BMA

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NHS England
Long Term Plan Engagement Team
Sent by email: england.ltp@nhs.net

28 September 2018

Dear Sir/Madam

Developing the long-term plan for the NHS

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. While the Association welcomes the opportunity to respond to NHS England's consultation on developing the long-term plan for the NHS, we have several concerns relating to the process of developing this plan. Including that:

- there is insufficient time to consider responses to this consultation before publication of the plan in November;
- there has been inadequate engagement with the medical profession to-date in developing the plan;
- the consultation is narrow in scope, seeking input on only a limited range of topics.

As well as responding to some of the specific topics set out in the discussion guide accompanying this consultation, we have therefore also included in our response recommendations on a range of other areas that our members believe hold significant potential for improving the way the NHS provides care over the next 10 years.

Please find enclosed the BMA's submission. Please do not hesitate to contact us for more information if required.

Yours sincerely

Raj Jethwa

Raj Jethwa
Director of Policy

BMA consultation response: Developing the long-term plan for the NHS

Summary

- With substantial and growing pressures on the NHS in England, a new long-term plan must secure a health service that can continue to deliver high-quality patient care and meet the changing health needs of the population.
- The NHS workforce plays a key part in delivering this. NHS England's long-term plan must set out clear steps for developing a well-staffed NHS with a culture in which staff are valued and supported to deliver high-quality patient care. We are not there yet. A recent BMA survey of doctors from all branches of practice highlighted:
    - the damaging impact of asking doctors to provide care without enough funding, doctors, other NHS staff, beds and equipment to meet the needs of patients;
    - that many doctors feel they are working in a dangerous and toxic environment, with a culture of blame and fear jeopardising patient safety and discouraging learning and reflection;
    - that poor lines of communication between primary and secondary care and lack of IT support is holding back efforts to encourage greater innovation and collaboration.
- NHS England must commit to meaningful engagement with clinicians as it continues to develop and implement its long-term plan. Doctors are best placed to understand what is currently happening at the frontline of the NHS and must be at the forefront of shaping its future.

The need for a long-term plan for the NHS in England is clear. Doctors have consistently highlighted the substantial and growing pressures facing the NHS. These pressures are reflected in recent performance data for the NHS in England: in the first seven months of 2018, there were almost 2.7 million emergency A&E admissions - a 6.6% increase on the first seven months of 2017; the number of people in England waiting for elective treatment is now over 4.3 million; and the number of consultations in primary care continues to rise. Increasing demand coupled with inadequate investment has resulted in spiralling workloads for staff across all parts of the NHS, difficulties in retaining staff – the lifeblood of the NHS – and stretched resources.

To better understand what is happening at the frontline of the health service, the BMA recently conducted a major survey of doctors from all branches of practice (see Appendix 1). The results highlight the reality of working in the NHS in England, where the situation is now so bad that it is threatening to compromise the quality of care that can be delivered to patients:

- four in five doctors say that a lack of resources is significantly affecting quality and safety in the NHS
- over 90% of doctors say they feel staffing levels in the NHS are inadequate to deliver quality patient care
- three-quarters of doctors say that financial targets still override patient care
- half of doctors report practising defensively because they feel there is a culture of blame

- ninety-five per cent of doctors say they are fearful of making a medical error, with over half fearing they will be blamed for errors due to pressures or system failings in their workplace;
- and - unsustainably - the majority of doctors reported that they are working over their contracted hours.

The BMA is therefore in the process of developing its vision for a health service that is caring, supportive and collaborative. We need a system that puts staff - those that deliver care every single day and night - at the heart of its commitment to high quality patient care. Against this background NHS England's long-term plan must secure a health service that can continue to deliver high-quality patient care into the future and set out clear steps to help develop an adequately resourced and well-staffed NHS with a culture in which staff are valued and supported

Alongside this, increased funding is crucial to create a safe, future-proof NHS. Although recently announced funding increases for the NHS are welcome, future projected spending remains below what the BMA and many policy experts believe is needed. Leading EU countries such as France and Germany continue to spend significantly more on health than the UK, even accounting for this new money. While there are a number of areas in which investment is required, the BMA's briefing paper on the NHS funding settlement, highlighted the importance of investing in:

- **Workforce:** With workloads rising and doctors' pay having fallen by 22% over the last decade, staff morale is low, and recruitment and retention is a key challenge for the NHS. In a recent BMA survey more than 80% of doctors said that individuals are encouraged to take on the workload of multiple staff. Brexit will only make matters worse. The period of falling real pay must end now and the government must start listening to a truly independent pay review body, restored to its original purpose.
- **Public health:** £550 million is required to reverse real-terms cuts to the public health grant in England since 2015/16. Lack of investment in prevention threatens to undermine the long-term sustainability of the NHS.
- **Primary care:** General practice has faced a decade of underinvestment at a time when patient consultations are increasing, the population continues to grow, and patients are living longer with more complex health needs. The BMA is calling for a minimum of 11% of the total NHS budget to be invested in general practice.
- **Capacity in secondary care:** Funding must increase capacity in line with rising demands on hospitals to ensure there are enough staff, and that those staff have the resources to do their job well. Currently this is not the case. The number of beds in the NHS in England, for example, has fallen (6,000 fewer beds since 2014/15), leaving patients with long waits for operations, and secondary care staff to try and cope during the worst winter on record.
- **Mental health services:** To achieve commitments to parity of esteem there must be increased funding for mental health services to more closely match the burden of disease. Mental ill-health accounts for 28% of the total burden of disease in England yet currently only accounts for approximately 13% of CCG spending.
- **Capital budgets:** Over recent years funding for capital investment has been reallocated again and again to prioritise day-to-day running costs. The new funding announced does not cover capital investment. The long-term plan must ensure money is available to invest in buildings and equipment, so patients can be treated safely, and doctors have the equipment they need to do their job.
- **Social care:** The need for social care reform remains urgent. The BMA welcomes the government's commitment to publish a green paper on social care this year. It is crucial that

this includes a long-term funding settlement, and that proposals are fully aligned with the long-term plan for the NHS.

