A VISION FOR NAILSEA PLACE

Health and social care services face unprecedented levels of demand, including the effects of obesity, an aging population, more people living with multiple long-term conditions, social isolation, and the impact of dementia. How people with long-term and often complex conditions live within their communities without becoming isolated is one of our great healthcare challenges, so promoting wellbeing and independence need to be key outcomes of care.

What has this got to do with town and parish councils? In practice a great deal, because they have a vested interest in health and wellbeing within their own communities. Yet typically, local councils have little or no interaction with health and social care providers. The goal is not parish councils providing services, though they may choose to do so: it is about optimising their assets (including buildings, money, people, influence and knowledge) to facilitate gains in health and wellbeing in their communities.

There are two fundamental issues we want to address:

1. **Models of healthcare.** The NHS medical model of care has a typical dichotomy of seeing people as 'well' or 'unwell', either in the 'system' or outside it, but health and illness is actually a continuous variable. Salutogenesis is a social model of care focussing on the factors that support wellbeing, and the relationship between health, stress and coping. Relevant knowledge is key to having the motivation to comprehend, manage events and confront challenges and to make individuals more informed about how to deal with issues they are facing. While the medical model focuses on disease, the social model focuses on people, addressing the reality, for example, that they may have a raft of non-medical issues underlying a medical condition, resulting in poor outcomes from care interventions.

2. **Silos.** Despite many innovative and effective initiatives across the country, health and social care agencies still operate largely in bureaucratic, financial and professional silos. The focus becomes process not people. The distinction between health and care structures and the services they provide is analogous to electrical wiring and the electricity that goes through it. For those dealing with multiple, often long-term, conditions this is a mass of wiring, impossible to untangle, undermining their confidence and wellbeing.

The Nailsea Place captures the opportunity to implement a model for wellbeing within our own community. This is not a one-stop shop: the building we are acquiring will be a hub for a network, plugged into the services provided by the public, commercial, charity and voluntary sectors in other locations. It will be a place for advice, services and activities supported by an extensive network: a venue for information and a base for local events, clubs, hobbies, volunteering opportunities, benefits advice, adult skills, employment programmes, money management, healthy lifestyle programmes and much more. A place where groups can meet for mutual support and sharing ideas, learning from each other in a safe environment. This is more than 'health literacy', it is about people being 'activated' to take positive actions to manage their own wellbeing. Social prescribing is now part of a GPs toolkit and Nailsea Place aims to be a reference centre for it.

People developing their confidence in using digital technology is vital. This includes ordering repeat prescriptions and sending emails to their GP Practice, health visitor or other care professional. Guided web-surfing, using trained volunteers if needed, can help people learn about their conditions and options, so they can truly give their informed consent to treatments, procedures and operations, or choose not to accept those interventions. All this needs to be available in the language used by the patient in their normal life.

Statutory organisations try to engage with communities: local organisations are part of communities and can be effective in other ways. Nailsea Place promotes the mutually reinforcing benefits of patient activation, peer support and patient leadership. Wellbeing is made at home and in communities, not in hospitals and clinics. The Nailsea Place wants to improve wellbeing in our community, incrementally and on a manageable scale.

Nailsea Town Council, February 2017
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EDITORIALS

CHRISTMAS 2016

Humanising healthcare

We have to start by building a more compassionate society

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When we are sick, injured, or facing an existential life crisis, our greatest human need is loving kindness and compassion in response to our vulnerability and suffering. One of us (MB) has previously described her first hand experience of the difference such care can make[1]:

In shock, I am admitted to a cancer hospital. Treatment must necessarily be aggressive. I am terrified. Will I die? I am so alone, but trying to be brave. A doctor in a white coat sits down and asks why I am there. When I tell him he encloses my hand with both of his. Instantly, I am encased in warmth, comfort, compassion.

Unconvincingly I say, "I'm not nervous."

"That's all right," he replies, "I'm enjoying it!"

We both laugh. And I leave my hand there. The encounter stays with me; I revisit it whenever I need the healing touch of a human hand.

Years later I am overjoyed to tell him what his kindness meant to me. But he can never really know how much, or the depth of my gratitude.

