DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Breaking Point:

Dermatology in Covid times

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Lessons from history

Many of us have tried to make use of extra time at home in the last year by learning a language – possibly for the first time or more often after many years of neglect. In the French class which I joined we discussed the wreck of the *Méduse*, a maritime tragedy of 1816 which shocked France and is commemorated by Géricault's enormous and gruesome painting in the Louvre (shown above). The story seemed to cover several strangely familiar themes.

The naval vessel *Méduse* was undertaking what was considered a very important mission for France, to take a new governor, officials and settlers to resume control of the vital trading post of Senegal, recently restored to France after the end of the Napoleonic wars and the restoration of the monarchy.

France had plenty of skilled and experienced mariners but none of these was chosen. Instead, it was decided to install royalists in all senior positions. A political supporter, Viscount Hugues de Chaumereys, was therefore appointed as captain even though he had never commanded a ship and had not sailed at all for at least 20 years. As well as being unsure about navigation, which he subsequently seconded to a handy philosopher passenger with no relevant qualification, he was anxious to arrive as quickly as possible and had been given the fastest ship.

Professional crew members and the experienced captain of an accompanying vessel advised him to stay well away from the African coast to avoid a huge sandbank. The accompanying ship subsequently had to sail away for its own safety, but unfortunately de Chaumereys ignored all the advice and also refused to take depth soundings. The *Méduse* was wrecked on the sandbank, 100 miles off-course and 50 miles from the coast of Mauritania.

De Chaumereys and the governor, with other senior officers, took to the ship's only boats, leaving 151 crew members and less important passengers on a rapidly constructed and unseaworthy raft with no provisions, means of propulsion or navigation equipment. At first this was towed by one of the boats, but after fears of swamping the boat the rope was cut and the raft just left to its fate. Two of the 15 survivors rescued a fortnight later wrote a detailed and graphic account of the despair, violence, murder and eventually cannibalism which had occurred. In spite of frantic attempts by the authorities to suppress it, the report was leaked and became a massive scandal now known to all

French schoolchildren.

Of course, there was an enquiry, carried out by a Monarchist naval officer, after which naval promotions were supposed to be based on ability and merit. De Chaumereys was court-martialled and found guilty of incompetent navigation and of abandoning the ship and its passengers. His 3-year jail sentence, rather than the more usual capital punishment applied for such misdemeanours, was generally felt to be a whitewash.

Surely, in a modern country like the UK, vital tasks would not be put in the charge of political appointees without relevant expertise, the advice and help of skilled experts would not be ignored or groups of vulnerable people knowingly left in danger? The Government would take expert advice in a crisis and there would be an early, independent and comprehensive enquiry to learn lessons for the future?

Sadly, we know the answer.

The Independent SAGE group of experts formed in May 2020 and has now met weekly for a year. Every week they have stressed the need for rapid and effective testing and contact tracing combined with isolation and support, because without this such outbreaks of infection cannot be contained. This, however, has never been adequately done (for instance contacts have not generally been tested unless symptomatic) in spite of the fact that these are the absolutely standard public health procedures which the World Health organisation, and SAGE proper, had strongly advised back in January 2020. This advice, as well as their advice about careful quarantine measures with financial support when needed, was ignored by those responsible for our safekeeping.

According to a video by Led by Donkeys, the UK in May 2020 was one of only three countries in the world to have no border controls, testing or quarantine, and this has still not been taken seriously. Ministers knew on April 1st this year of the concern over the Delta variant but did not tell the public until 15 days later, with travel restriction from India only imposed 8 days after that, when many thousands of people, many infected, had already come in to all parts of the UK. The Independent Sage group, in the meantime, has been subject to disparagement by the right-wing press, with allegations of 'sinister left-wing groups' at play [1].

There can be no rational explanation, other than cronyism and ideology, for the appointment of Serco and Sitel to run national testing and contact tracing, led by the entirely unqualified Dido Harding. The well-established (though seriously underfunded) local public health teams were deliberately sidelined and initially starved of information although many have now been able to take over their local contact tracing from the national 'service' which has never been sufficiently effective in spite of its immense cost. In fact a recent report from the House of Commons Public Accounts Committee concluded that it had made little difference to the spread of infection. The Directors of Public Health of Leicester and Newham, speaking at the Independent Sage meeting of April 30th, showed clearly why locally based contact tracing, combined with practical support for those needing to isolate, absolutely standard, everyday public health measures, was proving so much more successful. Professor Ivan Brown (Leicester) was asked, however, whether any of the £37 billion allocated for testing and tracing was coming to the local teams. It was not, and there must be serious questions about where all this money has gone.

Will there be an early public inquiry to ensure lessons are learnt during this pandemic? Unfortunately it appears that the official enquiry will start only in the spring of 2022 so is unlikely to report before the next election. Meanwhile the pandemic is certainly far from over, with more Covid-19 infections worldwide than ever before and the rapid spread of the Delta variant in the third wave in the UK, with an accompanying widespread unlocking of almost all social restrictions, and with Mike Ryan (Head of the WHO Emergencies Programme) accusing the UK

of' moral emptiness and epidemiological stupidity'.

There will inevitably also be new pandemics in future. An earlier enquiry has been requested many times, most recently by the Bereaved Families group in April 2021 who were told that the Government was far too busy to consider this. Business Secretary Kwasi Kwarteng, when asked the same question a month earlier, said that ministers were concentrating on reopening the economy. International evidence, however, shows that countries which (unlike the UK) have adopted a Covid elimination strategy, as well as having many fewer deaths, have had far less economic damage [2]. In the absence of an official investigation, the People's Covid Enquiry [3], organised by Keep Our NHS public and chaired by Michael Mansfield QC, has finished taking wide-ranging and often shocking evidence which is all publicly available.

As well as the enormous sums spent on Test and Trace, many more millions of pounds of public money has gone to political supporters and donors for supplies of PPE, often to companies with no relevant experience of producing it (a sweet manufacturer, a pest control business and a pub landlord spring to mind). It appears that there is a 'VIP lane' (qualification, party donation or ministerial connections) and its occupants were 10 times more likely to be awarded a contract than others. The crowdfunded Good Law Project, to which DFNHS has contributed, is seeking judicial review and proper disclosure of contracts awarded. It has found that excessive amounts were paid for PPE, some of which was unfit for use; according to the National Audit Office in November 2020 at least £10 billion had been wasted.

Meanwhile, at present, the immunisation programme (real NHS expertise, not masquerading private sector) is progressing well although nearly half of the population is not fully immunised. Covid levels are increasing rapidly because of the Delta variant. The government is milking this in the hope that we will forget what has gone before, the result of which is that the UK has the highest death rates of any OECD country and one of the highest worldwide, combined with the worst economic damage in Europe.

