**Help build a health service fit for the future**

**Response from Doctors for the NHS**

**Q1** **What does your organisation want to see included in the 10-Year Health Plan and why?**

**1.1 Commitment to the founding model of the NHS**

The NHS has proved a resilient model, which has shown itself able to adapt to meet changes in demand over more than 75 years, with varying success, but has overall served this nation well for much of that time. Systematic international comparisons, such as those of The Commonwealth Fund, have consistently ranked it as the best performing in the world over many years, in terms of care process and healthcare outcomes; access and equity; and administrative efficiency and spending – at least until 2014.

During much of this time, training places for careers in nursing and medicine have been over-subscribed and qualified doctors, nurses and clinicians in other disciplines have found fulfilling, long-term roles within the NHS.

Lord Darzi pointed out in his recent Independent Investigation of the NHS in England, “Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay.” (1, p131) There is no good evidence that switching to any of the systems used in another country would reduce the overall cost of healthcare to the nation, or be ‘more affordable’. Lord Darzi points out that, “Other health system models – those where user charges, social or private insurance play a bigger role - are more expensive.”

We want to see a clear statement of the commitment to the original operational model of the NHS as funded largely from a progressive taxation system, publicly provided (obvious exceptions exist for the purchase of drugs and equipment), and publicly accountable:

* a duty of candour at all levels of organisation, including commercial organisations and arms’ length bodies
* restoration of the duty of the Secretary of State to provide or secure the effective provision of services to promote a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of illness, this duty having been in effect until the passage of the Health and Social Care Act 2012.

**1.2 Exclusion from trade deals**

* We are also concerned that this model should not be jeopardised by any future trade deal. We want to see a formal declaration that the NHS is a “non-economic service of general interest” and “a service supplied in the exercise of governmental authority” so asserting the full competence of Parliament and the devolved bodies to legislate for the NHS without being trumped by EU competition law and the World Trade Organization’s General Agreement on Trade in Services.

**1.3 Risks of excessive specialisation**

It is essential for all doctors to have the confidence to recognise and treat most common conditions, while still recognising when you need to call on advice from a colleague. There is a need to rebalance training to allow the continuing development of generalist medical skills in the great majority of trainees, throughout their training, alongside more specialised interests. An excessive degree of sub-specialisation has been a major factor driving the proliferation of consultant posts and some of the resulting shortages. It also causes considerable problems in staffing safe on-call rotas and providing outreach services, particularly in more rural areas.

It is heartening to see the emphasis on developing and maintaining general medical skills expressed repeatedly in the NHS Workforce Plan.

**1.4 Develop and deliver on the NHS Workforce Plan**

We welcome the NHS Workforce Plan, but have serious concerns about the expansion of the Medical Associate Professional workforce in the absence of a clearly defined role.

The Plan attaches firm figures to the deficit of main groups of staff, with estimates of numbers of training places required, including not only lifting the cap on domestic entrants to existing medical schools, but an intention to establish additional schools in areas such as Cumbria, in the hope that this will encourage more graduates to join the local workforce.

However, more output from medical schools is pointless without the capacity of postgraduate training and there is a huge discrepancy between the number of applicants for specialty training in many disciplines, and the number of places available. (2) For example, there are about 1000 consultant anaesthetist posts vacant, but there has been a reduction in places on the Anaesthetics Core Training Scheme, resulting in four applicants for each available training job. These bottlenecks exist for almost every specialism ( even for the General Practice Specialty Training programme there were twice as many applicants as places ) and almost all have worsened since 2015, associated with the failure to protect the budget of Health Education England over that period.

There is an overwhelming need to switch the whole of the NHS in England into an organisation that prioritises training. It is inefficient, poor value for money and delivers a poor standard of patient care to try and continue with the large gaps that exist in so many areas.

**1.5 Improving patient safety through a fairer disciplinary system**

Sir Robert Francis, in his ‘Freedom to Speak Up’ review in 2015 criticised the use of disciplinary processes by NHS Trusts, saying, “*Employers often felt challenged in how to separate safety concerns from disciplinary issues”,* despite the publication of ‘*Maintaining High Professional Standards in the Modern NHS’ (2005)*, followed by further guidance, but with limited effect. (3) Some of the evidence presented at the Inquiry into infant deaths at The Countess of Chester Hospital has suggested that these problems persist. Two private members’ bills calling for an Office of the Whistleblower have been presented in the House of Lords within the last four years and have garnered significant support, but failed to progress.

