lose motivation and seek alternative work. Recognition of this by policymakers is essential so that other inequalities in the healthcare system are dealt with.

No country is likely to reward most highly those doctors caring for the poorest in society, but their material rewards must be at least equivalent to those of other doctors. The UK government recognised this tacitly in 1991 by introducing additional payments to general practitioners working in deprived areas. It never stated, however, whether it did so in recognition of the need to prevent income inequalities for doctors or to provide additional resources for patient care. The recent introduction of a "golden hello"[12] as a personal payment to doctors who opt to work in deprived areas in England for at least three years may represent an admission that the deprivation payment system has failed to address inequality in general practitioner distribution.

The most problematic issue is forcible control on the movement of doctors.[13] In the UK the Medical Practices Committee can prevent the creation of partnership vacancies in "overdoctored" areas, but doctors may move to other specialties rather than seek general practice posts in deprived areas. The problem in the developing world is vastly greater. Dr Lukwiya made his choice out of deep personal conviction. His medical school peers now working in Europe or the United States were attracted to do so by the mechanisms, outlined above, necessary to retain newly trained doctors where they are most needed. It would be a sad irony if once again the UK solved its medical staffing crisis by enticing away the brightest doctors from the developing world where they are most needed.

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The challenge of looking after people with dementia

Professional carers need higher expectations and better training and support

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Many people with dementia end up being looked after in nursing homes and long stay wards. A study in this week's *BMJ* shows that the quality of life for this very vulnerable section of our community may be unacceptable. Ballard et al found that none of 484 people with dementia living in nursing homes or hospital wards were experiencing what they refer to as a "fair standard of care" (p 426).[1] This state of affairs raises a host of issues—about regulation, expectations, and staffing.

The authors draw attention to perhaps the main one, the fact that the current systems of quality control are inadequate. In the case of independent nursing homes these are the registration and inspection teams. There is no parallel for long stay hospital wards in the NHS except the Scottish and English Health Advisory Services. In all parts of the United Kingdom the systems for registering and inspecting nursing and residential homes are going through a major overhaul, with national bodies being established to monitor and improve standards against a nationally agreed set of criteria. The aim is to make the process more consistent and transparent for patients, relatives, and staff. An opportunity was missed to include long stay hospital wards in this process.

However, the problem may not only be one of systems. It is also about expectations. Only relatively recently have we understood that people with dementia need to be more than clean, warm, and comfortable. Many staff may still believe that people with dementia are unaware of the world and unable to benefit from interaction. The inevitability of decline, which is so often emphasised in definitions of dementia, does not encourage staff to see their interactions as therapeutic. The change in expectations set in train by the early pioneers of reality orientation[2] has achieved a remarkable momentum, not least through the work of Tom Kitwood, who developed the quality assessment scale used in Ballard et al's study. Many registration and inspection officers and NHS managers were, however, trained well before the more optimistic models of dementia care were developed and many remain ignorant of them.

The problem is certainly one of staffing. Long stay NHS wards for people with dementia can be a clinical backwater. They are often in poor quality buildings and are staffed by people who have little motivation for the work. The sector has shrunk dramatically, leaving a concentration of the most difficult patients—a fact confirmed in Ballard et al's study, where all the patients were classified as having severe dementia. The challenge of caring for such patients is rarely recognised. It should imply highly trained, well supported staff with high status. The reality is that most

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staff are untrained, levels of agency staff are high, and management fails to provide the constant support and encouragement required. This results in burnt out staff who have neither the energy nor the drive to provide more than basic physical care.

This picture is paralleled in nursing homes. Many buildings are new but have failed to take advantage of the latest thinking in design, which can help both staff and patients with dementia. Dementia specific design features include high levels of visual access, highly visible and signed toilet doors, increased lighting, age appropriate fixtures and fittings, and individualised personal space.[3] Like the inspectors, staff are often unaware of recent thinking about dementia care. They too often have neither the time nor the energy to provide more than basic physical care.

Providing good quality care for people with dementia is not easy. These patients often have communication difficulties, which makes interaction difficult. They often communicate through their behaviour, which can thereby be very challenging. We do not know the level of sedation in the population in this study but it is likely to be high. The cycle of challenging behaviour, overuse of sedatives,[4] and diminished capacity to interact is commonplace. Many of these patients will also have high levels of incontinence, problems with eating, and impaired abilities in many activities of daily living. It is all too easy to blame the dementia for the extent to which patients spend their time sleeping or sitting apathetically around the walls of the communal areas. In a sense dementia lets staff at all levels, and those responsible for quality of care, off the hook.

This makes the issue of quality of care one of wider concern. People with dementia are very vulnerable. They cannot usually complain about their care, and if they try to communicate through their behaviour the response is often to see it as a symptom to be suppressed. Their relatives are often frail themselves or feeling guilty that they cannot provide care. There are often few alternatives to institutional care, especially for patients with challenging behaviour. Units that look after people with dementia need more investment—not just of money for staff and buildings, although these are important, but of time, skill, and energy. They need to be recognised as places where the highest level of skills are practised and sustained by continuous training; and where staff receive support, encouragement, and recognition and can move to easier work if they no longer have the passion required.

It would not be helpful if the response to this research was simply to pillory staff who are barely coping now, or to say it is "society's" fault for not providing resources. The responsibility lies with managers, doctors and senior nurses, commissioners of care, and those responsible for standards. Good practice does exist and can show us what can be achieved within existing resources.[5] The fact that it is not commonplace should concern us greatly.

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Hand hygiene

Use alcohol hand rubs between patients: they reduce the transmission of infection

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It is two years since the hand washing liaison group, a group of professionals interested in reducing the transmission of infection, drew attention in the *BMJ* to the importance of hand washing in reducing hospital acquired infections.[1] The issue has again received prominence in Britain with the recent publication of the "Epic" evidence based guidelines on hand hygiene, commissioned by the Department of Health.[2] The challenge now is to ensure implementation of the guidelines in daily practice. In recognition of the fact that washing with soap and water is not the only (or even the most effective) way of reducing the transmission of organisms our group has changed its name to the hand hygiene liaison group and has some practical recommendations on easy ways of improving hygiene.

Publication of the Epic guidelines on preventing hospital acquired infection follows reports[3 4] documenting the seriousness of hospital acquired infection and antimicrobial resistance in the NHS. Hospital acquired infections in the United Kingdom cost around £1bn a year[3] and affect nearly 10% of patients, causing over 5000 deaths a year (more than deaths on the road) and taking up thousands of bed days. Methicillin resistant *Staphylococcus aureus*, a surrogate marker for hospital acquired infection, is now responsible for 47% and 68%, respectively, of all cases of *S aureus* bacteraemia and surgical wound infection.[5] The National Audit Office report suggested that the incidence of hospital acquired infection could potentially be cut by 15% and that hand hygiene recommendations should be implemented as part of the NHS's national plan.[3]

Systematic review evidence, appraised and used by the Epic guideline developers, identified several well designed studies showing that patient contact resulted in contamination of health care workers' hands by pathogens.[2] For example, staff dressing wounds with methicillin resistant *S aureus* have an 80% chance of carrying the organism on their hands for up to three