Royal College of Physicians 2021 representation to the Spending Review 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 40,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Executive summary

The past year has demonstrated that the health system does not have the capacity to deal with emergencies while continuing to deliver routine care. The need for a more resilient and sustainable health and social care system is clear.

We welcome the funding injections that the NHS has received to support the recovery of elective services given the huge volume of demand that has built up since March 2020. Additional funding for operations, diagnostic checks and other procedures is welcome. But without a well-resourced workforce, it can only do so much. Workforce hampered our response to COVID-19 – it will be a limiting factor in managing the backlog, and a key limiting factor in the government's wider ambitions for healthcare.

This multi-year spending review is a significant opportunity to invest in expansion of the medical workforce. The Royal College of Physicians' report Double or Quits (enclosed) models the expansion of medical school places at a cost of £1.85bn per annum. While this is not a small sum, it is less than a third of what hospitals spent in 2019/20 on agency and bank staff.

The government's plans for improving our health and care service require a well-resourced workforce. Continuing to recruit from abroad is not a long-term solution. Investing in expansion of home-grown medics should be a firm part of the levelling up agenda – encouraging aspiring doctors to train and work in the communities they have grown up in. There should be a particular focus on widening participation, encouraging people who have direct experience of health and other inequality to enter the profession. We hope the government will take the opportunity of this SR to deliver a multi-year funding settlement for expansion of the medical workforce, aiming to provide medical school education across the whole of England.

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. We welcome the government's commitment to reform the social care system. The proposals set out in the recently published 'Build Back Better: Our plan for health and social care' document are an

important first step in this, and it is now vital that the forthcoming White Paper on adult social care provides comprehensive, sustainably costed plans to implement this vision. As part of this, we look forward to further detail of how the government will support the social care workforce, following the positive announcement of £500 million to fund professional development and mental and occupational health initiatives.

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 Spending Review:

1. **Double medical school places from 7,500 to 15,000 per year to tackle the NHS workforce crisis at a cost of £1.85bn a year. The government investment to tackle the NHS backlog will only go so far without people to deliver the work.**

2. **Spread clinical research across the UK to support regions missing out on its health and economic benefits by supporting ten NHS trusts, in regions where research activity is low, to pilot funding time for research at a cost of approximately £25m per year.**

3. **Build a preventative system by addressing the funding gap for public health as part of a cross-government strategy to reduce health inequality.**

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 doctors.

The biggest challenge facing the NHS is tackling the huge volume of demand that's built since March 2020. We welcome the funding injections that the NHS has received to support the recovery of elective services. Additional funding for operations, diagnostic checks and other procedures is welcome. But without an appropriate sized workforce, it can only do so much. Not having enough doctors, nurses and other clinicians hampered our response to COVID-19 – it will be a limiting factor in reducing the backlog, and in realizing the government's wider ambitions for healthcare.

We came into the pandemic carrying a large number of vacancies, with the 2019 RCP census showing that 43% of advertised consultant posts in England and Wales were unfilled due to a lack of suitable applicants. We're concerned that working with pandemic pressures long-term is pushing people to

consider early retirement. Our most recent member survey showed that 27% of consultants expect to retire within 3 years.

Even without the pressures of the pandemic, there are big challenges ahead for the NHS workforce that we need to take account of and prepare for now. The current consultant cohort is ageing. Even if experienced consultants do not take early retirement because of the pandemic, **it's still expected that 35% of current consultants will retire in the next decade as they reach mean age of retirement at 62.5 years.**

At the same time, the **majority (56%) of medical trainees entering the NHS are interested in working part-time.** This squeeze on capacity at either end of the system means we need to act now to feel the benefit before the impact of these shifts really hits the health service.

The RCP believes we need to increase the number of medical school places from 7,500 to 15,000 over the next decade. It will cost £1.85bn annually – but that is less than a third of what hospitals spent in 2019/20 on agency and bank staff. This includes costs for 2 years of foundation training.

The cost of increasing medical school places would depend on the scale and pace of expansion. It 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.