Throughout this pandemic the Government has ignored a great deal of expert advice, both from the UK and (with a sense of exceptionalism) internationally. It has spent astronomical sums of money doing little other than feathering its own nest and those of friends and seems to have regarded sections of the population as unimportant: Boris Johnson has been described (by Dominic Cummings [4]) as resisting lockdown in Autumn 2020 'because only over-80s were dying'. Meanwhile, under cover of Covid-19 it is continuing to embed the private sector throughout the English NHS while sneaking through measures which will limit our ability to scrutinise, oppose and protest about its activities.

As they found in France over 200 years ago, appointing unqualified cronies and ignoring the advice of experts, as well as being morally wrong, does not turn out well.

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View From The Chair: July 2021

Thoughts on what the NHS Bill will mean, workforce planning (see next articles also), and some hope on progress against discrimination

As the NHS turns 73, what birthday present is it getting from this Government? An above-inflation pay rise for its staff? A funded plan to restore safe staffing levels? The capital investment required to properly equip and maintain the instruments essential for diagnosis and treatment of patients?

No – by the time you are reading this, the Health and Care Bill will have been presented to Parliament, with its second reading just before Parliament breaks up for the summer.

The timing is particularly curious. A brand new Secretary of State, who apparently asked for this to be delayed until he had time to give proper scrutiny to the detail of a major Bill that he would be responsible for shepherding through Parliament, but whose request was denied by No. 10.

The Chief Executive of NHS England, to whom, it would seem, the drafting of the Bill has been outsourced, due to step down imminently, with the potential loss of his vast organisational knowledge accumulated over decades at the heart of the NHS, irrespective of one's view of the direction in which he has steered the service.

Surely we should expect that our law-makers understand fully the implications of the legislation that they are voting on?a Have the lessons of the 2012 Act been forgotten so soon? [1]. If our MPs find the Bill to be "unintelligible gobbledygook" once again, they should have a duty to refuse to vote on it until they have a translation they can understand. We each have a responsibility to help them in this endeavour, by helping them to understand the workings of the NHS and raising our concerns at all levels of the political and professional structure. In this spirit, DFNHS submitted evidence to the Health and Social Care Select Committee's inquiry into the White Paper [2].

We intend to provide a briefing paper once we have considered the text of the Bill, which will hopefully be of use to members wishing to lobby their representatives over the summer. There is likely to be a vigorous debate as to whether it would be best to mount a principled stand against the Bill in its entirety, because of the risks of placing private companies at the heart of decision-making in the NHS. Many others believe that the balance of power in the current parliament is such that outright opposition to the Bill is bound to be unsuccessful, but there might be scope to build support for amendments that could address some of the most serious concerns surrounding policies set out in the White Paper. It is likely that Keep Our NHS Public will also be mounting a strong campaign and interested members can find plenty of information publicly available on the KONP website, including access to The Lowdown, which your Chair recommends highly [3].

What seems certain is that the Bill, despite its title, will not even attempt to address the major problems affecting the NHS or Social Care. Remember, before the pandemic struck there were more than 4.5 million people waiting to have treatment and the proportion waiting more than 18 weeks was the highest since 2008. Nearly 3000 people were stuck on trolleys in A&E more than 12 hours after the decision to admit them. and

the 62-day target to start cancer treatment had not been met for 4 years [4]. There was a huge backlog before Covid came on the scene.

As the King's Fund recently acknowledged [5], the most pressing problem is the lack of an effective workforce strategy, to make sure that the NHS can employ adequate numbers of suitably qualified clinical staff to provide safe care around the clock. This affects almost every discipline and every specialty [6]. The additional undergraduate places at new and existing medical schools, allowing an increase from 6,000 a year in 2016, to 7,500 in 2018 and 10,000 this year, is of very limited value unless it is matched with the money and other resources for substantial increases in postgraduate training posts across NHS workplaces [7]. Particularly since 2012, NHS providers have increasingly sought to recruit fully-trained clinicians, rather than playing a full part in developing the staff required for the NHS as a whole. There needs to be a restoration of that wider responsibility and the money to allow it to happen. The White Paper's suggestion that the Secretary of State being required to make a statement on the state of the NHS workforce once during every Parliament is an inadequate response. We need a fully-funded workforce strategy across both the NHS and Social Care.

The toll that is taken on the resilience of clinicians, attempting to provide high quality care, in the face of severe and long-term staff shortages, by spreading themselves ever more thinly, is constant and draining to the clinician and unsafe for our patients. The frustration of having to use out-dated equipment that is unreliable and poorly maintained, because of inadequate capital budgets and the delay to diagnosis or treatment caused by shortages of MRI / CT scanners and the people to use them, can make simple tasks an extra challenge. Knowing what good care looks like, but lacking the ability to deliver it, causes many good clinicians to give up the struggle: a wastage that we cannot afford. It has also been a factor in many of the inquiries into service failures around the country. This discontent can be a major factor in driving increasing calls for pay increases, but greater pay alone will not bring job satisfaction [8, 9].

Although it is titled the Health and Care Bill, it contains no mention of the plan to "fix the crisis in social care once and for all." [10] Local authorities are working with a funding settlement that runs out at the end of this financial year, which allows for no medium term planning, let alone "once and for all." Once again, it is not simply a matter of funding, although the rank unfairness of the different eligibility criteria for health care and social care is outrageous: it is also the scandal of social care staff being paid below the Living Wage, the continuation of zero-hour contracts, lack of pay when travelling between clients, fixed duration of visits that bear little relationship to the time that proper care might require, access to training and lack of a proper career structure [11].

> "Will the Bill tackle the factors that have casued this under-provision of care? Or will it instead give more scope for middlemen to syphon off even more of the NHS budget? "

Will the Bill tackle the factors that have caused this under-provision of care? Or will it instead give more scope for middlemen to syphon off even more of the NHS budget before it gets anywhere near the clinic, the operating theatre or the ward? Our parliamentarians need to scrutinise this Bill carefully and amend it to make sure that public funds reach the sharp end of the service, otherwise it will end up like 'NHS' dentistry, with funding that only meets 20% of demand; with insurance and finance schemes to bridge the gap for those that can afford it, and most people going without care

until their disease is unbearable, rather than when it can be most effectively treated.

A glimmer of hope?

Most of us will have felt exposed and vulnerable when working at the edge of our capabilities, delivering care in understaffed and overstretched departments. We may also have recognised deterrents to speaking out about poor practice of more powerful colleagues or the institutions within which we work. These also have an important impact on the morale of the workforce.

Concerns about the application of disciplinary and regulatory processes within the NHS were explored in the April-May Newsletter. Very often, these cast a long shadow over too many years of doctors' working lives, while offering little to improve the safety of our patients and dissuading doctors and other clinicians from speaking out when they become aware of unsafe practice in their departments or trusts. Too often they do not appear to be applied even-handedly and there have been concerns that cases are brought much more frequently against black and other ethnic minority doctors.

