THE CONSULTANT

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HOT DEBATE:
DO WE HAVE AN ATTITUDE PROBLEM WHEN IT COMES TO ALCOHOL?

WHAT CAN THE CURRENT COMMISSIONING PROCESS LEARN FROM PREVIOUS MODELS?

DESIGNING HANDOVER OF CARE: A VALUE PERSPECTIVE

Click for Full Table of Contents

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THE CONSULTANT

Welcome to this twelfth edition of The Consultant.

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

We do hope that you enjoy this edition as it features a diverse range of articles designed to inform and stimulate debate. This month's Hot Debate focuses on UK attitudes to alcohol and how best we can curb the associated escalating costs for healthcare services. We know there's a vast amount of conflicting opinion out there around this topic and therefore I am particularly keen to receive direct feedback, comment and opinions, some of which will be published in next month's edition.

Elsewhere, we consider what the current Clinical Commissioning process can learn, if anything, from previous models in the run up to CCGs taking control next year, and, as the summer euphoria around the Olympics and Paralympics Games begins to subside, we speak to Paralympic Partner, Ottobock Healthcare, about their long association with the Paralympics and how they continue to drive forward technological innovation in Prosthetics and Orthotics.

We hope you enjoy looking through this edition.

Yours faithfully

Dr Sara L Watkin
Editor-in-Chief

In This Issue...

HEALTHCARE NEWS 4

What can the current commissioning process learn from previous models? 6

HOT DEBATE 8

The UK and alcohol: The Drinkaware approach 9

"We must all become more aware of the dangers of excessive drinking" 14

What does it take? How Scotland is attempting to turn the tide on alcohol misuse 18

Technological Excellence: Ottobock precision, mind control and the passion of the Paralympics 22

Designing Handover of Care: A value perspective 28

The Lotus Elise S - out of this world 34

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Experts step in to save Mid Staffordshire NHS Foundation Trust from financial meltdown

Mid Staffordshire NHS Foundation Trust, the latest in a growing list of Trusts to have hit financial trouble, is to be probed by experts tasked with finding options for the provision of healthcare services in Staffordshire.

Experts will investigate the Trust over the next few months before delivering a report to the independent regulator Monitor recommending the best way forward.

The move has been agreed with NHS partners nationally and locally.

Lyn Hill-Tout, Chief Executive of Mid Staffordshire NHS Foundation Trust, said:"We are hopeful that the outcome of this review by Monitor will be that decisions are made about which services are to be provided at Stafford and Cannock Chase Hospitals.

"Reviews of the Trust over the last few years and the changes to the way healthcare has begun to be provided nationally have led to a growing feeling of uncertainty about the future of the two hospitals.

We welcome Monitor working with our commissioners so that clear decisions are taken which ensure that the healthcare needs of local people are met in a truly sustainable way. We will of course give Monitor every support and will cooperate fully with their review team."

Dr David Bennett, Chair and Interim Chief Executive of Monitor, said: "We have been working closely with Mid Staffordshire NHS Foundation Trust to improve its performance. It has made significant improvements in the clinical care provided for patients, but we need to make sure these services can be secured in the long-term."

Monitor is due to receive a final report in spring 2013.

NHS Clinical Leadership Fellowship: Reshaping healthcare for patients

The task of transforming leadership in the NHS was given a boost this week with the news that 80 clinical professionals from NHS organisations around the country have joined the NHS Leadership Academy's flagship clinical leadership programme.

The programme gives clinical professionals the opportunity to develop their leadership skills through a structured learning programme which they can do alongside their existing clinical roles.

Jan Sobieraj, Managing Director of the NHS Leadership Academy, said "The NHS now needs clinical professionals who think innovatively, have a burning ambition to lead change and who want to improve services and outcomes for patients.

"The strength of the Clinical Leadership Fellowship programme is that it gives participants the tools and knowledge to do just this, in the real word. It is structured around academic learning but very much grounded by a real-time service improvement project.

"I welcome the 2012 Fellows on board and wish them every success on their leadership development journey."

Pictures shows: (l-r) Public Health Specialist Denise Thiruchelvam (new Fellow);Sir David Nicholson, NHS Chief Executive; Anna Soubry MP; Jan Sobieraj and Consultant Dr Andrea Lavinio (new Fellow).

Poots announces new health framework to change lives for the better in Northern Ireland

Health Minister Edwin Poots has unveiled a new strategic plan for improving the health and wellbeing of everyone in Northern Ireland.

The plan forms an integral part of Fit and Well – Changing Lives 2012-2022, the draft strategic framework for public health which is currently under consultation.

Mr Poots said: "Our health has been improving but unfortunately the rate of improvement is not the same for everyone in Northern Ireland. "Health outcomes are generally worse in the most deprived areas. Significant health inequality gaps continue to exist in terms of life expectancy, drug related and alcohol related mortality and suicide. Inequalities in population health are related to inequalities in society.

"If we are to break the cycle of disadvantage, it is vital that our children are given the best possible start in life. This starts from ante natal care, and includes childhood development, support for good parenting and opportunities for learning."

Specialised Services commissioning strategy outlined in new report

Recommendations as to which specialised services should be nationally commissioned from April 2013 have been made in a report published this week.

Although Clinical Commissioning Groups (CCGs) will be responsible for buying and planning the majority of health services from April 2013, specialised services need to be organised differently and commissioned on a wider scale.

Kathy McLean, Chair of the Clinical Advisory Group (CAG) which compiled the report said: "I am very grateful to the members of CAG for all their hard work that was carried out to a very challenging timetable. I think that publication of the report will bring clarity to commissioners, clinicians providing the services, patients and patient groups."

The Department of Health will consult with the NHS Commissioning Board on the CAG recommendations before a final set of regulations is published later in the year.

What can the current commissioning process learn from previous models?

By Stephen Foster, Non-Executive Director,Commissioning4health

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

Or to put it another way, what can the current commissioning process learn from previous models?

My first belief is that, although there are many great examples of what good looks like, we shouldn't try to be too much like the NHS of the past. We have a bad habit within the NHS of reverting to type – our regional commissioning boards are beginning to look too much like SHAs, and we are in danger of our CCGs becoming exactly like PCTs if we are not careful.

I spent five years in PCT land on the Professional Executive Committee of my local PCT, and found it a massively frustrating time. We spent hours and hours, sitting round large tables discussing strategy and ensuring that we "ticked all the boxes", and ended up buried so deep in the bureaucracy and administration that we seemed, in my opinion, to achieve very little.

The first lesson to learn, therefore, is not to get too embroiled in bureaucracy – a lean organisation is an effective organisation in my opinion, and I hope we see more clinicians doing clinical things than managers doing managerial things!

At the moment, CCGs are obviously concerned about how they are going to manage the workload, and are looking at recruiting people with the necessary commissioning expertise to perform such tasks. However, I must issue a warning about looking wholly to re-employ PCT commissioning personnel.

Some of the people are actually the problem rather than the solution, and I have been vociferous in my insistence that we do not simply TUPE over all existing PCT personnel to the new CCGs.

Furthermore, it is important that CCGs look for new blood for their Boards. We need new ideas and innovative approaches to service redesign, whereas in the past we have tried to save money by leaving vacancies unfilled.

What is going to change if the members of the new CCG Board are the same people who ran things in the PBC consortium?

The second lesson to learn, therefore, is to pick the right people for the job. Some commissioners have a tendency to be quite narrow-minded and short-sighted, and refuse to commission anything that does not produce in-year cost savings.

I understand that this is because the financial year runs from 1st April to 31st March, and that it is the way that budgeting currently works, but it doesn't mean that it is right.

Stephen Foster

Commissioning in the future needs to look more at the medium term than the short term. Sometimes, we need to invest to save. My own favourite example is around screening patients for COPD, where a relatively low cost intervention such as screening commonly enables us to diagnose patients at a much earlier stage, and acting quickly often prevents them developing the moderate to severe condition which becomes very costly to the NHS (as patients take a lot of expensive medication, and need care, oxygen and hospitalisation).

Although I have only talked about COPD, the same is the case for many other conditions. In my own practice, I commonly screen patients for gout, allergy and food intolerance and PSA levels in men, amongst other things. We also carry out regular diagnostic checks for blood pressure, diabetes and cholesterol.

Unfortunately, commissioners tend not to consider early interventions, preferring to wait until the patient is unwell enough to be treated – but surely prevention is better than cure?

Furthermore, commissioners commonly do not consider healthcare professionals outside General Practice. I had a conversation with my local Cardiovascular Commissioner a couple of years ago about how she intended to roll out the new NHS Health Checks service, and she replied that she would "offer it to GPs in year 1; offer it to GPs in year 2; and anything that wasn't met could be offered to other practitioners (such as community pharmacists) from year 3"!

Within my own pharmacy, we have carried out hundreds (if not thousands) of such health checks over the last few years, and are ideally placed to see the patients that aren't reached by their doctor's surgery.

A GP will typically see around 30% of the patients on their practice register in a year, but they don't see the other 70%, so what happens to them? Although they don't go to see their doctor, you can bet your bottom dollar that they visit their dentist for a dental check-up, their optician for an eye appointment, and their community pharmacist for 101 different things!

You may not be surprised to hear that, two years down the line, our PCT is struggling to meet its NHS Health Checks targets. The commissioners are now considering approaching other healthcare professionals (such as community pharmacists) to support them in meeting their targets! Why didn't they take up my offer of help two years ago to prevent us getting to this stage?

