give that little bit extra" but even then "they are having to follow a ridiculous schedule which means some elderly people having to wait for their breakfast until midday and others who are being put to bed at 6pm." Farrer said, "We simply cannot go on treating older people like this. There is no dignity."

He continued, "Rather than squeezing budgets, we should be investing in care of the elderly like other countries do. There also needs to be a cultural change in how we view older people. They should be seen as being precious rather than a nuisance. We should be learning from their wealth of experience. It is a huge shame that when you hit retirement age, the next step is seen to be death."

Instead of working to restrictive care contracts SureCare has opted to move away from providing purely domiciliary care services and is expanding into childcare, respite care and providing home services to carry out a full range of household tasks, he said.

The UK is facing a "care time bomb," a world in which more and more people will be working until they are 75 and living past age 100, he said. "Our carers tell us that, more often than not, what elderly people want more than most is time. I think we are starting to see a shift back towards the importance of community. Even the supermarkets are picking up on this trend and opening smaller, more community-based stores in towns.

"Local authorities must rethink the current approach to care contracts despite tight finances," he said. "They make sure the buses run on time and our bins are emptied, but they are happy to allow people who have given great service to this country to receive care visits of just a few minutes a day.

We need a government to be bold enough to find the extra investment needed to give our elderly the dignity they deserve but, alongside this, we also need a change in attitude."

The rush is on as digital libraries take off

Medical librarians are embracing digitisation to help translate research into meaningful knowledge so clinicians and managers make decisions based on the best and latest evidence base

By Wayne Sime

When I joined the Royal Society of Medicine in 2006, a year before the Kindle was invented and four years before the iPad dominated the tablet market, the Society's library was a very different place. Footfall was low, books and journals could take an age to locate as library staff and members needed to use card catalogues to retrieve items. Librarians could often take days to deal with more complex requests and often when they were able to provide the information, books from the historical collection were found in varying states of deterioration.

Fast forward just a couple of years and despite gradually replacing hardcopy books and journals with electronic versions, the wide reaching impact of commercial eBooks and tablets meant that our members, mostly made up of busy junior doctors and senior clinicians, were becoming frustrated that clinical reference material was not more readily available in a digital format to help them in their daily role. In addition, the RSM was reputed as the largest provider of Continuing Professional Development (CPD) training in the UK and it was our duty to ensure that members could find the training materials they needed in order to continue practising.

As with virtually every other aspect of their lives, members wanted content to just be there, with no blockages or difficulties. Whether that was in the hospital setting on the ward or even at home while doing research, medical professionals needed information as quickly and as easily as possible.

SO WHAT NEXT?

However, we faced the same challenges and questions as the many NHS organisations looking at the implications of digitisation. Would the building still be needed if almost everything was online? How would the role of the librarian change? Was going electronic really affordable?

With the library being one of the major reasons our 21,000 members joined the RSM, irrespective of our concerns, the demand could not be ignored. We knew that it was imperative that we did not just become a medical archive and a new strategy was developed, which made digitisation a key strategic priority. The outcome has been astonishing. The implementation of electronic resources, including recent products such as ClinicalKey, which has seen more than 3,000 journals including *The Lancet* titles and around 1,500 books accessed directly online, has increased the footfall through the library dramatically. In fact in 2006, 16,000 people came through our doors, and this year we are expecting over 30,000 visitors. Not only is this a record number of visitors for the library but also satisfaction rates for the library service are at an all-time high.

> **"As with virtually every other aspect of their lives, members wanted content to just be there, with no blockages or difficulties"**

KEEPING PACE WITH CHANGE

But why has providing information electronically had such a positive effect on the organisation? The amount of information that clinicians need access to is constantly changing and increasing. The vast amount of clinical trials, patient data and new drugs available combined with patients who are much more informed about their conditions, means that clinical reference material is becoming much more complex and readily available in greater quantities.

Clinicians struggle to keep on top of this using books and journals alone and often if they are not provided with an easy option, they will turn to the likes of Dr Google as a last resort. This can be problematic for clinicians in identifying whether the information they come across is really trusted and whether they feel confident that they are using the right information to make decisions, which may ultimately affect a patient's life.

It is because of this that medical librarians are becoming even more relevant and important to clinicians. Many clinicians struggle to find the answers that they need and require training and assistance in searching databases to find research evidence to answer clinical questions. In many ways, the librarians' role is increasingly moving towards becoming a trusted adviser, providing the collective ability to integrate services and practices into teaching and learning processes.

One day a medical librarian might help a doctor to find guidance for treating a rare condition, the next a manager might ask for evidence to support a staffing decision. Either way the role of the medical librarian is vital in helping to obtain and translate research into meaningful knowledge to ensure that decisions are made based on the best and most up-to-date evidence possible.

ON THE NHS FRONTLINE

Digitisation is also changing the role of the medical librarian and extending their remit beyond the walls of the physical space, moving the information to the clinician's workplace as opposed to waiting for them to come to the library – something that many healthcare professionals might increasingly struggle to find time to do. Librarians have the opportunity to become part of the frontline, which can be incredibly rewarding in seeing how patient care has been improved as a result of their role.

We see that digitisation is simply a way of enabling medical librarians to cope with the increasing demand on them to provide more information to the people who need it most, often using less resource. This challenge is likely to become even more prevalent as the financial strain on our NHS continues. As for the expense, we are reaping the benefits of using electronic resources. Our librarians are able to use their time more effectively as there is far less laborious searching for information. Although we continue to grow our content, we no longer have to worry about where new books and journals will be housed and are able to provide our members with enhanced working spaces. There will be less need to replace older books that are in poor condition and we are providing far greater access to our members at the same cost to them, as multiple people can view clinical reference material simultaneously.

By the beginning of 2014, we expect all our journals to be electronic. We anticipate footfall continuing to increase and have no doubt that the library will continue to evolve as the NHS faces more challenges and technology advances. For now, we are confident that the changes we are making are supporting the medical professionals of today in the best way possible.

- *Wayne Sime is Director of Library Services at the Royal Society of Medicine.*

Expert medico-legal guidance

Euro e-cigarettes ruling holds off licensing fears

Euro MPs say electronic cigarettes should not be licensed as medicines, a decision that could overturn MHRA's decision to introduce licences for e-cigarettes in the UK by 2016

By Andrew Carapiet

Users of electronic cigarettes in the UK are celebrating a crucial EU vote which decided against treating e-cigarettes like medicines and giving these products a reprieve from having to seek a medical licence for the time being. Euro MPs voted to reject an EU proposal to force e-cigarette manufacturers to apply for a medical licence, in line with pharmaceutical products such as nicotine replacement therapies, for their continued use.

This crucial vote threatens to overturn a UK decision by the MHRA (Medicines and Healthcare Regulatory Authority) to introduce compulsory licensing of these products as medicines by 2016. This means that e-cigarettes, currently unlicensed and freely available throughout the UK, Europe and worldwide, will continue to be available to their rapidly expanding army of fans, commonly called "vapers".

The short but turbulent history of electronic cigarettes is littered with regulatory battles and arguments, involving NICE, the MHRA and the European Union, as well ECITA (the trade body for e-cigarette manufacturers) and the tobacco industry. The regulatory environment keeps changing, but what is clear is that European law will almost certainly override UK legislation on any decision regarding these products, while the UK remains within the EU. Earlier this year, the MHRA announced that it would be forcing e-cigarette manufacturers to apply for a medical licence for their products, in line with pharmaceutical products, legislation which was supposed to be introduced by 2016. This vote by Euro MPs against the recommendations of the EU Commissioner, threatens to overturn and overrule the UK decision.

Unlicensed e-cigarettes have achieved a meteoric rise in use and popularity, over the last five or six years. Electronic cigarettes were actually invented 50 years ago, in 1963, but were first seen in any significant numbers within the UK in 2007. In just six years their use has increased to 1.5 million "vapers" in the UK alone. City analysts estimate that global sales of e-cigarettes reached $2 billion last year (2012) and will hit $3 billion this year (2013). This is still tiny compared with global tobacco sales, which are estimated at $700 billion per year.

E-cigarettes are tobacco-free, battery-powered devices which are designed to look like cigarettes and when inhaled, deliver nicotine to the user without tobacco and when exhaled, emit water vapour, which looks like smoke – to mimic a conventional cigarette. They come in different shapes and sizes, cost around half the price of conventional cigarettes and are available from stand-alone e-cigarette shops, corner shops and newsagents, kiosks and online.

E-cigarettes are currently unregulated (compared with conventional cigarettes which are subject to strict regulation surrounding their use and promotion within the UK and Europe). However, on June 12th 2013, after a Public Consultation and the issuing of NICE Guidance, the Medicines and Healthcare Regulatory Authority, which is responsible for assessing the safety, quality and efficacy of medicines, announced its intention to regulate these products as medicines. This change was expected to come into effect by 2016, until a vote by Euro MPs on October 8th 2013 rejected similar proposals by the EU, which meant that e-cigarettes would retain their unlicensed status.

NICE held a Public Consultation last year, between October and December 2012 "to help people who cannot stop smoking in one step" ie heavy smokers. The MHRA's recent announcement would have allowed e-cigarettes which are currently on the market to continue being sold "unlicensed" until the proposal to treat them as medicines and effectively licence them as medical products was introduced in Europe by the European Commission's Tobacco Products Directive. This was expected to be adopted by 2014 and come into effect in 2016, but recent events in Brussels have thrown all this into doubt.

E-cigarette manufacturers claim that licensing their products as medicines would cost millions of pounds and put them out of business, denying users the chance of quitting smoking more harmful conventional cigarettes. They claim that 99% of their users are smokers, heavily addicted to nicotine, who cannot quit smoking conventional cigarettes through nicotine replacement therapies, such as gum, patches or sprays. They claim that their products are far less harmful than conventional cigarettes, because they do not contain tobacco, and effectively offer users a lifeline which would otherwise be denied them if these products were taken off the shelves by over regulation.

The charity ASH (Action on Smoking and Health) originally welcomed the MHRA's decision, which it effectively lobbied for, because it wanted to bring these products into the same regulatory framework as nicotine replacement therapies, which are now sold over the counter in pharmacies and supermarkets. However its response to the Euro MPs "No" vote was downbeat. Its Chief Executive, Deborah Arnott, blames tobacco industry lobbying for Euro MPs rejecting their own Commission's recommendation – "Despite unprecedented levels of lobbying by the tobacco industry to undermine the (Tobacco Products) Directive it is gratifying that MEPs stood firm on many of the key measures. We now urge the Council, the Commission and the Parliament to strongly defend the Directive in ongoing negotiations." This would appear to mean that ASH is hopeful that ongoing negotiations will turn around this decision on e-cigarettes when the Commission next votes on its Directive.

In the UK, the MHRA seems resigned to being overruled by Europe and having its June decision overturned by EU law – if and when it arrives. However, in response to the EU announcement, MHRA would welcome voluntary applications for medical licences by e-cigarette manufacturers and would be happy to consider them. This seems extremely unlikely given that ECITA initiated a petition to Euro MEPs "to ensure that electronic cigarettes are classified correctly as General Sales Products and regulated appropriately for recreational purposes, rather than seek to define vaping as smoking, tobacco use or medical therapy".

The views of notable public health experts are interesting. Clive Bates, a former Director of ASH and Professor Gerry Stimson, an Emeritus Professor of Imperial College, London, believe in "tobacco harm reduction" and make two major points – namely that nicotine itself is not harmful, it is merely a stimulant, like caffeine – and that if there are safer ways of obtaining nicotine, ie without smoking tobacco, such as e-cigarettes, these should not be effectively banned by over regulation. They also believe that any strategy which either gets smokers off conventional cigarettes, or reduces the number they smoke, is a good thing.

Finally, what about the public? Within six years, e-cigarette use has accelerated to 1.5 million users in the UK alone. The vast majority of these are heavy smokers – many of whom have tried nicotine replacement therapies – and are now trying another form of nicotine replacement therapy – e-cigarettes. These "vapers" post videos of themselves vaping online and even have their own TV channel – vapourtrails.tv – run by a former journalist, David Dorn. For some, it is a matter of life and death, with claims that they have tried everything to give up cigarettes and failed and are now turning to e-cigarettes. Many say they would be devastated if e-cigarettes were regulated by the MHRA, or by the EU because they fear that most would disappear due to the high cost of clinical trials necessary for medicinal licences. They mostly reject the idea that these "unlicensed products" are unsafe and untested, because for them, what is most important is that they are tobacco free and nicotine rich – a mix they see as far less harmful than conventional cigarettes.

- *Andrew Carapiet is a contributing medical writer*

Is regulation of herbalists closer?

Statutory regulation of herbal practitioners would safeguard patients from being treated by unqualified herbalists, writes Michael McIntyre

Health issues dominate the headlines and are of major concern to the British public. With the NHS creaking at the seams as waiting lists rise, A&E units overloaded with minor ailments alongside major emergencies and local NHS rationing leading to a treatment postcode lottery, examples of exemplary care are all too often undermined by tales of incompetence and neglect. When the editor of the *British Medical Journal* writes "In the balance between benefits and risks, it is an uncomfortable truth that most drugs do not work in most patients" and calls for "doctors to find what works for whom in what circumstances" it is clear that a serious rethink about the way medicine is delivered is overdue.

At the heart of the debate about what to do is the call for more informed patient choice and, as part of this, public demand for the integration of conventional and complementary medicine – valued for its person-centred, gentle, less drug dependent approach to maintaining health and treating disease. But in this key area the UK has yet to take the final legislative steps that would give patients genuine choice and help relieve pressure on our healthcare system. The Government can do this quite simply by implementing the promised statutory regulation of herbal practitioners, a move long advocated by the Prince of Wales, eminent members of the House of Lords, Department of Health Committees and, more recently, by the Government itself.

This regulation is not at the expense of conventional medicine. It is in the interests of consumers, providing confidence and safety for the millions of people who choose herbal medicine as part of an integrated approach that combines the best of conventional and complementary healthcare.

Research by the Government's medicines' regulator shows around one in 12 people has consulted a herbal practitioner. But without statutory regulation the UK cannot safeguard people from the risks of being treated by unqualified and, at worst, bogus herbalists or buying unreliable remedies online.

There are other tangible benefits too – the choice made by many to seek herbal treatment means less pressure on NHS doctors, nurses and consultants and, a reduced UK drugs bill. At its best, complementary medicine has the potential to help its conventional counterpart deliver more efficient and effective healthcare, a point of view highlighted in a recent speech delivered by Mr Tonio Borg, the Commissioner responsible for European Health and Consumer Policy.

For over 30 years, the Prince of Wales has been a tireless advocate of such an integrated health approach not just in the interests of patient choice but also because it creates a powerful focus on the prevention of ill-health. In these tough economic times, with health budgets squeezed by the increasing demands of an ageing population and the spiralling costs of high tech medicine, the Prince's call for mainstream medicine to forge a closer relationship with complementary therapies has never been timelier. It is in this context that the Prince has consistently urged politicians and healthcare professionals to progress as fast as possible with the regulation of herbal medicine practitioners to safeguard the public.

He is far from alone in encouraging this course of action: the regulation of herbal practitioners has been on the agenda for years. The European Herbal and Traditional Medicine Practitioners Association, a body of UK professional herbal associations, has been working closely with the Department of Health for over 15 years to bring about statutory regulation of herbalists, an objective supported by the vast majority of UK herbalists. In 2000, a House of Lords' Select Committee on Science and Technology called for the statutory regulation of herbal practitioners and since then two Department of Health independently chaired working groups and two public consultations have, like the Prince, all agreed that this legislation is essential.

The Government itself has been similarly convinced of the need for this measure. In 2011 the Secretary of State for Health announced that, subject to usual Parliamentary procedures, the Government would introduce the statutory regulation of practitioners via the Health and Care Professions Council. He declared that the decision to take forward the statutory regulation of herbal practitioners marked a significant milestone.

The Government is to be congratulated on its intent to regulate herbal practitioners but it is now crucial that regulation should proceed as soon as possible. Unfortunately, there seems to be a hold up. The herbal profession has been told that EU legal constraints are a bar to this measure, but independent legal opinion says otherwise. However, as a result of recent changes to European Medicines law, lack of regulation is now undermining the ability of qualified herbalists to do their job.

Because of these legal changes, herbalists must be authorised health professionals (by being statutorily regulated) to continue supplying a range of herbal medicines that have been in use for decades. Now, because of the delay in granting statutory regulation, many patients are without the herbs on which they have come to rely. In addition, many herbal suppliers are being driven out of business or are making staff redundant. This cannot be in the interests of the millions of UK citizens seeking herbal treatment.

Earlier this year the Government's Chief Medical Officer warned that increasing drug resistance to antibiotics is now one of the greatest threats to health. Herbal medicines could prove of great value here as they have a significant potential to treat minor infections sparing the use of precious antibiotics for more serious cases. Moreover, researchers have demonstrated that a combination of antibiotics with plant medicines can enhance the action of antibiotics thereby helping to overcome antibiotic resistance. It can be argued that a regulated profession of expert herbalists would significantly contribute to effective patient care in the UK.

In 2008 Dr Margaret Chan, Director-General of the World Health Organisation (WHO), echoed what the Prince of Wales has been saying for years. She said "The two systems of traditional and Western medicine need not clash. Within the context of primary health care they can blend together in a beneficial harmony, using the best features of each system and compensating for certain weaknesses in each … The time has never been better, and the reasons never greater, for giving traditional medicine its proper place in addressing the many ills that face all our modern – and our traditional – societies."

In the interests of patients, it is now imperative that the Government should introduce statutory regulation of herbal practitioners without further delay.

- *Michael McIntyre is a former President and now Fellow of the National Institute of Medical Herbalists, a member of the Register of Chinese Medicine and of the College of Practitioners of Phytotherapy and Chairman of the European Herbal Practitioners Association.*

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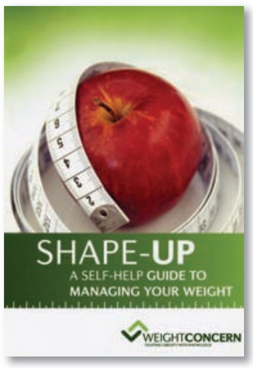

Weight Concern is a registered charity set up to tackle the growing problem of obesity in the UK. It offers a range of services for health professionals including training and education workshops on topics like "obesity" and "raising the issue of weight with patients". It also provides a structured, evidence-based, adult weight management programme called "Shape-Up" which can be delivered as an effective Tier 2 weight management service.

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Patients with LTCs wait years for self management support, finds survey

Patients who have long-term health conditions want advice on what they can do to manage their condition themselves, but nearly 50% of those diagnosed with a long-term condition wait five years or more before being referred to a self management programme, finds a survey conducted by self management uk.

Asked to choose three improvements to their care which would make a difference to their quality of life, 62% of patients said "getting the right advice to support me in managing my condition," 43% said "having a GP that understands the difficulties of living with a long-term condition," and 38% said "healthcare professionals treating me as an equal with a say in my treatment." Of those surveyed, only 16% said "being able to access care outside of usual office hours" and "being able to see my GP more often and for longer".

Over 70% of participants said they had to wait over two years before being offered a place on a self management course, with 48% waiting over five years.

Renata Drinkwater, Chief Executive, self management uk said, "These results are absolutely appalling. They show that patients who could be getting on with improving their wellbeing and better managing their condition are waiting far too long before receiving the support they want and need. We've known for many years that self management improves clinical and psychological outcomes for patients. The case for self management is clear – not only does self management improve patients' quality of life, but it also provides a solution to NHS savings in the short and long term."

self management uk has been working with patients who have long-term conditions for over 10 years and partners with commissioners and clinicians to improve outcomes for patients with LTCs including diabetes, arthritis, and COPD. Drinkwater said, "Although the rhetoric and policy around self management is sound, what we see on the ground shows a different picture. We need a co-ordinated and committed approach to self management where commissioners, clinicians, patients and other health and social care professionals work together to improve access to self management support and training."

> **"They show that patients who could be getting on with improving their wellbeing and better managing their condition are waiting far too long before receiving the support they want and need"**

Self management support can be crucial for patients with long-term conditions and the survey revealed that the majority of patients (60%) either agree or strongly agree that a self management course made a difference to their lives. Drinkwater said patients who self manage can save the NHS billions of pounds. Self management courses have been shown to significantly reduce costly visits to A&E and GP surgeries, freeing up time and resources. Data from the Department of Health shows the NHS could save £452 per year per patient, if it reduces health care professional visits, outpatient appointments; A&E attendances; and hospital inpatient bed days.

CHAIRMAN'S REPORT **By Dr Michael Dixon**

Raise your game – don't play the victim …

The season of mellow fruitfulness was aptly named this year for clinical commissioners and those working in General practice and primary care. It was a season when the changes of the past year began to make a noticeable difference for patients and communities.

Commissioning has been reported as a "minority sport" by one GP newspaper. Yet I know of a clinical commissioning group where 50 out of its 200 GPs are intimately involved in the process of commissioning. Certainly many frontline clinicians need to be involved in commissioning – however peripheral they may be. That is because commissioning – by aligning clinical and financial decisions – provides a connection between the NHS and its frontline clinicians and patients that the NHS never previously had and cannot afford to let go.

