Royal College of Physicians 2021 Budget submission

Building a more resilient health and social care system
January 2021

About the RCP

The Royal College of Physicians (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 UK and overseas with education, training and support throughout their careers. As an independent body representing over 39,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Executive summary

The need for a more resilient health and social care system has never been clearer. While the pandemic has highlighted the strength of our committed NHS staff and our world-leading clinical research sector, we have also seen the impact of under-resourced public health and social care sectors.

Although we have seen unprecedented demand, staffing was inadequate prior to the pandemic and will continue to be so in future unless it is addressed. Staff in post also need the protected time to improve services, challenge themselves and innovate. The government should recognise that a strong health and social care system focused on preventing ill-health is a national asset, and therefore prioritise the following three actions at this Budget:

1. **Doubling medical school places from 7,500 to 15,000 per year to tackle the NHS workforce crisis. We estimate this would cost £1.85bn annually, less than a third of what hospitals spend on agency and bank staff.**

2. **Building a preventative system by addressing the estimated £6.8bn funding gap for adult social care and public health as part of a cross-government strategy to reduce health inequality.**

3. **Spreading clinical research across the UK to support regions missing out on its health and economic benefits. Supporting ten NHS trusts, in regions where research activity is low, to pilot funding time for research would cost approximately £25m per year.**

1. Doubling medical school places

Workforce planning in the NHS has failed to keep pace with patient demand. As a result, the UK has to rely on international staff to fill shortages across the NHS. While the UK should always welcome the significant and vital contributions of international staff, we need to do more to move towards self-sufficiency in training of homegrown doctors.

We recommend that government funds a doubling in the number of medical students in the UK by the end of the decade at a cost of £1.85bn annually. This is less than a third of what hospitals spent in 2019/20 on agency and bank staff. RCP's 2019 census found that on average locums account for

around 10% of consultants in UK hospitals, with 4% having 30-40% locums. The cost of increasing medical school places would depend on the scale and pace of expansion and would fall across several financial years and likely at least two different parliaments. In time, the expansion of the workforce will bring savings by reducing locum costs, including by relieving some of the pressure on doctors which results in sickness absence.

Having more doctors would also enable the NHS to become a more flexible employer – crucial to retain doctors currently joining the profession whose expectations on work/life balance may differ from doctors of previous generations. From 2009 to 2019, the number of consultant physicians working less than full time grew from 14% to 23%. The NHS must become a more flexible employer if it is to retain staff and full-time equivalent, not headcount, must be planned for to ensure that enough doctors are trained.

The expansion figures are based on modelling first done by RCP in 2018, taking into account estimated future demand in an ageing population where multi-morbidity is common, and losses to the profession due to retirement or training. Our blueprint published this year reiterates this call, setting out in more detail the financial investment required to underpin the expansion alongside a plan for how and where the new places should be allocated across the UK to ensure equitable access to medical education.

To support the development of its blueprint, the RCP commissioned York Health Economics Consortium (YHEC), which estimated the total discounted cost for a 5-year undergraduate medical course in England as £207,418. The total 'public' cost is £192,981 and the total 'private' cost £14,437. The cost per medical school place comprises the cost for teaching incurred by higher education institutions, the healthcare placement providers and the cost of living to the medical student. The public cost includes the tuition fee loan provided to students and paid to institutions. Analysis by London Economics estimates that medical professionals will repay significant amounts of their student loan over their career.

The NHS interim people plan and Simon Stevens have both acknowledged the need to further expand medical school places. Most recently at our Medicine21 conference this month, the secretary of state rightly argued that '*we should seize the advantage of the big increase in interest in medicine as a result of the pandemic'.* We cannot fully capitalise on the current interest in medicine sparked by the pandemic unless we significantly increase the number of medical school places.

The government's decision to lift the cap on medical school places in England this year must act as a catalyst to make long-term decisions about the NHS workforce underpinned by the necessary funding. Investing in more medical school places will put the NHS medical workforce back on a sustainable footing – and is an investment in a healthier population.

Recommendations:

- double the number of medical school places from 7,500 to 15,000 per year, at an annual cost of around £1.85bn
- ensure that an expansion of places and the process of allocating places incentivises an increased focus on widening participation in medicine
- build on the successful work of the previous expansion to provide medical school education across the whole of England
- undertake further detailed work to fully understand the potential undergraduate applicant pool, asking UCAS to carry out research with potential applicants to medical school and other

science subjects to understand the appetite for places and the perceptions of the entry process to medicine

2. **Funding public health and social care**

This Government has an opportunity to create a healthier, happier and fairer well-led society where health and wellbeing are at the centre of all policies. We welcome the funding that the government has given the NHS throughout the pandemic. However, while desperately needed, these one-off injections of cash are only enough to keep the system ticking over. We need sustained investment in both health **and** social care.