Patient safety is reliant on the ability of members of the public and staff being able to speak up about concerns over the safety and quality of care in the NHS and other organisations, without fear of retribution and in expectation that their concerns will be investigated and addressed, if verified. We would like to see elected Scrutiny Panels established in each Trust, with statutory powers to gauge concerns raised about a doctor’s practice before recommending whether the Trust should embark on a formal investigation. The intention would be to stop unfair or malicious proceedings at the outset, reducing overall the number of formal investigations and suspensions, with their associated cost to the lives of doctors and their families, and the disruption of clinical services, while safeguarding the right of staff and the public to raise concerns.

**1.6 Abolish migrant charges**

When the NHS was established, the care that it provided was available to anybody who happened to be in the country, in the interest of basic humanity. In 2017, this universal access to healthcare was brought to an end by the introduction of charges for healthcare for migrants and visitors to the UK, as part of the ‘hostile environment’ policy of the time. This was accompanied by an obligation on NHS Trusts to carry out checks on patients’ entitlement to care and the flow of personal information between the NHS and the Home Office and its agencies. This process barely recovers the cost of its administration, is burdensome on the NHS and deters some of the most vulnerable from seeking care, particularly perinatal care. We are asking for these charges and associated checks to cease.

**Q2 What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?**

**2.1 Ensuring that funding the primary, community and mental health services are not repeatedly sacrificed to meet the need of the acute hospital sector.**

According to the World Health Organisation,

*“Primary care is the most inclusive, equitable, cost effective and efficient approach to enhance people’s physical and mental health”* (4)

It also offers huge benefits to the wider economy. (5) Healthcare investment in general gives a four-fold economic return, but every £1 spent on in primary care yields a £14 benefit to the general economy (6), so particularly good for economic growth.

It is also very efficient. Primary care sees 90% of all patient contacts, for 8% of NHS budget. The OECD average for the proportion of the healthcare budget allocated to primary care is 14%, it’s 17% in Spain and Estonia, and 18% in Australia.

Lord Darzi emphasised the need to:

*“Lock in the shift of care closer to home by hardwiring financial flows. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population ages. Financial flows must lock-in this change irreversibly or it will not happen.”* ( 1, p132)

It is essential to recognise that investment in primary care will not produce an immediate reduction in demand on hospital services, because of the accumulated backlog of work that will take several years to work through. There will be the need for a period of dual-running before spending in secondary care can be safely scaled back.

**2.2 The General Practitioner needs to remain the foundation of primary care**

Far from general practitioners being less skilled, they see the undifferentiated patient, a patient presenting for the first time with a new problem, or even a known patient with a completely new and unexpected set of symptoms. This requires excellent skills and detailed knowledge of how the human body functions in health and disease, the wide range of patterns of disease, the accompanying signs and symptoms, and the ability to assess whether these are the beginning of something serious, possibly life-threatening, or not. One of the key skills of all doctors, including GPs, is the ability to manage uncertainty, but to do this safely requires the level of background knowledge that takes years of education and training to acquire.

Diagnosis of the undifferentiated patient is key to timely, efficient and safe care, delivered at the NHS front door, and this requires a GP. It is not a task that can safely be undertaken by other professionals, except for some physiotherapy, or ophthalmology assessments in limited circumstances. The extent of training offered to Physician Associates falls far short of what is required and the lack of a defined scope of practice can result in them being put into positions of clinical responsibility for which they are poorly prepared. We welcome the forthcoming review of this role and in the meantime we believe that the BMA’s Scope of Practice Guidance is appropriate. (7)

For PAs, primary care is less well placed to offer the supervision and oversight needed, partly because of the style of working and the issue of the undifferentiated patient. So, far from ‘getting it right first time,’ which saves time and money, and increases GP productivity, patients are often seen many times, before or even if, the right intervention is offered and increases the likelihood of patients seeking care at A&E departments. (8, 9) Larger privately owned practices on Alternative Provider of Medical Services contracts, often in poorer areas, tend to employ more PAs and fewer GPs compared with the national average.

We believe the decision to regulate Medical Associate Professionals (MAPs) by the General Medical Council to be a mistake and that regulation by the Health and Care Professions Council, as occurs with Paramedics, would be much more appropriate and reduce the misunderstanding that seems to have led some employers to regard doctors and MAPs as interchangeable.