"Most of us wil have felt exposed and vulnerable when working at the edge of our capabilities. We may also have recognised deterrents to speaking out about poor practice"

This past month saw the first instance in which an employment tribunal found that the GMC discriminated against a doctor because of their race, in the case of Omer Karim, a consultant urologist, who had raised concerns about poor practice at his trust, back in 2014. The fact that this case has been ongoing since 2014, and that the GMC has decided to appeal, is in itself an indictment of the disciplinary process [12].

There was also the news that Hadiza Bawa-Garba is now able to practice without restriction, more than 10 years after the death of Jack Adcock from unrecognised septicaemia, which had resulted in her conviction of gross negligence manslaughter [13]. In this case also, the ability of the GMC to appeal the judgment of an employment tribunal has been criticised. A government inquiry proposed legislation to remove the GMC's right to appeal, but this has not yet been tabled.

And in another long-running case, that of Dr Chris Day, centred on the lack of protection afforded to whistleblowers, there is great news that the BMA has made major changes, following an extensive review of the support that it offers to members in such circumstances. The BMA will now be supporting Dr Day in the ongoing case [14].

Seize the moment

And finally, congratulations to KONP for organising The People's COVID Inquiry, which has just released its preliminary report [15]. The Government should have set up an independent public inquiry now, while the experiences that people have endured are still clear in their memories, and so that we can benefit from any lessons that are to be learned, so that we are better prepared for the next such health emergency. Instead, that responsibility has been taken by KONP, appointing Michael Mansfield QC as Chair. The evidence sessions are freely available on the inquiry's website, through the above link, and include vivid and detailed first-hand accounts from people directly affected by the pandemic and some of the people who have contributed much to the response, but who may not have been seen on our tellies. We cannot afford to lose their insights while they are still fresh.

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Covid and Beyond: Dermatology in Covid Times

'You'll be forgiven for thinking that as COVID-19 swept the nation in the Spring of 2020 we in dermatology were either sheltering from the eye of the storm at home, or like many of our colleagues nationwide heading for the wards. Neither were in fact applicable to us at the Countess of Chester Hospital.

'As our excellent general medical colleagues managed the increasing demands in the inpatient setting, we mainly focussed on our cancer, continuing to operate on and see fast track and urgent patients in relatively empty waiting rooms. We also had to risk stratify our immunosuppressed patients to allow shielding of the correct patients to take place. Our long-term patients were managed virtually mainly with the old-fashioned telephone and photos approach. All courses were put on hold and all meetings convened virtually.

'When summer came we realised that the needs of our routine new patients were suffering, alongside those with less aggressive cancers that still needed treatment. A trust decision was made to use the facilities of our local private hospital as a "clean" site. The staff were very welcoming and the facilities good, but with any changes of this magnitude there were always going to be logistical challenges, mainly IT. We still continue to see cancer patients and ward referrals at the Countess, but the more routine work was done at the Nuffield hospital so we straddled two sites.

'As a highly collaborative specialty the absence of the regional meeting was a real hardship. Prior to this we would put our heads together weekly to discuss challenging diagnoses and find solutions for those who had not previously responded to traditional therapies. However, after a year without this amazing resource I am pleased to say it has now resumed on a virtual basis.

'Repatriated fully to the Countess of Chester in the autumn we were getting back on track with our urgent, routine, fast track, minor operative and patch test service. However, at this time we did not know that round the corner an even bigger challenge was to come.

'On January 4th I attended outpatients to operate to find the whole department in shock as we listened to an announcement that all outpatient clinics had been cancelled and staff were to be repatriated to the ward. Our medical director kindly rang me to explain that I was heading to a Covid ward. At this time there were over 60% of beds were occupied by COVID patients. During my month on this ward I was surrounded by inspirational staff, who after a year of battling COVID, still had energy, dedication and enthusiasm for their patients. It was very humbling to work alongside colleagues who showed us much respect and gratitude. Although I had dusted off my stethoscope and could once again recognise changes on a chest x-ray I think we were most useful in family discussions, a skill which is honed through all specialties.

'Finally as we emerge from this crisis we are now able to offer patients more treatment options: UVB (paused during pandemic) and immunosuppression for those reticent to start when the COVID rates were high. We have more capacity to see patients face to face, but some new virtual methods of working such as meetings and remote consultations for the stable patients will remain as highly beneficial.

However, for dermatologists trained in using eyes above all senses, followed by touch, a face to face consultation will always be the gold [*and only, Mr Hancock. Ed.*] standard.'

Rhiannon Llewellyn
Consultant Dermatologist,
Countess of Chester Hospital

Rhiannon describes life of the last 16 months, just a little back from the coal-face of acute medicine and of A and E, but nevertheless faced with the problems created by the pandemic and its effects on her previously largely out-patient based practice.

Perhaps she and colleagues can hope to return to the even tenor of their ways as the next few months go by. There will be changes: some will be good and beneficial. There will be recovery problems specific to all specialties, some worsened by Covid, some un-masked by it and some created by it. Some were previously created and the tensions added by the pandemic have brought them to the fore and will be further worsened by the recovery.

Many were simply waiting to happen.

Covid admissions and deaths are down (for the moment) and the NHS can at least start to think about what happens now and how to address the enormous backlog of care.

According to the recent BMA analysis, most non-Covid services shut down during the first wave and there was also a change in patient behaviour. Many people were too scared to seek care or felt that they should not be bothering the doctor in the difficult circumstances. A&E attendances, for instance, were 42% less in May 2020 than they had been in 2019 and urgent referrals for myocardial infarction reduced by 50%.

Between April 2020 and March 2021, 3.37 million fewer elective procedures were performed, and there were 21.4 million fewer out-patient attendances – although this report does not state how many of those were replaced by a virtual consultation. By March 2021, 436,127 patients had been waiting over a year for treatment, a figure 378 times higher than in March 2019 and one that has risen steadily during the pandemic. In June 2021 the waiting list nationally rose to over 5 million.

Of course, all was not well even before the pandemic, after 10 years of austerity with seriously inadequate funding, wasteful marketization, inadequate bed numbers, a massive maintenance backlog – and most importantly, a staffing emergency which has worsened as a result of Covid.

The Royal College of Nursing mentions 50,000 registered nurse vacancies even before the pandemic, a situation which had been made much worse by the very unfortunate cuts in nurse training numbers in 2011. The national average was a 12.7% reduction in student places but in London this was 16%. Jeremy Hunt, chairing the Commons Health and Social Care committee, now rightly (in a recently released report) laments the lack of workforce planning but has perhaps forgotten that the nursing student bursary was removed in 2017 during his time as Secretary of State for Health, which was associated with a 31% drop in applications, particularly from mature students. Although a smaller bursary has now been reinstated and numbers increased, tuition fees, currently £ 9250/year, must be paid so the graduates still end up with considerable student debt. For many years about 5% of NHS staff have come from the EU, but after the Brexit referendum there has been a steep fall of in EU nurses working here, with an 87% drop in registrations while many already here have left.

