Saying the unsaid: An honest conversation, a beginning

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I have been reflecting on issues within the NHS for a while and then Wes Streeting asked us yesterday to write to him honestly and frankly. So here goes! I am mostly just scratching the surface, but I believe it's at least the start of an honest conversation.

1. **General Practice:**

General Practice, the bedrock of the NHS, has undoubtedly changed, probably like everything else. The other day I met a family Doctor who was about my age (I am 65) and he and I talked about what ailed general practice in the UK. Our thoughts seem to echo and he gave me the courage to speak up! We are coming to a time when things need to be said and someone's got to bell the cat.

The starting point probably was a situation created by general practitioners, which a lot of younger GPs today are completely unaware of. Coming off the "night on-call" (NOC) rota around 2004, when all NHS contracts were re-

negotiated by the government, the GP NOC service was contracted out to any GP wishing to do a NOC for extra payment. They did that for understandable reasons, some related to personal convenience for older GPs, others thinking they could offer better care in the day. It led to decreased contact between GP and patient. It also led to less ownership of patients, detachment of patients from the GP, and vice versa, detachment of the GP from the patient, and it very likely decreased some degree of patient- respect patient for the GP, and perhaps less appreciation of patient needs by the GPs. These small and minor, but important changes have had reverberations. A cynical suspicion i have is that the government feels they were taken for a ride in 2004, and still hold it against the profession.

The second issue was the emergence of salaried GPs. Once salaried, the commitment to their practice is likely to decrease, compared to a GP Partner, for whom a lot, almost everything is at stake. It is possible that it also led to decrease in the commitment towards their patients. This will raise eyebrows at the least, and perhaps howls of derision, consternation or anger from all the sincere GPs, as they mostly are, in my experience, but one cannot deny this possibility.

The third issue was the decrease in working hours. A recent study from the university of Manchester has mentioned that the average GP working hours are now 26 per week. Without having planned for appropriate replacement of working hours and patient facing duties, a decrease in working hours from 30 in 2016, to 26 this year is bound to cause, effect on patient care.

My GP friend, whose son is also a GP, recently told me that his son was often on holiday, attending meetings or on a day-off. Work was perhaps intensive on the day worked, but otherwise, life was about doing many other things as one went along.

GPs should also be allowed to request specialist investigations. The worry holding this back is that probably the system might get overloaded and flooded with inappropriate requests. Well, if GP s are indeed the gateway to patient care, they should be given adequate authority to request further investigations. Audit and re-audit by closing the audit loop will certainly iron out any initial gremlins.

2. **Joint working between Primary and Secondary Care**

One of my dreams since I was appointed consultant at the turn of the millennium was the practice of Joint Primary and Secondary Care under one

roof. This has now become a welcome practice in many areas of the UK, and has evolved according to local needs, initiative and staff availability. Just as Hospital Consultants offer specialist clinics in Primary Care, GPs also offer an Out of Hours service in many A&E departments around the country. This allows an option for the GP to obtain a Specialist opinion for any of their complex patients, who may happen to present to them in A&E.

3. Medical Education, both UG and PG has not evolved enough

In our rapidly changing, world, not always for the better, our education pathways have not evolved as per population needs and demands. Other countries have evolved their UG Training by introducing shorter courses, like 3 and 4 year MBBS courses, but the UK, as usual, steeped in stodgy tradition, has behaved in a cumbersome manner, unable to be demonstrate flexibility and adequate evolution.

Postgraduate training and education also needs a deeper look. Much shorter or longer training should be made available depending on the trainee, but tradition still stops us from enabling easy change. The Alternative Training Pathway and improvement in the treatment of SAS doctors is slowly happening, but not rapidly enough.

4. Multidisciplinary working and care

There are both good and bad aspects that get flagged up in multidisciplinary team working. While, it offers peer reviewed support to our colleagues, and controls to some degree wayward behaviour from maverick doctors, it also slows down the entire patient pathway. The pathway is only as quick as the slowest cog in the wheel, and at any given time, someone or the other is bound to slip up. The use of lateral thinking, technology, Artificial Intelligence solutions and valuable staff resources to enable swifter decision making, would help, instead of everyone waiting for the person at the top to make the necessary decision. Empowerment of appropriately qualified staff at every level is necessary for this to actually happen.

A patient being seen by somebody who cannot make a decision is a pointless exercise and a waste of time, so this needs to be addressed.

