House of Lords Debate Briefing – 19 April 2018

Long Term Sustainability of the NHS

1. Introduction
The Academy of Medical Royal Colleges (the Academy) is the coordinating body for the UK and Ireland’s 24 medical Royal Colleges and Faculties. We ensure patients are safely and properly cared for by setting standards for the way doctors are educated, trained and monitored throughout their careers. Healthcare is complex and increasingly there are issues where a cross-specialty perspective is needed. It is the Academy’s job to ensure this work is done effectively and then acted upon by policy makers, regulators and clinicians. This unique position gives us a leading role in the areas of clinical quality, public health, education and training and doctors’ revalidation. The 24 medical Royal Colleges and Faculties are members of the Academy, bringing together the views of their individual specialties to collectively influence and shape healthcare across the four nations of the UK. More information can be found at [www.aemrc.org.uk](http://www.aemrc.org.uk)

The Academy welcomes the House of Lord’s Debate on the long-term sustainability of the NHS and social care and the previous report from the Select Committee. The Royal Colleges and Faculties which we represent have been concerned for some time about the unprecedented challenges the system faces. There are many issues which must be addressed for the system to become truly sustainable, but for the purposes of this briefing we will focus on: resources and funding, workforce, public health, integration and reconfiguration.

Whilst the Academy and Colleges will identify concerns and challenges where we see them, we are committed to working with Government, national bodies and local employers on identifying and implementing workable solutions to deliver a sustainable health and care system for the benefit of patients.
2. Resources and Funding
The current funding envelope for the health and social care system in England is insufficient. We do seem to be in a position where it is now generally acknowledged that more resources are required and this is a welcome development.

The case for additional resources
General improvements in health, as well as medical progress, have resulted in people living longer, but this in turn has also put additional pressure on the system. This pressure has not been met with an increase in financial support. In addition, both social care and public health services have faced budget cuts, putting NHS services under further strain. The growth in demand without an increase in the necessary funding has left health and social care providers with unprecedented deficits and crucial targets missed. According to the King’s Fund most recent quarterly report, more than one third of CCGs are forecasting an end-of-year deficit and around half of NHS Trust Finance Directors are forecasting a deficit.

The UK spends less of its GDP [around 7.4%] on healthcare than most other developed nations and so the Academy believes that there is scope to increase overall spending. The Office for Budget Responsibility’s projections in 2016 suggested that UK health services require a real-terms increase of £40bn by 2030. This amounts to a rise from 7.4% to 8.8% of GDP over the next 14 years and is a proposal the Academy supports. The Academy believes that the overall funding for health and social care should be funded through increased taxation – hypothecated or otherwise. Colleges and Faculties also believe that taxation on products where there is evidence that this will improve people’s health, such as minimum alcohol pricing and further levies on sugar and tobacco products could fund an increase in the health and social care budget.

How additional resources should be allocated
If there is general support for increased resources there needs to be debate about how those resources should be allocated to be most effective in securing a sustainable NHS and improvements in healthcare.

There will be many legitimate calls upon additional resources but it will be important for there to be clear purpose towards achieving the objectives of the Five Year Forward View (5YFV) which the Academy has consistently supported. Real investment must be made to support a shift to community and primary care delivered services and prevention. We have previously argued for priority resources to be made available to support social care and it remains the case that without a sustainable social care system the pressures on the acute sector will not be relieved.

The Academy works to support a sustainable system by tackling the waste seen in the NHS through changes in clinical practice. Choosing Wisely UK is a part of a global initiative which works with both patients and clinicians to reduce unnecessary tests, treatments and procedures. This is an ongoing project, overseen by the Academy which aims to create a cultural shift in demand for inappropriate care and was launched by drawing up a list of 50 treatments and procedures of questionable value. It is essential to tackle clinical variation and inappropriate interventions for reasons of quality as well as efficiency.
3. Public health and prevention
Almost four years after the publication of the 5YFV, there appears to have been little meaningful development; the ‘radical upgrade in prevention’ has failed to materialise. Instead we have witnessed a £200 million cut to public health budgets in 2015.

The future sustainability of the NHS will be predicated on tackling three key public health issues: obesity, particularly in children, smoking and alcohol consumption. If we do not tackle childhood obesity with the seriousness it deserves, the NHS will face an ongoing and long-term crisis. Reducing public health budgets which cover these areas is the ultimate false economy. The decision to water down the childhood obesity strategy suggests that the Government does not take prevention sufficiently seriously.

4. Workforce
There is consensus across healthcare professionals, employers and national bodies that the greatest challenge facing NHS organisations relates to workforce issues.

Workforce supply
There are significant workforce shortages across staff groups and the health and social care systems in the UK. Most specialties in medicine face staff shortages, the exact number of which changes from year to year. This problem is exacerbated by three factors. First, a general lack of supply with shortages of doctors, nurses and other allied healthcare professionals; secondly, the impact Brexit may have on the EU workforce and finally a growing problem of retention of staff.