According to a report from the RCN mentioned by the Public Accounts Committee in May 2020, one-third of NHS nurses were considering leaving the NHS in the next year, because of long shifts, understaffing, low pay and exhaustion. Every departure puts more strain on the remaining staff and makes this worse.

For doctors the situation is equally worrying. As a bulletin from the Royal College of Surgeons [1] pointed out a year ago, the UK has only 2.8 doctors for every thousand inhabitants, while the EU average is 3.4 per thousand. In Europe, only Ireland, Slovenia, Romania and Poland have fewer than the UK. As with nursing students, cuts in medical student numbers were announced by the Coalition government in 2010, with a 2% reduction from 2013 onwards, even though the population, and numbers of patients, were continuing to increase.

Numbers entering medical school went down from 6200 a year in 2012-13 to 5880 a year in 2015-16. Jeremy Hunt, speaking in 2017, pointed out that 37% of current NHS doctors qualified overseas and calculated that the UK would need to train 8000 new doctors every year to become self-sufficient. There are clearly serious ethical concerns with recruiting from abroad, but with a global shortage of 2 million doctors that would not in any case be easy. Recent changes to the immigration system have added to this problem as salaries in many junior posts are insufficient to qualify for a visa. According to the RCS document, 9.7% of the entire NHS medical workforce comes from the EU; after the Brexit referendum 45% of these are considering leaving the UK.

Although several new medical schools have started or are planned, they are estimated to provide 1500 more places a year, which is barely sufficient and the BMA has also raised concerns that there will not be enough foundation posts for these new graduates.

But do they continue to work in the NHS? Retention of medical staff is increasingly a problem. Before the pandemic, in 2018, only 37.7% of F2 doctors went straight on to specialty training, a decrease from 42.6% the previous year while 14% planned a career break. There seems to be a peak of burnout at the end of the F2 year.

A more recent BMA survey in May 2021 [2], showed that of 4258 respondents from all specialties, 31.9% wished to retire early, 25% hoped to take a career break, 21% want to leave the NHS and 17% are considering emigration. There has been a significant change over many years; a cohort study by the BMA shows that while 90% of doctors qualifying between 1974 and 1983 are happy to work in the UK, this falls to 64% by 2012.

Early retirement has greatly increased; according to the RCS bulletin 60% of hospital consultants want to retire at or before 60, while early retirements among GPs have more than tripled in 10 years.

What is causing this unhappiness? A BMJ blog in February 2020 cites loss of respect, not feeling valued and loss of a real team. Service provision takes precedence over training opportunities and family life is damaged by long hours and chaotic scheduling of rotas. Workload is the biggest issue in the BMA survey in May this year and pay, now significantly lower (corrected for inflation) than before the 2010 pay freeze is mentioned by 29%.

Understaffing is a real emergency with obvious implications for workload throughout the workforce. The BMA in June 2020 was aware of at least 8278 FTE empty consultant posts, though the real number will be a great deal higher as many posts are not advertised unless a suitable candidate is available. Of those which were advertised, there were no suitable applicants for nearly half according to the RCP. In some specialties (such as dermatology) even though there is great competition for training posts, the government has consistently refused to fund any more.

Likewise for GP posts, in 2018, 15.3%, over 6000, remained unfilled. Although there have been efforts

to increase numbers since then, this has not kept pace with demand; numbers of GP appointments increased by 15% between March 2020 and March 2021.

Workforce shortages are a global problem, and in the US Bernie Sanders made ambitious proposals last month to address a national need for of up to 139,000 doctors by 2033, with a particular focus on incentives to train in primary care and to work in rural and underserved areas. Here in the UK, all the Royal Colleges have been concerned about the workforce issue and future plans in general. The Royal College of Physicians is asking for a doubling of medical school and training places while the Royal College of Surgeons has stressed the need for better funding and for numbers of doctors and hospital bed numbers to increase at least to the OECD average. The UK currently has 2.7 beds/1000, significantly lower than the EU average of 4.5 and lower even than the minimum of 3/1000 advised by WHO, but this number has gone down by another 5% during Covid because of infection control.

The RCS has also suggested elective surgical hubs in each ICS area which could continue to work with non-infected patients. While these could of course be entirely NHS facilities like the South West London Elective Orthopaedic Centre, there is little doubt, under this Government, that the private sector would be very much involved – maybe a reincarnation of Independent Sector Treatment Centres which in Merseyside were paid 25% over tariff on a block contract whether or not the procedures were actually performed, and careful cherry-picking also meant that any complex patients were excluded.

There is no doubt that the pandemic has provided opportunities for this government to do just what they always intended, under cover of Covid [3]. Ever more use of the private sector is planned, with £10 billion of the NHS budget earmarked for private providers to help with waiting lists. The shameful state of the NHS dental service [4] may be an indication of what is ultimately intended, with a steady erosion of what is provided and additional costs which are unaffordable for many, so that private care is the only option for anyone who can afford it.

A real plan for the future of the NHS and also social care is desperately needed, as outlined in the 2020 Rescue Plan from KONP Northeast [5], but there are enormous threats, in particular the imposition of Integrated Care Systems with the private sector already installed on some boards [6].

Meanwhile, some changes which started during Covid may be helpful, such as the use of phone or video consultations for monitoring of some known patients with chronic conditions although Hancock's suggestion that a majority of consultations can be by video and by algorithm (and by Health Care Assistant?) is clearly outrageous. There are huge challenges to come, not the least of which will be dealing with this sort of suggestion.

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NHS Staff Shortages and Workforce Planning

A former NHS workforce planner offers insights into the history and legacies of planning for the NHS workforce, with their attendant weaknesses and failures in policy over many years

Why are there shortages of nurses and doctors in the NHS? How far back do they go? Vacancies reach back as far as the post -war period.

Rather than improving pay and conditions for women, women were recruited from overseas mainly from the Caribbean but also from Ireland, Malaysia and Mauritius. Most of the Caribbean nurses were put on the 2-year state enrolled nurse programme and not on 3-year registered general nurse course as they had wished.

Doctors are very expensive to train. The UK has saved money by recruiting them from overseas with other countries paying for their education and training. These countries were invariably poorer than the UK so the economic consequences of losing such expensively developed staff was very detrimental. It is laudable that the UK has given aid to many of these countries, however, taking their expensively educated and trained doctors is not. While UK aid receives much press coverage, the negative impact of this recruitment does not.

