Royal College of Physicians

Submission

Long-term sustainability of the NHS committee

Royal College of Physicians' submission

1. Introduction

The Royal College of Physicians welcomes this opportunity to respond to the Lords Select Committee inquiry on the long-term sustainability of the NHS. This response is based on the experiences of our members and fellows (primarily hospital-based doctors).

2. About the RCP

The RCP plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing almost 33,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high quality care for patients.

3. Summary

In order to ensure the long-term sustainability of the NHS, the Royal College of Physicians (RCP) has long argued that we need to rethink the way we deliver healthcare: breaking down barriers between hospitals and the community, and working in partnership with patients to deliver joined-up care. To achieve this, we need a national health service that is funded to meet the needs of our ageing population. Yet the NHS in 2016 is underfunded, underdoctored and overstretched.

4. The long-term sustainability of the NHS is not predicated purely on finances. Government must strike the right balance between oversight of financial discipline and consequences for poor performance with equally vociferous protection for safe, high quality patient care. Meeting staffing requirements is one such fundamental. We are aware that many trusts are failing to fulfil existing medical staffing establishments – highlighted by the RCP's data on unfilled consultant vacancies and frequent gaps in rotas for trainee doctors – and that consultants are already struggling to find workarounds and ways to fill the gaps to protect patients. If this crisis is not resolved, patient care will be compromised.

- The NHS will struggle to meet the requirement, set out in the Five Year Forward View, to save £22bn by 2020
- Moving to innovative new ways of delivering care across traditional boundaries – such as the RCP's Future Hospital model is essential. However, redesigning services does not always lead to cost savings in the long-term
- The delivery of high quality patient care is vital to the long term sustainability of the NHS
- The UK does not train enough doctors to meet demand
- The use of other groups of healthcare professionals should be considered to fill the gap
- The expansion of the medical workforce will necessitate increases in medical school numbers, foundation training places, core medical training places and speciality medical training numbers now.

- Ensuring adequate funding, staffing levels and resources are key to making services more integrated, responsive and patient-centred
- Preventing ill health and improving health are amongst the most effective and cost effective ways to ensure our health service is fit for future generations.
- Cuts to spending on public health will have serious and lasting implications for both the health of communities across England and the long term sustainability of the NHS.
- Providers should use an agreed standardised structure and content for electronic records

Evidence

Resource issues, including funding, productivity, demand management and resource use

5. Numerous analyses of the current funding envelope for the NHS have come to the conclusion that the health service will struggle to meet the requirement, set out by the Five Year Forward View, to save £22 billion by 2020[1]. Recent analysis by the Nuffield Trust concludes that even if hospitals and other NHS providers made cost savings of 2 per cent a year, the funding gap would still stand at around £6 billion by 2020–21[2]. The Five Year Forward View proposes that much of this funding gap will need to be closed through efficiency savings by providers. However, there is scepticism that trusts can eliminate deficits through effective planning, good management and 'belt tightening', and increasing consensus that **the long-term sustainability of the NHS is predicated on fundamental change in the structure and delivery of health and social care services**. With eight in ten trusts operating in deficit, the current financial crisis clearly goes beyond individual organisations' financial discipline.

6. The approach must go beyond enforcing financial discipline on individual organisations through cost savings, to encompass holistic redesign of health and social care delivery in local health economies. **Moving to innovative new ways of delivering care across traditional boundaries – such as the RCP's Future Hospital (FH) model is essential[3]**. The Future Hospital Programme (FHP), developed from the Future Hospital Commission, aims to implement the vision of improving care for patients by bringing medical specialist care closer to the patient wherever they are, in hospital or in the community.

7. Transformation requires upfront investment, and relies on healthcare teams having the capacity to explore, implement, lead and share new ways of designing and delivering services. However, it is important to note that redesigning services does not always lead to cost savings in the long term. It therefore continues to be a concern that the allocations from the Sustainability and Transformation Fund to support innovative new models of care are far outweighed by the sums assigned to reduce the deficit.

[1] NHS Five Year Forward View. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [accessed August 2016]
[2] Gainsbury S (2016) Feeling the crunch: NHS finances to 2020. Nuffield Trust
[3] Future Hospital Programme. [accessed August 2016]

8. In a recent survey of members and fellows, 85% of physicians believe that current health service funding is not sufficient to meet demand[4]. Respondents identified several areas where efficiency savings have had an impact:

   - Reduction in staff: patient ratios (83%)
   - Reduction in the amount of time that physicians are able to spend with patients (71%)
   - Increase in waiting times (67%)

9. There are also concerns for the future: 82% of respondents believe that it will not be possible for their hospital to make further efficiency savings in 2015-2020 without this having a negative impact on patient care.

