10-Year Health Plan Consultation

Royal College of Physicians' response

November 2024

Royal College of Physicians

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

In the 10-year health plan the RCP wants to see patients put first by ensuring there are enough NHS staff who have time to deliver high-quality care, as well as plans to transform healthcare services to meet population need, deliver a cross-government strategy to reduce health inequalities and prevent ill health, as well as bold action to facilitate innovation and create a sustainable net zero NHS.

The government's three shifts must be underpinned by robust actions to address NHS workforce challenges. Staffing is one of the most significant challenges facing the NHS and one of the most important enablers in successfully delivering the government's aim to 'fix the NHS'. We welcomed the publication of a dedicated workforce strategy in 2023 and its commitment to expand medical school places. The 10-year plan must recognise the role of NHS staff in delivering the government's vision and account for the impact of current workforce capacity on delivering reform over the next decade. Current assumptions about staffing numbers, capacity and retention in the short, medium and long-term must feed into the 10-year plan to ensure the vision is ambitious but feasible. The next revision of the NHS Long Term Workforce Plan (LTWP) must set out the staff needed to deliver on the 10-year plan vision and meet the future needs of the population. That revision should commit to a review - of medical training, expand medical specialty places based on population need, include actions to retain our existing workforce and limit the pace and scale of the physician associate rollout. Government will need to deliver sufficient funding to implement commitments in the LTWP revision to ensure we have the workforce needed to change the NHS. Without this, patients will continue to wait too long for care, and morale among our existing workforce will continue to go down, risking staff leaving the NHS entirely.

We welcomed the additional funding to reduce waiting lists, but this alone will not fix the NHS' systemic issues. With an ageing population, advances in medicine and more people living longer with multiple conditions, providing high-quality care is more complex than it was. Consequently, demand for healthcare will only increase, so it is critical that we use NHS resources effectively and focus on how the workforce can add most value. A vision for transforming NHS services must be in the plan to ensure the way healthcare is delivered meets the needs of patients. As patients move between health and care services with more complex needs, efforts to improve the integration and coordination of these services must be prioritised. The RCP recommends these efforts focus on transformation across several areas including financial flows and incentives, digital systems, and ensuring sufficient workforce capacity and capability across community, primary and secondary care services. Outpatient care must move towards a model that prioritises holistic care closer to home, focusing on outcomes rather than activity. Doing more of the same will not meet demand.

A key element of reducing pressure on the NHS is reducing avoidable ill health and diagnosing illness early to avoid complications and greater use of NHS resources as people get sicker. There is an almost 20-year gap in healthy life expectancy between the most and least deprived areas of England, with over 2.5 million more people projected to be living with a major illness by 2040. Several things must be done to realise this shift. The first is addressing the factors that cause ill health in the first place – such as poverty, poor housing and food quality, employment, and air quality. The NHS is currently in the unsustainable position of treating avoidable illnesses caused by these 'non-health' factors. We need to end this cycle and tackle the social determinants of health that present a barrier to good health. The RCP has long called for a cross-government strategy to reduce health inequalities that considers the role of every government department and every policy lever in tackling the root causes of ill health. Now is the time to implement this. We welcome government establishing its health mission delivery board - it must be the vehicle to deliver a cross-government strategy. The 10-year plan must consider the wider determinants of health to truly deliver a service that is no longer simply treating sickness. The other priority is intervening early to prevent disease progression and deterioration which improves patient

outcomes and reduces the need for more care later down the line, which costs the patient, the NHS and the planet through avoidable use of resources. An integrated care approach, including re-designing outpatient care and addressing issues in social care, will contribute to this.

Innovations in digital technology, treatment, and quality improvement must be introduced safely by adopting robust safety assessments and governance. Very few digital innovations have been validated and evaluated for efficacy of use for clinical care, making it difficult to know whether they will genuinely work in the real world prior to implementation.