The expansion figures are based on modelling first done by RCP in 2018, taking into account estimated future demand. This includes an ageing population where having long term multiple health conditions is common, and losses to the profession due to retirement or training. Our blueprint, published this year, reiterates this call and sets out in more detail the financial investment required to underpin the expansion. It sits alongside a plan for how and where the new places should be allocated across the UK to ensure a diverse workforce through 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 cost to the public is £192,981 and the cost to the individual £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. Adding the cost of a 2-year foundation programme, estimated at £125,318 per person, to the public cost of a medical school place (and assuming an attrition rate of 10% between medical school and foundation training) takes us to a total of £1.85bn to train an additional 7,500 doctors. 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.

From 2009 to 2019, the number of consultant physicians working less than full time grew from 14% to 23%. The NHS knows it must become a more flexible employer if it is to retain staff and is taking steps to ensure all staff have the right to request flexible working. But our surveys show while that 59% of our members thought their department would support a request to work more flexibly, 41% say their department wouldn't. Of those who thought their department would not support such a request, the key issue was again workforce pressures with over two thirds (76%) citing not enough medical staff.

The growing interest in working part-time among those entering the NHS will have significant implications for workforce planning in 10 years, when that cohort begin to qualify as consultants. **We need a long-term recruitment and retention workforce strategy that looks at significant expansion of medical school places, alongside proper workforce planning to assess how many healthcare professionals we need in the system to continue to meet patient demand.** Enabling the NHS to become a more flexible employer is crucial to retain doctors currently joining the profession whose expectations on work/life balance may differ from doctors of previous generations – but this can't happen unless we have more doctors.

The pandemic has stimulated interest in medicine and the NHS. It's vital we take advantage of this. Our blueprint demonstrates that it is the cap on medical school places, and not lack of interest in studying medicine and a medical career, that is the barrier. We therefore welcomed the government's decision to expand medical school places for 2021 in response to a larger proportion than usual meeting the A level grade requirements for medical school, but it is a drop in the ocean compared to what's required.

Expanding medical school places supports the government's levelling up and health inequalities agenda. By offering the opportunity to study medicine to more people in the UK, we can increase the number of doctors who have direct experience of health and other inequality.

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

Public health and social care

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 increased their risk of dying from COVID-19 as adults in the present. Sufficient public health is vital for local areas to keep their populations healthy.

To stop people becoming ill or unhealthy in the first place, government must develop a cross-government strategy to reduce health inequalities that is led by and accountable to the prime minister. Since October 2020 the RCP, and the Inequalities in Health Alliance which it convenes, has been calling for a cross-government strategy to reduce health inequalities. Such a strategy could be devolved to the Office for Health Improvement and Disparities or sit at the heart of the Levelling Up white paper.

We also welcome the government's commitment to reform social care. The proposals set out in the recently published 'Build Back Better: Our plan for health and social care' document are an important first step in this. Ultimately these must be underpinned by comprehensive and sustainably costed plans for implementation. We hope that the forthcoming White Paper on adult social care will provide this, and are pleased that the government has said it will engage widely with users, providers and stakeholders. Supporting the social care workforce will be crucial to the success of these reforms, and we look forward to learning how the government intends to build on the very positive announcement of £500 million to fund professional development and mental and occupational health initiatives.

Expanding clinical research

The COVID-19 pandemic has vividly illustrated the power of clinical research, which has produced vaccines and treatments that have saved many thousands of lives globally. However, the last 18 months have also caused considerable disruption to non-COVID-19 research, which can have an equally transformative impact on patients' health and wellbeing. Recent figures published by the Association of the British Pharmaceutical Industry (ABPI) show that over 40% of NHS trusts had non-COVID-19 research studies paused during the first wave of the pandemic. Restoring levels of clinical research activity must be a key priority as we emerge from the pandemic.

The UK has a world-leading clinical research sector, but this research activity is not distributed evenly across the country (see appendix). Some regions do not experience the economic benefits in the form of job creation, and patients in these areas also cannot access the most innovative treatments and medicines.

A 2019 report by KPMG UK, commissioned by the National Institute for Health Research (NIHR), summarised the macroeconomic benefits and the boost to NHS finances from the UK's strong clinical research sector. It found that in 2018/19:

- clinical research backed by NIHR contributed £2.7 billion to the UK economy and generated over 47,000 jobs
- for each patient recruited onto a commercial clinical trial, on average the NHS in England saved £5,813.