It is said that clinical commissioners and CCGs in April entered a party that had already started without them – and with others already having formed their organisations and made up the rules. The approach of winter signals a time for the worm to turn. A high-level meeting at Downing Street with clinical commissioning leaders in early October was symbolic of a CCG upgrade and the beginning of a little bolshiness on the part of clinical commissioning leaders when faced with parts of the NHS system that stop them doing their best for patients.

CCG power is now here to stay and those that want to block the wishes of frontline clinicians and patients will find themselves increasingly isolated and under attack.

The same goes for General practice and primary care. A Cinderella service over the past 10 years in terms of resources and manpower, primary care is also set for an "upgrade" this winter. The Secretary of State has stated that whereas hospitals were his focus last year, primary care and returning the family doctor will be his focus over the forthcoming year. Government has put itself behind General practice, seeing it as the solution to an NHS that is not currently financially sustainable.

On the one hand, GPs are urged to revisit their USP – providing personal care and continuity with better access as family doctors. We know that these things keep patients out of hospital and are valued by them. On the other, General practice is being encouraged to up its game and provide an increasing range of services – some of which were previously provided in hospital.

Expect the winter to see ministers, the Department of Health and NHS England all working to support General practice to widen its remit against all the obstacles that are currently in its way and to get some resources to do this with. General practice will be faced with an important choice this winter and which way it chooses will mark its fate forever.

On the one hand, GPs can play the victim and say that any increased resources are not enough and they are unable to deliver better personal care, continuity and access because of a shortage of manpower and resources in the face of increasing patient demand. Alternatively, as GPs we can see this potentially as the new age of General practice with a vastly extended remit and profile and lead the way to getting more for less by conserving the use of high-tech expensive hospital services. It is going to be a while before the 50% of doctors becoming GPs shows any effect and probably an even greater period of time before the economy makes a substantial recovery.

No one can pretend these are ideal conditions for General practice taking on a leadership role but this may be General practice's last chance to show that it can do more with a registered list, that it has a right to lead the local NHS and that it can solve the whole problem of NHS sustainability.

"If it were best done then it was best done quickly." Many CCGs are already beginning to wonder where to park their community services next. Some are reconfiguring them entirely. General practice and primary care needs to be at the top of the queue for these discussions and ensure that it is given and that it takes every chance to develop its game.

So this winter much is expected of ministers, the Department of Health and NHS England to allow clinical commissioners and General practice and primary care to go full steam ahead. If they deliver on their promises then it will be up to us as commissioners and frontline clinicians to deliver on expectation and create that much talked about "Primary Care-led NHS."

• *Dr Michael Dixon is Chairman, NHS Alliance & President, NHS Clinical Commissioners*

Network drives people-powered changes

By Brian Fisher

The NHS Alliance People Powered Improvement Network has influenced a key NHS England document that summarises for Clinical Commissioning Groups their responsibilities in respect of the Health and Social Care Act.

The network has collaborated to make the document clearer on two main issues:

- That NHS organisations have to be responsive to the populations they serve, not just listen to them.
- That NHS organisations need to be proactive, offering continuous dialogue with their communities and consider community development as part of their work.

The new network is a coalition of 80 members who communicate via email. Members also volunteer to attend quarterly meetings at the Department of Health. Members include large organisations such as the National Institute for Health and Care Excellence (NICE), National Voices and the Centre for Public Scrutiny, as well as clinical commissioning group leaders and individuals – all of whom have an interest, experience and expertise in patient and public involvement.

The network's goal is better and more responsive patient and public involvement practice in healthcare. It aims to achieve this through influence, training and thought-leadership.

There are no formal commitments to the network or any formal expectations of the network.

The independence of members is respected and the network operates through co-operation and consensus.

Members have agreed on three workstreams:

- Responding to Francis from the patient responsiveness point of view. Helping NHS providers, including Foundation Trusts and commissioners, be more responsive to patient views.
- Making the case for patient and public involvement. Mainly the financial case, but also considering how to engage providers and commissioners and NHS England and the Care Quality Commission.
- Creating a more person-centred NHS – greater self agency. A National Support Service that the Alliance should campaign for, focusing on issues such as self-care and shared decision-making. The network has agreed that this should include community involvement as well as individual.

A Community Development Group has also been established by the network. This brings together community development workers, academics and people from Public Health England and NHS England. Policy and ideas that would make it as easy as possible for Clinical Commissioning Groups, Local Authorities and Health & Wellbeing Boards to commission community development are being explored.

• *If you'd like to get involved contact brianfisher36@btinternet.com or georgina@gcraigassociates.co.uk*

NHSCC urges commissioners to shape competition rules

Procurement and competition rules are so unclear that legislation may be needed to curb legal challenges to clinical commissioners' plans to reshape the NHS. But NHS clinical commissioners, a coalition of NHS Alliance, NAPC and the NHS Confederation, is taking the problem on board and has published a report for clinical commissioners urging them to make bold and far-reaching decisions based on their own interpretation of the procurement and competition rules. The report outlines the key issues that need to be fixed so commissioners can work unchallenged, as intended by the Health and Social Care Act.

CCGs must "have the confidence to do what is right for patients and populations and be willing to take risks to achieve the best outcomes," according to the report. It also calls on commissioners to "own and shape the regulations" rather than "slavishly following every clause" in them. CCGs must collectively take responsibility for shaping how procurement rules are interpreted and operated. According to the report "The more CCGs, and those who advise them, take a robust approach to shaping the way rules are implemented, the more the application of new regulations will be shaped by patient need and less open to challenge. Ministers, regulators and providers inside and outside the NHS will find it difficult to criticise or legally challenge a decision demonstrably taken in the interests of local people. CCGs need to assert that this is the right approach."

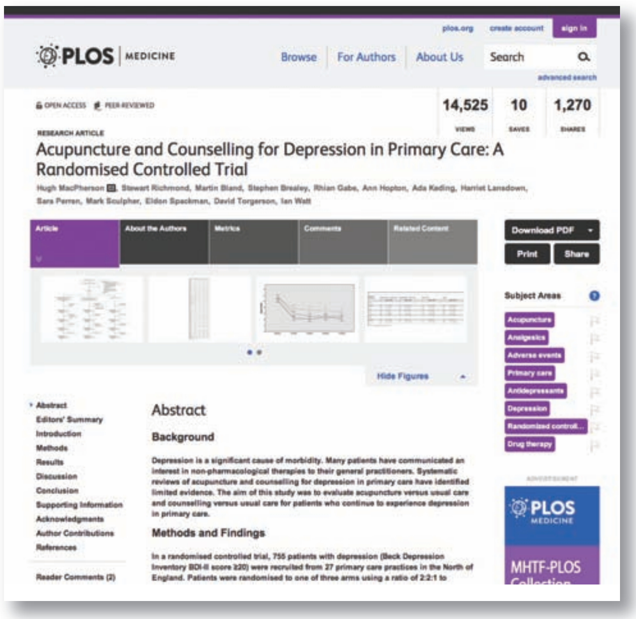
Dr Steve Kell, Co-Chair of NHS Clinical Commissioners Leadership Group and Chair of Bassetlaw CCG, said the procurement system is "an obstacle course that could create real hurdles to reshaping the NHS to meet the challenge of delivering higher quality at lower cost." He added, "We recognise there are a number of practical difficulties within the current system when clinical commissioners try to secure the best outcomes for patients. The rules around procurement and competition often seem like a distraction from – and even an impediment to – improving services and saving money."

Dr Michael Dixon, Interim President, NHS Clinical Commissioners, said, "The recent decision on Poole and Bournemouth Hospitals demonstrates additional layers of regulatory bureaucracy have been imposed on the NHS and commissioners. It is essential that ministers order a rapid review of the new complex interdependencies between competition regulators so that commissioners have the certainty they need to plan for and lead the large-scale transformations and really change outcomes for patients and communities."

Randomised controlled trial of acupuncture and counselling for depression published recently by a team at York University shows significantly reduced depression as measured by PHQ-9 scores, in primary care patients

British Acupuncture Council

A research study using a randomised controlled trial published recently in (open access) PLoS Medicine (http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001518) has concluded that acupuncture measured against the usual care, and counselling measured against usual care, for patients in primary care, and who continue to experience depression show significant reduction in the short to medium term, of their symptoms of depression as determined by Patient Health Questionnaire (PHQ-9) scores.



RESEARCH ARTICLE

Acupuncture and Counselling for Depression in Primary Care: A Randomised Controlled Trial

Hugh MacPherson, Stewart Richmond, Martin Bland, Stephen Brealey, Rhian Gabe, Ann Hopton, Ada Keding, Harriet Lansdown, Sara Perren, Mark Sculpher, Eldon Spackman, David Torgerson, Ian Watt

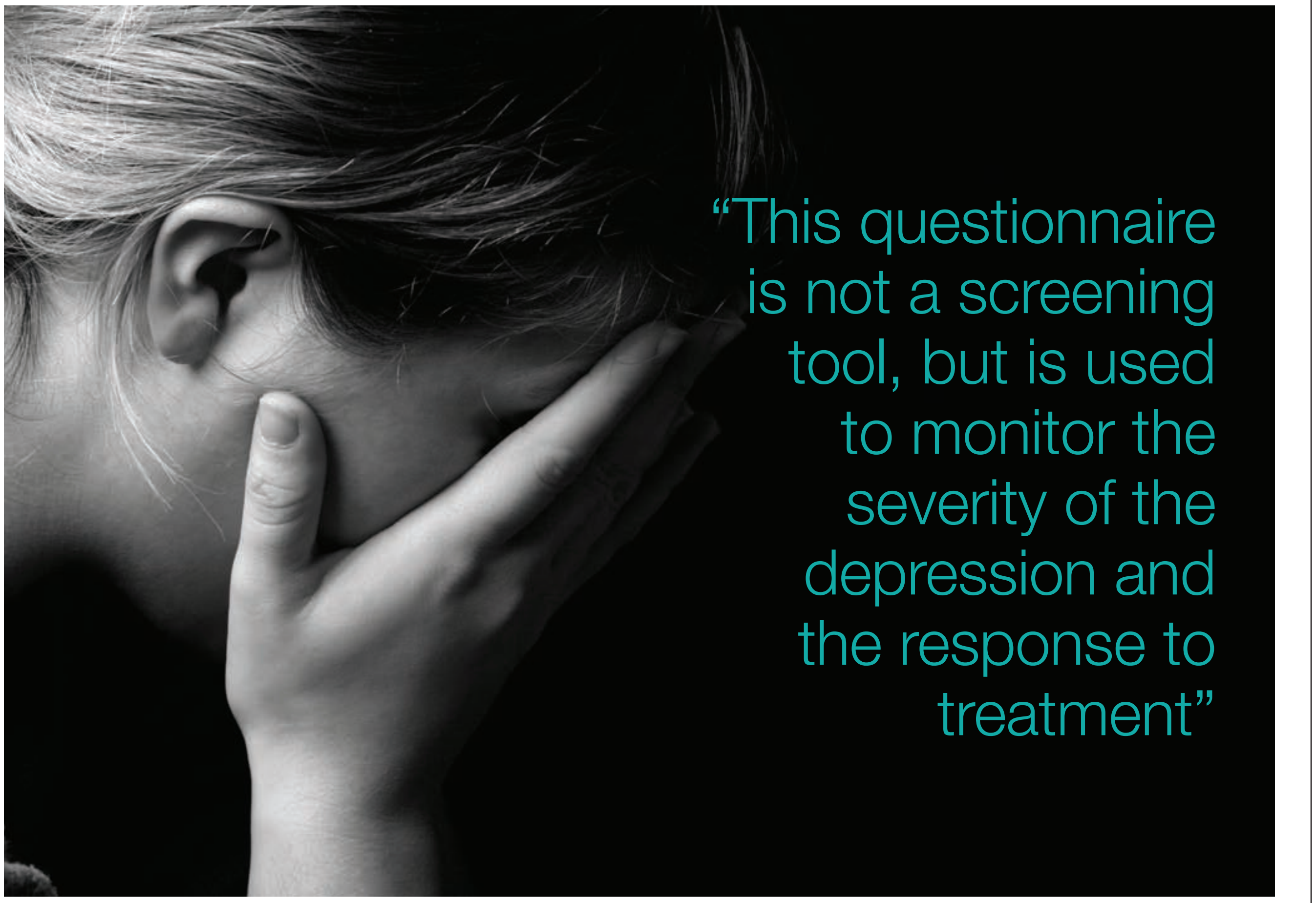
Abstract

Background

Depression is a significant cause of morbidity. Many patients have communicated an interest in non-pharmacological therapies to their general practitioners. Systematic reviews of acupuncture and counselling for depression in primary care have identified limited evidence. The aim of this study was to evaluate acupuncture versus usual care and counselling versus usual care for patients who continue to experience depression in primary care.

Methods and Findings

In a randomised controlled trial, 755 patients with depression (Beck Depression Inventory BDI-II score ≥20) were recruited from 27 primary care practices in the North of England. Patients were randomised to one of three arms using a ratio of 2:2:1 to



> "This questionnaire is not a screening tool, but is used to monitor the severity of the depression and the response to treatment"

The study, was carried out by a team of researchers at the Department of Health Sciences of York University, and funded by the National Institute for Health Research under its Programme Grants for Applied Research Programme. The purpose of the research was to determine both the clinical and cost effectiveness of acupuncture and counselling administered in short-term courses compared to the usual care of antidepressant medication. It is the first study to evaluate in a rigorous manner the clinical and economic benefits of using acupuncture and counselling to treat depression in primary care.

The research was conducted using 755 patients chosen from 27 primary care practices located in the North of England. Patients were selected for the trial from those who had consulted a GP in primary care within five years of the start of the trial, who continued to experience moderate to severe depression, and who achieved a score of >or= 20 using the Beck Depression Inventory.

The trial had three arms, with patients randomly selected in the ratio 2:2:1. The acupuncture and counselling groups each had 302 patients assigned, and the usual care alone group had 151 patients. The acupuncture and counselling consisted of a maximum of 12 weekly sessions. Both the acupuncturists and the counsellors used in the trial were all selected from recognised professional bodies. In the case of the acupuncture practitioners they all had at least three years' clinical experience, and were registered with the British Acupuncture Council. They adhered to a treatment protocol that allowed for customised treatments within a standard theory structure based on traditional acupuncture principles.

The primary outcome was measured using the Public Health Questionnaire (PHQ-9). This questionnaire is not a screening tool, but is used to monitor the severity of the depression and the response to treatment; It scores each of the 9 DSM-IV criteria. If scores over 10 are observed, this would indicate moderate depression, and scores of 9 and below, mild depression. The complete range of scores range from 0 to 27. Patients were given the questionnaire at three months, with a follow-up at 12 months. The scores of the acupuncture and counselling groups did not show a significant difference, but when both interventions were compared alongside the usual care there were significant statistical benefits at three months, with scores for example in the acupuncture arm of 9.4 versus 12.7 respectively. There were in addition, significant benefits seen over the 12-month period taken as a whole.

The trial had both strengths and limitations. It had a practical research question based around a trial design that based its model on what would happen if acupuncture and counselling referrals were routine. The randomised controlled trial was a pragmatic one with an emphasis on being able to be validated externally, and using typical patients and settings. However, pragmatic trials do not lend themselves to revealing much about assessing the benefits or otherwise of the different characteristics of the interventions used in the trial. But given this limitation the trial as a whole provides an estimate of the overall effects of the interventions, and which is of most interest to patients, practitioners and providers. The standardised treatment protocols for the acupuncture arm were designed to reflect what occurs in routine practice, and allowed for individualisation to meet patient variability.

The research has implications for clinical practice and future research. The trial provided evidence that patients who receive acupuncture and counselling compared to the usual care alone show, in the short to medium term, a significant reduction in the symptoms of depression. Furthermore, acupuncture and counselling are not associated with serious adverse events. The research team suggests that further research into both treatment regimens and a more thorough economic analysis of the cost benefits of each treatment are required to reveal the most cost-effective option.

Although acupuncture is used to treat depression, it is not common to see it provided within the mental health or primary care systems. Patients are keen to discuss the possibility of alternatives to antidepressant medications, with their general practitioner, so in this respect this trial is very welcome, and provides a significant start in publicising the possible benefits of acupuncture in the treatment of depression.

In addition to this, acupuncture has also gained the recognition of NICE in recent years, for the treatment of non-specific back pain in 2009, and in 2012, as a prophylaxis for migraine and tension headaches. The team at York has also published a study recently making use of a systematic review of 114 eligible studies on the use of acupuncture compared with a range of other physical interventions for treating pain associated with osteoarthritis of the knee. The conclusion was that acupuncture can be considered as one of the more effective physical interventions for this condition.

The British Acupuncture Council has over 3,000 members, and is the largest professional body representing traditional acupuncturists in the UK. All members have received a three-year degree level training that includes the relevant western biomedical training to enable them to correctly identify the need to refer to a medical practitioner.

Details of local registered British Acupuncture Council members can be obtained from the BAcC website at: http://acupuncture.org.uk/component/quickfap

Momentum builds for radical transformation of health and care


Rick Stern

The momentum for transformation, particularly in primary care, has never been stronger. Patients, providers, commissioners, and policy makers all need to rethink what we mean by healthcare as an ever larger proportion of the population engages with services regularly – particularly those services that are, or should be, delivered closest to the patient in primary care

By Rick Stern

These are undeniably testing times for providers and commissioners alike as we find our feet working together in completely new ways. Money is tight and getting tighter, and yet the pressure for ever greater quality at ever lower cost continues to intensify as we all get to grips with the new world of clinical commissioning.

Dr David Bennett, Chief Executive of Monitor, has said that even if we all work to our maximum capacity and efficiency – squeezing every last drop of effort and value from our people and our resources – we'll still only be able to find about two thirds of the savings we need to make in the long term to ensure a sustainable, free at the point of use NHS. For clinicians and managers doing the heavy lifting, these are grim words indeed; if not exactly a surprise. Certainly this warning chimes with what our members are telling us, particularly those in General practice, many of whom are under pressure as never before. They feel that they have no option but to find safety in numbers, in federations or other vehicles for bringing together groups of practices. And, whilst this is no doubt the latest phase of a long-term trend, it's not without its complexities and consequences for those involved. I scarcely need to add that it's just another thing that distracts from the number one priority of providing excellent patient care.

So what's the solution? We've known for a long time that we need to start doing things differently. We've known for a long time also that the pressure of demographic changes, allied to the emerging long-term challenges of conditions such as obesity and diabetes in the young and middle aged, will eventually break our service if we don't come up with a better, fit for purpose approach. We know we need to put the patient at the heart of the healthcare journey, rather than our historic processes dictating the course of that journey. It's like climate change; we know what we must do, but when are we going to face up to actually doing it? Most experts say something really bad needs to happen – a climate induced natural disaster – to shock us into action. It actually feels for many of us in the NHS like we are staring into the abyss right now. Maybe this is why the momentum for transformation, particularly in primary care, has never been stronger.

It's widely expected that clinical commissioning, once the CCGs have really bedded in, will be a key driver of this necessary transformation; but we can't expect that alone to be sufficient. Patients, providers, commissioners, and policy makers all need to rethink what we mean by healthcare as an ever larger proportion of the population engages with services regularly – particularly those services that are, or should be, delivered closest to the patient – which is another way of saying primary care. Here are some of the questions that we need to consider as a matter urgency; some of them seem to have been around for a very long time now, some address the very cutting edge of primary care thinking:

How can we genuinely listen to, and effectively use, patient feedback to improve care – and how do we keep doing it?

- How can we ensure that services follow the patient and not vice versa?
- How do we ensure that primary care can offer an excellent and trustworthy 24/7 service that doesn't depend on A&E – and persuade people to use it?
- How can we make access to GPs less onerous for patients?
- How can we reduce unscheduled admissions?
- How can we keep people out of hospital beds when they would be far better off at home?
- How can we get expert services out of hospitals and into the community?
- What services can be more effectively delivered outside of the surgery or the hospital?
- How can we effectively integrate health and social care?
- How can we break open obstructive professional and institutional silos?
- Should everything be free for everyone, every time?

Our Annual Conference this year focuses precisely on this urgent need to transform and integrate primary care in England. We've been listening closely to our members – particularly those from smaller practices, not for profit providers and smaller CCGs – and we have taken the decision to reconfigure the annual conference as a one-day summit, rather than the traditional two-day event.

We know many simply can't afford two days away from the business of caring for their patients, especially when there is so much more additional management to contend with as new systems and working relationships take shape.

We also know that many need to keep a very close eye on their management budgets, and so we aim to deliver much of what our delegates have come to expect from this much-loved annual gathering, but at a much lower cost.

