Professor Lord Darzi of Denham PC KBE FRS FMedSci HonFREng

By email

21 March 2018

Dear Lord Darzi

Institute for Public Policy Research Call for evidence – The Lord Darzi Review of Health and Care

The British Medical Association (BMA) is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The BMA welcomes the opportunity to respond to the Institute for Public Policy Research Call for evidence for the Lord Darzi Review of Health and Care. The evidence provided by the BMA in the enclosed submission is made up of research (including analysis of NHS data,) the surveyed personal accounts and experiences of doctors working in the United Kingdom and organisational views.

The BMA has elected to address questions 1,2,3,4,6 and 7. The BMA has chosen not to provide a response to question 5, as the Association does not take a position on the source of health and care funding, considering this to be a matter for elected officials.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Raj Jethwa
Director of Policy

Chief Executive: Keith Ward
Registered as a Company limited by Guarantee. Registered No. 8848 England.
Registered office: BMA House, Tavistock Square, London, WC1H 9JP.
Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.
The Lord Darzi Review of Health and Care, Call for evidence - Summary

1. What should our vision for the health and care system be in 2030?

The National Health System (NHS) is struggling to cope with unprecedented patient demand against a backdrop of crippling financial restraint. With bed occupancy at record highs, social care on the brink of collapse, and patients unable to reliably access general practice, the NHS is at breaking point. As a result, NHS doctors are working in a system which is under immense pressure to meet rising patient demand and is unable to recruit and retain the necessary staff required to deliver services. This increased pressure on the system leading to many doctors becoming overstretched and many suffering illness and burn-out. In the face of these challenges it is extremely important to establish a future vision for the NHS that is sustainable and that better supports doctors and other healthcare staff to provide high quality care for patients. To achieve this, the British Medical Association (BMA) is launching its own project to establish a future vision for the health and care system This future must be:

a. Properly funded
b. Properly supported to deliver high-quality, safe care
c. Sustained by a functioning and adequately staffed general practice
d. Supported by properly functioning social care and public health systems
e. Unaffected by Britain’s departure from the European Union

2. What is state of quality in the health and care system today?

The NHS is one of the best and most cost-effective health services in the world. It is universally admired as a just institution. However, with insufficient funding and annual increases in demand for care, the NHS in England is under a growing amount of pressure and has begun to noticeably struggle to meet targets. Individual staff are bearing the brunt of these pressures. As a result, vacant medical posts across the NHS are increasing. These pressures are already affecting the care patients can expect to receive. Nevertheless, the CQC has reported that the quality of care across England remains mostly good, owing to the efforts of NHS staff to deliver compassionate care in challenging circumstances. Data, compiled by the BMA below, provides some further insight into the state of quality in the health and care system.

a. Beds
   - The number of beds available overnight has reduced.
b. A&E
   - A&E attendances have increased steadily.
   - The 95 per cent, four-hour wait target has not been met since July 2015.
c. Delayed transfers of care
   - The number of delayed transfers of care has increased.
d. Referrals
   - There are 4 million patients waiting to begin treatment (including estimates for missing data).
e. Emergency readmissions:
   - Between 2012 and 2017, the number of emergency readmissions has increased.

Without major intervention, this situation will deteriorate further over coming 12 months.

1 BMA (2018) Pressure points in the NHS
2 Care Quality Commission (2017) State of Care
3. What can we do to drive innovation in the health and care system?

a. Archaic IT systems need to be updated to enable digital innovation across the health and care system

b. Sufficient funding is necessary to enable innovations to be adopted across the health and care system

c. Medical students and doctors should receive appropriate training to enable them to use and adapt to new technologies and to drive further innovation in the future

4. What are the current and future funding requirements of the health and care system?

a. Overall funding

The BMA has consistently called on political parties to match or exceed the average health spend of other comparable European countries as a proportion of Gross Domestic Product (GDP). In England this would mean spending £131 billion on health in 2017/18 and £143.1 billion in 2022/23. However, funding allocated to the NHS to date will see health spending in the UK fall dramatically short of these targets.

According to the Nuffield Trust, The King’s Fund and The Health Foundation, NHS spending will be £4 billion less than is needed in 2018/19 to match historical spending growth and rising health costs. This gap is projected to grow to £22 billion by 2022.

b. General practice

The BMA is concerned that the 2016 GP Forward View (GPFV) is not on track to deliver the full potential of its funding commitments. In addition, the BMA is concerned that the recently published NHS England Refreshed Planning Guidance appears to confirm that there will be no further increase in spending on general practice beyond the commitments made in the GPFV, despite the additional funding announced in the 2017 Autumn budget. There is currently an estimated £3.4 billion gap between current spend and the 11 per cent general practice funding target the BMA has called upon the UK Government to meet.

c. Social care

Social care funding has fallen significantly short of what is required and resultant failures within the social care system are impacting negatively on a stretched, overworked and underfunded NHS.