10. Many NHS trusts are struggling to deliver safe, effective patient care that meet quality standards and national targets, while simultaneously undertaking the required service transformation. Open and public debate about the limits of what the NHS can provide within the allotted cost envelope has also lagged behind what is needed.

11. It is also important to note that health spending in England has a direct impact on the devolved nations through the Barnett formula, which means that increased spend on the NHS in England has a direct effect on the sustainability of services in the devolved nations.

12. The financial challenge facing the NHS is having a real impact on the delivery of patient care. Although demand for services increases by 4% every year[5], NHS funding will increase in real terms by only 0.2% per year to 2020[6]. Cuts to the budgets of social care and public health services and recorded hospital deficits of £2.45 billion[7] are already impacting on patient care: growing waiting lists, patients stuck in hospital because of discharge delays, emergency departments closing their doors, and the threat of 'rationing' treatment.

13. These conditions put patient safety and recovery at risk. A truly 7-day health and care system will only be possible when we address the underlying and immediate threats to patient safety caused by insufficient investment in NHS finance and staffing.

Funding for social care

14. Investing in social care is vital to the long term sustainability of the NHS. Across the country, patients fit for discharge are waiting to leave hospital, in many cases because social care support is unavailable. The proportion of delayed discharges attributable to social care has risen recently (from 26 per cent at the end of 2014/15 to 31 per cent in the third quarter of 2015/16)[8]. This reflects pressures faced by local councils, which have seen significant cuts to their budgets in

[4] Royal College of Physicians (2015) The NHS: the doctors' view.
[5] NHS Confederation. *Key facts and trends in acute care*. London: NHS Confederation, 2015. www.nhsconfed.org/resources/2015/11/key-facts-and-trends-in-acute-care [Accessed 7 September 2016].
[6] Appleby J. New NHS inflation figures underline funding pressures facing the NHS. London: BMJ, 2016. http://blogs.bmj.com/bmj/2016/05/20/new-nhs-inflation-figures-underline-funding-pressures-facing-the-nhs/ [Accessed 7 September 2016].
[7] National Audit Office. Reports on Department of Health, NHS England and NHS Foundation Trusts' consolidated accounts 2015–16. London: National Audit Office, 2016. www.nao.org.uk/report/reports-on-department-of-health-nhs-england-and-nhs-foundation-trusts-consolidated-accounts-2015-16/ [Accessed 7 September 2016].
[8] What's going on in A&E? The key questions answered. The King's Fund [accessed July 2016]

recent years. Spending on social care began to fall in real terms from 2009, though it has fallen much more steeply since 2010[9]. The Local Government Association estimates that social care faces a funding gap of £4.3 billion by 2020[10]. **The RCP believes that it is unrealistic for the NHS and social care system to absorb these pressures**. The RCP has repeatedly called for both social care and the NHS to receive sufficient funding to ensure that care is focused around the needs of patients[11].

Workforce

15. The RCP's members and fellows are working in an, **under-funded, under-doctored and overstretched health service**, with rising demands of treating older comorbid patients and limited financial and workforce resources. Research conducted by the RCP between 2014-2015 shows that 40% of advertised consultant vacancies remain unfilled; the most common reason is due to a lack of suitable candidates[12]. This proportion of unfilled vacancies increased in 2015 to 43%. **This is significantly impacting on the ability of doctors to deliver high quality care for patients**. 28% of consultants have reported 'significant gaps in the trainees rotas such that patient care is compromised'. More consultants are now covering gaps in trainee rotas: 13% regularly do so, and almost a third of consultants cover gaps in trainee rotas as a one-off. Together with a shortage of nurses, this has left our hospitals chronically understaffed[13]. This increases pressure on NHS staff, impeding morale and putting patient care at risk.

16. The RCP's report *Underfunded, Underdoctored, Overstretched* outlines a range of options for increasing the supply of doctors to fill this gap and ensure the workforce is sufficiently and appropriately trained to meet the changing needs of patients[14].