Nurse vacancies and cost cutting

Saving money regardless of consequences is a recurrent theme. Nurses' accommodation was often located in prime city centre locations. Some needed money spent on maintenance due to neglect. Many homes were sold off, making it harder to recruit nurses who could ill afford the rising cost of the private rental market or buying accommodation and had much longer journeys into work as a result. This made it harder to recruit nurses in expensive locations, such as central London.

When financial cuts are the order of the day, education and training are easy targets. This is because money can be saved without any immediate negative consequences. Thus, if you cut nursing education places the effects will not be felt until 4 years later (it is a 3-year course and commissions are made a year in advance). Cuts of between 10-30 per cent were made between 2006 to 2007 purely to save money [1]. This is a false economy as more expensive agency staff are needed in future years.

The Conservative government's austerity programme adversely affected public sector pay. Nurses' pay compared to the cost of living fell by 9.2 per cent between 2010 and 2017. It has since recovered but it is still 1.8 per cent below 2010 levels by 2020 [2].

Nursing bursaries paid for the education and living costs of student nurses. Nursing was a hugely popular course in 2015, receiving applications from 57,000 people while the number of nurse training places remained at just over 20,000 [3]. The government declined to invest in more places through extra expenditure and sought to achieve this by abolishing bursaries and recycle the savings. This meant that nurse students needed to take out loans to pay for their education and living costs. Applications to courses fell by more than half. Nursing shortages increased. In recognition of this error, the government reintroduced a smaller

bursary in 2019, which varied between £5,000 to £8,000. The higher sum could be attained if nurses were eligible for a childcare allowance and for those who chose less popular specialties such as mental health or lived in parts of the country where shortages were particularly high [4].

NHS England had a 9.2 per cent vacancy rate, which equates to 34,678 nurses short in March 2021 [5]. This shows a gentle downward trend of three successive quarters. London, as has been historically the case, had the highest vacancy rate of 11.6 per cent. Mental health had the highest vacancy rates with London and the Southeast particularly adversely affected at 16.7 per cent. On current trends, in 10 years' time the NHS will have a shortfall of 108,000 full-time equivalent nurses. If half of this gap could be filled by increasing the number of nurses joining the NHS from training, it would require 5,000 more nurses to start training each year by 2021 [6].

"Current estimates suggest that almost one-third of doctors practising in the NHS are from overseas and that most of them are from the Indian subcontinent"

Doctor recruitment

There is also a long history of recruiting overseas doctors. One historian has estimated that by 1945 there were at least than 1000 Asian doctors throughout Britain, 200 of them in London alone and most of them GPs [7]. According to research by the Willink Committee in 1957, 12 percent of doctors were trained overseas. Their numbers grew and 'the Health Service would have collapsed if it had not been for the enormous influx from junior doctors from such countries as India and Pakistan' [8].

Current estimates suggest that almost one-third of doctors practising in the NHS are from overseas and that most of them are from the Indian subcontinent [9].

Overseas recruits are seen as a means of filling posts in unpopular specialties. For instance, overseas doctors have been over-represented in the care of older people, psychiatry, and general practice. When it comes to general practice, overseas GPs have been over-represented in the more deprived parts of the country which have greater healthcare needs and where shortages are greatest.

There is a very uneven distribution of GPs in England ranging from 1,768 patients per GP in the Vale of York to 2,989 in Luton [10]. The rate of increase in the number of GPs has been dramatically outstripped by increases in the medical workforce in secondary care – a trend at odds with the ambition to deliver more care in the community [11].

Workforce planning

There have been many changes to workforce planning for nurses and the many other non-medical professions. Education and training consortia of NHS trusts were charged with producing plans which were then fed to regions for validation and submission to the Department of Health between 1997-2009. Medical workforce planning was undertaken separately.

The Centre for Workforce Intelligence was set up in 2010 to improve workforce planning. It engaged with NHS employers and professional bodies as well as undertaking detailed statistical exercises and published an extensive range of reports on the many NHS staff groups. Its workforce planning framework covered policy analysis, horizon scanning, scenario generation and workforce modelling. Its early work was heavily criticised by medical colleges as the NHS information on its central computer which it used in its plans was less accurate than that of the colleges. The Department of Health, Public Health England and Health Education have taken

over many of their responsibilities in 2016.

The King's Fund criticised the lack of national data, particularly for temporary staff and the independent sector, which makes long-term planning very difficult [11]. The independent sector does not share detailed staffing information and plans as they considered this to be commercially sensitive. The easiest way for them to make money is by substituting expensive staff with those on lower pay. This can mean that expensive staff perform a supervisory role and undertake the most difficult procedures. Lower skilled staff are often trained up to work at an intermediate level under supervision.

Money

The main reason why the NHS has made the cuts and economies in workforce is that the UK spends less than comparable countries on healthcare. In 2017, the UK spent £2,989 per person on healthcare, which is the second lowest of the G7 group of large, developed economies, with the highest spenders being France (£3,737), Germany (£4,432) and the United States (£7,736). As a percentage of GDP, UK healthcare spending fell from 9.8% in 2013 to 9.6% in 2017 [12].

"The main reason why the NHS has made the cuts and economies in workforce is that the UK spends less than comparable countries on healthcare"

The number of intensive care beds in the UK is below the OECD average. The UK has 10.5, the OECD average is 12, France has 16.3 and Germany 33.9 per 100,000 [13]. These beds were vital when dealing with the sickest Covid-19 patients and yet we had so few. Hospital beds tell a similar story, with the UK having 2.46, the OECD average is 2.9, France 5.9 and Germany 8 per 1,000 (OECD, 2021) [14].

The NHS is unique in that it suffers from winter pressures when its resources are stretched to breaking point. Safe bed occupancy rates are generally considered to be 85 per cent, but this is often greatly exceeded. Contrast the NHS with the retail sector: they both are busiest at Christmas but do any shops complain that have difficulty coping? No, because they are adequately funded to buy in more stock and to increase staff.

Therefore, the NHS was and in a very poor state to meet the massive demands of Covid-19 patients. This meant that there was little or no scope to undertake surgery as general beds were required for Covid-19. As a result, waiting times have gone through the roof. By December 2020, there were more than 220,000 people waiting more than a year for routine planned care, compared to only 1,500 people in December 2019 [15].

Conclusion

While NHS workforce planning has been criticised for the lack of accuracy of some of its data on current staff and also for gaps with regard to the independent sector, this pales in significance when compared to funding levels as an explanation for staff shortages. The unwillingness to invest sufficiently in medical and nurse training on financial grounds has been the most important reason for their shortages. This is a reflection of the underinvestment in all aspects of the NHS, so why should the workforce be any different?

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George Blair
[George is a former NHS workforce planner and advisor with many years of experience at regional and national level.]