> **"We know we need to put the patient at the heart of the healthcare journey, rather than our historic processes dictating the course of that journey"**

As you would expect, Breaking Boundaries features all the key movers and shakers in primary care including:

- Rt Hon Jeremy Hunt, MP, Secretary of State for Health
- Rt Hon Stephen Dorrell, MP, Chair, Health Select Committee
- Liz Kendall, MP, Shadow Health Minister
- Ben Dyson, Director of Primary Care, NHS England
- Professor Steve Field, Chief Inspector of General Practice, Care Quality Commission
- Dr Robert Varnam, CCG and Primary Care Capacity and Capability Programmes, NHS Improving Quality
- Prof Aidan Halligan, Director of Education, University College Hospitals NHS Trust
- Jeremy Taylor, Chief Executive, National Voices
- Dr Michael Dixon, Chair, NHS Alliance & President, NHS Clinical Commissioners
- Dr Charles Alessi, Chair, NAPC & Chair, NHS Clinical Commissioners
- Dr Maureen Baker, President Elect, RCGP
- Dr Chaand Nagpaul, Chair, BMA General Practitioners Committee (GPC)
- Dr Peter Swinyard, Chair, Family Doctor Association
- Dr Claire Gerada, Head of Primary Care Transformation, NHS England, London Region
- Ruth Carnall, Adviser to the Mayor of London on Health
- Roy Lilley, Health Service Commentator

In addition to this excellent array of speakers, we have no less than 10 afternoon workshops, three lunchtime meetings and a breakfast meeting with NHS England, all of which will try to answer the questions posed above, and we hope, many more. For the first time ever the delegate entrance fee includes an invitation to our networking reception at the end of the day. Breaking Boundaries is being held in parallel with NHS England's regional meeting on transforming primary care in London, which is taking place in the afternoon at Dexter House, 2 Royal Mint Court, London EC3N 4JR.

Once again the NHS Alliance is in the vanguard of powerful roots-up movement to create a radically new primary care service, which preserves the best of our heritage, whilst at the same time releasing the power of some much needed creative destruction. However, as primary care is in the spotlight and under scrutiny as never before we know that a strong, collective voice for those providing services at the front line has never been more important. The NHS Alliance has long taken that responsibility, and we are well placed to continue to do so effectively, as we remain an important touchstone for government; a critical friend, often robustly so, with the capability to influence policy and the long-term development of primary care. Importantly, we see our role as speaking for providers beyond what is traditionally seen as primary care – the General practice – offering our support to colleagues in community care, housing, community pharmacy, the eye and dental care sectors and beyond.

If your day-to-day role is caring for people or supporting the health and wellbeing of your community, we can, and will, speak for you. Join us to see the future of primary care at Dexter House on 28th November.

- *Rick Stern is Chief Executive, NHS Alliance*

Care delivery groups – a model for integrated care

Is it time for a health service model in which patients choose to go to care delivery groups – groups of healthcare clinicians who have a range of clinical skills incorporating generalists, specialists and a wider group of non-medical clinicians? In this type of system patients would also choose where they prefer treatment – primary care centres, community hospitals or acute hospitals – within the limits of clinical safety and effectiveness

By Minoo Irani and Donal Hynes

The structure of health services in the UK remains fundamentally unchanged since the publication of the Dawson Report in 1920 (see *Interim Report on the Future Provision of Medical and Allied Health Services*; HMSO). The service consists of primary health centres and secondary and tertiary hospitals. Traditionally, General practitioners have been 'generalists' and hospital-based consultants considered 'specialists'. In recent years, boundaries have shifted and primary care is no longer synonymous with GPs and their teams, just as hospital-based consultants are not the only specialists in the health service. A sizeable number of consultant level doctors work closely with primary care colleagues outside hospitals and in community services; and clearly a new breed of General practitioners with specialist interest has emerged.

The frequency of healthcare service reforms and re-organisations probably means that policies and processes in healthcare have not achieved what patients, clinicians, and organisations need to deliver excellence in healthcare. The commonest frustration for patients is that real choice within the NHS remains unattainable — one has to negotiate professional and organisationally determined barriers (GP surgeries and hospitals, routine and out of hours healthcare) to realise the desired outcomes; no wonder then that patient satisfaction falls by the wayside.

The current healthcare reforms are designed to create opportunities for further blurring the boundaries between primary and secondary healthcare services, by placing GPs in the driving seat for improving the quality and effectiveness of local healthcare services, and demanding that secondary care specialists become more responsive to the voice of primary care. Barriers to clinical innovation and integration across boundaries are expected to be fewer in this environment. The aim, we are told, is to increase patient satisfaction – as determined by ease of access, professionalism of the clinician and meeting the individual's expectations of the outcome of the episode of care – and to improve quality, safety and clinical outcomes. To enable this, we need a radical change in our thinking. Primary, secondary and community healthcare should be viewed simply as historical policy-based structures and processes whose current form was not necessarily designed around the delivery of high quality patient care.

> **"Is it too much to ask of clinicians and services to maintain unwavering loyalty towards patient care and let professions, structures and organisations facilitate that process rather than the other way round?"**

We need to ask why we need GP surgeries, acute hospitals and community hospitals, all functioning in their own professional and organisational self-serving manner, rather than simply services designed to meet the needs of patients and serve the health of populations? Why is it that the more structures and processes we create, the more commissioning and provision 'gaps' we create at the same time too? Is it time for a model in which patients can choose to go to groups of healthcare clinicians with a range of clinical skills incorporating generalists, various specialists and wider group of non-medical clinicians and also choose where they would prefer treatment (primary care centres, community hospitals or acute hospitals) within the limits of clinical safety and effectiveness? Is it time to think of delinking clinicians from structures, professional and organisational loyalties? Is it too much to ask of clinicians and services to maintain unwavering loyalty towards patient care and let professions, structures and organisations facilitate that process rather than the other way round?

CONSIDER THIS NEW MODEL

We propose that our current understanding of integrated care within the NHS is extended to allow provision of health care by groups of clinicians who work outside organisational and professional constraints. This could be a group of medical generalists and specialists with a range of nursing and allied healthcare staff, commissioned by clinical commissioning groups and supported by a management framework. Social care providers whose services are involved in patient pathways would join these groups of healthcare clinicians and managers. These care delivery groups would offer a range of clinical services from a number of healthcare support estates including primary care centres, community and acute hospitals. Patients would be able to access care delivery groups for the whole spectrum of healthcare needs and would be managed along clinical care pathways within them without the problem of navigating different health systems, with different access criteria in different locations. Healthcare support estates would be used to facilitate episodes of care for the patients without being the organisational gateway to clinical services.

This is a model that overcomes the organisational and professional boundaries that have often limited the opportunities for wider integration of healthcare services with social care. Rather, it builds on the proven benefits of collaboration between services. A credible model for clinical integration in healthcare through care delivery groups would facilitate integrated service delivery with social care, where transformation of services designed around patients could become a reality. It could be made a requirement for care delivery groups to integrate delivery of relevant areas of their clinical services with social care, facilitated by health and well-being boards and underpinned by contractual levers.

It offers a range of advantages for patients, clinicians and commissioners and has the potential to:

- Provide person-centred care for patients
- Promote population-based health promotion
- Improve experience of care for patients with long-term conditions
- Enhance patient choice of care delivery groups and healthcare estates
- Reduce hospital admissions
- Improve clinical outcomes through reduced waiting times for investigation and treatment
- Reduce dependency of services on one group of professionals or workforce
- Facilitate the use of personal health budgets
- Deliver financial benefits to local health and social care economy.

In order to fulfil this potential, a number of policy drivers are required. Care delivery groups would, for example, need to develop flexibly and out of meaningful discussions between commissioners and providers in health and social care and patient groups. Health economies would need to develop and implement their own payment systems for episodes of integrated care. Care delivery groups would require capitated budgets to deliver services extending across prevention and treatment areas of health and social care services. Competition regulation would need to allow them to function as truly integrated services with integrated budgets.

TO SUM UP

While organisational and professional boundaries inhibit delivery of truly integrated care for the benefit of patients, the lack of a credible solution to overcome the practical barriers to integrated care has frustrated clinicians, managers and policy makers. Care delivery groups would bring together clinicians and managers across healthcare organisations for a common purpose of delivering integrated care in collaboration with social care services. The proposal for use of healthcare support estates for the right type of clinical care and patient episode, rather than restricting ability of services to move outside organisational boundaries, would overcome the disadvantage of models of integrated care which require structural integration. Blurring of boundaries between different professional groups in care delivery groups would facilitate better workforce planning, reduce variation of service delivery, enhance governance processes and eventually improve patient experience and clinical outcomes.

An earlier version of this article was published as part of the NHS Alliance's manifesto for primary care, Breaking Boundaries.

• *Dr Minoo Irani is Clinical Director at Berkshire Healthcare NHS Foundation Trust and NHS Alliance Specialists Network Lead. Dr Donal Hynes is Co-Vice Chair of the NHS Alliance.*

Primary care – does it smack of culture?

The rise in technology, the ageing population and increasing financial austerity demands a radical change in healthcare delivery and behavioural change – but as the culture shifts what will this new culture of primary care really look like?

By Yvonne Sawbridge

Culture is a ubiquitous word, often linked with leadership, and seen as the panacea for all ills. What does it mean though? There are numerous theories and concepts about culture, and one working definition is “the way things are done around here, when no-one is looking …”

Russell Mannion et al studied culture in a number of organisations and said, “What distinguished one culture from another is varying and vast pools of tacit knowledge which natives understand but are not necessarily conscious of knowing,” (see *Cultures for Performance in Health Care,* Open University Press, 2005). This then indicates that culture is shaped and communicated with members within that organisation or team, and therefore perpetuated. Culture has also been cited in many inquiries into poor care, most recently with Francis stating, “The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff,” (see Robert Francis’ *Independent Inquiry into Care provided by Mid Staffordshire,* January 2005-March 2009; The Stationery Office, 2010).

> **“If behaviours do not match individual underlying assumptions this can lead to anxiety”**

It is useful to understand what good looks like, and to think about ways of creating an ideal culture in which to provide health services. Given the complexities of defining, let alone shaping culture, we need to begin a dialogue on what the optimum culture in which to deliver good primary care might look like. As a framework to help us navigate the cultural landscape, Edgar H. Schein provides a helpful description (see *Organizational Culture and Leadership,* Jossey-Bass Publishers, 2004). Schein asserts that there are three layers of culture and all three are interrelated and form integral parts of the total picture. Therefore to accurately understand the culture, it is important to piece together from the three layers.

Layer 1 is described as artefacts. These are observable and therefore provide visual clues. Does your general practice have reserved parking spaces for doctors alone, do you include other clinicians or are there no reserved spaces? Does your community base have totally open plan offices or do some individuals have their own office? What kind of stories are told in coffee rooms? Are staff talking about the award scheme that exists or recounting battles they have fought against management to secure resources or change practice? What do the notices say in kitchens? Is it “please wash your cups” or “the kitchen will be locked out of use unless …?”

Table 1	**Present**	**Future**
Artefacts	Numerous buildings owned by different organisations. Rigid team structures.	Shared premises – ownership immaterial. Fluidity across teams and organisations.
Values	Longest serving GP becomes senior partner.	The member of practice staff with the right skill set leads the practice.
Assumptions	Post-Shipman era – prevent people from doing their worst. Professionals responsible for decisions.	Trust and enable people to do their best. Patients share in decision making.

Layer 2 Schein calls “espoused values.” These have developed into a common way of working and are usually written down. Medical and nursing codes of conduct are a good example of these values. As they tangibly exist, they can therefore be referred to and discussed in ways that the underlying assumptions *(see below)* cannot.

Layer 3 is the underlying assumptions that are described as so deeply embedded that they are within the DNA of the team or organisation. These are not openly discussed as there is no perceived need, given the assumption that everyone understands them. This can be challenging for new members who are trying to make sense of the culture and there are few clues provided about assumptions. For example, the assumption might be that quality is important and the best way to deliver this is to take a quality assurance approach - ie prevent people from doing their worst. Alternatively the assumption might still be that quality is important and that it is best achieved by enabling people to do their best (quality improvement). The former will be characterised by inspection, regulation, rigid rules and a largely punitive approach. The latter will be underpinned by trust, allowing professionals to exercise judgement and reward rather than punish. This mindset colours the way people and organisations behave, and if others in the group operate in a different prism, they are seen as different and “othered” in psychosocial terms, and largely unable to influence, contribute, or even perform. Understanding the different assumptions at play is crucially important. If behaviours do not match individual underlying assumptions this can lead to anxiety. If a GP assumes that their consultation is sacrosanct and if their patient needs more than the allotted time, then that will be prioritised, but if others assume that the efficiency and smooth running of the surgery is really important for patients then tensions will exist. This misalignment of competing assumptions can create anxiety in both parties.

What might good look like then in a primary care organisation in 2020? Predictions are often dangerous but most commentators would say that the rise in technology, an ageing population and increasing austerity will demand a radical change in healthcare delivery. Behavioural change requires a cultural shift. Table 1 outlines my suggestions of how primary care may need to change.

Primary care is the first point of contact for most patients in the NHS, and due to the eclectic organisational arrangements, there will be numerous cultures in operation. Over time, general practice has evolved to be less insular and more outward focused. Community services have been organised and run by a variety of organisations and may have suffered with identity issues as a consequence. All of this impacts upon culture and paying attention to cultural aspects is an important role of both leaders and followers within organisations.

The political and social context within which the NHS operates also shapes the culture. The UK is a democracy, with an elected government which agrees funding, structures, and designs the overall health and social care system. There are numerous examples of the system failing to meet the stated aim of placing patients at the heart of the services. Why are mental health workers unable to seek advice from NHS Direct on behalf of a client? Why do A&E departments routinely run out of pillows?

Maybe then we could start with changing two underlying assumptions. First, that the patient is a consumer. If this concept changed to that of citizen working together with the staff who deliver the public service that they, the citizen, funds, then how different relationships might be. Second, that you have to work within the system. Whilst there are many examples of working round the system, those that resolutely work outside of the system are usually mavericks and “othered”. What would happen if nurses in community hospitals refused to accept elderly infirm patients being transferred from an acute hospital on a cold winter’s night? Or if GPs ignored the five-minute appointment convention, or access targets? Clearly every action has a consequence, and change can just move the disadvantage rather than solving the problem, so none of these are advocated as a course of action per se. However, the notion of reacting differently to issues that have become routine problems is certainly worthy of consideration.

It may be that we need a good dose of anarchy, and a refusal to work within the rules unless they fundamentally improve patient care. Then the underlying assumption of primary care would be “we are here to look after our patients,” the values would support this statement and most of the car parking spaces would have signs saying “reserved for patients.”

- *Yvonne Sawbridge is Co-Vice Chair, NHS Alliance, and Senior Fellow, Health Services Management Centre, University of Birmingham. An earlier version of this article was published in Breaking Boundaries, the NHS Alliance manifesto for Primary Care.*

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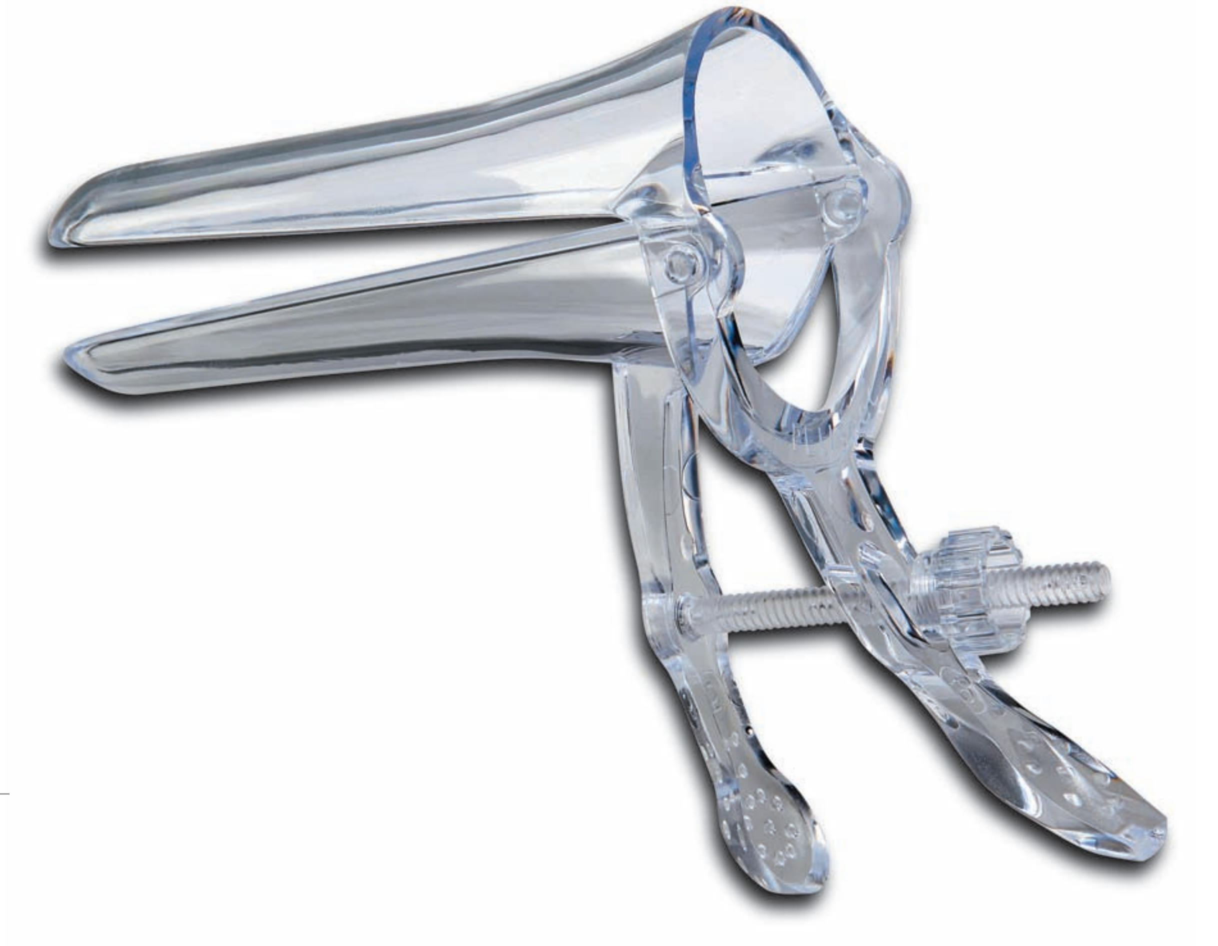

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Doing up houses, or doing up lives?

Question: Does being poor make you ill? In a career spanning six decades as a community nurse and health visitor, I've sought and found the answer – not if you have a voice and a choice

By Hazel Stuteley

In 1968, as a teenage student nurse at King's College Hospital, I was first introduced to health inequalities. Rather like the midwife in the Sunday evening BBC series, I cycled around Lewisham and saw for myself the startling contrast in health status between the families living at the bottom of the hill, and those at the top of the hill in Blackheath. The seemingly arbitrary unfairness of it had a great impact and shaped my career as a health visitor for the next 45 years.

Looking back I now realise I was living and learning my way to finding an answer to the complex issue of Health Inequalities (HI), through the decades which followed, whilst working with disadvantaged communities both urban and rural from London to Cornwall. And we urgently need some answers as the HI gap widens.

It has long been recognised that the NHS has a poor track record on primary prevention. Hence, even though we know that poor health behaviours are overwhelmingly linked to poor communities, a systematic approach to prevent these at population level has eluded us, and the silent epidemic of chronic disease marches relentlessly on. Which is why I'm now a co-director with a GP colleague of a programme called Connecting Communities, or C2 for short, which supports hard-pressed communities across the UK to find their voice and lead lasting change and transformative health and wellbeing improvement for themselves. We do this by working with service providers to create the enabling conditions for this to happen. It is cost-effective, requires no added resources and minimal funding as it uses what's already in every community and the most valuable resource of all – the residents themselves. The track record of success is consistent.

C2 is evidence based on the following story, which started it all.

THE BEACON PROJECT CORNWALL 1995-1999

In the 90s I worked for a decade as a health visitor in a heavily stigmatised community (pop. 6,000) in the poorest ward of the poorest county (Cornwall) in England.

My colleague and I were struggling to cope with the seemingly bottomless pit of need on this estate, even though it only constituted a third of our total caseload. Violence, poor health, poor housing, disconnection at every level, resulted in alienation on a huge scale and we knew we had to think and work differently if we were ever to bring healing to this fractured and ill community.

Faced with a solid wall of cynicism from service providers across the spectrum, who had given up and abandoned the estate, and no funding, we stuck to our belief that the residents were the solution and not the problem. We focused on their strengths and assets, not their deficits… but we couldn't do it alone. Five brave residents and a handful of service providers shared our vision of what this community could become and the Beacon Project was born.

We knew from our practice over several years that it was only a tiny minority of disruptive families causing all the problems (research shows it's usually only 1%). The vast majority of families displayed huge strengths and dignity in the face of relentless adversity, but they weren't connected to each other, let alone to service providers.