Doctors work in the service every single day, they know where funding is required to improve patient care. It is therefore vital that doctors are involved in decisions about where funding is spent. As highlighted in the letter accompanying this submission, we are concerned that there has been a lack of engagement to-date on the development of the long-term plan. The consultation discussion guide also has a narrow focus, and there are wide range of areas not included, such as the role of secondary care, service integration and collaboration. It is, therefore, vital that this consultation represents the start of a process of continued engagement. NHS England and other responsible bodies must commit to meaningful engagement with clinicians as the long-term plan develops, and proposals are implemented. To support this the BMA has developed a set of principles which form the foundation of good medical engagement.

The following sections set out some of the key areas that must be addressed in a new long-term plan, to help move towards an NHS that **values doctors, supports them to deliver safe, high-quality care, and is able to meet the changing health needs of the population**.

1. Promoting an environment and culture that delivers safe, high-quality care

Key message: To support the delivery of safe, high-quality care the NHS must invest in developing a genuinely supportive learning environment for staff, in which doctors feel safe raising concerns, and where bullying and harassment is not tolerated.

In meeting the challenges the NHS faces over the next 10 years, it is vital that long term planning includes serious consideration of how to promote a culture that supports the delivery of safe, high quality care to patients, supported by adequate funding. As highlighted in the BMA's 2018 report on working in a system under pressure (see Appendix 3), chronic underfunding and workforce shortages put quality of care and patient safety at risk, and contributes to a situation in which doctors are fearful of making a medical error. This is borne out in our recently published member survey, in which nine out of ten doctors (89%) say one of the main reasons for making errors is pressure or lack of capacity in the workplace. Creating a positive culture and environment that delivers safe, high-quality care requires sufficient resourcing, safe staffing levels and support for the wellbeing of doctors and other healthcare professionals (see Section 2). It also depends on developing:

- a learning culture in which: doctors feel safe to raise concerns; their learning and development is supported; and bullying and harassment is not tolerated
- proportionate, streamlined regulation that compliments a learning culture and can recognise the challenges presented by wider, systemic failures when assessing an individual's fitness to practise
- an NHS based on working collaboratively across the interface between primary and secondary care as one profession.

In relation to whether a learning culture exists within the NHS, responses to the BMA's member survey show that in England:

- nearly half of doctors (47%) said they are often fearful of making a medical error in their daily workplace and over half (56%) say they are more fearful now than they were five years ago
- three quarters of doctors are cautious about recording reflections for fear it could be used against them, with junior doctors expressing particular concern
- half of doctors (49%) said they do not have the time to learn and develop professionally in their role – when we know learning is key to future service improvement
- two-fifths of doctors said that bullying, harassment and undermining is often or sometimes a problem in their main place of work.

Supporting staff to deliver change and demonstrating that the NHS is the world's largest learning organisation is a commendable aim. As our evidence above suggests, there is a long way to go in realising these aims. As well as addressing deep seated issues related to funding and the workforce (see section 2), the NHS must also work hard to recover the trust of the medical profession following the recent ruling in the case involving Dr Bawa-Garba. As many agree, this case has had a chilling effect and set back any progress that may have been made following the 2013 Berwick report, *A promise to learn – a commitment to act.*[1]

Tackling the persistent culture of fear and blame in the NHS

A fundamental shift in the culture in the NHS is needed, involving the creation of a genuinely supportive learning environment for staff. This is essential to patient safety. Doctors need to feel confident to raise safety concerns; for their written reflections to be legally protected; and be allowed sufficient time for professional development (see Section 2). The NHS must build a strong culture of engagement allowing doctors and other staff to actively contribute to maintaining and improving the quality of care; and supporting staff who are victims of bullying and those who are responsible for resolving incidents so that these behaviours are dealt with effectively and through the appropriate process. The HSIB's (Healthcare Safety Investigations Branch) development of safe spaces for staff raising concerns about patient safety issues, is a valuable step in creating a learning culture in the NHS, and must form part of a wider cultural shift towards supporting and valuing staff.

A change in approach from those who regulate the profession and health services

This needs to start with a clear acknowledgement that errors may result from the environment in which a doctor works rather than being the fault of an individual. We welcome the GMC's commitment in the aftermath of the Dr Bawa-Garba appeal to explore how a human factors approach can inform its fitness to practise investigations. We also need action to reform the current inspection regime in primary care, which is reinforcing an unsupportive culture of blame.

Collaborative working across primary and secondary care

It is widely recognised that better joint working would help improve outcomes, efficiency and patient experience across the NHS, particularly between primary and secondary care.

In the BMA's recent member survey, a high proportion of doctors in England (76%) said that there are organisational barriers, unfunded workload shift and compromised quality and safety of patient care as a result of problems at the interface between primary and secondary care. In England, there is strong appetite amongst doctors an improved culture of collaboration and for finding better ways to collaborate across primary and secondary care. It is particularly concerning that, in England, just 8% of respondents to the survey are happy with current arrangements, suggesting that this needs urgent attention from policy makers.

In the future primary and secondary care clinicians should face fewer barriers to effective joint working across traditional settings. The BMA's findings show support for a range of potential solutions in England, including better data sharing, shared pathways, system-wide incentives to work together more closely and protected funding for schemes designed to promote joint working. These ideas will need further development and testing, as well as recurrent funding to support their sustainability, but provide a starting point for further work in this area. We are also calling for legislative change to end competition and fragmentation in the NHS, and support collaboration (see Section 8).

