

Comprehensive Spending Review 2020: Representation by the British Medical Association

1. Introduction

- 1.1. The COVID-19 crisis has demonstrated the vital role that NHS, public health and social care services play in our society. Investing in these services is the right thing to do not only to support people's health and wellbeing, but to ensure that as a country we have the resilience to deal with global public health threats and protect our economy.
- 1.2. At the outset of the pandemic these services were already struggling to cope with significant resourcing challenges. The NHS has experienced a decade of below-average spending increases, and both public health and social care have been hit by substantial cuts. This has undoubtedly made it more difficult for these services to respond robustly to COVID-19.
- 1.3. The winter ahead is set to be one of the most difficult on record. The NHS, public health and social care are facing the triple challenge of simultaneously coping with a second wave of COVID-19, a growing backlog of care as well as non-COVID winter pressures. Urgent action is needed to support services in the short and medium term. Hospitals and NHS estates need to be modernised, expanded and improved to cope with increased demand and the need to reduce the spread of COVID-19. Addressing workforce gaps also needs to be prioritised so we have the staff to cope with such pressures and reduce the risk of burnout in doctors.
- 1.4. Beyond this, it is vital that the NHS, public health and social care are put on a much more resilient and sustainable footing in the longer term, so that they can cope with increasing demand, modernise services and be better prepared for future public health crises.
- 1.5. A major multi-year funding injection is therefore now needed. In the coming Spending Review the Government should set out bold plans that move beyond pre-COVID spending commitments and significantly invest in the NHS, public health and social care to enable them to cope with the ongoing impact of COVID-19, whilst building up the resilience of these services for the future. To support this aim, investment is needed in four key areas:
 - Core NHS funding – to enable the NHS to prepare for a rapid increase of cases this winter, tackle the backlog, reduce waiting times for care, ensure the NHS estate is fit for purpose, and to expand and modernise services in line with the needs of a growing and ageing population
 - People – to fund the ambitions set out in the recent People Plan, expand the pipeline of future doctors and the wider NHS workforce and invest in rewarding staff for their work and improving retention
 - Public health – to rapidly reverse historic cuts to public health and ensure local public health teams are given the resources they need to deal with the ongoing pandemic and improve resilience for the future
 - Social care – to finally tackle the longstanding problem of poor access to social care by transitioning to a system that is free at the point of use to those who need it, and better integrated with NHS services
- 1.6. Due to health being a devolved matter the specific calls for investment set out below are England-focussed. However, many of issues highlighted are just as pressing in the devolved

nations, and we would expect to see any increases in health funding mirrored for the devolved nations through the Barnett formula.

Summary of asks

Ensure the NHS is properly funded

- DHSC budget to grow by 4.1% per year in real terms, taking it to £164.9 billion by 2023/24
- Additional funding to cope with the impact of COVID-19
- These uplifts in funding should cover:
 - Sufficient funding for tackling the non-COVID care backlog (at least £4.9 billion)
 - A multi-year settlement for capital funding
 - At least £6.5 billion capital funding to cover overdue maintenance costs
 - At least £4.2 billion capital funding for wholesale digital transformation
 - At least £1 billion capital funding for GP premises
 - An ongoing commitment to maintain adequate stocks of PPE (personal protective equipment), with this year's £15 billion spend repeated for at least 2021/22

Investment to boost the NHS workforce

- £3.5 billion per year to increase medical school places
- £10 million per year for a comprehensive occupational health service in primary care
- Ensure the NHS People Plan is fully resourced
- Increase pay for doctors who have experienced real terms pay cuts
- Abolish the annual allowance for DB pension schemes

Investment in public health and mental health services

- £4.5 billion by 2023/24 for the Public Health Grant
- Increase the budget for the future national public health structure, particularly the proportion going towards preventing infectious diseases
- At least £4.6 billion per year for investment in mental health services
- £30 million for drug and alcohol use disorder services by 2024/25

Social care reform

- An extra £12.2 billion in 2023/24 to meet demand, improve services and improve workforce conditions
- £5 billion in 2023/24 to implement free personal care in England

2. An increase in core NHS funding to meet the growing needs of patients and the unprecedented challenges posed by COVID-19

Overall health expenditure

- 2.1. The Government should use this Spending Review to announce a bold new multi-year funding deal for the NHS up to 2023/24 that substantially increases health spending above pre-pandemic spending plans.
- 2.2. Even before the COVID-19 pandemic, the NHS was in need of a funding boost to help it cope with increasing demand and to modernise services. Therefore, the BMA is calling for a recurrent annual real-terms increase in health spending of at least 4.1% (measured from a 2019/20 baseline). This would take total health spending from the planned £140.4 billion in

2019/20 to £164.9 billion by 2023/24, a £9 billion rise compared to Government's (pre-COVID-19) planned spending.

