

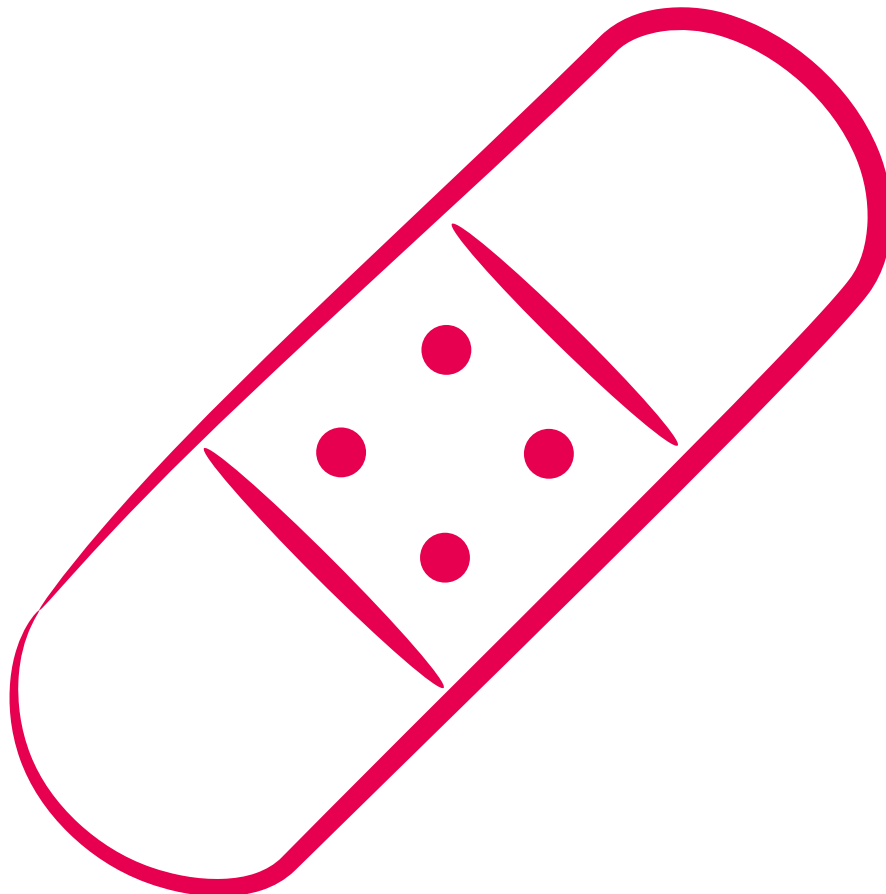
September 2022

Academy of
Medical Royal
Colleges



Fixing the NHS

Why we must stop normalising the unacceptable



Foreword



The Academy's members, the UK and Ireland's 24 medical royal colleges and faculties, between them represent over 220,000 doctors and while our normal concerns tend to be focused on the standards of education and training of the medical workforce, our primary concern has always been the quality of care patients receive.

Collectively, we are not known for vocal campaigns and of necessity much of our work takes place behind the scenes. The ability to be quietly influential is a precious commodity and not something to be given away lightly. However, having watched health and care systems deteriorate to the point where we are genuinely concerned that many NHS services are no longer safe, we have no option but to speak out loudly and clearly.

We need to recognise that these are not normal times. We are currently on a crisis footing and must plan and act accordingly. This short report sets out not just some examples of the failures of care we are now seeing, but also an agenda for change that will once again provide safe, dependable healthcare for all. Depressingly, there is nothing especially new or revelatory in setting out what needs to happen — we've been talking about seizing the opportunities of digital healthcare or reforming social care for decades.

What is new is the imperative. No one deserves to lie freezing on a concrete path under a makeshift tent for 15 hours with cracked ribs and a broken pelvis while they wait for an ambulance. This cannot happen to anyone in the UK in 2022. It is not acceptable. It's equally unacceptable for any of us to shrug our shoulders and say there's nothing we can do about it.

We must also accept that without urgent intervention, the situation will only get worse. As the cost of living crisis bites, more patients will be more sick, more frequently. We may well see the very young, those living with frailty and older people presenting with conditions directly related to poverty such as malnutrition or hypothermia. This is not scaremongering — there are reports this is already happening in some of the most deprived parts of our society. As is so often the case, it will be for the NHS to care for those who have fallen through the net.

This report is not about blame — we are beyond that. It is about the need for us to be honest with ourselves and with each other about the NHS we have, the NHS we want and the NHS we can afford. They are not the same thing and it's crucial we recognise that. Only then will we be able to step away from the *'we are very sorry, lessons must be learned'* soundbite in response to yet another tragedy or the fantasy predictions that *'everything will be back to normal soon'* and start to have a candid conversation about the change that surely needs to happen.

