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Lansley's NHS "reforms" are divisive and destructive

Something like this must never happen again

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As the editors of the *BMJ*, *Health Service Journal*, and *Nursing Times*, we have divergent views on the government's NHS reforms and its beleaguered Health and Social Care Bill. But on one thing we are agreed—that the resulting upheaval has been unnecessary, poorly conceived, badly communicated, and a dangerous distraction at a time when the NHS is required to make unprecedented savings. Worse, it has destabilised and damaged one of this country's greatest achievements: a system that embodies social justice and has delivered widespread patient satisfaction, public support, and value for money. We must make sure that nothing like this ever happens again.

The NHS is far too important to be left at the mercy of ideological and incompetent intervention . . . we need a broad public debate on the principles that should underpin the NHS

Health professional groups differ in their stance on whether to oppose the bill outright or work with the government to try to improve it. But all are united in their deep distress and lack of confidence in the government's plans among those who must deliver the service.

A chief executive of a primary care trust cluster admitted to one of us last week that the breakdown of the relationships between commissioners and hospital trusts caused by the structural mayhem had left him with no way of knowing for sure "if I've got another Mid Staffs on my doorstep." He was only reassured by the fact that "nothing much happens up here, so the local paper does a lot on health." One commentator told the *BMJ* that trusts are finding the current economic climate extremely tough and that "we've taken a running jump into the abyss."[1] The changes have already laid waste huge amounts of management capacity and have undermined the ability of trusts to cope.

The Department of Health has recently admitted that it still has "no clarity" over which new organisation will take on the functions performed by 11 000 primary care trust staff, while the number and size of emerging clinical commissioning groups is a matter of increasing tension between general practitioners who want to maintain local control and the Department of Health, which is worried about financial stability. The deadline for the new system to come into full effect is now only a little more than a year away.

The reforms did not have to result in this unholy mess. The Coalition Agreement released in the honeymoon period immediately after the election focused on clinical leadership and patient and public empowerment (http://bit.ly/m6HuDz). It was generally well received by those now at daggers drawn with the reforms.

But through a combination of poor political judgment and reluctance to engage with criticism, a set of (mostly) reasonable objectives morphed into an old fashioned top down reorganisation. This was the very thing the agreement had pledged to avoid. It also resulted in a bloated and opaque piece of legislation, the goals of which could have largely been achieved by other, more effective, means.

Despite calls from many quarters for the bill to be withdrawn, including the *BMJ*,[2] this is now unlikely to happen. So what will we be left with once the bill hauls its battered hulk across the royal assent finishing line? Firstly, despite the costly debate and scrutiny, we will still be in the dark about how much of the new system will work. Guidance and secondary legislation that will affect the function of key bodies—clinical commissioning groups, the health "sector regulator" Monitor, and the increasingly influential NHS Commissioning Board—are not due for many months.

Secondly, the system will have to rely on a set of complex and sometimes conflicting relations between the Department of Health, the Commissioning Board, clinical commissioning groups, as yet undetermined clinical commissioning services, local authority health and wellbeing boards, and a host of other national, regional, and local actors. Care integration—now shoehorned into the legislation as a supposed antidote to the drive for increased competition between providers—is ill defined and lacks any meaningful incentives to encourage its adoption.

Thirdly, because the proposed new system will have little resilience or cohesion, the next government will find it necessary to overhaul the NHS again. This is not good for anyone, least of all the front line staff. But ironically this may be Lansley's one great achievement: reforms designed and implemented so badly that another major NHS reform programme is guaranteed within five years.

The NHS is far too important to be left at the mercy of ideological and incompetent intervention. Health policy has to respond rapidly to demographic and technological changes. But, rather than relying on policy makers to build brave new worlds in back rooms, we need a broad public debate on the principles that should underpin the NHS, how decisions on priorities should be made in a cash limited system, and what role clinicians and private sector organisations could and should play.

This debate will require restraint on behalf of all involved if it is to escape being characterised yet again by polarised views, (often disguised) vested interest, political point scoring, and conspiracy theories to the benefit of none. As part of this process, parliament should now establish an independently appointed standing commission, similar to the Sutherland and Dilnot commissions, to initiate a mature and informed national discussion on the future of our national health system.