The Local Government Association puts the Adult Social Care funding gap at £3.6 billion by 2024/25 and the Advisory Committee on Resource Allocation calculates that public health similarly needs an extra £3.2 billion.

It was disappointing to not see public health receive any money in the Spending Review last year. As we said in our recent letter to the prime minister on behalf of the Inequalities in Health Alliance, the pandemic has reminded us of the importance of high levels of general good health, which is why the government must increase public health funding to stop people becoming ill or unhealthy in the first place. It is indisputable that the rates of infection are worst in areas where people are poorer. There is a clear moral case for reducing health inequality, as well as recognition that a healthier population would take pressure off the NHS. Investing in public health is a vital part of this, as a national cross-government strategy to reduce health inequalities. COVID-19 has demonstrated how health inequalities can have an impact in just a matter of weeks – and how we are paying the price now for public health policy decisions taken in the past. For example, by allowing more and more children to become obese in the past, we have increased their risk of dying from COVID-19 as adults in the present.

The under-resourcing of social care increases the number of people who need to be in hospital and delays them being discharged – therefore freeing up beds for new patients to receive inpatient treatment. The funding announced at the Spending Review last autumn is far from what is required. The government must bring forward the proposals on social care that it has promised and the prime minister needs to deliver on his commitment to sort out on social care.

The NHS does not operate in isolation. It is part of a wider health and care ecosystem, and the government must recognise that unless we invest in all parts of the system, plans for truly integrated care will never be realised. This would mean patients being failed, and demand on the NHS continuing to grow in an unmanaged way.

Recommendation:

- Build a preventative system by addressing the estimated £6.8bn funding gap for adult social care and public health as part of a cross-government strategy to reduce health inequality.

3. **Supporting clinical research workforce capacity**

The pandemic has shown that UK clinical research is world leading and the NHS is critical to this. From setting up multiple trial sites in a matter of weeks in order to test the Oxford University/AstraZeneca vaccine, to establishing the efficacy of treatments like dexamethasone through the RECOVERY trial, our clinical research sector has helped improve the outcomes of COVID-19 patients and plot a path to overcoming the pandemic.

But the success of RECOVERY was in one way unusual. That is because recruitment into clinical trials has historically had a regional imbalance, meaning patients in these areas miss out on accessing the best treatments. This imbalance has also meant these regions have also not enjoyed the economic benefits of a thriving clinical research sector.

Figure 1 in the appendix shows there are large parts of the country where little clinical research is taking place, such as the east coast of England. Figures 2 and 3 show that there is no link between illness prevalence and research: relatively few patients are being recruited for mental health research in the north west and Greater Manchester, despite these regions having the highest rates of severe mental illness. Similarly, the north east has some of the highest rates of diabetes, but low levels of diabetes research.

Regions that are doing less clinical research are also missing out economically. A report by KPMG UK, commissioned by the National Institute for Health Research (NIHR), found that clinical research generated over 47,000 jobs and contributed £2.7 billion to the UK economy. Significant financial savings for the NHS can also be achieved – the same study found that for each patient recruited onto a commercial clinical trial, the NHS in England saved on average £5,813.

One of the key reasons for the regional imbalance is because smaller, more rural NHS trusts often feel they do not have the workforce or resources to be able to support clinical research. In a survey we conducted in January 2020, we found 57% of physicians wanted to be more involved in research but were unable due to lack of time.

The problem was especially noticeable in rural hospitals, where 40% of physicians not participating in research said they would like to. Rural NHS trusts face particular challenges supporting their workforce to become involved in research given the higher costs they face, as highlighted by the Nuffield Trust. Such a move would be likely however to boost the morale of the workforce, improve retention rates. Two-thirds (67%) of physicians surveyed said having dedicated time for research would make them more likely to apply for a role.

But the funding challenge for rural and smaller hospitals has been further exacerbated by the pandemic. One of the key short-term destabilising hits to the UK's capacity to conduct clinical research is funding. UKRD and NHS R&D Forum summarised well the commercial funding shortfalls that are affecting NHS research in their July 2020 report.

As we focus on building back a more resilient NHS that tackles health inequalities, and continuing to be a leader in research post-Brexit, building clinical research capacity into workforce planning is crucial.

The Academy of Medical Sciences has estimated the costs of providing dedicated time for research. In a pilot across 10 NHS trusts, they estimate the cost of 20% of consultants having 20% of their time protected for research was between £21.7 and £25 million per year. The government should support such a pilot, targeting ten NHS trusts where research activity is low, and in regions where research activity is also low.

As the UK's chief medical officers and Professor Steve Powis highlighted in an August 2020 letter to trusts, we need to restart paused research because causes of health other than COVID-19 have not

gone away. The pilot we have outlined will help that, as will investment in the medical workforce that frees up time for clinicians to do research.

