

Integrated care is crucial to prevent abuse of patients

Too many adult patients at risk of harm are lost into the gulf between healthcare and social care, says **Billy Boland**

On 14 May 2013 the health minister Norman Lamb announced the UK government's intention for health and social care to be fully integrated by 2018.¹ A cohort of experimental sites will be unveiled in September to trial new ways of delivering care, he announced. Healthcare providers and local authorities will forge new partnerships to tackle unmet need with the aim of avoiding patients falling between two stools.

Support for integration from patients and their carers is strong. National Voices, the "national coalition of health and social care charities in England," champions this cause, calling for integrated care to develop "quickly and at scale."² Its influence is considerable and growing: for example, it has worked closely with the NHS Leadership Academy in developing new programmes to make sure the "patient experience is central to the programme."³

From the perspective of patients, integrated care makes complete sense. In 2010-11, 95 000 adults were referred for safeguarding because of suspected abuse in England and Wales, with 44% referred by social care staff and only 22% by healthcare staff. Referrals from primary and community care made up a mere 9.4% of the total.⁴ This may represent a relative lack of awareness among healthcare staff about abuse and a bias in reporting of concerns.

Healthcare providers have much to learn from colleagues in social care. Abuse passes through clinics unrecognised, and harms are being allowed to continue. Lamb is advocating that clinical commissioning groups spend about £1bn of their budget to fund integration, already angering some commentators.⁵ Opponents of integration say that it is expensive and unnecessary and won't bring the changes that are needed. But with the scale of abuse occurring, can we afford not to?

The distinction between healthcare and social care is artificial because needs are inevitably interwoven. Social ills such as abuse, poverty, and lack of social connectedness are indelibly linked to poor health outcomes. Conversely, social initiatives such as the government's "fit note" scheme (statement of fitness to work) introduced by Carol Black, former president of the Royal College of Physicians, shows medicine's fascination with improving health through social means.⁶

Individual needs can affect each other, amplifying disabilities, resulting in more



PATRICK LANDMANN/SPL

complex and profound harms. Immobility breeds isolation, and isolation breeds depression. Health and social needs are two halves of a whole person. As Lamb has put it, "People don't want health care or social care—they just want the best care. This is a vital step in creating a truly joined-up system that puts people first."

The UK's attention has already been turned to abuses inflicted by those delivering care in a system that is supposed to protect patients. The horrific abuse of patients at Winterborne View Hospital, exposed by a recent BBC *Panorama* programme, highlighted what can happen when things go wrong.⁷

A lack of cohesion between NHS commissioners and the hospital's local authority made sharing concerns about care difficult. Events at Winterborne might not have occurred had scrutiny of health and social care been integrated. A review has criticised NHS commissioners for failing to ask searching questions of the care provided by the hospital and calls on the Department of Health to bring "clarity across the health and social care spectrum about commissioning responsibilities for hospital based care."⁸

The Francis report on Mid Staffordshire NHS Foundation Trust also captured this mood. Blinkered working practices and silo mentalities meant that needs of patients and carers at Mid Staffs were routinely neglected or ignored. A failure to share information about serious incidents made it easier for staff to turn a blind eye to bad practice and allow harms

to occur. Recommendation 35 in the Francis report calls on regulators to "go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern."⁹

The evolution of services has created an unnecessary gulf into which people who need both health and social care are being lost. Local authorities and NHS providers have developed independent empires, minding their own businesses and staying on task. Inflexible working practices have resulted in elderly patients laid unnecessarily in hospital beds for want of a care home: transfers to care homes now take an average three days longer than when the coalition government formed, despite efforts to reduce delays.¹⁰ Once in care, patients (and their families) are raising concerns that their physical health needs are being neglected.¹¹

We desperately need integration of health and social care if we are to take the protection of people at risk of harm seriously. Safeguarding adults at risk currently requires multi-agency working.¹² Merging healthcare and social care providers would promote dialogue that would advance patient safety. Harms flourish where communication is neglected, as we have seen. A single provider model would ensure that healthcare and social

care staff know how to identify harm and make it easier for them to share intelligence and do something about concerns. Integration offers the promise of a holistic service that

safeguards against bad practice and care. And patients and carers are crying out for it.