We can no longer stand by while others seek to normalise the unacceptable when it comes to health and care.



Professor Dame Helen Stokes-Lampard
Chair of Council, Academy of Medical Royal Colleges

This is not acceptable



Credit: SWNS

David's story

This picture has come to typify what is wrong with the NHS today.

An 87 year old man with prostate cancer tripped and fell in his back garden breaking seven ribs and fracturing his pelvis. On the advice of NHS 111 call handlers his family was told not to move him. They were so concerned for his welfare as they waited for an ambulance they built a makeshift tent around him to protect him from the rain.

He waited 15 hours.

Executive summary

The issue

The UK health system is under unprecedented strain. The COVID-19 pandemic exacerbated these pressures, but it did not create them. The Academy of Medical Royal Colleges and its member organisations believe that as a country we are not facing up to the scale of the current challenges and we are not producing any coherent strategy to tackle the problems. Only when we confront these challenges will we be able to begin to fix the NHS.

A combination of pressures means that the system is providing care and services which are sub-standard, threaten patient safety and fall below what should be expected in a country with the resources of the United Kingdom. If we do not act with urgency, we risk permanently normalising the unacceptable standards we now witness daily, to the detriment of us all.

What needs to happen

Above all we need to be honest with ourselves about the extent of the problems and the implications of the solutions. That requires an open and honest national conversation among politicians, patients and the public, healthcare professionals and policy makers, one which leads to action and meaningful change.

What does a reformed system look like?

A system fit for the twenty-first century must centre the needs of the whole person and of the whole population. This requires:

- Expanding workforce numbers
- Improving patient access to care across all settings
- Reforming social care
- Embracing new ways of working
- Grasping the digital agenda
- Valuing our staff
- Modernising the NHS estate
- Revitalising primary care
- Greater focus on prevention and tackling health disparities
- Making better use of resources and ensuring there is adequate investment

Introduction

The UK health and care system is under extraordinary and unprecedented pressure. Most staff say they have never experienced challenges as acute, pervasive and substantial as they are now. We are facing mushrooming waiting lists for elective care, severe problems with primary care access, and record delays in emergency care pathways. While COVID-19 exacerbated the situation, these difficulties were already visible and growing before the pandemic.

At the heart of all these challenges lies a chronic workforce shortage. Whether in hospitals, primary, community or social care, we do not have sufficient staff to meet rising patient demand. Coupled with this, we have a system that, despite wonderful examples of innovation, does not meet the standards expected of twenty-first-century organisations. Due to funding shortages and the way the system has operated — whether in terms of capital infrastructure, use of technology or ways of working — the health and care system is too often out of date, inefficient and unresponsive.

This means that the system is providing increasing proportions of care or services which are sub-standard, threaten patient safety, and should not be acceptable in a country with the resources that we have in the United Kingdom. All this is at a time when the demographic changes of an aging population with ever-increasing numbers of chronic long-term conditions per head of population, are inexorably increasing demand.

The real danger that the Academy and its member colleges see is that we are drifting into a position of normalising the unacceptable. Standards which would once have been perceived as intolerable are too often met by the public, politicians, managers and clinicians alike with a fatalistic acceptance of the situation — *'That's just how it is now'*. That is bad for patients and the public — and it does not have to be like this.

There are plans to address specific problems and proposed solutions to particular issues. People across the system are working tirelessly to address the challenges and hopefully they will tackle some of the urgent problems. However, we see little sign of a clear overarching strategy that acknowledges the extent of the problems, connects the pieces, and sets out both a system-wide long-term solution and plan for how this can be implemented and maintained.

Serious and potentially difficult conversations that have been avoided need to happen as a matter of urgency. They are already overdue. The public needs to be fully aware of the scale of the problems and the radical nature of required solutions. If government does not want the cost of the NHS to keep growing or the conversation to remain fixed on acute pressures, it must recognise that this change is needed.

The medical profession does not claim to have all the answers but colleges, as the professional voice of doctors, bring extensive clinical expertise and insight to identifying the challenges and effective ways of addressing them. It is essential that we involve the public in co-producing a new vision of health and care for our future. We must also recognise that just as the problems are interlinked so too are many of the solutions.