The third lesson to learn, in my opinion, is to consider a multi-professional approach to commissioning and provision.

With a few notable exceptions, Practice-Based Commissioning (PBC) has been a failure. One of the major failures of PBC was to assume that GPs could do everything, when clearly they can't as there aren't enough hours in the day, and we need to recognise that some healthcare professionals are better placed to commission and deliver certain services than GPs.

The size of the new task is immense, and GPs need to recognise that they can't go it alone. There are thousands of pharmacists, nurses, dentists, optometrists and allied health professionals in every locality who are passionate about their patients, experts in their own areas and willing to help – CCGs need only to ask and they will undoubtedly be overwhelmed with offers of support.

One of my other roles is that I am the national lead for the Healthcare Professionals' Commissioning Network (HCPCN) which supports the interests of the above-mentioned professions, so I am well placed to comment on this desire to support the commissioning process.

The NHS challenge over the next three years - £20 billion of real savings – is an immense one, but CCGs, GPs and commissioners need to remember that they are not alone. We are all in this together, and working collaboratively we can deliver what we are required to do.

This will undoubtedly take a lot of hard work, but with the right attitude, the right decision-making and the support of all the healthcare professions, it is not impossible.

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

THE HOT DEBATE

Stimulating open discussion

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

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

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

The September Debate

Do we have an attitude problem when it comes to alcohol?

For many of us, the answer is unquestionably yes. The Statistics on Alcohol: England report for 2011 estimated that the cost of treating health problems which are specifically related to alcohol abuse was £2.7 billion – a truly eye watering sum.

However, ways of tackling escalating costs, such as introducing minimum alcohol pricing, has shown that the government (as well as in each of the devolved parliaments) is willing to adapt its policies in a bid to transform the UK's historically permissive attitude to drinking – an attitude which, if it continues unchecked, seriously threatens to cripple health services.

Providing an insight this month into the likelihood of sustainable change are the views of three highly respected figures deeply involved in changing the way the UK's attitude to alcohol: Professor Paul Wallace,Chief Medical Advisor toDrinkaware, Dr Evelyn Gillan, Chief Executive of Alcohol Focus Scotland, and Jenny Willott MP, a noted campaigner for alcohol policy reform.

Against a backdrop of financial austerity for healthcare services, each discusses the extent of the issue and the difficulties inherent in attempting to alter entrenched attitudes and behaviours.

Sara Watkin
Editor-in-Chief

The UK and alcohol: The Drinkaware approach

Britain's relationship with alcohol dates back centuries. It is deeply embedded in our culture - as a symbol in religious and social rituals, as a mood elevator and as a means of enhancing social interaction.

By Professor Paul Wallace, Clinical Director,
NIHR Primary Care Network and Chief Medical Advisor to Drinkaware

Its misuse through excess consumption contributes to significant health, social, physical and psychological harms and is estimated to cost UK society £21 billion annually. Despite small improvements in some areas, such as a dip in the percentage of men drinking to increasing risk levels, there is ample room for positive change. There were 8,790 alcohol related deaths in the UK last year according to 2011 ONS figures, and for England and Wales, alcohol-related deaths increased by 2% between 2000-10 . Alcohol-related admissions also rose by 11% between 2003-10.

The impact of alcohol related harm extends beyond family and the home; it also has implications for the workplace. An estimated 17 million working days a year are lost due to alcohol misuse. 15% of workers report having been drunk at work and 10% report having a hangover once a month.

Adults aged 45 and over are three times as likely as those aged under 45 to drink almost every day; however, young people's drinking is more extreme. 22.9% of deaths for 16-24 year olds were attributed to alcohol compared to only 1.1% of deaths among those aged 75 and over.

With different cohorts of the population affected by alcohol in different ways, to varying degrees, it is necessary to identify the groups upon which it is possible to make an impact. Alcohol awareness charity, Drinkaware, focuses on parents of under-18s, young adult binge drinkers and adults regularly drinking over the guidelines, using education as a lever for behaviour change.

Parents and young people

Between 2007-10, 20,000 under-18s were admitted to hospital in England as a result of drinking alcohol. For young people, alcohol can contribute to multiple harms such as poor educational performance, risky sexual behaviour, teenage pregnancy, crime and disorder, and a range of physical and psychological harms.

According to the recent NHS Information Centre report on drinking among young people in England , the number of children who have ever had a drink has declined steadily from 61% in 2001 to 45% in 2011. The percentage who said they have drunk alcohol in the last week has more than halved from 26% to 12% over the same period. Whilst this is a significant reduction, it means there are still 360,000 young people who have drunk alcohol in the last week alone.

Those children who are drinking are being introduced to alcohol at an earlier age. Drinkaware research shows this is mainly by parents who are sanctioning the use of alcohol at home in the hope that it encourages a more "grown up" attitude but are unaware of the impact on their child's development and future drinking behaviour.

Young adults

The fall in average weekly alcohol consumption among young adults (aged 16-24) from 16.9 units in 2005to 11.1 units in 2010 is also encouraging. However, 24% of young men and 17% of young women are still binge drinking. Defined as drinking double the daily unit guidelines, heavy episodic or binge drinking can have adverse neurodevelopmental effects. This is in addition to the multitude of harms that put pressure on A&E resources over at the weekends.

Drinking is an integral part of young adults' social lives and there is strong acceptability and desirability to getting drunk. Regular recreational consumption and binge drinking in young adulthood is a predictor of alcohol dependency later in life.

Adults

Long-term binge drinking and regular consumption above the government guidelines is associated with a range of health harms including cancer. 34% of men and 22% of women are drinking above the weekly guidelines of 21 units per week for a man and 14 units per week for a woman. The main problem for this group is that many adults do not realise they are drinking to excess, whether it be through lack of knowledge, understanding or acceptance of the daily guidelines. 25% of men and 19% of women aged 25-44 are drinking double the daily guidelines on any one day, which by definition also makes them binge drinkers. What sets adults and young adults apart is their motivation for consuming alcohol.

The Drinkaware approach

Drinkaware provides consumers with the facts to make informed decisions about the effects of alcohol on their lives and lifestyles. Its public education programmes, grants, expert information, and resources help create awareness and effect positive change. An independent charity established in 2007, Drinkaware works alongside the medical profession, the alcohol industry and government to achieve its goals.

Drinkaware targets groups whose behaviour can be influenced using integrated marketing campaigns,developed using detailed consumer insights. Campaigns are tested and independently evaluated and although the tactics vary, all campaigns use the same social marketing principles, which are to:

- challenge existing perceptions and promote positive behaviours;
- encourage peer to peer conversations;
- empower through knowledge to build confidence;
- promote aspirational messaging;
- acknowledge and target gender and regional variations;
- add value to the consumer and give them something in return for changing their behaviour.

Key to establishing new social norms is reaching critical mass. Drinkaware works with a range of strategic partners who can help extend the reach of its campaigns through their relevant consumer or patient channels.

Parent power

Family and parents are the most important influence on children's expectations, attitudes and behaviours relating to alcohol use, with parenting style one of the most important and statistically reliable influences on whether a child will drink responsibly in adolescence and adulthood. Yet, the majority of parents donot plan to talk to their children about alcohol, viewing it as less of a concern compared to issues such as drugs or bullying. Parents also are not looking for information about alcohol, thinking they

can handle situations involving alcohol up based on their own experience.

Drinkaware research shows that the average age of first supervised drink is 13.3 years. A key outcome for Drinkaware's 'Your Kids and Alcohol' campaign is to delay the onset of drinking by increasing the age of first drink. The campaign encourages parents to talk to their children at an earlier age about alcohol and empowers them to answer difficult questions by providing them with simple facts, conversation starters and age appropriate advice – online, in print and through parenting networks such as Mumsnet.

Since its launch in October 2011 the parents' section of the Drinkaware website has received 69,000 hits, more than 50,000 advice leaflets have been distributed to parents and there have been 370,000 plays of the charity's interactive video online. Independent evaluation showed that after engaging with the campaign, 19% of parents said they would not allow their children to drink under the age of 16. 44% said they went on to have a conversation with their child and 44% also said they spoke to their partner about the issue.

To deepen the impact of the campaign, parents are being encouraged to recognise the effect their own drinking has on their child and to address their own relationship with alcohol. The Drinkaware website provides information about drinking in the presence of children and directs parents to a simple unit calculator so they can start evaluating their own consumption.

Drinking to have a good time

Since 2008 Drinkaware has championed 'Why let good times go bad?', an industry supported campaign to make drunkenness among 18-24s, and its associated behaviours, undesirable and unacceptable. Without preaching, the campaign shows both the good and bad times young adults experience with alcohol, and provides simple harm minimisation tips such as avoiding rounds and eating before drinking.

'Why let good times go bad?' has been successful in increasing awareness of the consequences of drunken behaviour and acceptance of sensible drinking advice, with 8 in 10 young adults willing to adopt one of the campaign tips on a night out to moderate their drinking.

With females drinking for confidence and men drinking due to social pressure, moving this group beyond 'willingness' on the behaviour change journey is challenging. Young adults do not view their behaviour as problematic, having grown up in a society where drinking is a huge part of the culture and is glamorised by the media and reality TV. They have also watched their parents and peers misusing alcohol.

'Why let good times go bad?' focuses on making tips accessible to young people before, during and after their night, and close to the point of consumption. Social media is used to support peer to peer discussion and to help the audience make the connection between sensible drinking and the impact on their future aspirations.

