



Royal College
of Physicians



Against the odds

Experiences from the NHS front line

**Mission:
Health**

February 2017

Introduction

The NHS offers some of the highest-quality, most efficient and most accessible healthcare in the world. It tops the Commonwealth Fund ranking of world health systems¹ and heads up polls of what makes people proud to be British.² That's a lot to be proud of, but it's no excuse for complacency. This report shares the experiences of doctors working in NHS hospitals between December 2016 and January 2017. It tells a story of NHS staff striving to deliver for patients, against a backdrop of unprecedented demand.

The Royal College of Physicians (RCP) has long argued that we need to rethink the way we deliver healthcare: breaking down barriers between hospitals and the community, and working in partnership with patients to deliver joined-up care. Our population is growing and we live longer, often with complex health and care needs. Innovation and new treatments continue to save lives, but can increase financial costs: the bill for drugs is increasing and we expect more from the health service, whether that's greater access to treatments or higher standards of care. People in hospital tend to be older, sicker and in need of more intensive support because of conditions such as dementia. However, social care services that could help to support people outside hospital have had their funding cut and UK health spending continues to lag behind other major countries in Europe.³

If we are to meet the needs of our growing population, we need to invest in health and social care. As we entered 2017, we were presented with a clear picture of what happens when health and social care services struggle to meet demand, with widespread reports of ambulances queuing in car parks, people stuck on trolleys, cancelled operations, and staff working long hours to keep patients safe. These are not challenges exclusive to winter. Our health and social care system is under increasing pressure throughout the year, leaving little flex to respond to the peaks in demand caused by cold weather or winter bugs. In this report, doctors and patients explain in their own words what an overstretched NHS looks like in practice. The experiences of front-line staff paint a clear picture of NHS staff striving to keep patients safe, sometimes against the odds.

About this report: Against the odds

This report collates hospital doctors' experiences of working in NHS hospitals between December 2016 and January 2017. Experiences were sought from a group of 50 senior physicians and members of the RCP's Patient and Carer Network, with additional examples from the RCP's wider membership. Experiences have been themed, anonymised and edited for clarity. Quotations as written in this report have been approved by original authors as a true record of their comments.

The RCP would like to thank the doctors and patients who shared their stories with us. We would also like to thank the dedicated NHS staff who work long hours and intense shifts to keep patients safe.

Support from the RCP

Open letter to the prime minister

On 11 January 2017, the RCP wrote an open letter to the prime minister, setting out the need for extra investment. www.rcplondon.ac.uk/news/quality-patient-care-threatened-physicians-tell-pm

Underfunded, underdoctored, overstretched

Our September 2016 report sets out the financial and workforce challenges facing the NHS. www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016

Being a junior doctor

This report from December 2016 explores the challenges that face the NHS from the perspective of junior doctors. www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor

Keeping medicine brilliant

A comprehensive set of recommendations for improving the morale of doctors working in acute hospitals. www.rcplondon.ac.uk/guidelines-policy/keeping-medicine-brilliant

Future Hospital

The RCP's vision for the future of healthcare, including real-life examples of excellence from across the UK. www.rcplondon.ac.uk/fhp

Urgent care

Read our joint report on building the resilience of acute and urgent care services. www.rcplondon.ac.uk/news/ten-priorities-action-improve-care-acutely-ill-patients

Time for action

The RCP believes patients and communities deserve an NHS that is funded and staffed to meet their needs, now and in the future. In September 2016, the RCP called on government to take urgent action to address an underfunded, underdoctored and overstretched NHS.³

1 Invest in health and social care

Social care funding has been cut and the NHS budget has not kept pace with demand. The RCP calls on government to:

- > urgently invest in social care services
- > deliver an NHS budget that matches the increase in demand
- > invest in NHS capital improvements, such as upgrading hospital equipment
- > set realistic targets for Sustainability and Transformation Plans and efficiency savings
- > protect funds for transformation, with upfront investment to free up staff.



2 Support NHS staff to deliver excellent care

Hospital teams and patients are feeling the pressure of staffing gaps. We need to:

- > incentivise doctors to work in the most challenging and in-demand areas of medicine
- > address nurse shortages and promote innovative models of staffing, such as physician associates working alongside doctors
- > take cross-governmental action to relieve immediate pressure on the NHS workforce
- > ensure that training numbers are sufficient to deliver enough doctors across all parts of the workforce.