2. Ensuring a workforce fit for the future

Key message: Long-term planning must ensure the NHS has adequate numbers of trained, motivated and healthy staff, with the right skills delivering care in the right places.

We agree with NHS England that the workforce must be a key focus to ensure the success of its long-term plan. The NHS is facing pressures all year round and doctors are increasingly doing more complex and intense work in environments that are woefully under-resourced. As highlighted in the BMA's response to Health Education England's draft health and care workforce strategy (see Appendix 2), the health service is facing severe medical workforce shortages that will not be corrected for years to come. Despite an increase in medical school places from 2018/19, it takes more than a decade to train a senior doctor. This means that any impact on the workforce will not be seen in the immediate future. Working under such conditions without adequate capacity or support puts both doctors and patients at risk. These pressures are key drivers of the dissatisfaction with working life for doctors and other NHS staff, which in turn impacts on morale, wellbeing, the quality of patient care and the long-term sustainability of the NHS. To move towards an NHS workforce that is fit for the future, the BMA has identified the following priority areas.

Better workforce planning supported by adequate data

It is vital that the appropriate infrastructure is put in place swiftly to enable robust and frequent workforce planning. This will ensure the future healthcare workforce needed for NHS England's long-term plan is sufficiently staffed and has the flexibility to deliver care in different locations. To support this, there must be accurate data to conduct future workforce projections and the planning and commissioning of training and educational needs.

Safe staffing levels and tackling shortages

It is critical that patients are cared for by the right staff, in the right numbers and at the right time, which is why the BMA is calling for the creation and enforcement of safe staffing levels across the NHS. Ultimately this means that the NHS must address medical workforce shortages, including improving both recruitment and retention of doctors, if it is to continue to meet demand. Given that current medical workforce shortages will not be corrected in the near future - in part because of the time it takes to train a senior doctor - the NHS must consider other strategies to support doctors to deliver the best patient care. This must include investment in retaining experienced staff to increase workforce capacity (see Section 3).

Other healthcare professionals cannot replace the work that doctors do and should not be seen as a solution to a professional supply problem, but the expanding multi-disciplinary doctor-led team can help address current workforce shortages. In the short to medium term, investment is also required to mitigate the impact of rota gaps and unfilled vacancies on service provision and doctors' workload and wellbeing. The BMA has developed a set of practical recommendations for doing this.

General practices must also be given the flexibility to set safe working limits. In the BMA's recent member survey, 91% of GPs said that difficulties retaining staff are driven by excessive workload pressures. Unmanageable and unsafe workload is the primary reason behind doctors leaving general practice and is leading to a series of serious issues including practices closing to new patient registrations, practices closing altogether, GP burnout and patients being put at risk of receiving unsafe care. In Saving General Practice the BMA have set out the steps required to control workload and safeguard the future of general practice (see Section 5).

International recruitment

If the NHS is to continue to provide safe and reliable healthcare services, and to remain globally competitive in the life sciences, it must be able to recruit and retain doctors and other staff from the UK, the EEA and elsewhere in the world. International staff play a key role in delivering the service

already. Around 139,000 out of the 1.2 million NHS staff in England currently report a non-British nationality. This is 12.5% of all staff for whom a nationality is known, or one in every eight[a].

Difficulties facing the NHS with doctors' recruitment and retention are expected to exacerbate following Brexit; a BMA survey of EEA doctors working in the UK found that more than four in ten are considering leaving following the EU referendum result. Combine this with the fact that pay for doctors in some other countries in the EU and overseas can be much higher than the UK (which is exacerbated with the recent fall in the value of the pound), workforce shortages are expected to worsen. The BMA is therefore calling on the government to implement a flexible immigration system which facilitates the entry of doctors, nurses and other key health and social care staff to the UK, and enables UK-trained doctors to work in the EU should they so choose.

Improving health and wellbeing of NHS staff

Sound staff health and wellbeing benefits the NHS by improving staff engagement, reducing costs associated with turnover and absence, and improving patient outcomes. At a time when the NHS is under-resourced, over-stretched and facing significant recruitment and retention problems, it is even more vital that the health and wellbeing of hard-working NHS staff is prioritised.

A forthcoming report by the BMA on staff wellbeing, to be published in October, will show the current problems doctors are facing accessing support services and will call for investment in support services, including occupational health, to tackle ill-health among the medical profession. This applies equally for employed doctors and for GPs (as well as practice staff), who currently do not have access to a proper occupational support service, a situation that must be addressed. Investment is also required to improve facilities and reduce fatigue. The BMA has developed a fatigue and facilities charter, which we urge all trusts to sign up to. The report will also highlight that a comprehensive approach to health and wellbeing requires good leadership and a culture of care that recognises the contribution that staff health and wellbeing makes to delivering NHS core objectives.

An improved training experience for doctors

Medical education, training and development must evolve alongside the population's health requirements and ever changing technological practices. They should therefore represent a central strand alongside the new long-term plan for the NHS. All necessary training and education opportunities for doctors and staff within the NHS should be consistently funded and organised, not lost to service provision demands, and be available to staff throughout their careers. This will ensure that the future needs of the service over the next 10 years are met. To support this, doctors who work as trainers should have protected time to do this.

Flexible working options

With the changing demographic of the workforce and the rising retirement age it is essential that specific consideration is given to flexible working for doctors. Otherwise we risk increasingly poor levels of retention. BMA research shows that specialty choices are already heavily influenced by perceived control over workload and opportunities to work flexibly. While trusts and practices are short of staff and funding, there will continue to be pressure for staff to work longer than rostered hours and staff will not be able to take up flexible working options. NHS England must commit to working with employers to support flexible working.