Habitual drinkers

Of those that drank in the last week, 20% of men and 11% women aged 25-44 reported drinking on four or more days of the week (compared to 9% of men and 5% of women aged 16-24). Adults drink predominately in the home, routinely using alcohol as an enjoyable reward or to assist relaxation after a busy day. Almost all have heard of units but struggle to equate them to drinks or measures, particularly the ones they are pouring at home. Only 1 in 5 can predict the unit content of a large glass of wine, the drink they consume most often.

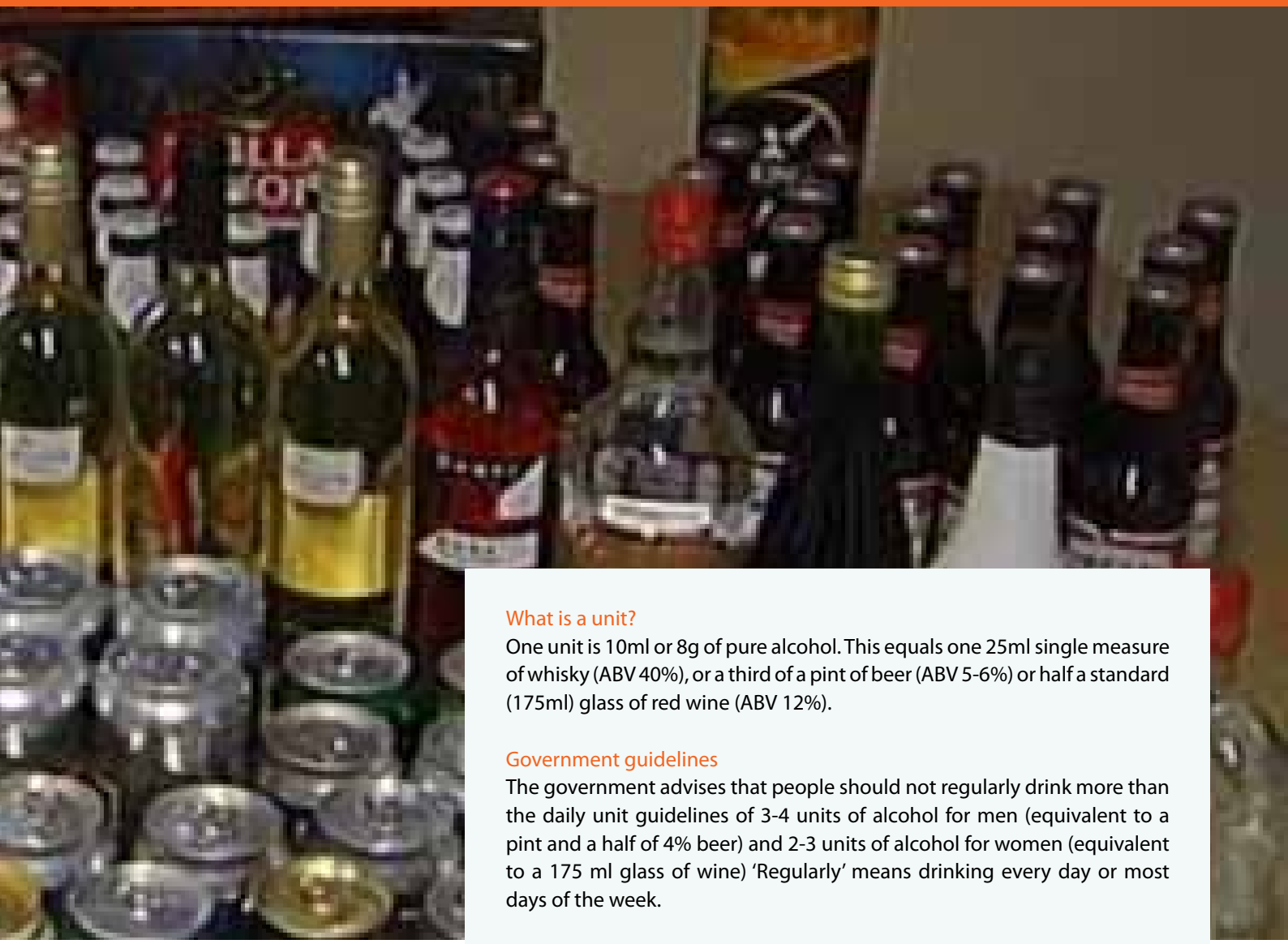
Drinkaware research showsless than a third can accurately recall the daily unit guidelines, so few realise that they are exceeding them most days of the week. Because they view their behaviour as normal, they do not consider themselves at risk. They see little need to limit themselves and reject the idea of daily guidelines as too restrictive.

Drinkaware's strategy is to interrupt and challenge the habitual behaviour of increasing risk drinkers (those regularly drinking above the guidelines) and provoke self-evaluation before their drinking becomes more harmful. MyDrinkaware, the charity's online drinks diary, is proving successful at supporting behaviour change. The tool has over 190,000 registered users giving them access to unit information, calorie and exercise equivalents, health advice and personal feedback. Independent evaluation of the tool showed an increase in awareness of health harms across all users but most importantly, active users of the tool reported a reduction in their alcohol consumption from 5 to 3.9 units per day – two to three drinks less per week.

My Drinkaware has been developed to make it more sociable, supporting Drinkaware's commitment to peer to peer discussion. The tool also offers enormous potential for primary care and workplace settings as a non-intrusive means of engaging patients and employees on the subject of alcohol. Drinkaware recognises that engaging adults in these environments will help them make the connection between alcohol and their wellbeing, with the workplace providing the opportunity to establish a social norm among colleagues.

The role of consultants

Alcohol can cause or exacerbate health issues and impede patient recovery. With less than a third of adultsable to accurately recall the government's daily unit guidelines,



health professionals play a key role in helping to improve their awareness of the guidelines and their understanding that regularly drinking abovethem can result in health problems.

Supported by an independent medical advisory panel, Drinkaware is a source of consumer friendly, medicallyverified information. The Drinkaware website receives over 330,000 unique visitors a month making it a usefulsignpost for patients and a valuable resource for healthprofessionals. To be confident in your delivery of theresponsible drinking message and foraccess to a range of interventions, encourage your teams to visit drinkaware.co.uk and start tracking their drinking with MyDrinkaware.

What is a unit?

One unit is 10ml or 8g of pure alcohol. This equals one 25ml single measure of whisky (ABV 40%), or a third of a pint of beer (ABV 5-6%) or half a standard (175ml) glass of red wine (ABV 12%).

Government guidelines

The government advises that people should not regularly drink more than the daily unit guidelines of 3-4 units of alcohol for men (equivalent to a pint and a half of 4% beer) and 2-3 units of alcohol for women (equivalent to a 175 ml glass of wine) 'Regularly' means drinking every day or most days of the week.

CMO alcohol advice for children

The chief medical officers in the UK recommend that an alcohol-free childhood is the healthiest and best option.

Binge drinking

NHS Choices refers to binge drinking as drinking lots of alcohol in a short space of time or drinking to get drunk.

Researchers define binge drinking as consuming eight or more units in a single session for men and six or more for women.

Increasing risk drinkers

Those who are at an increasing risk of alcohol-related illness are defined as: Men who regularly drink more than 3 to 4 units a day but less than 8 units per day, and women who regularly drink more than 2 to 3 units a day but less 6 units per day.

Higher risk drinkers

Those who have a high risk of alcohol-related illness are defined as:
Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week, and women who regularly drink more than 6 units a day or more than 35 units of alcohol per week.

"We must all become more aware of the dangers of excessive drinking"

By Jenny Willott MP

In January the Office for National Statistics published figures showing the number of alcohol related deaths in the UK in 2010. The results made depressing reading. A staggering 8,790 people died as a result of excessive drinking, an increase of 26.7% over just 10 years before. Whilst the figures have stabilised in recent years, with some years even showing slight decreases in the number of deaths, the simple fact is that not enough is being done to reduce the numbers dying as a result of excessive drinking,

However, these figures only tell half the story. For every death there are numerous cases of serious chronic illness and lucky escapes. Home Office statistics suggest that there were 1.2 million alcohol-related hospital admissions in 2010/11 and around 1 million violent crimes directly related to alcohol. Further studies have suggested that for every 100,000 people in the UK, 2,000 will be admitted to hospital because of drink, over 3,000 people will show signs of alcohol dependence and 500 will be moderately or severely dependant on alcohol.

These problems not only represent massive human tragedy, but also place a huge financial burden on the UK. In 2008 it was estimated that alcohol-related harm costs the NHS around £2.7 billion a year in England alone. With alcohol-related illness higher in both Wales and Scotland than England, the full financial burden on the NHS is even greater. Additional costs such as those related to policing anti-social behaviour caused by drinking, counselling and other support not provided directly by the NHS also increase the total amount Government spends dealing with problems caused by alcohol.

Excessive drinking doesn't just place a burden on Government finances. It also has an impact on businesses across the UK as well. In 2009 the Institute for Alcohol Studies (IAS) suggested that absenteeism from work due to alcohol misuse cost the economy around £1.5 billion a year. Around 17 million work days are lost as a result of heavy drinking, and that is just those who are in work. The IAS estimates the likelihood of being able to find and keep employment drops by between 7 and 31% for a man with an alcohol problem.