3 Improve the working lives of NHS staff

A cared-for workforce delivers better outcomes for patients. Work with the RCP – as the collective voice of physicians – to:

- > find new solutions to service and workforce pressures
- > showcase new ways of working and the very best of the NHS.



Mission: Health

Against the odds is part of the RCP's Mission: Health campaign, which calls for urgent action to address pressures on the health service. Throughout 2017, the RCP will be working with patients, professionals and policymakers to develop our vision for the future of the health service. Drawing on their experiences, expertise and evidence, we will explore the major issues facing the NHS, develop solutions and showcase good practice. Share your suggestions and examples of what works by emailing missionhealth@rcplondon.ac.uk, or visit www.rcplondon.ac.uk/missionhealth to find out more.

Under pressure: 3 months in the NHS

The year-on-year increases in demand for NHS services, alongside cuts to social care, leave little additional capacity to respond to the peaks in demand that winter brings. By summer 2016, the NHS was already missing more than half of its targets, with patients experiencing increasing delays in accessing care both inside and outside hospital.¹¹ By winter, services were under acute pressure, despite comparatively mild weather and levels of flu within the expected range. The pressures on our hospitals this winter are not the result of extreme conditions. With sufficient investment in health and social care, we can reverse the trends illustrated so starkly not only by the past 3 months, but by the past few years.

27 December and 2 January were the busiest days in our hospitals so far this winter (2016–17). Around 60,000 patients attended A&E on each day, with some hospital trusts reporting increases of around 20% in the number of patients attending A&E in the first weeks of the new year.⁴

Double the number of hospitals diverted patients from their A&E to other local hospitals at the start of 2017. In the week ending 15 January, there were 52 temporary diversions from one A&E to another across England – almost double the level for the same week in 2016.⁵

Only three-quarters of people arriving at A&E were seen and treated within 4 hours, according to early data.⁶ Although official data had not been released at the time of writing, the final figures will fall some way short of the 95% ‘4-hour standard’, with some patients reportedly waiting for upwards of 12 hours.

Since 31 December 2016, around half of all hospital trusts in England have reported pressures so serious that there was ‘significant deterioration in the quality of patient care’.^{5,7} Direct comparisons with previous years is difficult,⁸ but evidence suggests that ‘the average number of trusts reporting pressures... was above the level ever reported in previous years’⁵

In the second week of January, 95.3% of hospital beds were full.⁵ Hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages and increased numbers of healthcare-acquired infections.⁹ The number of additional ‘escalation’ beds opened by hospitals in early 2017 was 25% higher than for the same period last year.⁵

Since October 2016, hospitals have cancelled an average of 40 operations per week to cope with increasing demand. Information gathered by the Royal College of Emergency Medicine from over 50 trusts shows that individual hospitals have cancelled up to 357 elective operations per week.⁶

The number of patients stuck in hospital unnecessarily has climbed steeply since the end of December.⁶ In order to leave hospital safely, many patients often need extra support to return to their own homes or to beds in the community. If this support is not available, or if there are delays within hospital, this can lead to ‘delayed transfers of care’, when patients are stuck in a hospital bed, even though they do not need that level of medical support.

What it feels like for patients



‘I was seen by the out-of-hours GP in June 2016. He requested an ambulance to take me to my local hospital: it arrived 5 hours later. After a few days in hospital, I was referred on to the colorectal surgical team. In July, I was put on the list for surgery, with an expected 8-week wait. In September, I was informed that my surgery would be in November. In November, I was told that my surgery would be after Christmas. In mid-December, I received a surgery date: 23 December.

I was shocked when I arrived at the admissions unit at 6.30am on the day of my surgery. There were about 30 patients waiting for beds before surgery could begin. I was beginning to feel as though I was being held in a cattle pen, waiting for confirmation that a bed would be free. The pressure that staff must be under in this situation is immense. To see so many staff – including anaesthetists and surgeons – waiting to see whether they could complete their operating list was really difficult. There was a feeling that we, the patients, were just another number.

I had been informed that, for the previous 2 weeks, complicated cases had been cancelled owing to bed shortages. I wondered how long those patients would have to wait. I asked what happens to those patients who are sent home. They are advised to go to A&E should their condition worsen, and rescheduled for surgery.