[a] https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7783

Widening participation

NHS England's long-term plan must recognise that medicine is still behind other professions in attracting students from more diverse and lower socio-economic backgrounds. Although national and local initiatives have now been established to widen access to medicine, there remains more work to be done to join up these initiatives. Further consideration needs to be given to the range of factors that prevent people from poorer/more diverse backgrounds studying medicine – including financial and cultural factors, as well as academic constraints. Over the next 10 years the service must become more representative of the people it looks after.

3. Valuing doctors

Key message: Unless meaningful steps are taken to address the real terms cuts in doctors' pay over the long-term, the negative impact on doctors' morale, recruitment and retention will only exacerbate. Inaction on pay would make any long-term plan likely to fail.

We welcome recognition by NHS England that there is no NHS without the dedicated, professional and compassionate staff who are there to provide care. Doctors want to see an NHS where workloads are manageable, and they can provide safe care in a supportive environment (see Section 1). To support this, and to ensure the best and safest care can be delivered to patients, investment in the workforce is required. This must include steps to address the significant drop in real-terms earnings over the past decade. Broadly speaking, doctors' pay has been cut in real terms by around 20% since 2008. The latest pay increase announced in the summer of 2018 led to yet another drop in real-terms earnings. When coupled with pension and tax changes in recent years, the impact on recruitment and retention is real and growing.

As highlighted by the BMA, doctors have seen the greatest fall in gross hourly earnings of all pay review body occupations and doctors' recent capped pay awards of 1 per cent were about 60 per cent less than in the wider economy. Due to this, more and more doctors are choosing to retire early or leave the NHS (to work privately or move abroad), exacerbating the workforce crisis with fewer people choosing medicine as a career. Those who choose to remain working in the NHS are being spread more thinly, covering extra services and working longer hours, in turn affecting their wellbeing and morale. This not only has a negative effect on the doctors themselves, but also on patient care and outcomes. The NHS is also spending more on using locums to plug gaps in services.

Through appropriate remuneration and appropriate terms and conditions for all doctors, the NHS will save in the long run through long-term staffing solutions that will improve recruitment and retention, reduce absence and lead to happier, more productive staff. At the moment, the opposite is happening. The NHS Staff Survey, for example, showed that staff are increasingly taking sick leave because of work related stress thus putting further pressure on employers and the service.[2]

The failure of the government to implement even the insufficient award recommended by the DDRB, has had a significant impact on doctors. It means not only have doctors not received the pay uplift they require, but they have also lost confidence in the DDRB and the value the government places on NHS doctors. As young people become more aware of the growing threats to doctors' pay and working conditions, they are less likely to want to train to join the profession. BMA data collection on university applications indicates this may have already started to happen, with fewer people

applying to study medicine over recent years. The current pension taxation system is also having an impact on retention, with senior doctors being incentivised to leave the NHS prematurely.

Looking ahead, we must have a mechanism to address the real terms cuts in doctors' pay over the long term. The BMA is seeking investment in contracts for doctors working across all branches of practice, to ensure they are able to deliver their full potential; work in a supportive and caring environment; have job reward; and deliver safe, quality care and with fair remuneration. This will improve recruitment and retention and help address workforce challenges (see Section 2).

Consultants

The BMA is seeking increased investment in the consultant contract to recognise and respond to the sustained pressures of the health service in the context of a decade of declining pay. Within an increased pay envelope, we aim to secure a contract which delivers a flatter two-point scale, which is better suited to a career average pension scheme, while retaining internationally competitive starting and final salaries that appropriately remunerate consultants for their senior role within the NHS.

Furthermore, in response to recent changes to pension arrangements which have, for many of our members, rendered continued membership of the NHS Pension Scheme costly and untenable, we are seeking agreement with HM Treasury around a range of potential pension flexibilities, such as the recycling of a proportion of employer pension contribution into individual pay. We are also seeking to develop a suite of safeguards that provides protections more relevant to the way consultants work in a modern health service, including robust provisions for shift workers and improved compensatory rest. This will enable consultants to preserve and improve their work-life balance – crucial to ensuring the care they deliver is safe.

Any contract reform would seek to foster an environment where education, training, innovation and research by both NHS and academic consultants can flourish. In negotiations with NHS Employers, we intend to develop a performance pay scheme which is more readily accessible, rewards consultants based on collaboratively agreed objectives, and is viewed by all members as equitable and transparent.

These changes to pay and performance awards will mean that reward is tied to activity and excellence thus promoting innovation, staff development, quality of care and efficiency, which are all key components of a better NHS. With a growing population in need of care, the NHS cannot stand still on the way it provides services. We need to incentivise staff to make the service work better. Consultant contract negotiations, based on a something-for-something deal, need to be properly funded to secure better services across the week. We would recommend that NHS England gives particular thought to the steps required to prevent consultants and patients being placed under intolerable pressure to take on increasing workloads due to staffing gaps (see Section 2), and through bullying during job planning.

General practitioners

The BMA is seeking increased levels of financial support for general practice, to allow expansion of the primary care workforce (see Section 5). We are also seeking resolution of long standing problems around 'last partner standing' situations, and wider premises issues, as well as issues related to pensions (similar to those mentioned for consultants). Resolution of these issues would not only relieve pressure and show the NHS' commitment to its staff but would also serve to encourage GPs to stay in the workforce for longer, rather than seek early retirement – crucial given current pressures on the service.

The announcement of a state backed indemnity scheme for GPs, similar to that provided for hospital staff, is an essential and important change and was welcomed (see Section 5). However, this stands to be undermined if GPs see a negative impact on their pay to fund the scheme, which would fossilise the inequity between GPs and other doctors and therefore not resolve the current GP workforce crisis.