But while the economic toll of excessive drinking is significant, it is more than matched by the social impact, particularly on children. In 2004 it was estimated that between 780,000 and 1.3 million children

Jenny Willot

lived in families where their parents were affected by alcohol problems. Here in Wales, around 64,000 children are adversely affected by parents with drinking problems. Numerous studies have shown the impact a parent's relationship with alcohol can have on their children, including an increase in anti-social behaviour, problems with learning at school and severe emotional problems in later life.

It is little surprise given the increase in the UK's excessive drinking culture that more and more young people are copying the adults around them and becoming

involved in alcohol at a younger and younger age. 88% of all 15- 17 years olds have drunk alcohol, with some starting to drink from as young as 13. 13% of the young people surveyed drink at least once a week, with 1% of those aged between 15 and 17 drinking every day. Wales is once again an even gloomier picture: we have the highest percentage of 13 year olds who have been drunk more than twice out of 40 countries, including England and Scotland. Whilst in the past the problems of excessive drinking at a young age have been associated with teenage men, recent statistics show that in 2006 more girls under 16 were admitted to hospital with alcohol related problems than boys suggesting that the image of binge being linked with 'laddish' behaviour is no longer reflected by the evidence.

These statistics are also reflected in health problems in later life. Between 2008 and 2010 the number of deaths due to liver disease among those aged under 35 increased by a staggering 23%. Most of this was as a result of excessive alcohol consumption. Given that liver disease due to alcohol takes around 10 years to develop, the effects of increases in heavy alcohol consumption amongst the very young are only now becoming clear.

The impact of excessive drinking is seen at a personal and family level, but also within the community. Nowhere is the impact of binge-drinking more apparent than in my own area in Cardiff. Weekend nights in Cardiff city centre can be a terrifying experience! Here the full impact of our binge drinking culture is laid bare. Police line the streets to keep order, volunteers from the excellent Street Pastors hand out bottles of water and flip flops to those who need help and in the run up to Christmas field hospitals are set up around the city centre in an attempt to reduce the numbers of patients arriving at the local A&E.

It is remarkably well handled by the authorities: the model of policing used in Cardiff to tackle weekend anti-social behaviour is now replicated across the country. This includes working closely with nightclubs and bars with a traffic

light system that quickly identifies premises who are serving underage or drunk customers, or which cause other problems, so that they can be closely monitored and, if necessary, their licence can be taken away.

Cardiff Council also plays its part: they have moved street furniture, such as bus shelters, barriers and benches, away from club exits to reduce bottlenecks that can lead to violence. Pedestrianising the roads has also cut down accidents in the city centre.

However, the fact is that whatever Local Authorities or the Police do they will always struggle to contain anti social behaviour, let alone reduce it. I believe that ultimately we need to tackle excess drinking through a broader mix of measures, including tackling the underlying behaviour, rather than just focusing on the end results.

That is why I'm pleased that the Government has committed to trying out new ideas in its Alcohol Strategy. For me, one of the most important commitments is to introduce a new minimum price per unit of alcohol.

I have been a long time supporter of minimum pricing: other policies previously tried to control excess drinking, such as alcohol exclusions zones, rely on already stretched policing and enforcement capacity and tackle the results rather than the cause. In contrast, minimum pricing seeks to tackle the market for cheap alcohol that fuels much of the problem.

If you go into Cardiff city centre on a Saturday night, one of the things you notice is the amount of broken glass on the street. This is a sight common across the UK, and causes many injuries, particularly amongst women who take off their high heels when tired. The glass doesn't come from pubs and clubs, which use plastic bottles and glasses, following the suggestion of Professor Jonathan Shepherd at Cardiff University (another Cardiff idea which has since been adopted nationwide!)

Instead the glass comes from bottles of cheap alcohol, bought in supermarkets and consumed outside on the street. Go into almost any supermarket and you will see countless special offers on strong beers and cheap spirits. Even without the offers, the cost per unit of alcohol in many supermarkets makes it remarkably cheap for people to get very drunk before even starting their night in town.

Minimum pricing would tackle this problem. There is substantial evidence that it could help change behaviour and reduce the problem of "pre-loading". The Government is currently consulting on the level at which the price should be set, but personally I agree with organisations promoting responsible drinking such as the Campaign For Real Ale and Alcohol Concern, who suggest it should be set at 50p per unit. However, wherever it is set, simply introducing the principle of a minimum price would make a start by showing society's attitude towards alcohol is changing.

Research by the University of Sheffield suggest that a 50p per unit price in Scotland would result in a fall in hospital admissions of 1,600 in the first year alone and 6,500 within 10 years. In total the study estimated that there would be a financial saving as a result of minimum pricing, due to lower healthcare costs, higher employment and lower levels of violent crime, of around £942 million over 10 years. A similar policy in England and Wales could do a great deal to reduce the strain on vital public services.

Minimum pricing could, ironically, also help struggling pubs. 77% of pub owners support minimum pricing as a way to level the playing field between pubs and supermarkets, and given the escalating rate at which community pubs are closing, this policy could help to revive community pubs, which often help encourage safe, responsible drinking.

Progress has been made in recent years in ensuring the drinks industry itself takes more of a role in promoting responsible drinking, though there is still a long way to go. The Responsibility Deal, which the Government agreed with the industry, has led to better labelling of products, clearer and more responsible advertising and actions aimed at tackling underage drinking, but clearly much more needs to be done.

The Government is looking at requiring changes to product placement so alcohol cannot be advertised near marketing aimed at children. I also think there is merit in the recommendations of the House of Commons' Health Select Committee, which recently suggested the Responsibility Deal could be made compulsory, and called for clearer guidelines so alcohol cannot in any way be marketed at those under 18.

I believe that the Government's and the Health Select Committee's proposals could together have a significant impact. However, we must also all become more aware of the dangers of excessive drinking. This means a stronger focus on education but also for the whole of society to take a different attitude towards alcohol, which is clearly much easier said than done! Our experience in Cardiff shows that tackling the anti-social behaviour and violence caused by excessive alcohol is best done by all agencies working together and thinking in new and different ways. We need to apply the same approach to the broader impact of alcohol on society. I'm not saying that we should all stop drinking, but everyone needs to be more aware of how much they drink and their role in encouraging others to drink responsibly - the cost of not doing so is too high, both for our own health, but also for society as a whole.

Jenny Willott is the Liberal Democrat MP for Cardiff Central. She is a Deputy Government Whip and has previously severed as a Lib Dem Shadow Home Office Minister and Shadow Secretary of State for Work and Pensions. Before entering Parliament she was head of Victim Support South Wales.

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What does it take?

How Scotland is attempting to turn the tide on alcohol misuse

By Dr Evelyn Gillan, Chief Executive, Alcohol Focus Scotland

The eyes of the international public health community are on Scotland right now as the Scottish Government puts in place a range of alcohol policies to address the rising tide of alcohol harm. For the first time, the alcohol policies that are being introduced in Scotland are based on evidence about what measures will be most effective in reducing alcohol harm.

Alcohol – Scotland's favourite drug

Evidence on the global burden of disease clearly implicates alcohol as one of the leading risk factors for death and disability. Alcohol results in 2.5 million deaths each year and has a wide range of negative health and social consequences that go far beyond the physical and psychological health of the individual drinker. Alcohol harm is directly linked to increased consumption – the more alcohol a nation consumes, the greater the burden of harm it will experience and vice versa.

In Scotland, our drinking has been steadily increasing over the last 50 years from around 5 litres per annum for each adult in 1960 to over 11 litres in 2007. And with 44% of men and 36% of women in Scotland currently drinking above the low risk limits, we can no longer pretend that only a small minority of the population misuse alcohol.

The number of people dying from alcohol-related conditions has nearly tripled since the 1980s and alcohol-related hospital admissions have more than quadrupled. Scotland has gone from having one of the lowest rates of liver cirrhosis in Western Europe to having one of the highest. An estimated 65,000 children in Scotland live in families affected by harmful parental drinking. Last year, alcohol was a factor in 37% of assaults and accidental injuries. The total cost of alcohol harm in Scotland is estimated at £3.5 billion each year.

Such a profound level of harm must be tackled with upstream policies that focus on making alcohol less affordable, less available and less visible.

Alcohol pricing and availability

There is no 'silver bullet' to turn the tide on levels of drinking and harm but the ground-breaking nature of the approach that the Scottish Government has taken is based on a recognition of the scientific evidence spanning three decades which confirms that the best way to reduce alcohol harm is to reduce overall alcohol consumption in the population. The science tells us that the most effective method of reducing consumption is to make alcohol less affordable and less available.

Dr Evelyn Gillan

One of the main reasons we are drinking more in the UK is the increased affordability of alcohol. Alcohol is almost 70% more affordable now compared to thirty years ago and as the price of alcohol has dropped, our consumption has gone up.

The introduction of a minimum price per unit of 50p in Scotland could mean 60 fewer deaths, 1600 fewer alcohol-related hospital admissions and around 3500 fewer crimes in the first year. Minimum pricing is a targeted measure that will increase the price of the very cheapest products, most often drunk by those causing most harm to themselves and society as a whole, while having very little effect on the spending of moderate drinkers.

One of the arguments against minimum

pricing that we keep hearing is that price is not the main issue; that what we need to tackle is our peculiarly British drinking culture.
But contrary to what is often reported, the UK has not always had such a problematic relationship with alcohol.