The nature and extent of current challenges

The perfect storm of growing demand, shrinking supply and prolonged underinvestment

Rising demand

The system is facing an escalating volume of consultations and record referrals*. Every 24 hours more than a million people come into contact with the NHS³ — that's more than all the people who live in Liverpool being seen by a professional NHS worker every day. It is only set to intensify — as the UK population ages, demand for health and care services will rise, and patient needs will become more complex. Two-thirds of over-65s are expected to be living with multiple health conditions by 2035. 17% will be living with four or more diseases, and a third will have a mental illness.⁴ The over-85 age group is the fastest growing in the UK. There will be three times as many over-85s by 2066 as there are now.⁵

Waiting times

Waiting times are skyrocketing across healthcare settings and across the UK:

- More than one in ten people in England are now waiting for treatment by the NHS.⁶
- In June 2022, over 22,000 patients in emergency departments in England were delayed for 12 hours or more from decision to admit to admission; a 15% increase from the previous month.⁷ Many patients experience very long waits of more than 12 hours.
- In Northern Ireland, in June 2022, the median time patients who were admitted spent in an emergency department was over 12.5 hours.⁸ The longest wait for a urology appointment was reportedly 7 years.⁹
- Years of underinvestment in mental health have created the largest backlog in NHS history, with 1.5 million people with mental illnesses currently awaiting care.¹⁰

*. On average, as of April 2022, each GP looks after 2,056 patients — a 10% increase since 2015. In 2021, general practice carried out almost 370 million consultations, up 18.5% from 2019.¹ Mental health services received a record 4.56 million referrals during 2021/22.²

In Northern Ireland access to paediatric urology specialists is so difficult that one 13 year old boy waited so long for an appointment he actually passed the age of eighteen before he was seen. He then had to join another queue to see an adult urology specialist.

This is not acceptable

Although there is pressure on all parts of the system, the problems are particularly acute in children and young people's care. In April this year more than a third of a million children were waiting to be treated by a consultant — the highest number since records began and an increase of 100,000 on the previous April.¹¹ The greatest cause of hospitalisation among five to nine year olds is for reasons of poor oral health and teeth extractions.¹² Nine in ten of these cases are entirely preventable and are directly related to deprivation and lack of access to dental care.¹³

Sean's story

Lack of patient access was cited by a coroner as a compounding factor in the tragic death of a teenage boy from Gosport in Hampshire.

Seventeen-year-old A-level student Sean Mark was found dead in his bedroom by his parents, after months of struggling to access help and without ever having a face-to-face appointment for his mental health concerns.

This is not acceptable



Sean described himself as an 'anxious paranoid mess' and believed he might have ADHD.

Four months before his death, he had a phone consultation with a GP, which recommended he seek advice online. Over the next few months, he carried out e-consultations, which noted he had moderate depression and would benefit from talking therapy, but the waiting time for the local service was six to eight months. Sean said in a later online consultation he'd downplayed his concerns in his original GP phone call. He was found dead on 4 December 2021, the day after completing another NHS online form. He still had not received any face-to-face contact with a healthcare professional.

The area coroner, Rosamund Rhodes-Kemp, recorded a verdict of death by misadventure, as she could not be sure he intended to kill himself. Rhodes-Kemp highlighted the GP shortage and lockdown restrictions as underlying issues, but said: *'Whether — had he had that face to face — this could have been avoided, I don't know. But it certainly would have been helpful. Sean had bravely contacted the GP surgery about his problems. He was desperate for help. There was no doubt Sean was frustrated by all of that and felt palmed off.'*

Since his death, Sean's parents have been working with the GP surgery to improve continuity of care and access to face-to-face appointments.

Workforce issues

Workforce shortages are endemic across specialties. We have over 1,500 fewer full-time equivalent GPs than we did in England five years ago¹⁴ (despite the Government promising in 2015 to increase that number by 5,000 by 2020) and last year more than half of consultant physician posts advertised in England and Wales went unfilled.¹⁵ Since 2017, there has been a 30% increase in the number of vacant or unfilled consultant psychiatrist posts in England,¹⁶ and more than half of advertised community sexual and reproductive health consultant posts across England were left unfilled due to a lack of applicants from 2018 to 2021.¹⁷ It is estimated that the shortfall in anaesthetists is preventing 1 million operations and procedures from taking place per year.¹⁸

System capacity

There is increasing recognition that capacity within the system is insufficient. This includes the bed base in hospitals, the availability of diagnostic services, the extent of mental health provision and issues with technology and infrastructure.