Research needs to be at the heart of the 10-year plan. The COVID-19 vaccine illustrated the fundamental importance of clinical research in healthcare and the UK's status as a world leader. Research is currently severely threatened, with less time for NHS staff to conduct research and a marked drop off in those pursuing clinical academic careers. Findings from the 2023 RCP census of UK consultant physicians found that just 41% respondents undertake research. 52% cited lack of time in job plans as the main barrier to taking part in research. Embedding research in everyday practice for all physicians is vital to ensure the NHS has the research capacity it needs and patients have access to the latest treatments and innovation. The government needs to support clinical academia at all career stages and doctors must have protected ringfenced time for clinical research.

Finally, addressing the health impacts of climate change and reducing the NHS's carbon footprint is key. Lord Darzi's independent investigation into NHS performance said the NHS must 'stick to its net zero targets'. The NHS constitution should include the net zero targets and initiatives to reduce the environmental impact of healthcare delivery within the NHS must be appropriately funded, including capital investment. The climate crisis is the biggest threat to global health – rising global temperatures will mean a greater prevalence of antimicrobial resistance, vector-borne infectious diseases and excess heat-related deaths. Flooding, conflict and famine, leading to climate migration, will create challenges for human health and healthcare service delivery. Throughout the plan, the government's proposed measures must support the NHS to reach the net zero ambitions in NHSE's Green Plan. The 10-year plan is a vital opportunity to embed sustainability in the design and delivery of healthcare.

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

Shifting care from hospitals to communities is a crucial part of keeping people well, treating and managing acute illness and long-term conditions, as well as supporting people to self-manage. The RCP has advocated for this for 20 years through our work on Teams without Walls and the Future Hospital Commission (including a 10-year review). Physicians have led the development of specialist services being integrated with local communities. Most major medical specialties have developed and delivered community-based specialist services, but their spread and sustainability has been prevented by financial priorities and flows, training opportunities, and continued separation of "hospital", community and primary care. The renewed focus on neighbourhood health is an opportunity for more radical change where the expertise of specialists, community care, primary care, and local communities meets people's health and care needs in a more integrated and holistic way. This can also remove duplication of care and focus on interventions with the greatest benefit to populations.

The government must consider the role of physicians to work in and contribute to neighbourhood healthcare teams. There are well developed local models of integrated care in geriatrics, palliative medicine, diabetes, respiratory, cardiology, musculoskeletal, and dermatology. The principles apply across all disease areas, and further integration with mental health and social prescribing will improve outcomes. This also joins up neighbourhood health with wider aspects of specialist care when needed. With wider recognition of the physicians' leadership role in this area, improved training for physicians to

work in this way, and appropriate financial flows, significant shifts and improved outcomes can be achieved. Physicians should be a:

- neighbourhood champion for patients with a specific condition or groups of people most at risk for specific conditions
- local expert for patients and health professionals seeking advice
- provider of specialty care in collaboration with other healthcare professionals in primary and community settings
- translator of new evidence and research on specific conditions
- trainer and educator of primary and community healthcare professionals.

Outpatient care transformation should be part of the shift towards neighbourhood health. The RCP's shared vision on outpatient transformation aims for eight shifts:

- From appointment-based care to a wide range of options for holistic care
- From services that are difficult to access and navigate to simplified, timely pathways of care closer to home
- From one size fits all to shared decision making that meets a patient's individual needs
- From diagnose and treat to predict and prevent
- From teams working in siloes to integrated pathways of care working across the healthcare system.
- From burnt out and disenfranchised healthcare workers to empowered and engaged teams
- From counting activity to delivering best possible health outcomes and patient experience
- From post code lottery to consistent standards of care.

Modern outpatient services should be delivered by multiprofessional teams, using multiple modes of consultation and assessment, including face to face, remote, group and other communication channels (such as email). It may incorporate several specialties for effective and efficient management of the patient's health and condition(s). Breaking outpatient care into advice and prevention, diagnosis, shared decision making on treatment, pre-assessment for procedures and surgery, monitoring, and supporting people with ongoing condition management and support enables better integration with neighbourhood health services. Current financial incentives and flows encourage more of the traditional model of outpatients, which will not meet today and tomorrow's demand.

