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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Covid-19 will make us stop some activities for good

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As the saying goes, "necessity is the mother of invention." With the global covid-19 pandemic, we're seeing scientific evidence evolve quickly, new technologies develop, and real time, ever changing plans for epidemiology, public protection, and ensuring that health services remain viable.[1 2]

When, hopefully, we're through the pandemic and have time to reflect, no doubt some practices will see a step change for the better. Our planning, preparedness, and understanding of transmission, protection, and treatment will have to change. Arguably, it was learning from the SARS pandemic that meant some South East Asian nations were better prepared for covid-19 and tackled it sooner.[3]

But what of the things we stop doing? After the pandemic passes, will we return to our old ways or be grateful for what we've learnt?

In acute hospitals, we're already moving to stop most non-urgent outpatient activities such as routine follow-ups and less urgent planned operations, tests, or procedures. We're moving many more consultations to online or telephone. Clearly, we don't want this war footing to become the new norm. Patients in many cases rely on such work and have their lives saved or transformed. Clinicians get valuable training in those settings.

However, organisations such as the Health Foundation and the Royal College of Physicians have been arguing for some time that outpatient appointments need reform,[4 5] as have the NHS 10 year plan and the Getting it Right First Time programme.[6 7] This may help accelerate the process of focusing on value.

Perhaps we need more one stop, rapid access clinics for new patients and more self-directed follow-up—often with advice and remote consultation rather than physical trips to car parks and clinic suites, which are especially burdensome for patients with multiple conditions seeing several teams. Hospitals are also redeploying specialist clinicians to allow more fast-track access to their skills, away from emergency departments that were already overcrowded and pressurised. This is overdue.

A detailed letter sent on 17 March by the NHS chief executive, Simon Stevens, and its chief operating officer, Amanda Pritchard, also included a provision to move away from "payment by results" tariffs towards block contracts, removing some financial penalties for trusts in deficit.[8]

In reality, this purchaser-provider split and contracting for hospital services has always been fraught. Apart from the bureaucracy and transaction costs and incentives to compete and focus on the "business model" or "cost improvement," the tariff paid to acute hospitals for urgent activity doesn't reflect its true cost[9]—whereas it allows us to make a margin on outpatient and elective work, effectively cross subsidising unscheduled care. This creates all kinds of perverse incentives we could do without, when we may be better collaborating to plan care for a local population.

For now, hospitals seem to be suspending the annual consultant job planning cycle. The process has its virtues, but how much would we really miss it, and why every year? As for the paperwork involved in revalidation, appraisal, and a whole raft of mandatory training, perhaps we'll learn that it can be slimmed down—as it will have to be if we're to welcome recent retirees back to work, who might not have retired completely were it not for the paperwork.[10]

The Care Quality Commission has also been stood down by the NHS leadership for now, so that hospitals can get on with providing pandemic care. Its inspections have long been a subject of debate: independent reports question how much value they really add and how much stress and admin burden this places on frontline operational and clinical staff each time.[11 12] Many will be cheering this amnesty.

When former clinicians or former frontline NHS managers are forced to switch back to their old roles for a while, it could transform their insights and our working lives.

I suspect that the crisis will reveal which staff groups really are critical to the business of healthcare (not just clinicians but key workers in operational management, human resources, occupational health, logistics, estates, information technology, cleaning, and catering)—and which individuals, quangos, or consulting firms won't be missed.

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