> "Faced with a solid wall of cynicism from service providers across the spectrum, who had given up and abandoned the estate, and no funding, we stuck to our belief that the residents were the solution and not the problem"

We discovered that by initiating and becoming a visible part of a resident-led intervention, in partnership with education, police and local government in supporting roles, that together we could effectively address the "causes of the causes" of their poor health, and brought transformative and lasting change. We had no funding, no strategy, no business plan, no committee, just a nurse's healing intuition and a shared vision with the people.

IN A NUTSHELL THIS IS WHAT WE DID:

We reorganised the way we worked: eg we asked for and got the practice social worker to free us up from the constant emergency referrals. We stopped weighing babies (highly controversial!) and empowered parents to do it for themselves.

We re-engaged statutory agencies, local government, police, the employment agency and education and got their commitment to listen to residents.

We engaged "key" residents to form a residents association (RA) and unlock the wider community to articulate and prioritize their issues face to face with agencies, which turned out to be crime, housing and jobs.

Table 1: Health, environment and educational outcomes between 1995-2000

Health benefits	Environmental outcomes	Educational outcomes
Increased breast feeding rates by approximately 50%	£2.2 million accessed by tenants and residents	On site training for tenants and residents
Postnatal depression rates down 77%	Gas central heating to 318 properties	After school clubs
Child Protection registrations down 60% Childhood accident rate down 50%	Loft insulation in 349 houses: cavity wall in 199; external cladding to 700	Life skills courses all ages
Lower incidence of asthma and schooldays lost	Fuel saving estimated at £180,306 p.a., releasing disposal income to residents	Parent and toddler group and Big Baby feeding Club (BBC breast and bottle!)
78% Reduced fear of crime Unemployment rate reduced by 60%	£160,000 traffic calming measures	Boys' & girls' key stage 1 SATS up 26%
Beacon Care Centre providing on site health advice	Provision of safe play areas and resource centre	IT skills training for seniors
Sexual health service for young people	Recycling and dog waste bins	Crèche supervisor training for NEET parents
All crime, vehicle, burglary and violence reduced by 50%	Skateboard park	Boys' SATS key stage 1 results up 100%

Within six months the RA, supported by agencies, won a bid for £2.2 million to improve housing. We formed Beacon Community Regeneration Partnership with residents leading the budget spend but guided every step of the way by the local authority.

By 1999 the estate looked very different and we'd impacted on their three priorities:

- Crime at every level (anti-social behaviour, violent, burglary and vehicle theft) had dropped by 50%
- Improvements to over 1,000 homes (recladding, central heating, showers)
- Unemployment down 71%.

Job done! But … there were some other startling outcomes, as shown in Table 1.

In the words of the Partnership coordinator then and to date, Cllr Grenville Chappel, born and bred on the estate, "We thought we were doing up houses but we were actually doing up lives." He was right.

In parallel to all the housing improvement something else was happening which I believe led to such profound outcomes and health improvement.

Generating the funding for themselves in 1995 was hugely empowering for this community, it wasn't a handout. This resulted in a collective sense of confidence, self-belief and high levels of self-organisation leading to a complete rebirth of community spirit, which has survived to this day. Numbers of new social clubs catering for all ages and new leisure activities soared. The carnival was revived, gardening competitions flourished, transforming the estate visually alongside the colourful cladding. While it is impossible to prove causal links, this was an entire community with a strong sense of self-belief taking collective responsibility for each other and where they lived.

Health outcomes continued to emerge beyond the life of the project. By 2004 the teenage pregnancy rate had dropped to zero. Crime rates fell even further in ensuing years.

The resident-led, multi-agency Beacon Partnership continued to meet monthly, as it does to this day, governing, problem solving and co-ordinating estate life and service provision.

In 2001 the Beacon Resource Centre became the community hub, offering a wide range of services and remains the beating heart of this vibrant community. VIP visitors including three Secretaries of State for Health and HRH The Princess Royal have visited and the partnership has run out of wall space to display its many awards!

Since 2010 The Beacon Enterprise Garden/Handyman Scheme has employed local people and contributes to the running of the Centre. Crime is at an all time low, and continues on a forward trajectory of improvement, recently attaining "dementia friendly" status. Times are undoubtedly hard but there's a collective sense here that this resilient and vibrant community will weather the storm.

LESSONS FROM THE BEACON STORY

During recent years Sir Harry Burns, Scotland's Chief Medical Officer has strengthened the evidence base for our assets based approach to improving population health.

Sir Harry is able to effectively demonstrate the physiology and biology of poverty, ie the damaging effects of raised cortisol levels on the brain and all the body's major systems, and we've had the pleasure of working with him and some hard-pressed communities in Scotland.

He draws on the work of American sociologist Aaron Antonovsky, who argued that long-term chaos and failure to manage a difficult environment impairs physical and mental health. Scientific data for chronically raised stress associated with deprivation is now robust.

Antonovsky also castigated medics for being obsessed with the causes of disease (pathogenesis) rather than the creation of health (salutogenesis). He defined the ability to manage a difficult environment as having a sense of coherence, made up of three core values:

COMPREHENSIBILITY

A belief that things can happen in an orderly and predictable fashion and a sense that you can understand events in your life and reasonably predict what will happen in the future.

MANAGEABILITY

A belief that you have the skills and ability, the support, the help or the resources necessary to take care of things and that things are within your control.

MEANINGFULNESS

A belief that things in life are interesting and a source of satisfaction: that things are really worth it and that there is good reason to care about what happens.

My experience in Falmouth and in the many communities we've worked with since has shown me that this sense of coherence, ie manageability, meaning and control are absent for huge swathes of our population living in poor socio-economic circumstances. Alienation is rife. There is no sense that they have any control or influence in decisions affecting their environment. Over many years and spanning generations, they've become the passive recipients of services and it's making them ill!

But it doesn't have to be like this. We now have cost-effective health creating solutions like C2 that work to turn this around and bring back that all important sense of coherence within our challenged communities.

But we in the NHS need to wake up and smell the coffee and start believing in our communities' capacity to heal themselves and start commissioning and mainstreaming community empowerment interventions for long-term health.

- *Hazel Stuteley OBE, RN, is Programme Director, Connecting Communities (C2), Exeter.*

Yes, the NHS can improve the patient experience for people with AS...

GPs must get better at diagnosing the condition, and speeding access to physiotherapy and hydrotherapy would enable patients to keep their condition more stable

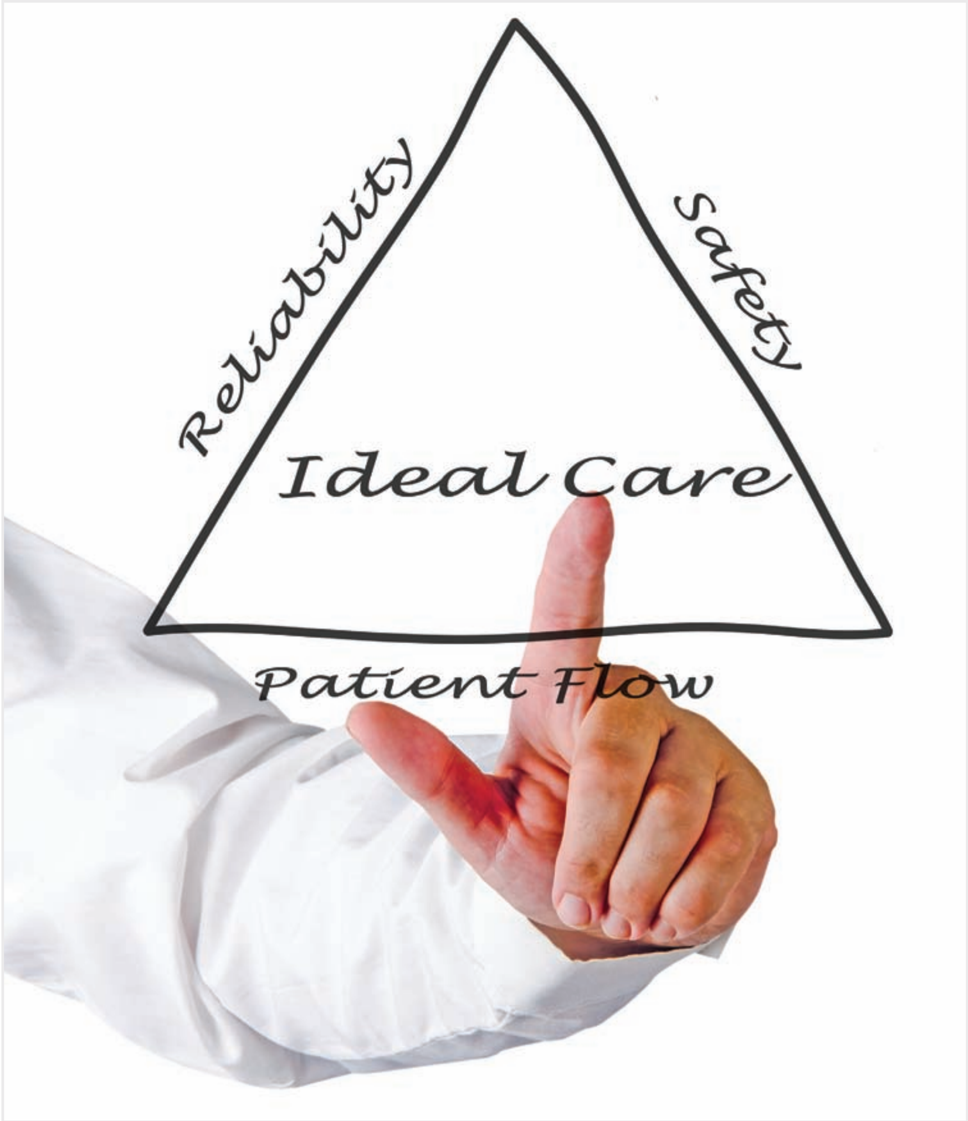
By Kelvyn Morris

I am a "Spondy" as we ankylosing spondylitis sufferers affectionately call ourselves and I have had the disease since my late teens. I am now 58 years old. Through my role as the Secretary of the Newport and Caerphilly branch of the National Ankylosing Spondylitis Society I have been privileged to meet many people who have ankylosing spondylitis and I've listened to their healthcare experiences, some going as far back as 50 years.

> "I had to cope with the hammer blow – being told that ankylosing spondylitis is a progressive, degenerative disease with no cure"

I distinctly remember the onset of my own condition at 18 years of age, as it started with inflamed hip joints which made walking uncomfortable over any distance. Then within a year or two I experienced very acute lower back pain which was put down to back problems by my GP. Frequent visits to a chiropractor had little impact, as did a spell in traction. By now the constant pain and stiffness associated with ankylosing spondylitis was taking hold but I just got on with my life without any medication other than painkillers. It was not until I was in my thirties that I was referred to a rheumatologist and found that I had the HLA-B27 gene marker associated with ankylosing spondylitis. That was when I finally knew what my problem was, and it was a great relief.

But then I had to cope with the hammer blow – being told that ankylosing spondylitis is a progressive, degenerative disease with no cure. I could have done with some support or counselling at that point. But at least I started to receive the right medication and tried several anti-inflammatory drugs before settling with a Cox-2 type which I now use combined with stomach protecting medicine. I endeavour to manage my ankylosing spondylitis rather than let it manage me by going to weekly hydrotherapy sessions provided by the National Ankylosing Spondylitis Society at a local pool and supervised by a qualified physiotherapist who tailors the exercises to suit the individual. This, plus simple stretching and strengthening exercises done at home, help to maintain my posture and reduce pain and stiffness.



Clearly the delay in my diagnosis allowed the disease to progress unchecked and as a result I have a mostly fused spine, limited range of neck movement and will face hip replacement operations over the coming years. The worst impact, however, has been the effect it had on my life where the pain was so debilitating that I could not lead a normal life and the simple things, like bending over to tie my shoe laces or holding a child, would become difficult if not impossible. But with a grin and bear it attitude I managed to remain employed and never lost days due to my condition.

New medicines are being developed and we now have access to a range of treatments including Anti-TNF which can in some cases have an almost immediate life changing effect. I believe we need to focus on reducing the time it takes to get a diagnosis, which in my case was well over 10 years and is not uncommon talking to other Spondies, so that treatment can start earlier and can help people to maintain a good quality of life, remain active and stay in employment.

In my opinion there are many things that the NHS can and should do better to support people with ankylosing spondylitis. Below is a summary:

- Improve GP awareness of AS to aid earlier diagnosis
- Complete annual check-ups with medication reviews and measurements, charting disease progress
- Provide better access to MRI scans to pick up the disease earlier
- Speed access to physiotherapy/hydrotherapy when the condition is in flare
- Build a closer working relationship with NASS to provide ongoing support, both mental and physical. At all levels of the NHS, GPs, rheumatologists and physiotherapy.
- Organise regular extended in-hospital courses, five to 10 days, providing intensive physiotherapy and hydrotherapy which AS patients can elect to join. I have seen the positive impact this can have, particularly in those cases where ankylosing spondylitis is newly diagnosed.

> "It is estimated that there could be around 200,000 people with ankylosing spondylitis in the UK"

In the more progressive health boards in Wales some of these points have been enacted and are already available but it is far from uniform practice across the country, as I have experienced first hand. It is estimated that there could be around 200,000 people with ankylosing spondylitis in the UK and adopting the above recommendations would undoubtedly go a long way to improving the outcome and quality of life for people with ankylosing spondylitis. NASS has over 90 branches in the UK and provides help and advice via their website – www.nass.co.uk – and helpline 0208 948 9117. GPs and staff working in primary care could signpost this to patients when they are newly diagnosed to help them to manage their condition in a more effective way.

- *Here at Primary Care Today we want to read your story. Do you know a patient who is full of ideas about what it will take for the NHS to become truly patient centred? Through their own experiences do they see ways of doing things better? We want to hear from them. Contact norma.beavers@tenalps-publishing.com*

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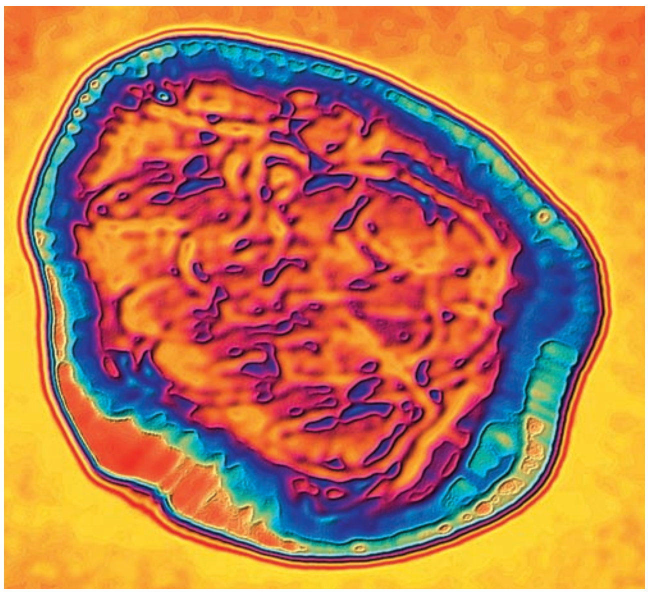

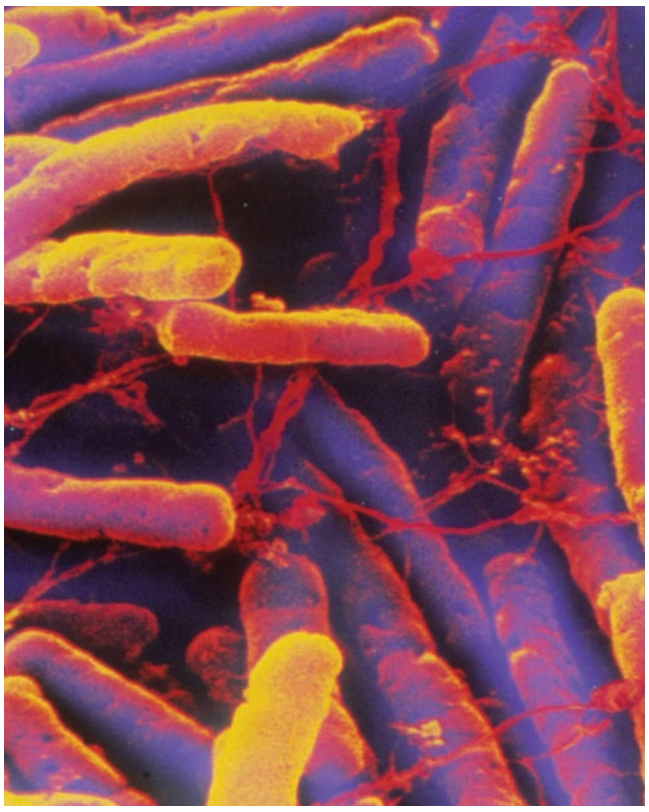

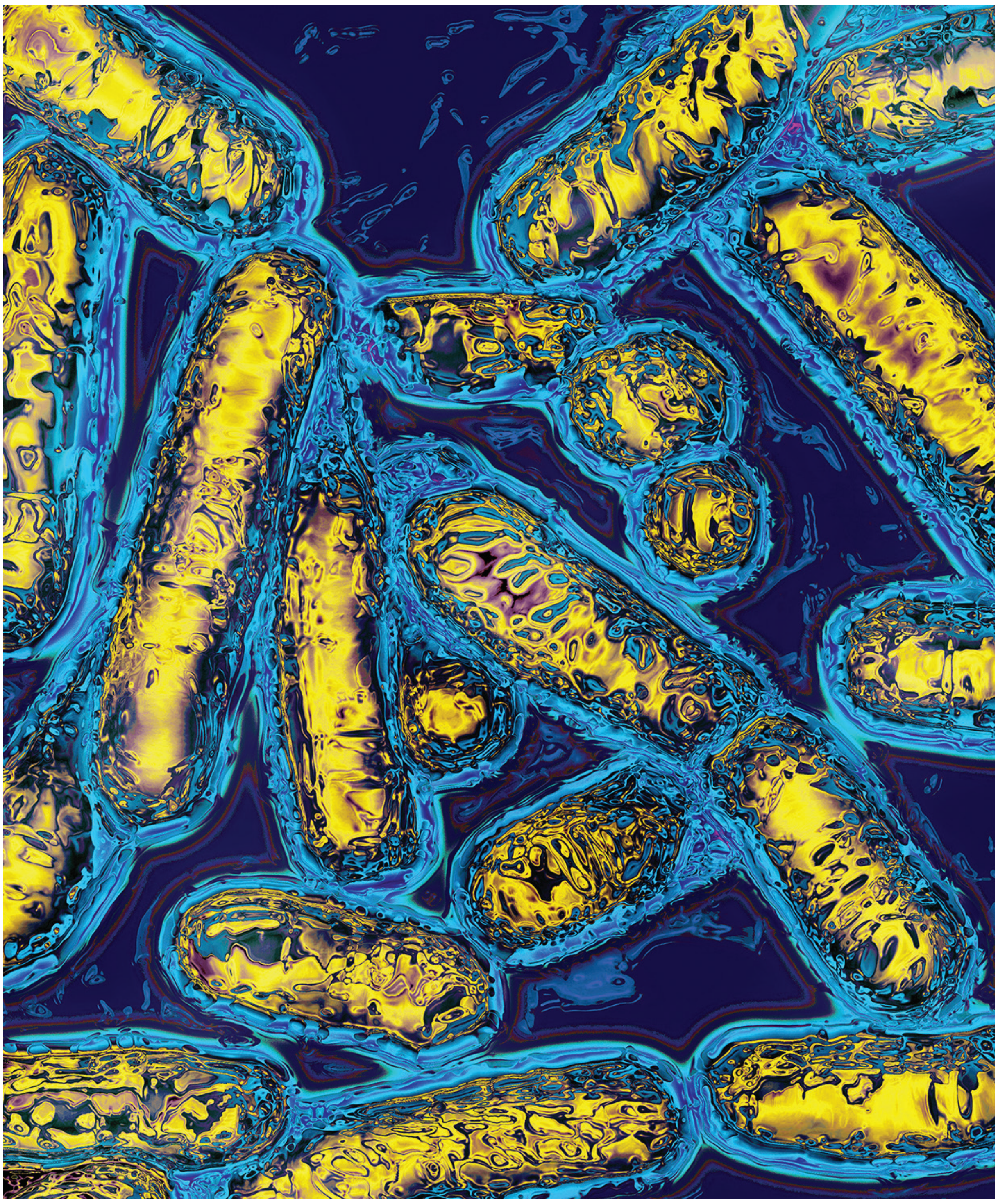

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Tax avoidance – too risky to chance it?

With the increase in the tax burden it is vital for any business to maximise tax deductible expenditure – but what is tax deductible and which expenses carry an element of risk?

By Christine Newitt

It will come as no surprise following the considerable amount of publicity regarding tax avoidance that HM Revenue & Customs (HMRC) is under huge pressure to increase tax receipts from all sectors of the economy. Barely a week goes by without a newspaper headline on some aspect of tax avoidance or aggressive tax planning. The NHS is not immune from attack, with headlines in June this year alleging NHS Trusts have been avoiding VAT when employing agency staff.