Many of the aspects of care traditionally provided to hospital inpatients can also be provided in community settings or the patient's home. The RCP calls this Hospital at Home. It should include:

- multiprofessional, consultant-led daily review of care
- blood and other diagnostic tests
- medication, including intravenous therapies
- oxygen therapy
- physiological monitoring throughout the day
- call and response systems for if the patient's condition deteriorates

The RCP View on Hospital at Home – which are sometimes called virtual wards – sets out that delivering this model successfully requires the right staff with the right skills, sufficient capacity to manage all patients who would benefit or require it, the ability to deliver care 24 hours/7 days a week and escalation of care as required. We urge government and NHSE to use the term Hospital at Home, rather than virtual wards, to avoid confusion among patients and families that this is a solely 'remote' or

'online' offering. This model can enable whole episodes of care to be delivered in community settings or the patient's home, or care that reduces the length of time the patient needs to be in hospital. It may be particularly appropriate for patients who are nearing the end of life. Acute hospital-level care at home has been delivered for many years in some NHS services across the UK. Ensuring there is sufficient capacity and capabilities in the primary, community and secondary care workforce is a key enabler of this shift. This will require training for clinicians which is currently limited. The UK Hospital at Home Society has developed a range of resources and guidance and will be essential for fundamental standards of care to be delivered, and for the development of a wider workforce who can deliver this care.

It is critical that further research and evaluation is undertaken to understand fully the benefits and risks of each type of care provision, and how best to provide these services in people's neighbourhoods and homes. This shift will undoubtedly reduce the increasing demand for hospital-based care, but it will take many years. In the meantime, the overall demand for current hospital care will continue to increase with the changes in population need. As we develop the evidence of how best to deliver neighbourhood health, for both acute and non-acute care, increase its delivery and training of clinicians, the public will develop confidence in and familiarity with these services.

Working in an integrated way offers the prospect of achieving better outcomes from the collective resources available across the health and care system, helping to avoid duplication and reducing the need for carbon-intensive hospital admissions, care and travel. Building patient and community resilience and making better use of local community resources as part of the new model of neighbourhood care – building on the success of initiatives such as green social prescribing – is another key enabler to this shift.

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

One of the biggest challenges to this shift is that digital systems in healthcare are too often difficult to use, do not communicate across different platforms, and do not allow systematic coding of patient data to support care. Hardware is often out of date, broken or poorly designed for the task. This is a cause of frustration and burnout for physicians, increasing the time it takes to perform basic tasks and making patient care harder. In the context of current patient demand, this is having a significant impact on workforce wellbeing. In the RCP 2023 census of UK consultant physicians, physician respondents ranked clinical workload, poorly functioning IT and staff vacancies as the three things most negatively affecting wellbeing at work.

We often hear clinicians' frustrations about working with digital systems and the differences between hospitals – what might be one process in one system in one hospital might be five or six processes in two systems in another. Poorly designed digital systems contribute to unsafe care, but these risks are new and poorly described. There is evidence of harm, for instance, that widespread copying from one note to the next can lead to inaccuracies within the record. Poorly designed observation charts and dashboards mean it's harder to identify patients at risk and electronic referrals and other handovers get lost in the system. Lack of usability in the current digital technologies available in the NHS, and variability across healthcare providers, risks patient care as well as workforce frustration and burnout.

We need to get the basics right – functioning IT is central to improving patient care and the working lives of clinicians. Again, according to findings from the RCP 2023 census of UK consultant physicians, improved IT systems was most commonly cited by respondents when asked what would improve workforce satisfaction. In practice, this means clinicians must have access to functioning computers and laptops, reliable Wi-Fi, interoperable systems and records to improve access to information across the

NHS. To then make systems work, healthcare organisations must invest in ongoing training and commit to valuing clinical input to iteratively improve workflows that embed systems into pathways. Systems should be implemented with a focus on the NHS Design Principles which includes the need to involve patients and staff. Having the right kit is one part of the puzzle – ensuring that all clinicians feel competent and confident to use it is the other. Investing in improving the usability of digital systems will also pave the way for more ready engagement. Clinical adoption of innovation and AI will likely be low whilst 'digital basics' are perceived as a barrier to good clinical care.

