Royal College of Physicians of Edinburgh

Response to what the future of the NHS provider landscape should look like

Call for views by Monitor

The Royal College of Physicians of Edinburgh (the College) is pleased to respond to the call for views by Monitor on what a high quality, financially sustainable health care service might look like in ten years' time. The College has more Fellows and Members working in the English NHS than in other parts of the UK and the following observations and comments have been collated through our English Policy Board.

Summary

The College envisages that seven day working will be the norm in the NHS in ten years' time. This will help improve patient flow, patient safety and teaching opportunities for junior medical staff. The acute sector may have specialist centres of excellence in larger hospitals, while there will be a focus on general and geriatric medicine in smaller local hospitals and in community settings. The patient will be at the centre of everything the NHS does and quality of care and patient safety will be the key drivers behind every decision.

Interaction between primary and secondary care

Some hospitals are likely to be very large in future and provide the bulk of highly specialised care. Smaller hospitals will be able to provide initial, early emergency and basic care more locally, i.e. the district general hospital. A patient with an easily managed condition should be treated locally, for example, if there is a simple exacerbation of COPD or pneumonia. More specific levels of support – for example complex and specialised surgery- will be available in larger hospitals. Patients will therefore need to travel to get specialist treatment in the relevant centre of excellence; local and national politicians, however, have recognised that this is clinically desirable and will improve patient care and safety.

Local hospitals will likely have an emergency department (ED) to provide initial emergency care, then treat and transfer patients when necessary. This may take the form of an ED, combined with medical assessment and surgical assessment units. This will be particularly the case for more isolated areas, while in areas with a higher population density the emergency treatment unit could be in a larger hospital.

There may be locally provided minor injuries units, staffed by GPs, which will prevent the need for all patients to travel for care. Outpatient clinics should also be provided in GP surgeries or other facilities not necessarily connected to hospitals. Procedural specialities such as gastroenterology could provide some endoscopy in these community centres but the bulk of high level procedures (advanced therapeutic endoscopy, coronary angioplasty etc) will be in the larger hospitals.

Generalists will have a much greater role in the hospital, and recognising the changing demography there will be need for increased training in geriatric medicine.

Junior doctor training will be provided in the larger hospitals but with periods of experience and training in the smaller community clinics and hospitals. On call in hospitals will still be by junior doctors and this will be supplemented by seven day consultant working and availability of technology e.g MRI, CT on a seven day basis.

There will be a relatively free flow of patients between larger hospitals and community hospitals because, following acute care, the patient will be transferred to their locality for further recovery.

The majority of patients will be older people who have long term conditions. Education and access to IT resources will be provided to allow patients to educate themselves about their condition and to seek help via electronic systems.

There will be increased awareness of cognitive impairment and dementia among healthcare professionals.

There will be a commitment by all providers to health prevention and health promotion. The NHS will have a greater focus on prevention and detection, and improve care pathways to facilitate appropriate management of common conditions affecting the elderly population.

Financial Drivers

Tariffs will be national and not locally negotiated. Cost efficiencies are maintained by appropriate quality control and the ability of a large organisation to negotiate rather than the current local negotiating.

The NHS is often compared with other health systems in the developed world, without accepting that many of the health systems in western countries such as Germany, US etc are partly funded by patients/ insurance etc, which of course considerably strengthens the funding pot available. There needs to be greater dialogue and transparency over the limitations and rationing of services available through the NHS.

Integration of health and social care

The division of health and social care will have been addressed and a joint budget put in place in ten years' time.

Primary Health Care teams will include input from social services teams and this will be the norm in the community. They will identify patients at an earlier stage and initiate appropriate assessments of older patients and provide referral to Community Geriatricians to provide specialist input so reversible disease factors can be addressed. The primary care team will then initiate a plan to maintain a patient in the community. There will be a new relationship with the community – including e-consultation, online communication with patients, and possibly telecare. Like secondary care, primary and social care will also work on a seven day basis in order to provide the best service to patients.

The cost of social care remains a challenge due to our ageing population and imaginative solutions could be proposed such as tax breaks for carers or an extended carers allowance to reduce pressure on institutional care.

Quality of care

Quality is the key to a system that will be highly valued in the future. All quality measures for all providers should be published and accessible to the public. The seven day working agenda is essential for both primary care and secondary care in terms of ensuring high quality and high value.

All providers, including those in primary care, should commit to participate in all relevant National Clinical Audits to populate quality measures.

Improving technology

A continuing revolution in data and IT will allow greater benchmarking, validation of quality processes, efficiency, and patient interaction. There will be e-prescribing and e-administration of drugs. There will be a drive to replace higher risk processes with IT solutions, for example tracking results, test ordering, prescribing (all of which can have rules based functions).

Patient 'smart card' electronic records will ensure the interface between primary and secondary is seamless.

Advances in technology will also ensure that lower CO_2 levels are produced; that more efficient procurement processes are introduced; more waste is recycled and transport is used more effectively, all of which will contribute to substantial savings for the NHS.