BMA

BMA organisational submission to - Change NHS: A health service fit for the future

2nd December 2024

British Medical Association
bma.org.uk

The BMA has submitted the following organisational response to DHSC and NHS England's Change NHS consultation, which is intended to inform the UK Government's upcoming 10 Year Health Plan.

This response has been developed collaboratively across the Association and has been submitted on the behalf of the entire BMA.

Please contact healthcare.delivery@bma.org.uk with any questions regarding the submission.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The BMA is the foremost professional association and trade union representing and negotiating on behalf of all UK doctors and medical students. It is a leading voice advocating for outstanding health care and a healthy population.

We have consistently highlighted Doctors' concerns about the dire state of health and care services, compounded by short term targets, and political and managerial imperatives. We believe that, with the right policies and investment, a 10 Year Plan could provide the change needed to fix the NHS.

This plan must start by addressing the longstanding failure to properly value, support, and empower doctors. Many doctors believe the NHS shows a disregard for their professional expertise, competence and skills, contributing to a rising number leaving the NHS and with many doing so earlier than they otherwise would have done so.

The exodus of doctors is also being driven by inadequate pay, punitive pensions rules, burnout, ill-health, and the desire for a better work-life balance – but too little is being done to remedy these issues.

Research shows that this turnover of staff is linked to increased patient deaths in hospitals,[1] and that it is impeding the productivity of the NHS as a whole.[2] This clearly illustrates the imperative to reverse the flow of doctors leaving the NHS. A failure to do so imperils core Government priorities to improve the quality, safety, and efficiency of the health service.

As the plan develops, it is crucial to have ongoing consultation with frontline doctors, medical students, and trade unions. Therefore, we ask that the BMA is invited to join all relevant working groups and events taking place as part of this process, so that doctors

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[1] **See:** https://www.bmj.com/content/387/bmj.q2578.full

[2] **See:** https://ippr-org.files.svdcdn.com/production/Downloads/From_the_frontline_Nov24_2024-11-21-164416_sdmh.pdf

can contribute to the shape of a future NHS dependent on gaining the best use of doctors' unique skills and expertise.

This plan must include, and then deliver, genuine change, including:

A fundamental shift in the way doctors are valued – financially and culturally

Doctors working in the NHS feel undervalued, both financially and culturally. This heavily impacts their morale and undermines staff retention. The plan should:

- **Commit to achieving pay restoration for doctors** and reversing the pay erosion experienced since the 2008 financial crash, ensuring pay scales increase above RPI (Retail Price Index) inflation in 2025/26 and beyond, with increases in global sum funding to ensure GPs receive the same. This aids the UK's competitive place in a global health market.
- **Tackle pension taxation and childcare cost disincentives** by retaining the Lifetime Allowance abolition, indexation of the Annual Allowance threshold, a solution to the unfair interaction between the Annual Allowance taper and the NHS Defined Benefit pension scheme, and addressing the cliff-edge caused by existing income thresholds for free and tax-free childcare.[3] This enables those doctors in a position to take on additional waiting list activity to do so without facing punitive disincentives.
- **Restore the independence of the DDRB** (Review Body on Doctors' and Dentists' Remuneration) to ensure doctors can be confident in its decisions. This enables fair pay in recognition of doctors' skills and expertise.
- **Ensure career progression** by removing bottlenecks, creating additional opportunities, and developing specific career pathways for SAS (Specialist, Associate Specialist and Specialty) and LEDs (Locally Employed Doctors). This meets the needs of patients and overcomes the ineffectual workforce planning that has besieged the NHS over the last decade.
- **End doctor unemployment,** including providing sufficient funding to immediately address salaried and locum GP unemployment, in line with the BMA model contract and pay scales.[4] This helps address inequities in supply of services to the rising demand of patients.
- **Embed clinical leadership, representation, and engagement** throughout NHS organisations, so that doctors can shape services and provide vital checks and balances to ensure patient safety and high-quality care. This maintains the link between doctor, patient and those ultimately responsible for facilitating provision of safe care.
- **Maintain the high standards of medical practice that doctors alone work to**, ensuring they will never be replaced by other, non-medically qualified staff. The

[3] **See:** https://www.bma.org.uk/media/f4rl0iqm/bma-autumn-budget-representation-2024.pdf
[4] **See:** https://www.bma.org.uk/media/qe2l3uyi/bma-sessional-gp-a-vision-for-the-future-june-2024.pdf

NHS must urgently review the role of MAPs (Medical Associate Professions) and pause recruitment to those roles This ensures long term availability of adequately trained medical expertise for patient demand.