Too often, what patients actually receive is rushed, clinical, and emotionally detached care. Physicians have many evidence based guidelines for disease management but little evidence based medicine for care of the whole person.[2]

Sometimes, the inhumanity is failure of the wider system. RY's daughter spent three months in spinal traction with a broken neck. Many days she went hungry. She could not see a television or read a book. But the hospital prioritised clinical care, not her needs as a human being.[3]

The system is also dehumanising to those who work within it; witness the emotional exhaustion, depersonalisation, and cynicism now so widespread among health professionals.

Multiple wins

Randomised controlled trials have provided good evidence that compassionate care also improves clinical outcomes. Empathetic and supportive preoperative consultation improves wound healing and surgical outcomes, halves opiate requirements, and reduces length of stay.[4,5] Patients in emergency departments are 30% less likely to return if treated with compassion.[6] Early access to palliative care reduces costly interventions, improves quality of life, and prolongs survival in cancer patients.[7] Meta-analysis suggests that having a caring doctor reduces five year mortality in men more than does stopping smoking.[8]

Compassionate caring also gives meaning, joy, and satisfaction to health professionals, aligns with their ideals, and protects against burnout.

Human centred care is therefore good for patients, professionals, and funders. Why isn't it spreading like wildfire?

After decades of campaigning for a more humane health system, we conclude that the underlying values of the healthcare system are incompatible with compassion, caring, and healing.

Societal failings

Although health professionals care deeply about their patients, the values of the wider system are competition, rationalism, materialistic science, productivity, efficiency, and profit. There is no room for healing. We call this the "industrialisation of healthcare."

As campaigners, our mistake was to assume that these values were somehow intrinsic to healthcare and that the system could be fixed. However, these values are adopted from society; if we want to re-humanise healthcare we have to build a more compassionate society.

Heroic models of leadership—always campaigning and battling to "win the war" against cancer or drugs—sabotage our efforts. We need our leaders to be healers more than heroes; it begins with self compassion and self care.

We call for a new breed of physician leader-activist; people who are "internal activists" in the workplace, role modelling the best of human centred care, and also social activists in wider society, leading the movement for compassionate communities. The compassionate cities programme (charterforcompassion.org) is a good starting place.

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In the 1980s the International Physicians for the Prevention of Nuclear War rose up to address the global threat of nuclear war. It is now time for physicians to stand together and address the societal values that are driving us to social breakdown, epidemics of chronic disease, and ecological collapse.

Our work in humanising healthcare became much more successful when we gave up battling the system and changed our leadership style[9]:

- Being non-judgmental and compassionate—rather than moral crusading
- Showing humility and vulnerability—rather than persuading and evangelistic
- Seeking the wisdom of individuals and communities we serve—rather than casting ourselves as the experts
- Giving away our materials, offering our time for free, and asking for donations—rather than seeking transactional business relationships
- Using appreciative inquiry to seek stories of what works best—rather than a focus on problems

These same ways of being are also a powerful foundation for patient centred medical practice and fulfil the promise in the Declaration of Geneva: "I solemnly pledge to consecrate my life to the service of humanity."

We are encouraged by seeing new organisations joining our Hearts in Healthcare campaign (heartsinhealthcare.com), including the *Journal of Compassionate Healthcare* and the International Charter for Human Values in Healthcare (http://charterforhealthcarevalues.org).

Compassion is the golden rule of every religion. This festive season, will you reflect on how your compassionate care of patients might be extended to our communities and the broader healthcare system?

See also: Robin Youngson's TEDx talk, "Perfectly broken and ready to heal" (https://youtu.be/jTYSzLtbYTU).

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Joan Higgins MBS Blog

On a recent visit to Greece, I was interested to learn more about the so-called 'Golden Age of Athens' (which lasted from around 461 BC to 429BC, when Pericles was Governor). It made me think about the factors which lead people to argue that a particular period of time was a 'Golden Age' and to ask, much more parochially, whether we could ever say there had been a 'golden age' in the NHS - or in health policy more broadly.