- 2.3. In addition, it is crucial that extra funding is also provided in the short-medium term to cope with the ongoing impacts of COVID-19.
- 2.4. The short-term injections of COVID-19 funding announced by the Government since March have lifted spending by around £9.6 billion¹ for 2020/21 to cope with the crisis, but with the fight against COVID-19 ongoing, and a growing backlog of care to deal with, the NHS needs certainty about future funding arrangements for the coming years.
- 2.5. Health services need additional funding to enable them to cope with both the direct and indirect impact of COVID-19 alongside pre-existing pressures they are facing going into the coming winter and beyond. With cases now rising again across the UK, the BMA is extremely concerned about how the NHS will cope with these challenges alongside having to deal with a rapid second increase in patients being hospitalised with COVID-19.
- 2.6. To cope with a likely rise in COVID-19 cases this winter the NHS urgently needs:
 - Funding to ensure effective infection control procedures are followed, particularly the maintenance of adequate stockpiles of PPE. The Government has not, so far, released detailed information about current/projected stockpiles and how these match up to expected demand in the event of a large increase in COVID-19 cases. Further assurances are therefore needed at the Spending Review that funding will be in place to ensure adequate supplies of the right kind of PPE – e.g. ensuring sufficient quantities of gowns and FFP3 masks, which were in particularly short supply earlier this year. The Government has previously stated that it has spent £15 billion on PPE this year – the Spending Review should set out funding plans for PPE at least for 2021/22 covering health and social care.
 - A functioning test and trace system through which we can track the spread of the virus in communities. In recent weeks it has become clear that despite increases in capacity there are serious problems with lack of lab capacity to process tests, and ongoing funding will be needed to improve this.
 - To improve NHS buildings to cope with rising demand, social distancing and the need to prevent the spread of COVID-19 in all care settings;
- 2.7. As the NHS heads into winter, it faces the added challenge posed by a growing backlog of care that continues to build up, with millions of patients having missed out on outpatients appointments, elective procedures, cancer care and other services due to the disruption caused by COVID-19. BMA analysis of the latest data highlights the size of the backlog of care that the NHS is now facing in a number of areas. The BMA estimates that between April and July 2020 there were:
 - 12 million fewer outpatient attendances than expected, potentially costing £1.4 billion² to work through;

¹ This is based on announcements made by the Government - [£6.6bn COVID fund for NHS announced in April 2020](#), [extra £3bn COVID fund for NHS announced in July 2020](#).

² [Provisional Monthly Hospital Episode Statistics for Admitted Patient Care and Outpatient April 2020 - June 2020](#) and [2018/19 National Schedule of NHS Costs](#)

- 858,000 fewer first elective treatments, costing approximately £3.5 billion³ to work through.
- 2.8. Additional resources are needed to support doctors to work through this backlog. For example, an increase in diagnostics capacity in the community is urgently needed to help address historic under-capacity and enable doctors (regardless of location) to order rapid tests for their patients. Due to increased online/ remote consultations it will become increasingly important that primary, community and secondary care clinicians as well as patients have rapid, and ideally same-day access to a properly commissioned community-based monitoring and diagnostic services. These services would reduce the need for patients to attend hospitals and allow clinicians to continue their care for patients in terms of diagnosis and longer-term monitoring.
- 2.9. Other areas where additional recurrent resources are needed include:
- Ongoing COVID-19 funding for general practice to reimburse for the additional costs that will continue to be incurred, such as increasing premises capacity and taking on additional staff and additional clinical and non-clinical capacity (see sections 2.19 & 3 below);
 - Increased demand for mental health services (see section 4.6 below);
 - An increased role for local and national public health services in the fight against COVID-19 (see section 4 below);
 - Reduction in Trust revenue from other areas, such as medical research that has been cancelled or delayed. NHS Trusts receive an average pharmaceutical cost saving of £5,250 per patient recruited to each clinical study. Any loss of such funding would need to be filled by the governments of the UK⁴.