Increasing the supply of doctors

17. **The reason there are such a high number of unfilled consultant posts is because the UK does not train enough doctors**. There are fewer medical students now than in 2010[15], despite an increasing number of patients. The number of qualified doctors training to be medical specialists has also fallen[16] and in recent years there have been difficulties in filling significant numbers of specialty training posts[17]. This in part due to the relatively high number of doctors in core medical training (CMT) who choose not to progress to specialty training and become medical registrars. Another major factor is a mismatch between the number of doctors at CMT level and the number of specialty training posts: current CMT numbers would fill only around three-quarters of medical registrar posts. This leaves the NHS reliant on importing doctors from other countries and doctors returning

[9] How serious are the pressures in social care? The King's Fund [accessed July 2016]
[10] *Adult social care funding: 2014 state of the nation report*. Local Government Association. 2014
[11] Doctors urge chancellor to increase social care funding. BBC News [accessed July 2016]
[12] Federation of the Royal College of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2014-15.* London: Royal College of Physicians, 2016
[13] Institute for Employment Studies. *One in three nurses to reach retirement age within ten years*. Brighton: IES, 2016. www.employment-studies.co.uk/news/one-three-nurses-reach-retirement-
[14] Royal College of Physicians of London. 2016. *Underfunded, Underdoctored, Overstretched. The NHS in 2016.*
[15] UCAS. *End of cycle 2015 data resources: DR3_015_01 acceptances by detailed subject group*. Cheltenham: UCAS, 2016. www.ucas.com/sites/default/files/eoc_data_resource_2015-dr3_015_01.pdf [Accessed 8 September 2016].
[16] Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary*. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].
[17] Joint Royal Colleges of Physicians Training Board. *2015 Annual Specialty Report*. London: JRCPTB, 2016. www.jrcptb.org.uk/documents/2015-annual-specialty-report [Accessed 8 September 2016].

from time out of training. The shortage of medical registrars increases the pressure on existing doctors-in-training and discourages core medical trainees from moving into these roles, and compromises patient care[18].

18. It also has a knock-on effect on more senior roles: **hospitals are unable to recruit two out of five consultant physician posts that they advertise, owing to a lack of suitable candidates**. This failure to appoint is even higher for in-demand roles focused on caring for the acutely ill and older people[19]. Despite the continuing increase in demand for experts in geriatric medicine, the number of training places for this specialty fell in 2015[20].

19. Training a physician is a long and expensive process that takes an average of 10 years from graduation. The expansion of the medical workforce will take time to achieve and will necessitate increases in medical school numbers, foundation training places, core medical training places and speciality medical training numbers now.

20. Given we are not training enough doctors in the UK, **recruiting from overseas** is another option. As immigration rules have proven to be a major barrier to doctors working in the NHS, the government must consider relaxing Migration Advisory Committee (MAC) rules for doctors. The RCP's **Medical Training Initiative (MTI)** provides another avenue through which to recruit doctors from overseas[21]. The MTI is a mutually beneficial scheme that provides junior doctors from all over the world with the opportunity to work and train in the UK, while giving trusts a high quality, longer-term alternative to using locums to fill rota gaps.

21. The **use of other groups of healthcare professionals** is another option but will take time to achieve. The success of physician associates (non-medical allied health professionals specifically trained to support medical teams and deliver defined medical care) makes them a potential solution with many new training programmes starting up around the UK. Physician associates work alongside doctors, GPs and surgeons providing medical care as an integral part of the multidisciplinary team[22]. Duties include taking patient histories, carrying out physical examinations, and developing and delivering treatment plans. The current output from physician associate programmes in the UK is 80 per year, which is set to increase to 700 in 2017–18. Despite this expansion, it seems unlikely that a sufficient workforce will be in place before 2025[23].

Issues with recruitment, retention and morale

22. Although physicians are in demand more than ever before, recruitment and retention in hospital medicine is challenging. **In 2014-15 the NHS was unable to fill 40% of the consultant physician posts it advertised and there are vacancies in trainee rotas[24].** Alongside this increase in demand,

[18] Royal College of Physicians . Under-funded, Under-doctored, Overstretched. 2016
[19] Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary*. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].
[20] Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary*. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].
[21] https://www.rcplondon.ac.uk/education-practice/advice/medical-training-initiative
[22] Who are physicians associates? Faculty of Physicians Associates
[23] Goddard, A. 2016. Ensuring a general medicine workforce for the future. Future Hospital Journal 2016 Vol 3, No 1: 40–4
[24] Federation of the Royal College of Physicians of the UK. Census of consultant physicians and higher specialty trainees in the UK 2014-15. London: Royal College of Physicians, 2016

there is also a decreasing interest in pursuing hospital medicine as a career and poor satisfaction rates in General Internal Medicine (GIM) training. In addition, negotiations over the proposed junior doctor contract have left many doctors in training feeling beleaguered and demotivated. This dispute highlights the many financial and workforce challenges facing the NHS. A combination of falling morale, leading to falling productivity and difficulties in recruitment ultimately compromises patient care.