'If I were Minister of Health': More on Democratising Healthcare

A further selection of the entries from last year's Essay Prize as a sign of the quality we can expect this year. Once again, an encouraging number of entries have been received this year (some from overseas)

The year 2020 will primarily be remembered as the year of Covid-19. With health issues brought to the forefront, the world reflected on their mortality and the state of their healthcare system. Like the ugly duckling's magical transformation into a swan, healthcare workers became more applauded than footballers, overwhelmed with generosity and goodwill from the public. The spotlight fell on health ministers; the scarcity of personal protective equipment (PPE) reminding people of the limitations in resources.

Adapting quickly to an ever-moving uncertain environment has been the burden of many organisations, in particular the healthcare industry. If I were Minister of Health, I would take advantage of this drive for innovation to reform and reshape our healthcare system in a positive yet sustainable way.

Goals

If I were Minister of Health, a good healthcare system would meet the following ideals: equity, cost-effectiveness, compassion, and a growth mindset.

Equitable healthcare is available to everyone without prejudice, with structures in place to eliminate barriers to access. Though significant financial investment is paramount, running cost-effectively while reducing waste will optimise the utilisation of resources available.

Not all valuable assets are quantifiable; good healthcare should never lose its sense of humanity and compassion as those intrinsic motivators bring purpose and meaning to the job. Evidence shows that using intrinsic motivators – autonomy, mastery, and purpose – often improve performance and job satisfaction more than the classic carrot-and-stick approach [1]. As a result, being a compassionate minister might render the job intrinsically more rewarding.

Underpinning all of the above is a growth mindset. A growth mindset, as described by Stanford professor Carol Dweck, describes a mindset where people see intelligence and skill as something that can be improved with time and effort [2]. As such, setbacks and challenges are seen as learning points (as opposed to a fixed mindset where intelligence is seen as static and intrinsic, and negative criticism is avoided). If I were health minister, I would need to promote this mindset both at a personal level and at a healthcare level; we can be proud of the NHS and yet still endeavour to learn from constructive criticism.

Targets

Fans of SMART goals know it is important for goals to be measurable [3 ; "What gets measured gets managed" – a maxim often attributed to Peter Druckers.

Targets – such as cancer 2-week-wait or A&E 4-hour-wait – are proliferative within the NHS as a means of providing measurable outcomes and

external accountability. However, they are not without drawbacks. Extrinsic motivators such as financial incentives can hinder intrinsic motivation. They can widen the gap between resource-rich and resource-poor institutions: the former continues to meet targets and prosper whereas the latter, penalised for failing to meet targets, might see their restricted resources diminish.

Patient-focused care can be impeded if targets – primarily focused on healthcare delivery at a populational level – cause a tunnel-vision which reduces individual patients to statistics. Lastly, in rare cases, people might be encouraged to manipulate figures or behave unethically to meet targets – examples of this have been seen in the corporate world, in sporting, in teaching, and even healthcare [4,5].

"Targets ... can widen the gap between resource-rich and resource-poor institutions. Patient-focused care can be impeded if targets cause a tunnel -vision which reduces individual patients to statistics"

Even so, removing all targets is unrealistic and undesirable – they can provide a benchmark for measuring standards and monitoring progress. If I were the health minister, I would use targets judiciously; changing the zero-sum attitude whereby you either pass or fail. Rather than arbitrary targets, I would focus on patient-centred outcomes [6] . By looking at clinical outcomes in combination with patient-reported outcomes, both clinicians and patients would be at the forefront of driving change.

How would I change the NHS?

In 2019, the government proposed an NHS long-term plan hoping to mitigate this instability that NHS faces with every government change [7] . As the NHS is publicly funded, depoliticising the NHS is impossible. However, if I were the health minister, I would create a cross-party Health Committee (ironically likely dissolving some of my power as Health Minister). A cross-party consensus might allow a congruence of diverse opinions and minimise drastic overhauls every 5 years.

Health Inequality

Tackling health inequality is likely the most important healthcare change that needs to be addressed. The inverse care law, first described by Dr Hart In 1971, suggests that those who most need healthcare are least likely to receive it [8-10]. Even in the NHS where healthcare is free, the same inequalities still exist. Public Health England (PHE) found that the prevalence of behavioural health risk factors such as obesity, poor diet, inactivity and smoking varied depending on social deprivation, gender and ethnic origin [11]. Additionally, social factors such as employment, educational attainment and living standards affect both physical and mental health [11].

During the current Covid-19 pandemic, the inequalities continued to be highlighted as the Intensive Care National Audit and Research Audit (ICNARC) data showed disproportionate intensive care admissions for those who were of the male gender, lower socioeconomic status, or black and minority ethnicity (BAME) background [12].

Tackling this inequality will be a slow and cumbersome endeavour requiring an upheaval of cultural beliefs and behaviours, and collaboration between a multidisciplinary team including scientists, management consultants, economists, and behavioural psychologists. As Minister of Health, I would promote increased representation

in positions of power from communities facing the greatest healthcare disparities to further understand and overcome barriers met. Standardisation of care does not necessarily make an equitable healthcare system. Instead, I would promote a more customised approach which specifically considers the divergent needs of vulnerable groups.

To achieve all this will need significant investment in social care. However, between 2010 and 2018, social care saw a real-terms spending decrease of 3% [13]. Proposals in the 2019 long term NHS plan seek to address this, and as health minister, I would ensure the sustained investment in social care [7].

NHS Staff Wellbeing

The foundations of a good healthcare system are the staff working in it; caring for them is as important as the care they give to patients. The benefits of improved staff wellbeing are plentiful: increased job satisfaction, reduced burnout, and improved staff retention.

"The foundations of a good healthcare system are the staff working in it; caring for them is as important as the care they give to patients. The benefits of improved staff wellbeing are plentiful"

Staffing numbers is an issue; the UK has fewer doctors (2.8 doctors per 1000 population) and nurses (7.8 nurses per 1000 population) in comparison to EU averages (3.4 doctors per 1000 and 8.5 nurses per 1000) [14]. Increasing workforce numbers eases the strain on current staff, improves patient safety, patient care and staff wellbeing. The re-introduction of bursaries for student nurses to start in September 2020 is a good first step towards improving access to training but more still could be done to improve staff numbers.

Enhancing the working environment will aid staff retention; tackling the blame culture that exists within the NHS is one of the ways of achieving this. Following the example of the aviation industry, I would promote a culture whereby we learn from errors rather than apportion blame which in turn would reduce clinical errors and improve staff wellbeing [15]. As a health minister, I would have the opportunity to lead by example and embody the values I seek to foster by adopting a growth mindset.

Environmental Sustainability

The Lancet Commission called climate change "the biggest global health threat of the 21st century" [16]. The healthcare sector plays a role in anthropogenic climate change, with greenhouse gas emissions estimated to be 27.1 million tonnes CO_2 [17].

There are already many organisations seeking to improve the environmental sustainability of the healthcare industry such as the Sustainable Development Unit which has focused on pharmaceuticals and medical devices, energy, waste, and travel [18].

