Now, where are those matches at the end of this tunnel?

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The NHS is punch-drunk, lurching from crisis to crisis and poorly protected against the threat of a final flurry of knockout blows. Resources and funding consistently fail to keep pace with an inexorable increase in clinical demand; an imbalance severely compounded by a funding structure, designed in the 1940s, that patently cannot cope with the exigencies of the second decade of a new millennium. Blurred responsibilities between health and social care have resulted in overwhelmed emergency departments, inappropriate hospital referrals and bed shortages – and the rising tide of 'black alerts' should come as no surprise to anyone. Neither should the fact that morale among NHS personnel is now at an all-time low and we are faced with increasingly worrying deficits in staff recruitment and retention. The majority of hospital trusts and virtually all clinical commissioning groups (CCGs) in England are reported to be in dire financial straits, Simon Steven's *5-Year Forward Plan* is now a *3-Year Forward Plan* (having shown little sign of progression during the first 2 years of its existence) and the threat of industrial action by junior doctors continues. In tandem with all of this, there exists a growth industry pedalling relabelled models of clinical care in an attempt to encourage the belief that, somehow, a new title will make the implementation of much needed change easier. It doesn't. Sustainability transformation planning (STP) is the most recent incarnation of this relabelling strategy but, sadly, its proud title fails to live up to either of its epithets – it isn't sustainable and it doesn't transform. In fact, this is just another financial recovery plan, labelled obscurely for the sake of appearances, but equally likely to be doomed to failure as were its predecessors. Finally, and as the unpalatable dessert to this disastrous menu, we have the mismanagement of junior doctors that has resulted, tragically, in a generation of professionals whose only experience of practising medicine has been while under the spectre of industrial action. With such a catalogue of negativity, it would be reprehensible to massage the facts to 'tell it the way we would like it to be, rather than the way it truly is'; and therein lies the challenge of this introductory editorial.

In this edition of *Future Hospital Journal* (*FHJ*), we have commissioned an eclectic mix of papers and their arrival has, fortunately, brought a much needed injection of optimism. The manuscripts, kindly contributed by a breadth of accomplished authors, provide comforting evidence that sensible people not only recognise and understand the salient challenges that face modern healthcare services, but also have a vision for realistic strategies that may help to resolve them. The adage that 'the quality of a message is more important than the position of the person offering it' is valuable here – especially if one substitutes the term 'position' with that of 'seniority' or 'rank' or even 'age' – and a particular strength of this edition is that it has been written by people who, although not exclusively 'senior' (or antique), are deeply informed about the subject matter on which they write. They posit and work towards solutions to the problems that face the NHS, as opposed to merely talking about them and this is largely because they live through the problems and situations they describe during each working day. Moreover, many of them represent the future generation and they are staring down the barrel of a long and difficult career pathway if the opinions and plans they espouse for improvement are unrealistic.

The topics covered in this edition are wide-ranging and include medical leadership,[1,2] advances in medical training,[3,4] the potential role for trainees in quality improvement[5] and the current plight of the medical registrar.[6,7] We are delighted once again to include an article from Australia[8] illustrating that, despite many challenges being shared between the hemispheres, there exist important differences in opinion and approach from north to south and we can learn so much from one another.

Despite the diversity of topics, fundamental themes can be clearly identified with a consistent overlapping of opinion between authors that is particularly refreshing. These include the pivotal importance of strengthening medical leadership, support for the reincarnation of general medical specialties and suggested changes in postgraduate medical training to support this rebirth. We are close to the concepts of integrated care here (a theme of an earlier edition of *FHJ*) and, in particular, the case for developing multidisciplinary teams (commonly, but not exclusively, led by senior doctors) trained to work across the traditional boundaries of primary, secondary and community care and demolishing outdated silos of practice as they do so. These innovations (and others like them) are where the optimism for the future of the NHS lies.

Despite these challenging times, there must be a lamp at the end of this tunnel; the wick may be tired and damp, and several matches may be needed to relight it, but there are undoubted opportunities to support the reform, revitalisation and rebirth of a highly functioning NHS. Successful redesign may well

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demand a very different paradigm, but a return to the highest quality of care is achievable, and I hope that this edition of *FHJ* provides a suitably positive core message that offers optimism for the future while accepting the realities of the present.

The times they are a'changin

Bob Dylan, Nobel Laureate for Literature 2016 ■

Conflicts of interest

The author has no conflicts of interest to declare.

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