Our Profession in Today's NHS

By Matthew Crockett

2018 marks the 70th anniversary of the NHS. Aneurin Bevan's three founding principles were to meet the needs of everyone, be free at the point of delivery and be based on clinical need and not the ability to pay. Modern Britain has a very different landscape with an increasing and ageing population, spiralling costs of treatment and reduced real-terms funding. But, rather than focus upon the challenges of today determining the future, I think our aspirations for the future should shape our approach today. This article will paint an exciting picture of how I hope the NHS will look in another 70 years and how we can achieve it.

Technology is constantly evolving and challenging us. Innovations such as new surgical or endoscopic tools to magic bullets and nanotechnology will revolutionise the way we treat patients. Growing new organs or mechanical replacements is achievable in our lifetimes (1) and some of the greatest strides are taking place in information technology and artificial intelligence. In the future, self-diagnosis through mobile phone applications and video consultations will become commonplace; the introduction of app-based appointment bookings will evolve within the next few years and digital assistants able to generate clinic letters from dictation are available now. These technologies reduce costs and improve efficiency allowing clinicians to focus upon improving patient care. Importantly, this change is being embraced at the top levels of government with Theresa May recently committing to placing "the UK at the forefront of the revolution in Artificial Intelligence and other technologies that can transform care" (2).

The introduction of standardised electronic systems nationwide has to be a top priority. Imagine having the ability to view all of a patient's results from any test, scan or inpatient stay performed in any part of the UK. It would hugely benefit continuity for patients and greatly improve efficiency by eliminating the duplication of work. The National Programme for IT has been lauded as the biggest IT failure ever seen in the UK, costing the taxpayer £10bn over 10 years (3). Suggested reasons behind this catastrophe include political motivations pushing the project too hard ('more haste, less speed'), the lack of confidentiality and different technology contractors for five regional clusters preventing data transfer (4). But, with a bottom-up approach involving healthcare and technology experts collaborating from the very beginning to develop a clear plan, I believe success can be achieved and should absolutely be tried again.

There has already been a push to centralise care into centres of excellence with the idea that it would improve outcomes by increasing specialisation and exposure. The Getting It Right First Time (GIRFT) report did not reflect this; for example outliers for the 30-day readmission rates after cystectomy were not those from high or low volume centres (5). Nevertheless, it is still logical that a surgeon performing the same operation a larger number of times will have better outcomes than a surgeon in a smaller volume centre. However, the centralisation of services from smaller centres has not resulted in a reciprocal movement of non-specialised services to those same smaller centres. Why should we not allow major centres to specialise in major treatments and smaller centres to specialise in minor treatments? Wouldn't we then all be specialists?

In another 70 years care will be individually tailored and patients will be involved in, or even lead, the design, monitoring and delivery of services. Patients are probably one of the most under-utilised tools in the NHS and NHS England has committed to improving patient-centred care; 'people are interested in their lives, rather than just their conditions' (6). By empowering and partnering with patients we can ensure that services are more efficiently designed, fulfil patients' true needs and reduce inequality

whilst managing expectations. This model may also be cost effective with one programme for patients with long term conditions projected to save up to £1.38bn per year (7).

We will also have moved away from the current target-based culture towards high quality audits where we can learn from each other. Current targets have undoubtedly improved patient care by focussing resources and streamlining pathways for urgent and cancer care. The maximum four-hour waiting time target was introduced in 2004 to combat crowding and on balance it is probably associated with a reduction in mortality. However, due to the crippling financial repercussions of failure to meet them they inspire fear and divert resources away from departments without targets. In spite of the four-hour target the overall adherence in the NHS has fallen from 95% in 2014 to 86% in 2018 with the new Health Secretary now considering changing or abandoning it. Four hours is arbitrary and not evidence based. Only by high quality national audit, such as GIRFT, can we determine the average performance and identify outliers. In short, the top performers should be celebrated, studied and mentor the poorest performers rather than punishing the weak.

The future will see equal access to treatment no matter where you live. The current variation in services funded by different Clinical Commissioning Groups (CCGs) has led to a 'postcode lottery', most notably for IVF treatment. It is unacceptable that some services are withheld from a portion of the population purely due to location. The National Institute for Health and Care Evidence (NICE) already provides guidance on procedures that are determined to be cost-effective which could be used to set standards that all CCGs would have to adhere to. The current system is inherently unfair and must be addressed.

Our grandchildren will have to have health insurance, but this isn't a bad thing! As mentioned previously, a founding principle of the NHS was that it is 'free from the point of delivery'. It is interesting that this was removed from the seven key principles in the NHS constitution, published by the Department of Health in 2011. But I think this is a positive move. Missed appointments may be unavoidable or due to administrative error, but often the patient is at fault. Last year, there were 7.94 million missed appointments costing nearly £1bn and 7.5 million patients were sent home from A&E with advice alone (8). Professor Jane Cummings has implored the public to cancel appointments 'in good time' and that 'sticking to appointments is a small but effective way that the public could wish the NHS a happy birthday' (8). Patients and staff today hugely underestimate the costs involved in their care (9). Sending patients a copy of the cost of their treatment will help them appreciate the service they receive and encourage them to use the NHS more responsibly. However, with healthcare costs increasing at a rate of between 3-5% per year, a European style of 'complementary insurance' and cost reimbursement may be necessary. As Christopher Smallwood argues "the principle of 'free at the point of use' is holding us back" (10).

I do not know whether healthcare in 2088 will look like this but I do believe the NHS will continue to thrive and will remain one of the best healthcare models in the world. We have an opportunity to let our ambitions shape the service rather than letting current turbulence drive unfocussed change. From its beginnings as an ambitious project in post-war Britain it has woven itself into our national identity and represents a symbol of equality and empathy. The NHS must evolve to conquer each new challenge and it's existence will be bitterly fought for both within and outside the institution. As a medical professional in today's NHS I am proud to be a part of this fantastic organisation and with visionary leadership I sincerely hope we will still be proud in another 70 years!

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