‘Having been in pain for so long myself, I began to feel that quality of life is not something the NHS is striving for. It is now purely about survival.’

I was stressed, but lucky: I had a bed and I had my surgery. The clinical staff were amazing, working in difficult circumstances. Even on Christmas Day, my surgeon was in and the medical staff were doing a round. But, there were a couple of really sick surgical patients on the ward who needed a lot of care, and patients with dementia who needed extra care. Patients like me did not get medication on time, particularly pain relief. The staff really worked hard and I felt cared for. But, they only had one pair of hands each and certainly no time for a meal or refreshment break. During my wait to go home on Christmas Day, I heard the chatter of the meal-serving staff: not enough dinners were on the trolley to feed the patients.

I’m left feeling that patients like me will be kept out of crisis, but there is no capacity for providing excellence. I worry for patients and staff alike. As a patient with a complicated long-term condition, it is scary not feeling confident that I will have good access to secondary care. ▶

‘I only have praise for those who care for me in increasingly, visibly difficult circumstances. But, what happens when difficult becomes unsafe?’

Member, RCP’s Patient and Carer Network

Stories from the NHS front line

‘I feel strongly that we continue to have a duty to try to ensure those members of the public who don’t witness the current stress the NHS is under are made aware of just how bad the current situation really is, in the hope of their adding to the pressure on politicians.’ **Senior doctor**

This report draws together first-hand accounts of working in NHS hospitals between December 2016 and January 2017. It tells a story of NHS staff striving to deliver for patients, against a backdrop of unprecedented demand.

Nowhere to go



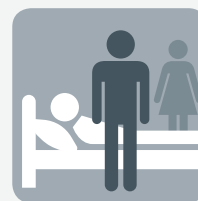
‘All hospitals in my area are trying to divert ambulances simultaneously. My hospital has 99 delayed discharges and 60 medical outliers in surgical beds. You can see the mismatch

between projected admissions and available beds. Now critical.’

‘Our hospital struggled in a big way over a period of about 2 weeks from the weekend of New Year. There was relentless pressure of new admissions, patients were scattered all over the hospital in surgical and other non-medical specialty wards. Patients faced long delays in initial assessments despite there being extra consultants (acute medicine) working until 10pm every night of the week. The number of medical outliers exceeded 100 and discharges were delayed. All elective surgery (except day cases) was cancelled for 2 weeks, resulting in severe delays for some patients with cancer. Apparently we were one of the best hospitals in the country with regards to the 4-hour A&E target – although we were hitting between 82% and 90%.’

‘I have been one of four experienced consultant physicians all working in acute medicine at some pace today and also having to spend time in A&E. We are on the worst 4-hour waiting time performance that any of us can remember, some 12 hours too. We started the day 73 beds down, despite cancelling elective work and escalating to badly staffed temporary areas. It took the four of us 4 hours each to get round all the people in the acute medical unit, short-stay unit and observation areas.’

Not enough beds



‘We have had 40–60 patients in the emergency department (ED), which is designed for 23 patients, with twice as many patients as cubicles in resus at times, and another 40–70 patients in ‘minors’ most of the time.’

‘I regularly go the ED to do consultations. Today’s patients had no bed or couch, but were somewhere in the department waiting rooms or outside, as every bed and chair inside the ED and resus were occupied. The waiting area was

packed and always seems to be. I did not ask how many ambulances were waiting outside. I had to find a spare cubicle to see one patient, which seemed to be a carousel for a succession of cases coming in and out for assessment by various people. »

« A frail patient in his 70s who had been transferred from neurosurgery had become more comatose, and his CT scan showed a recurrence of his subdural haematoma (blood clot around his brain). I was unable to find any bed in the hospital. Normally in this situation, we would try and do a three-way swap of various patients on various wards – even this was not possible. I then spent the best part of 2 hours phoning other neurosurgical units. Fortunately (and purely by luck), his consciousness level improved so we could wait. »

‘A whole industry has been set up to get people home before they hit deeper hospital wards, but the ones that do make it beyond are really sick.’

