Parliamentary brief
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BMA

BMA briefing: Health and Care White Paper

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Overview

The BMA has advocated for a more collaborative health and care system since the introduction of the Health and Social Care Act 2012.

The Bill is coming at a time when the NHS is experiencing unprecedented pressures. The immediate challenge for the NHS will be addressing the greatest backlog of care our health service has ever faced[1]. It is vital attention is not diverted away from addressing this critical challenge by reorganisations of the NHS.

There are a number of critical areas where the Bill must be amended and strengthened to ensure it creates a health and care system that delivers integrated, safe and sustainable patient care for the future:

- **Workforce:** The NHS had insufficient staff when it entered the pandemic and the impact of this has been clear, with staff emerging from the pandemic exhausted and non-COVID care backlogs mounting. The success of the NHS and delivery of safe patient care depends on its staff, which is why Government must be accountable for ensuring adequate numbers of staff. To do this we believe the bill must include a responsibility for the Secretary of State to produce ongoing accurate and transparent workforce assessments which will directly inform recruitment needs, now and in the future.
- **Clinical leadership:** A truly collaborative and integrated healthcare system must have strong clinical and patient leadership, engagement and involvement at its heart. To ensure this is the case, clinical leadership and representation must be embedded at every level of Integrated Care Services, including formalised roles for local medical representative bodies and public health doctors.
- **Procurement and outsourcing:** The Bill would replace the current competition and procurement rules for the NHS, scrapping Section 75 and automatic competitive tendering in recognition that this has led to costly procurement processes, fragmentation and the destabilisation of services. However, simply abolishing Section 75 is not enough. To truly end disruptive competition and establish a collaborative, joined-up health care system, as is the Government's stated aim, the NHS must be established as the default option for NHS contracts.
- **Safeguards to curb political influence over NHS policy setting:** The Secretary of State's powers must be limited in the Bill to avoid inappropriate political influence in NHS decision-making.

[1] The BMA estimates that between April and December 2020 there were between 989,000 and 1.3m fewer first elective treatments than would normally have been expected, potentially costing the NHS between £4bn and £5.4bn to work through – BMA (2021) Pressure points in the NHS

Ongoing open and transparent workforce assessments

Without its staff there would be no National Health Service. The Government must, therefore, be accountable, through legislation, for ensuring health and care systems have the workforce required to meet the needs of the population, now and in the future.

The NHS does not currently have enough staff to cover patient demand. The number of overall vacancies in England, including clinical and non-clinical roles, stands at 88,801 FTE unfilled posts (a 7% vacancy rate), which is deeply concerning. Nine in 10 (91%) doctors responding to a UK-wide BMA survey[2] say that current staffing levels are 'inadequate to deliver quality patient care' and most doctors (74%) felt that situation had worsened within the previous year.

COVID-19 has highlighted and exacerbated the demands on the workforce and burnout has led to significant numbers of doctors considering leaving the profession or reducing their hours. 32% of respondents to the BMA's April 2021 COVID-19 tracker survey[3] said they were now more likely to take early retirement, whilst half reported being more likely to reduce their hours.

Without significant and sustained action, acute shortages of staff and episodes of unsafe staffing are expected to increase rapidly, before escalating exponentially. By 2030, the Nuffield Trust, Health Foundation and King's Fund have estimated that the gap between supply of, and demand for, staff employed by NHS providers in England could reach almost 350,000 FTE posts.[4] Worryingly, that was based on pre-pandemic calculations.

Overcoming unsafe staffing levels is an essential measure to ensure patient safety and to boost the wellbeing, morale, and productivity of staff working in the NHS. The forthcoming legislation presents a real opportunity for government to take sustainable action to alleviate issues relating to workforce supply and demand in England.

The white paper proposes a new duty for the Secretary of State to make it clearer *who* is responsible for workforce planning and supply in England. Whilst we welcome this new reporting requirement, we do not believe it will be sufficiently meaningful unless the Bill also addresses *what* must be delivered. Without a shared knowledge of what needs to be delivered, we cannot hold to account those responsible for delivering the levels of staffing needed to meet population need, now and in the future.

The BMA - alongside key organisations[5] representing healthcare professionals, including the RCN, NHS Confederation, NHS Providers, and the Academy of Medical Royal Colleges - is calling for a duty to be included in the Bill to provide open and transparent modelling of staffing requirements. This assessment will provide a shared understanding of the levels of staffing needed to meet national, population-based demand and should inform local and regional recruitment needs.

This workforce assessment modelling must be publicly available, and presented to Parliament, to enable proper scrutiny and debate about what policies and investment are needed to prevent instances of unsafe staffing occurring.

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[2] Future vision for the NHS: all member survey, British Medical Association (2018)

[3] Thousands of overworked doctors plan to leave the NHS, BMA finds, BMA (2021)

[4] The health care workforce in England: make or break? The Nuffield Trust, Health Foundation and King's Fund (2018)

[5] For example, a joint letter from the BMA, NHS Confed, and the Academy of Medical Royal Colleges was sent to the Secretary of State (April 2021), available at: https://protect-eu.mimecast.com/s/2X9lCA1pphNN7DwHG2r4b?domain=bit.ly

Clinical engagement at the heart of the NHS

The BMA agrees with the aim of improving integration and supports placing Integrated Care Services (ICS) on a statutory level to ensure they are transparent and accountable, as well as the introduction of a duty to collaborate.