Improved, long-term investment in the NHS and public health services

Austerity broke the NHS and severely undermined public health services. The reality is that this can only be reversed with serious, sustained investment. The plan should:

- **Ensure annual real terms increases to resource and capital health budgets**, of at least the 6.7% average funding growth seen under the previous Labour Government.
- **Commit to longer-term spending plans**, allowing providers to plan ahead based on population need – including for winter.
- **Restore the public health grant**, ensuring public health services have the resources they need to support prevention.
- **Recognise that long-term underfunding is the principal barrier to improving productivity** and that investing in staff, equipment, IT, and estates is the key to enabling a more productive NHS.

Bringing back the family doctor and giving general practice the resources it needs[5]

General practice plays a pivotal role within the NHS and is critical to the plan's success, serving as an exemplar of cost-effectiveness and efficiency for the rest of health system. However, conscious long-term underfunding has left GPs caring for more and more patients, overstretching practices and placing excessive costs unnecessarily elsewhere in the system. The plan should:

- **Commit to negotiating a new contract that revitalises general practice** and reverses the erosion of the value of the current GP contract.
- **Invest in general practice** to ensure GPs can meet demand, increasing funding by at least £40 per patient (£2.5bn in total) – just 1.5% of current NHS spending.
- **Stabilise practice finances**, including by increasing GP practices' funding for staffing expenses to cover the cost of rising National Insurance contributions.
- **Address GP-patient ratios**, to ensure that GP workload is manageable and safe, supports genuine continuity of care, and allows patients to be seen more quickly.

[5] **See:** https://www.bma.org.uk/media/eh2nupm5/bma-safety-stability-hope-a-vision-to-rebuild-general-practice-in-england-comms-final-web-1.pdf

A major programme of investment to fix and modernise NHS infrastructure[6]

NHS infrastructure is crumbling, risking staff and patient safety, impeding productivity, and limiting adoption of new technologies. The plan should:

- **Introduce sustained, long-term capital funding models** to ensure hospitals, GP premises, and NHS facilities are modernised and expanded, and that ringfenced money is provided to improve the increasingly outmoded and often dangerous mental health estate.[7, 8]
- **Provide urgent, short-term capital funding** to address the £13.8bn maintenance backlog in secondary care and the equivalent backlog in general practice, to ensure all NHS estates are safe for staff and patients.
- **Establish a new deal for GP premises,** committing to funding practices of the future and allowing all premises costs, including management fees, to be reimbursed.
- **Commit to continued investment in IT and digital infrastructure** to enable improvements to productivity and to make a digital NHS achievable.

Long-term workforce planning that achieves safe staffing levels

We need a long-term workforce plan that matches the political and public expectation for health and social care, is fit for purpose and that addresses how the NHS will educate, train, recruit, and retain the doctors it needs to meet future demand. The plan should:

- **Set out plans for safe staffing legislation,** establishing minimum safe staffing levels across the NHS to protect patients and staff.
- **Base long-term workforce planning on independent, publicly available, and multi-year modelling to plan for the future of healthcare**, accounting for demographic trends, local population needs, and health inequalities.
- **Expand specialty training places and reform the rotational training model,** to help meet demand from increasing numbers of students and to address critical vacancies and shortages.
- **Place MAPs in the assistant roles to doctors their occupational group was designed for,** preventing blurring of lines between MAPs and doctors.
- **Support the professional development of SAS and LED doctors and expand the use of specialist grade roles**, to increase capacity and best utilise the skills available in the medical workforce.