The NHS estate is not fit for purpose. In 2021, it was reported that at least 280 urgent operations are cancelled each month due to lack of critical care bed capacity.¹⁹ Operating at or close to maximum capacity adversely affects patient mortality, length of stay and acuity of admissions.²⁰ Patients with acute mental health needs continue to be sent miles away from home for care because there is not a suitable bed available locally.²¹

The recent heatwave revealed the lack of air conditioning or environmental management across healthcare settings, with some hospitals having to cancel operations and IT systems failing. The chief medical officer at Epsom and St Helier Hospital in south-west London, Dr Ruth Charlton, said:²²

'Our hospitals are very busy — without air conditioning, we are struggling to keep patients and staff as cool as we would like — the buildings are not fit to deliver the 21st-century healthcare we would like to deliver in normal circumstances let alone at this time of extreme heat.'

Social care problems

Social care suffers from chronic workforce shortages and a lack of capacity to deal with patient demand. Before the pandemic struck, Age UK estimated that 1.6 million people aged 65 and over did not receive the care and support they need in England, warning that this could grow to 2.1 million people by 2030, a situation intensified by the pandemic.²³

Many, although not all, of the problems of emergency department and ambulance delays go back to the inability to discharge patients from hospital to social care facilities. In January 2022, over 12,000 patients who were medically fit to be discharged remained in hospital.²⁴

What happens if these pressures are not fixed?

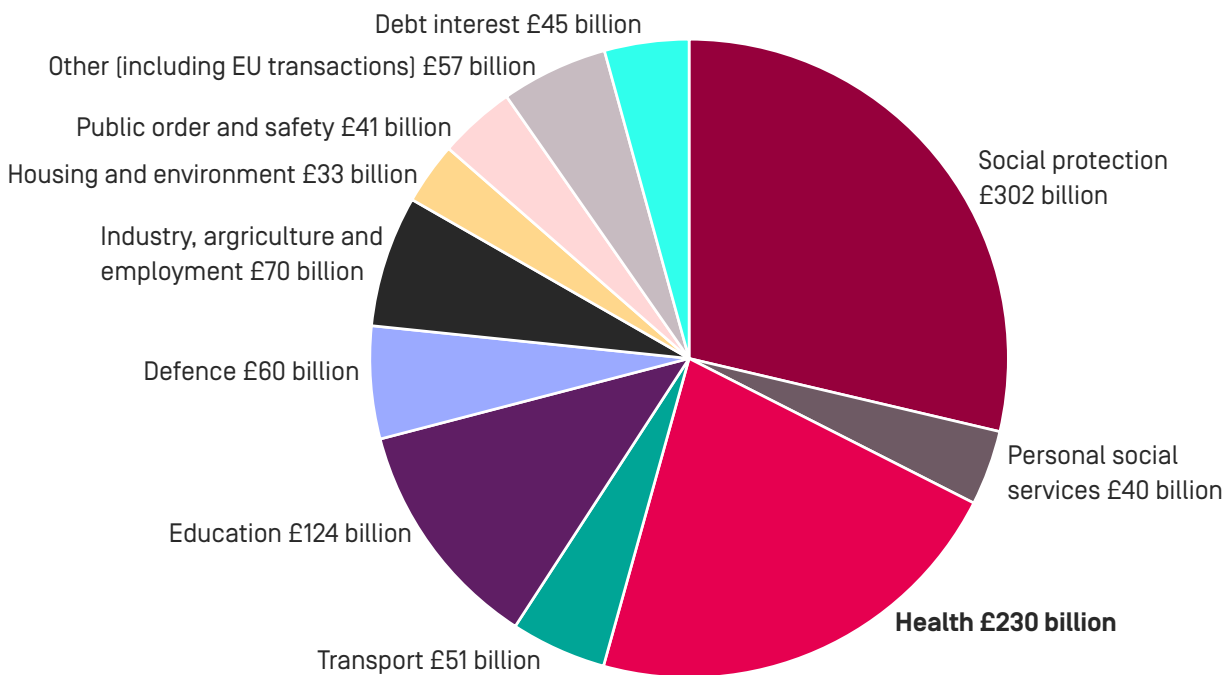
In the short to medium term, a 'broken' or 'overwhelmed' NHS is unlikely to mean hospitals or GP surgeries closing their doors in greater numbers. But we will see worsening waiting lists, a significant reduction in access to services across a range of settings and the experience of care being increasingly less safe and less satisfactory for patients. The experience for staff working in this downward spiral will also deteriorate further, with measurable increases in moral injury, leading to more staff being burnt out, experiencing ill health and even more leaving the service prematurely.

All this has a direct impact on the health of the population. This is not simply about inconvenience and dissatisfaction. It means patients enduring pain and suffering for longer (with potentially long-term and permanent consequences); coming to avoidable harm in ever-increasing numbers; and even dying prematurely or unnecessarily. This all has a direct economic impact on our nation.

