Parliamentary brief
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BMA

Health and Care Bill

House of Commons, Second Reading
Wednesday 14 July

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 Bill is coming at a time when the NHS is experiencing unprecedented pressures and when the immediate challenge for the NHS will be addressing the greatest backlog of care our health service has ever faced. It is vital that this Bill does not create great upheaval or disruption from addressing these challenges facing frontline services

There are a number of areas where the Bill must be amended and strengthened:

- **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 staff numbers. Clause 33 would require the Secretary of State to publish at least once every five years a report describing the system in place for assessing and meeting the workforce needs of the NHS. However, to ensure meaningful accountability for delivering the levels of staff needed, 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 Systems, including formalised roles for primary care, secondary care and public health doctors.
- **Procurement and outsourcing:** Schedule 12 of the Bill would replace the current competition and procurement rules for the NHS, scrapping Section 75 of the Health and Social Care Act and automatic competitive tendering, recognising 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. To guard against conflicts of interest and undue influence in decision-making, the BMA is also clear that private providers must not be involved in the leadership of ICSs or any commissioning decisions they make.
- **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.

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.

COVID-19 has highlighted and exacerbated the demands on the workforce with burnout leading 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[1] 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.[2] Worryingly, that was based on pre-pandemic calculations.

It's not just future projections which are highly concerning – today's staffing levels are already far behind where they should be. According to new BMA research, the number of doctors per 1,000 people in England is 25 years behind comparable OECD European Union nations, second lowest only to Poland. To put it starkly, based on current medical workforce growth rates, we estimate it will take until 2046 for the NHS to reach parity with the average three doctors to 1,000 people ratio that comparable OECD EU nations have today. We are already almost 50,000 doctors short by those standards. Not only does this shortfall impact patient care and safety, but it also puts immense pressure on existing NHS staff, many of whom are being stretched to the limit, being forced to take on extra - often unpaid - work to make up staffing gaps and increasingly telling us they are or have reached breaking point.

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 bill proposes a new duty at Clause 33 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 and key organisations[3] representing healthcare professionals, including the RCN, RCP, NHS Confederation, NHS Providers, and the Academy of Medical Royal Colleges, have jointly called for a duty to be included in the Bill to provide open and transparent modelling of staffing requirements. Likewise, the King's Fund, Health Foundation, and the Nuffield Trust have called for the Bill to deliver independently verified projections of future workforce supply. The Health and Social Care Select Committee, too, has been clear[4] that objective, transparent, and independent reporting on workforce

[1] Thousands of overworked doctors plan to leave the NHS, BMA finds, BMA (2021)
[2] The health care workforce in England: make or break? The Nuffield Trust, Health Foundation and King's Fund (2018)
[3] 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
[4] The Health & Social Care Select Committee's recommendation is included both in its report on 'Workforce burnout and resilience in the NHS and social care' (May 2021) and on 'The Government's White Paper proposals for the reform of health and social care' (May 2021).

shortages and future staffing requirements is an essential measure for inclusion in the Bill, to address workforce shortages that are 'endemic in the NHS'[5].

Transparently providing workforce assessment modelling should deliver a shared understanding of the levels of staffing needed to meet national, population-based demand and should inform local and regional recruitment needs. To that end, it 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.

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, as achieved in Clause 13 of the Bill, which should help ensure they are transparent and accountable.

However, it is vital that clinical leadership and representation is embedded at every level of Integrated Care Systems, including formalised roles for doctors working in primary care, secondary care and public health. Clause 1 of the Bill sets out core, minimum membership of Integrated Care Boards (ICBs), which includes a member nominated by GPs and primary care, a member nominated by NHS or Foundation Trusts, and a member nominated by local authority representatives. The BMA is concerned that this provision, and further detail set out in the NHSE ICS Design Framework, falls short in respect of ensuring clinical leadership and representation with no mention of LMCs or LNCs, or the need to involve consultants, SAS doctors, or junior doctors in the work of the ICS NHS Body.

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. Greater and broader representation of doctors is needed throughout ICBs, ICPs and ICSs, with a formalised role for LMCs and LNCs, and public health doctors.[6]

NHS established as the default option for NHS contracts

Schedule 12 on the removal of functions relating to competition will remove Section 75 of the Health and Social Care Act and automatic competitive tendering, as called for by the BMA. 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]

However, the move to a new procurement regime is a step that must be taken carefully. For its many faults, the present system does ensure that procurement decisions are subject to thorough scrutiny. This has been exemplified by a number of high-profile Government contracts handed to the private sector throughout the Covid-19 pandemic, a lack of oversight and transparency can lead to poor outcomes – in respect of finances, quality, and public confidence.

We are concerned that under the proposed provider selection regime, commissioners will be expected to determine and expand their Any Qualified Provider lists (from which patients are able to choose

[5] See page 23 of the select committee's report on the Government's white paper proposals, available at: https://committees.parliament.uk/publications/5827/documents/67112/default/
[6] BMA (2019) Briefing: Integrated Care Systems
[7] BMA (2019) Independent Sector Provision in the NHS revisited

providers for qualifying treatments) without any tendering process. This presents a gateway for independent sector providers (ISP) to the more profitable NHS services and could potentially deprive NHS providers of vital resources.

It is essential that the Bill establishes the NHS as the default option for services. This would provide necessary safeguards for ensuring the private sector[8] is only used when absolutely necessary and that there is adequate scrutiny and transparency when contracts are tendered, by requiring commissioners to present a case as to why a non-NHS provider would be better placed to hold any such contract.

Additionally, in the event that an ISP is awarded a contract, we believe that it must be subject to the same transparency and FOI requirements as NHS providers and that the details of its contract and performance should not be protected by commercial confidentiality.

ICS body membership: The legislation also leaves open the possibility for corporate healthcare providers to gain seats on ICS boards and, as a consequence, could allow them to influence ICSs overarching strategies and risk conflicts of interest in commissioning decisions. Although Clause 13 of the Bill includes some measures to mitigate against conflicts of interest, including a requirement to declare conflicts of interest and a duty on ICBs to make arrangements for managing them, the BMA is clear that ICSs should be run by NHS and publicly accountable bodies and there should be no place for corporate healthcare providers in their decision-making structures.

If the Bill is to truly end disruptive , unnecessary competition within the NHS and establish a joined-up, collaborative approach to delivering services – as the Government has stated is its intention – then the NHS should 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.

To guard against conflicts of interest and undue influence in decision-making, private providers must not be involved in the leadership of ICSs or any commissioning decisions they make.

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. However, we are concerned that proposals in the bill with regard to Secretary of State accountability, focus more on securing power over the NHS for politicians than accountability for its performance.

Schedule 6 of the Bill would give the Secretary of State new powers to intervene in service reconfigurations, Clause 3 would enable 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), whilst Part 3 would give the Secretary of State powers to modify or abolish arms length bodies. The BMA is concerned that these new powers could increase political influence over the day-to-day running of the NHS and undermine long-term planning if and when political imperatives might change. Whilst limited safeguards are included in the bill in relation to the Secretary of State's powers to amend and abolish ALBs, more stringent measures are needed to limit the use and scope of these powers to prevent major changes being made to health bodies without appropriate scrutiny.

[8] The BMA's definition of ISP includes the private sector, ISTCs (independent sector treatment centres) and social enterprises, in line with DHSC data collection.

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 the Bill.

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