Recommendation:

- Tackle regional health and economic inequalities and improve workforce retention by supporting a pilot in ten NHS trusts, where research is low, to provide more research time for consultants. The cost is estimated to be between £21.7 and £25 million per year

For more information on any of these policy proposals, please contact policy@rcplondon.ac.uk

Royal College of Physicians

Appendix – Regional variation in clinical research and disease prevalence

Figure 1: Research activity in England and Wales

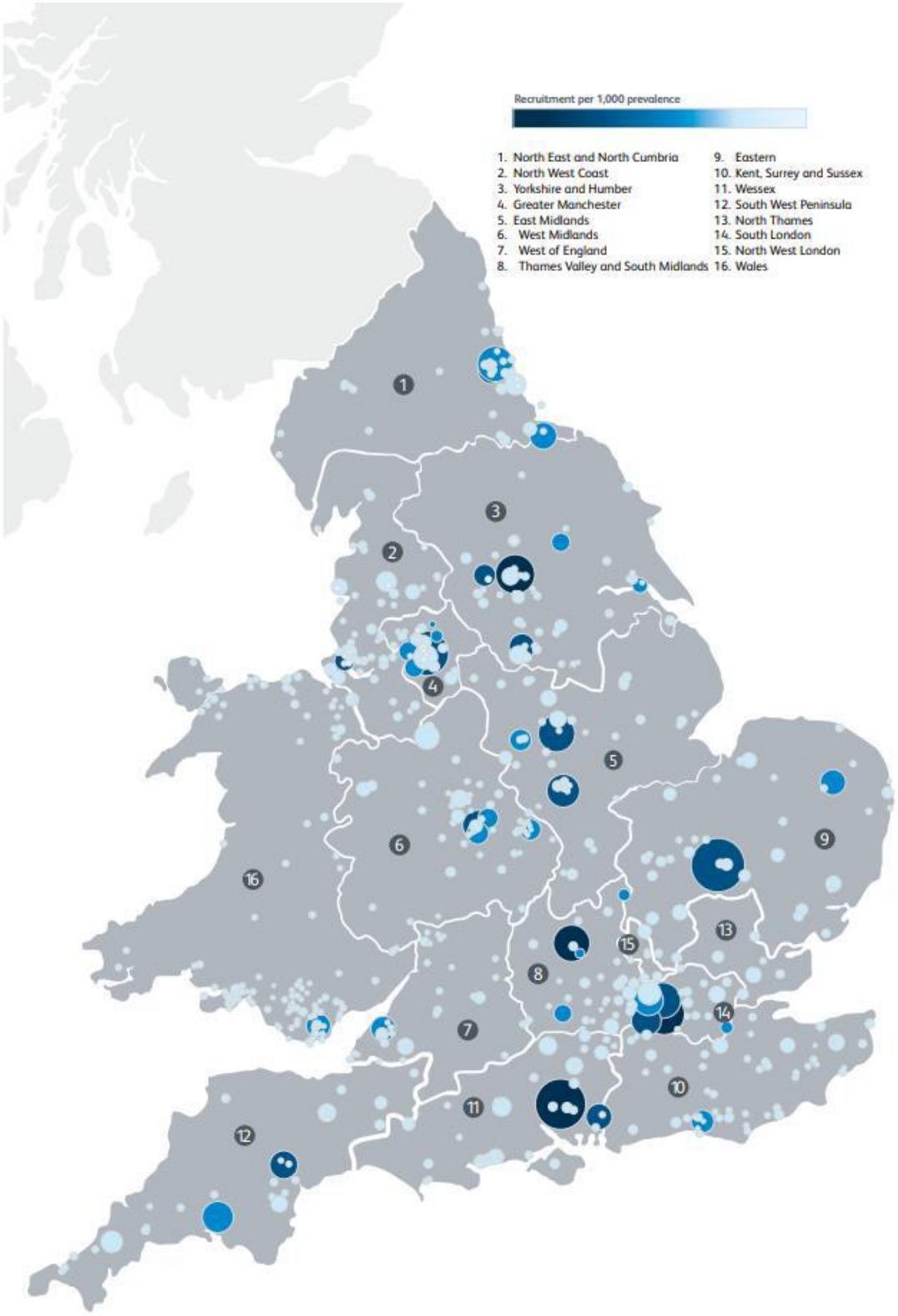

Fig 1: Map of recruiting studies in England and Wales based on NIHR data

This bubble map plots sites of research activity. The bubble sizes show the number of recruiting studies per site, while the colour of the dot indicates the number of participants.