In this situation, I have heard of patients being referred by the GP to Physiotherapy, instead of the being directly referred to the Hospital Consultant, which is what would be appropriate, given the Patient's history. However, such circumnavigation is not permitted and direct referrals by GPs would simply get rejected. A system need to be flexible and adaptive, so professionals can offer what is appropriate and sensible. On the other hand, anecdotally, I have heard of vaginal prolapse patients being referred via the

2 week wait pathway, because no-one has bothered to examine the patient or there is no other method to get a much-suffering patient seen by the Hospital team.

Multidisciplinary team working in all truth means involving every paramedical and allied health profession to work within a supportive framework and effective governance, within their skillset.

5. **Multiple appointments for one condition**

As a T2 Diabetic of 25 years, I can well see the changes over the years, a lack of holistic care. In the beginning, I would have two visits a year, where a single visit would involve total care with all reviews done in a single sitting. Now, I can't even make an appointment for my next B12 Injection when I go for one. Appointments for every point are splayed and spread out. This means more patient encounters to report, but each are for a single issue. We must simplify appointments, but also optimise patient encounters.

6. **International recruitment**

The treatment of international medical graduates has been a matter close to my heart. Around the time that GPs came off the NOC rota, government policy changed and the recruitment of International Medical Graduates

from out with the European Union was dissuaded. These EU graduates found that though money was initially good, career progression was erratic at best. Many South Asian and African medical graduates come to the UK for reasons for personal advancement, but also believing that the national health service needs doctors to carry out the work and address workforce issues. However, over recent years, after coming here a lot of them find that they are unemployed after having spent hundreds of thousands of pounds, trying to get through difficult exams and get a post that actually pays them appropriately. I have heard stories of many of these colleagues resorting to desperate measures to maintain a living.

Racism is a big issue that faces international medical graduates. For a multitude of reasons they do not get the career progression that they deserve and desire.

It is understandable that one may want local UK graduates to do better, but once we invite someone into our workforce, we need to treat them equally, as equal to everyone else. Otherwise a two tier system will arise causing bitterness and resentment. At presently, it undoubtedly exists. I can see a Post Office like scandal taking place in the NHS in the future, once the

system has the courage to address this issue, though I doubt it. Normal human feeling will always lead to revolt and revolution when people are treated as second and third class.

7. NHS management layers

There are far too many NHS managers as we all know, so the government can maintain a complex system of datasets. Well, let their salaries come out of the government pot, and not the NHS pot. This would definitely decrease NHS spend, and we would know how much is spent of Patient-care and how much on government penpushers who are there to do the government's bidding.

In the old days, a simple system where a consultant and a secretary managed everything from a diary. Okay, make it electronic to modernise it!! Easy and best, this would allow doctors to have a charge of their own diary and their own workload. Of course should their workload go over a certain level then it would be only appropriate that some of that work gets shifted to other colleagues

What is happening now? The medical profession has had its autonomy, pride and professionalism destroyed. Soon, it will go further and US-like mega-organisations will swoop in and destroy health care as we know it. So

called progress is not aways healthy change! Managers should purely be there to facilitate doctors, at least that that's how it used to be, in the US, but I understand recently that things have changed there. The emergence of multi-nationals, huge businesses and corporations which run healthcare supported or run by Big Pharma is another nail in the coffin of the health service. As long as money rules the world, health services will suffer and it'll get fragmented, just like British rail ran efficiently in the past before John Major privatised it into 100 small corporations, and now is a complete mess.

8. **Working conditions:**

There is no doubt that our doctors must be paid well, which would make the profession competitive and desirable, and at present, it is obvious that Resident Doctors are not. As a profession, doctors also have changed perhaps in that maybe there is a higher proportion of doctors who now work shorter hours and look after themselves and their families in this high - pressured world of today. Hospital doctors during my time worked without giving much thought to hours and pay conditions. All we did was simply work, enjoying our work and we had few stressors. Now things are different with a lot more stress on younger doctors, though like most young people in our society. Training often is more sparse than it used to be due to the

number of decrease in working hours, more sub or super specialisation, which also affect the experience and the confidence. It was suggested over two decades ago, that there should be junior and senior consultants in the health service, but that was stamped out. In actual practice that does happen that our senior consultants who take newcomers under their wing and support them during difficult times which is a great thing.

9. Hospital issues and professional disrespect:

The use of senior consultants with the health service has been unpredictable. By the time one gets to a certain age, one expects some professional respect to come their way. Often this does not happen in the NHS. Burn out, stress, poor working conditions and difficult Medical and Managerial colleagues can also cause senior doctors to leave and take their experience with them. As a retired doctor I can tell you that it can be good fun to work with like-minded colleagues but this does not always work out as one would want.