d. Mental health

Even though mental health problems are the single largest source of burden of disease in the UK (28 per cent), a disproportionately small amount of the total CCG budget is spent on mental health (13 per cent in England). Without increased funding allocated from central government,

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3 BMA (2017) BMA position on health spend
4 The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care
5 The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care
7 BMA (2017) Pre-Budget consultation
8 BMA (2018) Lost in transit? Funding mental health services in England
CCGs will continue having difficulty increasing their spending on mental health services. The BMA continues to call for increased investment in mental health services in the context of increased funding for the NHS as a whole.  

e. Public Health

Despite published intentions to improve public health in the *Five Year Forward View* (FYFV), planned cuts to local authorities are continuing. Current funding of £3.215 billion will not sustain growing population health needs. Greater investment is needed to tackle public health issues. This will help to reduce the increasing prevalence of long-term health conditions, and the associated pressures on the NHS and its staff.

5. What are the future funding options for the health and care system?

The BMA does not have a position on how health and care funding should be raised, as we consider this to be a matter for elected politicians to decide following public debate.

6. What changes to care models should be undertaken post *Five-Year Forward View*?

The BMA has consistently called for greater integration and collaboration between different parts of the health service. However, while supportive of integration in principle, the BMA does not believe that the organisational and contractual changes set out in the ACO proposals are necessary to achieve integration. We have several specific concerns regarding ACOs. These include:

a. ACOs, like ICSs and STPs, have no legislative basis. As such, it is unclear where accountability within the new care models will rest.

b. The current procurement framework in England mean that ACOs, which combines multiple services into one contract, risk opening whole health economies to privatization.

c. There has been a lack of clarity surrounding the way NHS staff will be employed within an ACO.

d. The ‘fully integrated’ ACO model, in which general practice becomes part of the ACO contract, is incompatible with retaining GP’s independent contractor status.

e. The ‘partially integrated’ ACO model may limit the services that general practices can be paid to provide, as primary care services which fall outside of core general practice may fall under the scope of the ACO.

f. Given the implications they have for the NHS, there has not been sufficient consultation with NHS staff, nor the public on the development of new care models.

7. What reform to the system is needed to enable these changes to take place?

The BMA has called upon the UK Government and NHS England to make the following reforms:

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9 BMA (2017) [BMA position on health spend](#)  
10 NHS England (2014) [*Five Year Forward View*](#)  
11 BMA (2018) [Feeling the squeeze: The local impact of cuts to public health budgets in England](#)  
12 UK Government (2018) [Public health grants to local authorities: 2018 to 2019](#)  
13 BMA (2017) [Models for collaborative working](#)
a. Competition and procurement regulations, currently enshrined by the *Health and Social Care Act 2012*, pose substantial risk to continuity of NHS services, particularly under a new ACO model, and should be repealed

b. New, ring-fenced funding should be allocated to enable integration and shift the focus behind new care models away from ‘efficiency’ and toward improving patient care

c. Reform payment systems that incentivize siloed working
1. What should our vision for the health and care system be in 2030?

The National Health System (NHS) is struggling to cope with unprecedented patient demand against a backdrop of crippling financial restraint. Cuts to acute beds and the chronic underfunding of health and social care has resulted in patients facing unacceptably long delays for treatment. With bed occupancy at record highs, social care on the brink of collapse, and patients unable to reliably access general practice, the NHS is at breaking point. To make matters worse, the NHS has just endured the most challenging winter on record. Whilst the increasingly milder weather should bring some relief, it is unlikely that the health service will experience anything like the traditional recovery that it usually enjoys during the Spring, with its scope for recuperation increasingly limited. The term winter crisis seems less and less appropriate, as the NHS appears to be entering a year-round crisis.

As a result, NHS doctors are working in a system which is under immense pressure to meet rising patient demand and is unable to recruit and retain the necessary staff required to deliver services. This increased pressure on the system leading to many doctors becoming over-stretched and many suffering illness and burn-out. This makes it even more concerning that the current professional regulatory system assesses doctor’s fitness to practise without always sufficiently recognising the challenges and contribution of systemic failures.

In the face of these challenges it is extremely important to establish a future vision for the NHS that is sustainable and that better supports doctors and other healthcare staff to provide high quality care for patients. To achieve this, the British Medical Association (BMA) is launching its own project to establish a future vision for the health and care system. This future must be:

f. Properly funded

The BMA continues to call on political parties to match or exceed the average health spend of other comparable European countries as a proportion of Gross Domestic Product (GDP). In 2015, the average health spend as a proportion of GDP for the 10 leading EU countries was 10.4 per cent (compared to 9.8 per cent in the UK). If the UK matched this percentage, the UK’s health spending would have been £10.3 billion higher in 2015.