Indeed, going back to the 1930s, Royal Commissions on Licensing in both England and Scotland reported that drunkenness had gone out of fashion. The Scottish Commission concluded that: "…sobriety has increased, instances of public drunkenness have become fewer…a younger generation is growing up to which, as a whole, any resort to alcoholic excess as a necessary or usual practice is almost totally unknown."

What this tells us is that there was a time in the not too distant past when alcohol did not have the central role in our society that it has today. At that time there were significant controls on the price and availability of alcohol. These have been steadily eroded over the last forty years as successive governments have embarked on a process of deregulation and liberalisation. This has created an excessively pro-alcohol environment with alcohol more affordable, more available and more heavily marketed than at any other time. This is the culture that has driven up consumption and caused the historically high levels of alcohol harm we are seeing right across the UK. Putting regulation back into the system will begin to turn this picture around.

Other action which is being taken in Scotland includes action by local licensing boards to restrict the availability of alcohol. Scotland is the only country in the UK to have an objective to protect and improve public health as part of its licensing legislation. There have been some good examples recently of Licensing Boards refusing alcohol licences for new supermarkets on the grounds that the area is already 'over-provided' for and allowing more alcohol to be sold would potentially damage public health.

Lowering the drink driving limit from 80mg to 50mg, is another effective policy which the Scottish Government has pledged to introduce after examining evidence from other countries which shows lower limits result in a reduction in drink-drive injuries and fatalities.

In addition to these 'upstream' policies, Scotland has recognised that effective treatment services that are responsive to the needs of people who have alcohol problems are critical to helping recovery. Consequently, the Scottish Government has invested heavily in a programme of alcohol brief interventions (ABIs). However, the pro-alcohol environment in which we live encourages excessive drinking and this can impact negatively on an individual's recovery journey. Making the environment less pro-alcohol, is the best way to reduce the number of people who develop alcohol problems and will also provide a conducive physical and social environment for those in recovery.
Alcohol marketing

When thinking about freedom of choice, we should acknowledge the ubiquity of alcohol in the physical and social environment that surrounds us. The alcohol industry spends around £800 million every year on the promotion of alcohol brands in the UK, an amount far in excess of the money available for health information campaigns. Thus our 'free choice' is heavily influenced by the environment we live in. The tobacco control evidence base shows that the most effective public health response to unhealthy marketing is to reduce exposure.

During the London Olympic games,

sponsored by Heineken, Tesco ran a promotion encouraging people to "share in the glory" by purchasing half price alcohol. This is a measure of how normalised excessive drinking has become in our culture when no-one questions alcohol producers and retailers associating sporting success with alcohol through promotions and sponsorship.

Concerns about the excessive marketing of alcohol are of particular concern when it comes to protecting children and young people from alcohol harm. Young people are an important target group for global alcohol producers, with a growing evidence base identifying a positive relationship between alcohol marketing and the volume and pattern of young people's consumption of alcohol. The evidence shows that alcohol promotion encourages children to drink at an earlier age and in greater quantities than they otherwise would. A recent survey funded by the Medical Research Council highlighted that 96% of 13 year olds in the UK were aware of alcohol advertising and on average had come across it in five different types of media. Of particular concern is the likelihood of children being exposed to alcohol marketing via social networking sites.

The power of the alcohol industry

The global alcohol market is dominated by just a handful of trans-national corporations who have extensive resources for promoting their alcohol brands and dedicating time and money seeking to influence alcohol policy in their own business interests. While commercial vested interests can be involved in the implementation of alcohol policy, their involvement should be confined to areas which pertain specifically to their role as producers and retailers of alcoholic beverages. For example, labelling and server training. They should not be involved in the identification of public health goals to inform alcohol policy given the obvious conflict of interest and the fact that their expertise is in producing and selling alcohol and not in protecting and improving public health.

When the ban on multi-buy incentives was introduced in October 2011, the big supermarkets simply changed their offer

from 3 bottles of wine for £10 to one bottle of wine for £3.33. Not illegal, but certainly not in the spirit of the new legislation. Such irresponsible pricing practices calls into question their claims to be responsible retailers.

In this context, the public health community in Scotland is extremely disappointed (although not particularly surprised) that the Scotch Whisky Association has decided to mount a legal challenge to minimum pricing. This action suggests that the alcohol industry intends going down the same path as the tobacco industry in seeking to delay legislation that has the potential to save lives. This shows that when effective policies that will reduce harm and save lives are introduced, the big alcohol producers simply close ranks and pool resources to prevent their implementation. The evidence suggests that minimum pricing will bring significant health benefits so to contest this makes it clear that some sections of the alcohol industry are motivated by profit not public interest. Quite simply, this is big business putting profit before the health and well-being of the people of Scotland.

Conclusion

The harm caused by alcohol to individuals, families and communities is no longer acceptable and Scotland is leading the way in introducing evidence-based policies that will begin to turn this around.

Successful changes in culture in areas such as smoking, seat belt use and drink driving have come about through a combination of regulation, enforcement and public information. Without action on price, any other measures to reduce alcohol consumption and harm will be swimming against a very powerful tide.

Alcohol Focus Scotland was established in the early 1970's as the Scottish Council on Alcohol, primarily to support local councils on alcohol by providing training for their volunteer counsellors. Becoming Alcohol Focus Scotland in 2001, the organisation works with a wide range of partners to advocate for evidence-based policy; deliver training and development programmes and provide accurate and accessible information about alcohol to the media, policy-makers, practitioners and the general public.

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Technological Excellence: Ottobock precision, mind control and the passion of the Paralympics

Interview by Fraser Tennant

The scenes of celebration in central London earlier this week were a splendid sign off to a sensational summer of sporting excellence, the likes of which we may never seein this country again. The Olympics and, latterly, the Paralympics, demonstrated that the UK can indeed deliver world class Games that will be remembered for generations, despite what the merchants of doom have led us to believe over the preceding seven years. Of course, it goes without saying that the stars of the show were the participants, but, behind the scenes, there were many individuals and organisations -known as Paralympic Partners -who contributed much to the stunning sporting spectacle millions have enjoyed over the summer months.One such organisation, Ottobock Healthcare, supported more than 4,200 athletes at the Paralympic Games with technical services including prosthetic, orthotic and wheelchair repairs. Indeed, Ottobock's relationship with the Paralympic Games encompasses the best part of 25 years as Managing Director Philip Yates explains to The Consultant's Fraser Tennant…

We've been involved since Seoul in 1988, so we're well versedin terms of providing support to the Paralympians during the Games. We're there to repair equipment for the athletes - wheelchairs, prostheses or orthoses - irrelevant of which manufacturer's equipment they've got. We're there to make sure they're available to compete. We had eighty technicians across three main workshops, twelve satellite workshops, and a mobile unit as well, so quite widespread. It's a little bit like the pit lane in Formula One. It's great to see people overcome the issues that they've got and compete at Paralympian level.

The Consultant: How much of your core business is public as opposed to private?

Philip Yates (PY): It varies from country to country. In the UK it's between five and six percent private, the rest is predominantly throughout the NHS. So private is quite a small market for us. The NHS, because of its structure, has been predominantly the main provider of orthotics, prosthetics and wheelchairs to the disabled community.

The Consultant: How quickly does the NHS embrace innovation in prosthetics and orthotics technology?

PY: Although the Government do talk about embracing new technologies, a typical example is the C-Leg which is a micro-processor knee which has been available on the market since 1998 and available on the NHS framework agreement since around 2000. The biggest stumbling block is funding. The C-Leg is a product that's more expensive than the current mechanical type knees that are available but it's certainly a fantastic product that enables increased stability and improved safety and comfort for the user. But, due to funding issues, the NHS tends not to embrace the technology. It's three or four times more expensive than a mechanical knee joint, and as such, the NHS only prescribes around 11 C-legs a year on average, in comparison with somewhere like Germany that has 600 or 700 knee units prescribed a year. Sweden does 300, as does France. Therefore, the sale of C-legs into the UK has predominantly been through the private area and also through the Ministry of Defence. The MoD also embraced the technology and was more in tune with

getting the best patient outcomes and not so concerned around the funding.

The Consultant: So the NHS will go by what's affordable rather than the patient need?

PY: They are really constrained by their budgets. We supply eleven C-legs to the NHSand we supply into the UK around about 100 hundred units a year, so it is a very small cohort of patients that actually get that. And they have to go through special case funding, through their PCTs, which is quite a shame really, because the technology is there, it does improve and there is clear clinical evidence that it improves the outcome of patients. But it's quite a slow process within the NHS to do that.At this level, a case has to be built up through the consultant, the prosthesis and the patient, in terms of an exceptional need.

The Consultant: A little difficult to quantify I would have thought?

PY: It is. The NHS views the C-leg, for example,as such an expensive product in comparison with what they feel they can afford, that they push quite hard on exceptional funding. If the Government put in, say another three or five million pounds in the component budget of the NHS, then it would allow at least another hundred amputees to have the latest technology, improve their life and not be so reliant on the normal social framework for that funding.

The Consultant: TheNHS has been tasked with saving 20 billion pounds over the next five years. That's got to come from somewhere. How will this impact on the service you provide?

PY: We run a number of contracts around the UK andwe are seeingbudget constraints all around the NHS. There is, in real terms, a reduction in the funding available.

The Consultant: What has been the most significant technological advance you have seensince you became Ottobock Managing Director in 1992?

PY: I think it's the advances in micro-processor technologyand the results that this can give topatients. Ottobock spends around forty million Euros a year in research and development andthe micro-processor technology is by far the one that has

benefitted the company as well as the users of our products.