Capital expenditure

- 2.10. The NHS has suffered with long term underinvestment in capital funding. For example, the proportion of the NHS' budget spent on capital fell from 5% in 2010/11 to 4.2% in 2017/18 – mainly as a result of capital budgets being diverted into revenue to pay for day-to-day running costs⁵.
- 2.11. The COVID-19 pandemic has demonstrated the need for investment in NHS estates and equipment to ensure they are fit for purpose and able to cope with increased demand. For example, A&E departments' capacity will need to be expanded to help ensure appropriate social distancing and infection control.
- 2.12. We recognise that Government has announced additional capital funding over the past few months to help cope with the impact of COVID-19. However, for a long time now, the NHS has received episodic funding announcements rather than a long-term capital investment plan. We are now calling for Government to provide a multi-year capital funding settlement for the NHS. This will allow trusts and GP practices to plan for the long term and transform their services and equipment. Such a plan also needs to set out how the Government will fund its promise to expand NHS capacity by building 40 new hospitals.
- 2.13. Key areas where capital investment is needed are:

³ Monthly number of admitted (unadjusted) referral to consultant-led treatment ([RTT](#)) pathways and [2018/19 National Schedule of NHS Costs](#)

⁴ NIHR (2019) <https://www.nihr.ac.uk/documents/impact-and-value-report/21427>

⁵ NHS Providers (2019) [Rebuilding our NHS: why it's time to invest](#)

Overdue maintenance

- 2.14. The latest data from 2018/19 shows that at least £6.5 billion is needed to tackle the backlog of maintenance costs. Over half of this (£3.4 billion) is needed to address issues that present a high or significant risk to patients and staff⁶.
- 2.15. It is important to note that the backlog maintenance costs are now likely to be even higher since this data was published. In addition, this data only records the costs of restoring the existing NHS estate. The capital costs of modernising and transforming the estate, will be significantly higher. This is especially the case with the Government announcement of plans to develop more than 40 hospital building projects, including six large new hospitals to be delivered by 2025⁷. The cost of adequate maintenance and transformation of the primary care estate is also not included in this data (see below).

Expanding overall NHS capacity

- 2.16. The Government has committed to expanding NHS capacity by building 40 new hospitals in the coming years. The Spending Review should set out in detail how this commitment will be funded, and what it will mean for the NHS in terms of additional space, workforce, and ongoing spending, as well as timescales.
- 2.17. Various estimates of the cost of building 40 hospitals have been made, with the IFS for example suggesting this could cost between £12 billion and £24 billion⁸. The Spending Review should provide clarity on this and set out where funding will come from. Expecting significant funding to come from selling off existing NHS buildings and land is, in the BMA's view, short sighted and will leave the NHS with a reduced estate which it may need to expand in future, especially in high-cost areas where purchasing land previously sold would come at an added cost.
- 2.18. The Spending Review should also clarify how much additional capacity new hospital buildings will add to the NHS in the coming years, and how they will be staffed. The average number of beds for an NHS Trust in England is around 600 – so 40 entirely 'new' hospitals would be expected to add potentially almost 25,000 extra beds⁹. If this is not the case (e.g. because some of the new hospitals are rebuilds which won't expand bed capacity) this needs to be made clear. An average NHS Trust employs around 500 full time equivalent doctors, so again the Government needs to make clear whether building 40 new hospitals will need to be matched by increasing the medical workforce by around 20,000, or whether this will be lower in reality¹⁰.

GP premises

- 2.19. We have long highlighted the sorry state of general practice premises. Our survey published last year, showed that half of GP practice buildings are not fit for purpose, and only two in every ten practices were fit for the future. The results of our survey informed the General Practice Premises Policy Review, led by NHS England and agreed by the DHSC and the General Practitioners Committee of the BMA. The review reported in June 2019, with a recommendation that 'capital is required both to bring up the standard of current

⁶ NHS Digital (2019) [Estates Returns Information Collection Summary page and dataset for ERIC 2018/19](#)

⁷ DHSC (2019) [New hospital building programme announced](#)

⁸ Johnson's '40 new hospitals' pledge costed at up to £24bn, Guardian, 8 Dec 2019:

<https://www.theguardian.com/politics/2019/dec/08/boris-johnson-40-new-hospitals-pledge-costed>

⁹ NHS England (2020) [Bed Availability and Occupancy Data – Overnight - NHS organisations in England, Quarter 1, 2020-21](#)

¹⁰ NHS Digital (2020) [NHS Workforce Statistics May 2020](#) (excluding staff employed by CCGs and Ambulance Trusts)

estate and to transform primary care estates across England, to deliver what is required for the clinical and service vision of the Long Term Plan in purpose-built premises’.