10. Financial strangulation

Money, or lack of it is an issue with the NHS , often called a Bottomless pit. The last decade has been hugely destructive from every possible aspect, but

Finance is key. On the other hand, we have new expensive treatments which seem to be taking over the health service, some beneficial, some experimental. That needs review and perhaps we should have a standard package of care available on the NHS. Unusual non-standard treatments should not be offered unless proven.

11. Physician Associates launch

The absolute debacle afflicting the profession has been the unregulated, often unsupervised and wild introduction of physician associates to see undifferentiated and subspeciality patients. This has been done by work in tandem by some of the Royal Colleges, the GMC, the Government and NHSWTE. That is a blow to the unsuspecting public clearly below belt. It is not acceptable that, the government introduces a system where patients die due to negligence and poor care by unqualified practitioners who are not allowed and should not be treating patients, unless they are closely supervised. Some of these colleagues, both PAs and doctors, may have been put into an awkward position without realising what they were getting into, when they signed up for the job. It would be interesting to know who would be culpable in cases of patient harm, with cases already in the public domain.

At present, the profession is at war with the authorities on this and one cannot stress how important that is? We shout from the rooftops about this second rate practice of our profession. It may be possible that this is due to a shortage of doctors but I am aware that there are plenty of doctors, mostly International Medical Graduates, post PLAB examination, with no jobs, who can carry out the work safely.

12. Increasing Complexity of medicine:

Medicine is becoming increasingly complex with rapid advances in every field. Patient demand is ever increasing, and Social Media has made sure that publicity to never-events is rapid and often destructive to the involved professionals, who we must remember, are only human.

13. Public contribution

Another issue is that we have become a nation where seem unable to take action against people who are troublemakers. Shoplifters, not all of them drug users to fund their habit, simply walking away with no one having any powers to do anything is about the same way in the NHS! People do take the NHS for the ride and there's nothing we can do about it . We need to address

these issues and we need to find leadership who are allowed to make bold decisions of all sorts that must be supported.

14. Poor planning and lack of vision:

The reluctance, and often refusal to increase Medical School places over the last 25 years in accordance with population needs, clampdown on allowing immigrant doctors to come to the UK, cutting Resident doctor hours without planning appropriate addressing of workforce issues has led to the health service becoming a dangerous system. Maternity issues are a disaster around the country, with maternity care being worse for Black and Ethnic minority patients. Increased maternal mortality for some groups, and birth trauma for both mother and child are problems that need bold and corrective action.

15. Lack of political clarity:

Over the last 15 years, there has been lack of political clarity on the direction the NHS is moving. All kinds of resources have been inadequate, starting for Staff, Estates and investment. It would help immensely if the NHS was no longer a political football, but that may not be a consideration, yet. Stories about 40 new hospitals, crumbling estates, perhaps the longest ever waiting

lists in recent history, increased litigation, unsafe maternity care, cardiac and cancer patient deaths while on waiting lists are all hugely depressing with no comeback for the leaders who have been directly and indirectly responsible for this. Not just political leaders, mind you, professional leaders and the Colleges too.

16. Unprecedented Barrage of Social Media:

Social Media has been very useful in bringing matters to the attention of those in senior positions. Not everyone takes notice, but we hope they do, and more importantly, act on the concerns of the population. Anonymous accounts which take potshots at anyone in a position of authority are unwelcome.

17. Use of Artificial Intelligence and the NHS App

Joint working between various AI organisations in a principled manner would be of immense help in speeding up of diagnostic patient pathways. The singular use of the NHS App as the go-to app for all patient medical information should be the solution for our Medical Records system. Whilst I appreciate that there are interface issues between various layers, the UK

has some of the best brains who can make that a possibility. It will also help patients take some responsibility for their own health. The recent guidance about the issuing of health smartwatches to a group of patients is an interesting start.

So what is ideal:

Sometimes I think we are not really the rich nation that we think we are, because I see wealth sequestrated in very few hands. Covid certainly threw us back. Are we expecting too much from our State, without adequate finance, staff and infrastructure. Without going into detail here, the solution I suggest is much broader as this is really a broad societal problem, but the solution can be simple if each of us did more of our little bit. I am aware that many of us already do that, and perhaps even more, but if each of us loved this country, and the NHS as much as we say we do, and learnt to appreciate it without abusing it, it would make a difference. Our politicians need to be brutally honest about where we are, without playing the blame game, and make some difficult decisions, that we must support, without sitting in our corner defiantly. Then we stand a chance. Let's do it!

Broad issues that require sorting are:

Finance

Staffing

Infrastructure

Morale

Public expectation

Appraisal of situation

Political honesty

And perhaps, delinking from politics