Over the last few years several campaigns have been launched, including the Medics Tax Health Plan campaign, which closed in June 2010 and raised more than £10 million. As you might expect, HMRC is using the information gleaned from this exercise and other sources to follow up other individuals in this sector. Up to 30th November 2012 HMRC's follow-up action has recovered a further £9.7 million in unpaid tax.

While non-declaration of income will be a continuing avenue of investigation, those working in the primary care sector are just as likely to experience an attack from HMRC in relation to expenditure claims. With the increase in the tax burden it is vital for any business to maximise tax deductible expenditure, but what is tax deductible and which expenses carry an element of risk?

For any expense to be allowable for tax purposes it must be incurred 'wholly and exclusively' for the purposes of the trade or profession. The majority of routine expenditure incurred by a business will fit squarely within this definition. Capital expenditure is also a deductible expense, but the amount that can be claimed is subject to complex rules. With the increase in the annual investment allowance to £250,000 from 1st January 2013, the allowances at present can be very generous. It is also possible to claim allowances on items that are gifted, which can be useful if donations are raised by the general public for a specific piece of equipment.

However, there are areas that HMRC will scrutinise and which therefore require further consideration.

MOTOR AND TRAVEL

Travel to and from the base of operation of the business, whether a GP surgery or an out-of-hours surgery, will not be a tax deductible expense. HMRC is currently attacking this point through the courts in the Dr Samadian case. While this case relates to a private consultant working in the secondary care sector, the same basic principles apply to all businesses.

It is clearly established that travel from home to the business premises for most healthcare professionals, including principal GPs, is not deductible on the basis that they are travelling to their place of business. Travel to patients and to attend business meetings and courses from home or the surgery is deductible business mileage. What is less clear following this decision is the case for deducting business mileage where a GP undertakes private work, treating home as a business base, but where the work is actually carried out from another business base, for example a private hospital, clinic or out-of-hours provider premises. The basic principle is that travel to get to a place of business is disallowed but travel in the course of a business is allowed. The bar is now set high in any case involving a taxpayer's home to determine whether this is a base of operation. HMRC says no but Dr Samadian's advisers clearly disagree and have confirmed that they are now taking his appeal to the Upper Tier Tribunal.

Clearly it will be important to maintain mileage logs detailing the start point, destination and purpose of each journey while a final decision is reached in this case. Each case for mileage travel claims will be based on the facts pertaining to each individual case.

> "For any expense to be allowable for tax purposes it must be incurred 'wholly and exclusively' for the purposes of the trade or profession"

USE OF HOME AS OFFICE

Within the primary care sector most health professionals will work from dedicated premises such as a GP surgery. Some, however, will be required to do some work at home.

It is acceptable to apportion the use and cost of a room in the house on a time basis, and to allow the expense of the room during the hours in which it is used exclusively for business purposes, in the same way that it is possible to calculate the business expenses of a car which is sometimes used for business purposes exclusively and sometimes used for pleasure.

How much can be claimed will depend on the underlying facts. If there is only minor business use of the home HMRC will accept a reasonable estimate consistent with the underlying facts. In relation to employed individuals required to work from home, HMRC accepts a rate of £4 per week without the need to produce receipts. This rate would likewise be a reasonable estimate for self-employed individuals working on a similar basis.

A claim above this amount would require production of receipts and a calculation involving the area of the home used for business purposes and time spent working from home.

HMRC STATUS ENQUIRIES

Payments to those employed in your business must be paid through the payroll and the payments notified to HMRC on a real time basis. But what about those who are not on the payroll, for example the cleaner, the gardener, the handyman, who all present an invoice for payment on a weekly, monthly or ad hoc basis? Employers need to examine these arrangements carefully to ensure that these individuals are correctly classified as self-employed and not employees of the business. HMRC has devised an online employment status indictor (ESI) tool to assist businesses in this respect. This is however a complex area of tax law and results produced by the ESI tool should be treated with caution. The responsibility as to status sits squarely with the employer and failure to operate PAYE when it should be operated can result in large payments in arrears of tax and national insurance.

ENTERTAINING

Entertaining someone for business purposes other than employees is not an allowable business expense and for businesses that are VAT registered, recovery of input tax is also blocked. Care should be taken to ensure any expenditure in restaurants, hotels or similar establishments is correctly treated. Food provided at business meetings of the proprietors of the business, eg GP partners, are likewise not a deductible expense.

SPOUSES' REMUNERATION

Salaries paid to spouses for assisting in the business will always be scrutinised closely by HMRC to ensure that they are commensurate with the duties actually performed. It is vital that a contract setting out their duties, hours of work and rates of pay are kept up to date and reflect the facts relating to their employment.

Tax is a complex area of law and guidance should always be sought from a professional tax adviser in relation to specific circumstances and facts surrounding claims for expenditure.

- *Christine Newitt is a Partner at Duncan & Toplis chartered accountants.*

Travel expenses – lessons to learn

Dr Samadian has a full-time employment in a hospital. He undertakes private patient clinics at two different private hospitals in a self-employed capacity and hires a room to see private patients on a sessional basis. In addition, Dr Samadian has a dedicated office at his home address which contains the usual office equipment, patient clinical records, basic medical equipment and business records.

While the office at home is not used to examine patients, all business correspondence with patients and GPs show the home address and clearly time spent diagnosing and planning treatment of patients is undertaken at that location.

Tax legislation states that where there is any duality of purpose in relation to an item of expenditure, then the entire cost is not deductible, ie not relievable for tax purposes.

However, if an expense is incurred for more than one purpose, then a deduction is still available for an identifiable proportion of that expense if it is incurred wholly and exclusively for the purposes of the trade.

The tribunal decided that the travel from Dr Samadian's home to a private clinic and then back to his home had a "mixed object" in that part of the object of the journey must "inescapably" be to maintain a home in a separate location to the private hospitals, being his other places of business. The mileage to and from these locations is not expenditure that can be deducted for tax purposes.

Will the Care Bill bring

Policy leaders appear finally to see that health and social care are inextricably linked, and regulations and

By Ross Griffiths

If the Care Bill goes through it should be easier for Clinical Commissioning Groups and Local Authorities to agree common priorities and objectives. While The Care Bill could modernise health and social care with its proposal to put people's wellbeing at the centre of care and support, a lot is riding on whether health and social care can be truly integrated.

The Government estimates that an extra 1.4 million people will need care and support in the next 20 years. Politicians and industry leaders also appear to have the UK's ageing population in mind – the latest projections expect there to be 5.5 million more elderly people in two decades time, and further expect this number to nearly double by 2050. With the health system facing a drastic increase in demand for services and tight budget allocations as well as harsh criticism on various issues, the Government has acknowledged that policies and practice need to be improved and is now taking steps to make the necessary changes through the provisions in the Care Bill. Policy leaders appear finally to see that health and social care are inextricably linked, and regulations and practice must change to reflect this inter-relationship.

Under the current regulatory framework, local authorities and NHS bodies have been able to work together, integrate services, pool budgets and even create special purpose organisations for some years. But it seems that examples of success are comparatively few, and even fewer operate at scale. Looking back over various iterations of law and policy concerning integration of health services and social care services, it has been permissible but not mandatory for the main players, NHS bodies and local authorities, to work together. Choosing to work more closely with an NHS body or a local authority has perhaps been rare, as operational integration would require a great deal of proactivity and collaboration.

The Care Bill will place more responsibility in the hands of local authorities, and requires them to work closely with NHS bodies in order to best look after those who need social or health care. Local authorities are now required to ensure the integration of care and support with health wherever it promotes wellbeing, delays the onset of need for care or improves quality of care and support for adults and carers.

IS INTEGRATION NEW?

Looking back, attempts have been made to make integration easier both for local government and the NHS. In the early days of the last administration, the Office of the Deputy Prime Minister's Strategic Partnering Task Force was set up with integration as one of its major work streams. This initiative identified barriers to integration and means of removing them. The barriers were many and some remain to this day.

However, since then there have been a number of fundamental changes in the way in which the public sector generally, and the NHS in particular, are structured and operate. Back when the task force was in place in 2002 to 2006, Primary Care Trusts were combined commissioners of health services as well as providers of services. The local authority was in a similar position in relation to adult social care. Because of the dual responsibilities that faced local authorities and primary care trusts, the merging of these two bodies would have required the pooling of funds and the sharing of power over decision making. It would also require two separate management structures and skilled community health and social care staff to work in an integrated pathway whilst being employed by separate organisations. Letting go of control of an already stretched budget, having no managerial control over how efficiently it might be spent, and ambiguity over whose workforce would have precedence presented great difficulties for organisations to agree and, apart from a few instances, integration did not have a great take up.

> "Under the current regulatory framework, local authorities and NHS bodies have been able to work together, integrate services, pool budgets and even create special purpose organisations for some years"

In a proposal parallel to the Care Bill, the Government has set out its goals for creat-

integration closer?

practice must change to reflect this inter-relationship

ing a joined-up health and social care system by 2018. The proposals include fines on service providers that ask a patient to "re-tell" their issues. The new proposals are a part of the Government's wide approach to fixing the health care system, with the stated aim to help end patients suffering disjointed health care and social support services.

In the past few years, there has been a movement towards separating the commissioning of services from the provider-side of health and social care. Commissioning budgets in the NHS are now held by clinical commissioning groups (CCGs) and the community health workforce is employed by separate organisations (NHS hospital trusts, community health social enterprises or community foundation trusts). Meanwhile, in local government, the provider-side is being separated from commissioning in a number of ways, but the major impact comes from allocation of personal budgets to social care users.

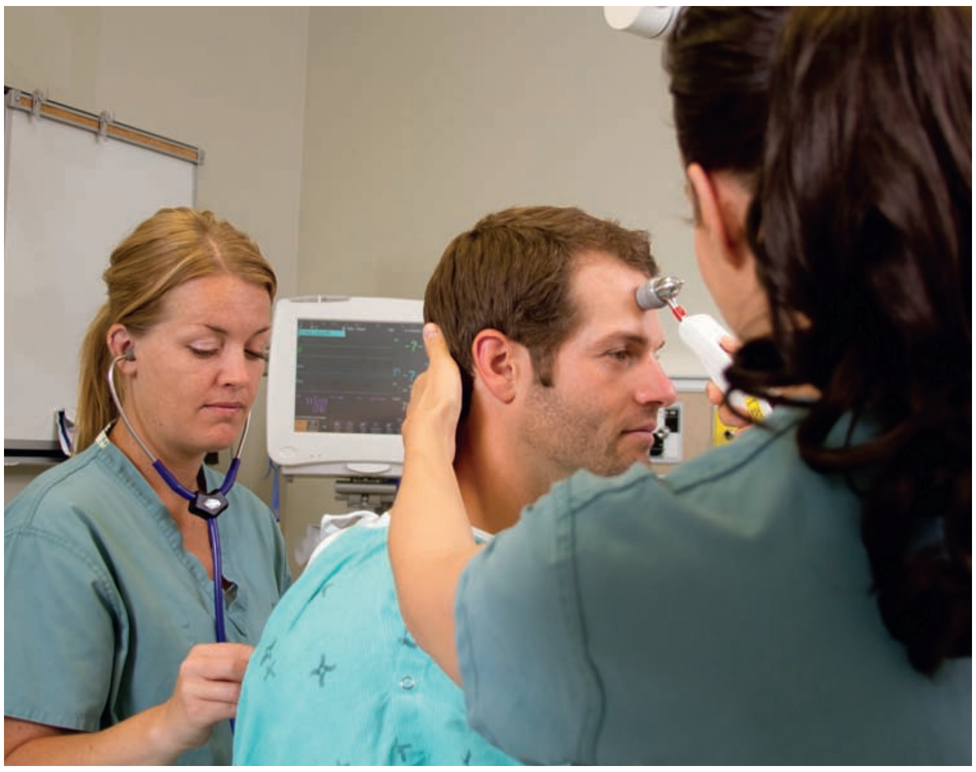
In the new environment, if the Care Bill goes through, it should be far easier for CCGs and local authorities to agree common priorities and objectives – as they will both sit on the Health and Wellbeing Board – and then to commission jointly, unencumbered by the traditional linkage with the provider arm.

In general, community health providers and some social care providers are now under different ownership but focused on being service providers trading in public services. This has a significant effect on the way in which health providers and care providers can relate to each other in delivering their respective services to the same individual users. Because they are focused on the business of service delivery and returning a surplus on turnover, they are better able to enter into commercial-style joint ventures with other providers. What was a difficulty in the past: agreeing a common currency between NHS and local government, is resolved by the common currency of surplus or profit to the joint venture. It is sensible to harness commercial concepts and language if doing so facilitates the joining up of two elements of a caring service.

There is still a long way to go, but new system architecture would seem to give integration a better chance to happen, and for the policy objectives that successive governments have attempted to be achieved.

- *Ross Griffiths is a Partner in the Healthcare Sector Group at business law firm DWF LLP.*

> **"The new proposals are a part of the Government's wide approach to fixing the health care system, with the stated aim to help end patients suffering disjointed health care and social support services"**



Is 800 calo to revoluti 2 diabetes

Researchers are exploring whether a low calorie diet can push Type 2 diabetes into remission. Over the next two to five years they will track patients' progress in a bid to deliver a new eating and lifestyle programme that could revolutionise the way Type 2 diabetes is treated

By Norma Beavers

Diabetic patients know they have to monitor what they eat carefully but an upcoming new study looks set to reveal whether consuming just 800 calories a day can begin the process of forcing Type 2 diabetes into remission. If it does, the research could result in an evidence-based programme that could help patients keep Type 2 diabetes at bay when they follow the new eating plan and make certain lifestyle changes. An earlier study showed a very low calorie diet can remove fat overloads from the pancreas and allow normal insulin secretion to be restored in a matter of weeks.

Professor Mike Lean, the lead researcher at the University of Glasgow, which is conducting the research alongside researchers at Newcastle University, said, "If our analysis shows that this approach to weight loss and weight management is both clinically effective and cost-effective, we would aim to produce a programme that can be implemented in the NHS as soon as possible."

Professor Roy Taylor, the lead researcher at Newcastle University, said, "We know that changes in calorie intake can produce changes in body composition that, at least in some people, can put Type 2 diabetes into remission. But this new study will evaluate how well people do using this approach and uncover problems that might be faced. We are exploring uncharted territory and along the way there will be challenges, details to unravel, and other questions to ask. But I believe this study will lead to a quantum leap forward in our understanding of how best to manage Type 2 diabetes."

The new research comes at a time when rates of diabetes are soaring in the UK and worldwide. A diabetes league table developed by Diabetes UK finds across the UK 7.4% of people aged over 16 are now thought to have diabetes a figure that's projected to rise to 8.4% by 2020. Most of the new cases are likely to be Type 2 diabetes, where risk factors include being overweight; having a large waist; being over 40 – or over 25 if the person is South Asian – or having a close relative who has diabetes.

The low calorie diet research, funded by Diabetes UK, will see GP surgeries recruit 140 Type 2 diabetics who will take the low calorie liquid diet for 20 weeks. They will consume healthy diet shakes which will then be replaced by solid meals. The Type 2 diabetics will be taught how to change their eating habits and lifestyles to keep the lost pounds and diabetes risks in check. Each of them will be monitored over the next two years to track their progress.

The group's results will be compared against a group of 140 people who have not followed the 800 calorie a day diet but have instead consumed what is currently accepted as best practice advice for managing weight.

Researchers at Newcastle and Glasgow Universities will monitor the long-term effects of the diet. The plan is for some participants to undergo MRI scanning so that researchers can consider what is happening inside their bodies during the diet.

The research will build on the findings of a 2011 study in which 11 people with Type 2 diabetes followed a 600 calorie a day diet for eight weeks. Each consumed a liquid diet and 200 calories of non-starchy vegetables. All 11 saw their insulin production return to normal and their Type 2 diabetes went into remission. Three months

ries going onise type care?

Case study

CASE STUDIES

Gordon Parmley from Stocksfield in Northumberland is in his 60s and took part in the 2011 low calorie study at Newcastle University. He said, "I love playing golf but I was finding that when I was out on the course sometimes my vision would go fuzzy and I would have trouble focusing. It was after this that I was diagnosed with Type 2 diabetes. That was about six years ago and from then on, I had to control the diabetes with a daily combination of tablets – the diabetes drug, gliclazide and tablets for my cholesterol.

When his doctor told him about the study he decided to get involved to help himself and other diabetics. "I came off my tablets and had three diet shakes a day and some salad or vegetables but it was very, very difficult and I'm not sure I'd have done it without the support of my wife, who went on a diet alongside me."

Parmley said, "At first the hunger was quite severe and I had to distract myself with something else – walking the dog, playing golf – or doing anything to occupy myself and take my mind off food, but I lost an astounding amount of weight in a short space of time.

"At the end of the trial, I was told my insulin levels were normal and after six years, I no longer needed my diabetes tablets. Still today, more than 18 months on, I don't take them. It's astonishing really that a diet – hard as it was – could change my health so drastically. After six years of having diabetes I can tell the difference – I feel better, even walking round the golf course is easier."

after the diet seven of them remained free of Type 2 diabetes *(see the case study)*.

Results from the 2011 Newcastle University clinical study showed weight loss which averaged 15kg (2st 5lb) over eight weeks caused two distinct sets of changes. Within seven days, liver fat had fallen by 30%, liver insulin sensitivity returned to normal and fasting blood glucose became normal. By eight weeks, pancreas fat content had returned to normal and insulin secretion by the pancreas had also returned to normal.

The 2011 study was designed to understand the biological processes in the body but was small scale and only followed its participants for a short time. Scientists do not yet have conclusive evidence about the long-term effects of low calorie liquid diets.

The new study, which is due to begin next year, will consider the benefits of a restrictive diet and evaluate whether the benefits outweigh any adverse effects. The 2011 study was carried out in a research setting and so it is unclear whether such diets can be transferred to a larger scale as part of routine GP care, where large numbers of overweight people with Type 2 diabetes are managed.

Dr Matthew Hobbs, Head of Research for Diabetes UK, said, "Type 2 diabetes will always be a serious health condition but perhaps it won't always be seen as a condition that people have to manage for the rest of their lives and that worsens inevitably over time. The 2011 study and evidence from bariatric surgery has shown us that it can be put into remission. If we can do this safely, on a bigger scale and as part of routine care, then following a low-calorie liquid diet would be a real game changer in terms of reducing people's risk of devastating health complications such as amputation and blindness."

He added, "We don't know whether this diet will put Type 2 diabetes into remission in the long term. Even more fundamentally, this kind of diet is certainly not an easy option or a quick fix. People will still have to maintain a healthy lifestyle to stop their Type 2 diabetes coming back. We are also talking about consuming so few calories that people taking part are likely to feel hungry quite a lot of the time and there are real questions about what proportion of people will be able to stick to this for the length of time needed for it to be effective."

The research is being set up to answer these questions and until it does "we are not in a position to recommend that people with Type 2 diabetes follow this type of diet, or to advise the NHS to offer it as a treatment option. That uncertainty is exactly why we are supporting these researchers with this grant. This new study should provide the evidence we need in order to give definitive answers to these questions," he said.

Professor Lean said, "The reason for doing this research is that we do not know whether the extra effort, and possible stress, of following a very restrictive diet for several months will indeed bring benefits in the long term. Although benefits are possible, we know that weight regain after liquid diets has been common in the past, and could have harmful effects. This is why we need to study sufficient numbers of people for long enough to be sure that the benefits outweigh the costs."

> **"We don't know whether this diet will put Type 2 diabetes into remission in the long term. Even more fundamentally, this kind of diet is certainly not an easy option or a quick fix"**

Diabetes.co.uk
the global diabetes community

DIABETES INTELLIGENCE REPORT

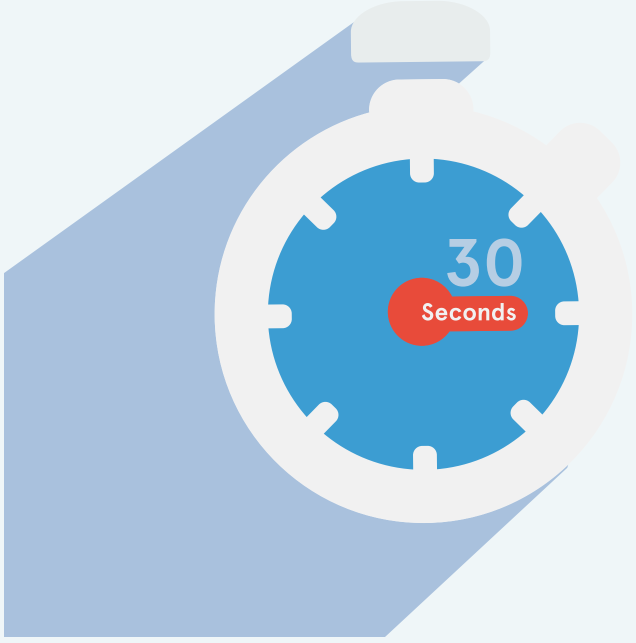
A look into the concerns of over 20,000 people affected by diabetes in the UK.