The Golden Age of Athens involved strong leadership and a clear vision of the future, a commitment to civil society and the rule of law, public support for major building schemes (like the Parthenon), subsidy of theatre, the arts literature and philosophy and the teaching of logic and aesthetics. Intellectuals and writers played a dominant role (Sophocles, Aristophanes, Euripedes, Pythagoras and, later, Socrates). Hippocrates led a complete shift in thinking about the causes of ill health and its treatment. One of the essential features of this 'Golden Age', and of others, was the interrelationship between different societal parts (science, technology, engineering, the arts and culture, public policy, governance and civil society and ideas, values and ethics). The whole was much greater than the sum of the parts and no aspect of society was seen in, or developed in, isolation.

If we apply this analysis to UK health policy, could we say that there has ever been a 'Golden Age' in which all these features coalesced? We would be looking for a broad consensus on priorities and on ends and means, an holistic approach involving integration of public policy with wider societal goals; we would be expecting a paradigm shift in ways of thinking and respect for (and inclusion of) experts, professionals and intellectuals.

There are, perhaps, two periods in which some of these qualities were present. There was the great period of Victorian reform (around the 1830s-70s) which resulted in public health legislation and improvements in housing and social welfare. As in the period of Hippocrates, there was a radical shift in our understanding of the causes and spread of disease and a commitment to tackling them. The Great Exhibition of 1851 underscored the links between different aspects of Victorian society and celebrated improvements in health and medicine alongside investments in art, architecture, science and technology. 100 years later, in 1951, the Festival of Britain boosted industrial design, technology and engineering at the same time as highlighting the unprecedented investment and progress in post war housing, health care and social benefits.

At a lower level, we might talk of 'golden periods', if not Golden Ages. I would point to just two of them. In the early 1960s, under the leadership of Enoch Powell (the, then, Minister of Health) the Government launched The Hospital Plan (1962). It promised a huge building programme for new hospitals (90 of them) and the modernisation of 134 more. It committed itself to new funding, of £571 million over a 10 year period, for District General Hospitals but also for community hospitals and improvements in primary care. In the second 'golden period', in the early years of the Blair Government, the Secretary of State, Alan Milburn, launched The NHS Plan,(2000). It was the result of widespread consultation and commanded broad ranging support (as evidenced by the long list of signatories in the Preface). These two periods were not all embracing and

we did not build a Parthenon, but they did reflect a shift in thinking and a new consensus.

The problem in the 1960s and 1990s (and at other times) is that the NHS, far from being part of an integrated drive for broader societal improvement, has been seen as a thing apart, special, an institution to be protected at all costs, including through hypothecated funding. The danger is that such a particular status can stop innovation in its tracks as well as preserving in aspic those features which need to be challenged, in order to improve health and wellbeing. Some of the current debates about integration of services and adequacy of funding have become so inward looking and sterile that they have blinded us to fundamental questions about the purpose of health policy and the NHS in a prosperous society. How do we know how much money is *enough* money, for example, if we are not agreed about what it is FOR? Governments have shrunk from this question for many years, but it is becoming increasingly urgent. We cannot avoid the issue by saying that all would be well in the NHS if there was simply more of the same. It isn't just about the money. It is about attitude of mind, it's about confidence and imagination – as well as breadth of vision, it is about an openness to new ideas and innovation and a willingness to take risks. In the Golden Age of Athens, intellectuals had a leading role in framing and debating questions like these and there is a challenge today for those of us who are interested in public policy analysis. We need to draw on a wide range of perspectives to inform the discussion – I would point to demography and geography, in particular, as well as law and ethics as disciplines which can, and should be considered. Just as the practice of health care in the UK has become parochial, inward looking and detached from wider world issues, so its analysis is in danger of becoming so.

In my view, intellectuals and policy analysts have a social obligation to use their skills and knowledge for the public good. They bring expertise, independent mindedness and objectivity. They can interpret evidence for different audiences and disseminate information. There are challenges of course, when they are funded by Government. They must conspicuously maintain their integrity and distance (which can be easier said than done). There is often the opportunity for 'hands on' practice, interpreting Government policy and facilitating implementation but I think there is a duty to go beyond that. University Departments, in particular, despite current pressures still have the freedom to test out ideas, to challenge the status quo and to formulate new paradigms. This may not feel like a Golden Age right now but intellectuals have always been central figures in creating the knowledge and conditions for reform. They are sometimes at their best and most influential in periods of crisis. This is the moment to walk towards those challenges and not away from them.