The government's NHS reforms have proved divisive and destructive. They have slowed the improvement of NHS services and cost the UK money that it can ill afford.[4] Let us try to salvage some good from this damaging upheaval and resolve never to repeat it.

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EDITORIAL, p 8
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The consequences of abandoning the Health and Social Care Bill

Even at this late stage, the government would be wise to withdraw the bill

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The Health and Social Care Bill has now spent more than a year in parliament undergoing prolonged legislative scrutiny and some modification. During this time, opposition to it has hardened, and the coalition government's NHS reforms now command little support from the health professions, healthcare organisations, think tanks, patient groups, the media, or the public.[1] With many voices now calling for the bill to be withdrawn, it is worth giving serious consideration to what would happen if the government were to abandon it, and what the consequences would be for the NHS and for patients.

In anticipation of the reform legislation, the existing organisational structure of the NHS has already undergone substantial change. The 152 existing primary care trusts (PCTs) have been effectively wound up and replaced by about 50 PCT "clusters"—effectively, much larger PCTs. The 10 strategic health authorities have similarly been merged into four new larger ones. All, it is proposed, will become part of the new NHS Commissioning Board when it is established.[2]

About 260 clinical commissioning groups have been established in shadow form, and much effort has been expended on planning for them to take on responsibility for commissioning health services.[3] Similarly, much work has been done to scope and plan the role and function of Monitor, the proposed new economic regulator, and to plan for the transfer of the public health function from PCTs to local authorities and a new national agency, called Public Health England.

Stopping the Health and Social Care Bill now would mean abandoning most of this preparatory work, on which thousands of civil servants and NHS managers have toiled for the past year or more. It would mean that work on the new structures—the NHS Commissioning Board, Monitor, and clinical commissioning groups—would halt, and the transitional structures that have been put in place would become permanent. But it would have little or no adverse effect on the actual business of the NHS—providing healthcare to patients—which has continued much as usual, despite the negative impact that the turmoil of the health reforms has started to have on NHS performance.[4] More positively, stopping the bill now would have three clear benefits.

Firstly, it would put an end to the damaging period of prolonged organisational uncertainty in the NHS that started when the white paper was published 18 months ago, and will otherwise probably continue well into 2013 and beyond. Immediately, those working in the new clustered PCTs and strategic health authorities would know where they would be working in the future, and whether they had a job or not. These new PCTs and strategic health authorities already have management teams and boards in place that could get on with the job of running the NHS. At a local level, they could pick up and take forward much of the work that has been done by nascent clinical commissioning groups to engage general practitioners and others in commissioning. Veterans of past NHS reorganisations would argue that the value of structural change is much over-rated, and that the existing structures could prove just as fit for purpose as those envisaged in the bill.[5]

Secondly, it would allow NHS organisations to focus on what is the real and urgent problem for the NHS—improving efficiency and productivity, and sustaining performance in the face of years of future financial austerity. Efforts to do this so far have been disappointing,[6] and the NHS reforms have been a huge distraction from the task. Making the 4% year on year efficiency savings that are needed requires real and painful service reconfiguration, and that demands consistent, painstaking, and dedicated attention from senior managers and leaders, who have, up to now, been spending far too much time on the details of the NHS reforms.

Thirdly, abandoning the bill would save a lot of money. The government claimed that the proposed NHS reforms would save at least £1.5bn (€1.79bn; $2.35bn) a year in reduced administrative costs,[7] largely from abolishing PCTs and strategic health authorities, although the arithmetic in their impact assessment has been contested. However, most of those savings have already been made, through reductions in staff numbers and clustering of PCTs and strategic health authorities, and the current transitional structure is probably leaner and less costly than any the NHS has known in the past two decades. Going ahead with the bill means setting up the NHS Commissioning Board (with an annual running costs of £492m), 260 clinical commissioning groups (with an annual running costs of £1250m), and the new economic regulator, Monitor (with its anticipated annual running costs of £82m). Each of these new statutory organisations will have additional set-up costs—perhaps amounting to a one-off spend of £360m. If the bill were stopped now, it would save all those set-up costs, and at least £650m in annual running costs—just over £1bn in 2013.

Of course, dropping the Health and Social Care Bill would be politically painful and damaging for the government. However, it might be worth paying a short term political cost to avoid some of the longer term political consequences of the legislation and its implementation, if it is passed, which are likely to continue well beyond the next election.