Given the vital importance of clinicians in ensuring a research-active NHS, it is extremely disappointing that, having agreed to take on the honorary contracts for senior academic GPs in 2012, it has taken NHS England so long to agree and issue honorary contracts. NHS England must commit to supporting this key group of medical academics and ensure that they have full access to local clinical excellence awards.

Specialty and Associate Specialists

NHS England must create an environment in which SAS doctors are valued, recognised for what they do, and able to fulfil their potential. The BMA would like to see increased opportunities for career progression for SAS doctors through the reopening of the AS (Associate Specialist) grade at the national level, by ensuring that SAS doctors who return to training are not penalised by facing substantial pay cuts, and through the allocation of increased funding for SAS doctors so that their remuneration reflects the vital role they play within the NHS, and addresses substantial issues surrounding recruitment and retention.

The BMA strongly supports and recommends the reopening of the AS grade at the national level. The closure of the AS grade is a key limiting factor to the contribution of SAS doctors and exacerbates recruitment and retention issues, as it removes a key mechanism through which SAS doctors were able to progress to senior roles. The BMA, DDRB, NHS Employers and NHS Providers have all acknowledged that there is a persistent problem pertaining to low morale and a feeling of being undervalued among SAS doctors. Many Trusts are now reopening the grade locally in order to deal with workforce shortages and address issues of low morale.

The BMA also believes that increased funding for SAS doctors is vital in order to retain doctors and address workforce shortages; the DDRB's 2017 report noted that SAS doctors showed "stubbornly high dissatisfaction with rates of pay" and a BMA survey in 2017 showed that 71% of SAS doctors reported SAS vacancies where they worked. With pay stagnating after 17 years of work, SAS doctors face a long career ahead of them with limited opportunities for progression, and the 2016 terms and conditions of service for junior doctors have exacerbated this problem, as SAS doctors who return to training are no longer pay-protected in most specialties.

The NHS is currently failing to take full advantage of this group of doctors. With investment and recognition through the AS grade, an increased pool of fully trained and motivated doctors who cost less than consultants will be available to deliver high quality services to the NHS. This is a clear win-win for staff and the service.

Junior doctors

Junior doctors are still angry after a new contract was introduced without their agreement nearly two years ago. When the contract was negotiated the BMA committed to commission jointly with NHS England a review of the efficacy of the contract in 2018, and we are hopeful that this will allow us to address trainees' outstanding concerns, so it can be accepted by our members and the dispute ended. To do this, it is vital that the government commits the necessary resources to deliver real improvements to the contract, including ensuring that any savings made as a result of the new

contract are reinvested back into the pay envelope through negotiations with the BMA. In particular, it is vital that evenings and weekends are remunerated fairly and in a way that recognises the impact unsocial hours working has on junior doctors' working lives. Similarly, the review must ensure that less than full time trainees do not suffer any financial detriment compared with their full-time peers under the new contract; and that safety limits and rest requirements in the contract are preserved and strengthened.

4. Supporting health throughout the life-course

Key message: Meeting the changing health needs of the population, and reducing health inequalities, requires investment both within and outside the NHS.

An upgrade in prevention and public health

Prevention has been a key theme in past NHS plans and action must now follow words. Despite strong previous commitments, including in the Five Year Forward View to achieve a 'radical upgrade' in prevention, this has only translated into limited action. Yet, the NHS has a vital role to play in preventing ill-health. As one of the largest employers in the world and a trusted source of health information, the NHS is arguably uniquely placed to prevent ill health, promote and support healthy behaviours. Creating environments that support people to quit smoking is one example of the preventative approach the NHS can take. One in four patients in acute settings are smokers, as well as many of the staff who work for the NHS.[3]

A focus on prevention needs to be supported by investment, both within and outside the NHS. In recent years, significant cuts to local authority public health funding are leading to reductions in vital public health services and impacting patient care. Since 2015/16 spending on public health services has been cut by around £550 million in real terms[4]. This is compounded by cuts to local authority functions that influence the wider determinants of health, such as children's services, housing and the environment. The NHS is seeing the impact of these cuts first-hand. The BMA's 2018 briefing, Feeling the squeeze, documented how budget reductions are leading to unacceptable variation in the quality and quantity of public health services available to the public, increasing pressure on the NHS and ultimately requiring more NHS funding for treatment in future years rather than addressing the underlying causes of disease.

The disproportionately low spending on prevention and public health activities compared to treatment services must be addressed by Government, the NHS and local authorities to secure the long-term sustainability of the NHS. We need to move away from short term investments towards a care model of ill-health prevention. This means improving population health and reducing health inequalities must become a central goal of future NHS planning at a local and a national level and be translated into clear evidence-based action (see below). Comprehensive regulatory, legislative and educational measures must also be introduced at a national level to tackle the key lifestyle factors driving ill-health, as highlighted in the BMA's recent paper Prevention before cure: securing the long-term sustainability of the NHS.

Health inequalities

Key to preventing ill-health is addressing the wider societal factors that influence people's health behaviours. As highlighted in the BMA's 2016 report on Growing up in the UK, the health and

wellbeing of a child born in the UK still remains significantly dependent on their social position, with the UK continuing to lag behind many other European countries on a range of health outcomes for children and young people. Latest data show that males in the least deprived areas of England still live 9.3 years longer than males in the most deprived areas. For women the figure is 7.3 years, as highlighted in PHE's 2018 annual health profile.[5] This has wide-ranging consequences for health. The gap in years lived in good health between the most and least deprived areas of England is even starker, at around 19 years for both males and females.[6]

While the NHS itself cannot change all wider societal factors that lead to poor health, it has a role to play in addressing health inequalities. For example, the NHS can help to improve patients' health literacy, provide links to non-medical sources of support within the community (including through social prescribing) and develop local strategies to empower vulnerable groups in accessing health services. This should be underpinned by a 'health in all policies' approach, which would commit all government departments and public bodies to explicitly consider health in all policymaking. The core principle of the NHS is that it provides comprehensive healthcare for all, free at the point of use. Deteriorating quality measures and increased rationing are likely to further exacerbate inequalities in health outcomes.