JH 20.11.16

PROF EMERITA, MANCHESTER HEALTH MANAGEMENT CENTRE

Despite its limitations, the Dutch experience contrasts starkly with Britain's. The *Health of the Nation* devoted only one page to what are referred to as "variations" (not "inequalities") in health among socioeconomic groups.[4] These are said to be the result of "a complex interplay of genetic, biological, social, environmental, cultural and behavioural factors." The same list of factors was given by Mrs Bottomley in her message to the BMA's conference on inequalities in health,[3] with the rider that "there are no easy answers" in this area.

Yet surely there is some obfuscation here: it is inconceivable, for example, that changes in the genetic make up of different socioeconomic groups have occurred over the past 15 years to produce the increases in differences in mortality in Britain discussed above. Although behaviour related to health is regarded as the appropriate target for health promotion activity, it must be recognised that eating, smoking, drinking, and participating in exercise do not occur in a social vacuum. In poorer areas less healthy food is available and is often more expensive than in affluent areas.[18] Similarly, the reason why smoking breaks the rule that households with low incomes cope by decreasing the personal expenditure of adults cannot be reduced to personal failure. Thus for women caring for children in adverse socioeconomic circumstances smoking may be one of the few activities undertaken solely for themselves and one that provides some respite from the strain of coping with the consequences of material deprivation.[19]

Policies that ignore the social and economic constraints on behavioural change may produce increases, rather than decreases, in inequalities in health. A more fundamental approach than oversimplifying the origins of behaviours related to health would be to recognise the close association between the size of income and differences in mortality between 1921 and 1981,[7,20] with the recent widening of inequalities in health mirroring the gross upwards redistribution of wealth since 1979.[21] If progress is to be made it is necessary at least to start addressing the fact that increasing inequalities in health are a consequence of our increasingly polarised society.

The government's new working party will be judged by its efforts to move the national debate forward to remedying and preventing inequalities in health, with measures that can be started now. The NHS has its part to play—for example, in the allocation of resources to primary health care in inner cities.[22] Research shows, however, that the main agenda lies elsewhere and should focus on child and family poverty, on housing (which will also create employment), on the provision of nursery education, and the like. The recommendations of the working party on such issues are awaited. "Interdepartmental" commitment, which is central to the *Health of the Nation* and its credibility, will be tested here. Any such measures will, of course, be costly. But then so is the waste of human capital in the premature death that the multiplying statistics represent—not to mention the burden of disability and mass of human misery that are entailed.

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Beyond health care

Attention should be directed at the social determinants of ill health

The aims of health policy ought not to be contentious. Topping the list should be a commitment to improve the length and quality of life of everyone and to minimise avoidable differences in health status among social groups. The corollaries of such goals include improving our understanding of the determinants of health and intervening in public policy to deliver the required outcomes. Unfortunately, no evidence exists that any political party in Britain has grasped the extent to which thinking must change. Debates about the financing, governance, and structure of the NHS remain as dominant as they are largely unconstructive. What is needed now is a radical change of direction away from tinkering with the organisation of health care towards developing new approaches to health policy.

The importance of this proposition is illustrated in a new book produced under the auspices of the population health programme of the Canadian Institute for Advanced Research. *Why are Some People Healthy and Others Not?* contains contributions from internationally renowned analysts, including economists, epidemiologists, and political scientists.[1]

The book's central argument is based on a synthesis of evidence—both familiar and newly emerging—suggesting that "factors in the social environment, external to the health care system, exert a major and potentially modifi-

able influence on the health of populations, through biological channels that are just now beginning to be understood."[2]

Recent scientific advances show ways in which people's perceptions of their social environments can stimulate chemical and electrical responses in their body's endocrine, immune, and neural systems. These new studies lend credence to older ones that have emphasised the health promoting qualities of social support. A key determinant of health turns out to be the extent to which humans and other primates are able to rely on their own resources, or the support of others, to overcome the pressures associated with social and environmental factors.