23. **Falling morale**: one-quarter of doctors in-training report that their working pattern leaves them feeling short of sleep on a daily or weekly basis. Yet, despite compelling evidence showing the benefits to patient safety[25], many doctors are actively discouraged from taking naps during night shifts[26]. Three-quarters (74%) of doctors-in-training go through at least one shift per month with insufficient hydration, and over one-third (37%) do not drink enough water on seven shifts per month[27]. Poor working conditions lead to doctors feeling undervalued and disengaged. Four out of five doctors-in-training report that their job often or sometimes causes them excessive stress[28], and half of consultants report working under excessive pressure[29].

24. **Falling productivity:** Given the fall in levels of morale it is not surprising that sickness rates among physicians has increased. The NHS lost 15.7 million days to sickness absence in 2015[30]. Two out of every five doctors have considered taking leave owing to work pressures, while one third (36%) have seriously considered reducing their hours. Seeing more senior colleagues under pressure discourages the next generation of consultants: for eight out of ten doctors-in-training, the lack of work–life balance for medical registrars is a deterrent to pursuing a career in medicine[31].

25. **Falling recruitment figures**: Hospitals are finding it increasingly difficult to recruit to jobs at the front line of hospitals resulting in significant shortages for 'generalist' posts[32]. Fewer doctors choosing to work in general medicine increases the workload for those who do, leading to a poorer trainee experience and more challenging working conditions[33].

26. **Falling patient safety and experience:** Poor staff wellbeing and morale threaten patient care: 95% of doctors-in-training report that poor morale is having a negative impact on patient safety in their hospital, with half reporting a serious or extremely serious impact[34]. Engaged doctors make fewer mistakes, and better staff wellbeing is associated with lower death and MRSA infection rates. When staff wellbeing suffers, patient satisfaction and experience suffer too: NHS organisations with 'poor' staff health and wellbeing are, on average, among the 25% worst performers in patient satisfaction

[25] Horrocks N, Pounder R. Working the night shift: preparation, survival and recovery – a guide for junior doctors. London: RCP, 2006. http://shop.rcplondon.ac.uk/products/working-the-night-shift-preparation-survival-and-recovery [Accessed 8 September 2016].
[26] Lintern S. Exclusive: patients at risk as doctors forced to work without rest at night. London: HSJ, 2016. www.hsj.co.uk/topics/workforce/exclusive-patients-at-risk-as-doctors-forced-to-work-without-rest-at-night/7006252.article [Accessed 8 September 2016].
[27] Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).
[28] Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).
[29] Federation of the Royal Colleges of Physicians of the UK. Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].
[30] Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to patient care. London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-
[31] Royal College of Physicians. The medical registrar: empowering the unsung heroes of patient care. London: RCP, 2013.
[32] Doctors in general internal medicine (GIM) diagnose, treat and manage the care of inpatients and outpatients with acute and long term medical conditions
[33] Royal College of Physicians. Under-funded, Under-doctored, Overstretched. 2016
[34] Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).

reviews[35]. **We need to start prioritising staff wellbeing and engagement as red flags for patient safety, taking urgent, preventative action when they are threatened**[36].

27. Evidence shows that when staff feel healthy, valued and engaged they deliver better care, with improvements in patient safety and experience, and reduced costs[37] [38]. **We need national and local action to make all doctors feel valued and empowered, and to retain their experience and expertise in the NHS.** In its guidance to CEOs and Medical Directors, the RCP outlined some of the key steps that can be taken by NHS trusts to improve the working lives of doctors in training[39]. These include:

    - **Create a positive working environment**: establish a robust induction programme for all trainees; monitor workloads and support flexible working
    - **Ensure strong teams and effective rotas**: establish a regular on-call team; develop team rotas that reflect role and career stage; prioritise time for handover; plan rotas that allow time for training
    - **Protect time for training and teaching**
    - **Build capacity**: explore opportunities to employ international medical graduates

28. **Geographical location** also affects recruitment and retention. In a recent study, location was identified as the single biggest factor affecting where foundation applicants applied to, followed by perceived reputation of the hospital trust and job track[40]. Participants identified free/heavily subsidised accommodation or the offer of additional qualifications in leadership or teaching as the main incentives that would have a positive effect on applications to geographically undesirable trusts. The study found that overall; these efforts should lead to savings in recruitment costs, a reduction in vacant training posts and thus a decreased reliance on locum doctors, culminating in improved patient care.