Further information regarding the BMA’s position on health funding can be found below at Question 4, as well as the BMA’s position on health spend, and the BMA’s submission to the 2017 Pre-Budget consultation.

g. Properly supported to deliver high-quality, safe care

The BMA continues to call for:

- The delivery of high-quality training and education at every stage of a medical career.
- A long-term solution to the capacity and staffing challenges overwhelming the health and social care system to ensure there are sufficient doctors for safe working, planned time for training is not eroded, and shifts are organised so doctors are not forced to sacrifice rest or sleep.

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14 BMA (2017) BMA position on health spend
15 OECD (2015) Health expenditure and financing
16 BMA (2017) BMA position on health spend
17 BMA (2017) Pre-Budget consultation
- Investment in the medical workforce over the long term to create a caring and supportive working environment, with fair terms and conditions and a fit for purpose occupational health service that will attract and keep the doctors we need to deliver safe and effective care.
- Fundamental change to ensure that the vision set out in the Berwick report is realised, with a move away from a culture of blame toward a culture of learning.
- Better regulation of the profession and the health service which is proportionate and takes account of the pressurised environment in which care is provided.

Further information regarding the BMA’s position on the health and care workforce can be found in Working in a system under pressure, Pre and post qualification training and development of doctors, and the State of medical recruitment.

h. Sustained by a functioning and adequately staffed general practice

The BMA continues to call for:
- Putting in place the necessary funding and support to deliver manageable, safe workloads for General Practitioners (GPs).
- Making general practice more attractive as a career option to increase recruitment and retention of the GPs upon whom the health service relies.

Further information regarding the BMA’s position on General Practice can be found in Saving General Practice and BMA briefing: GP recruitment and retention.

i. Supported by properly functioning social care and public health systems

The BMA continues to call for:
- A public health strategy focused on tackling the causes of ill health over a generation developed in consultation with health professionals.
- Sufficient funding to be made available to ensure that public health services can meet the health needs of local populations.
- Common, minimum standards for the provision of public health services to address local variation in quality and quantity.
- Greater recognition of the evidence that prevention and early intervention is cost effective, and a renewed focus on maintaining access to cost effective public health services that reduce future demand for healthcare.
- A sufficiently funded and adequately staffed social care sector.

Further information regarding the BMA’s work on improving public health and social care can be found in Feeling the squeeze: The local impact of cuts to public health budgets in England, Preventing ill health, Adult social care, and on the Public and population health webpage.

j. Unaffected by Britain’s departure from the European Union

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18 BMA (2018) Working in a system under pressure
19 BMA (2016) Pre and post qualification training and development of doctors
20 BMA (2017) State of medical recruitment
22 BMA (2018) BMA briefing: GP recruitment and retention
23 BMA (2017) Feeling the squeeze: The local impact of cuts to public health budgets in England
24 BMA (2017) Preventing ill health
25 BMA (2017) Adult social care
The BMA continues to call for:

- Permanent residence for highly skilled EU doctors and medical researchers who currently live in the UK – on whom the health service relies.
- A flexible immigration system, which meets the needs of the UK health service and medical research sector.
- Preservation of reciprocal arrangements, including mutual recognition of professional qualifications and measures that protect patient safety.
- Secure ongoing access to EU research programmes and research funding, to maintain the UK’s world-leading science and research base.
- Assurance that Brexit will not hinder the UK’s ability to play a leading role in European and international efforts to tackle global health threats.
- Consideration of the unique impact Brexit may have on the health service in Northern Ireland.

Further information regarding the BMA’s work on the impact of Brexit on the health and care system can be found in Healthcare first – a Brexit blueprint for Europe.26

2. What is state of quality in the health and care system today?

The NHS is one of the best and most cost-effective health services in the world. It is universally admired as a just institution. However, with insufficient funding and annual increases in demand for care, the NHS in England is under a growing amount of pressure and has begun to noticeably struggle to meet targets.27

Individual staff are bearing the brunt of these pressures. The BMA’s tracker survey, which follows medical staff across the UK, shows that 68 per cent of GPs and 44 per cent of consultants considered their workload to be unmanageable,28 and in 2017, 41 per cent of doctors taking part in the BMA’s quarterly survey described their morale as being low or very low.29

As a result, vacant medical posts across the NHS are increasing. In 2017, 65 per cent of hospital specialty respondents and 47 per cent of GPs reported vacancies,30 and 71 per cent of hospital-based respondents reported rota gaps.31 In addition, 4 in 10 surveyed EU doctors have reported that they are considering leaving the UK following the EU referendum result.32 This will place even greater pressure on the medical workforce.