The use of digital technologies will enable many more patients to be cared for at home during acute episodes of care. Remote consultation for some assessments reduces the frequency of travel to hospitals or health centres, or travel to the patient's home. There are environmental benefits from empowering people to manage their own health using digital tools, avoiding the need for unnecessary travel, and reducing waste and inefficiency that arises from barriers to data-sharing and communication. Importantly, multiprofessional teams can work together using videoconferencing technologies to review and ensure the right care for the patient. This can create considerable efficiencies in staff time and can ensure wide involvement of the right expertise for the patient. But it is critical that there is the appropriate digital infrastructure and availability of staff training.

Medical devices such as apps and wearables are increasingly able to generate data. These devices can now connect to clinician held electronic patient records, apps prescribed to patients specifically to help manage their conditions, and to monitoring devices that can directly control disease such as closed-loop systems for type 1 diabetes. While these innovations to medical technology can help patients have more control over their health, there is a risk of excluding the 13% of the population who do not have access to a smartphone or internet connection. Healthcare advancements must be accessible to all parts of the population. We must better understand how digital exclusion relates to the wider determinants of health given the correlation between digital and social exclusion.

The advent of generative AI changes the kind of problems that can be solved by digital systems, but it can only be deployed in a meaningful way if systems support data interoperability. One of the key enablers is ensuring that AI development starts with conversations with clinicians to aid a better understanding of the problems that AI can solve – this way, companies can develop AI and tech solutions that improve clinicians' working lives and patient care. Training for all staff is vital too. The potential of AI cannot be realised while clinicians do not feel comfortable or confident to use it.

Another enabler is having a vision from government, set out in this plan, for how AI should be used in the NHS and why. In the last three years, we have had open access to tools that are able to create text, images and computer code using predictions trained on very large datasets. However, with no overall vision for how AI should be used in the NHS and why, there is a growing risk of variation in approaches to use of AI in healthcare. While this may stimulate innovation, it risks mimicking the problems we see with different digital systems being used across the NHS. For AI implementation to be successful, it requires access to large volumes of patient data and interoperable systems so that it can be seamlessly integrated into live clinical systems at the point of care. That is why getting the 'basics' right of interoperable systems and access to large accurate datasets to train AI on is a key dependency for AI's successful deployment.

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

A broader shift towards prevention will bring health, environmental and economic benefits. Reducing avoidable illness is critical to reducing avoidable demand for the NHS and reducing pressure on the health service in the long-term. In March, polling conducted by the RCP found that 55% of UK consultant

physicians had seen more patients with ill health over the previous three months due to social and economic factors and almost a quarter (24%) said more than half or almost all of their workload is due to illnesses or conditions related to the social determinants of health.

To reduce avoidable illness, we must tackle the causes of ill health. That is why the RCP and over 250 other member organisations of the Ineqaulities in Health Alliance are calling for a cross-government strategy to reduce health inequalities that tackles the things that make us ill in the first place, such as poverty, poor housing, lack of educational opportunity, employment (including how much money someone has), racism and discrimination, food quality and ability to make healthy choices, transport and air quality. Many of these factors sit beyond the remit of the health system, which is why government must set an expectation for a coordinated approach that considers every department in tackling the drivers of ill health and health inequalities. Tackling these wider determinants is a vital enabler to a prevention-first approach and the shift from sickness to prevention. Highest need areas should be prioritised for action and funding, but a nationwide cross-government approach will identify the national policy changes relevant for all communities.