However, these measures on their own are insufficient to delivering better integrated care. We are concerned that integration will be undermined by foundation trust statutory requirements that encourage them to focus on their financial performance, hindering efforts to break down barriers between primary and secondary care. Unless the statutory requirements on foundation trusts that encourages them to focus on their financial performance above all other priorities are removed, the duty to collaborate will be insufficient to break down the barriers between care sectors.

The White Paper states that clinical commissioning groups (CCGs) will be absorbed into their local ICSs, but there is limited detail on what this will mean at this point. It also remains unclear how system leaders and board members, at both 'Place' and ICS level, will be chosen and how leaders will be held accountable to the public. Clarity is urgently needed, to provide reassurance that power will not be concentrated at ICS level – which remains remote from frontline doctors as well as patients. It is vital the positive functions of CCGs, namely a strong clinical voice; local expertise and knowledge; skill and experience in commissioning services; and accountability to clinicians and patients, are not lost in this process.

Those working within the system and patients know best where the barriers to greater integration lie. Clinicians and patients must be at the heart of decision making in the NHS, including those working in general practice, secondary care, community care and public health. ICSs must have a formalised role for LMCs and LNCs, and public health doctors.[6]

NHS established as the default option for NHS contracts

The BMA welcomes the proposed removal of Section 75 of the Health and Social Care Act and automatic competitive tendering, which should reduce the costly disruption caused by the present procurement process. A 2018 BMA survey found that 73% of doctors were concerned by independent sector provision of NHS services. The most common reasons for concern were the destabilisation of NHS services, the fragmentation of NHS services, value for money and quality of care. Nearly 7 in 10 (66.5%) doctors who work in sectors with high independent sector provision felt that it has had a negative impact on the quality of service provision.[7]

Removing automatic tendering means it will be easier for current contract holders to retain their contracts and there may be less scope for private sector providers to increase their foothold in the UK market. However, it is vital that the new provider selection regime NHSE/I has proposed ensures sufficient scrutiny and transparency over the tendering and awarding of contracts. The COVID-19 pandemic has clearly shown the shortcomings of a lack of scrutiny for the public purse. We are also concerned that services will remain open to any provider leaving the option to tender out services in local commissioners' hands.

If the Bill is to truly end disruptive bureaucracy and fragmentation as a result of unnecessary competition within our national health service, and establish a joined-up, collaborative approach to delivering services – as the Government has stated is its intention – then the NHS must be established as the default option for NHS contracts. This would ensure the private sector is only used when necessary with commissioners required to present a case as to why a non-NHS provider would be better placed to hold any such contract.

[6] BMA (2019) Briefing: Integrated Care Systems

[7] BMA (2019) Independent Sector Provision in the NHS revisited

Public accountability and Secretary of State powers

The BMA has advocated for clear lines of political accountability for the NHS at Secretary of State level and we were critical of the removal of responsibility for the NHS from the Secretary of State from the 2012 Act. However, we are concerned that the proposals in the White Paper focus more on securing power over the NHS for politicians than accountability for its performance.

A principle example of this is the power to amend or abolish health sector arms length bodies () via a statutory instrument following consultation, which while presented as a means of formally merging NHS England and NHS Improvement, would in theory allow for a Secretary of State to disband NHS England itself and without robust parliamentary scrutiny.

Likewise, the power for the Secretary of State to direct (or redirect) the NHS proactively and outside of the existing system of the NHS Mandate (the annual publication from government to the NHS setting out objectives and budgets) may provide important capacity for rapid changes in policy where needed, but could also increase political influence in NHS decision making and undermine long-term planning if and when political imperatives might change.

To avoid increased political influence in NHS decision making and undermining long-term planning if political imperatives change, the BMA is calling for clear safeguards and limits on the use of these powers to be included in any legislation.

Data sharing

The White Paper outlines new powers for the Secretary of State to mandate standards for how data is collected and stored with the intention that this will allow a greater range of data sharing from a technical standpoint. It is unclear how far these powers will extend, specifically in relation to the use of data extracted from GP records for planning and research under the recently launched programme of the same name (GP Data for Planning and Research, GPDPR). It also proposes that NHS Digital's legal framework is changed to introduce a duty upon it to 'have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions.'

Whilst the BMA welcomes efforts to improve data sharing, we are concerned about any powers that would circumvent or make null the protections put in place regarding the dissemination of patient data. Safeguards over the reach and nature of these powers must be included within the Bill to provide clarity on their extent and ensure they do not undermine current protections over the use of patient data.

What you can do

To help us ensure the forthcoming legislation creates a sustainable health and care system that delivers integrated and safe patient care, you can:

- arrange a meeting with a BMA representative to discuss our key calls for the Bill in more detail by contacting: Leah Miller, Senior Public Affairs Officer on lmiller@bma.org.uk
- support any forthcoming amendments to the Health and Care Bill that address these key priorities
- raise these issues directly with the Secretary of State