These pressures are already affecting the care patients can expect to receive. The Care Quality Commission (CQC) 2017 State of Care report warns that health and care services are stretched and that some services have deteriorated.33 Further, in 2017, 50 per cent of surveyed consultants told the BMA their workload has had a negative or significantly negative impact on the quality of patient care,34 and 84 per cent of surveyed GPs stated that excessive workload is preventing safe delivery of care.35

26 BMA (2017) Healthcare first - a Brexit blueprint for Europe
27 BMA (2018) Pressure points in the NHS
28 BMA (2016) Survey of GPs in England
29 BMA (2017) Quarterly survey Q4 2017
30 BMA (2016) Patient safety under threat from pressures in General Practice
31 BMA (2017) Quarterly survey Q4 2017
32 BMA (2017) Future of UK health care at risk as more than four in ten European doctors considering leaving UK following Brexit vote
33 Care Quality Commission (2017) State of Care
34 BMA (2017) Consultant workload survey
35 BMA (2016) Survey of GPs in England
Nevertheless, the CQC has reported that the quality of care across England remains mostly good, owing to the efforts of NHS staff to deliver compassionate care in challenging circumstances. This assessment is again reflected in the findings of a recent survey conducted by The King’s Fund. That survey found that while public dissatisfaction with the NHS is at its highest since 2007 (29 per cent), reasons for dissatisfaction relate primarily to resourcing issues. For example, lack of funding and staff, long wait times, government reforms to the health service, and inefficient use of funds were listed at the top five reasons for dissatisfaction. Meanwhile, reasons for satisfaction with the NHS centered on quality. Quality of care provided, positive feelings about NHS staff and the range of services were amongst the top five reasons provided for satisfaction.

The following data, compiled by the BMA, provides some further insight into the state of quality in the health and care system.

f. Beds

- Between the first quarter of 2010/11 and the first quarter of 2017/18, the number of beds available overnight has reduced by 14,000. This equates to 10 per cent of total bed-stock.
- The mental health sector has lost the largest proportion of beds, seeing a reduction of 22 per cent.
- Occupancy of all overnight beds has increased from 84.8 per cent to 87.2 per cent. On general and acute wards, this figure was 89.1 per cent, and on mental health wards 89.3 per cent.
- Over the same period, the number of day beds available increased by only 5 per cent.

g. A&E

- Between 2011 and 2017 attendances and admissions via A&E have increased steadily.
- A&E attendances grew by an average of 1.7 per cent per year, while emergency admissions increased by 2.6 per cent per year. The 95 per cent, four-hour wait target has not been met since July 2015. Patients experiencing the longest waits are often most in need of treatment.
- In February 2018, performance against this target reached its lowest level (85 per cent) since 2010.
- In 2017, 565,365 trolley waits of four or more hours were recorded. This is more than were recorded in 2012, 2013 and 2014 combined.
- Since 2012, trolley waits of 12 or more hours have increased by an average of 149 per cent per year.

h. Delayed transfers of care

- The number of delayed transfers of care (measured in days) increased by a rate of 7.7 per cent per year between 2011 and 2017.

i. Referrals

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36 Care Quality Commission (2017) State of Care
37 BMA (2018) Pressure points in the NHS
- There has been steady growth in the number of patients waiting to begin elective treatment since 2009/10, currently there are 4 million patients waiting to begin treatment (including estimates for missing data).
- The proportion of patients beginning treatment within 18 weeks reached its lowest level in December 2017 (88.2 per cent) since March 2009.42

j. Ambulance Quality Indicators

- Between 2012/13 and 2016/17, the proportion of Red 1 and 2 (life-threatening) calls responded to within 8 minutes fell from 74.0 per cent and 75.6 per cent to 69.3 per cent and 61.6 per cent respectively.43

k. Emergency readmissions:

- Between 2012 and 2017, the number of emergency readmissions has increased by 22.8 per cent.44

Without major intervention, this situation will deteriorate further over coming 12 months. Currently, the BMA’s projections show that over the next 12 months there will be:

- 23.8 million attendances at A&E (an increase of 345,000).
- 2.95 million people waiting over 4 hours at A&E (an increase of 370,000).
- A decrease of 1.3 per cent in the performance against the four-hour wait, which will average 87.6 per cent.
- 6 million emergency admissions (an increase of 148,000).
- 815,000 trolley waits (an increase of 250,000).
- An average of 4.28 million people waiting for treatment every month (an increase of 360,000).
- A drop from 89.2 per cent to 90.1 per cent in the average proportion of patients treated within 18 weeks.45

Further information can be found in Working in a system under pressure,46 the BMA’s weekly analyses of trust-level data (the winter situational reports) published by NHS England, Pressure points in the NHS,47 and NHS Pressures – Future trends48 which makes predictions as to the state of the NHS in the future based on current trends.

3. What can we do to drive innovation in the health and care system?

a. Archaic IT systems need to be updated to enable digital innovation across the health and care system

Successful digital innovation can improve information sharing between care settings, and optimise patient outcomes and quality of care. Unfortunately, progress in this area has been slow due to reliance on outdated IT systems which are not interoperable (meaning data cannot be shared between them).