With Insights from: Boehringer Ingelheim • Bristol Myers Squibb • Glucose Rx JDRF • Johnson & Johnson• Sanofi • NHS • Spirit Healthcare • Roche

5 MINUTES OF FACTS

12 EXPERT INSIGHTS

20,000 PATIENT VIEWS



This report in 30 seconds...

Diabetes.co.uk set out to discover two things:

1. What are the most significant challenges for people affected by Diabetes in the UK
2. How effective the education support currently is for people with Diabetes.

About Diabetes.co.uk

Diabetes.co.uk is a privately owned company that provides support and education to people with Diabetes.

The Diabetes.co.uk portal attracts over 750,000 unique visitors each month, and is supporting over 125,000 registered members with a twice weekly newsletter. Diabetes.co.uk has a range of innovations coming to market, ranging from structured education to an innovative subscription service.

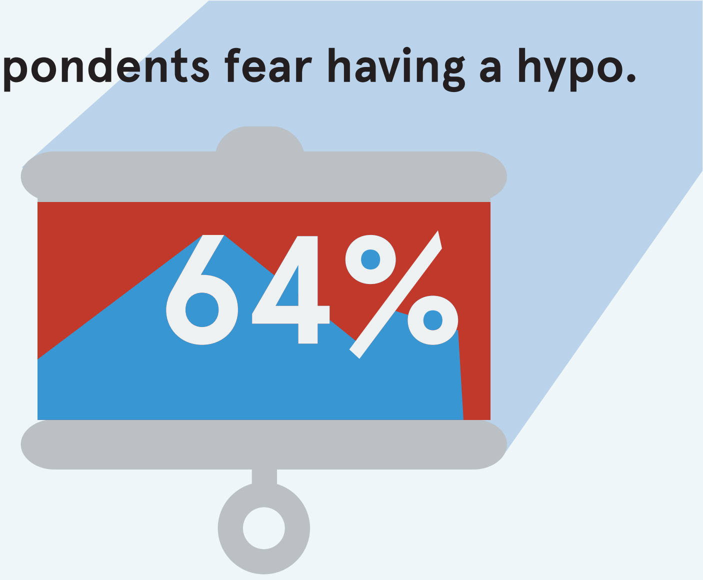
For more information and to stay up to date with the latest, please join us at: **www.Diabetes.co.uk.**

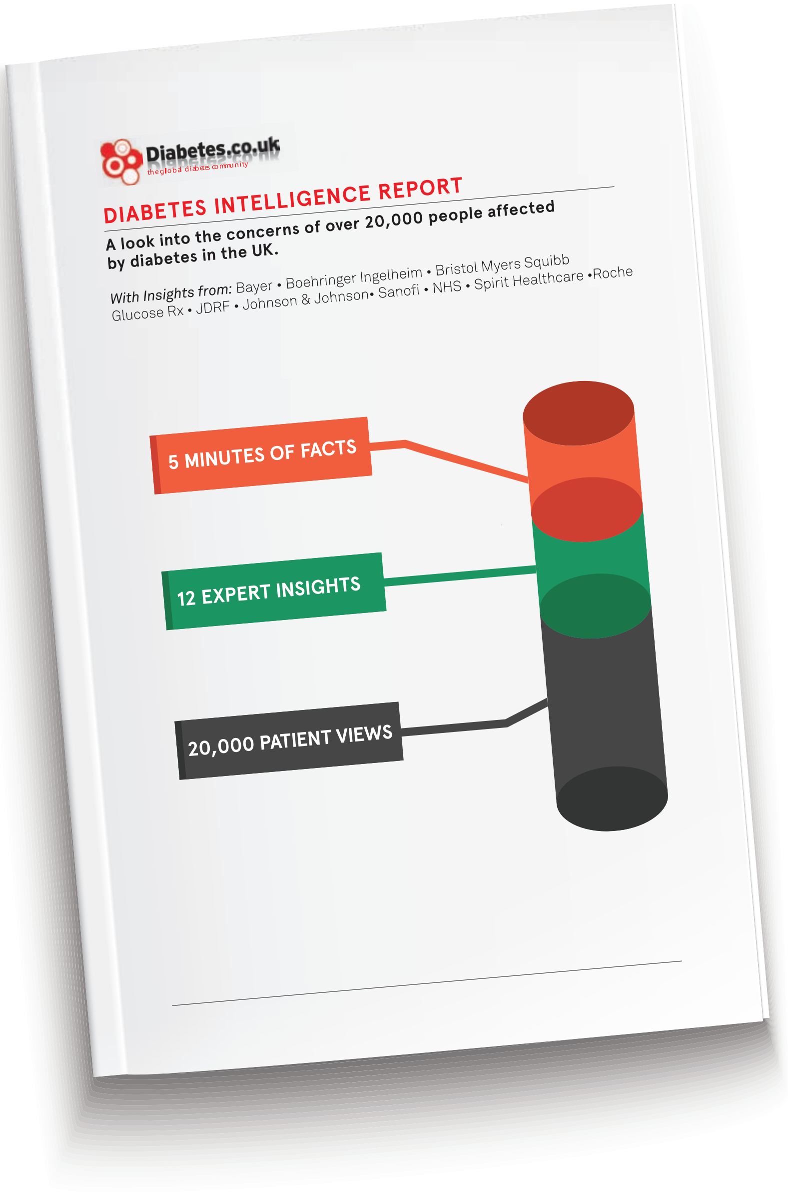
Diabetes.co.uk asked 125, 000 people to contribute to a 52 question survey, within 4 weeks over 20.000 people contributed. PatientsCreate took the key insights to *Bayer, Bristol Myers Squibb, JnJ, Boehringer Ingelheim, Glucose Rx, Sanofi, NHS, Spirit Healthcare Ltd, and Roche* to get their views.

One of the most alarming figures we uncovered is that 18% of both, patients with type 1 and type 2 diabetes had in the last year experienced having their glucose monitoring supplies either restricted or refused!

Whilst 48% of all respondents stated either some or strong anxiety in regards to restricted or reduced access to test strips.

64% of respondents fear having a hypo.





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Patient Story

Kris Wood, 27: "I have taken part in various type 1 clinical trials, which has meant I've received a higher level of care than most people, from 24 hour phone access to a consultant in the 12 months following my diagnosis, which was really impressive! My Diabetes Specialist Nurse tends to change a lot but they are usually really helpful. My current DSN recommended me the latest glucose meter, which I'm glad to have. "*I've seen first hand a variation in the quality of care that you receive depending on where you are in the UK.* When I lived in Newcastle, there were never any problems collecting medicine and test strips from my pharmacist. Since moving to London, there's always a delay or something missing in my prescription when I try to pick it up."

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a **patients create** publication.

Will mobile devices overtake paper records?

Combining effective mobile technologies with education can ensure clinicians and patients reap the benefits of both self care and preventative care without rekeying paper records

By John Sanderson

The shift to community-led care provides clear opportunities to improve the support and management of conditions such as diabetes, high blood pressure and obesity. With early intervention and the right preventative care, the NHS can reduce factors that lead to hospitalisation and in the process improve the quality of care and reduce healthcare costs.

This is, however, a new and rapidly evolving model. What is the best way to ensure secure mobile access to patient information whilst still delivering a joined-up care model and encouraging patients to take control over their own disease management?

With the responsibility for commissioning now in the hands of GPs, the shift from hospital-based provision of services to a growing reliance on smaller community centres and home visits looks set to accelerate. The emphasis is also on improving disease prevention. Encouraging patients to take greater responsibility for managing conditions and providing a raft of tools, services and information resources can enable individuals to both recognise early signs of deterioration and achieve the early interventions that are proven to reduce critical incidents and minimise the secondary care burden.

This forms a key part of the strategy that must address a predicted funding shortfall of up to £29bn a year by 2020, according to figures from the Nuffield Trust. A recent research report by the Trust commissioned by the National Association of Primary Care (NAPC) identified that recent NHS reforms present opportunities for a more proactive approach to prevention and population health. Report author Ruth Thorlby, Senior Fellow at the Nuffield Trust, commented, “There was real enthusiasm for change amongst staff from these general practices, who feel that much more could be done to reach out to their local communities and prevent chronic conditions, at the same time as taking better care of those with long-term conditions. Achieving this vision will require support, to help practices make better use of their staff and data, and form strong working partnerships with other practices and providers.”

INFORMATION MODEL

Indeed, while the evolution of joined-up care into the community makes sense for GPs, welfare providers and patients alike, the delivery of this care and the provision of the right information and services at the right time continue to challenge budget holders. What is the best way to provide the clinician – from community nurse, to specialist diabetes or dementia care provider to doctor – with access to critical patient information when working in the community? How can this information remain secure? And how can clinicians gain access to multiple information resources to ensure complete management of patients suffering more than one chronic condition?

For this model to work it is essential to avoid paper-based recording of information to be updated later. In addition to adding time and cost to the process, manual rekeying of information is always prone to error. Such an approach would also risk creating multiple, duplicate patient records and risk a delay in clinicians spotting and taking action to remedy key indicators of disease escalation.

There are a number of approaches being discussed to facilitate effective community-based care, but the key requirement flagged by most teams is the need for tablet/mobile device access to the existing systems used within hospital departments. Extending the diabetes care system, for example, into the community by providing mobile access to information via the secure NHS Internet ensures the clinician has access to the complete patient history at all times, as well as new information on pathology tests that may need to be discussed with the patient.

With this mobile information resource, clinicians can also immediately record critical tests – from blood, glucose and blood pressure to weight and urine analysis – in the main system, rather than relying on updating information at a later date. Critically, this model can leverage the workflow processes already within a proven solution to ensure potential issues are flagged, additional tests immediately booked and consultants made aware of potential problems early.

PATIENT EMPOWERMENT

There are also clear opportunities for patients to take a more proactive role in managing day-to-day conditions – from mobile apps that provide reminders and advice to the use of apps or portals to upload daily test or meter reading results. The key is to combine ease of use for the patient with a solution that is tightly integrated with the core application to provide a seamless information resource. Combining effective technology with education will ensure patients understand the real benefits of taking control over their conditions and improving preventative care.

This approach provides an opportunity not only to improve the patient’s understanding of disease management but also to transform the depth and quality of patient information collected – improving both short-term outcomes and longer-term understanding of factors that may cause an acute incident. By flagging trends in behaviour that are undermining patient well-being, the system can enable a proactive response from the community care team to educate and, hopefully, change behaviour to further improve overall health.

In an NHS that is based on – and funded by – targets associated with chronic disease management, the ability to combine patient portals/apps with community-led care will be an increasingly important component of care provision. Combining the essential factors of improved local care and disease prevention with real time reporting, the mobile model will enable the NHS to extend services that have previously been only available in an expensive secondary care environment into primary care.

> **“There was real enthusiasm for change amongst staff from these general practices, who feel that much more could be done to reach out to their local communities and prevent chronic conditions, at the same time as taking better care of those with long-term conditions”**

REALISING THE VISION

Making community care work is going to be the biggest challenge for the next decade: the figures for reducing NHS costs and improving patient care will not add up unless more services are successfully delivered in the community and hospital admissions are reduced. Today, the funding for community-based care services remains somewhat confused as the transition to GP Commissioning Groups continues. Yet, there remains no doubt that secondary care providers are actively seeking to extend the use of mobile devices to drive improvements in day to day management of chronic health conditions, from Parkinson’s to heart disease and diabetes, within hospital and outpatient departments.

Extending this model to the community has clear potential to improve patient care and enable local groups to meet targets for the management of chronic conditions and achieve the cost-savings required. And it is only once this is in place that the NHS can look more closely at opportunities for community-based collaboration with other involved institutions, to achieve the whole life care that will undoubtedly be the model for future service provision.

- *John Sanderson is Director at Hicom.*

NEW LYXUMIA®▼ LIXISENATIDE – a once-daily GLP-1 receptor agonist for patients with Type 2 Diabetes Mellitus[1]

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Lyxumia is administered with an 'easy-to-use', fixed-dose pen.[2]

Lyxumia®
lixisenatide

Lyxumia® (lixisenatide).

Please refer to Summary of Product Characteristics prior to use of Lyxumia. Lyxumia 10 micrograms solution for injection: Each dose (0.2 ml) contains 10 micrograms (mcg) of lixisenatide (50 mcg per ml). **Lyxumia 20 micrograms solution for injection:** Each dose (0.2 ml) contains 20 micrograms (mcg) of lixisenatide (100 mcg per ml). **Indications:** Treatment of adults with type 2 diabetes mellitus to achieve glycaemic control in combination with oral glucose-lowering medicinal products and/or basal insulin when these, together with diet and exercise, do not provide adequate glycaemic control. **Dosage and administration:** Starting dose: dosing is initiated at 10 mcg Lyxumia once daily for 14 days. Maintenance dose: a fixed maintenance dose of 20 mcg Lyxumia once daily is started on Day 15. Lyxumia 20 micrograms solution for injection is available for the maintenance dose. Lyxumia is administered once daily, within the hour prior to the first meal of the day or the evening meal. If a dose of Lyxumia is missed, it should be injected within the hour prior to the next meal. No dose adjustment is required based on age. The clinical experience in patients ≥75 years is limited. No dose adjustment is required for patients with mild renal impairment (creatinine clearance: 50–80 ml/min). Limited therapeutic experience in patients with moderate renal impairment (creatinine clearance: 30–50 ml/min) and Lyxumia should be used with caution in this population. There is no therapeutic experience in patients with severe renal impairment (creatinine clearance less than 30 ml/min) or end-stage renal disease and therefore, it is not recommended to use Lyxumia in these populations. No dose adjustment is needed in patients with hepatic impairment. The safety and efficacy of lixisenatide in children and adolescents less than 18 years of age have not yet been established. **Contraindications:** Hypersensitivity to lixisenatide or to any of the excipients. **Precautions and warnings:** No therapeutic experience with lixisenatide in patients with type 1 diabetes mellitus and it should not be used in these patients. Lixisenatide should not be used for treatment of diabetic ketoacidosis. Use of glucagon-like peptide-1 (GLP-1) receptor agonists has been associated with a risk of developing acute pancreatitis. If pancreatitis is suspected, lixisenatide should be discontinued; if acute pancreatitis is confirmed, lixisenatide should not be restarted. Caution should be exercised in patients with a history of pancreatitis. Lixisenatide has not been studied in patients with severe gastrointestinal disease, including severe gastroparesis and therefore, the use of lixisenatide is not recommended in these patients. There is limited therapeutic experience in patients with moderate renal impairment (creatinine clearance: 30–50 ml/min) and no therapeutic experience in patients with severe renal impairment (creatinine clearance less than 30 ml/min) or end-stage renal disease. Lyxumia should be used with caution in patients with moderate renal impairment. Use is not recommended in patients with severe renal impairment or end-stage renal disease. Patients receiving Lyxumia with a sulphonylurea or with a basal insulin may have an increased risk of hypoglycaemia. Lyxumia should not be given in combination with basal insulin and a sulphonylurea due to increased risk of hypoglycaemia. Lyxumia should be used with caution in patients receiving oral medicinal products that require rapid gastrointestinal absorption, require careful clinical monitoring or have a narrow therapeutic ratio. Lixisenatide has not been studied in combination with dipeptidyl peptidase 4 (DPP-4) inhibitors. There is limited experience in patients with congestive heart failure. Patients treated with Lyxumia should be advised of the potential risk of dehydration in relation to gastrointestinal adverse reactions and take precautions to avoid fluid depletion. This medicinal product contains metacresol, which may cause allergic reactions. **Interactions:** Paracetamol: No dose adjustment for paracetamol is required but the delayed t_{max} observed when paracetamol is administered 1–4 hours after lixisenatide should be taken into account when a rapid onset of action is required for efficacy. Oral contraceptives: The reduction in C_{max} is of limited clinical relevance and no dose adjustment for oral contraceptives is required. Atorvastatin: Changes to t_{max} and C_{max} are not clinically relevant and therefore, no dose adjustment for atorvastatin is required when co-administered with lixisenatide. Warfarin and other coumarin derivatives: Frequent monitoring of INR in patients on warfarin and/or coumarin derivatives is recommended at the time of initiation or ending of lixisenatide treatment. Digoxin: No dose adjustment for digoxin is required when co-administered with lixisenatide. Ramipril: No dose adjustment for ramipril is required when co-administered with lixisenatide. **Pregnancy and lactation:** Lyxumia is not recommended in women of childbearing potential not using contraception. There are no adequate data from the use of Lyxumia in pregnant women. Lyxumia should not be used during pregnancy. The use of insulin is recommended instead. If a patient wishes to become pregnant, or pregnancy occurs, treatment with Lyxumia should be discontinued. It is unknown if Lyxumia is excreted in human milk. Lyxumia should not be used during breast-feeding. **Adverse reactions: Very common:** Hypoglycaemia (in combination with a sulphonylurea and/or a basal insulin). Headache. Nausea, Vomiting & Diarrhoea; These tend to be mostly mild and transient during the first 3 weeks after starting treatment. Thereafter, they progressively decrease during the following weeks. **Common:** Influenza, Upper respiratory tract infection, Cystitis & Viral infection. Hypoglycaemia (in combination with metformin alone). Dizziness, Somnolence, Dyspepsia, Back pain, Injection site pruritus. **Uncommon:** Anaphylactic reaction and Urticaria. **NHS price:** Lyxumia 10 mcg: 1 pre-filled pen: £27.07, Lyxumia 20 mcg: 2 pre-filled pens: £54.14, Lyxumia 10 mcg + 20 mcg: 1 pre-filled pen + 1 pre-filled pen: £54.14 **Legal category:** POM. **MA holder:** sanofi-aventis groupe, 54, rue La Boétie, F – 75008 Paris, France. **MA Number(s):** Lyxumia 10 mcg: 1 pre-filled pen: EU/1/12/811/001, Lyxumia 20 mcg: 2 pre-filled pens: EU/1/12/811/003, Lyxumia 10 mcg + 20 mcg: 1 pre-filled pen + 1 pre-filled pen: EU/1/12/811/005. **Full prescribing information is available from:** Sanofi, One Onslow Street, Guildford, Surrey, GU1 4YS. Tel: 0845 372 7101. **Date of Revision:** February 2013.

Adverse events should be reported. Reporting forms and information can be found at **www.mhra.gov.uk/yellowcard**. Adverse events should also be reported to the Sanofi drug safety department on 01483 505515.

References: 1. Lyxumia SPC. **2.** Stauder *et al.* A user study comparing pen devices for administration of lixisenatide, exenatide and liraglutide. Poster P459 presented at Diabetes UK Professional Conference, 13–15 March 2013, Manchester, UK.

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Date of preparation: August 2013

SANOFI DIABETES

Health coaching reduces COPD admissions risks

A health coaching pilot has mentored patients to take charge of their health. The programme's success is being duplicated to cover other long-term conditions

Leicester City Clinical Commissioning Group is partnering with Totally Health to expand its health coaching pilot programme which supports patients who have chronic obstructive pulmonary disease (COPD). The contract builds on Leicester's experience of integrating health coaching and telehealth for a 50-person group of patients which has already saved Leicester City Clinical Commissioning Group more than £353,000 in the first 26 weeks.

Leicester City CCG has upscaled and expanded the clinical model from the current 50 COPD patients into a redesigned Long Term Conditions service model with health coaching for 150 existing COPD patients and 250 newly diagnosed COPD patients.

> "We wanted to be able to give our patients access to qualified, specialist advice services so that we can shift the balance and focus from a model that responds to illness, to one which promotes health and well-being"

The programme, which has been developed and delivered through a partnership between the CCG, Leicestershire Partnership NHS Trust and Totally Health, averted 87 hospital admissions for patients registered with the service during the first 26-week period of the original pilot. The hospital admission rate for this 50-person group of patients has fallen from an average 3.29 unscheduled admissions to 1.24. This evidence shows that the service has already delivered considerable cost-savings and, crucially, significantly improved the patient experience.

The Totally Health programme combines Shared Decision Making, the new COPD patient decision aid, health coaching and telehealth monitoring – underpinned by a system that links local GP and secondary care databases. Prior to its launch, Leicester City CCG used risk stratification to identify the COPD patients at greatest risk of repeated hospital admissions that it considered would benefit from monitoring and advice from qualified care providers. It is also using similar risk stratification tools to expand the service, as well as introducing newly diagnosed patients to health coaching as they are identified as most likely to benefit from the mentoring approach that health coaching presents.

Totally Health provides a two-way health coaching service that supports individual patients across their total care pathway. Totally's experienced health coaches are registered nurses, who help patients to manage their condition by providing mentoring and support via telephone calls, alongside telehealth monitoring.