29. The workforce we need is ageing like the population that it serves, and issues related to the **time of potential retirement** also need to be considered. As doctors near the end of their careers, pension provision, workload and health affect decisions about whether to continue working and in what way. Recent changes to the NHS pension have moved the retirement age from 60 to 67–8 for those younger than 50 in 2015, which will result in younger consultants working longer in the NHS but could also lead to an early loss of many older consultants if working conditions worsen. Already, there are predictions of substantial losses from the primary care workforce, which could be mirrored in the hospital workforce. **If we plan to increase the workforce, we need to ensure that we keep pace with losses and changes in participation**.

[35] Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to patient care. London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care [Accessed 8 September 2016].
[36] Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).
[37] Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to patient care. London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-
[38] Royal College of Physicians. *Work and wellbeing in the NHS: why staff health matters to patient care*. RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care [accessed August 2016].
[39] Valuing trainees resource for CEOs and MDs. Royal College of Physicians. 2016. [accessed August 2016]
[40] Curran, J & Baker, P. Future Hospital Journal. 2016 vol 3, no.1, 17-20

Ensuring the workforce receives appropriate training

30. An increase in the workforce trained in and delivering general medical services seven days per week has been proposed as a solution to the crisis facing acute hospital system in the NHS[41]. The inpatient population is becoming older with more comorbidities. The skills of the physician workforce therefore must be appropriate to meet the needs of these patients and general medicine is seen as a solution. For example, a patient on the respiratory ward could also have diabetes, Parkinson's and heart failure. Therefore we need to ensure that our specialists are also generalists.

31. **It is very unlikely that a generalist workforce can be achieved in less than 10 years** without a clear strategy from government and increased staffing levels. In a consultant survey about general medicine, 64% of respondents stated that they 'practised general medicine', which also varied substantially between specialties[42].

Models of service delivery and integration

32. Integration can take many forms, whether it is between health and social care providers or between different elements of healthcare provision such as primary, secondary and community care. **Ensuring adequate funding, staffing levels and resources are key to making services more integrated, responsive and patient centred**.

What are the practical changes required to provide the population with an integrated National Health and Care Service?

33. The case studies in a recent RCP and Royal College of GPs report give examples of how integration can be achieved and developed, and provide learning about how physicians and GPs in particular can work more closely together[43].

34. **The ability to work across geographical boundaries and locations is a vital aspect of integrated working**. In Tower Hamlets, to provide multidisciplinary diabetes support, 35 GP practices are grouped geographically into eight networks of four or five practices. Six times per year, a consultant attends each network to undertake a 2-hour multidisciplinary team (MDT) meeting with GPs, practice nurses, dieticians, diabetes specialist nurses and a diabetes psychologist. This has resulted in more improvements in blood pressure and cholesterol control in Tower Hamlets than in any other clinical commissioning group (CCG) in England over a 2-year period[44].

35. **More than just physical integration is required**; many of the case studies demonstrate success using virtual platforms. Highly rated services feature innovative ways of connecting GPs and physicians for advice, and virtual clinics can help to build relationships and make subsequent collaboration more straightforward. An example is the Whittington Health Integrated Community Ageing Team (ICAT),

[41] Doctors in general internal medicine (GIM) diagnose, treat and manage the care of inpatients and outpatients with acute and long term medical conditions.
[42] Moore A , Newbery N , Goddard AF . Consultant perception of general internal medicine – a survey of consultant physicians . *Clin Med* 2015 ; 15 : 511 – 9 .
[43] Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016
[44] Royal College of Physicians and Royal College of General Practitioners. P*atient care: a unified approach*. 2016. P.18

which established a telephone advice line for GPs to discuss the health needs of care home residents and a community geriatric service for the wider population[45].

36. Patient needs are complex and do not neatly sit within one part of care delivery. The Rapid Elderly Assessment Care Team (REACT) at Mid Yorkshire Hospitals is a multi-disciplinary team (MDT) made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The MDT meets daily to coordinate the care and treatment of patients to help them to be fit to leave hospital and prevent unnecessary admission. The MDT is able to care for patients in a person-centred way as they can offer people access to both the health and therapeutic services they need.