44 Healthwatch (2017) What do the numbers say about emergency readmissions to hospital?
46 BMA (2018) Working in a system under pressure
47 BMA (2018) Pressure points in the NHS
Due to chronic underfunding for IT, Primary Care clinics and NHS hospitals are forced to rely on outdated IT systems. In addition, most NHS hospitals are operating multiple digitally fragmented IT systems that do not speak to each other. This means that achieving interoperability within and between Primary and Secondary Care IT systems is a distant reality. It also means that digital innovations, for example apps and wearables, cannot be successfully integrated into the current IT infrastructure, limiting their usefulness and impact.

b. Sufficient funding is necessary to enable innovations to be adopted across the health and care system

Secure, dedicated, new funding for IT and innovation is required to allow the adoption of helpful innovations across the health and care system. However, to date IT and innovation funding has been sporadic and non-recurring. This limits the likelihood that innovations will be adopted across the health and care system. For example: NHS England recently launched a £45 million fund to support practices to purchase online consultation systems. However, practices will only have access to the fund for the next three years. As such, practices are unlikely to engage with this digital innovation. This will result in poor uptake of a potentially beneficial tool.

In addition, IT and innovation funding is rarely ringfenced, and the constant redirection of funding is extending the impact of underfunding. For example: it was recently announced that £21 million in capital funds will be ‘reprioritised’ from the paperless NHS programme to fund cybersecurity in the wake of the WannaCry cyber-attack. There are similar acts of ‘reprioritisation’ occurring across the NHS IT portfolio. This constant shift of funds means no real progress is made on any one issue.

c. Medical students and doctors should receive appropriate training to enable them to use and adapt to new technologies and to drive further innovation in the future

The BMA is concerned that current medical education and training is not preparing medical students and doctors for emerging and future technological innovations. During their education and training, doctors must be exposed to emerging technologies to ensure their familiarity with those technologies before providing patient care. This is particularly important in an age in which patients have greater access to information concerning their treatment. In addition, doctors who are confident in dealing with current innovations are more likely to influence and steer future innovations.

4. What are the current and future funding requirements of the health and care system?

f. Overall funding

The BMA has consistently called on political parties to match or exceed the average health spend of other comparable European countries as a proportion of Gross Domestic Product (GDP). In England this would mean spending £131 billion on health in 2017/18 and £143.1 billion in

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49 BMA (2017) Premises, IT infrastructure and administrative support to enable the delivery of quality care
50 Guardian (2018) Archaic IT is hampering the NHS. But innovation is coming
51 The King’s Fund (2016) Interoperability and the NHS: are they incompatible?
52 NHS England (2017) GP online consultation systems fund
53 Digital Health (2018) Review confirms money was diverted from paperless fund to cybersecurity
54 BMA (2017) BMA position on health spend
2022/23. However, funding allocated to the NHS to date will see health spending in the UK fall dramatically short of these targets.

According to the Nuffield Trust, The King’s Fund and The Health Foundation, NHS spending will be £4 billion less than is needed in 2018/19 to match historical spending growth and rising health costs.\(^{55}\) This gap is projected to grow to £22 billion by 2022.\(^{56}\) In November 2017, Simon Stevens, Chief Executive, NHS England, urged the UK government fill this gap by allocating the additional £4 billion required in the 2017 Autumn Budget.

Unfortunately, the UK Government has ignored these calls, allocating just £1.6 billion in additional funds in the 2017 Autumn Budget. Coupled with an additional £540 million to be made available by the Department of Health and Social Care (DHSC), this represents a 2.4 per cent increase in NHS England’s funding for 2018/19. The UK Government has also planned for a significant funding slowdown in 2019/20. NHS England can expect to receive a 0.2 per cent increase in additional funding that year, which translates to a drop of 0.8 per cent in health spending per person when age-weighted population growth is considered.

Of additional concern is the fact that the source of the additional £540 million is yet to be made clear by DHSC. If these funds are to be taken from other sections of the DHSC budget this could mean further cuts to areas like public health, which would place even greater strain on the NHS. If this is the case, the DHSC funding will mask a smaller increase in overall health spending as defined by the total DHSC budget. The fact that this will be followed by a smaller increase in funding for the subsequent year leaves the NHS without a sustainable long-term funding plan. The BMA has called upon the UK Government to urgently clarify the source of the DHSC funding.

According to NHS England, of the £2.14 billion in total additional funding, £1.05 billion will be allocated to Clinical Commissioning Groups (CCGs) and trusts to shore up existing deficits. As a result, NHS England says the CCG sector is expected to achieve budget balance in 2018/19, and NHS Improvement has specified that the trust sector will do the same. What this means, is that approximately half of the additional funding for 2018/19 will be spent on shoring up existing deficits in the system.