The initial programme was launched in December 2012 to provide the CCG with immediate support during the winter months when, traditionally, unplanned and often avoidable hospital admissions increase due to exacerbations caused by poor preparation for severe cold weather. Health coaches work with patients and carers to ensure people suffering from long-term conditions are adequately prepared, are fully compliant with their treatment regimen and, when exacerbations occur, use their rescue medication in a timely and appropriate manner. In the process, the service helps to minimise exacerbations and reduce expensive, unnecessary unplanned hospital admissions.

A hospital admission is qualified as "averted" based on a measure of the respiratory specialist nurse and/or the health coach providing an intervention to support the individual patient to manage their condition, to the extent that without this clinical support the patient would have been admitted. If the patient is not admitted for a period 14 days, after the 14th day the intervention is classified as a saved hospital admission.

The integrated programme has so far proved to be a success for Leicester City CCG. Beyond the substantial reduction in avoidable admissions, the service has also led to a demonstrable improvement in patient experience and patient satisfaction. During the first quarter of the 12-month programme, each patient had an individual "symptom response plan" developed and was supported to increase their confidence to ensure the plan was put into action when appropriate.

A total of 54% of patients subsequently activated their plan in response to an exacerbation of their condition. In addition, each patient was contacted and supported to ensure that they were optimally prepared for severe weather during the winter months. As a result of the service, almost a third of patients (30%) are already reporting an improvement in their sense of well-being.

Leicester City CCG's Programme Manager, Emma-Jane Roberts, said the early successes of the service vindicates the CCG's approach to change management. "We wanted to be able to give our patients access to qualified, specialist advice services so that we can shift the balance and focus from a model that responds to illness, to one which promotes health and well-being," she said. "The health coaching service provides the continuity for these patients to ensure that they maintain the improved self-management of their condition."

> "Our patients get the support of managing their own condition at home.We know patients are happier and recover quicker when their care is managed at home"

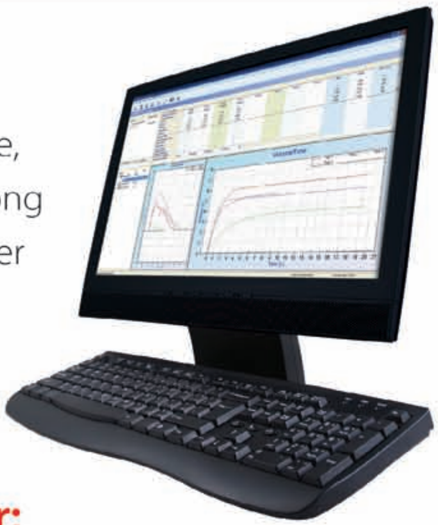
Dr Durairaj, GP and Lead for COPD for the Leicester City Clinical Commissioning Group, said, "Our patients get the support of managing their own condition at home. We know patients are happier and recover quicker when their care is managed at home. We are really pleased that the scheme is working and the project has enabled patients to avoid a hospital stay."

Leicester City also believes that taking an integrated approach to case management using health coaching and telehealth promises major long-term patient benefits in the management of multiple long-term conditions. "A real advantage of dovetailing the health coaching into the telehealth scheme and beyond, is that it provides a service that can offer true patient-centred care for those who have several long-term conditions," said Roberts.

Wendy Lawrence, Chief Executive, Totally Health, said further evaluation of the service is planned. "We are looking forward to working with Leicester City CCG on their evaluation of these additional services, ensuring that once further evidence of the successes of the programme are available we can work with a greater number of the people of Leicester, across more disease areas, ensuring that they directly benefit from this service."

Leicester City has a series of strategic objectives, one of which is the management of COPD. The CCG works in partnership with the local acute trust, University Hospitals of Leicester NHS Trust and also a community trust, Leicestershire Partnership NHS Trust, in a three-way partnership as part of a wider COPD change management programme.


the difference is clear



Asthma – patients say it's controlled but …

A European study finds asthmatics' perceptions of being in control is far from reality with many resorting to high cost hospital care

A study of asthmatics across 11 European countries, including the UK, finds 91% of them think they have got their asthma under tight control. In reality only 20% are under control. The findings place Germany, Belgium and France at the bottom of the table for asthma control while Austria leads ahead of Sweden and the UK for having some control over asthma symptoms. In Austria 28% of people with asthma have achieved control over it although 86% of respondents said they thought they were in control of their symptoms. Similarly in Sweden 26% actually have control but 88% think they have achieved it although they have not.

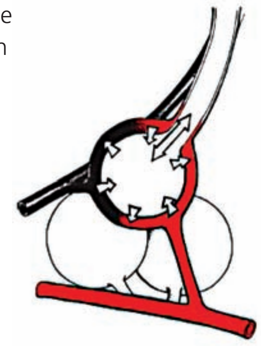
The findings also show 53% of people with asthma have not had their inhaler technique checked in the past 12 months. The data from the Recognise Asthma and Link to Symptoms and Experience survey (REALISE) show a worrisome 45% of all respondents reported having acute asthma exacerbations requiring oral steroid use in the past 12 months. This finding was evident even amongst those meeting the Global Initiative for Asthma (GINA) criteria for current clinical control. Asthma exacerbations are associated with significant societal costs and have a negative impact on the day-to-day lives of patients. The latest findings point to the need to address the problem through greater understanding of patient experiences of asthma to help achieve tighter control over symptoms.

Professor David Price of University of Aberdeen, UK, said, "REALISE highlights that the way patients describe the impact of their condition is inconsistent with their actual experience of symptoms, lifestyle limitations and exacerbations. And this is seen across healthcare systems in Europe. I think a new model for engaging with our patients is required. An approach which seeks to understand patient attitudes and experiences in a way that works for them, for example, through the use of online resources, could make a difference in addressing this disconnect and ultimately improve the way asthma is managed."

Eight thousand asthmatics aged 18-50 took part in the REALISE survey. More than 35% of respondents who met the GINA criteria for current clinical control (20% of survey population) had experienced symptoms on one or two days in the previous week and 7% had been treated in hospital emergency rooms in the last year because their symptoms were severe.

Spirometry fundamentals

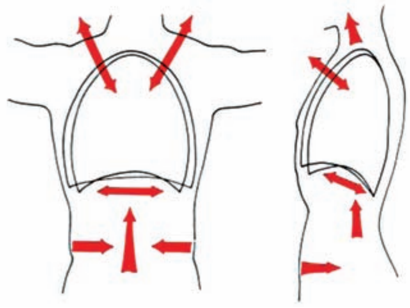
What spirometry measures



Spirometry is all about measuring the lung mechanics – how the volume in the lung empties. This is a very important part of ventilating the lungs for the purpose of getting oxygen into the bloodstream and carrying away carbon dioxide and other waste gasses and vapours excreted by the lungs.

Spirometry is a simple way to get an objective measure of a complex process. Expanded alveoli empty into small airways and small airways empty into large airways. Measuring the volume of the forced expiratory air is a way to determine the limits of the lung mechanics. This is measured by a timed volume displacement measuring device or a flow measuring device which then integrates the flow with respect to time to estimate volumes.

The thoracic cavity



The arrows show the movement of the lung within the thoracic cavity on these frontal and sagittal views of the torso.

Inspiration causes upward and outward movement of the ribs and a flattening of the diaphragm using the intercostal muscles and the muscle of the diaphragm. This causes the expansion of the thoracic cavity and lowers the pressure of the pleural space surrounding the lung. Thus air enters the lungs and they expand.

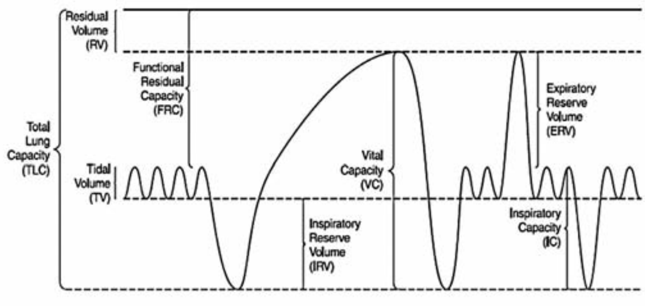
Quiet exhaling is a passive act – the inspiratory muscles relax and the intra-pleural pressure becomes less negative. The elastic recoil of the lungs that had resisted inhaling causes the pressure in the periphery of the lung to increase and the flow of air is reversed. A forced exhaling is assisted by the use of muscles, particularly contraction of the abdominal muscles, which push the diaphragm upward to reduce the size of the rib cage.

The work of respiration is done during inhaling. The intercostal muscles perform the majority of the work, helped by the diaphragm. Exhaling is a normally passive act, but of course not during forced expiratory spirometry.

Static and dynamic lung volume measurements

There are two main kinds of tests performed on simple spirometers:

1. Static lung volume measurements, obtained in spirometry using the slow VC (Vital Capacity) measurement method.



STATIC LUNG VOLUME NOMENCLATURE

2. Dynamic lung volume measurement, or forced spirometry. The vital capacity (VC sometimes called SVC, slow VC) is the air that can be exhaled from fully inflated lungs. The residual volume (RV) is the air that remains (cannot be exhaled due to closure of the small conducting air passages). Thus, the total lung capacity (TLC) is the sum of the VC (also FVC in normal lungs) and the RV. In obstructive disease, the RV and TLC are usually increased. In restrictive disease, they are decreased. Tidal volume (TV) is the amount of air exhaled in resting breathing, which is an important measure when compared to the inspiratory capacity (IC). In many types of lung disease the IC is almost the same as the TV. This means that the sufferer has no more capacity to breathe in – the classic case of an acute asthma attack. The asthmatic feels unable to breathe in enough. Whilst this it true, it is in fact caused by the asthmatic not breathing out enough, because of severe airways narrowing.

The remaining lung volumes shown bottom left cannot be measured on a simple spirometer, to measure these laboratory lung function analysers are required.

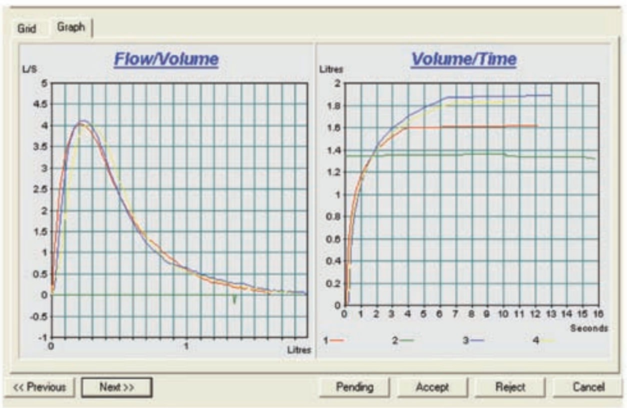
Expressing expiratory airflow

The expiratory volume/time curve gives the simplest and most informative picture of the expiratory spirogram in a forced expiratory test. This is because the FEV1, FVC, and expiratory time can be directly visualised from the curve.

Exactly the same information is available from the flow volume curve. But the FEV1 and expiratory time cannot be directly visualised. Some experts believe that there are some quantitative advantages to being able to view the contours of the expiratory flow volume curve (i.e. the progressive concavity associated with the loss of elastic recoil). But there are many disadvantages to only viewing the f/v curve, not least the loss of quality control.

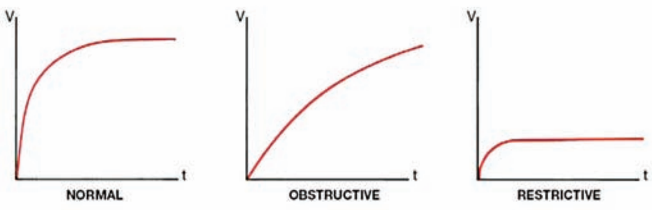
For example, these flow/volume curves and volume/time curves were recorded simultaneously in a test session. Looking at only the flow/volume curves the test appears to be good.

The volume/time curves show the real story, though. The evidence of premature forced exhalation is very clear on every blow.



Spirometry curve patterns: Airways obstruction and restriction

Lung diseases are grouped into two types of disease: obstructive disease and restrictive disease. Obstruction of the airways means that they are narrower than they should be so that air cannot exit the lungs as fast as a normal lung. Restriction of the airways means that they are limited in the amount of air that they can exhale, in other words the exhaled volume is smaller than a normal lung.



NORMAL, OBSTRUCTIVE AND RESTRICTIVE PATTERNS ON THE SPIROGRAM

Of course, some people can have both types of pattern simultaneously, called mixed pattern. But by far the most prevalent pattern is obstruction.

Interpretation

Spirometric interpretation needs to be simple. This is why the two basic parameters of FVC and FEV1 are normally the only ones used. The normal ratio between FEV1 and FVC is 0.70 to 0.75. FEV1 is an index of air flow, which is the volume expired in a second. Since the FEV1 is an index of flow, a reduced FEV1 indicates a flow or obstructive abnormality. Since the FVC is an index of volume, a reduced FVC indicates a volume or restrictive ventilatory abnormality.

Preparation for a spirometry test

A spirometer that is not accurate and reliable is worse than useless. But having an accurate spirometer is not a matter of belief or faith; it is a matter of proof. Furthermore, this must be documented proof. Without a documented daily accuracy check your spirometry measurements are useless, no matter how accurate you believe your spirometer to be. All spirometry standards say that daily accuracy checks are essential. It is also common sense. It only takes two minutes at the start of the day to assure yourself, and have documented proof, that your spirometer is accurate.

Also, as with any precision measuring instrument, a spirometer requires an ongoing program of preventative maintenance that includes regular accuracy and linearity assessment, cleaning and performance checks. Just like your car, an annual service is essential to validate proper functioning, safety and routine replacement of certain components, but medical devices with a measuring function additionally require hygiene procedures and calibration certification, traceable to international standards.

Precision syringe for checking accuracy of your spirometer

A 3-L precision syringe is the essential tool to check spirometer accuracy. All spirometry standards recommend a check each day that the device is used. This is different to the need to adjust the calibration, which will be very infrequent or never on today's spirometers.

To conform to the required standards, spirometers must be accurate to within ±3%. The precision syringe needs to be at the same temperature as the spirometer and for this reason it is usually stored near the spirometer.

Conducting a spirometry test

It is essential that the subject performing the test be clearly instructed in the procedure prior to the commencement of each test. To achieve good results, carefully explain the procedure to the patient. A very enthusiastic demonstration by the operator is required so that the subject when carrying out the forced expiratory test makes a maximum effort.

Comparing the spirometry measurements with previous measurements on a test subject is the most valuable information that can be gained from a spirometry test.

This can be done very simply on a single sheet of paper by recording the FEV1 value at age of test. This is a serial spirometry record.

Some computerised spirometers do this automatically, but often this simple paper chart is still the best thing to file in the medical record.

Make the test subject comfortable and fully explain the procedure. Use a new disposable noseclip and SafeWay mouthpiece or BVF with each subject.

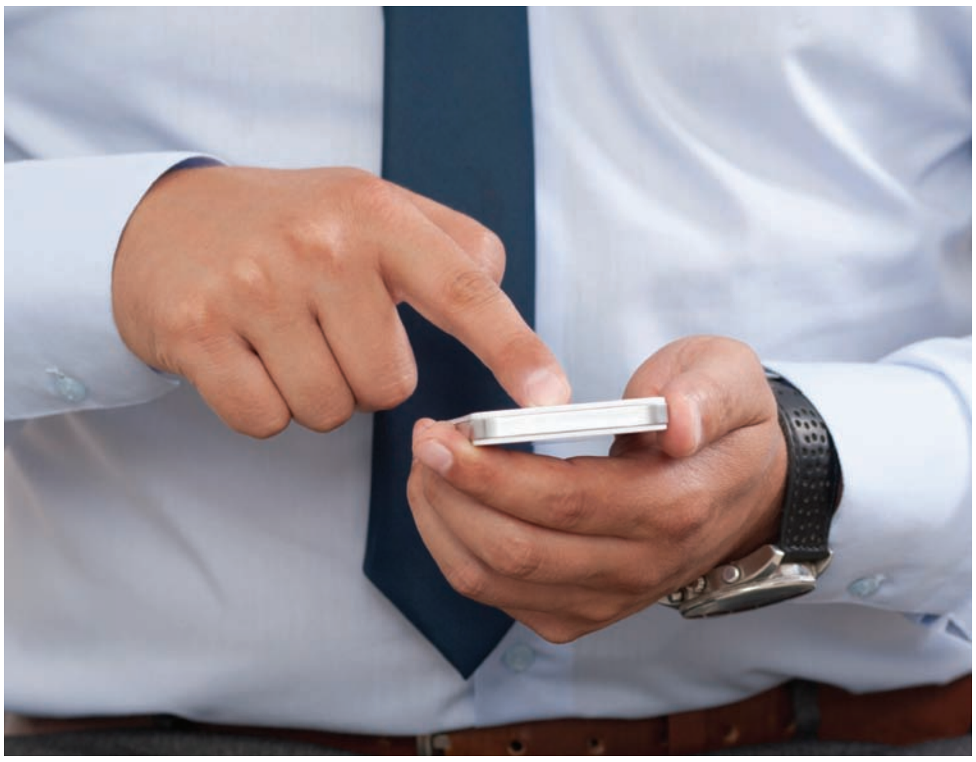
SPIROMETRY STEPS

1. **Measure standing height (without shoes).**
2. **Explain and demonstrate the test procedure.**
3. **Observe and enthusiastically coach the subject on each effort.**
4. **Repeat until acceptable test repeatability obtained.**
5. **Use the Serial Spirometry Record* to record: Date of Test; Measured Values; (Name; I.D.; D.O.B.; Gender; Height; Posture.)**

Bipolar self-help takes to the web

The Living with Bipolar project funded by Mersey Care NHS Trust is the first national trial of a web-based self-management intervention for bipolar disorder

By Steven Jones



For the 1 million people in the UK diagnosed with bipolar disorder, accessing psychological interventions can be a problem. Online psychological interventions are a recently adopted solution for some groups, recommended in the NICE guidelines for mild to moderate anxiety and depression, and providing self-directed support to many people at a reduced cost to the NHS. However, there are currently no established evidence-based online interventions for people with bipolar and the majority of websites provide a poor quality of information on mental health problems. As one of the contributors to our research said, "I still remember being given an A4 page and being told 'this is your condition'. I am sorry I have got to live with this for the rest of my life … I need more than this, I need to continue to be able to be a productive human being."

People's needs for care vary by individual across the course of bipolar. Self help approaches are important in offering another option and in helping meet the need among service users for more independence, to have the opportunity to care for themselves and monitor their own condition in order to lead a more normal life. Our work is dedicated to developing a range of psychological support options so that there can be more matching to client needs.

The Living with Bipolar (LBW) project,[1] funded by Mersey Care NHS Trust has been the first national trial of a web-based self-management intervention for bipolar disorder. By talking to five focus groups of current service users we were able to identify their needs and what they wanted from a resource. In general they made it clear they wanted a different approach from the traditional services, a focus on "recovery", the chance to live alongside their symptoms, achieving what they wanted in life while accepting they might not eradicate all the symptoms. A participant in LWB explained, "For me, recovery is certainly not about being symptom free … it is about coping and having a reasonable quality of life, being able to work productively and enjoy things outside of work." Participants also wanted an opportunity for self-management rather than an approach dictated by professionals who might be removed from their individual circumstances and experiences, and a means of overcoming some of the negativity and taboo around mental health by being less dependent on professional services.[2]

More specifically, the service users wanted a resource that was focused less around managing mood swings, and more on the practical interpersonal skills needed to live through episodes. They wanted information on how to retain the highs associated with bipolar disorder, but at a more manageable level, so the range of emotions they felt was less extreme. "I value my mood swings … I don't want to be absolutely flat … I want an interesting life … but to be able to maintain relationships, a good quality of life and to be useful to someone." And a resource that would allow them to take control of their own wellness by being empowered to be an "expert by experience." The service users did not focus on a "cure" as their desired outcome but instead personally defined recovery goals and improved quality of life.[3]

The resulting web resource LWB included 10 modules or sessions that users could pick and choose from, working through specific topics when they wanted to. The modules included the "recovery" approach, self-management, bipolar, medication, recognising mood swings, staying well, depression, how to talk about their condition, and dealing with moments of crisis. Most importantly, each area includes examples and case studies written by people with bipolar disorder in order to show the resource users that they are not alone and share common experiences, as well as the practical insights and hope they provide. The resource also includes interactive worksheets to encourage more thought about the topics, a mood checking tool to guide people to different parts of the intervention at times of distress, and a support forum. The forum proved to be very important to people trialing the system, to share advice and support, and as motivation for continuing to login and use the system even during periods when they were stable.

