Four years before the mast

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As my 4 years as president of the Royal College of Physicians (RCP) come to an end, I should reflect on what have been momentous years for health.

I started as president in the summer of 2010, when Andrew Lansley released his unexpected plans for the National Health Service (NHS). The RCP then spent 2 years trying to modify these radical and unwise reforms, with some marked successes, including ensuring that secondary care clinicians had a voice in commissioning. I know that some fellows of the RCP believe that the 2012 Health and Social Care Act heralded widespread privatisation. I do not think so. Outsourcing and privatisation had started long before, and indeed the new act limits its application, demanding integration, education and training, and research in any outsourced service. This is not to say that there are not examples where these rules have been flouted, and we protest loudly about them.

The second wave that broke over our bows was the realisation that consultants, trainees and nurses were straining to cope with the increasing pressure on acute internal medicine, which was increasingly becoming care of the elderly. This led to more specialists substantially opting out of internal medicine to concentrate on their speciality.

The 2012 reports from the RCP – *Hospitals on the Edge?*[1] and *The Medical Registrar*[2] – graphically described the deteriorating situation for hospitals, senior and trainee doctors, and, crucially, the impact on patients – concerns that were also echoed in the second Francis report.[3] In response, the RCP set up the independent Future Hospital Commission to suggest how internal medicine in particular could be reconfigured. It is now moving into the implementation stage, namely the Future Hospital Programme, in which ideas of good practice are being sifted, and we are working with development sites to test these ideas. The findings will be disseminated widely, and I am particularly looked forward to seeing the new *Future Hospital Journal*.

At the same time came the Shape of Training report,[4] which among other ideas took up our concept of more generalism in hospital practice, heralding a move away from specialism. Specialism has achieved much, but the balance needs to be redressed if we are going to cope with the complexity of acute internal medicine and still maintain standards of care.

The narrative from commentators is that improved services in the community – social, home, primary, transitional and telecare – will reduce the acute pressures on hospitals. Sadly, the evidence is poor, perhaps surprisingly so, and even if it were suddenly to become more effective would only skim off some excess admissions and facilitate some earlier transfers back into the community; these are unlikely to produce real savings in overloaded secondary care. Nevertheless, the government, and many others who have never worked in the NHS, are so convinced by this move to community care that it was proposed to steal billions from the NHS to fund local government to achieve this unevidenced miracle; I believe that this is premature and dangerous.

Then we are told by these observers that reconfiguration will be the answer. Small hospitals and their accident and emergency departments can close and the remaining larger hospitals will be more efficient and effective. Again, the evidence is thin. For major surgery, percutaneous coronary intervention and stroke, for instance, there is good evidence that volume can improve results, sometimes strikingly. But the evidence that the many interrelated conditions of the elderly have better outcomes in larger units is selective. What larger hospitals and units do have are more doctors and nurses per patient, which strongly correlates with better mortality. Hence, a partial solution could be to redistribute some of the trainees from London and larger centres to smaller hospitals to improve their fractured rotas and provide good experience in internal medicine. This has for a long time been put into the 'too difficult tray'.

The closure of hospitals and emergency departments has proved difficult, and in the case of Bournemouth and Poole, anticompetitive, rather flying in the face of the rosy mantra of competition coming from Whitehall! Meanwhile, we are exhorted to listen to patients, and they do not to want to close emergency departments. I suspect that an elderly patient would prefer to be cared for locally, rather than being taken away from their friends and family to a larger centre for the dubious advantage of surviving a year or two more in a care home. The RCP is looking at the peculiar strengths and weaknesses of smaller hospitals.

Throughout my time at the mast there has been a robust message from Whitehall that there is no more money for the NHS, and we should be grateful that we were ring fenced. This is a dishonest message and will not be popular with the electorate who day-to-day witness the problems in the NHS. As I have said in public, the NHS is cheap and effective; it is underbedded, undernursed, underdoctored and underfunded compared to other OECD countries. We can, and should, afford more. Meanwhile, the staff suffer the cuts as frozen pay, increased workload and gaps in medical and nursing rotas.

Another disappointment for me has been the endless criticism of the NHS. I greatly admire the lifelong commitment given

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by clinicians to their patients, day in and day out. There are awful examples of bad care, and doctors should do more to stop these happening, but they should also be encouraged to raise standards. Instead we see the widespread bullying of hospitals by the centre and of staff by management. Trust and morale directly affect standards of work and care.

The royal medical colleges have influence but no direct political power. We can only promote high standards and collect and disseminate good ideas, hoping that our members and fellows will act on them, and that the Department of Health and NHS England will listen. Sadly, I feel more and more that we are not heard enough; some choose to dismiss the difficult messages it is our professional duty to deliver as being reactionary and protective. The opposite is true, for our members and fellows are innovative, know the frontline and have a better understanding of what needs to improve and what patients want, than do ministers and officials.

All this is not to say that we have not achieved. The medical royal colleges and their members and fellows are driving up standards, outcomes and safety. We should be proud of what we have done for our patients, and I am proud to have been a small part of the positive changes that the RCP has achieved in the last 4 windswept years. ■

References

1 Royal College of Physicians. *Hospitals on the edge? The time for action.* A report by the Royal College of Physicians. London: RCP, 2012. www.rcplondon.ac.uk/projects/hospitals-edge-time-action [Accessed 9 June 2014].

2 Royal College of Physicians. *The medical registrar: empowering the unsung heroes of patient care.* London: RCP, 2013. www.rcplondon.ac.uk/projects/medical-registrar-empowering-unsung-heroes-patient-care [Accessed 9 June 2014].

3 Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery Office, 2013. www.midstaffspublicinquiry.com/report [Accessed 9 June 2014].

4 Greenaway D, Shape of Training. *Securing the future of excellent patient care.* London: Shape of Training, 2013. www.shapeoftraining.co.uk/reviewsofar/1788.asp [Accessed 9 June 2014].

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