This is not acceptable, but the danger is that it comes to be treated as the norm. In one of the richest countries in the world, we have the privilege of being able to act to prevent this happening. While few can be happy with the quality of service as it is today, the NHS has historically delivered world-class care. If we want the system to return to providing consistently high levels of service then we must recognise there is a cost to that.

What does good healthcare cost?

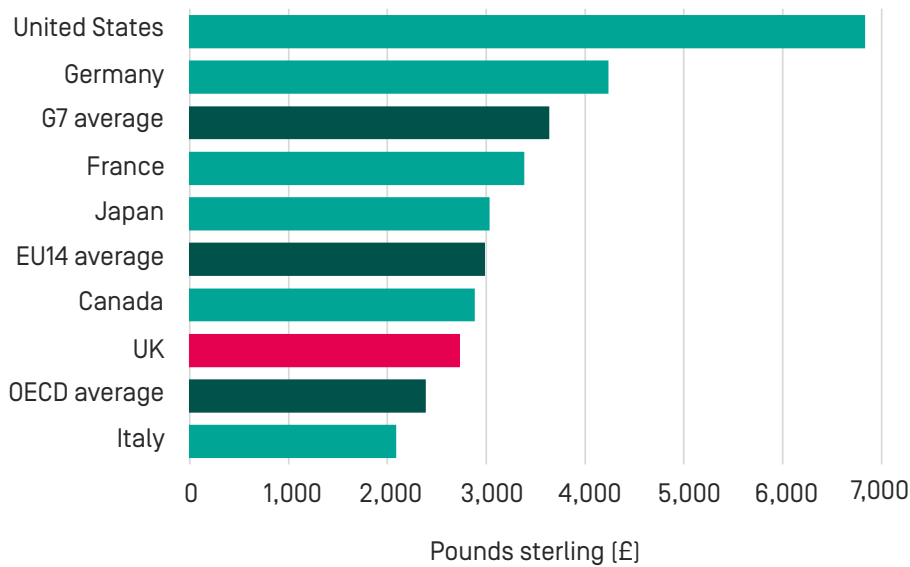
How the UK Government spends its money [2021 budget]



Source: Office for Budget Responsibility and HM Treasury calculations²⁵

Public discourse is split between a love for the NHS (our 'national religion') and huge frustration and even hostility towards individual services and healthcare professionals, which will inevitably increase if we do not tackle current problems. We need to recalibrate and see these as part of the same web with more constructive critique of systems-level problems and more respect for individual services and staff.

Public healthcare spending per person in pounds sterling (£) adjusted using purchasing power parities (PPP)



Source: REAL Centre, The Health Foundation 2021

Perpetual rhetoric on the 'world-beating' NHS is a dangerous distraction. While recognising our achievements is essential, we must not mislead patients about the standards of care they are seeing and the service they are experiencing.

While the UK spends around 10.2% of its Gross Domestic Product on healthcare, which is roughly on a par with other developed nations, when measured on the basis of spend per head the UK falls far lower than comparable nations like France and Germany. The UK also falls below the OECD average when it comes to the number of hospital beds per 1,000 of the population [2.5 compared to 4.4] and the number of doctors per 1,000 of the population [3 compared to 3.6].²⁶ We recognise that international comparisons are not straightforward but they do serve to illustrate our considerable shortfall in capacity, workforce and long-term capital investment.

Overcrowding in emergency departments (EDs) has a direct impact on patient care. These stories are provided by the Royal College of Emergency Medicine and based on real-life experiences:

A patient presented to a crowded ED in pain and waited for over an hour before being triaged. Staff members worked hard to admit the patient, but there were no beds or even trolleys available. The patient's condition deteriorated, and they had a cardiac arrest in the waiting room. Their family and other patients watched this unfold.

This is not acceptable

A frail, older patient waited in pain in the back of an ambulance outside a hospital for more than three hours. They had a broken hip and were scared and confused. Fractured hips are common injuries, and timely care is critical, influencing long-term survival as well as pain and distress levels.

This is not acceptable

A patient collapsed and stopped breathing while waiting in an ED corridor. They were resuscitated on the floor, an invasive procedure usually carried out in a designated room. This was a terrifying, traumatic ordeal for the young patient and their family, and difficult for staff who are not trained or equipped to work in corridors.

This is not acceptable

To preserve patient confidentiality, some details have been omitted.

What do we want from a health and care system of the future?

We need to be clear about the principles upon which we should be providing care; what we believe a health and care system should and should not be doing; and our basis for determining what are acceptable care and standards.