**2.3 Striking the right balance between timely access and continuity of care**

Continuity of care is the magic ingredient in good medical care, particularly in primary care and comes with important benefits, including increased productivity, with a 5.2% reduction in total consultation demand (10), improved job satisfaction and better staff retention. It reduces mortality, morbidity, A&E attendances and hospitalisations. (11) Both over-treatment and under treatment are reduced, and compliance with treatment improved.

The further fragmentation and depersonalisation of out-of-hospital care should be resisted. The prescriptive roll out of Same Day Access Hubs should be halted, with Primary Care Networks given discretion on how best to improve access and continuity. There is no good evidence to support the benefit to either healthcare or the patient experience of promoting access over continuity of care.

**2.4 Realising the potential of good primary and community care**

Primary care could do very much more than at present, if it were properly resourced and resources targeted to those parts of the country that are most affected by the social determinants of health.

The proportion of healthcare spending allocated to primary care in the average EU country is 14%; in the UK it is 8%, despite its demonstrable value for money.

There has been a rapid reduction in the number of practices across the country, with 20% fewer practices, affecting particularly rural and poorer communities, which receive 7% less funding than more affluent areas. (12, 13) Targeting will necessitate reweighting the Carr Hill and the ARRS formulae to take greater account of levels of deprivation in different communities, if we are to address the reduction in healthy life expectancy that is greatest in deprived communities.

This has been accompanied by amalgamation of practices into larger units, under different structures. One might anticipate that larger practices might offer greater access to patients and a wider range of services, but a longitudinal study into the impact of increasing practice population (14) found a more mixed and nuanced picture, some of which might be associated with a reduction in continuity of care. This study showed that, as practice populations increased:

* The quality of clinical care worsened in four out of six domains of QOF
* Prescribing practice showed less use of generic medicines
* Rates of antibiotic use declined
* The rate of unplanned admission of patients with ambulatory care sensitive conditions reduced
* Patient satisfaction with their care declined
* There was no association between practice size and avoidable attendance at emergency departments

Caution needs to be exercised in moving to upscale primary care and to keep practices to a human scale.

In addition, there needs to be an ambition for a primary care system that meets the most critical need. The Deep End Movement, started in Scotland in 2009, bringing together GPs working in some of the most deprived communities in the country, to pool their experience, provide mutual support and share good practice. They celebrate the differences that patients bring and work differently with them, rather than trying to make them fit into an NHSE system, which completely fails to accommodate the needs of people ground down by chronic ill health or caring responsibilities and long-term poverty. They coordinate, engage with their community, have good links with universities, and have created centres of good practice, showing what primary care can aspire to. (15, 16)

The Born in Bradford project is another that shows the power of networks and collaboration in bringing together research, training and treatment. (17)

**2.5 Reflecting that ambition in the workforce strategy**

Effective measures are needed to raise the status of general practice and make it an inspiring, attractive career option, to encourage medical graduates to train in the specialty, and to stay, developing their skills and their practices, and also inspire former primary care clinicians to return.

Between 2010 and 2020 there has been a serious reduction in the numbers of key members of staff working in important disciplines in the community, with 48% fewer District Nurses; 37% fewer Health Visitors and 35% fewer School Nurses. (18) The move to shift even more care from hospital to community cannot take place safely without restoring the District Nursing workforce, with their training in the holistic care of patients with long-term and complex conditions, and their confidence to work away from the resources and easy access to advice that is available in hospital. Working in partnership with general practitioners and other members of the primary care team, they can greatly expand the scope of care that can be safely delivered in the patient’s own home and support care in nursing and residential homes.

The depleted number of Health Visitors, with the almost doubling of each Health Visitor’s caseload has had a serious impact on their ability to support young families at this crucial period of child development, contributing to the UK’s lack of investment in its future citizens and workforce, as reported by the Academy of Medical Sciences. (19)

Similarly, the reduction in School Nurses neglects the opportunity to instil healthy habits and behaviour at a formative period of life, when young people are brought together in one place and are potentially open to education to benefit their future physical, sexual and emotional health.

In many areas, there is scope to increase the collaboration and coordination of care between primary and community care, to provide mutual support, which should be to the benefit of the patient. Working from a single base, sharing the same physical location, increases the opportunity for such cooperation and informal communication that is essential to good teamwork.