- 2.20. In addition to this research and review outcome, the Government has since pledged 6,000 additional GPs, and 27,000 additional staff in primary care (as part of Primary Care Networks). We, with NHSEI (NHS England & Improvement), are implementing the plans to meet this pledge, with recruitment and retention initiatives for GPs, and the recruitment of new staff via PCNs, which will provide an average additional five staff members per practice in England. If this manifesto commitment is to be realised, those individuals will need physical space from which to operate – which will require upgrades/extensions to existing premises, and new premises to be built. Without this, recruitment of the additional workforce will not be possible, and without the additional workforce the Government will not be able to deliver its commitment to the public of increasing access to general practice.
- 2.21. We are therefore calling for urgent capital investment in GP premises, alongside recurrent revenue funding. This includes at least £1 billion already agreed as part of the GP contract over the next three years, funding that had originally been promised by the Estates and Technology Transformation Fund set out in the GP Forward View back in 2016, but large amounts of which did not reach practices.

NHS Information technology

- 2.22. Historically, IT funding has taken a back seat to other priorities within the NHS. In light of government spending during the pandemic there will continue to be competing priorities, but we cannot afford to withhold digital transformation funding for the NHS. In a recent BMA survey, 27% of doctors estimated they lose more than four hours a week because of inefficient hardware systems. Amidst workforce shortages across the NHS, better IT would free up valuable clinical time and go some way towards mitigating the negative effects of poor staff retention. Fundamentally, core IT systems are still inadequate compared with equivalent systems across the private and consumer sector and further neglect will only exacerbate this.
- 2.23. In its 2020 budget submission, the BMA called for an immediate scoping exercise to be undertaken across primary and secondary care to estimate the capital investment required to bring IT infrastructure up to standard. As the NHS seeks to return to a degree of normality and given the impact of poor IT infrastructure on COVID-19 preparedness and response, a review is now urgently needed to establish how much capital funding should be released in 2021/22 to modernise IT infrastructure across the NHS. In 2017, NHSE’s Chief Information Officer suggested £4.2 billion would be needed for wholesale digital transformation. While this is now out of date, it gives some sense of the task at hand.
- 2.24. Greater remote working has long been touted in the NHS as a way to offer greater flexibility to both staff and patients in how, where and when they have consultations. The pandemic has accelerated work already underway in this respect, with the primary drive being the need to minimise exposure to others in otherwise busy GP surgeries. As remote working and remote working preparedness become a long-term reality, adequate financial support must be given to all primary and secondary care clinicians to enable them to work remotely. Laptops must be provided and software purchased to facilitate the use of clinically appropriate remote contact.
- 2.25. Specific funding should urgently be provided to secondary care trusts to procure APIs (Application Programming Interfaces) for their clinical information software. This will enable interoperability within the trust and between the trust and its neighbours. APIs are still

considered an ‘add-on’ by many IT system suppliers and are therefore optional, however the ability to exchange data seamlessly in a clinical setting is both necessary and overdue.

- 2.26. The lack of adequate and interoperable IT infrastructure is indeed one of the biggest barriers to creating a more collaborative and coordinated NHS. In a BMA survey carried out in 2019, just 16% of doctors felt there was clear communication between primary and secondary care and just 9% say patients experience coordinated care between hospitals and general practice. Over the past four months, enhanced sharing of data via the Summary Care Record (SCR) has been implemented as a way to ensure a greater range of patient information from the GP record is made available to clinical staff in secondary care. While this is an important step towards ensuring information governance processes are in place to allow greater information-sharing between primary and secondary care, the infrastructure to do this is still largely absent. Greater interoperability between secondary and primary care would naturally facilitate better communication and better, more coordinated care for patients.
- 2.27. It is also crucial that all patients have the ability to access healthcare and their health information through digital platforms. Therefore, Government should ensure investment is provided to remove any barriers or inequalities to the public accessing the internet and digital tools. With more and more people working remotely, removing such barriers will benefit both the economy and the nation’s health.

3. Investment to boost the NHS workforce, and fair remuneration for healthcare workers who have consistently gone above and beyond

- 3.1. In addition to ensuring that NHS estates such as hospitals and GP practices are fit for purpose, it is crucial that Government invests in the staff that work in them.
- 3.2. At the end of June 2020, the NHS’ medical workforce had an estimated deficit of nearly 15,000 primary and secondary care doctors. There were at least 8,278 FTE secondary care medical vacancies in England (6.1% of all NHS vacancies)¹¹. FTE qualified GPs working in the NHS also reduced by 714 between the end of December 2019 and June 2020¹². In light of the Government’s commitment to increase the workforce by 6,000 qualified GPs from 2024/25¹³, the NHS still requires at least 6,714 FTE qualified GPs.
- 3.3. In total, there are thousands of medical, clinical and non-clinical vacancies across the whole NHS workforce. The overall number stood at 83,591 FTE posts at the end of June 2020, meaning 6.7% of the posts in the overall workforce were unfilled. The highest percentage is seen in the ‘Nursing and Midwifery Registered’ staff group, which accounted for over 45% (37,821) of all the vacancies.
- 3.4. The result of a more than a decade of austerity, the NHS workforce crisis has left the NHS unprepared for a major public health crisis and serious questions remain as to just how long it will take to fully recover. As the NHS looks to accelerate the full return of non-COVID services and overcome a growing backlog of millions of non-COVID patients who have not received care as a result of the pausing of non-COVID services, doctors and staff are exhausted from working in an already pressured environment made worse by the ongoing pandemic. Sickness absences are at an all-time high and the NHS has had to call upon retired doctors and nurses to return to clinical practice.