37. The REACT team has also established joint partnerships with third sector professionals, namely Age UK, to ensure that patients are receiving safe transfers of care into the community[46]. Age UK regularly come into the acute assessment unit at the hospital and physically help patients return home; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has enabled frail older patients to receive personalised care in the community and has helped them to maintain their independence which in turn prevents readmission.

How can local organisations be incentivised to work together?

38. An often-cited barrier to new ways of working is the current commissioning, contracting and payment system. Where barriers to joined-up care exist, they should be dismantled, and commissioning should be based on whole pathways of care[47]. Long-term planning is also essential so that initiatives can operate in a secure environment. A move away from commissioning for activity to a payment system that rewards added value and shared, desirable patient outcomes is likely to drive the process of professional integration. Involving both commissioners and healthcare professionals in the early stages of planning and development is a way of overcoming any potential barriers. Oxfordshire CCG's new Musculoskeletal service has been developed with a costed business plan, followed by joint commissioning with local providers to refine the details. A delivery plan is currently being developed, which will then be implemented[48]. By integrating care, pressure on the whole system will be relieved; however, funding must be provided to support services, irrespective of the setting in which they are provided.

Prevention and public engagement

Delivery of public health and commissioning arrangements

39. Following the Health and Social Care Act, fragmented commissioning arrangements have had an impact on the delivery of public health interventions and on patient care. In many areas of England, patients are experiencing the adverse consequences of fragmented care, particularly with regard to sexual health services. The different services that make up sexual healthcare are now commissioned respectively by Clinical Commissioning Groups (CCGs), NHS England and local authorities. Some local

[45] Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016. P.10
[46] http://www.ageuk.org.uk/brandpartnerglobal/wakefielddistrictvpp/documents/frailty%20conference/frailty%20in%20secondary%20care.pdf
[47] Royal College of Physicians. Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015.
[48] Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016. P.14

areas such as North West London and Leicester are leading the way, with integrated sexual healthcare that brings together the whole patient pathway[49]. These exemplars enable patients to access seamless care at every stage of their journey. Unfortunately, this patient-centred approach is not available everywhere, despite national guidance. In many areas of England patients are facing the serious consequences of fragmented care[50].

40. **The RCP believes that 'place-based' commissioning, where organisations work together to commission health and care for an entire local population, must become the norm[51].** Furthermore, clear lines of accountability must define which commissioner is responsible for each area of patient care. No services should fall through gaps between commissioning organisations. Patients must be able to access the same high-quality standard of care wherever they live.

Funding of public health and prevention

41. Additional funding is just one element needed to build a sustainable NHS. We must also reduce the number of patients requiring care. This can only be done through investment in prevention. The RCP is gravely concerned that cuts to local authority public health allocations will cause serious and lasting adverse implications to both the NHS and the health of the people it serves. The cuts announced in the 2016 Spending Review will have a major impact on the many prevention and early intervention services carried out by local authorities. These include tackling the nation's obesity problem, helping people to stop smoking and tackling alcohol and drug abuse. **The RCP strongly opposes the introduction of these cuts and we urge against any further cuts to public health funding**. Investing in prevention ultimately saves lives and improves long term patient outcomes. This is in addition to saving money for other parts of the NHS by reducing demand for hospital, health and social care services.

42. Data collected from local authorities shows that a substantial proportion of public health funding is spent on services delivered by NHS providers. In some councils this is as much as 80% of the total public health budget[52]. This means the planned £200 million funding reduction will have an immediate impact on the NHS. The explicit function of local public health services is to prevent ill health and improve health. Funding reductions will impede local authorities' ability to achieve these goals, thereby increasing the burden of ill health on the NHS. **The NHS faces unprecedented financial pressures, continued growth in demand, and an increasingly complex range of patient need. It is therefore a false economy to impose funding reductions that will directly and adversely impact on the health service and the health of the people who rely on it.**

Promoting public health through government intervention

43. The RCP believes that the food and drinks industry must do more to safeguard the nation's health and that government must take a balanced approach to promote this, particularly given the failure of voluntary agreements such as the Responsibility Deal[53] [54] [55].