Between 2018-19, the NHS produced 526,000 tonnes of waste costing £115,000,000 [19]. Concerns regarding the transmission of Creutzfeldt–Jakob Disease(CJD) contributed to a rise in single-use equipment. Life cycle assessment and cost assessment suggest reusable equipment may work out more environmentally friendly, and cheaper than single-use equipment with no clinical compromise [20,21]. As health minister, I would be keen to work with manufacturing companies to reduce unnecessary packing and increase the availability of reusable products. Changes are already happening on a local and individual level to reduce environmental impact; this must remain ongoing.

Conclusion

The end of the Second World War marked a shift in government priorities; the focus on welfare sparked the creation of the NHS. Necessity is the mother of invention, and this pandemic has already spurred so many changes. If I were minister of health, I would seize this drive for change to further develop the NHS. I would focus on tactical investment in healthcare, improving health inequality, social care and staff wellbeing as well as promoting environmental sustainability which, fortunately, aligns with proposals from the 2019 NHS long-term plan.

However, the most important and onerous task will be overhauling the culture. Promoting a culture of compassion to ourselves and others returns to the humanistic ideals that underpin healthcare. Shifting from a blame culture to one of growth mindset will improve staff wellbeing, promote honest communication between staff and patients regarding errors, and enhance opportunities to learn from them. As Minister of Health, I would have to drive these changes from the top, by adopting a growth mindset myself. As Gandhi would say, I would need to "be the change [I] want to see in the world". Some of this growth could be achieved by ensuring those in positions of power come from diverse backgrounds and potentially differing viewpoints to mine.

Ultimately, resources are limited and I would have to accept that any progress might be slow. Any increased investment in healthcare will mean making alternative sacrifices: more borrowing, increased taxes or decreased spending in other sectors. But if this pandemic has taught us anything, it is that our health is invaluable and worth investing in.

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Gloria Ashiru

'If I were Minister of Health ...'

"I believe it (the NHS) will lift the shadow from millions of homes".

– Minister of Health Aneurin Bevan

On the 5th July 1948 the National Health Service (NHS) rose from the ashes of the Second World War, in a time of economic hardship, widespread disease and disability.

It was held as the shining beacon of hope and compassion for the masses.

Almost 72 years later, the NHS again takes on the mantle of providing hope, care and protecting the nation's health. However, rather than dealing with the ravages of a war with guns and bombs, it is a silent and invisible threat that hangs over the country now. The NHS is 'lifting a shadow from millions of homes'.

As a doctor on the front lines of this new war against COVID19, I am struck by the great resilience, hope, innovation and compassion that the NHS has inspired across the UK and beyond.

If I was Minister of Health… I would build on the five things that the NHS has represented for me, in this time of crisis and fear.

1. Innovation, research and academic excellence

The COVID19 pandemic highlighted the need for fast, responsive and adaptable research networks that span the world. The initial reports from the Hubei Province of Wuhan, China were posted on the 31st December 2019 [1]. Incredibly, just 13 days later China released the genetic sequence for the virus to the world's researchers [2]. In the space of 6 months there have been over 27,000 journal articles on Pubmed related to COVID19.

The United Kingdom has been at the forefront of this research. Doctors and scientists in the NHS have been instrumental in forming International Policy, with papers such as those produced by Imperial College [3]. The ventilation strategy for COVID-19 was formulated with the help of Intensive Care Doctors from St Thomas' Hospital [4]. Oxford University has pioneered the development and production of potential vaccines.

In addition to the scientific literature, Medical Social Media was set ablaze with discussions and sharing of information. The open letter written by Italian intensivist Professor Maurizio Cecconi et al [5] is credited for catalysing the amazing response by many NHS trusts to the looming threat of COVID19.

Despite what has been achieved in this challenging and time-pressured period, the gaps in academic organisational infrastructure have been stark. We need to streamline research, dissemination of literature and develop systems to provide robust, clear national guidance.

As Minister for Health I would suggest a 5-point plan to address this:

1. Integration of the National Academies of Science with the Royal Colleges. This would create a unified, respected and above all qualified group of experts who would quickly respond to issues such as a novel viral pandemic. In a time of financial hardship, the focus should be on streamlining existing research pathways and reducing bureaucracy. This will also allow large multicentre studies to be started with minimal delay.
2. Improving international collaboration and patient communication. COVID19 was the first time in many generations where the whole world's scientific community were focussed on one problem. The world responded admirably, but it was slow to start. It was hindered by a lack of communication and technology. As time went on researchers found methods of communicating with applications such as Zoom and Microsoft

Teams, despite their limitations. The NHS needs a focus ed plan on improving digital communication with safe and potentially bespoke software to ensure confidential and reliable methods of discussing sensitive patient related (or research related) data. In addition to organising a commission to look at improving digital communication, significant investment is required to improve our IT infrastructure. These IT services can also be used for the safe and secure consultation with patients for routine medical care. This will allow more virtual clinics, saving patient's time (reducing travel to clinics and waiting times for appointments). It will also allow more clinics to run simultaneously, as there would be no premium on clinic space.

3. Rewarding and promoting academic excellence. The UK must promote and encourage research. This involves providing dedicated PAs (Programmed Activities) for personal academic projects. Much like the 'blue sky' time provided by Google that helped develop Gmail and Google Docs, there is the potential for significant innovation if we provide people in the NHS time to explore their ideas. I would start an initiative to help clinicians develop commercial ideas and any personal projects to improve clinical care.
4. Removing barriers to research. The UK invests millions into research, but for many doctors these funds seem inaccessible. Smaller local funds will improve access and remove many of the financial barriers to carrying out a project.
5. World-class research support. In addition to financial support, many research projects need help with statistical analysis and trial conduct. We should expand and enhance existing research infrastructures with the help of bodies such as the NIHR and Academies of Medical Science.

2. Teamwork

It was inspiring to witness the camaraderie and teamwork exhibited by everyone in the NHS during COVID19. From porters to professors, the focus was on streamlining the service to cope with the huge influx of sick patients. The flexibility, tenacity and understanding shown by fellow specialists and multi-disciplinary teams was amazing.

We should capitalise on this and promote cross-speciality working. Nurses often expressed their enjoyment of coming to Intensive Care and learning how to manage critically unwell patients. Doctors in less acute specialties also enjoyed learning about Critical Care. Some specialities such as Anaesthesia were thrust into the spotlight, allowing junior doctors to gain a wider exposure to the discipline.

As Health Minister I would improve teamwork by promoting multidisciplinary working and allow more flexibility for people to work across specialities. This would allow people to learn from others and find solutions to service and operational problems that may have been faced.

COVID19 highlighted that the NHS encounters similar problems across the UK. By sharing solutions across specialities and hospitals we can prevent duplication of work.