The principles upon which we should be providing care

The Academy and its members firmly believe that the principles and values set out in the NHS Constitution²⁷ should continue to guide the NHS — the concern is that we are not able to deliver them. The Academy is clear that a tax-funded system free at the point of use

Principles in the NHS Constitution:²⁷

- The NHS provides a comprehensive service, available to all
- Access to NHS services is based on clinical need, not an individual's ability to pay
- The NHS aspires to the highest standards of excellence and professionalism
- The patient will be at the heart of everything the NHS does
- The NHS works across organisational boundaries
- The NHS is committed to providing best value for taxpayers' money
- The NHS is accountable to the public, communities and patients that it serves.

remains the best way to meet those principles. Countless studies and investigations have confirmed that there is no other way of funding healthcare that is fundamentally better or more efficient than what we already have.

Social care is not provided on the same basis as NHS healthcare and it remains a key stumbling block to getting the NHS back on track. How it is to be provided and funded is still to be resolved. Recent Government initiatives in England have sought to begin tackling the issue, but few commentators believe that the problems have been even remotely addressed. Despite commitment after commitment from governments stretching back to 1997 this issue is consistently ducked.

Natalie's story



I gave birth to my daughter at a major London hospital. It was an extremely traumatic experience. Ten months later and I am still dealing with the psychological and physical scars it has left. This could have been avoided had the hospital had more staff available.

I went into labour in the early hours of Saturday morning. By 9am my contractions were regular enough to go into hospital. But when I arrived I was told I was not dilated enough and to return later. When I returned the midwife-led birth centre was closed due to staff shortages. Although I was disappointed, I was assigned a wonderful midwife who let me stay in the Day Unit where the first stage of my labour took place. She was kind and attentive and I will be forever grateful for her support throughout that first stage.

After 12 hours of contractions the pain was too much and I requested an epidural, so I was moved to the maternity ward. I waited over an hour for the anaesthetic doctor – she was clearly rushed off her feet and very stressed. She fitted a cannula, left the room and never returned. I found out later that there had been a number of crash calls and she was the only anaesthetic doctor working that evening.

Within a couple of hours I was fully dilated so it was too late for the epidural. I was in excruciating pain and told to push. After hours of pushing, my baby's head just would not come out. I ended up needing an oxytocin drip because my contractions had stopped. This caused even more pain which could have been prevented if I'd had the epidural. I was allowed to keep pushing for nearly four hours before there was an intervention, completely going against NHS guidelines of two hours. My baby's heartbeat started to drop so doctors rushed into the room and my baby was born with a ventouse delivery.

I gave birth just after midnight. At 3am my partner was asked to leave and I was taken to the maternity ward with my baby. I had just experienced the most traumatic event of my life. I was unable to get out of bed, I was covered in blood, sweat and faeces. I was left alone without care all night. The next day, still unable to walk, I was discharged. No one checked on my stitches or asked if I was OK. It was clear that the beds were needed so I was out. I left hospital traumatised, exhausted and feeling very low. I am still experiencing PTSD. Had there been more doctors and midwives available I would not have had to go through this horrible experience.

This is not acceptable

What we believe a health and care system should and should not be doing

Our support for the existing principles and values of the NHS does not mean continuing to do everything that has been done before and in the same way.

The NHS is principally a sickness service, as many commentators have pointed out. It focuses on diagnosis and treatment based on a bio-medical approach to healthcare and revolves around institutions and services established to deal with individual conditions. Many patients and clinicians expect the NHS to deliver a medical intervention which solves a specific problem. That expectation has to continue to be a core part of the NHS's offering, but it is clearly not sufficient and should not be the sole aim.

The current system does not focus on either the needs of the whole person (complex and frequently involving a range of physical, mental and social aspects) or the needs of the population as a whole. Solutions could therefore include a range of non-medical or social interventions.

Doctors know the system must change and that they must lead and drive that change by owning the solution — not just complaining about the problem. There are many initiatives underway to rethink the way medicine is practised — even the phrase 'rethinking medicine' has come to mean looking at health and care from the perspective of population-based and whole person-centred care. This puts responsibilities on clinicians and patients alike to consider through shared decision-making what options are best for them in their circumstances. The Academy's Choosing Wisely programme²⁸ is a good example of this. And while cost reduction is certainly not a prime consideration, it is a beneficial by-product of tackling over-medicalisation.

Similarly the Evidence Based Interventions Programme²⁹ led by the Academy for NHS England looks at whether a range of current interventions are actually adding value and when alternatives should be considered. While this identifies where there would be real benefit from fewer of a particular intervention, it also identifies where there is clear evidence that there would be value in increasing the number of interventions to reduce the burden on the NHS in the longer term.