¹¹ NHS Vacancy Statistics, [NHS Vacancy Statistics England April 2015 – June 2020 Experimental Statistics](#), NHS Digital (August 2020)

¹² NHS Digital, <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2020>

¹³ [Government committed to increasing the GP workforce by 6000 by 2024/25](#)

3.5. Short-term solutions to workforce gaps are essential, but the NHS must grow its workforce for the future and any further iteration of the NHS People Plan must outline immediate actions to address long-standing workforce shortages through a combination of effective long-term recruitment and retention strategies underpinned by significant new investment.

3.6. The Government should:

Increase medical school places

3.7. HEE (Health Education England) is currently given insufficient annual resources to ensure health and care staffing supply is safe now or in the future. We note that the Royal College of Physicians believes that around 7,500 additional medical schools places are required by 2023/24¹⁴, which would take us to an annual cohort of around 14,000-15,000 medical students per year – up from the confirmed intake of 6,800 in 2019/20¹⁵. Such an increase in medical student numbers would require a significant investment in medical school infrastructure and staffing and NHS capacity. The Government needs to start planning for this now, seeking to at a minimum double its annual investment in the yearly medical school student intake by 2025/26. Likewise, the Government’s recent decision to lift the cap on medical school places for 2020 must be matched by sufficient clinical placements, foundation programme places and corresponding specialty and GP training places. Increased resources and staff/educators in medical schools are also required to deliver the increased workload. It would be inconceivable to deny newly qualified doctors the opportunity to progress their careers and failing to guarantee access to the Foundation Programme is contrary to the efforts to address NHS workforce shortages.

3.8. It is difficult to estimate the full cost of increasing medical schools places, but based on the data available from the DHSC’s own estimates in 2017, this amounts to an expenditure of at least £3.45 billion per annum on medical school placements alone¹⁶, with the current annual investment being around £1.725 billion. We emphasise that this will not fully account for additional costs for staffing and other resources needed to provide undergraduate medical education as well as ensuring Foundation Programme and specialty training posts for newly qualified doctors.

Ensure access to occupational health services for all staff working in the NHS

3.9. Improving the provision of occupational health services, will comfortably provide return on investment through improved retention. While the People Plan states that improved OH support with a wider wellbeing offer will be piloted, it does not address our long-standing concerns that basic provision for staff is not available in some parts of the NHS.

3.10. This is particularly the case for general practice. Practices and their staff are unable to access the occupational health services that are provided for secondary care staff. The current provision of NHS England-commissioned occupational health services for general practice is inadequate in its provision and patchy in its commissioning. Access to OH services in England is based on the [national occupational health specification](#) published in 2016. According to this, NHS England commissioned services for healthcare workers would only cover access to basic services and any additional services have to be paid for by the GP practice or self-funded.

¹⁴ Royal College of Physicians (2018) [Double or quits: calculating how many more medical students we need](#)

¹⁵ Office for Students (2020) [Medical and dental intake 2018-19 and 19-20](#)

¹⁶ [Department of Health and Social Care, Expansion of Undergraduate Medical Education, 2017](#) – cost to put UK/ EU national through medical school is around £230,000

- 3.11. This has been a longstanding issue for general practice, which has been further exacerbated by the requirements placed on practices during the COVID-19 pandemic. The Government requires a risk assessment, including appropriate input from occupational health, for all general practice staff to ensure their safety in the workplace during the pandemic, but the Government has failed to provide general practice with an occupational health service to carry this out.
- 3.12. COVID-19 aside, the benefits to the NHS of an occupational health service for general practice far outweigh the costs. Improving staff health and wellbeing reduces the costs of sickness absence; improves productivity and staff retention; and increases patient satisfaction. A fully commissioned and comprehensive occupational health service for general practice will provide these wider benefits. A comprehensive OH service for primary care staff in Scotland is backed by £920,000¹⁷ and funding is provided on a recurring basis, therefore, we would estimate that a similar service in England could be delivered at around £10 million per year. This should include paid time for GPs to attend OH appointments.