The government could argue that, in the special economic circumstances of the day it makes sense to drop the bill, and that they have already made the substantial savings in NHS administrative costs that they promised. They might get some credit from the media and the public for listening and learning, but they would also neutralise an issue which has become increasingly politically toxic. A plan to accomplish much of their intended reform agenda—greater patient choice, more involvement of general practitioners in commissioning, and increased plurality and competition in healthcare provision—could be implemented using existing legislative provisions. The NHS could then get on with the serious business of delivering healthcare to patients while finding ways to do more with less.

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As the world population ages and becomes more industrialised and urbanised, the decline in coronary mortality is predominantly in rich nations

The decline in coronary heart disease: did it fall or was it pushed?

Probably both, but we need better data where incidence is increasing

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Three linked studies assess the decline in mortality from coronary heart disease and its determinants in three European countries.[1-3] National comparisons on this subject anticipate the Olympics. Who fell first? Furthest? Fastest? Started late? Why?[4]

Three decades ago, mortality from coronary heart disease in the United States, which had been high since the second world war, was found to be falling. The reasons were obscure. Cardiovascular risk factors had been studied in circumscribed cohorts, not in populations repeatedly sampled over time. Measurements were inadequately standardised.[5] The effect of treatment was unknown, but it seemed unlikely to be so much greater in the US than in countries not experiencing a decline in mortality. In 1978 the US National Heart Lung and Blood Institute convened a conference to clarify what was known.[6] Reinforcing existing surveillance, the report also inspired new initiatives: the Atherosclerosis Risk in Communities (ARIC) study in the US and the World Health Organization MONICA project (MONItoring trends and determinants in CArdiovascular disease).[7 8]

Observing that mortality in the population was the product of coronary event rates and their case fatality, MONICA hypothesised that a decrease in event rates was driven by a commensurate change in cardiovascular risk factors, and that case fatality was reduced by improvements in coronary care.[8] Its protocol was followed across 37 populations in 21 countries. Collaborators monitored and validated 10 year population trends in non-fatal myocardial infarction, coronary mortality, coronary care, and risk factors.

MONICA's final results were reported at the turn of the century.[8-12] On average, two thirds of the decline in mortality was attributed to falling event rates and one third to falling case fatality.[9] In most populations, event rates and risk factors were falling, but when trends in 10 year coronary event rates were plotted against trends in risk factors they showed a poor fit, although the correlation improved when a four year time lag was introduced.[10] Across populations case fatality, mortality, and event rates all decreased greatly as coronary care improved.[11] In contrast, ARIC showed that the recent US decline in mortality went with a minimal change in event rates and a greater fall in case fatality.[12]

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Reports since MONICA extend into the new millennium of medical interventions.[1-3] The Danish study by Schmidt and colleagues shows a 25 year decline (1984-2008) in both the incidence of those first episodes of myocardial infarction that involved hospital admission and the associated mortality, even though mortality was exacerbated by comorbidities.[1] The study by Bandosz and colleagues used the IMPACT model to assess how changes in treatments and risk factors have contributed to the decline in mortality in Poland since adoption of a market economy.[2] The authors conclude that about 37% of the decline was attributable to treatments and about 54% to changes in risk factors, although confidence intervals were wide. The third study by Smolina and colleagues shows a continuing decline in myocardial infarction and case fatality in England, with a hint of levelling off in the youngest age group.[3] All three studies suggest that the recent decline is associated with the effects of evidence based treatments in primary prevention, coronary care, and secondary prevention.

Are other factors contributing to the decline? The IMPACT model and the INTERHEART study imply that there is little need for additional factors.[2 13] MONICA could not exclude them.[10] Classic risk factors for heart disease are not the sole determinants of risk, otherwise risk scores would not need to be recalibrated according to the population studied. In prevention, coronary risk is multiplicative, so interventions that affect one or two modifiable risk factors disproportionately benefit overall risk. Other factors matter less.