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Letter: Helping people die at home (*BMJ* 2013;346:f3182)

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FROM THE FRONTLINE Des Spence

Bad medicine: epilepsy

Money is the great motivator. The anti-convulsant drug phenytoin was recently replaced by a generic drug, in exploitation of a loophole in UK policy and increasing the cost to the NHS by £40m.¹

Epilepsy is profitable, with lifelong multiple medication, so a huge range of putatively new drugs have been developed to seek a slice of the profits. They are all pitched at the same price, in the drug industry's traditionally sham competition. Anticonvulsants have an additional big business bonus, too. The industry has been fined billions for promoting anticonvulsants off licence in pain and psychiatry specialties.²⁻⁶

Antiepileptic prescriptions in England rose from seven to 17 million in a decade, with annual costs tripling to £389m.⁷ These large rises are attributable to the new antiepileptics, despite these having no proved benefit over older drugs such as valproate and lamotrigine.⁸⁻⁹ Evidence is also emerging that the new drugs are being used inappropriately.¹⁰ These prescribing patterns must



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also reflect increasing polypharmacy in epilepsy. Yet monotherapy is the treatment goal, and polypharmacy adds little to control seizures.¹¹⁻¹²

Rapid and unexplained increases in prescribing are a sign of overdiagnosis. So is this happening in epilepsy, especially partial or focal epilepsy? In partial epilepsy, unlike generalised tonic-clonic seizures, the diagnosis is often only clinical,¹³ with defining symptoms such as déjà vu, detachment, feeling frightened, memory problems, tingling, and many more subjective effects. All diagnoses based on self reporting and clinical judgment are open to overdiagnosis phenomena.

Yet there is scant epidemiological data on changes in the prevalence of epilepsy in adults, and concerns about overdiagnosis are merely anecdotal. Paradoxically, in children, for whom a diagnosis of epilepsy is less subjective, incidence has halved since the mid-1990s.¹⁴ Accurate diagnosis is fundamental in epilepsy because treatment is life long, although epilepsy often spontaneously resolves.¹⁵

There are, however, no national initiatives to withdraw anticonvulsant drugs.

Some of the rationale for more prescribing in epilepsy is to protect against the rare but devastating sudden unexpected death in epilepsy (SUDEP). SUDEP is most commonly associated with people with tonic-clonic epilepsy activity, not partial non-generalised epilepsy.¹⁶ Undoubtedly seizure control reduces SUDEP,¹⁷ but there is no evidence that this massive increase in antiepileptic treatment has had an effect on SUDEP. Lastly, predictably, and depressingly, the educational agenda of epilepsy is a gravy train of international conferences and drug industry sponsorship.¹⁸

The numbers for antiepileptic prescribing just don't stack up clinically, demand further research, and risk overtreatment. This is bad medicine.

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STARTING OUT Kinesh Patel

Is clinical examination dead?

"I tried to listen to some heart sounds last week. Couldn't hear a thing." So an eminent professor of medicine told me recently. "It's all quackery, you know."

This is something I'd thought for a while, but I'd not heard it summed up with such frankness. Although I continue to teach undergraduates the distinction between reverse and fixed splitting of the second heart sound, I have never detected these conditions myself. And I've got a strong suspicion that most cardiologists confidently declare "a clear case of a loud P2" only after furtively inspecting the echocardiogram report.

So why do we promulgate this quackery? Perhaps it's a sense of tradition: it's the way things have always been done. Perhaps it's a bit of pride at the perceived superiority of British medicine: "We know best."

The truth is that the sensitivity of

such tests is atrocious. As another example, I can't remember the last time I felt an abdominal mass in a new patient who turned out to have cancer, yet I diagnose an abdominal cancer every couple of weeks endoscopically.

We teach our students charades. Kneeling on the floor like a supplicant to examine the abdomen, percussing the lung bases as part of breast examination, and using a piece of paper placed on outstretched hands to check for thyrotoxicosis all hark back to a bygone age.

These clinical tests and others had use in an era when diagnostic tests were unavailable or unreliable, but they are exceptionally operator dependent, and today they are redundant. It is no longer acceptable to use only clinical examination to screen for conditions, because the miss rate is just too high.

If we plan on formal testing anyway,



If we plan on formal testing anyway, what does it matter if we go through the rigmarole of examination?

what does it matter if we go through the rigmarole of examination? I remember my first clinical firm as a medical student. The consultant used to have the nurse strip each patient naked after taking the history before examining them thoroughly. He would see at most six patients in an afternoon.

Now the consultant is expected to see twice as many patients, and something has to give in the race for efficiency. The inevitable result is that the first nails are already in the coffin of clinical examination. We just need to have the courage to admit it to ourselves and, more importantly, to our students.

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