Fully fund NHS People Plan commitments to safeguard health and wellbeing

- 3.13. The NHS People Plan 2020/21 includes many encouraging commitments, including setting expectations for how NHS staff should be supported in work. The Plan outlines the wellbeing ‘offer’ aimed at NHS staff during the pandemic including a dedicated confidential helpline, access to wellbeing apps, guides, webinars, group and one-to-one support, coaching, mentoring, and free car parking. These have been well received however, there is no clarity about how they will be resourced in the long-term.
- 3.14. In 2019, we welcomed a £10 million funding agreement to improve rest facilities at hospitals across England, and one year on the difference this funding has made can be seen in a number of trusts where money is being used to provide new or refurbished mess rooms, bedrooms, shower rooms and kitchens. We would like to see additional investment into healthy workplaces as outlined in the BMA’s [fatigue and facilities](#) and [mental wellbeing charters](#), including provision of food, drink, wellbeing spaces, counselling and other types of local support.
- 3.15. The People Plan states that ‘resilience hubs’ will be piloted to improve access to mental health support. These must be backed by additional funding to ensure resources are not directed elsewhere. These must also be provided in the long-term to account for the delay in staff coming forward with mental health issues following traumatic experiences, such as a major pandemic, and be delivered across all regions in order to avoid geographical inequalities.

Ensure the NHS and the wider health and social care system is exempt from the Immigration Skills Charge

- 3.16. As the ISC (Immigration Skills Charge) is a charge on employers when recruiting international staff, it is potentially damaging for NHS workforce numbers. Recent analysis of data released under Freedom of Information laws suggests that since 2017, 52 trusts paid over £15.5 million to the Government through the ISC¹⁸. It cannot be appropriate to divert funding away from the budget for front-line health services and the training of health professionals in this way.

¹⁷ <https://news.gov.scot/news/extra-support-for-gps-and-practice-staff>

¹⁸ Labour (2020) [press release](#)

- 3.17. While the Government has said that funds raised from the charge would be reinvested back into the UK workforce and health system, it is not transparent how this has been achieved. At the end of the transition period when freedom of movement ends, employers of EU nationals wishing to work in the NHS will also have to pay the ISC.
- 3.18. Given the ongoing pressures on both NHS and social care finances, the sustainability of services, the recruitment and retention of staff, and the added pressure of COVID-19 on the provision of these services the BMA has called for NHS and the wider health and social care system to be exempt from the ISC.

Increase pay for doctors

- 3.19. Since 2008, doctors have experienced a prolonged period of pay freezes, caps on increases and sub-inflationary increases. As a result, the medical profession has seen the biggest drop in pay compared to all other pay review body professions. Even though some of our members have suffered cumulative, real terms drop in pay of more than 30%, the Government has yet to take any positive steps to address the years of underpayment and low pay awards. The 2.8% uplift this year for some doctors goes nowhere near addressing this long-term decline. The pay degradation since 2008 has created substantial, cumulative lifetime losses, which for some doctors can exceed £435,000 in lifetime earnings. Pay cuts have had a damaging impact not only on doctors' living standards but also on their morale, recruitment and retention. When asked about their level of morale in a recent BMA survey, 7 out of 10 consultants described it as low to moderate.¹⁹
- 3.20. Doctors have had to work in a system which is under immense pressure as a result of chronic underfunding, workforce shortages, and rising patient demand. The resultant impact on doctors' mental and physical wellbeing is well documented: intense workloads, understaffed rotas, and long hours are leaving doctors at risk of illness and burnout, forcing many of our members out of the profession altogether.
- 3.21. 56% of the 569,440 respondents to the 2019 NHS staff survey said that, on average across England, they work up to five or more unpaid hours over and above their contracted hours per week. 9% of all respondents worked six to 10 additional unpaid hours per week, whilst 3.5% of respondents worked 11 or more additional unpaid hours per week.
- 3.22. Staff must be paid for the hours they work and not be relied upon to work for free. This only serves to paper over cracks caused by underfunding, unsafe staffing levels and shortages of available staff within the overall workforce. Goodwill quickly dissipates when staff are left overworked, exhausted and, often, unwell, and their contractual terms are regularly flouted. It is important to make the necessary funding available to enable exception reporting for all staff in England – as is the case in Scotland, following the [Health and Care \(Staffing\) \(Scotland\) Act 2019](#) receiving royal assent in June last year.
- 3.23. Fair remuneration and terms and conditions for all doctors will save money in the long-run, as they will improve recruitment and retention, reduce absence and lead to happier, more productive staff. We, therefore, call for a mechanism and the necessary funding to counter the real terms pay cuts that doctors have experienced since 2008.
- 3.24. We also call for meaningful funding to be made available to support the principle of pay parity for doctors working in the NHS and public health whether their substantive employer is a university, bodies such as Public Health England, or a local authority. The principle and the funding to support this is essential to ensure that academic medicine and public health

¹⁹ <https://www.bma.org.uk/media/3070/bma-covid-tracker-survey-full-results-aug-2020.pdf>

remain attractive places to work, that staff can move easily round the system and that the workforce can respond to the changing demands placed upon it. The benefits of both medical academics and public health doctors have been firmly underlined during the pandemic.