Are prevention policies correct and governments in control? Many countries did not have prevention policies until after their decline in mortality from coronary heart disease began. Ensuring that effective treatments are prescribed is less challenging than changing people's lifestyles. People are resistant to rapid cuts in salt consumption and total fat—it is easier to substitute the type of fat. Fish are scarce and expensive. There is a hard core of nicotine addicts. Obesity and diabetes are increasing. But atherogenic lifestyles are unsustainable in terms of world food and energy resources.

Governmental effectiveness cannot be tested in a controlled trial. One indicator is the ability of the health department to counteract vested interests, such as those of the tobacco industry and manufacturers of processed foods, thereby knocking out the props that hold disease rates up. In Poland the decline in coronary heart disease began with the change from a socialist command economy, which subsidised animal fats, to a market economy, where fruit and vegetables were more competitively priced.[2] In the early 1980s, the then European common market had no mandate to consider human health when subsidising production of animal fats and tobacco. Britain had no coronary prevention policies. Now the European Commission and British health departments have relevant policies in place.

As the world population ages and becomes more industrialised and urbanised, the decline in coronary mortality is predominantly in rich nations, while rates increase in dozens of others.[14] Can these countries learn from us, or must they repeat our mistakes? Standardisation of population risk factor measurements—led by the former MONICA Data Centre in Helsinki (www.ehes.info/)—facilitates comparison, prediction, and possible action. Better data from countries where coronary disease is increasing are needed, but motivation and resources may be scarce.

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RESEARCH, pp 16, 17, 18

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SSRIs and persistent pulmonary hypertension of the newborn

Observational evidence suggests a link, but causation is yet to be established

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Persistent pulmonary hypertension in the newborn is a life threatening neonatal syndrome characterised by failure of reversal at birth of the high vascular resistance seen in the fetal pulmonary circulation.[1] The syndrome occurs in 1-2 per 1000 live births, typically in full term babies. The resulting ineffective oxygenation and respiratory failure necessitate respiratory support and drug treatment in an attempt to induce vasodilation of the pulmonary vessels. A cause can be established in some cases, and meconium aspiration, perinatal asphyxia, sepsis, and cardiac malformations are the leading known causes.[2] Different series have reported a mortality of 5-10%.[1]

In 2006 a case-control study found that significantly more mothers of babies with this syndrome than mothers of healthy neonates had reportedly used selective serotonin reuptake inhibitors (SSRIs) in late pregnancy.[3] Subsequent studies assessing this association have produced conflicting results.[4-7]

In the linked cohort study, Kieler and colleagues collected data from more than 1.6 million mother-infant pairs. They found that exposure to SSRIs after 20 weeks' gestation was associated with an increased risk of pulmonary hypertension in the newborn (adjusted odds ratio 2.1, 95% confidence interval 1.5 to 3.0).[8] The study's large sample size allowed the authors to assess whether the association was specific to certain SSRIs; they found that the risk was similar across all SSRIs studied (sertraline, citalopram, paroxetine, and fluoxetine).

Pharmacoepidemiological studies can show an association but cannot prove causation, yet the authors imply causation. But then how can causation of an adverse pregnancy event be proved if randomised controlled trials are not possible? One of the key questions is whether the putative effect makes biological sense, and research in a rat model has shown that fluoxetine can induce pulmonary hypertension in the newborn.[9]

A major challenge in prescription database studies is to prove that the prescribed drug was taken. A recent study showed that many women with depression did not take their prescribed antidepressants during pregnancy.[10] In Kieler and colleagues' study the timing of exposure was based on the pharmacies' date of dispensing and defined daily dosages (which may differ from the prescribed doses), but they did not mention the uncertainty around the timing of exposure and how it was calculated. In addition, without having validated the diagnosis or reviewed the medical charts of each case, it is difficult to estimate the quality of Kieler and colleagues' definition of pulmonary hypertension in the newborn. In the 2006 case-control study, 40% of the potential cases were rejected after a neonatologist reviewed the medical records.[3]

Another challenge in epidemiological studies is the ability to control for confounders and effect modifiers that might cause or modify the adverse event. Kieler and colleagues adjusted their statistical models for time of exposure in pregnancy, maternal smoking, age, body mass index, growth restriction, caesarean delivery, and psychiatric morbidity.