Why, given that the importance of social and environmental determinants of the health of populations has been known for many years, has policy taken so little account of it? The short answer is that the combination of economic interests and political influence associated with the health care industry is so powerful that a predominantly biomedical system of beliefs dominates the development and practice of health policy.[3]

We have been indoctrinated into accepting the superiority of biomedical and disease oriented explanations of the determinants of health to the detriment of socioeconomic ones. For example, probably the dominant lay view in modern industrial societies is that the main causes of premature death are cancer and heart disease. The almost inaudible counterview is that the principal killers are the "lack of social support, poor education, and stagnant economies."[4] The result of the bias inherent in the prevailing system of beliefs is that enormous effort is put into researching and marketing such fripperies as cholesterol free crisps. On the other hand, serious study of ways of over-coming the stress associated with hierarchies in the workplace or of providing "companionship and support for the widowed elderly"[4] and other vulnerable social groups is neglected.

Arguing that social sciences should supplant medical ones would, however, be the worst kind of backward thinking. More multidisciplinary research and policy analysis are needed. At present a major bias exists in research funding. Most of the available resources go into the invention of new technologies even though their aggregate contribution to the population's health is modest. Relatively little effort goes into assessing the effectiveness of the existing health care system, and almost nothing is invested in looking at the non-medical influences on health. What's urgently needed is a more systematic programme of research to improve our understanding of the socioenvironmental determinants of health and of how to design public policies that will prevent or ameliorate poor health.

More generally, debate on health policy in countries such as Britain needs a new perspective. A sustained effort should be made to persuade not only politicians and patients but also those who earn their living in the health care industry that it makes economic and social sense to limit spending on health care to free resources for other policies that promote health. Investing in health remains a worthwhile objective, but it means much more than spending on the NHS.

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Liver biopsy: blind or guided?

Benefits of guided biopsy are clear only for focal lesions

Despite advances in imaging techniques and serological investigations percutaneous needle biopsy of the liver is still important in accurately diagnosing hepatic disease. The basic technique, described by Sherlock, has changed little over the past 50 years.[1] It is simple, cheap, and relatively safe and can be carried out at the bedside. In the past few years, however, ultrasonography has been increasingly used to guide the biopsy needle. A recent large survey of consultant gastroenterologists showed that 1 in 8 always used ultrasonography guidance for biopsies.[2] Some consultants now believe that ultrasonographically guided biopsies are so much safer that blind biopsy can no longer be defended. Before this policy is adopted uncritically, however, it is important to examine the current evidence concerning safety, diagnostic yield, and cost.

Percutaneous liver biopsy has a mortality of 0·01%-0·1%.[3,4] Death is usually due to bleeding or to biliary peritonitis as a result of puncture from the gall bladder. The incidence of bleeding is probably proportional to the incidence of formation of haematomas, which is not affected by the use of ultrasonographic guidance.[5] Although, intuitively, guided biopsy might be expected to reduce the risk of puncturing the gall bladder, no randomised controlled trial has been large enough to show reduced mortality with ultrasonography. Identifying deaths related to procedures is not easy. There is an overall mortality of 19% among patients within three months of biopsy, but most deaths are due to underlying disease.[6] Retrospective reviews may therefore fail to give a true indication of the risks of the procedure.

The 1991 national audit of liver biopsies reviewed 1504 biopsies, of which a third were guided by ultrasonography.[6] Two deaths definitely related to the procedure occurred, one each from bleeding and from biliary peritonitis. Both biopsies were carried out without ultrasonographic guidance. Surprisingly, postmortem examinations were not performed, but the second death might have been avoided had ultrasonography been used. Data were also collected on pain and bleeding after the biopsy. Pain was experienced by 25% of the patients who had non-guided biopsies and 22% of the patients who had guided biopsies. Serious bleeding occurred in 1·6% of non-guided cases and 2·5% of guided biopsies. These differences were not significant.

The largest single controlled trial is that of Papini and colleagues, who randomised 240 patients to guided or