Corridor wards



« We have a policy to help each ward – not just the acute admissions wards, but each ward in the hospital – decide who is the ‘least bad’ patient to approach to ask to sleep on a bed in the corridor. We have a plan for which nurse takes responsibility for taking observations – they are recorded in ‘the corridor folder’. This certainly qualifies under the ‘things I never expected to see in my lifetime’ category. »

« As a registrar in the early 1990s, I remember dealing with patients in corridors on trolleys and patients who lived in the hospital for weeks or months, but I wasn’t really expecting to see it two decades into my consultant career. It’s not a great environment in which to work or be cared for. »

« Our hospital has got so full in A&E that they ran out of corridors to place people and had to open up endoscopy to allow people to wait on trolleys there. This now happens regularly and has an impact on patients requiring endoscopy for cancer, as there is nowhere for these patients to recover – and it is resulting in routine and regular cancellations of the endoscopy service. »

Patients in danger



« As a regional hospital, it is almost impossible to get patients transferred in for specialist services. Patients are dying as a result of not accessing specialist care, as the hospitals are jam-full. It is also impossible to get patients transferred back to district general hospitals once patients have received specialist input. »

« It is pretty dire out there, and it’s depressing to see increasing levels of panic (my interpretation) at management level to get patients moving through the hospital system. It’s meaning that infection-control rules are being rewritten: 2 weeks ago, three bays on my ward were closed owing to patients having flu. This week, we have a new case of flu, but the bay remains open. The patient is being ‘barriered’, but those in the rest of the bay get Tamiflu, and bed turnover continues as before. So more Tamiflu is required. Patients are being moved before swab results are available, so infection spread is a greater risk, and outliers are everywhere. ‘Medically fit’ patients are being moved from base wards to outlier wards, which in some cases delays discharge (‘therapy incomplete’) – and the new ward hasn’t the expertise. And now we’re sending patients to a nursing home to wait for home-care packages to become available. Just waiting for an outbreak of flu/norovirus there. »

‘As physicians we will continue to do all we possibly can for our patients and colleagues.’

‘I saw a patient on the ward who we cannot get to the regional neuroscience unit / intensive care unit (ITU), where he really should be. We also could not get him into our own ITU and he was therefore left with escalating medication in the acute ward for 24 hours, while his seizures continued. Today I insisted that we need to transfer him to our ITU so we could treat more aggressively with adequate respiratory support. This was agreed, but there were no beds. Two ITU cases were awaiting transfer to wards but had nowhere to go.’

‘Us neurologists have long ‘given up’ on the notion that acute neurology seen in the district general hospital can be transferred to the regional neurosciences unit for appropriate multidisciplinary diagnosis, care, timely specialist investigation and treatment by subspecialists. The regional units have the same bed problems that we have, and have no protected neurology beds. There are ever-longer waiting times for outpatient appointments that managers fret about and clear periodically with expensive locums, leaving us to sort out the admin and follow-ups.’

Stuck in hospital, or sent home without support



‘Talking to my colleagues – all mature, measured, calm, experienced clinicians – we all feel like we are taking the least risky, least unsatisfactory of two equally unsatisfactory options for the sake of flow, and sending people home who we would rather hang onto for an extra day or sending

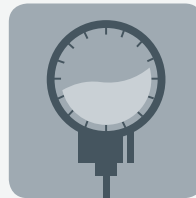
them to clinical areas that aren’t right. Community and social care services are full.’

‘In my hospital, we have three wards of medically fit patients awaiting discharge – mostly, but not exclusively, to social care. We currently have approximately 180 medical outliers in surgical beds, of whom approximately 120 are medical, older patients.’

‘One patient (a single parent with a spinal cord injury) spent so long waiting for social care (more than 4 months) that her family were bringing in Ikea furniture to make her hospital bed area more ‘homely’.’

‘It is almost impossible to link in with social care if patients are from outside our own catchment area – thus delaying discharge. This is something that happens all too frequently in a centrally located teaching hospital with an active network of satellite hospitals.’

Pressure across the system



‘I have done a quick survey of responsible physicians in as many trusts as possible in our region to assess the situation in the past 48 hours. The vast majority report a 20% or so increase in acute admissions, with departments under severe stress, worse than any of the past 10 or so years. Yes, some highlight the bed problem due to lack of community places for stabilised patients, but there does seem to be a real increase in appropriate admissions.’