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[6] **See:** https://www.bma.org.uk/media/eigjgpb4/bma-brick-by-brick-estates-report-september-2024.pdf
[7] **See:** https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/investigation-report/
[8] **See:** https://www.bma.org.uk/media/ddclsiii/bma-mental-health-report-2024-web-final.pdf

- **End the scandal of doctor joblessness**, ensuring all doctors can find work and taking particular steps to address the challenges experienced by sessional and locum GPs.
- **Fix funding for medical students**, including ensuring undergraduate and graduate students are eligible for full maintenance loan provision for all years of study, and improving access to NHS Bursary funding.[9]
- **Tackle the rising cost of continuing education and training**, including covering costs of mandatory examinations.
- **Value and invest in education, training, and CPD (continuing professional development) for all staff** to ensure a sustainable NHS workforce and improve research and innovation.
- **Improve professional regulation across the NHS**, including moving to a just, equitable and learning culture, and introducing regulation of managers.

Ensuring that all staff are valued and are supported to succeed

The NHS needs to ensure that doctors are able to work, learn, and develop in safe, supportive, and encouraging environments. The plan should:

- **Commit to comprehensive gender, ethnicity and disability pay-gap reporting**, and steps to resolve those gaps.[10]
- **Introduce standardised inductions for International Medical Graduates** to ensure they receive comprehensive and culturally sensitive support to begin careers in the NHS and lives in the country.
- **Tackle systemic racism and discrimination throughout the NHS**, ensuring all doctors and medical students work in positive, respectful environments.
- **Identify specific support to improve the experiences and working lives of disabled doctors**, including promoting disability equality, improving access to reasonable adjustments, raising awareness, and amplifying the voices of disabled medics.[11]
- **Establish specific workforce planning and funding for doctors who are pregnant** or on parental leave, to ensure those doctors can continue working whilst safeguarding their own and their child's health.

[9] **See:** https://www.bma.org.uk/our-campaigns/medical-student-campaigns/funding/fixing-funding-for-medical-students-in-england
[10] **See:** https://www.bma.org.uk/pay-and-contracts/pay/how-doctors-pay-is-decided/review-of-the-gender-pay-gap-in-medicine
[11] **See:** https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/disability-equality-in-medicine/disability-equality-in-medicine

- **Aim to end sexism in medical training and workplace culture**, addressing the critical issues of sexual harassment, underreporting of incidents, and inequalities around career progression.[12]
- **Ensure safe working environments for all doctors**, free from violence, verbal abuse, or intimidation.
- **Doing more to address mental and physical ill health within the workforce**, ensuring all staff have access to high-quality physician-led occupational and psychological health services.
- **Commit to ensuring all doctors feel able to speak up and be welcomed for raising concerns**, to protect their safety and that of patients.
- **Address workplace bullying and harassment**, in line with BMA guidance on promoting a positive working environment.[13]

Strengthening medical academia and research[14]

Support for medical academics and the medical research sector is critical to the future workforce and to developing new treatments. The plan should:

- **Establish a plan to grow the medical academic workforce**, with collaboration between DHSC and the Department for Science, Innovation & Technology.
- **Guarantee pay parity between the NHS and medical academics**, to help recruit and retain medical educators.
- **Ensure NHS bodies are properly supporting medical research**, including expanding legal duties to promote research.

Genuine reform of the social care system[15]

Any plan for health is doomed to fail unless deficiencies in social care provision are addressed. The plan should:

- **Commit to overhaul the social care system** to create a sustainable model that values social care staff and enables collaboration with the NHS, cuts delayed discharges, reduces hospital admissions, and facilitates community-led care.

[12] **See:** https://www.bma.org.uk/media/4488/sexism-in-medicine-bma-report-august-2021.pdf
[13] **See:** https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/bullying-and-harassment-guidance/promoting-a-positive-working-environment
[14] **See:** https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-academic-workforce-planning-for-the-future
[15] **See:** https://www.bma.org.uk/media/5717/20220217-ccc-social-care-report-june-2022.pdf

Learning the lessons from COVID-19 to ensure the NHS is prepared for the next healthcare crisis

The COVID-19 pandemic exposed deep fault lines in the health and care systems. These must be addressed, and strategies established to ensure the NHS is prepared for the next pandemic. The plan should:

- **Build on existing pandemic preparedness funding** to maintain and strengthen the ability of health and care services to respond to crises, including investing in adequate PPE, system-wide resilience, and surge capacity.
- **Enshrine a permanent focus on avoiding and ameliorating the unequal impacts of healthcare crises**, with a specific focus on protecting at-risk and marginalised communities.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Shifting more care into the community can be beneficial for patients and lead to better health outcomes, but it must be managed carefully and gradually. Any changes to working arrangements needed to deliver this shift must be formally agreed with trade unions. The plan must address the following points:

Proper resourcing of both secondary care and community services is essential to ensure sufficient long-term capacity and the safe, sustainable transition of care

Shifting care to community and primary care services cannot be rushed. Secondary care currently lacks capacity to meet current demand and needs more – not less – support in the short-medium term. The plan should:

- **Commit to increase capacity and bed numbers in secondary care and mental health services,** in line with the recommendation that the NHS needs 10,300 additional beds.[16] The NHS cannot repeat failed policies of cutting secondary care capacity with the aim of under-prepared community care services taking up the slack.[17]
- **Establish how community care capacity will be increased before any shift in care begins**, so that those services are not overwhelmed and that patients do not simply end up being treated in secondary care regardless.

[16] **See:** https://res.cloudinary.com/studio-republic/images/v1653990264/RCEM-Acute-Insight-Series-Beds/RCEM-Acute-Insight-Series-Beds.pdf?_i=AA
[17] **See:** https://www.bmj.com/content/365/bmj.l4312.full

- **Place doctors and their patients at the heart of decision-making around the shift of care**, ensuring that clinical insight and patient safety are driving changes – not cost savings.
- **Reflect the centrality of secondary care doctors in delivering elective recovery** by ensuring staff are properly paid for extra elective work, on terms agreed with trade unions nationally.

Neighbourhood health services will hinge on GPs and general practice that need to be resourced accordingly

General practice is the pivotal part of the NHS. The proposed shift to neighbourhood and community-led care makes it absolutely essential that GPs are given the resources they need to fulfil this role. The plan should:

- **Build-on the current financial, managerial, and clinical efficiencies, agility, and overall effectiveness of general practice**, in preference to inefficient, costly, and overly complex bureaucratic processes and models that fail to respond to the health needs of local communities.
- **Create a new Family Doctor Charter** to signal commitment to rebuild a universal GP-led continuity of care model for NHS general practice.
- **Expand the GP workforce**, to ensure practices are able to take on the additional work associated with shifts in care, including the creation of a two-year fully funded GP fellowship post-CCT (Certificate of Completion of Training) practice-level scheme.
- **Allow GPs greater flexibility in using their resources, including broadening the ARRS scheme**, enabling practices to recruit based on need, including practice nurses in ARRS and introducing practice-based GP nursing fellowships.
- **Ensure GP practices and neighbourhood care centres have sufficient capacity and the right infrastructure**, including investment to expand premises, improve technology, and provide diagnostic equipment.
- **Recognise the importance of out-of-hours GP services to community-led care,** ensuring they are properly funded and led by GPs.

More effective commissioning of services, to ensure resources and funding flows are directed appropriately

The proposed shift in care requires new services to be commissioned and some existing services to be commissioned differently. The plan should:

- **Ensure ICBs (Integrated Care Boards) have the medical expertise they need to make informed and strategic commissioning decisions**, with clinical representatives and qualified public health experts able to inform and challenge plans for service transformation, a formal voice for LMCs (Local Medical Committees), and sufficient resources to employ competent commissioners.

- **Establish how funding flows will be directed to facilitate this shift**, including how general practice and community care is commissioned to undertake new services.
- **Prevent unfunded workload shift within the NHS**, particularly into general practice, building on the Darzi Review's findings to address this issue.

The interface between primary, community, mental health, and secondary care services must become seamless for success

The interface between different health and care services is critically important, often overlooked, and poorly navigated, which needs to be addressed as a priority. The plan should:

- **Enable doctors to work and collaborate effectively across the NHS and with care services**, reducing unwarranted barriers between organisations.[18, 19, 20]
- **Address longstanding challenges around the transition of care between services**, majorly reducing delayed discharges and improving information sharing.
- **Support wider multi-agency working between health and social care, and other sectors**, including the voluntary sector, education and early years services, to support prevention and early interventions.

Ensuring any workforce implications of this shift - including moving staff into communities – are handled appropriately

The proposed shift of care will almost certainly lead to a shift in where certain doctors and other NHS staff are deployed, building on existing programmes that have sought to place some secondary care doctors in the community. The plan should:

- **Mandate that any change in working patterns or places of work is voluntary.**
- **Ensure all changes to work patterns or places of work for staff groups are subject to negotiations with the relevant unions**, to protect staff wellbeing and terms and conditions.