> "I have encountered insights in the modules that have significantly helped me to survive the blackest moments. I cannot measure the value of this, as it has contributed to the difference between life and death"

The trial involved 122 participants with bipolar disorder and ran over a period of six months.[4] Participants engaged with the approach and feedback was positive. The intervention was found to improve recovery and quality of life. The specific results of this trial are due to be published. Participants found the intervention accessible, practical and recovery focused with a flexible interface allowing participants to take responsibility for their wellness. The peer support forum in particular was thought to be very supportive and helped keep them engaged with the intervention. One participant commented: "… part of it is feeling very alone … you don't get that and I do think that the forum works extremely well with the intervention…" Participants left the intervention with a less threatening view of their condition and were becoming more confident to take control, which meant they used more mood management techniques and changed the way they used services. The therapeutic benefits included improved stability, accessing additional help from friends and family, less reliance on services and being more likely to turn to self-management. One service user said, "I have encountered insights in the modules that have significantly helped me to survive the blackest moments. I cannot measure the value of this, as it has contributed to the difference between life and death. My husband and I are sincerely grateful for the immeasurable impact this has had on our family."

The results provide some encouraging early evidence for "recovery" focused CBT and psycho-educational self-management packages as an acceptable and effective form of psychological intervention in bipolar disorder. Web-based interventions could be part of the improving access to psychological therapies (IAPT) initiative which is currently being extended into severe mental health. The aim for our work is to continue to develop our online interventions in light of feedback and to run further controlled trials of the site, to assess clinical and cost effectiveness.

The Spectrum Centre at Lancaster University is running other trials of online programmes. One, funded by the Medical Research Council, is looking at the challenges faced by parents with bipolar disorder. The instability that characterises the condition can make it challenging to provide the consistency important for constructive parenting. In our clinical experience, parents often say they lack confidence in parenting and worry about whether their bipolar disorder is impacting on this. However, it is also rare for people in this situation to seek out additional parenting support for fear of further stigma and often due to mixed feelings about care services.

> **“We are also keen not to ignore the needs of relatives of people with bipolar experiences”**

We have already conducted a pilot study which showed potential benefits for parents and children.[5] The current pilot uses an interactive website[6] which offers information on both bipolar disorder and parenting with extensive use of video material from parents with bipolar disorder. The focus of the parenting side of the intervention is around how essentially “normal” the challenges of parenting can be (and not specific to having a mental health diagnosis) and constructive suggestions on effective ways to increase parenting confidence and reduce child problem behaviours. The website has been developed in partnership with parents with experience of bipolar disorder. We are in the process of recruiting 100 parents to this study and will be assessing its impact on parenting, child behaviour and parental mental health and day to day functioning.

Our research has already established that training care coordinators in mental health teams in relapse prevention can improve outcomes for the clients with bipolar disorder in their care,[7] however many people with this diagnosis are not in such teams and do not therefore have access to this support even if it is widely adopted. The Early Relapse Prevention web intervention[8] draws on the principles of enhanced relapse prevention but delivers it via an interactive website including video material of service users. The website provides interactive strategies for learning to detect early warning signs of mood change and to develop coping strategies to reduce the likelihood of such changes developing into full mood episodes.

This study is currently recruiting participants and will assess how acceptable the intervention is, as well as its impact on clinical and functional outcomes.

We are also keen not to ignore the needs of relatives of people with bipolar experiences. They also face many challenges and need ready access to high quality information and specific strategies they can use to manage their own stress, and to know how best to help their relative. The Relatives Education And Coping Toolkit (REACT) was originally developed to support relatives of people with psychosis. We are currently seeking funding to adapt this to meet the needs of relatives.

- *Professor Steven Jones is Director of the Spectrum Centre at The University of Lancaster, Lancaster, UK.*

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ABRIDGED PRESCRIBING INFORMATION

Inactivated Influenza Vaccine (Split Virion) BP

Refer to Summary of Product Characteristics for full product information. **Presentation:** Inactivated Influenza Vaccine (Split Virion) BP contains 15 micrograms of antigen (per 0.5 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as single dose prefilled syringes each containing 0.5 millilitre of suspension for injection. The vaccine may contain traces of eggs, such as ovalbumin, neomycin, formaldehyde and octoxinol 9 which are used during the manufacturing process. **Indications:** Prophylaxis of influenza especially in those who run an increased risk of associated complications. Inactivated Influenza Vaccine (Split Virion) BP is indicated in adults and children from 6 months of age. **Dosage and administration:** Adults and children from 36 months should receive one 0.5 millilitre dose. In children aged 6 months to 35 months clinical data are limited and dosages of 0.25 or 0.5 millilitre have been used. Children who have not been previously vaccinated should receive a second dose of vaccine after an interval of at least 4 weeks. Doses should be administered intramuscularly or deep subcutaneously. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, neomycin, formaldehyde, and octoxinol 9. Immunisation should be postponed in patients with febrile illness or acute infection. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. **Pregnancy and lactation:** Inactivated influenza vaccines can be used in all stages of pregnancy. May be administered during lactation. **Undesirable effects:** Common side effects include: injection site reactions (redness, swelling, pain, ecchymosis, induration) and systemic reactions (fever, malaise, shivering, fatigue, headache, sweating, myalgia, arthralgia). These usually disappear within 1 to 2 days. Other serious side effects have been reported and include, allergic reactions (in rare cases leading to shock, angioedema), convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095 **Legal category:** POM. Date of last review: April 2012

INTANZA® 9 microgram/ strain suspension for injection [Influenza vaccine (split virion, inactivated)]

Refer to Summary of Product Characteristics for full product information.

Presentation: Intanza 9 microgram contains 9 micrograms of antigen (per 0.1 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as a 0.1 millilitre suspension in a pre-filled syringe with a Micro-Injection System, with attached micro-needle. **Indications:** Prophylaxis of influenza in adults from 18 to 59 years of age. **Dosage and administration:** Adults from 18 to 59 years of age should receive one 0.1 millilitre dose. Doses should be administered intradermally. The deltoid is the recommended site of administration. Intanza 9 microgram is not recommended for use in children and adolescents below 18 years. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to residues of eggs, such as ovalbumin, and to chicken protein. The vaccine may also contain residues of the following substances: neomycin, formaldehyde and octoxinol. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. Re-vaccination is not required in the event that liquid is present at site of injection. **Pregnancy and lactation:** Inactivated influenza vaccines can be used in all stages of pregnancy. The vaccine may be used during lactation. **Undesirable effects:** Very common side effects: headache, myalgia, malaise and injection site reactions (redness, swelling, pain, induration, pruritus). Common side effects: fever, shivering, and ecchymosis at the injection site. Other side effects that may potentially be serious include allergic reactions (in rare cases leading to shock, angioedema), febrile convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose pre-filled syringes in single packs, basic NHS cost £9.05, packs of 10 single dose pre-filled syringes, basic NHS cost £90.50. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France **Marketing authorisation number:** EU/1/08/505/001 EU/1/08/505/002 **Legal category:** POM ® Registered trademark **Date of last review:** February 2013

INTANZA® 15 microgram/ strain suspension for injection [Influenza vaccine (split virion, inactivated)]

Refer to Summary of Product Characteristics for full product information.

Presentation: Intanza 15 microgram contains 15 micrograms of antigen (per 0.1millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as a 0.1 millilitre suspension in a pre-filled syringe with a Micro-Injection System, with attached microneedle. **Indications:** Prophylaxis of influenza in individuals 60 years of age and over. **Dosage and administration:** Adults of 60 years of age and over should receive one 0.1 millilitre dose. Doses should be administered intradermally. The deltoid is the recommended site of administration. Intanza 15 is not recommended for use in children and adolescents below 18 years. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to residues of eggs, such as ovalbumin, and to chicken protein. The vaccine may also contain residues of the following substances: neomycin, formaldehyde and octoxinol. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. Re-vaccination is not required in the event that liquid is present at site of injection. **Pregnancy and lactation:** This vaccine is intended for individuals aged 60 years of age and over. Therefore, this information is not applicable. **Undesirable effects:** Very common side effects: headache, myalgia and injection site reactions (redness, swelling, pain, induration, pruritus). Common side effects: fever, malaise, shivering, and ecchymosis at the injection site. Other side effects that may potentially be serious include allergic reactions (in rare cases leading to shock, angioedema), febrile convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose pre-filled syringes in single packs, basic NHS cost £9.05, packs of 10 single dose pre-filled syringes, basic NHS cost £90.50. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France **Marketing authorisation number:** EU/1/08/505/004 EU/1/08/505/005 **Legal category:** POM ®Registered trademark **Date of last review:** February 2013

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Reporting forms and information
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www.mhra.gov.uk/yellowcard
Adverse events should also be reported
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UK16961 10/13

Vaccination of health and social care workers is recommended by the Department of Health to reduce the spread of flu. This can help protect you, your family and your patients.[1]


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Why lip service alon deliver patient parti

The drive to include patients on the commissioning journey can succeed when practical steps are tak which the patient's voice is heard, understood and embedded in the commissioning of health and ca

By Leigh Cantero

Equity and Excellence: Liberating the NHS sets out the Government's long-term vision for the future of the NHS and aims to put patients at the heart of everything the NHS does with the motto of: *No decisions about me without me*. But how can this idea be operationalised in a practical way so that the impacts of the objectives are delivered?

Money is paid into a National Insurance by everyone for health care and the patient is buying a service with the expectation that the system will deliver a quality service as a response. The patient expects to be treated "right." The expectation should be they are receiving a good service. This proposal has always assumed that the practitioner knows how to include the patient on this journey and that the patient knows what good care should be.

Sourcing the right services, or buying the services the customer wants supports the objectives of the White Paper which are to:

- put patients at the heart of everything the NHS does
- focus on continuously improving those things that really matter to patients – the outcome of their healthcare
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

GPs and other healthcare providers who are delivering these visions are responsible to patients for the commissioning of care. With this responsibility is the need for a process to be able to effectively bring the patient on this journey of care as a partner with the practitioner towards delivering a system which continually improves.

The idea of supporting this relationship of care is the vision and to be able to influence decisions directly with practice teams and deliver patient centric services would be the outcome.

Each one of these visions, needs to be tackled to be able to deliver a way forward or create a platform to support building blocks for success.

To do this practically a few ways are illustrated below:

BE BUSINESS SAVVY

The patient has expectations for the services they have in their mind already bought through the inclusion of their monies into a National Insurance Fund. These patients need to be understood, as customers. What do the customers want to buy, for how much and are they satisfied with the services are all business issues that need to be managed. Putting the customer first and always trying to better the service for the customer, because the customer will always come back to the service and buy more products or services, is the goal.

The patient wants to walk into a health service, be smiled at, be known through the right systems, correctly identified, and seen in a timely fashion. The system then directs the patient to the right area of care, to the practitioner who can lead them through a process of correct analysis and then to the support services which can facilitate care such as pharmacies, or community services to have care closer to home. Technology, information systems, enabling services, locality of services, transport, and correct diagnosis would all be factors for patient satisfaction at the end of the service.

Being business savvy is understanding the patient's journey at each stage. From when the patient walks into any services, until the end of care, each moment needs to be taken into consideration for better service. How are staff treating the patient when he or she arrives is as important as the actual clinical service they are receiving for a diabetic pathway, for example. For that particular diabetic patient, eye specialists, along with podiatry services need to be easily obtained, and the commissioning which will support these services need to buy the services patients want.

RESEARCH

Knowing what the patient wants takes time, through desk review, experience and research. Clinicians can influence the way health services are provided by understanding local needs of the population and addressing them through recommending new services, or redesigning existing ones to better meet patient needs. Only through understanding what is needed can any commissioner actually make change, or influence a different state. The only way to do this is through research.

Key data, for example, such as referrals, prescribing activity, associated costs and expected health improvements are all important to improve services and a way to continue to commission the right services in the future.

Understanding patterns is the way to understand the patient journey and to take them into consideration to make a better service. Buying services, or discontinuing services can only happen with accurate information and research to guide practice.

Identifying the opportunities and informing best practice is important to make changes to pathways, clinical models of care and the business in general. Being able to report to people, with information is key to change.

PARTNER FOR A STRONGER VOICE

Partnership is not just the clinician and the patient, it is partnering with the system. Partnerships are important to create a stronger voice supported by pooled resources from multiple development partners in this new game change of commissioning.

Partners whose voices can change the patient's journeys in the healthcare environment are:

- Consortium of GPs
- Grouped Practices
- Individual GPs, as a team of leaders guiding change
- Not-for-profit social enterprises
- Representation to the GP commissioning board
- Patient advocacy groups
- GP representatives in particular practices

Meeting monthly to ensure a local focus, for example, with key data to show patterns of what is happening on the ground, will guide the journey of healthcare and in the end do the right thing for the patient. Having groups of individuals who can voice concern will make changes and these voices can be the voice of the patient.

COMMUNICATE

Commissioning Boards and GP consortia working together to make effective and efficient commissioning decisions can only happen through communication and transparency. GP consortia working closely with secondary care, community partners and other health and care professionals to design joined-up services that are responsive to patients and the public is the objective. Communicating effectively on what are the visions and the overall goals of the business is important to stay on track and to gain momentum in this new environment of commissioning.

Working with clinical leaders, patients and suppliers to identify and promote best practice, identifying new treatment approaches and taking action to improve patient experience and outcomes will be ensured if communication is continued through board meetings, newsletters, social events, patient gathering, and overall marketing the services which are provided.

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en by commissioners to achieve partnerships in
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Marketing – through communication channels such as emails, conferences, print material – can bring together clinicians, commissioners, and Public Health experts with the patients and carers who use the relevant services and show everyone what is being delivered at what price. Community members who have a particular interest, knowledge or experience of a specific area of specialised healthcare and wish to contribute can be involved through these events.

Marketing also means using the research to better the communication. Using forums, such as a Thursday night every three months in a GP consortia to go through data, patient surveys, comments and staff issues can better the services and direct commissioning.

> “The idea of supporting this relationship of care is the vision and to be able to influence decisions directly with practice teams and deliver patient centric services would be the outcome”

BE EFFICIENT AND EFFECTIVE

One of the central features in “Liberating the NHS” is to devolve commissioning responsibilities and budgets but this needs information to be efficient and effective. Research and data can drive efficiency. De-commissioning is a leader’s responsibility and monies saved can be reinvested towards what the patient has been asking for through communication of surveys or other means.

Databases, profit and loss statements, and budget books are all information that can drive through success to the business and be levers towards change because there is evidence to show what is needed to change. Saving money to the system is a way to redirect the funds to services that are needed, and/or buying technology to enable services to make the patient’s journey better.

MONITOR AND EVALUATE

How GP consortia and commissioning boards can best involve patients in improving the quality of health services is to show how to improve their performance and become more consistent in providing high-quality care.

Identifying change can only happen with consistent performance reporting. Setting targets over time to achieve, while monitoring and evaluating how to change those targets for the better will change the patient’s journey. Ensuring the targets are achieved will support improvements in outcomes within limited resources.

Monitoring and evaluating the services provided is key to direct change, and ensuring quality and right care.

BE INNOVATIVE

Sometimes in business it is also about being innovative and trying new things.

- Create and maintain a common mapping platform of what is happening end-to-end for the patient and practitioner, but think also about the data journey (what is happening with data?)
- Develop visualisation tools to display and distribution at all levels to support research, and monitoring and evaluation.
- Develop and apply technology to create patient feedback mechanisms (surveys, events, databases).
- Build leader capacity to provide feedback on results through informing choice and directing the commissioning journey.
- Each of the building blocks above can practically ensure the commissioner is doing the right thing for the patient.

• Leigh Cantero is a healthcare consultant and contributing writer.

Lilley's View

By Roy Lilley

Quality – don't test it, build it

Why should the NHS stake its reputation for quality on a handful of clipboard carriers turning up and turning over General practices?

In the late sixties the German motor manufacturer Volkswagen sent a team of engineers to Japan. They were interested in the likelihood that the Japanese might be thinking about exporting cars to Europe. They spent several weeks snooping around and came back to write a report that has become something of a course classic for MBA students.

They wrote a long report. The upshot of it was: Japan is a long way away, their standards of manufacture aren't great, they don't understand European tastes, it would be impossible to send and store enough spares to support their exports and you could never make a car on the other side of the world, ship it, service it, support a dealership network and make a profit.

Well, hands up who drives a Honda or Toyota or any of the other Far East exports.

How did they do it? Well the Germans reckoned without a man called William Edwards Deming. Deming was a US physicist who had been sent to Japan as part of the post-war reparations programme. Half of Japan was starving; their agricultural industry had been laid-waste by the bombing and the aftermath of the nuclear conflagration. By using pioneering data analysis techniques Deming was able to revolutionise Japanese farming. As a result he was feted and rewarded by Emperor Hirohito.

Deming then turned his skills to the automotive industry. Most American manufacturers expected the Japanese export onslaught would come from cheap products, undercutting US home-produced items. In fact, Japanese cars and other products were of fantastic quality and at a price that undercut the American industrial equivalents. The impact nearly destabilised the American economy.

How did they do it? Deming developed manufacturing techniques based on statistical analysis and applied them to manufacturing. He measured and tested to predict typical results. Work was broken into component parts and there was a ruthless commitment to making sure every step of the way was correct before the next step was started.

US and European manufacturers made their cars and inspected them to see if they were OK. The result – huge time wasted in taking cars apart to deal with faults, some faults were just overlooked and cars were shipped with defects. Japan's techniques were entirely different. They later developed into the Toyota Lean methodology.

> **"Deming is right. If you inspect and everything is OK, you've wasted your time. If you inspect and it's rubbish … it's too late"**

Deming was the godfather of modern quality and went on to write his famous 14 points for managers, the third of which was: "Cease dependence on inspection to achieve quality. Eliminate the need for massive inspection by building quality into the product in the first place."

Deming is right. If you inspect and everything is OK, you've wasted your time. If you inspect and it's rubbish … it's too late.

Every management guru since has agreed. Inspection doesn't work. Michael Porter, Charles Handy, Tom Peters, all of them say the same thing. Inspection doesn't work.

So, why would the NHS stake its reputation for quality on a handful of clipboard carriers turning up and turning over your practice?

The truth is, I have no idea! I know of no other mission critical organisation that relies on post-event inspection as a quality marker. I can guess the reason the NHS is doing it is because the politicos in the Department of Health think that by announcing inspection by a doctor it will make everyone think the NHS is safe.

According to the people doing the inspection; it's far from safe. For 14 years the Care Quality Commission has been inspecting the NHS. Some weeks ago they announced that despite all this effort and time and money 25% of hospitals are still unsafe. Do you want any more proof that inspecting doesn't improve quality?

Well, now it's your turn. Primary Care is to be inspected. In fact, the inspections have started. I heard a story of a practice manager reduced to tears by an inspector because she couldn't provide any record of when a set of modesty curtains, around an examination table were last laundered. In fact, the practice manager takes them home to launder them but couldn't call to mind when it was last done.

Someone else told me that some out of date drugs were found in a fridge. Apparently they were there awaiting disposal. As the practice was on EMIS and all drugs must be bar-code checked on the computer before they can be administered, they couldn't have been used. Plus all drugs have to be signed for as correct and in-date before they are used. The "inspector" was unaware of this.

> **"For 14 years the Care Quality Commission has been inspecting the NHS"**

Another case was of a treatment room whose window looked onto a 10ft brick wall with Wisteria just three feet way, across a Hawthorne bush on the boundary. The inspector created hell because there were no curtains at the window.

I'm amazed the British Medical Association is putting up with this. I guess the problem is, if you make a fuss about inspection it looks like you are not into quality and improvement and all the other good stuff that "inspection" is a proxy for.

Anyway, good luck and do let me know how it goes! I might pop round to see how you're doing; I'll buy a clipboard and a flat cap!

- *Roy Lilley is a healthcare commentator and publishes a daily e-newsletter for health service managers. See www.nhsmanagers.net*

Let's think it through …

It's funny how quite important changes to the NHS can sneak in under the wire.

Cast your mind back to 2011; a pilot scheme that allowed pharmacists to access summary care records in Bradford was scrapped. There was a bit of a brouhaha about it at the time but it was quietly laid to rest.

Last week, in Parliament, Health Secretary Jeremy Hunt announced the go-ahead for the scheme nationally.

Pharmacists are always lobbying to be able to do more in the primary care sector. Trapped in the canyon between the sun cream and the condoms, I've never had a lot of confidence in the idea I can have a confidential chat over the Nurofen about the irritating little spot that I have some place that the sun rarely sees.

Allowing the pharmacists access to patient records might stop a few errors, might help with medicine reviews but could also open the door to all sorts we might be less happy about.

Technically it's not going to be too easy. Connecting a pharmacist working in the practice is one thing. However, for a patient looking to fulfil a prescription on the way to work, whilst travelling, or out shopping would mean allowing any pharmacist access to any patient's record. This is a big technological ask.

Is it me or do they never think things through?

Support for health professionals working with people with autism

The National Autistic Society

The National Autistic Society offers a wide range of services for health care professionals which will help you to develop your skills base and learning.

The National Autistic Society's Professional Conference

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Key speakers will include:

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- **Dr Roy Richard Grinker,** The George Washington University
- **Ros Blackburn,** autism speaker and advocate.

Clinical stream highlights include:

- gastrointestinal issues and autism – is there an overlap and, if so, what are the implications?
- understanding sleep problems in autism
- the role of the GP in ASC: driving guidelines into practice
- understanding and working with eating problems in ASDs.

www.autism.org.uk/conferences/professional2014

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