Surprisingly, the authors excluded neonates with one cause of pulmonary hypertension in the newborn, meconium aspiration, but chose not to do the same with all other known causes. This decision is not justified, especially when the registries available to the authors included clinical details on all other known causes of the syndrome. By not controlling for these confounding or modifying conditions, the authors have missed an opportunity to calculate the attributable risk of SSRIs in causing pulmonary hypertension in the newborn.

Can the associations found in the current study be explained by the underlying mental illness rather than the use of SSRIs? Although the authors argue against confounding by indication their analyses clearly show that women who did not use antidepressants in pregnancy but who had been admitted to hospital for psychiatric reasons were more likely to give birth to infants with pulmonary hypertension in the newborn (odds ratio 1.3, 1.1 to 1.7).

In the 1990s, Shepard introduced criteria for establishing causation of teratogenic effects of drugs in humans (table).[11] Review of these criteria suggests that the association of SSRIs with pulmonary hypertension in the newborn implies causation, although more work is needed as some studies found that a confounder, not SSRIs, was associated with pulmonary hypertension in the newborn.[7] Kieler and colleagues' study, with its large sample size, corroborates previous positive case-control and cohort studies.[3 4] An important question is not the relative risk of an SSRI causing the syndrome, but rather the absolute attributable risk. As estimated previously, this syndrome may occur in less than one in 100 pregnant women treated with an SSRI.[3] If the infant has no life threatening known causes of pulmonary hypertension in the newborn—such as meconium aspiration, sepsis, congenital heart disease, or diaphragmatic hernia—the chance of a full recovery is high. Future studies, or additional analyses of Kieler and colleagues' large cohort, may be able to quantify this risk, or the lack of one.

Criteria for proof of human teratogenicity applied to selective serotonin reuptake inhibitors (SSRIs) and pulmonary hypertension in the newborn[11]

Item	Criterion	Fulfilment by SSRIs
1	Known exposure to drug at critical time(s) in prenatal development	No
2	Consistent findings by two or more epidemiological studies of high quality:	Yes
	Control of confounding factors	No
	Sufficient numbers	Yes
	Exclusion of positive or negative bias factors	No
	Prospective studies, if possible	No
	Relative risk of six or more	Yes
3	Careful delineation of the clinical cases; a specific defect or syndrome, if present, is helpful	No
4	Teratogenicity in experimental animals	Yes
5	The associations should make biological sense	Yes
6	Proof in an experimental system that the drug acts in an unaltered state	Placental transfer has been shown

Items 1, 2, and 3 are essential criteria. Items 4, 5, and 6 are helpful but not essential.

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RESEARCH, p 20

Both dual and triple renin-angiotensin blockade have been investigated. Most trials did not consider the potential pathophysiological consequences of blocking the system at multiple levels

Dual renin-angiotensin system blockade

Combining a renin inhibitor with an ACE inhibitor or ARB is risky

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Some 30 years ago, captopril became the first angiotensin converting enzyme (ACE) inhibitor available for clinical use. Since then, several other ACE inhibitors have been introduced, as well as drugs from the angiotensin II type 1 receptor blocker (ARB) family. More recently, an orally active renin inhibitor, aliskiren, has become available. It is now possible to block renin itself, to inhibit the conversion of angiotensin I into angiotensin II, and to block the main target receptors of angiotensin II in a single patient. In the linked systematic review and meta-analysis of randomised controlled trials, Harel and colleagues examined the safety of dual blockade of the renin-angiotensin system using the renin inhibitor aliskiren and an ACE inhibitor or ARB.[1]

Many investigators have evaluated whether delivering a combination of drugs that interfere with specific functions of the renin-angiotensin system would be more effective at reducing blood pressure or protecting target organs (or both) than giving one drug only. Both dual and triple renin-angiotensin blockade have been investigated. Most trials did not consider the potential pathophysiological consequences of blocking the system at multiple levels. A meta-analysis that compared combinations of an ACE inhibitor and ARB with single drug treatment—mainly in patients with diabetes or kidney disease—showed that, among other positive findings, patients on dual treatment had a greater reduction in proteinuria than those taking a single drug.[2] However, the authors cautioned that most of the included studies were small, varied in quality, and did not provide reliable data on adverse drug reactions.[2] At the same time concerns about the safety of combination treatment with an ACE inhibitor and an ARB, particularly in patients with left ventricular dysfunction, emerged from another meta-analysis.[3] Hypotension, worsening kidney function, and an increase in serum potassium were the most worrying adverse events. Two large randomised trials evaluating dual treatment in high risk patients reported similar adverse findings.[4 5] The combination of an ACE inhibitor and an ARB seems to affect potassium values more than it affects overall renal function, which suggests that raised serum potassium is only marginally related to a reduction in glomerular filtration rate, if at all. ACE inhibitors and ARBs have opposite effects on angiotensin II concentrations, and a reduction in glomerular filtration rate in response to one of the agents may be partially offset by the other. Both drugs, however, lower plasma aldosterone, and the combination of a fall in plasma angiotensin II together with adrenal angiotensin receptor blockade could possibly induce a state of relative hypoaldosteronism, leading to a rise in plasma potassium.