The Academy has long argued it is essential that the health system rigorously and continuously reviews all its activities and interventions to ensure that they are genuinely of value. Continuous improvement of the care we provide should be part of day-to-day business for driving patient safety, but it is also likely to realise financial and resource savings if we cease activity which does not add value.

The ability to do this is currently hampered by the very pressures we are trying to address. In the face of huge demand, clinicians do not have the headroom to consider fully improvement, innovation and value.

Patients will need to join doctors in rethinking medicine and recalibrating their expectations too. Many patients complain they feel 'short-changed' if they do not walk out of a GP surgery with a prescription or an opportunity to see a specialist consultant at a hospital. We need to help patients and the public to buy in to new models of care and explore ways of doing things differently.

When we know the principles on which we want to provide care and what it is we should be doing as a health and care system, we can, based on clinical expertise and patient experience, determine the standards we believe are acceptable and which are not.

This discussion is not always going to be comfortable for patients or clinicians but it should result in better outcomes for patients, a more rewarding experience for healthcare professionals and a better way of providing healthcare.

What are the issues that need to be addressed?



Expanding workforce numbers

Staff shortages are the root of most of the current pressures. The NHS is paying the price for decision makers having ignored workforce planning and issues over many years.

The Health Foundation/REAL Centre's analysis³⁰ points to an overall workforce supply-demand gap of around 103,000 full-time equivalent staff across the NHS Hospital and Community Health Service and general practice in 2021/22, a gap which is projected to escalate.

The Academy supports a substantial increase in medical school places, with expansions needed in specialty training places too. The Royal College of Physicians³¹ and the Royal College of Psychiatrists³² have both called for medical school places to increase to 15,000 per year, while the Medical Schools Council³³ has recommended that the number of medical students should be increased by 5,000 to a total of 14,500 graduating per year. Many colleges and faculties have produced their own calculations of workforce shortfalls and projections.

Historically, workforce planning was the poor relation of financial and service planning at national and local level. That failure to invest has resulted in the current problems. The mindset seems to have shifted among politicians and national and local NHS leaders. However, fixing a workforce crisis is considerably harder than recognising it. Training the healthcare professionals of tomorrow in greater numbers is a long-term investment that the Treasury cannot keep avoiding.

A sustained commitment to workforce growth across the system and across professions is required, with open, transparent and regular workforce planning involving all stakeholders. We have to be mature enough to identify honestly what we need, but also to recognise that we may not be able to meet all requirements simultaneously.

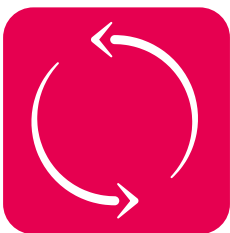


Improving patient access across all settings

We have an immediate and pressing problem with patient access to services. The pandemic created havoc in increasing the backlog for elective treatment and access to primary care. Work on tackling waiting lists is underway but access remains a critical issue.

Some groups are disproportionately affected by difficulties with access. In a March 2022 survey by the Faculty of Sexual and Reproductive Healthcare on sexual and reproductive health provision, one respondent commented,

'we used to run drop-in clinics prior to the pandemic but no longer do this or even plan to get back to this. Making an appointment is difficult for most of our patients but our young vulnerable patients have no chance of achieving this.'



Reforming social care

Reform of social care is imperative to delivering a comprehensive health and care strategy. A well-functioning social care system is absolutely crucial to making sure people can lead healthy and fulfilling lives and to the effective operation of the NHS. Colleges acknowledge the recent apparent recognition by the Government in England as a welcome step in the right direction, but it does not come near to actually solving the issues around social care.



Embracing new ways of working

The NHS has been slow in adapting the way staff work. This is partly due to professional boundaries and hierarchies. Team working across diverse multidisciplinary groups is increasingly recognised as the best way to deliver care, however. That means utilising the skills of all professionals in the most effective and appropriate way while ensuring safe delivery of care. Clinicians working 'to the top of their licence', outside silos and across organisational boundaries, and fully utilising technology has to be the future way of working.

A key example would be embedding high-quality perioperative care, with shared decision-making processes and prehabilitation programmes as standard. Further, more could be done to promote the use of day cases to free up beds, the adoption of enhanced care between standard ward-based care and critical care, and better discharge planning. According to a systematic review,³⁴ ensuring that appropriate support is available on discharge can reduce readmissions by 11.5% which may translate to reduced waiting lists and lower costs for the health system.