Figure 2: Comparison of recruitment into mental health research with prevalence of severe mental illness in England

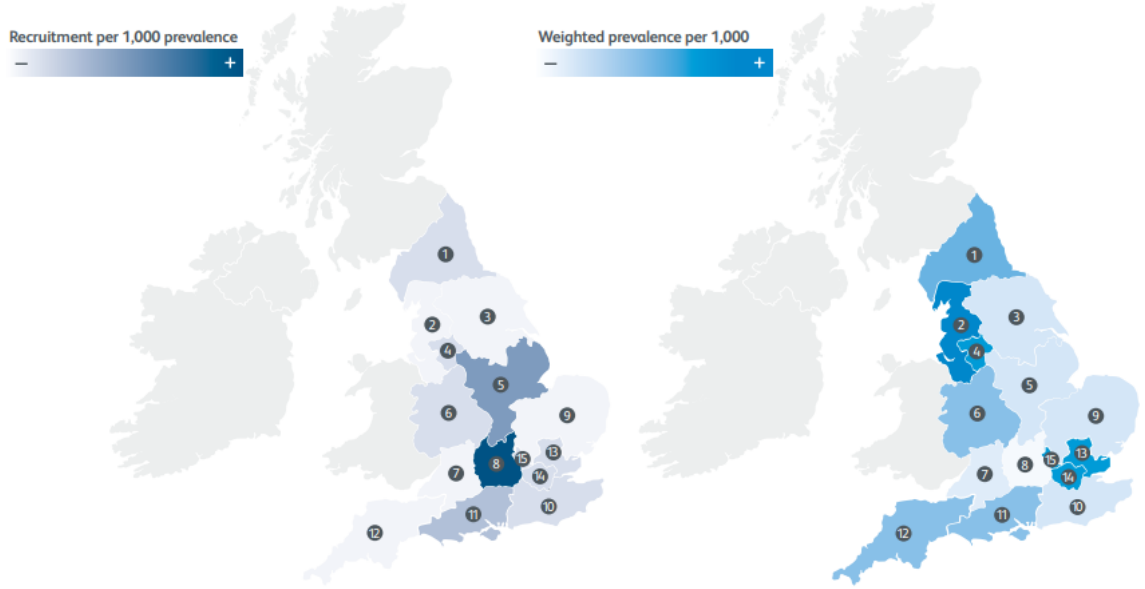

Fig 2: Comparison of recruitment into mental health research with prevalence of severe mental illness in England
Analysis on mental health / severe prevalence and research activity in all years.

Figure 3: comparison of recruitment into diabetes research with prevalence of diabetes in England

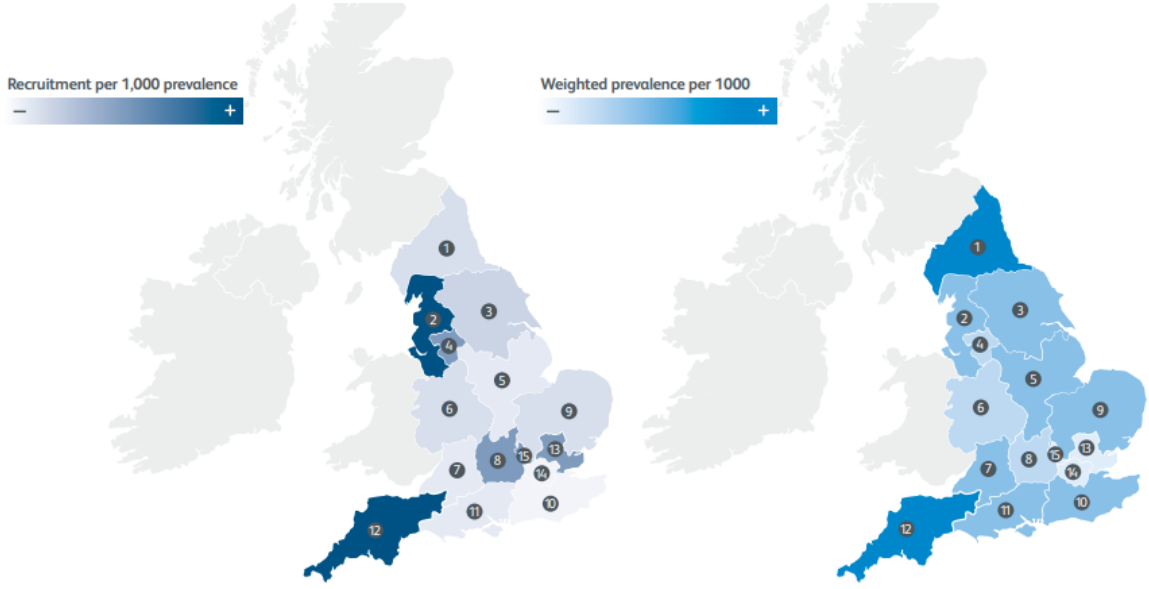

Fig 3: Comparison of recruitment into diabetes research with prevalence of diabetes in England
Analysis of diabetes (type 1) prevalence and research activity in all years.