[18] **See:** https://www.bma.org.uk/media/3334/bma-supporting-effective-collaboration-between-primary-secondary-care-covid-19-oct-2020.pdf
[19] **See:** https://www.bma.org.uk/media/3908/bma-csc-future-vision-nhs-report-sept-19.pdf
[20] **See:** https://www.aomrc.org.uk/wp-content/uploads/2023/05/GPSC_Working_better_together_0323.pdf

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The BMA has consistently called for the improved use of technology in health and care services, which must come with proper safeguards and protections for patients, and NHS staff. The plan must address the following points:

Interoperability must be included in any software packages supplied to the NHS - at no extra cost

Ensuring NHS IT systems interact is critical to delivering a digital NHS. Moves to properly regulate the supply-side sector are welcome and would support significant improvement to data storage and sharing, saving staff time and improving patient outcomes. The plan should:

- **Set out the major, NHS-wide change needed to overhaul existing legacy systems and ways of working**, which have led the NHS down a digital cul-de-sac.
- **Ensure all software utilised in the NHS has built-in interoperability**, allowing health services to effectively share information, better integrate care, and save invaluable staff time.

IT infrastructure badly needs investment, to provide doctors with the equipment they need and eliminating significant time wasted using outdated technology[21]

Poor IT infrastructure is a barrier to a digital NHS and must be addressed urgently - the BMA estimates that millions of clinical working hours are lost each year due to inadequate IT. The plan should:

- **Set out a programme of IT infrastructure improvements and hardware upgrades** in order to facilitate better data sharing and ensure doctors have the equipment they need to deliver efficient care. A 2022 BMA survey found that just 11% of UK Doctors felt they had the right equipment to do their job.[22]
- **Acknowledge that new software, programmes, and AI cannot work on outdated, failing IT**, and the necessity to upgrade hardware prior to the procurement of new software.
- **Recognise that trading administrative staff for additional technology paradoxically can waste invaluable clinical time**, with doctors left using poor quality equipment to undertake administrative tasks far more slowly than dedicated staff would.

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[21] **See:** https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf
[22] **See:** https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf

The role of GPs as data controllers needs to be protected

Reaching a consensus on how best to provide GP Data for Planning and Research has proved challenging. However, this should be understood as a reflection of GPs commitment to balancing upholding patients' confidence that their information is safe from improper use or access with permitting information sharing for important public benefit purposes. The plan should:

- **Ensure that confidential patient information remains under the data controllership of family doctors.** The GP's role as the custodian of their patients' data is long established and is an integral part of the trust relationship between patients and doctors. Any new proposals for sharing, or allowing access to, confidential data must be in-line with doctors' legal and ethical obligations of confidentiality and the reasonable expectations of patients.

Wearable technology is not a silver bullet and cannot replace well-funded services

Wearable technology can provide valuable benefits for many people, including enabling live monitoring of serious health conditions, but they are not a panacea. The plan should:

- **Be clear how the technology integrates with clinical services**, ensuring its adoption
- **Be realistic about the role of wearable technology**, recognising that it cannot create additional clinical capacity but is a means of augmenting wider services.
- **Ensure new market entrants are properly vetted** before distribution of technology to patients, to ensure their reliability and safe usage.

Expanding the adoption and use of technology must not exacerbate existing health inequalities

The use of new technologies creates enormous opportunities, but also risks widening inequalities. The plan should:

- **Ensure that innovation within the NHS does not exacerbate digital exclusion**, with support available for those with lower digital literacy or access to technology.