Grasping the digital agenda

The NHS has been at the forefront of innovative technology and treatment in many areas and yet paradoxically often appears to function in a digital and technological stone age. Many hospital trusts still rely on paper-based medical records. A lack of information sharing between primary and secondary care due to different and incompatible systems is completely unacceptable in 2022.

There can be no excuse for not grasping the digital agenda. It is vital that digital records are comprehensive, integrated and accessible across the health and care system to ensure critical information is available to be reviewed and acted upon. While not always delivering everything its proponents claim, the digital agenda has the power to transform the experiences of patients and working lives of clinicians.



Valuing our staff

Many staff do not feel valued by the NHS or social care and have not had the time and space to recover from the exhaustion of the pandemic. The culture within health and care remains too hierarchical, closed and punitive and behaviours among and between professionals are often sub-standard. In too many places the NHS has been slow to adopt flexible working.

Problems with staff retention risk exacerbating workforce pressures. Issues of terms and conditions are not within the remit of the medical royal colleges or the Academy. However, what cannot be ignored is the impact that pay and conditions have on how staff feel they are valued and ultimately on staff recruitment and retention. Pay levels do need to be perceived as fair by staff across the NHS. There is also a need to urgently tackle the punitive pension tax arrangements which are

leading doctors and other senior staff to reduce their hours, not take on extra commitments or retire early, creating staffing and capacity shortfalls.

There is clear recognition at national level of the need to value and treat staff properly and the People Plan³⁵ and Our People Promise³⁶ are positive initiatives. The challenge is turning good intentions into action at local level and ensuring positive actions are not negated by the pressures of workload and staff shortages.



Modernising the NHS estate

Much of the NHS is crying out for capital investment — particularly in mental health and primary care which suffer from a significant amount of severely substandard estate. There is a hospital improvement programme underway in England but this is only a small part of the overall challenge. Improvement has to spread further and faster.



Revitalising primary care

Primary care is the bedrock of the healthcare system in the UK and should remain so. It has been under immense pressure for several years primarily due to population needs, increased workload pressures as more work migrates to the community, and chronic staff shortages. There seems to be recognition of these pressures, but we need a new and ambitious plan to support general practice, as called for by the Royal College of General Practitioners. This should cover improved recruitment and retention, the removal of bureaucracy, improved IT systems, and greater use of new roles. As recognised by the Fuller Stocktake,³⁷ there needs to be a comprehensive review of premises and significant investment to make practices fit for purpose, including to accommodate an expanding staff team.



Greater focus on prevention and tackling health disparities

We need a paradigm shift on health prevention. Everyone recognises that investment in prevention is the right thing to do to deliver whole-person care and tackle health disparities. It is cost effective in the medium term, although evidence for release of substantial short-term savings is limited. This shift is not only important for managing the prevalence of disease, but also work within the NHS. On-the-day

cancellations and post-procedure complications can both be minimised if patients' co-morbid health conditions are addressed by 'prehabilitation' ahead of intervention.



Making better use of resources and ensuring there is adequate investment

This report is not just another call for more funding for the NHS and social care. We acknowledge the substantial investment that the Government has made and that the answer to the problems in health and care are not just about funding. Many of the changes that need to happen are down to the health system itself — changes in the way it operates and the way it behaves. However, to pretend that finance and resources are not a significant part of the solution is as naïve as saying they are the only solution.

If the population grows and people are ever more likely to develop ill health, it is logical that we will inevitably spend more on health and care. We may have a record number of doctors, but we also have a record number of people who need help. Additional staffing, better estate and digital infrastructure have a cost. Money spent on that from the NHS budget will not be available for other service developments.

The need for improved social care funding is even stronger. Most commentators believe that the additional, and welcome, funding for social care will result in a stand-still position at best. It may have staved off a collapse, but it will not deliver reform.

Improving the health of the nation is not just about NHS funding. The health improvement agenda is about investment in housing, education, transport and other areas. Additionally, the environmental challenges of global warming have a direct impact on the health of our nation. A healthier planet and healthier population are good for society and the economy.

The inconvenient truth

Open discussion and a full debate about the state of the NHS and social care are currently being avoided. We need to confront the scale of the problems we are facing.

We need a comprehensive strategy rather than piecemeal solutions.

We need to be honest with the public and the NHS, that radical solutions must be found and these may not always be popular.

We need to be clear that unless we do all these things, we will only continue to normalise the unacceptable which will result in irreparable damage to the institution we cherish and the quality of care we deliver. And that is not acceptable.

This conversation needs to happen now and it needs to result in a clear commitment and set of actions that will bring long-lasting change.

If we don't we will only see services continuing to collapse before our eyes.

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