However, this injection is unlikely to close the NHS’s underlying deficit. Analysis by the Nuffield Trust in 2017 estimated that NHS trusts have a real deficit of around £5.9 billion once non-recurrent savings are discounted.\(^{57}\) This means that, depending on the scale of efficiency savings trusts can make, the NHS will need to make further one-off savings, divert funding from elsewhere in recurrent budgets and/or raid capital budgets intended for investment in equipment and infrastructure to achieve budget balance.

The BMA is also calling the UK government to ensure that secondary care is not pressured to make unachievable savings. The BMA considers that the 2 per cent efficiency factor set by the national tariff in England is unrealistic given the savings that have already been made, the average rate of improvement in productivity in the wider economy and the local deficits that already exist.

The BMA considers that the 44 Sustainability Transformation Plans (STPs), which are meant to bring about innovative service change to deliver a clinically sustainable health service that will address these deficits, are not realistic. Particularly because the Sustainability and Transformation Fund (STF) has largely been used to plug provider deficits rather than support system change. The BMA has estimated that at least £9.5 billion of additional capital will be

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\(^{55}\) The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care

\(^{56}\) The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care

\(^{57}\) Nuffield Trust (2017) The NHS deficit is here to stay
required to fund STPs if they are to succeed.\textsuperscript{58} The Vanguard scheme funding will also end in 2018, which will lead to local areas being expected to develop new models of care without new funding to make this possible.

Further information on the BMA’s position on health spending can be found in BMA Briefing on NHS England’s Refreshed Planning Guidance,\textsuperscript{59} BMA position on health spend,\textsuperscript{60} Pre-Budget consultation\textsuperscript{61} and BMA briefing: NHS funding.\textsuperscript{62}

g. General practice

The BMA is concerned that the 2016 GP Forward View (GPFV), which pledged to provide £2.4 billion in additional funding to general practice by 2020/21, is not on track to deliver the full potential of its funding commitments. It is disappointing that little discernible progress has been made in leveraging additional investment for general practice from the rest of the system through clinical commissioning groups and STPs.

In addition, the BMA is concerned that the recently published NHS England Refreshed Planning Guidance appears to confirm that there will be no further increase in spending on general practice beyond the commitments made in the GPFV, despite the additional funding announced in the 2017 Autumn budget. Although the Autumn budget states that there will be a 4 per cent increase from April 2018, it will be counterbalanced by the 36 per cent increase to ‘sustainability’ for trusts and a 7 per cent increase in funding for specialised services. This appears to continue a trend of falling overall investment in general practice, noting that the NHS England budget going to general practice, excluding the reimbursement of drugs has dropped from 9.6 per cent in 2005/06 to 7.1 per cent in 2018/19.\textsuperscript{63}

The BMA has consistently called upon the UK Government to invest 11 per cent of England’s NHS budget in general practice to ensure quality and safety levels can be maintained.\textsuperscript{64} However, there is currently an estimated £3.4 billion gap between current spend and this target.\textsuperscript{65} The BMA is also also called for further clarification on the amount of funding expected to be invested in general practice in 2018/19, whether the new funding framework for the NHS, set out in the new planning guidance, will result in the lower investment in general practice and whether additional funding for general practice will be allocated beyond the GPFV trajectory.

Further information on the BMA’s position on general practice spending can be found in BMA Briefing on NHS England’s Refreshed Planning Guidance\textsuperscript{66} and Saving General Practice.\textsuperscript{67}

h. Social care

Social care funding has fallen significantly short of what is required and resultant failures within the social care system are impacting negatively on a stretched, overworked and underfunded
NHS. From 2009/10 to 2016/17 gross Council spending on social care fell by 7 per cent due to cuts to local authority budgets. As a result, 25 per cent fewer people are accessing social care services. According to the Nuffield Trust, The King’s Fund, and The Health Foundation, despite the £2 billion funding boost delivered by the 2017 Spring Budget and the introduction of council tax, there remains and estimated annual social care funding gap of £2.5 million by 2019/20. This gap must be filled, to avoid adding further pressures onto the NHS.

Further information on the BMA’s position on social care spending can be found in Adult social care, and Pre-Budget consultation.

i. Mental health

Even though mental health problems are the single largest source of burden of disease in the UK (28 per cent), a disproportionately small amount of the total CCG budget is spent on mental health (13 per cent in England). As a result, mental health care providers are struggling to keep up with demand. In addition, nearly 10 per cent of mental health care staff posts are reported to be vacant, leaving trusts unable to staff services safely. CQC inspection reports for all 54 mental health trusts have identified an increased risk to patient safety as a result of problems with staffing.

The BMA welcomes recent mental health funding announcements in England, but it is important that committed funds reach front line services. Greater investment is required to fund the provision of crisis mental health care and to ensure adequate round the clock provision. Further investment is also required to eliminate of out of area placements; provide timely access to early intervention in psychosis’ services; provide comprehensive evidence-based specialist perinatal mental health services; assess and manage physical health needs of people living with severe mental health problems; provide routine access to evidence-based psychological therapies for adults with anxiety and depression; and provide comprehensive child and adolescent mental health services.