The cornerstone of good teamwork is communication. I would foster this by focussing on training and encouraging managers to work in clinical areas more often to develop a clearer understanding of the problems encountered.

We should also learn from the pandemic response implemented in countries such as South Korea. There was excellent state and hospital wide communication. Clear information was provided immediately to healthcare workers and the government.

Communication between healthcare workers needs to be improved. Reliance on antiquated systems like bleeps are thankfully being upgraded

to Wi-Fi phones. However, this is not enough. In the era of smart phones, we should embrace the potential for video calls and photos to aid referrals to other specialities, and remotely consult on patients. The initial financial burden would quickly be offset by streamlining clinical care.

3. Caring for the most vulnerable in society

COVID19 highlighted the vulnerabilities within certain parts of society. The virus seemed to be particularly devastating to ethnic minorities and the elderly. Although the exact cause is unclear, deprivation and inadequacies in healthcare provision are likely contributors.

As Minister for Health, I would focus on improving health inequalities. More attention is also needed on the care of our elderly. This involves investing in more nursing homes and giving them the equipment and staffing to allow our elderly to live with dignity and enjoy the latter part of their lives.

Healthcare must become more accessible to ethnic minorities. There must be more screening of chronic diseases such as hypertension and diabetes. In addition to healthcare education there should be a greater investment in clinics and outreach through vulnerable communities.

4. Compassion for the sick

During the pandemic, communication with the patient and the family was challenging. One major improvement was early, open, and frank discussions about end of life care. Patients had comprehensive conversations about escalation limits. The public also had a better understand of the repercussions of Intensive Care. This included the impact on quality of life (physically and mentally) for people who survived Critical Care.

One of the hardest aspects of managing critically unwell patients during the pandemic was communication with the patient's family and loved ones. Due to isolation protocols, family were not able to visit dying relatives. We embraced technology to utilise video chatting and conference calls to keep family up to date and allow patients to interact with loved ones.

As the Minister for Health I would invest in a network infrastructure to allow more regular video and conference conversations between healthcare professionals, patients and family.

The use of video conference calls can be further utilised to revolutionise outpatient appointments, as discussed previously.

For those that are being cared for in the community it also allows more frequent follow up, as the GP is not required to travel to the patient. It may also improve safety for GPs as they do not have to leave the GP practice to communicate with patients. Specialist clinics (which tend to be London-centric) will also be able to cater for a wider range of patients from all over the country (and potentially the world).

5. Bringing the country together

As dire as the COVID19 pandemic was, one of the most remarkable aspects was the way it brought the country together. Seeing healthcare professionals risking their lives to care for the sick, was awe-inspiring.

During the pandemic it became abundantly clear how much respect, kindness, and admiration the public has for frontline healthcare workers. We need to build on that gratitude and ensure we provide equal access to high quality medical services throughout the country.

There are geographic disparities in healthcare provision. The King's Fund published a report in 2011 highlighting the disparity in healthcare provision [6]. The authors suggest several steps to try and address this. The first and most important is to get better data, with routine collection and analysis of healthcare variations. The Department of Health Atlas Variations was an attempt to address this, started in 2010 [7].

The COVID19 pandemic also highlighted

the fragility of the healthcare infrastructure. Hospitals were on the verge of running out of oxygen, consumables such as Personal Protective Equipment (PPE) and cleaning fluids. The IT systems suddenly had extra strain on them as many services went digital.

There needs to be massive investment in the infrastructure of hospitals and care homes. In the 21st Century we should recognise the integral part technology will play in future healthcare. The unfortunate failure of the NHS IT project NHS SPINE was a significant shame. We need a fully integrated, reliable, and safe IT system that spans the NHS. It will allow information to be shared faster for individual patients and a more joined up service nationally.

As the dust settles and we recover from the devastation caused by COVID19, we must be mindful of the damage caused to certain services. Many transplant programmes and non-urgent surgeries were cancelled. We need to ensure these services are restarted quickly and safely. There will have to be an increase in service capacity to ensure the waiting times are reduced quickly. This is especially important for cancer patients. It will require central funding to allow more operations (potentially 7 days a week) and increased hospital capacity to cope with more patients. This needs to be balanced with the workload on clinicians, which is why investment in technology to streamline services is so vital.

Conclusion

More than 70 years from the inception of the NHS, it remains the shining light for many in the UK. As Healthcare Minister, it is vital to build on the talent and expertise showcased during this pandemic. The simple investments proposed in this essay would require minimal capital investment, but save millions in the longer term, and secure the NHS as a world leading institution. This will help us prepare for the next 70 years of challenges.

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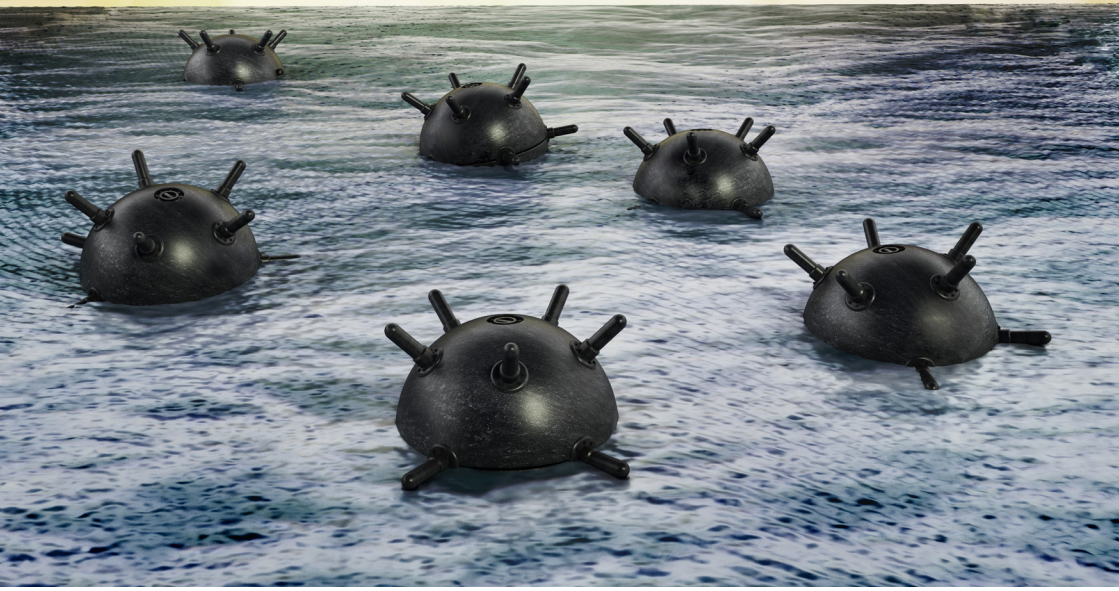

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- The public don't see the damage being done.
- You didn't take up medicine to see the NHS die.

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