**2.6 A sustainable financial environment**

A new GP contract is needed to ensure good care, NHS terms and conditions for all staff, time set aside for training and meetings, funding for premises and equipment, and also provide sufficient reward for the work involved in running a practice. The original uplift of 1.9% does not cover these costs. By contrast, the contracts issued to APMS practices offer a 14% higher rate of payment per patient.

The cost of premises is a problem, as is space for expanded teams. Darzi pointed out that 20% of GP practices are working out of buildings that were built before the NHS was founded. Costs have risen considerably, including administration charges levied on many practices by NHS Property Services Ltd. Might not England benefit from Scotland’s Equity Transfer Scheme which was introduced to phase in a move to GPs no longer owning their premises, which gradually become state assets, rather than being a liability on the practice, and one of the reasons that many practices close and are sold?

Now is not the time for a major review or reorganisation, including that of the partnership model; supporting both partnerships and NHS salaried models will be the most cost effective and least disruptive option.

**2.7 Remove artificial barriers**

Since 1974, there has been a fairly arbitrary distinction between healthcare and social care, which have different funding arrangements and eligibility conditions, which act as a major barrier to the provision of holistic care to individuals and introduce administrative hurdles to the discharge of patients from hospital as their medical condition improves, but their need for supportive care or reablement persists. Given that England has one of the lowest supplies of hospital beds per head of population in the OECD, we either have to make the most efficient use of those beds, or increase their number, together with increasing hospital staffing levels accordingly. In many hospitals it is not unusual for 30% of beds to be occupied by patients who could be looked after in the community.

The current situation is hugely wasteful of resources as well as undermining of the human rights of many people with disabilities, denying them as full a degree of independence and participation in wider society. It is also arbitrary, with the personal care needs of patients with a diagnosis of cancer being met by the state, but those of people with dementia being expected to fund their own care. Surely the time has come to tear down these barriers and establish a National Care Service that can run in parallel with the National Health Service, so that the needs of an individual can be addressed as a whole, including supporting independent living for people with long-term disability, to the greatest extent possible, with care provided according to the individual’s need, not their ability to pay.

**Q3 What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?**

**3.1 Experience so far**

Clinicians have generally been keen to embrace technological advances when they make their working life easier, or clearly improve the care that can be delivered to their patients.

Unfortunately, the experience with the roll out of electronic patient records has often been more problematic, with systems being commissioned that seem to have been developed principally as tools for billing patients for item of service in health systems that are insurance-based, with less priority given to their utility in recording clinical details and retrieving records of previous episodes of care. These problems can be compounded by the need to refer to a number of different free-standing systems and databases that do not ‘talk’ to each other, requiring multiple log-ins and clicking through a number of screens. The ‘Connecting for Health’ debacle was costly in terms of more than just money. Too often, the introduction of IT systems in the clinical workplace increases the length of a consultation, adds to a sense of frustration in the job being harder than it needs to be, and draws the clinician’s attention away from the patient.

Often we hear the comment, “The doctor didn’t bother to look at me – they kept their eyes on the computer screen.” Good communication involves much more than listening to the words that someone utters: recognising and responding to facial expressions is essential, and very important in building trust and confidence that can be crucial to establishing a diagnosis, or assessing their preference for a particular choice of treatment.

**3.2 Thinking like a machine**

There are suggestions that artificial intelligence (AI) has the potential to change radically the way that healthcare is delivered, reducing the need for highly trained clinicians. Some of this blind faith in AI comes from a misunderstanding that the information required to make a diagnosis, and plan a course of treatment that meets an individual patient's own personal needs (which often includes not proceeding with treatment), and support a patient through the ups and downs of that course, and coming up with a plan B if necessary, can all be obtained through blood tests, scans etc, which can be fed into an algorithm and out comes the answer (which may well be 42).

Much of the information required to make a diagnosis, and to understand what a patient wants from any treatment, can only be obtained by sitting down with them, listening to what they are telling you, and asking a lot of questions based on our understanding of medicine and human nature, and listening carefully to the answers to those questions. We all know that there is a huge variety in the way that people express themselves. We all know that patients often don't tell you what is really worrying them until the consultation is nearly at its end, and they have built up enough trust, or courage, to tell you. We believe we are a long way from having an intelligent machine that can make sense of what most patients present to us.