Mental health

We agree that improving mental health should be a clinical priority for the long-term plan. Across the UK, a severe lack of resources has meant that people of all ages with mental health problems have faced significant challenges in accessing the care they need. Too often people receive little or no support, face long waits for treatments, or are placed in hospitals far from home. This has led to a vast amount of unmet need, substantial levels of preventable morbidity and avoidable deaths. There are a range of actions required to improve this situation, which the BMA recently set out in our vision for mental health.

Over the next 10 years, the overarching priority should be increased funding for mental health services to more closely match the extent of disease from mental health problems, which affect one in four people in England. Steps must also be taken to ensure that mental health funding is only spent on mental health services, particularly in areas where provision is poor, by ringfencing where necessary. A long-term plan must address the following gaps in service provision:

- The provision of **perinatal mental health services**, despite some recent improvements, remains far from optimal. Commitment to further investment are required, particularly when funding ceases to be ring fenced from 2019 onwards.
- **CAMHS (Children and adolescent mental health services)** are also under significant pressure, and struggling to meet demand, with concerns that funding commitments made in 2015/16 are not having the intended impact on frontline services.
- There are indications that **psychological therapies in secondary care** have been deprioritised, with data published earlier this year by the BMA indicating that just over a quarter of CCGs and only half of mental health trusts are increasing their real-terms spending on psychological therapies. As highlighted by the BMA, this is leaving people who are too ill for IAPT (Improving Access to Psychological Therapies) without the support they need.
- **Access to metal health support in primary care:** The BMA's progress report on the GPFV (GP forward view), highlighted concerns from GPs that, despite commitments, there is often limited access to mental health therapists in primary care.

- Steps should be taken to address the **physical health needs of people living with mental health problems**. As highlighted in the BMA's 2014 report 'Recognising the importance of physical health in mental health and intellectual disability' this should be achieved by better integrating intellectual disability, mental health and physical healthcare.
- In recognising the social determinants of mental health, a long-term plan for the NHS should be supported through a w**ider commitment from government to promoting public mental health**.

The BMA is a signatory to the Equally Well 'Charter for Equal Health', which sets out broad principles for supporting the physical health of people with mental health conditions, principles which must be reflected in a long-term plan for the NHS.

Healthy ageing

It is projected that the population over 75 in the UK will double in the next 30 years, and that by 2040 nearly one in four people will be aged 65 or over.[7] This has been driven by improvements in life expectancy over recent decades – though there are concerns that increases in life expectancy in the UK have recently stalled.[8]

The BMA's 2016 briefing, Growing older in the UK sets out a range of actions that need to be implemented to address the health needs of an ageing population: healthcare systems should focus on multiple conditions; better co-ordination between health and social care services; improved access to services and the delivery of 'person-centred' care – taking into account individuals' needs, circumstances and preferences. Action in this area needs to extend to more than just the absence of disease. It should look to support the ability and opportunity for people to play an active role in society and shape their own lives as they grow older. It is crucial that the Government's expected green paper on social care includes a commitment to a long-term social care funding settlement, and that proposals are fully aligned with the long-term plan for the NHS.

End of life care

We welcome NHS England's focus on improving care at the end of life. Throughout 2015 the BMA undertook a major project seeking views from doctors and the public on their experiences, views and perceptions on end-of-life care. From our findings we identified three key areas where improvements should be made to support discussions about wishes and priorities for end-of-life care:

- There should be high-profile public information campaigns encouraging people to think about, and make known, their wishes regarding end-of-life care: it was clear from speaking to members of the public through our project that most people did not think or talk about end-of-life care, and found such conversations uncomfortable and relatively taboo. If the public is not supported and encouraged to consider their wishes for end-of-life care, it will be nearly impossible to ensure open and honest conversations with healthcare professionals about how to put them into place.
- Caring for dying patients should be a crucial element of training for all medical students and doctors, embedded at all stages of their careers: doctors involved in our project highlighted some anxieties about recognising when patients are approaching the end of life and initiating conversations with patients and carers about advance care planning. To ensure that people are offered the opportunity to have conversations about their priorities and wishes for care, we must ensure that doctors are confident and skilled at having these discussions.

- Clinicians must be supported by colleagues, managers, and systems which allow them to have conversations about the end of life appropriately and sensitively: conveying information about terminal illness and options for care in an appropriate way; ensuring that information is understood; and managing these conversations sensitively takes time. This requires current pressures on workforce, workload and doctors' time to be addressed.

5. Supporting primary care

Key message: In response to rising pressure and growing concern over patient safety, urgent steps are required to safeguard the future of general practice.

NHS England has rightly recognised that with a growing population and more patients with complex conditions there are increasing pressures on primary care services. GP services are struggling to provide enough appointments, with consequential delays for patients to see a GP.