[49] Making it work A guide to whole system commissioning for sexual health, reproductive health and HIV
[50] Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015
[51] Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015
[52] Taken from a survey of directors of public health conducted by the Association of Directors of Public Health.
[53] Responsibility Deal pledges [Accessed August 2016]
[54] Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol. Institute for Alcohol Studies. November 2015.
[55] Food industry 'responsibility deal' has little effect on health, study finds. Guardian 12 May 2015. [accessed August 2016]

Tackling obesity

44. Despite a commitment to introduce a levy on sugar sweetened beverages, the RCP is extremely disappointed that after such a long wait for the childhood obesity strategy, the government has published a downgraded plan that fails to address key issues such as marketing and promotion of sugar-filled and unhealthy foods to children[56]. The estimated cost of obesity to the UK economy is approximately £27bn[57]. A consequence of failing to act now is to commit the NHS to greater expense in the future as it struggles to fund care and treatment for obesity-related medical conditions. A strong package of measures and concerted action across all government departments is required to turn the tide on obesity. As a member of the Obesity Health Alliance, the RCP will continue to campaign to ensure the health harms related to obesity are tackled effectively[58].

Tobacco control

45. The RCP hopes that the government's upcoming tobacco control strategy will be ambitious and go further to ensure that the burden of ill health caused by tobacco is reduced. The total cost of smoking to society, including healthcare, social care, lost productivity, litter and fires, was conservatively estimated in 2015 to be around £14 billion per year[59]. The RCP therefore welcomed the planned increases in tobacco duty of 2% above the rate of inflation for manufactured cigarettes and 5% for hand-rolled tobacco at the 2016 Budget. These measures will provide a significant boost in the campaign to reduce smoking and reduce the burden of ill health in the long term. However, cuts to local authorities' public health budgets are having a damaging impact on services that help people to stop smoking[60]. We hope that the government's upcoming tobacco control strategy will set out ways to support these vital services. **There is evidence which demonstrates that expenditure on tobacco control provides good value for money: reduced smoking results in a net annual benefit of £1.7bn, in addition to tobacco tax revenue[61].**

46. The government must also look at the application of harm-reduction strategies to tackle tobacco dependence. A recent report published by the RCP recommends that it is **in the interests of public health to promote the use of e-cigarettes, nicotine replacement therapy and other non-tobacco nicotine products as widely as possible as a substitute for smoking[62].** The report found that e-cigarettes are not a gateway to smoking. In the UK, use of e-cigarettes is limited almost entirely to those who are already using, or have used, tobacco[63]. Furthermore, e-cigarette use is likely to lead to quit attempts that would not otherwise have happened[64].

[56] https://www.rcplondon.ac.uk/news/rcp-president-jane-dacre-disappointed-government-childhood-obesity-plan
[57] 'The Economic burden of Obesity', National Obesity Observatory, PHE, October 2010.
[58] New alliance on obesity outlines priorities for action. [accessed August 2016]
[59] Action on Smoking and Health. Smoking still kills. Protecting children, reducing inequalities. London: ASH, 2015. www.ash.org.uk/files/documents/ASH_962.pdf [Accessed 10 June 2015].
[60] *Results of a survey of tobacco control leads in local authorities in England.* Action on Smoking and Health.
[61] http://www.ash.org.uk/information/facts-and-stats/fact-sheets
[62] Royal College of Physicians. *Nicotine without smoke: Tobacco harm reduction*. London: RCP, 2016
[63] Royal College of Physicians. *Nicotine without smoke: Tobacco harm reduction*. London: RCP, 2016
[64] Royal College of Physicians. *Nicotine without smoke: Tobacco harm reduction*. London: RCP, 2016 p129

Alcohol

47. The RCP supports the introduction of a minimum unit price for alcohol (MUP). Alcohol misuse places a huge burden on the NHS, police, criminal justice system as well as the wider community. The simplest way to reduce demand for alcohol is to raise the price. The RCP is committed to MUP because it is an evidence-based intervention which has been shown to be effective in tackling health inequalities and reducing consumption[65]. Of all alcohol sold, it is the very cheap products such as large bottles of strong cider, that play the biggest part in alcohol-related harm. **A minimum unit price of 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price**. The impact of a 50p minimum unit price has been modelled by Sheffield University, who found that if implemented, there would be 35,100 fewer hospital admissions per year by the tenth year following introduction of the 50p MUP[66].

Air pollution

48. A recent report from the RCP and Royal College of Paediatrics and Child Health (RCPCH)[67] found that each year in the UK, around 40,000 deaths are attributable to exposure to outdoor air pollution, which plays a role in many of the major health challenges of our day. It has been linked to cancer, asthma, stroke, heart disease, diabetes, obesity and changes linked to dementia. The health problems resulting from exposure to air pollution have a high cost for people who suffer from illness and premature death, for our health services and for businesses. In the UK, these costs add up to more than £20 billion every year.