Less is known about safety when the new renin inhibitor aliskiren is combined with an ACE inhibitor or an ARB, which is why Harel and colleagues analysed the risk of acute kidney injury and hyperkalaemia when various blockers of the renin-angiotensin system are combined. One message that emerged from their analysis of a large number of studies is that the risk of renal impairment associated with dual treatment with aliskiren and an ACE inhibitor or ARB is smaller than many clinicians might believe. However, their definition of acute kidney injury was fairly liberal, with a cut-off value that many nephrologists would consider too high, and it did not take into account baseline creatinine. Moreover, it is not certain that reported cases of renal impairment were truly related to kidney damage because a rise in creatinine can sometimes be explained entirely by intrarenal haemodynamic factors.

An important message from the current study is that use of a combination of aliskiren and an ACE inhibitor or ARB increases the risk of hyperkalaemia. This adverse effect could again be explained by suppression of endogenous aldosterone. The patient's clinical background is important, but the current study did not show a clear association between the risk of hyperkalaemia and the patient's clinical state. Although the authors tried to differentiate between low risk and high risk patients when estimating the risk of hyperkalaemia, they were not able to show a significant difference between the two groups for this outcome. It is therefore not clear whether or not clinicians should exercise caution in prescribing dual treatment in the subgroup of patients with hypertension but no other risk factors for hyperkalaemia. Another drawback is that ACE inhibitors and ARBs were considered together as a single class. The authors understandably wished to simplify the analysis of data, but unfortunately this reduces the usefulness of the study's findings from a pharmacological perspective. The two drug classes have divergent effects on angiotensin II concentrations and receptor occupancy, and their effects may also differ when combined with aliskiren. Finally, it is not clear whether the patients who were included in the various studies were representative of the general population of patients with hypertension. Indeed, there was a preponderance of men and younger people in the included trials. The risk estimates from the current meta-analysis may not accurately reflect risk in "real life"—the risk of developing severe hyperkalaemia may be greater still.

It is noteworthy that the ALTITUDE trial, which was designed to explore whether dual blockade with aliskiren combined with an ACE inhibitor or ARB would reduce morbidity and mortality in a broad range of high risk patients with type 2 diabetes,[6] was stopped prematurely in December 2011. The trial's data safety monitoring board advised against continuing the study because "the active treatment group experienced an increased incidence of non-fatal stroke, renal complications, hyperkalaemia, and hypotension over 18 to 24 months of follow-up." The committee concluded that patients were unlikely to benefit from aliskiren on top of standard antihypertensive treatment.[7]

Given these concerns, clinicians should avoid using a combination of renin-angiotensin system blockers in high risk patients and be extremely cautious when using combination treatment in low risk patients. Another lesson may be that sound pathophysiological data rather than logical reasoning should guide the design of large and costly trials. Future work should concentrate on how different renin-angiotensin system blockers interact and in which types of patients the combination can be used safely.

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RESEARCH, p 19

Ensuring dignity in the care of older people

Should be the aim of all healthcare professionals, including doctors

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The Patients Association annual report, *We've been listening, have you been learning?*, was published in November 2011. It detailed 16 accounts of poor hospital care, of predominantly older people, heard by its helpline in the past year.[1] The report focused not only on the care patients received from nurses, but also on experiences of care from other professionals, including doctors.