The Consultant: How far can this kind of technology be pushed?

PY: There is talk about mind control prostheses. Certainly with the lower limb, there is no great need to have mind controlled lower limb prosthesis. With upper limb prosthesis, that's a more difficult area for an amputee to control. What is coming out at the moment is connection into the previous muscle groups and the previous muscle system that actually control the movements of a hand, such as opening or closing or rotating your wrist. With developments that are currently going on in Vienna, we are able to tap into those existing muscles and nervous system andit becomes more of a natural process than it has ever been in the past. More communication with those specific areas, specifically the upper limb, is key in terms of getting more of the controlthat we talk about in today's latest technology.

The Consultant: How does Ottobock remain so successful and stay at the forefront of innovation in technology?

PY: Ottobock is still a family owned business, even after nearly 100 years. Therefore, we're not pandering to shareholders. It's the will and enthusiasm of the owner, Hans Georg Nader, which makes sure that Ottobock stays in front. He's prepared to invest huge sums on research and development. That's great for the company. He's also seen emerging markets such as Latin America and Asia and again invested heavily by opening branches there to ensure direct communication with end users.

The Consultant: After 20 years, how do you retain your passion for what you do?

PY: I love the business I'm in because I can see the results that we get. When you see a small child fitted with a prosthesisrunning about, that's great. It's great to see adults who are going back to work. It's also fantastic to see the Paralympians performing at the Games. There's no limit to them in terms of their activity.

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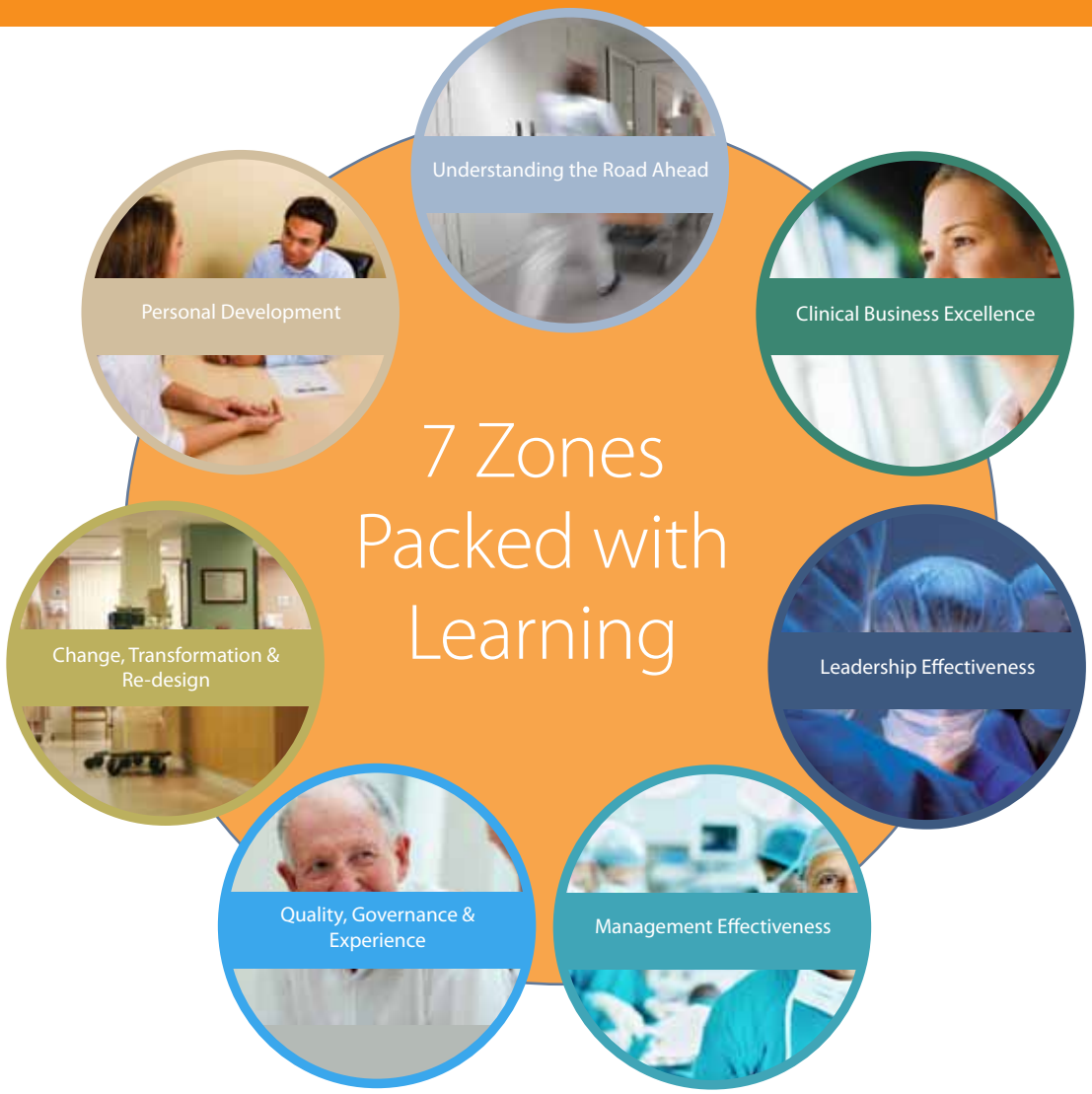

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Designing Handover of Care: A value perspective

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

It is now widely accepted that handover of care is an important step in a patient's journey both from the perspective of continuity of care and clinical risk. Whilst it can be argued that healthcare has been slow to fully recognise the issues involved, improved guidelines have been issued in the UK. There have been three recent papers that have systematically reviewed relevant literature in this area. Riesenberg et al (2009) highlight two categories of study, barriers to effective handover and strategies to improve the process of handover. Table 1 summarises some of their review findings.

Barriers and strategies to handover (from Riesenberg et al, 2009)

Lyons et al (2010) review 50 articles in their attempt to improve handover in neuro-critical care. They indentify a variety of human factors that may lead to less-effective handover, ranging from who controls the handover meeting to the factors that disrupt and disturb those present at the meetings. They found that distractions correlated with longer handover meetings. Cohen and Hilligross highlight some areas for further work, including the clear definition if handoff concepts, the understanding of standardisation as a means of improvement and the understanding of trade-offs between patient safety and other functions. Importantly they suggest the literature has not shown marked gains in measured patient outcomes when standardisation has been attempted.

These reviews conclude that the literature on handover of care is patchy and often inconsistent, e.g. in how handover is defined. Our own reading of the literature uncovered a number of problem-solving perspectives that have been taken to help diagnose and improve handover processes. For example, Aurora et al (2010) use a competency approach that ensures participants have the right skills to perform handover. Catchpole et al (2007 & 2010) use the lessons from motor racing to help devise high-reliability systems. Their analysis focuses on three aspects of the process: teamwork& communication, threat & error management and the task design itself. The result showed the comparably poor awareness of protocols, limited team training, poor communication and poor coordination and lack of consistency in the healthcare setting.

In this paper we have attempted to take a different perspective using the lean thinking concept of value (Womack and Jones, 1996). We ask what value is added by the handover activities how the process can be made more effective by maximising the value-added time used to conduct handover meetings. We defined clinical handover as the transfer of responsibility and accountability for patient care from one provider or team to another. At a practical level, the objective is to design a handover process that maximises benefit to the patient. Our assumption is that people should be more willing to participate in handover meetings if they feel their time is being used effectively.

Background

This report is based around a series of interventions in the neurology department of DerrifordHospital in Plymouth, UK. The hospital itself is the largest in the south-west region of the UK and is a teaching hospital with 900 beds, providing a full range of general and specialist services to a local population of 700,000.

This project was initiated as part of a larger patient safety programme. Although the hospital had not specifically identified

handover as a problem, a survey revealed staff concerns about the risks presented by poor continuity of care. Consequent backtracking of incidents revealed that handover issues may have been a contributory factor in some instances and that improved handover practices could well inhibit some errors. A preliminary analysis suggested poor protocols and only a small proportion of patients handed over.

Method

The following techniques were used to analyse and diagnose the issues:

- Extensive and detailed observation of nursing and medical handovers
- Shadowing medical staff at all levels
- Documentation review
- Process mapping of the patient pathway
- Structured and semi-structured interviews
- Case note reviews and in depth case studies
- Task analysis of the handover process
- Documentation of the current state with system and contextual factor analysis

Analysis

Causes of Handover failure

On-site analysis confirmed much of the preliminary diagnosis of the problem. It quickly became evident that the weekly handover meeting had no agreed starting time. Staff were not always willingly attend or be available for meetings and there was no specific person who took responsibility for gathering the team, starting the meeting or set an agenda. Culturally, there appeared a desire to finish the meeting to be able to get on with other pressing tasks, as ward rounds were seen as the "real work". Patients would often be skipped from the list to be discussed so that meetings could finish quickly. Many of the patients on this type of ward have a long length of stay where recovery from illness is often slow and steady at times. For these patients it is always tempting to drop them from the discussion list as it is rare that a new event needs to be reported. However, it was judged that such omissions made discharge planning of these patients somewhat passive and also did increase the risk of some complication being missed.