- 3.25. To cope with the unprecedented demands posed by the pandemic, many doctors had to go above and beyond to support the national effort to tackle the virus. Doctors have shown their resilience, dedication and professionalism, working for very long hours, frequently in unfamiliar healthcare settings, often risking their lives and the lives of their loved ones in the process.
- 3.26. These unprecedented demands on doctors are unlikely to be eased anytime soon, as beyond the pandemic, doctors will have to deal with the massive backlog of non-emergency work which has accumulated over the last months and the potential of a second wave. Consequently, it is now more important than ever that staff are appropriately remunerated for their extraordinary efforts, in order to at least partly mitigate the deepening of the ongoing retention crisis.
- 3.27. Long term pay deals should be similarly supplemented to reflect the current situation. The multi-year pay awards that junior doctors and GPs in England secured through their respective contract negotiations, do not take into account the immense efforts of those groups of doctors in responding to the unforeseen challenges presented by the pandemic and therefore, they should also be awarded recognition for this work.

Address the pension taxation issues facing doctors

- 3.28. The introduction of the annual allowance taper in 2016 had major unintended consequences for public sector defined benefit schemes, such as the NHS schemes. It led to the perverse outcome that many doctors faced either earning less or receiving a lower pension if they undertook additional work. As a result, many doctors reduced their working hours at a time when waiting lists were at their highest. The Government's decision to increase the threshold income for all workers to £200,000 was the right first step and helped remove the majority of doctors from the effects of the annual allowance taper.
- 3.29. However, many doctors with income lower than the threshold will still face tax bills as a result of exceeding the standard annual allowance, which remains at £40,000 if their pensionable pay increases even slightly (e.g. by taking on a leadership role). Of these pay rises are temporary, doctors may pay large tax charges on pension growth that they don't actually receive. The current level of the lifetime annual allowance also remains a powerful driver of early retirements, at a time when we need to maximise workforce capacity in the NHS to address the backlog of patients requiring treatment following the COVID-19 pandemic. The BMA calls for the annual allowance to be scrapped for public sector defined benefit schemes as it is unsuitable in this type of scheme.
- 3.30. It must also be recognised that the current system of pensions taxation in the NHS, can result in the same pensions savings in effect being taxed multiple times. Higher earners already for their tiered pension contribution rates, meaning that the majority of consultants and GPs will pay contribution rates of 14.5% (compared to 5% for the lowest paid NHS workers), one of the highest rates within the public sector. A key rationale for this tiering was to offset the effect of higher rate tax relief. Consequently, what is now a career average revalued earnings pension scheme, many higher rate tax payers will pay more for the same amount of pension than a basic rate taxpayer. Despite this they are still subject to further

taxation if they exceed the annual allowance and once again if they exceed the lifetime allowance.

3.31. In this context it is vital that the Government does not introduce yet another limit to pensions tax relief, particularly without addressing the current problems within the pensions taxation system and its interaction with the NHS pensions schemes in particular. Any future changes to pension tax relief, particularly if introduced with the aim of making short-term savings to the Treasury, without a significant review, could have far ranging and damaging consequences for the healthcare workforce at a time when we need to not only retain doctors in the workforce but to ensure they can take on additional work and leadership roles without being financially penalised as a result.

4. Protect the NHS and the UK economy by reversing cuts in public health and investing in mental health services

Public health

- 4.1. COVID-19 has demonstrated the importance of public health services and how they help to reduce pressure on the NHS. But public health services are significantly underfunded, with long term funding cuts having led to reduced services. It is crucial that these services are invested in now to help cope with the impact of COVID-19 and to be prepared for future pandemics.
- 4.2. At a local level, the BMA and others have previously called for an increase of £1 billion to the public health grant to return funding to 2015/16 levels, with additional investment year on year increasing to £4.5 billion by 2023/24.
- 4.3. The national public health budget has experienced cuts since 2016/17. For example, the operational budget of Public Health England dropped from £401 million in 2016/17 to £396 million in 2018/19. It is crucial that this is increased and protected from cuts in the future.
- 4.4. Parts of Public Health England's work require national coordination and oversight. While it is still unclear how these functions will be organised, and it would be premature to call for a specific amount of funding, nonetheless the Government must commit to the principle that every level of public health will be better funded than it was pre-pandemic. COVID-19 has shown us the importance of public health and the chronic underfunding of public health services must not be carried over into the new organisations.
- 4.5. The Government must commit to ensuring that the newly formed 'National Institute for Health Protection' (NIHP) is adequately resourced to ensure that our response to COVID-19, future pandemics and other hazards is as robust as possible. Only an average of 21% of the operational Public Health England budget went towards preventing infectious diseases over the past three years. This is entirely inadequate. It also remains unclear as yet whether the £10 billion set aside for test and trace will be amalgamated into the budget for the NIHP.
- 4.6. Investment in capacity in public health higher specialist training is also needed to meet challenges post-COVID and future threats of infectious diseases.

