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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: What might the Queen's speech mean for hospital doctors?

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The Queen's speech contained little consolation for the NHS, with no meaningful pledges about funding, sustainability, or workforce gaps.[1]

Since she became prime minister, Theresa May has repeatedly made clear that the NHS has received budgetary protection in contrast with other departments, as well as the widely disputed "£10bn it asked for in its own plan."[2 3] I see little hope that healthcare will be a priority during the Brexit turmoil, not least because a system funded from general taxation is intrinsically dependent on economic growth and stability. I expect to see decisions and accountability increasingly delegated to arm's length NHS leadership bodies.

This shouldn't stop doctors from campaigning relentlessly, highlighting problems and shortfalls. Nor can doctors afford to throw up our hands in learned helplessness, and I don't think for a minute that we do. Despite considerable system pressures, I've seen many examples of resourceful hospital colleagues doing whatever they can to sustain or transform services.

> We can't duck our responsibility to make the best of a tough policy climate

We are arguably the most influential staff group and take on various leadership roles. Decisions we make around treatments, tests, or services account for a high proportion of spending. We can't duck our responsibility to make the best of a tough policy climate.

We must surely do all we can in our own teams to improve working conditions, morale, engagement, and retention of medical staff of all grades, from foundation years to senior consultants.

We must co-lead and engage locally in efforts to improve the flow of patients through scarce and costly hospital beds and minimise avoidable harms or delays.[4 5] We must ensure that patients, where possible, are admitted to hospital only when it's the best option for them.

We have a duty to ensure that the kind of evidence based best practice set out in clinical guidelines is implemented more reliably and consistently.[6] We know from national clinical audits that this doesn't always happen.[7]

Through initiatives such as Realistic Medicine[8] or Choosing Wisely,[9] we should also challenge treatments, tests, or service models that are poorly evidenced or that add poor value, and we should be vocal about this in the national public conversation, not just in our own circles.

To do this well we should engage across hospital walls with social, community, and primary care partners and collaborate on processes to best use our specialist clinical knowledge.[10 11] Hospital specialists need the chance to take more ownership of population medicine.[12] It isn't enough to manage patients well when they arrive at our door: we also need to play our part in reducing need and variations in population health indicators.

If we're to make a greater shift towards clinicians driving better value for healthcare spending,[13 14] we must also do more to minimise major variations in processes and outcomes specifically for hospital patients.[15] To do any of this we need better clinical data and IT, as well as training to use these tools to improve care. We also need the permission, protected time, and organisational support to innovate and improve.[16 17]

These enabling factors may be present in some units in some hospitals, but they need to become the norm if we're to play our part.

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