The exact shortfall of any given specialty changes from year to year, but the most recent data from Colleges highlights the current shortages:
- In October 2017 29% of advertised consultant posts in emergency medicine were unfilled
- The Royal College of General Practitioners found in February 2017 that 38% of surveyed GPs said that they had at least one vacancy for more than three months
- The Royal College of Physicians of London’s Census 2016/17 found that 1,542 consultant jobs were advertised, but only 853 certificates of completion of training were awarded
- Royal College of Radiologists’ Clinical Oncology Workforce Census 2016 showed that 1 in 5 clinical oncology trainee posts went unfilled

Short and long-term solutions are required to address the workforce crisis. While we welcome the 1,500 additional medical student places announced by the Government this will take a number of years to flow through to the system and will in any case probably be insufficient to address the chronic shortages described above. To ensure that no specialty faces a shortage in any given year, as most currently do, the Academy advocates a strategy of modest oversupply. Significant over-supply makes little economic sense for the system or individual doctors, but we are currently witnessing the effects of undersupply on quality of care for patients and quality of life for clinicians.
Colleges do not believe we can decrease our reliance on staff from overseas until the investment in sufficient training places in the UK has borne fruit. Taking into consideration the 1,500 increase in medical school places, we are still behind what we need. As part of the interim solution, the Academy would like to see easier access to Tier 2 visas for healthcare staff from overseas and a significant expansion to the Medical Training Initiative (MTI), a scheme which allows doctors from across the world, particularly Department for International Development priority countries, to work and train in the UK for up to 2 years. The MTI benefits the NHS, the individual doctor and their country of origin to which they return after a fixed period. Alongside HEE and employers, the Academy and Colleges strongly believe it would be beneficial to the system to significantly increase the number of visas available (thus enabling the scope of the scheme to be widened) as well as the length of time they are able to work in the UK.

**Brexit**
Following the UK’s exit from the European Union, the Government must ensure there is sufficient flexibility in the immigration system to allow EU nationals to work in Health and Social Care. Over 161,000 EU citizens work in the sector and while Colleges welcome the recent agreement in principle to give the right to remain, we must ensure future EU staff are able to join the NHS post-29 March 2019. This would require a different approach to immigration which recognises the importance of staffing important sectors like the NHS, rather than individual earning potential. The Academy fully recognises that doctors from the EU will in all likelihood continue to be welcomed post-Brexit because of their highly specialised skills and expected contribution to the UK economy. However, they will be unable to operate effectively without a wide range of non-medical staff, particularly in social care.

**Multi-disciplinary working**
The Academy also believes that a more sustainable system can be supported through better development of multi-professional team work. It is vital that the NHS uses the skills and expertise of the full range of health professionals to the best level of their practice. Trained doctors, which are an expensive resource, should deliver care and services which only they are trained to do. Freeing up consultants and doctors in this way, utilises their skills more effectively and improves quality of care for patients. One way of achieving this is to develop and support Medical Associate Practitioners, advanced care practitioners and other similar roles. However, before these associate professions can be scaled up to become a key part of the workforce, they must be regulated.

**Retention**
Efforts to improve recruitment and supply of staff will be fruitless if we fail to address the significant retention issues facing the service. Workload pressures and a strong feeling of not being sufficiently valued are resulting in more staff choosing to leave health and care than we should expect. The position, of course, varies from area to area and across different groups but a sustainable NHS requires better retention of staff. This requires more imaginative and flexible approaches to employment and more attention being paid to staff health and well-being. It may be a truism that looked-after staff means looked-after patients but it is fundamentally correct.
5. Integration and reconfiguration

There is widespread consensus that greater integration between all parts of the system: health and social care, primary and secondary care, public health and mental health is urgently required to ensure sustainability. There is also a consensus that the whole system should shift its focus from internal competition to genuine collaboration. NHS England’s New Models of Care and Integrated Care Systems supports the development and implementation of integrated models in certain areas across the country.

However, there are a range of barriers which stop this from happening. The first, is that health and social care providers work to very different sets of organisational and financial drivers. There is also no powerful incentive to work together. The way in which we inspect and regulate the system must also change. The Care Quality Commission (CQC) basically inspects institutions rather than systems or pathways, and therefore does not reflect a patient’s journey and does not support collaborative and integrated working. There must be a shift from service silos to system outcomes. There are, however, pockets of good practice which the CQC should recognise as part of their inspections and assessment of quality, for example the accreditation and registration schemes available for specific services, many of which are supported and run by medical Royal Colleges and Faculties, which support integrated and collaborative working in their inspections.

A single capitated budget would support integration and collaboration between health and social care by joining all resources and care for a local population. This would support a move away from a disease-specific approach to care and put the patient at the centre of provision of care. This does require the cooperation of all providers and organisations in a local area and some local STPs are looking at ways this may work.

The Academy has more details on the issues outlined above and further position statements relating to the suitability of the NHS and Social Care system. If this is something you are interested in, please call Joan Reid on 0207 490 6819 or email joan.reid@aomrc.org.uk