To respond to these rising pressures, it is widely recognised that urgent steps are required to safeguard the future of general practice. In 2017 the BMA published Saving General Practice (see Appendix 4), which sets out in detail the steps we believe are required to keep general practice from collapsing. This includes action in the following areas (see also Sections 2 and 3):

- **Recurrent and sustainable funding and resources**, including a minimum spend of 11% of the total NHS budget must be invested in general practice - a funding deficit that is currently estimated at £3.7 billion.
- **A workforce strategy that is recurrently funded** to enable expansion of a collaborative multi-disciplinary general practice and community workforce working both in practices and within localities. This would help manage increasing levels of workload and would support the provision of a more efficient and effective service for patients.
- **A sustainable, long-term indemnity package for general practice** that covers all GPs on the national performers list and all staff providing NHS general practice services both in and out of hours (OOH).
- **Enabling practices to manage their workload** to deliver safe services and empower patients and carers as partners in care. This should include giving general practices the flexibility to set safe working limits.
- **The retention of a national core contract** for general practice that provides a high-quality service for patients.
- **Premises, IT infrastructure and administrative support** to enable the delivery of quality care.

NHS England has recognised digital innovation and IT as key enablers of improvement (see Section 6). This should be focussed on supporting clinicians to deliver care to patients. General practices currently struggle with slow and outdated IT systems that cause delays in consultations and difficulties with data sharing. In Saving General Practice the BMA has set out several steps required to improve IT infrastructure in primary care.

The way primary care is arranged and organised is likely to change over the coming decade (see Section 7) but the key component of primary care, General Practice, must be supported. By ensuring GPs can do their jobs properly with adequate resource, any move to new structures will be more likely to succeed. General Practice is the best foundation on which to build, or any change will falter, and money will be wasted on fragmented change.

6. Benefiting from technology and promoting research and innovation

Key message: The NHS must ensure medical research and innovation is at the heart of what it does, and that new technology supports the delivery of high-quality patient care.

Digital innovation and technology

As recognised by NHS England, it is vital that digital and technological innovations are focused on supporting improvements in the care that can be provided to patients. Over the next 10 years it is crucial that IT infrastructure finally becomes fit for purpose and interoperable to enable staff to work across organisations easily, and to improve their working lives. Requiring staff to have multiple log-in details or to use systems that do not work with each other is likely to be a continuing barrier to staff effectively working across different settings and may, in the worst cases, endanger patient safety. This will take investment in current infrastructure and a requirement that all future software is interoperable with other systems. The BMA is currently analysing the impact of IT and the use of digital technology on clinical practice and we are calling for the development of minimum standards for IT and digital infrastructure. We have also highlighted in our report on Saving General Practice the investment required to support improvements in IT infrastructure in primary care (see Section 5).

Digitalisation, artificial intelligence, genomics, big data, robotics, virtual reality, tissue engineering and 3D printing are all already in use in the NHS, as well as countless other innovative tools. It is very likely that in the next 10-20 years the use of these tools will increase further, but we are not currently preparing our medical workforce for these changes. During their education and training, the doctors of the future must be exposed to these emerging technologies, so they are familiar with them when they start providing patient care. This is particularly important in an age where patients have greater access to information about their treatment, and treatments that are available or in development. Medical schools are well positioned to provide this exposure, which in the long term will significantly benefit doctors and patients. In addition to this ongoing training in new technologies is required for the existing NHS workforce (see also Section 2).

Promoting research and innovation across the NHS

Rather than being a niche topic on its own, medical research should be at the heart of all that the NHS strives to do. We know from the *2013 Keogh review on hospital deaths* that ensuring that staff have an understanding of and are engaged in research, helps ensure high quality care for patients.[9] We also know that doctors yearn for a better work-life balance and that the intellectual challenge of research in primary and secondary care can help provide that for them and help lengthen careers, which is to the benefit of an over-stretched and under-staffed health service.

The BMA, therefore, welcomes NHS England's intention to - over the next 10 years - make the NHS the best place in which to undertake research and to encourage, support and involve more patients in research in general practice and in hospitals.

Enabling innovation

Innovation - the identification of new treatments and the development of new procedures - is at the heart of what it means to be a doctor. The best mechanism to advance medical science is through well-regulated research and clinical trials. However, we recognise that it can be necessary for

doctors to explore non-standard treatments with their patients and innovate outside of a research context. The current law allows doctors to innovate provided they can show their actions were supported by a reasonable body of medical opinion (the 'Bolam Test') and are logical.

To ensure the NHS capitalises on these innovations as much as more formal research, it is vital for the findings from individual instances of innovative practice to be disseminated to other doctors and researchers. It is crucial, for example, that where any instances of non-standard practice have occurred, the experiences of doctors and patients are shared. This generates an evidence-base to inform future research studies. The Access to Medical Treatments (Innovation) Act 2016 provides a requirement that the results of innovative treatment are recorded in public record. We are keen to work with the Government on how this may best be implemented, and the contents shared with relevant NHS staff. NHS England could play a key role in that respect.

Encouraging participation in research

NHS England should continue to support the use of data for research and inform patients about the importance of pseudo-anonymised data for research and thus care. It should encourage innovative ways of identifying potential research participants, such as registers of interest. NHS England, hospitals and GPs have a role in informing patients about medical research; about the appropriate use of their medical records, and in facilitating their participation in medical research. It is essential that patients and carers are provided with sufficient information to make an informed choice. Those undertaking research must ensure that patients have a clear understanding of what their participation will involve including the purpose of the research, the data that will be used, who will have access to the findings and how the results will be disseminated.

NHS England must also take an active role in ensuring appropriate information and resources are provided to GPs, trusts and patients. GPs are dealing with an increasing workload with falling resources and there must be flexibility in terms of the level of their involvement in facilitating participation in research.