The work of the government's health mission delivery board must feed into the 10-year plan to ensure that action is taken to across primary, secondary and tertiary prevention. We know primary prevention will reduce the number of people avoidably requiring diagnosis and treatment in the first place. The outcome of these efforts will be realised over time, and must be accompanied by action on secondary and tertiary prevention. Reducing the impact of disease through early detection and diagnosis, as well as helping patients to manage diseases and conditions, are important aspects of achieving the shift away from sickness. Brief interventions for prevention should be included in all health and care contacts. These three areas of prevention are critical for a holistic approach to prevention and action on all three is central to achieving this shift.

The most disadvantaged population groups are at a higher risk of smoking, obesity, and harmful alcohol consumption. The RCP's 2021 report on smoking and health showed that smokers from more deprived communities in the UK disproportionately bear the burden of the health harms of combustible tobacco use. Illnesses and conditions resulting from public health issues, such as asthma, cancer, and cardiovascular disease, are contributing to the extremely high demand for healthcare services. In 2022-23, there were over 1.2 million hospital admissions in England where obesity was a primary or secondary diagnosis and 400,000 smoking-related hospital admissions. There are opportunities to address these public health challenges. Funding an opt-out approach to NHS smoking cessation services for all smokers at any point of contact with the NHS and funding for equitable access to NHS weight management services must be part of government's prevention-first approach.

Intervening early to prevent disease progression and deterioration improves patient outcomes. However, with over 6.3 million individual patients in August 2024 waiting for treatment, there are challenges to achieve this. While staff are working hard to see as many patients as possible, current staffing levels impact the ability to tackle the waiting list. In the RCP 2023 consensus of UK consultant physicians, 59% reported consultant vacancies in their departments and 62% were aware of weekly or daily gaps in resident doctor rotas. More than four-fifths of people on the waiting list for treatment need an outpatient appointment. This is a crucial point in the pathway where patients receive a diagnosis, advice or treatment that prevents their health worsening, the development of associated conditions and complications and the need for further intervention or treatment. Without significant reform and re-design of outpatient care, the system's ability to reduce the waiting list and prevent people from getting sicker will continue to be stifled. This is made all the more urgent given current staffing challenges – given these are unlikely to change anytime soon, reform is critical to ensure the NHS can meet the needs of patients and reduce sickness.

Where someone receives a diagnosis, it is vital they are given the support needed to manage and live well with their condition. Patients often, and increasingly, have multiple conditions. With the arguable exception of primary care, most services and support functions are not designed in a way to treat people living with multiple conditions. Healthcare services need to be designed around the patient and their conditions managed as a whole, rather than as individual illnesses that do not interact. This requires joined up and integrated care across the health and care system, which is what the Health and Care Act 2022 set out to do. However, patients still tell us that their care is fragmented, and systems can be confusing to navigate. Patients should be able to access their health records, engage in two-way communication with clinicians, access care when they need it without harmful delays, and feel supported to manage their own health. We must also recognise that a "single model" approach to prevention will not be successful. Approaches will need to be relevant to different populations with different challenges and needs, including the differing behaviours, beliefs and priorities of different sections of communities.

Getting this shift right will reap many varied rewards. Measures to improve health often have environmental benefits – for example, supporting people to walk or cycle instead of car use increases physical activity while reducing emissions. As people's health improves, the need for carbon-intensive resources for diagnosis and treatment reduce. The link between climate change mitigation and improved health outcomes should be recognised and leveraged in national, regional, and local health inequalities work, including through the delivery of duties under the Health and Care Act 2022 as well as NHS green plans.