Without increased funding allocated from central government, CCGs will continue having difficulty increasing their spending on mental health services. The BMA continues to call for increased investment in mental health services in the context of increased funding for the NHS as a whole.

Further information on the BMA’s position on mental health spending can be found in Lost in transit? Funding mental health services in England.

j. Public Health

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68 BMA (2017) Pre-Budget consultation
69 The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care
70 The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care
71 The Kings Fund (2017) The Autumn Budget: Joint statement on health and social care
72 BMA (2017) Adult social care
73 BMA (2017) Pre-Budget consultation
74 BMA (2018) Lost in transit? Funding mental health services in England
75 Nuffield Trust (2017) The NHS Workforce in numbers
76 The King’s Fund (2018) Mental health funding gap widens further
77 BMA (2017) BMA position on health spend
78 BMA (2018) Lost in transit? Funding mental health services in England
Despite published intentions to improve public health in the *Five Year Forward View* (FYFV),79 planned cuts to local authorities are continuing, averaging 3.9 per cent a year to 2020/21.80 These budget reductions are leading to unacceptable variation in the quality and quantity of services available to the public. This is likely to have a detrimental impact on population health, increase future demand for treatment services, and risks widening health inequalities. Current funding of £3.215 billion81, down from £3.30bn in 2017/18, will not sustain growing population health needs. Greater investment is needed to tackle public health issues, including smoking, alcohol, poor diet and physical inactivity, which have been estimated to cost the NHS more than £18 billion per year. 82 This will help to reduce the increasing prevalence of long-term health conditions, and the associated pressures on the NHS and its staff.

The BMA has called on the UK Government to reverse cuts and make further funds available to meet health needs of local populations, establish common, minimum standards for the provision of public health services to address local variation in quality and quantity and to recognise the evidence that prevention and early intervention is cost-effective. A renewed focus on maintaining access to cost effective public health services will reduce future demand for healthcare.83

Further information on the BMA’s position on public health spending can be found in *Feeling the squeeze: The local impact of cuts to public health budgets in England*.84

5. What are the future funding options for the health and care system?

The BMA does not have a position on how health and care funding should be raised, as we consider this to be a matter for elected politicians to decide following public debate.

6. What changes to care models should be undertaken post *Five-Year Forward View*?

The BMA has consistently called for greater integration and collaboration between different parts of the health service.85 However, while supportive of integration in principle, the BMA does not believe that the organisational and contractual changes set out in the ACO proposals are necessary to achieve integration. We have several specific concerns regarding ACOs. These include:

   g. ACOs, like ICSs and STPs, have no legislative basis. As such, it is unclear where accountability within the new care models will rest. This is especially concerning in the case of partially or fully integrated ACOs, which will necessitate significant change.

   h. The current procurement framework in England requires that public procurements over €750,000 be put to tender. This means that an ACO, which combines multiple services into one contract, risks opening whole health economies to privatization. As a result, health services could be run for profit, removing much needed funding and investment from the NHS. The BMA strongly supports the ongoing provision of a publicly funded and

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79 NHS England (2014) *Five Year Forward View*
80 BMA (2018) *Feeling the squeeze: The local impact of cuts to public health budgets in England*
81 UK Government (2018) *Public health grants to local authorities: 2018 to 2019*
83 BMA (2018) *Feeling the squeeze: The local impact of cuts to public health budgets in England*
84 BMA (2018) *Feeling the squeeze: The local impact of cuts to public health budgets in England*
85 BMA (2017) *Models for collaborative working*
publicly provided NHS, and calls for the government to clarify what safeguards will be in place to ensure that ACOs do not enable an increase in the role of commercial providers.

i. Thus far, there has been a lack of clarity surrounding the way NHS staff will be employed within an ACO. As such there is a risk that doctors will be employed outside of national terms and conditions.

j. The ‘fully integrated’ ACO model, in which general practice becomes part of the ACO contract, is incompatible with retaining GP’s independent contractor status, which underpins fair and consistent health service delivery in England.

k. The ‘partially integrated’ ACO model may limit the services that general practices can be paid to provide, as primary care services which fall outside of core general practice may fall under the scope of the ACO.

l. Given the implications they have for the NHS, there has not been sufficient consultation with NHS staff, nor the public on the development of new care models. The BMA welcomes the announcement of a new consultation on ACO’s in 2018, and has called on NHS England and the Department of Health and Social Care to ensure that this and future consultations allow proper scrutiny of the proposals, with maximum transparency and opportunity for patients, doctors, and other health and care professionals to raise concerns.

Further information regarding the BMA’s position on new care models can be found in the BMA’s briefing on Accountable Care Organisations, the BMA’s guidance on the Accountable care contract, and the BMA’s response the to the UK Government Department of Health consultation.