49. As a member of the UK Health Alliance on Climate Change (UKHACC)[68], the RCP will be campaigning with colleagues across health and social care to highlight better approaches to tackling climate change that protect and promote public health, whilst also reducing the burden on health services. An upcoming report from the UKHACC considers the ways in which integrated strategies to address air pollution and climate change will simultaneously lead to greater health benefits, tackling issues such as obesity, and cost-savings, rather than strategies which address them separately.

Digitisation of services, Big Data and informatics

The use of information technology across the health system

50. Information technology should be used to share data and improve communication between acute and community settings. In particular, **health service providers should use an agreed standardised structure and content for electronic records**. The RCP has produced a standardised structure for electronic records, which includes a uniformed format for discharge and transfer of care notes[69]. **One of the main barriers that our members and fellows face when trying to achieve a smooth transition within hospital services and between community and hospital settings for their patients, is fragmented and complex IT infrastructures and patient records**. There is often little standardisation of clinical data in source systems, either in the headings under which data are

[65] Wagenaar, A.C., Salois, M.J., Komro, K.A. (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction 104(2): pp 179-90.
[66] Income group-specific impacts of alcohol minimum unit pricing in England 2014/15. University of Sheffield. 2013. [accessed August 2016]
[67] Royal College of Physicians. *Every breath we take: the lifelong impact of air pollution*. Report of a working party. London: RCP, 2016.
[68] http://www.ukhealthalliance.org/
[69] http://theprsb.org/publications/bible-sets-out-the-latest-agreed-standards [accessed 19 September 2016]

recorded or in the definition of individual clinical terms. This has led to huge variations in record structures and clinical language, and major problems with the coding of clinical concepts.

What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

51. The most important aspect of digital technology that has the potential to reduce NHS costs is the electronic health record. A good electronic health record system will capture data faithfully and contemporaneously in usual clinical practice, it will ensure that the data are structured and organised (so that they can be easily retrieved, interpreted or transferred), and will make the data available in appropriate formats for patients (to help them understand their condition), clinicians (to enable them to make appropriate decisions), health service planners (to ensure that services are able to cope with demand) and researchers (to find out ways of improving the quality or reducing the cost of healthcare). This will reduce costs by avoiding duplicate investigations, improving patient safety and enabling better decision support systems which can inform clinicians of the cost-effectiveness of potential investigation or therapy plans. Better electronic communication can avoid the need for paper-based administrative and secretarial tasks. For example, dictation of clinic letters may be replaced by voice recognition and direct data entry into the patient record.

52. The use of telemedicine for supporting effective and timely discharge of frail older patients should be explored and implemented if there is local infrastructure able to support its introduction. The FHP development site at Betsi Cadwaladr University Health Board in rural Wales is using telemedicine to offer people who live far away from specialist care follow-up appointments with their consultants via video conferencing which is hosted at their local community hospital[70].

What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

53. The main barrier is the lack of structure, standardisation and usability of electronic health record systems in current use. These systems often depend on proprietary operating systems requiring expensive hardware. Interfaces between the different systems are expensive to maintain because they are not standardised. Vendor lock-in creates a monopoly situation where the cost of modifications or additional software is unconstrained. Development of new electronic health record systems is prohibitively expensive so only large companies are able to do it, which stifles innovation.

54. The key change required is for systems to become modular and to use standardised, open interfaces. The openEHR standard will ensure that data has the same meaning in different systems regardless how it is physically stored[71]. Modularity will allow individual components of the information system (e.g. the user interface, the openEHR server) to be independently developed and exchanged. This will accelerate innovation and lower the bar to entry, allowing clinicians and small-medium size companies to develop software that can actually be used (e.g. assisted by the HANDI-HOPD project[72]). Standardisation across the NHS will reduce the development costs of multiple software systems. Use of a fast, open-source operating system will avoid premature hardware obsolescence.

[70] https://www.youtube.com/watch?v=GRlan_4oDtw
[71] http://www.openehr.org/
[72] http://handihealth.org/introducing-handi-open-platform-demonstrator-handi-hopd/

Contact

Methela Haque | Public Affairs Adviser
Royal College of Physicians
11 St Andrews Place | Regent's Park | London NW1 4LE
Direct line +44 (0)20 3075 1447 | Mobile: +44 (0) 7990 745663