Figure 1 shows there are large parts of the country where little clinical research is taking place, such as the east coast of England. Figure 2 shows 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 (figure 3).

A key issue hampering a fairer regional distribution is NHS workforce capacity. In January 2020 we found 57% of physicians wanted to be more involved in research but were unable due to time.

The problem of low participation was particularly acute in rural hospitals, where 40% of physicians not participating in research said they would like to. Rural NHS trusts find it particularly difficult to support their workforce to become involved in research given the higher costs they face, as highlighted by the Nuffield Trust.

This 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 summarise well the commercial funding shortfalls that are affecting NHS research in their July 2020 report.

The Academy of Medical Sciences estimated the costs of providing dedicated time for research in January 2020. In a pilot across 10 NHS trusts, 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 conduct another such programme, targeting ten NHS trusts where research activity is low, and in regions where research activity is also low.

Appendix | Regional variation in research and disease prevalence

Figure 1: Research activity in England and Wales

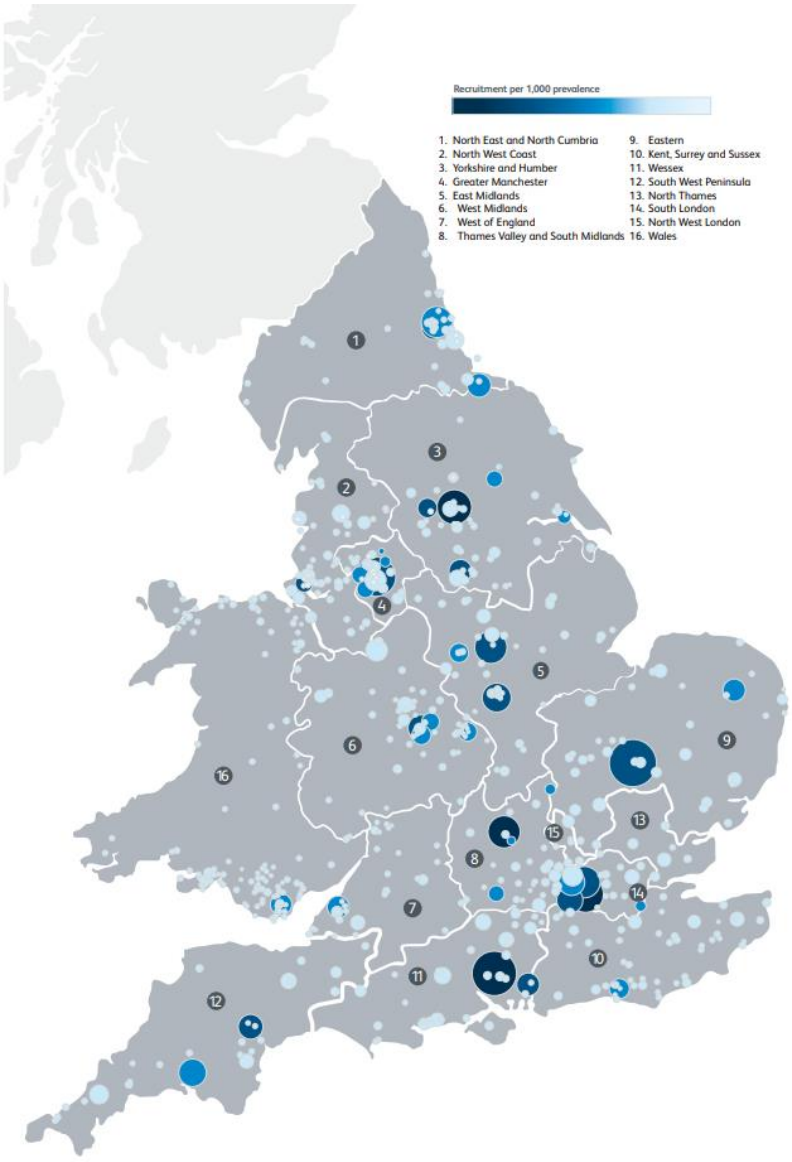

Fig 1: Map of recruiting studies in England and Wales based on NIHR data

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

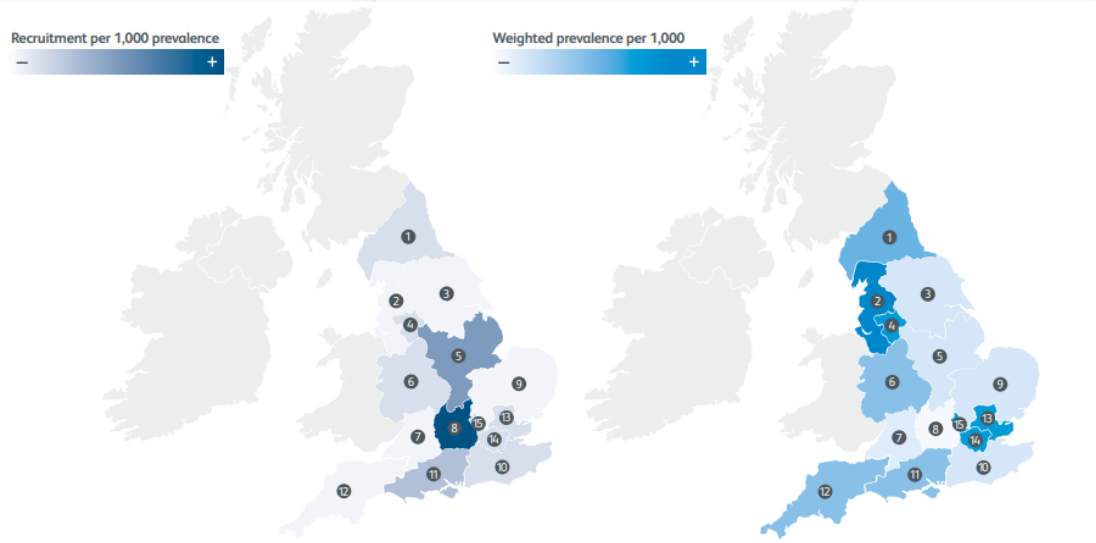

Fig 2: Comparison of recruitment into mental health research with prevalence of severe mental illness in England
Analysis on mental health / severe prevalence and research activity in all years.

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

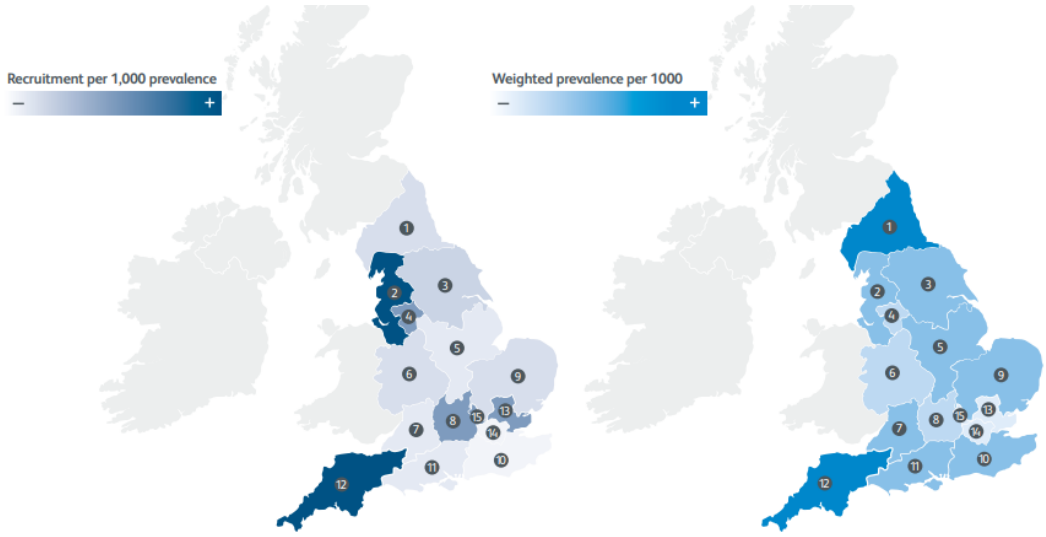

Fig 3: Comparison of recruitment into diabetes research with prevalence of diabetes in England
Analysis of diabetes (type 1) prevalence and research activity in all years.