A consultation gives us the opportunity to explore the level of understanding that a patient may have of the way their body works in health and sickness, and how one might best explain their situation and the options available to them.

And there is also the question of trust. Most of the things we do to patients involve discomfort, pain and the risk of ending up worse, rather than better. People who are ill feel very vulnerable and need to feel cared for. We don't think we have any caring machines yet.

**3.3 Patient choice**

And the idea that we are anywhere near being able to provide the level of information that would allow an informed choice of where to have care, or from which clinician, is an illusion. There is no shortage of quantitative indicators of quality and safety, but there is good evidence that their meaning and usefulness is not that great.

With much of the data that is collected routinely, a slight alteration in the weighting applied to the data can make a radical difference to where an organisation is ranked within the hierarchy. (20) Extreme outliers can be identified, but for most NHS organisations, the data don’t tell us that much. Similarly, looking at the use of surveillance tools by the CQC to identify problems, or stratify inspections, the data don’t actually correlate very well with the findings at inspection, so they are probably of limited value in telling us much about quality and patient safety, and the sheer number of indicators can be overwhelming. (21, 22)

**3.4 Ensuring an equal partnership**

The NHS is unique in being a sole insurer for the great majority of the healthcare of the entire population, so its data is an extremely valuable resource, not only for research into diseases and their treatment, but also into ways to turn the data into financial profit.

There are obviously huge opportunities for the NHS and other public bodies, such as universities, to share in the value that can be derived from this knowledge, but instead, when big tech corporations are involved, they seem to adopt an extremely predatory attitude, which can be seen if you compare the rates at which research is co-authored with other organisations, compared to rates of co-ownership of resulting patents. Fewer than 1% of the collaborations result in co-ownership of the intellectual property rights that emerge from these research partnerships.

We need a mechanism for the more equitable sharing of the benefits of research based on our health data to ensure a continuing funding stream to our public services and to reduce the risk that the publicly-funded NHS ends up having to pay through the nose, in perpetuity, to use the tools that could only have been developed with the co-operation of the NHS. We should be exploring the possibility of a UK Tech model, developing data and other IT services in a collaboration between UK universities and companies; retaining the jobs, expertise and intellectual property benefitting the UK and its public services.

**Q4 What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?**

The decline in physical and mental health of young children, outlined in a recent report from the Academy of Medical Sciences, should cause serious concerns because the foundation for so much chronic illness in later life is laid down at the start of life (19) and the future prosperity of this country depends on our investment in the next generation.

The BMJ Commission on the Future of the NHS reports include evidence of the intersecting factors contributing to these inequalities. (23)

Importantly the Commission makes clear recommendations for government action:

* Implement policies to tackle poverty, so that individuals and families can lead healthy lives, including the level at which national minimum and national living wages are set, the level of Universal Credit and a more equitable distribution of corporate profits to reduce in-work poverty
* Investment in housing compatible with good health, including affordable, good quality, sustainable housing and retrofit of the existing housing stock
* Giving every child the best start in life, through policies to reduce childhood poverty, targeting additional spending towards supporting early years in more deprived areas and reversing the decline in mental and physical health of children and young people.

It interestingly highlights actions that can be taken by the NHS, as the largest employer in the country, to improve the working conditions of its staff and the conditions of their families, as well as the role of NHS organisations as anchor organisations in their communities.

It must be understood that investment in improved public health will not pay dividends immediately: it is an investment in the UK for the medium to long term.

**Q5 Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:**

* **Quick to do, that is in the next year or so**
  + **Commit to founding model of NHS (1.1)**
  + **Exclusion of NHS from trade deals (1.2)**
  + **Abolish migrant charges (1.6)**
  + **Pause and review expansion of MAP posts (1.4)**
  + **Negotiate a new GP contract (2.6)**
  + **Don’t sacrifice continuity of care for improved access to primary care. (2.3)**
  + **Improve primary care services in more deprived communities e.g. Deep End model (2.4)**
* **In the middle**
  + **Rebuild community care workforce (2.5)**
  + **Establish Trust scrutiny panels to screen safety concerns (1.5)**
  + **Address bottlenecks in postgraduate medical training (1.4)**
  + **Hardwire financial flows to primary care, community care and mental health (2.1)**
  + **Establish a National Care Service (2.7)**
  + **Establish a UK Tech model (3.4)**

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