The analysis forced the team to recognise the need to structure and control the meeting,

BARRIER CATEGORIES	
Communication Barriers	General communication problems Hierarchical/social barriers Language and ethic barriers Communication style
Lack of standardisation	No standardisation or structure No requirements Lack of tool/protocol
Lack of training	
Missing information	Incomplete information Errors
Physical barriers	Interruptions/distractions Chaotic environment
Lack of time	Process too slow Time constraints
Complexity	Task complexity Large numbers Cross-coverage
Strategy categories	
Standardisation	Standard processes Tools & techniques Preparation Face-to-face communication Read-back Mnemonics Technology
Communication skills	Skill sets Hierarchy issues
Physical environment	Location Limiting interruption Address environment
Transfer of responsibility	Recognition

so that important items were not missed. The ideal meeting would start on time in a suitable location where the environment was conducive to clear communication, without staff being disturbed. The meeting should comprise of all relevant medical staff, with opportunity for everyone to contribute to information sharing and decision-making.

Value-adding processes

Within the meeting itself, the improvement team found five separate value-adding roles took place within handover:

1. Diagnosis
   Diagnosis itself is a value added step in the patient journey. Handover can be used to ensure that ongoing process of diagnosis occurs without error or delay. Faster, uninterrupted diagnosis should lead to faster initiation of treatment, shorter length of stay and better clinical outcomes.
2. Acute Treatment
   The hospital has already developed protocols for the fast admission of patients onto acute wards from the emergency department. Consequently wards are often involved in the stabilisation of newly-admitted patients and this can occur across shifts.
3. Ongoing Treatment
   One characteristic of the neurology wards involved in the study is the extent to which post-stabilisation treatment can occur, for example with stroke patients. Many of the patients have complex needs, so handover needs to coordinate other value-adding activities such as OT assessment and social care visits.
4. Manage complications
   Patients often present with multiple issues which create complications and make the course of treatment complex to handle. Handover should create a shared mental model of what needs to be done, by whom and when.
5. Functional Stability/rehabilitation
   On the wards in this pilot study rehabilitation is a key element of the overall care package. This care needs to be coordinated over time, with appropriate, timely changes to care arrangements.

Figure 1 The Value Steps in Handover of Care

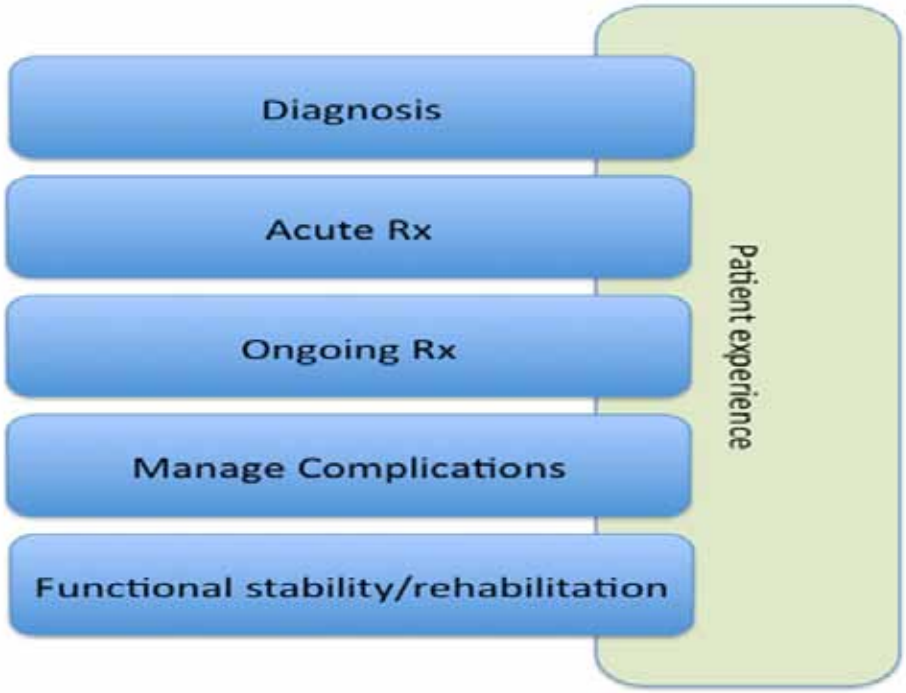


Figure 1 summarises our conceptualisation of the value elements of clinical handover:
Figure 1 The Value Steps in Handover of Care

STRATEGIES FOR CHANGE

Structuring the handover around value added steps is intended to bring the clinicians' focus on to diagnosis, investigations and treatment. An aim is to establish that the time spent in handover is itself an integral part of a normal work pattern. It was decided that the effectiveness of handover could be measured using the following metrics:

On-time start

1. Starting the meeting on time was judged to be a good measure of the deterministic nature of the meeting. For this measure to be achieved, a number of other characteristics need to be present. All necessary staff need to be available at the right time and they need to have an expectation that the meeting will start to schedule. The venue needs to be available and clear, so staff sharing the same facility, but not attending handover, can expect to have to work elsewhere.
2. All patients discussed
   In order to ensure that no patient is overlooked, it is essential that all patients are given some attention during the meeting. For specific reasons previously explained, the omission of some long length of stay patients is a known failure mode on the wards used for this study.
3. Items discussed
   An identified risk is that the discussion does not have all necessary activities that contribute to successful discharge discussed for each patient. This measure assesses the coverage of the discussions.

Eight separate improvement steps were proposed to assist in the improvement of the effectiveness of the weekly handover.The table below shows the steps that have been taken to improve the handover of care.

Table 2 The Proposed Improvement Interventions in Weekly Handover

This series of changes works steadily towards a standard operation procedure (SOP). The SOP establishes a number of practices that tackle some of the most commonly observed problems associated with handover of care. Figure 2 shows how this set of procedures

INTERVENTION	Method
Handover Support Tool	Checklist of discussion items based upon the value-adding steps. Success was measured by weekly checks of adherence to the checklist. Seen at this stage as an "aide memoire" rather than SOP
Meeting planning	Start time, location and required attendees agreed for each meeting. The suitable location is set and the start standardised
Compliance assessment	Measurement tool introduced to assess compliance.
Integration with MAU handover	Verbal handover of patients admitted overnight via Medical Assessment Unit included in the handover protocol.
Feedback system	Participant feedback system introduced, to identify previously undetected lack of compliance or quality issues.
Speakerphone handover	To avoid duplication of effort, MAU handovers can now occur via speakerphone during the actual handover meeting.
The "Silent Cockpit"	
Full SOP	

links together in a defined sequence of events, complete with the explanation provided within the SOP for staff.

Figure 2 Standard Operation Procedure for Handover of Care

FIGURE 2 IN HERE

RESULTS

Figure 3 shows the (compressed) SPC chart for handover meeting start time. The first data points, prior to the implementation of any changes, shows that the start time was very variable. Sample data points indicate meetings that start 40 minutes late and the control limits suggest that the meeting could potentially start within a two-hour time span. This implies that some clinical staff would wait to be called rather than attend but not have anything to do for some considerable time.

Figure 3 The timeliness of weekly handover

Once the first changes had taken place the meeting start time is more controlled, with a much lower variation. On average, the meeting now takes place with just 5 minutes average lateness, indicating that start times have considerably improved. However, the last data points show a "run of seven" above the mean, indicating that start time is beginning to slip again.

Figure 4 shows the number of data items covered in a similar (compressed) SPC chart. At the start of the project the proportion of safety critical items discussed was as low as 20% on some days. Again the data is variable, with a variety of factors, such as the people attending the meeting, influencing the levels of success of those meetings.