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

<u>Workforce</u>

- Support and funding the 2025 revision of the LTWP, with revised independently verified workforce projections, continued funding for the expansion of medical school places, and a plan to increase capacity for medical education and training.
- Fund the expansion of foundation and specialty training places based on population need, determined by robust workforce modelling of postgraduate medical specialties.
- Work with NHS employers to ring-fence time for education, career development, clinical research, and quality improvement in job plans.
- Ensure consultants and specialists have balanced, team-based job plans, that give time for wider professional activities that drive professional reward and commitment.
- Delivery of a plan for retention, valuing staff, balanced professional activities (e.g. time for research), prioritising workforce wellbeing and getting the basics right, including ensuring staff can access hot food and drink, as well as rest facilities at all hours of the day.
- Limit the pace and scale of the physician associate (PA) roll-out, working with NHS England to review the projections in the LTWP for growth in the PA workforce.
- Commission a review of postgraduate medical training that looks at how doctors will want to learn and work in the future.
- Reverse the declining number of clinical academics at all career stages.
- Make clear there is a zero-tolerance approach to workplace harassment, racism, discrimination, bullying and sexual misconduct in the NHS and develop systems to hold individuals and organisations to account

<u>Hospital to community</u>

- Recognise the leadership role for physicians in delivering care for local populations as part of the neighbourhood health team.

- Prioritise initiatives to reduce the environmental impact of healthcare delivery within the NHS, ensuring these are appropriately funded, including capital investment where necessary.
- Expand integrated models of care by commissioning services in a way that incentivises joint working across primary, community, and secondary care and shift payment mechanisms to focus more on outcomes, rather than activity.
- Providers delivering outpatient care should evaluate their model and make changes to improve access and outcomes for their local population, with appropriate funding made available at a national level to undertake an evaluation.
- Over time, expand the Hospital at Home model of care to enable a shift of acute care services to the community, accompanied by appropriate training for clinicians and digital infrastructure.
- Proactively support patients to manage their own health at home while enabling them to contact health professionals when they need help.

Sickness to prevention

- Deliver a cross-government strategy to reduce health inequalities that considers the role of every government department and policy lever to tackle the wider determinants of health, with clear measurable goals and metrics, underpinned by the necessary funding settlement. The government's mission delivery boards should be the vehicle that develops this.
- Deliver funding to ensure equitable access to weight management services across the country.
- Fund and deliver opt-out NHS smoking cessation services at any point of contact with the NHS to help smokers quit.
- Commit to multi-year public health funding settlements.
- Use data on health inequalities to better understand the population and deliver a prevention-first approach to healthcare to those that need targeted services the most.
- The government must adopt a holistic approach to prevention with a view that the three elements of prevention (primary, secondary, and tertiary) are inextricably linked to health outcomes and action on all three must be prioritised in the 10-year plan.
- Prioritise preventative interventions that deliver combined health, environmental, financial, and social benefits, ensuring that these wider benefits are measured, tracked, and reported in order to inform future decision-making and prioritisation.
- Recognise and leverage the link between climate change mitigation and improved health outcomes in national, regional, and local health inequalities work, including through the delivery of duties under the Health and Care Act 2022 as well as in NHS green plans.

Analogue to digital

- Invest in well-functioning, interoperable IT systems, NHS equipment, facilities, estates and digital infrastructure with an ambitious multi-year capital funding settlement.
- Commit to funding optimisation of existing systems, considering the functions of electronic patient records that should be standardised across the system (e.g. NEWS chart).
- Redesign workflows based on user experience of both clinicians and patients to integrate the use of IT systems.
- Ensure consistent data capture at the point of care by clinicians and patients from digital systems used in care – this data should be used to drive improvement, learning and research.
- Digital systems should be designed in accordance with NHS design principles which incorporates the need to involve patients and staff.
- Ensure access to training for NHS staff to ensure they feel confident using new technology or digital clinical systems and committing to value clinical input to iteratively improve workflows.
- Develop a vision that targets the entire digital innovation development cycle/pipeline from design to testing, assessment and evaluation involving clinician (and patient) input at every stage.

- Develop a dedicated government/NHS England 'AI in healthcare' strategy to set out a vision for the use of AI in the NHS.
- Regulate AI systems so that their efficacy and safety is evaluated before introduction, rather than afterwards.
- Better understand how digital exclusion relates to the wider determinants of health given the clear correlation between digital and social exclusion.