The use of AI tools needs to be managed carefully to maximise benefits and minimise risks[23]

While AI is an understandable focal point for the shift from an analogue to digital NHS, its use requires careful consideration. The plan should:

- **Confirm that AI will transform doctors' jobs and not replace them**, with an emphasis on enhancing job quality, easing administrative burdens, and allowing doctors to focus more on complex, high-value tasks.
- **Adhere to the BMA's principles for AI policy and implementation**, to ensure doctors can have confidence in the way it is being introduced to the NHS.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Better prevention and earlier detection of ill-health are essential to the long-term sustainability of the NHS and improving patient outcomes. A strong public health system, with the workforce and resources it needs, is central to achieving this shift. The plan must address the following points:

Austerity decimated public health services and undermined prevention – those services must now be resourced properly [24]

Austerity and sustained cuts to public spending devastated local authority budgets and the critical public health services they provide. This included a 28% real-terms, per person cut to the public health grant since 2015/16.[25] For success, the plan should:

- **Restore the public health grant** in real terms per person to at least 2015/16 levels, ensuring local public health services deliver effective programmes.
- **Properly fund public health at the national level** to enable OHID (Office for Health Improvement and Disparities) and UKHSA (UK Health Security Agency) to recruit the staff they need and fulfil their vital roles.
- **Address the broader impact of austerity on local authorities and the wider determinants of health**, including addressing the effects of underfunded social care, housing, and transport departments on public health and wellbeing.

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[23] **See:** https://www.bma.org.uk/media/njgfbmnn/bma-principles-for-artificial-intelligence-ai-and-its-application-in-healthcare.pdf

[24] **See:** https://www.bma.org.uk/media/uvpd204n/bma-the-country-is-getting-sicker-september-2024.pdf

[25] **See:** https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed

The public health medicine workforce needs to grow and be given a leading voice in health and care systems

Public health doctors need to be at the forefront of the shift towards a preventative system, but a lack of long-term planning means the system has too few of these vital staff, undermining service planning and commissioning. The plan should:

- **Commit to the development of a long-term public health workforce plan**, aiming to achieve the recommended minimum ratio of 30 FTE (full-time equivalent) public health consultants per million population.
- **Specifically target the recruitment and retention of doctors in shortage specialties**, heeding the warning of the Royal College of Psychiatrists that addictions psychiatry could be wiped out in this decade due to underfunding.[26]
- **Ensure public health doctors and qualified specialists have a leading role within the health system and ICBs**, including mandating all ICBs to have an independent, qualified public health specialist on their board, as recommended by the House of Commons Health and Social Care Select Committee.[27]
- **Deliver pay parity between NHS and public health doctors** to improve their recruitment and retention.

Prevention services must be properly funded alongside the greater use of technology

While various technological solutions could make a genuinely positive impact on preventing ill-health, dedicated prevention services remain vital – but persistently underfunded. The plan should:

- **Improve overweight and obesity services rather than over relying on access to medications**, including adopting the OHA's (Obesity Health Alliance) calls for immediate action, with a full review of existing NHS obesity services.[28]
- **Support services to help smokers quit alongside limiting access to tobacco and vapes**, ensuring a holistic approach, preventing people from taking up smoking but also intervening to minimise the ill-health experienced by the six million people who currently smoke.[29]

[26] **See**: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/02/17/addiction-psychiatry-could-be-wiped-out-in-a-decade-without-urgent-government-funding
[27] **See:** https://committees.parliament.uk/publications/34611/documents/190541/default/
[28] **See**: https://obesityhealthalliance.org.uk/2024/10/16/treatment/
[29] **See**: https://ash.org.uk/media-centre/news/press-releases/new-tobacco-and-vapes-bill-backed-by-public-health-charities-and-politicians

- **Establish long-term funding for a holistic approach to gambling addiction,** avoiding reliance on short-term levy funding and siloed service provision, given the known link between gambling and other behaviours associated with harm.[30]
- **Commit to reducing alcohol-related harm** via serious interventions like minimum unit pricing, stricter advertising regulations, and reducing the legal blood alcohol limit for driving.[31]
- **Support and enhance Early Years services**, including properly funding family hubs and Start for Life programmes, to ensure prevention strategies are deployed as early as possible in people's lives.
- **Ensure proper funding and resourcing to deliver the NHS vaccination strategy**, including target areas and groups with low uptake.
- **Create a renewed inequalities strategy for screening services** to tackle inequalities in screening uptake.

The wider determinants and drivers of ill health cannot be addressed through health services alone

Tackling the causes of ill health requires addressing the wider determinants that drive ill health in the first place. The plan should:

- **Adopt a 'health in all policies' approach and establish how Government departments will collaborate to address the wider social and economic drivers of ill health**, including housing, poverty, food, and education.
- **Recognise the role of commercial determinants of health** and outline how cross-departmental work can minimise their impact, including by improving commercial regulation and restricting advertising.

