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VIEWS AND REVIEWS

NO HOLDS BARRED

Margaret McCartney: Let's have a report on what resources the NHS needs

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The Care Quality Commission's chief inspector of hospitals, Edward Baker, has told the *Daily Telegraph*, "We need a model of care that is fit for the 21st century and the population as it is now."[1]

Baker has written to English hospital chief executives,[2] who are doubtless feeling the shivers of winter. He explains the rules to them: people who arrive in ambulances should be timed from when they arrive in the car park, not the emergency department; "corridor care" should not be normal care; and staff should be led effectively and consistently.

"For many trusts," he writes, "their greatest risks to patient safety are likely to be in their emergency departments." In due course, Baker intends to share lessons culled from staff working at trusts that the CQC has deemed good or outstanding.

He's right: the NHS isn't fit for purpose. And, in a relatively rich country, with the NHS constitution standing, this is inexcusable. Waiting lists for consultant led treatment are 25% longer than three years ago.[3] Vacancies in the NHS are up 10% on 2016 figures.[4]

But why? Regulators are in a powerful position, but placing blame and the locus of control for the safe running of hospitals is not in the gift of single chief executives. Baker's interview in the *Telegraph* was followed by an interview with David Behan, CQC chief executive, on the *Today* programme.[5]

Behan identified demand and complexity as reasons for the system struggling. He cited a GP project at Yeovil Hospital whose "impact is a 30% reduction of admissions into hospital," and the *Today* programme's John Humphrys seized on this as an example of a failure to roll out an obviously good idea. But these statistics in fact relate to a group of 200 patients with high care needs, not to the population in general, and no cost effectiveness calculations or absolute risk of admission reductions are available.[6]

Preventive healthcare initiatives can be valiantly pursued, but they don't seem to affect emergency admissions.[7 8] Case management is also unproved as a way of reducing admission rates significantly.[9] We know that hospital admissions often happen because cuts mean that social services can't meet needs,[10] especially in deprived areas.[11] But we don't know what's going on behind closed doors. I hope that the higher echelons of the CQC are taking the prime minister to task on the political leadership failures that led to this mess.

Notably, Baker has asked the medical royal colleges to identify safe workload standards for junior doctors.[12] But the CQC shouldn't stop there. How much can GPs, consultants, staff grade doctors, nurses, and physiotherapists reasonably be expected to do safely? And what resources do we need to do that work?

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Poor care due to healthcare workers being lazy or disorganised is very different from poor care due to an understaffed, under-resourced, overwhelmed NHS. And the treatments for each are remarkably different. I don't want "transformations" based on speculative evidence that doesn't look for harms. I want us to get the basics right.

Enough of scolding reports telling us what we're failing to do: tell us instead how much time, resources, and staff we need if we're to expect safe, humane care as standard.

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