Figure 4 The Percentage of necessary data items covered in a meeting

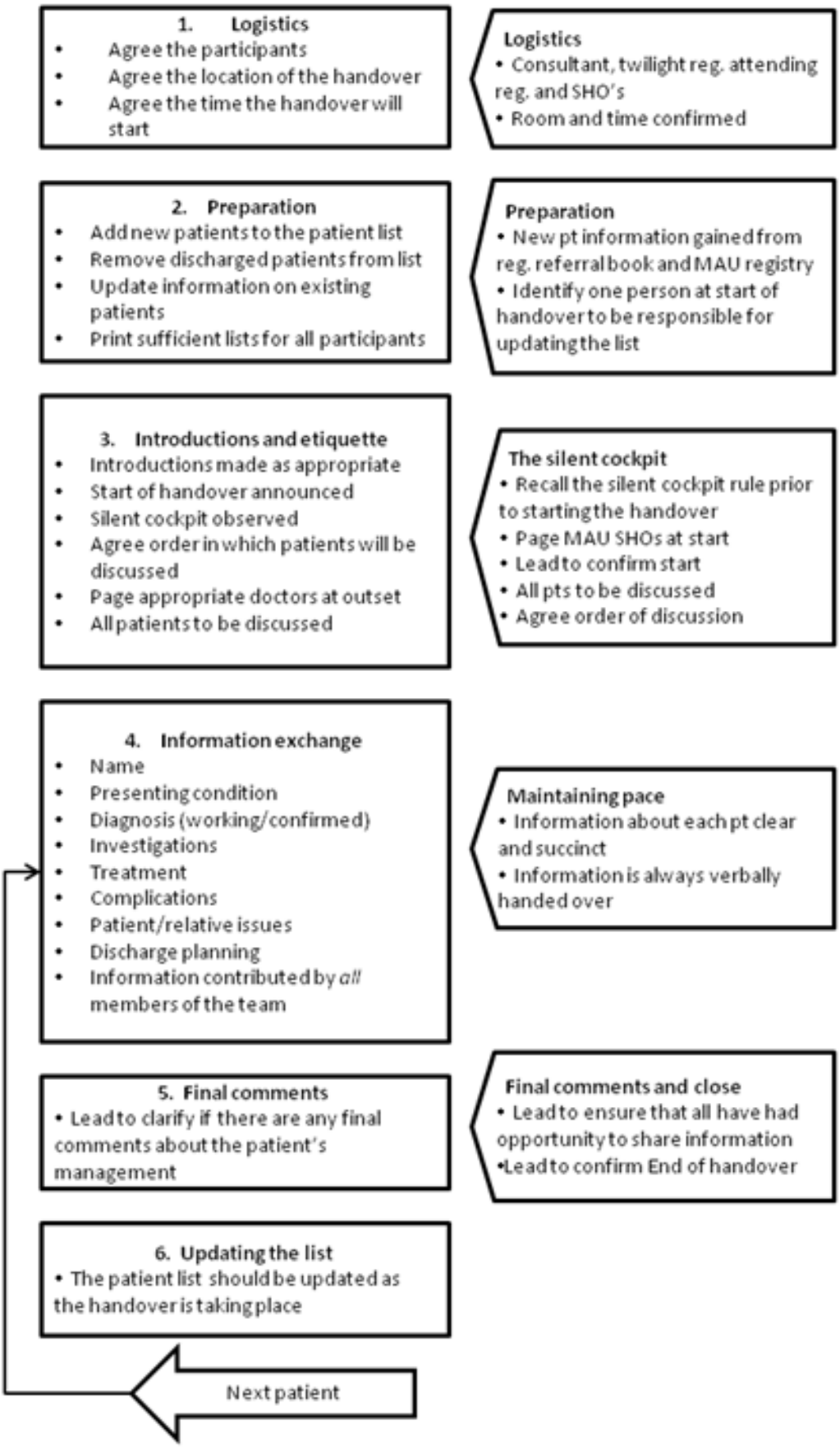
FIGURE 4 IN HERE

Once the initial "aide memoire" was put into place, the proportion of items discussed increased to a mean of just over 80% for the first few months. However, once again we identified a run of seven data points, below the mean, and a recalculation of the control limits shows that not all this improvement is sustained. A number of factors probably contributed to the reduction in success levels over time. Attending to Attending handover is very vulnerable to absences caused by annual leave, sickness or public holidays. Work was conducted to enable absent colleagues from contributing by phone, where this was possible. Meetings are not always led by a consultant, but the aide memoire enables the same rigour to be maintained.

LESSONS AND MESSAGES

It is very clear to us that the value perspective has enhanced our understanding of the handover process. Activities that were previously seen as mundane or unimportant are viewed in a new light once we ask the question of what adds value for the patient. The value perspective allows analysis of activities that positively contribute to the progression of the patient's treatment and recovery, ensuring that all the necessary actions from a wide range of potential contributors can take place. There is also an error prevention and elimination aspect to the value perspective. Many of the activities that occur during meetings are highlighting where something might go wrong, such as complications from changes to drug regimes or co-morbidities. Once this error-prevention activity is highlighted as a positive step, there is better commitment to this type of work.

The changes that were made have tackled some of the most commonly reported issues associated with handover of care. The analysis was able to identify factors such as the work environment, the leadership of the meeting, the equality of contributions of team members and the thoroughness of the discussion as key aspects that could be tackled with standard operating procedures.


1. Logistics
• Agree the participants
• Agree the location of the handover
• Agree the time the handover will start
Logistics
• Consultant, twilight reg. attending reg. and SHO's
• Room and time confirmed
2. Preparation
• Add new patients to the patient list
• Remove discharged patients from list
• Update information on existing patients
• Print sufficient lists for all participants
Preparation
• New pt information gained from reg. referral book and MAU registry
• Identify one person at start of handover to be responsible for updating the list
3. Introductions and etiquette
• Introductions made as appropriate
• Start of handover announced
• Silent cockpit observed
• Agree order in which patients will be discussed
• Page appropriate doctors at outset
• All patients to be discussed
The silent cockpit
• Recall the silent cockpit rule prior to starting the handover
• Page MAU SHOs at start
• Lead to confirm start
• All pts to be discussed
• Agree order of discussion
4. Information exchange
• Name
• Presenting condition
• Diagnosis (working/confirmed)
• Investigations
• Treatment
• Complications
• Patient/relative issues
• Discharge planning
• Information contributed by all members of the team
Maintaining pace
• Information about each pt clear and succinct
• Information is always verbally handed over
5. Final comments
• Lead to clarify if there are any final comments about the patient's management
Final comments and close
• Lead to ensure that all have had opportunity to share information
•Lead to confirm End of handover
6. Updating the list
• The patient list should be updated as the handover is taking place
Next patient

There was initial success that led to an 80% reduction in the variability of meeting start time and there is now 80% coverage of every value-adding aspect of clinical care at handover meetings. Our aim is to bring this as close to 100% as possible and to achieve 100% discussion of all patients. The metrics that we used were useful in conveying the levels of success of the changes and the process behaviour. It did become clear that strictness of regime, especially in terms of starting time and requirements for availability staff, made a significant difference to the effectiveness of the meetings. However, we have also been able to show that sustainability of the changes is, once again, one of the biggest challenges. Our lesson is that monitoring, support and encouragement is necessary for long periods of time, especially in situations where there are many factors that mitigate against sticking to procedures and protocols. We would suggest that this support needs to remain until such changes become culturally embedded in the organisation. We would speculate that high-level support from both managers and clinicians would assist in embedding acceptance of protocols. A next step is to look at training staff to lead and to contribute to a non-hierarchical handover. These skills will ultimately be part of induction training.

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Dr Steve Allder

THE LOTUS ELISE S O

THE LOTUS ELISE S looks out of this world. It's sleek and aggressive, with clever creases, sexy headlamps and more scoops and vents than you can shake a stick at.

And it's low; very low. I mean, preferably, you need to practice a bit of yoga before you get in one of these for the first time. Of course, I'm jesting, although, honestly, it isn't the easiest of cars to get in or out of. But so what? That's one of the joys of owning a true, sit on the floor, sports car - they're not run of the mill – therefore they're allowed to be quirky.

So, once you've folded yourself into the Elise, turned the key, pressed the starter button, and set off on real-world, less-than-smooth, well used roads, you generally get all sorts of 'crash, bang, wallop' sensations from the Norfolk-made motor. But you really don't care because the car is just such crude fun. If truth be told, it's brilliant precisely because of its bone-shaking rawness. There's no power-assisted steering and the clutch is heavy, but it doesn't affect the pleasure obtained from hammering what is, effectively, a finely-tuned, delightfully made, go-kart around corners and up the straights.

Not surprisingly, if you ask car lovers to define Lotus in recent years, many will point to the Elise as a perfect example of exactly what makes the UK based car maker a firm favourite in the hearts and minds of petrol-heads. The small lightweight, quick to respond, two-seater mid engine sports car revolutionised the market sector when it was introduced back in the 90s. By rigidly sticking to Lotus' core values of performance through keeping everything lightweight, the Lotus Elise was, and still is, able to produce supercar performance with city car economy.

UT OF THIS WORLD

Of course, like all good motor manufacturers, Lotus has regularly added to the Elise range, tweaking and improving the much loved entry level sports car - and now, the new Elise S takes a step closer to motoring Mecca. Why? Well, it's very simple – it replaces the less than environmentally friendly, albeit very quick, Elise SC with a new 1.8 supercharged engine capable of delivering 217 bhp and, consequently, even more shove. With the new powerplant and an improved throttle response the Elise S gives an even more stimulating and intoxicating driving experience. It thrusts you from a standing start to 62 mph in 4.6 seconds and the needle only stops when it gets to the speedometer's 145 mph marker. Yet, ingeniously, the engine results in lower fuel consumption – now an average of 37.5 mpg - and less CO2 emissions than the old Elise SC.

Even though the Elise S has a relatively unsophisticated cabin, it does have supportive, sculpted sports seats and functional, easy to operate, controls. The highlights are a standard lightweight aluminium passenger footrest, a black leather gear lever gaiter, a polished aluminium gear knob and handbrake sleeve, and an engine start push button. The shirt-button sized, leather-clad steering wheel is a delight to grasp – and it instils confidence with razor-sharp, direction-finding, precision. In fact, if you think your car steers well, you need to try an Elise, because the level of feel, accuracy and weighting is matchless.

The Lotus hangs on to the bends effortlessly and not many cars can supply the out of the ordinary balance that Lotus weaves into the Elise's DNA. The S's engine is the perfect accomplice to that inborn stability - and the brakes erase momentum as quickly as speed is achieved in the first place. Only the slightly stubborn, stiff, gear shift action disappoints.

Very few cars in this sector will match the thrill you get from driving – or even being a passenger in the new Elise S. An obvious competitor - the Japanese made Mazda MX-5 is miles cheaper and more refined, but it has nothing on the performance and image of the Lotus.

FAST FACTS:

- Max speed: 145 mph
- 0-62 mph: 4.6 secs
- Combined mpg: 37.5
- Engine: 1798 cc 4 cylinder 16 valve supercharged petrol
- Max. power (bhp): 217 at 6800 rpm
- Max. torque (lb/ft): 184 at 4600 rpm
- CO2: 175 g/km
- Price: £37,150 on the road

PROS 'N' CONS:

- Fast √
- Sexy √
- Road-holding √
- Steering precision √
- Gear shift action X