‘Although care in the community is an issue, we must not forget the need to boost the capability and capacity of the acute medical area. For the past 20 years I have listened to people proposing magic schemes to reduce admissions, rather than using those resources to increase the capability and efficiency of the place that nearly all acutely ill people go when other systems fail, especially in holiday periods. None of those schemes have made a significant impact, but many seem to have taken up considerable amounts of money and staff.’

‘Of the people I saw this morning, not a single one had been referred by the GP, despite several having primary care-amenable problems – they had bypassed primary care and defaulted straight to A&E. It’s an environment where all colleagues, nursing, managerial and allied health professionals, are stressed with little in reserve, where tensions are unavoidable and where risk is inevitable. And patients’ relatives – many patients being older and frailer and relying on care – are understandably anxious and hungry for information and reassurance.’

Staff at risk of burnout



‘Many of my colleagues who were on 6-hour shifts for wards earlier in the day were here for 10 hours. Today I have spent from 08.00 to 18.00 in the emergency department,

supporting my colleagues, seeing patients, supporting the coordinator, and taking some pretty risky decisions on patients. I will be doing the same tomorrow, and until we have a safer position. On New Year’s Eve, my acute physician consultant colleague had to work as the only medical registrar for the whole shift – as one rang in sick, and the other went off sick early in the shift – as well as doing the consultant role. This is the situation throughout my region.’

‘Consultants felt under huge pressure and worked extremely hard to just keep the place ticking over. Many consultants and senior nurses stayed on for long hours to try and facilitate patient movement.’

‘I have never before known a time when consultant colleagues are constantly exhausted, trainees so disillusioned (as director of medical education, I receive daily visits and emails from trainees who want to talk about leaving medicine) and hospitals under unremitting clinical and financial pressures. Of course, problems with recruitment also apply to other healthcare professionals – particularly nurses.’

‘I was meant to finish at 20.30 yesterday. I stayed until 00.30 to ensure that patients were as safe as possible and that juniors were supported.’

Why is investment in health and social care important?

The RCP believes patients deserve an NHS that is funded and staffed to meet their needs, now and in the future. If we are to meet the needs of our growing population, we need to invest in health and social care.

As we entered 2017, we were presented with a clear picture of what happens when investment and capacity do not match the demand for services. Without greater investment, we can expect to see the problems experienced in 2016 worsen as demand for services continues to increase. The pressures usually experienced during cold weather or a flu epidemic will become increasingly common across the year. However, this is not inevitable: with sufficient investment, we can reverse these trends and deliver the high-quality care that our communities deserve.

What underfunding means for patients

Longer waits.



People are joining an ever-longer queue for treatment, with waiting lists at their longest since 2007. More people are waiting for longer than 4 hours in A&E than at

any time since 2003/4.¹¹

Restricted access.



As demand increases and finances stagnate, there will be increasingly difficult decisions about the availability of care and treatment. Health bodies are already making the news

for considering 'rationing' some drugs and cancelling non-urgent operations.^{13,14}

Delays getting to hospital.



Demand for ambulance services has increased by around 5% a year for the past 5 years. In 2015/16, half a million ambulance hours were lost due to delays

at emergency departments. As a result, performance against target response times is worsening.¹²

Closed doors.



Evidence suggests that more hospitals are reporting pressures serious enough to divert ambulances from A&Es.⁵ Reports of hospitals temporarily closing their

doors are not unusual, not just in winter, but throughout the year.¹⁵⁻¹⁷

Delays leaving hospital.



The number of patients stuck in hospital because of delays in being discharged has increased by 80% in the past 5 years.¹¹

Unsafe care.

High levels of bed occupancy – ie when over 85% of hospital beds are full – are associated with healthcare-acquired infections,⁹ and can mean that patients are cared for in inappropriate wards and by staff not equipped to manage their illness.



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About the RCP

The RCP aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Get involved

The RCP provides expert advice to government, national organisations and policymakers. We are also keen to share and promote examples of what works, and to hear your suggestions of how we can address the challenges faced by hospitals and the wider NHS. Throughout 2017, the RCP will:

- > work with NHS teams, patients and carers to identify solutions to the pressures facing the NHS
- > push for action from across government and the NHS
- > showcase the very best of medicine.

To join the debate and help shape the future of health, healthcare and the NHS:

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