7. What reform to the system is needed to enable these changes to take place?

The BMA has called upon the UK Government and NHS England to make the following reforms:

d. Competition and procurement regulations, currently enshrined by the Health and Social Care Act 2012, pose substantial risk to continuity of NHS services, particularly under a new ACO model, and should be repealed.

The BMA has consistently called for the withdrawal of the Section 75, National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations, finding that their existence prevents collaboration. These regulations should be replaced with unambiguous regulations which are reflective of the prior Government assurances that commissioners will not be forced to use competition. This principle should be stated explicitly in the regulations.

Further information regarding the BMA’s work on competition in the NHS can be found in Competition law and the NHS, and Lords debate on motion to annul Section 75 regulations, 24 April 2013.

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87 BMA (2018) ACO member briefing
88 BMA (2018) ACO member briefing
89 BMA (2018) ACO (MCP/PACS) contracts
90 BMA (2017) Accountable care models contract: proposed changes to regulations
91 BMA (2016) Competition law and the NHS
92 BMA (2016) Lords debate on motion to annul Section 75 regulations, 24 April 2013
e. New, ring-fenced funding should be allocated to enable integration and shift the focus behind new care models away from ‘efficiency’ and toward improving patient care

Since the publication of NHS England’s FYFV in 2014, local areas have been encouraged to develop new approaches to the way they deliver healthcare and better integrate services around patients. Sustainability and transformation plans (STPs), announced in December 2015, set out how the FYFV was to be delivered locally and marked a decisive shift away from competition by requiring NHS organisations to collaborate with each other and with local partners.

Unfortunately, guidance from NHS England and other national bodies made clear from the outset that the primary focus of STPs was not to be improving patient care, but achieving cost savings to meet overstretched NHS budgets. STPs were told to detail the funding they thought they would need by 2020/21 compared to how much they will have, setting out the amount of overspend if they do not put any changes in place (‘do nothing deficits’). Combining health and social care, these deficits add up to £26 billion. STPs were then required to show how they would achieve financial balance.

Although the majority of STP plans provide some detail surrounding the savings they propose, methods vary, and it is not always clear how savings will be achieved. In addition, a number of STPs include their share of the Sustainability and Transformation Fund (STF) in their plans to fill financial gaps. In 2017/18, only £1.1 billion of the £2.9 billion set aside for the STF was allocated to the transformation of services. This is concerning, as this means that a large portion of the STF will be used to plug deficits, rather than enable transformation.

To put changes in place and deliver projects within the STPs, funding is required. An investigation conducted by the BMA in February 2017 found that STPs require at least £9.5 billion of capital funding to make the necessary changes. The funding set aside for STPs in the Autumn Budget does very little to allay concerns. Although additional capital investment in the NHS is welcome, the £2.6 billion allocated to STPs falls far short of the £9.5 billion needed. The BMA believes that it is vital that upfront transformation funding is provided to enable services to address long term challenges and achieve many of the aims set out in STP plans, including the successful integration of community and public health services.

The BMA has also continually stressed that the overriding aim of integrating health and care services must be to provide better quality care to patients and not to deliver savings. Even though most STP plans do consider how to provide a more seamless, integrated patient experience, the fact that savings of £26 billion are expected to be made by STPs inside of five years is extremely worrying in terms of impact of patients.

Further information regarding the BMA’s work on integration and STPs can be found in BMA briefing: NHS Sustainability and Transformation Plans, Capital crisis: STP money fails to materialise, and Delivery costs extra: can STPs survive without the funding they need?

f. Reform payment systems that incentivize siloed working
In recent decades NHS payment systems have evolved, particularly in England, where the national tariff (‘payment by results’) currently dominates payments made to the acute sector. The BMA does not support the national tariff (‘payment by results’) as the main way for paying acute providers in England. This is mainly because it does not reflect the true cost of treatment, leads to perverse incentives and poses a barrier to integration within the NHS. This is because individual providers are encouraged to increase their activity, meaning other providers can be viewed as competition for patients. This prevents collaborative working between providers and can result in negative patient outcomes.\(^{97}\) For example, the treatment of some patients may be better suited to the community rather than the acute setting.\(^{98}\)

The BMA has lobbied heavily on transforming the tariff, including calling for an end to the punitive financial policies that have been applied through the tariff in recent years. These include the efficiency factor and the marginal rate rule for emergency admissions. The BMA has called for a new payment model to be introduced that facilitates and encourages closer working between different parts of the health service, around the needs of patients.

Further information regarding the BMA’s work on payment models can be found in Models for paying providers\(^ {99}\) and The BMA position on payment by results\(^ {100}\).


\(^{99}\) BMA (2017) Models for paying providers

\(^{100}\) BMA (2016) The BMA position on payment by results