Global risks to public health cannot be ignored or underplayed

The COVID-19 pandemic and its ongoing effects shows the extent to which global health risks impact this country's health and wellbeing. Continued action must be taken to manage wider global risks to public health facing the UK. The plan should:

- **Establish how the NHS will continue working towards achieving net zero**, including how building improvements will reduce emissions and increase resilience to the effects of climate change, like rising summer temperatures.[32, 33]
- **Set out how to tackle anti-microbial resistance** and what role the NHS and health and care systems play in a cross-sector approach to the problem.

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[30] **See:** https://www.bma.org.uk/media/o5cfet4j/bma-response-to-the-gambling-levy-consultation-14-december-2023.pdf

[31] **See:** https://www.bma.org.uk/what-we-do/population-health/supporting-people-to-live-healthier-lives/alcohol-drugs-and-driving-consensus-statement

[32] **See:** https://s41874.pcdn.co/wp-content/uploads/Lancet-Countdown-2024_United-Kingdom-Policy-Priorities.pdf

[33] **See:** https://www.property.nhs.uk/media/v5rbaqmt/nhsps-crfd-report-2024.pdf

- **Establish steps to minimise the risk of future pandemics** including how the NHS will learn lessons from COVID-19 to protect patients and staff from preventable harm.

Ensure all policies account for and address health inequalities

Efforts to address, minimise, and prevent health inequalities must be embedded throughout all wider plans for health services.[34] The plan should:

- **Establish an overarching plan to address health inequalities**, setting out how the NHS, DHSC, and other organisations will seek to improve health equity.
- **Embed efforts to understand and tackle health inequalities in all policies**, with a particular focus on ensuring reform does not exacerbate them.
- **Ensure primary, secondary, and mental health services have the capacity and capability to deliver high-quality care and support for children and young people**, for the sake of their immediate wellbeing and the long-term health of the nation.

Q5. Specific policy ideas for change

Short-term:

- Restore the independence of the DDRB in line with its original purpose and adopt the BMA's calls for DDRB reform.[35]
- Increase GP practice core funding by at least £40 per weighted registered patient.
- Pause recruitment to MAPs roles while a clear national scope of practice for PAs is set that ends dangerous practices where MAPs are substituting for doctors.
- Require that all organisations employ locally employed doctors and RMOs (Resident Medical Officers) on contracts with fair terms and working conditions.
- Start negotiations with the BMA on a national framework for pay, terms and conditions for additional elective recovery work.
- Give doctors a formal voice and role within health systems by mandating representation on ICBs for LNCs, LMCs, and qualified public health specialists.
- Restore the NHS rainbow badge scheme as part of wider ongoing efforts to value diversity across the health service.
- Conduct a nationwide assessment of NHS estates to determine the scale of need and where to target investment.

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[34] **See:** https://www.bma.org.uk/media/uvpd204n/bma-the-country-is-getting-sicker-september-2024.pdf

[35] **See:** https://www.bma.org.uk/media/7612/report-into-the-failings-of-the-pay-review-process-for-doctors-and-dentists-sept23.pdf

- Immediately inject additional capital funding to totally clear the highest risk maintenance backlog across NHS estates.
- Link the annual allowance tax charge to inflation.
- Reform the annual allowance taper by removing the annual allowance from public sector defined benefit schemes.
- Restore the public health grant in real terms per-person to at least 2015/16 levels.
- Increase health budgets in line with the historic average annual increases achieved by the previous Labour Government.
- Allow all GP premises costs, including management fees, to be reimbursed.
- Negotiate a new GP contract that protects practice stability, continuity of care, and the partnership model.
- Expand the use of the specialist grade.
- Adopt the BMA's principles for the use of AI in healthcare.
- Increase the High Income Child Benefit Charge threshold to account for previous inflation, and index it to inflation thereafter.
- Remove the income eligibility threshold for free childcare hours and tax-free childcare.
- Ensure both undergraduate and graduate students are eligible for full student finance maintenance loan provision for all years of study.
- Immediately provide dedicated funding to address salaried and locum GP unemployment, in line with the BMA model contract, pay scales, and Locum Practice Agreement.[36]

Medium-term:

- Deliver pay restoration for doctors, addressing pay erosion since 2008 by ensuring pay scales increase above RPI annually until achieved.
- Introduce new capital funding models for primary and secondary care.
- Require - and achieve - full interoperability across NHS IT systems.
- Introduce legislation to ensure safe staffing levels across the NHS.
- Develop long-term general practice investment plans, to secure GP practice stability and enable the shift to community-led care.
- Increase the availability of specialty training, core and foundation training places to meet demand and address vacancies.
- Develop and introduce a long-term workforce plan for public health.
- Introduce professional regulation of NHS managers.
- Increase the number of available secondary care beds in line with RCEM's analysis.

[36] **See:** https://www.bma.org.uk/pay-and-contracts/contracts/salaried-gp-contract/bma-locum-practice-agreement

- Embed safety, education, training, and CPD in NHS culture - from patient to boardroom.

Long-term:

- Long-term capital investment, clearing the maintenance backlog and delivering modernisation of NHS estates.
- Provide long-term investment in IT infrastructure to enable effective adoption and use of new technology.
- Deliver genuine reform of social care.

References and further information

As suggested within the consultation documentation, this response includes a number of links to other documents and webpages.

These are included both as references and as sources of further detail and information, which we believe should be reviewed alongside the BMA's response, and are collated here:

- BMJ: *Higher staff turnover is linked to increased deaths in NHS hospitals, study finds*, 2024
- IPPR: *From the Frontline: Empowering Staff to Drive the NHS Reform Agenda*, 2024
- BMA: *Autumn Budget Representation*, 2024
- BMA: *Sessional GP: A vision for the future*, 2024
- BMA: *Safety, Stability, Hope: A Vision to Rebuild General Practice in England*, 2024
- BMA: *Brick by Brick: The case for urgent investment in safe, modern, and sustainable healthcare estates*, 2022
- HSSIB: *Mental health inpatient settings: Creating conditions for the delivery of safe and therapeutic care to adults*, 2024
- BMA: *Its broken: Doctors' experiences on the frontline of a failing mental healthcare system*, 2024
- BMA: *Fixing funding for medical students in England*, 2024
- BMA: *BMA commentary on Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England*, 2020
- BMA: *Disability equality in medicine*
- BMA: *Sexism in Medicine*, 2021

- BMA: *Promoting a positive working environment*
- BMA: *Medical academic workforce planning for the future*
- BMA: *Who Cares? The need for real reform for social care in England*, 2022
- RCEM: *RCEM Acute Insight Series: Beds in the NHS*, 2022
- BMJ: *NHS chief admits that bed closures need to be reversed*, 2019
- BMA: *Supporting effective collaboration between primary, secondary and community care in England in the wake of Covid-19*, 2020
- BMA: *Caring, supportive, collaborative: Doctors' vision for change in the NHS*, 2019
- AoMRC: *General practice and secondary care: Working better together*, 2023
- BMA: *Getting IT Right: The case for urgent investment in safe, modern technology and data sharing in the UK's health services*, 2022
- BMA: *Principles for Artificial Intelligence (AI) and its application in healthcare*, 2024
- BMA: *The country is getting sicker: The urgent need to address growing health inequalities and protect our health in the face of an economic crisis*, 2022
- The Health Foundation: *Investing in the public health grant: What it is and why greater investment is needed*, 2024
- Royal College of Psychiatrists: *Training in addiction psychiatry: current status and future prospects*, 2020
- House of Commons Health and Social Care Committee: *Integrated Care Systems: autonomy and accountability*, 2023
- Obesity Health Alliance: *A Way Forward for the Treatment of Obesity*, 2024
- Action on Smoking and Health: *New Tobacco and Vapes Bill backed by public, health charities and politicians*, 2024
- BMA: *Response to Department for Culture, Media and Sport consultation on the structure, distribution and governance of the statutory levy on gambling operators*, 2023
- BMA: *Alcohol, drugs and driving consensus statement*, 2024
- Lancet Countdown: *2024 Climate and Health Priorities for the UK*, 2024
- NHS Property Services: *Climate-related Financial Disclosure Report*, 2024
- BMA: *Report into the Failings of the Pay Review Process for Doctors and Dentists*, 2023
- BMA: *BMA Locum Practice Agreement*