Mental health

- 4.7. Mental health providers are already reporting significant increases in demand and the severity of new referrals due to the pandemic²⁰. The Government must commit to

²⁰ The Health Foundation (2020) [Emerging evidence on COVID-19's impact on mental health and health inequalities](#)

increasing mental health spending given the acute increase in demand we are already starting and will continue to see due to COVID-19.

4.8. We have recently called for mental health spending to be doubled in real terms over the period of the NHS Long-Term Plan, alongside increased investment in primary care, public mental health, mental health research and the mental health estate²¹. This would mean investing at least £4.6 billion a year by 2023/24. Dedicated additional funding should be made available to Clinical Commissioning Groups in light of the anticipated increased demand created by COVID-19.

4.9. The effects of COVID-19 on population mental health could be considerable, and any mental health provision outside of the NHS must also be prepared for an increase in demand. Specific funding should be allocated to local authorities, in order for them to substantially increase spending on public mental health. For example, we endorse the Royal College of Psychiatrists' ask for substance abuse services to be allocated £30 million of capital funding for drug and alcohol use disorder services by 2024/25^{22,23}.

5. Make sure everyone who needs it can access high quality social care services free at the point of use, and support more people to stay independent for longer by investing in preventative care in the community

5.1. Increased pressure on the social care system is resulting in rising levels of unmet need, increasingly impacting the NHS and causing unnecessary strain on critical services, where there is little to no capacity – a situation that has been highlighted and exacerbated by the COVID-19 crisis. In order to address these issues, significant investment is needed in key areas of the social care sector.

5.2. The Government should:

Provide an overall funding boost

5.3. Social care funding across the UK has not kept up with rising demand for services and costs are continuing to rise. It is crucial that substantial funding is provided to enable the sector to meet rising demand, whilst also improving services and workforce conditions. This will cost an extra £12.2 billion in England in 2023/24²⁴. Additional funding will be needed on top of this to ensure better access to care by providing more services free at point of need. An additional £5 billion would be needed in England, for example, to implement free personal care in 2023/24²⁵.

Widen access to care services by making social care free at the point of need

5.4. Very few people have access to free social care in England, with it often being limited to those with low levels of saving or greatest needs. More social care services, such as personal care, should be free to increase the availability of and access to care. This will improve the lives of those who need care and also help reduce pressure on the NHS by reducing delays in finding care packages for vulnerable patients.

Invest in the social care workforce and value those who work in social care

²¹ The BMA (2020) [The impact of COVID-19 on mental health in England; Supporting services to go beyond parity of esteem](#)

²² [Royal College of Psychiatrists \(2020\) Next steps for mental health funding in England](#)

²³ This is for public mental health and therefore in addition to the £4.6bn needed for secondary care mental health services.

²⁴ The Health Foundation (2020) [The social care funding gap – our updated estimates and figures explained](#)

²⁵ The Health Foundation (2020) [The social care funding gap – our updated estimates and figures explained](#)

- 5.5. Workforce shortages are a major issue for the social care sector, with 122,000 vacancies in England alone²⁶. As a low paying sector, social care staff should be provided with opportunities for salary and career progression. Ensuring social care employment terms and conditions mirror those of the NHS would help to improve the situation and improve retention and access to skilled personnel.

Focus on prevention and support people to stay independent for longer

- 5.6. Debate around the future of social care focuses too much on care homes. Priority should be given to supporting people to stay independent for longer in their own homes. Integration of local NHS, social care and community services can help prevent people from needing to go into a care home, as well as preventing avoidable need for NHS care. To enable this, more funding should be set aside to jointly commission health and social care, so that professionals can work together more effectively, and resources can be used more efficiently. More investment should also go into domiciliary care services, home care teams and community services, supporting them to work with both NHS bodies and local public health teams.

²⁶ The Health Foundation (2019) [Health and social care workforce](#)