Supporting research in topics that have traditionally been under-examined

For NHS England to achieve its ambitions in this area, it is vital it works with other bodies, particularly HEE, to ensure that a wide range of NHS staff have the training that provides and supports research skills and capabilities. It is primarily through the development of the research skills of clinical staff that research activities in general and in 'under-examined' areas can be enhanced. This will also require working with universities and other higher education institutions and the Department of Business, Energy, Innovation and Skills to ensure that there are the academic posts and research funding available to support activity in these areas. Worryingly, the Clinical and Health Fellowships Survey produced by the Medical Research Council and Medical Schools Council in 2017 demonstrated a decline in the number of mid and late career fellowships since 2009.[10]

A further positive activity would be the enhancement and greater protection of the time of NHS clinical staff that is devoted to research activities. We suggest that NHS England works with NHS Employers on the achievement of this outcome.

Genomic medicine

NHS England highlight genomics as a priority research area. The processes involved in genomics are advancing at great speed and offer both great promise in medicine as well as a range of significant

risks. In healthcare, the techniques could, for example, lead to significant advances in the treatment of inherited conditions. There are risks, though, and the modification of human and other genomes is an ethical issue as the outcomes may alter characteristics in ways which are unacceptable politically or ethically. There are also serious issues regarding consent and monitoring with regard to genomics. A key activity, therefore, should be ensuring patient awareness of and consent to what is being proposed.

7. Engaging with doctors on service transformation

Key message: Engagement on the transformation of the NHS must be a principal element of any long-term plan for the health service.

We welcome recognition from NHS England that the success of the long-term plan requires ongoing engagement with stakeholders, staff and patients. The link between good medical engagement and better outcomes and reduced risks to patient safety is widely evidenced and acknowledged, and the BMA has called for greater medical involvement, through engagement, in the design and planning of healthcare. The transformation of the NHS and the integration of health and care services present very real opportunities for the improvement of doctors' working lives and for the provision of more timely, co-ordinated and effective patient care. Therefore, engagement on the transformation of the NHS must be a principal element of any long-term plan for the health service.

Unfortunately, too often has this been ignored in the past. A lack of medical engagement has been a key reason of the BMA's criticism of the development and initial delivery of the STP (Sustainability and Transformation Partnership) programme, announced as NHS England's primary vehicle for the integration and transformation of health and care in 2015. Our principal concerns regarding STPs have been their core role in delivering savings; the severe lack of transparency and clinical engagement in their development; and the lack of any legislative basis for their introduction.

A recent survey of BMA members illustrates the alarming lack of clinical involvement with STPs. 78% of respondents answered that they had not been involved in or engaged by their STP in the last 12 months, while 42% said they knew nothing about their local STP. The survey results also show a serious lack of confidence in the STP process, with 80% of doctors saying that they believe STP plans are driven primarily by cost pressures, 51% that their STP plans will mean a cut in services, and only 5% saying that their STP's plans will transform services for the benefit of patient care.

Although the focus of transformation is now shifting beyond STPs and towards ICSs (integrated care systems) and ICPs (integrated care providers), these core concerns still stand. Despite the recent launch of a new consultation on the contractual arrangements for ICPs and a general improvement in transparency, there remain significant concerns around how closely doctors have been involved in these models; their lack of legislative basis; and how compatible they are with existing competition rules.

To secure a viable future for the integration agenda and any vehicle for its delivery, the long-term plan must include a clear, accountable, and proactive strategy for engaging clinicians in the transformation of the NHS. This should not only set out how clinicians should be informed about plans for national and local reform, but also how their opinions can and will be used to shape

and drive that change. It is also essential that clinicians and the public are able to fully scrutinise local plans and that any opposition they may have to them is formally considered.

Furthermore, significant questions will remain regarding the accountability and governance of STPs, ICSs and ICPs while they have no statutory basis. There has been no formal parliamentary scrutiny of these models and, as highlighted in the Health and Social Care Select Committee report into integrated care, this remains a significant and widespread concern.[11] That report also recommends that, if pursued, these bodies should be made statutory. We would support this position and believe that the long-term plan should consider what legislation is needed to ensure that current and future reforms have proper legal accountability and are subject to full public and parliamentary scrutiny.

8. Promoting collaboration over competition

Key message: The imposition of competition onto commissioners creates fragmentation, distracts from the primary goal of providing the best quality care, and presents a barrier to integration and cooperation.

The NHS should be the preferred provider of NHS services and the BMA has long-standing concerns about the increasing role of the independent sector in the provision of publicly funded healthcare. Large sums of money are currently wasted on dealing with competitive processes in the NHS. As highlighted in the BMA's 2016 report on Privatisation and independent sector provision of NHS healthcare, estimates for the cost of creating and maintaining an internal market in the NHS range from £4.5 billion a year to £10 billion, money that could otherwise have been spent on patient care. The imposition of competition onto commissioners also creates fragmentation and presents a barrier to integration and cooperation.

Competition rules, as codified by legislation such as the Health and Social Care Act 2012, run counter to the aspiration of a collaborative model of care and, ultimately, integration itself. The long-term plan must set out clear steps for delivering genuine integration of health and care, including changes to legislation that presently holds this back.

The rigid separation of commissioners and providers creates inherent barriers to integration and collaboration and is fundamentally outmoded. As Lord Prior has very recently highlighted, it is essential that new models of integrated care, including ICPs, are NHS-only bodies to ensure any public confidence in them (see Section 7). We firmly believe that this will also be needed to ensure the confidence of clinicians in the process. However, under existing competition law ICP contracts will be open to bids from private companies, which has been a major source of concern for clinicians and the public.

Appendix 1

See enclosed BMA report Caring, supportive, collaborative? Doctors' views on working in the NHS

Appendix 2

See enclosed BMA's response to Health Education England's draft workforce strategy

Appendix 3

See enclosed BMA report on working in a system under pressure

Appendix 4

See enclosed BMA report on Saving General Practice

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