Poor communication; a lack of empathy; and a failure to listen, respond, or explain were common complaints. Impaired hearing and sight often went unnoticed. The report highlighted failures to promote control, continence, and independence and a reluctance to give people time to be heard. It also noted poor pain control and poor management of distress, which led to inadequate end of life care. Relatives explained how disturbed they were to see patients ill-kempt, with dirty fingernails and soiled clothes. Hospital wards were often described as dirty and unhygienic. The cases illustrated the humiliation of being left in soiled sheets as patients were told to pass urine and faeces in their beds because it was easier for staff to change sheets than to take them to the toilet. Patients were not encouraged to eat or drink, and food and water were often out of reach. In some cases nobody seemed to be in charge, and absence of continuity led to inadequate care. Poor multidisciplinary collaboration, communication, multiple transfers between wards, and a lack of leadership were all highlighted as components of undignified and inhumane care in hospital.

Such components of inhumane care were also identified in the British Geriatrics Society led campaign, Do not Forget the Person, launched in 2010.[2] Recent reports from the Health Service Ombudsman,[3] the Care Quality Commission,[4] and the Equality and Human Rights Commission[5] have also shed light on some appalling practices in care. The mid Staffordshire catastrophe,[6] which led to an independent inquiry, highlighted failures of staff to deliver person centred care in hospital, in some cases ignoring patients and other individuals with fatal consequences. The final report of the mid Staffordshire inquiry is awaited with interest, and it promises to include a recommendation to have a senior geriatrician on every elderly care ward and standards for the recruitment, training, and regulation of healthcare support workers and nurses who care for older adults.

Population ageing has led to an increase in the prevalence and proportion of older inpatients with complex physical and mental health problems. A recent prospective study reported that a quarter of patients over 70 undergoing acute admission have dementia.[7] However, the 2011 national audit of dementia care in general hospitals showed that only 6% of 210 hospitals had a care pathway for people with dementia, only 6% of those with dementia were administered a test of cognition on admission and discharge, a quarter of hospital notes did not include an assessment of pain, and only 5% of hospitals required staff to be trained in the care of patients with dementia.[8] Assessments of nutritional status were performed in only 70% of the sample of case notes examined in the audit. Less than half of medical notes audited had a special place for information about people with dementia.

A more recent prevalence study conducted in a general hospital found that 50% of people over 70 years admitted to hospital had cognitive impairment, 27% had delirium, 24% had possible major depression, and 8% had definite major depression, 8% had delusions, and 9% were agitated or aggressive.[9] In addition, 47% of patients admitted were incontinent, 49% needed help with feeding, and 44% needed major help with transfers—for example, from bed to chair or bed to toilet. General hospital staff may feel ill equipped to deal with the increasing proportion of older adults admitted as an emergency with physical problems who also have mental health problems or cognitive deficits. The Preventing Abuse and Neglect in the Care of Older Adults (PANICOA) study—a qualitative study of older patients, their carers, and hospital staff commissioned by the Department of Health for England and Wales—found that older patients often described acute hospital wards as "confusing and inaccessible" and staff expressed the almost unanimous view that the acute hospital is not "the right place" for older people.[10] The authors concluded that hospital wards were not fit for purpose as places to treat people over 65, which is difficult to ignore when such people account for most hospital users.

A Royal College of Nursing project that undertook several surveys of more than 700 professionals and almost 1500 family carers, supporters, and people with dementia, found that older people with dementia have more complications and stay longer in hospital than those without dementia.[11] The researchers concluded from their respondents that staff should be informed, skilled, and have time to care; that family carers and friends should be involved, unless the person with dementia indicates otherwise; and that all patients aged over 70 should be offered cognitive assessment to support early identification of cognitive impairment and the delivery of appropriate care. Care plans should be multidisciplinary—supporting nutrition, comfort, and control—and should be based on the clinical, physical, emotional, cognitive, and physical needs of the individual. What should apply to patients with dementia could apply to most older people.

The imminent publication of the *Commission on Improving Dignity in Care* by the NHS Confederation, Age UK, and the Local Government Association is awaited with interest.[12] Hopefully, it will make all hospital and community doctors aware that it is every doctor's responsibility to know about and have skills to care for and treat older people with complex conditions or frailty (or both). In future, undergraduate and postgraduate training will need to ensure that all doctors are trained to work in a holistic, humane, and multidisciplinary way that respects the dignity of patients. The Patients Association report applies to all who work with older adults and not just nurses.

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