Parliamentary brief
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BMA

Health and Care Bill

House of Lords, Committee Stage
January 2022

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 believes the Health and Care Bill is the wrong bill at the wrong time. The NHS is still under huge pressure from the pandemic; it is not the right time for the health and care system, or patients, for the biggest reorganisation in a decade.

We are calling for crucial amendments to the Bill to address our concerns with the legislation as it stands, which would:

- **Improve government accountability for safe staffing** – The BMA estimates that the NHS is currently facing a shortfall of around 50,000 full time equivalent doctors. 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. There is urgent need for drastic action to address the huge workforce shortages across the NHS.
    - **The BMA, alongside a coalition of almost 90 health and care organisations, including colleagues in the Royal Colleges, influential think tanks and charities, is calling on peers to support Amendment 170 to Clause 35 tabled by Conservative peer Baroness Cumberlege, supported by Lord Hunt, Baroness Brinton and Lord Stevens.**
    - **The amendment would place a duty on the Secretary of State to publish regular independently verified assessments of the workforce numbers needed now, and in the future, to meet the growing needs of the population. The data gap on how many staff we need must be resolved to put the NHS and care workforce back on a sustainable footing. Read more about the overwhelming support from across the health and care sector for the amendment here.**

- **Safeguard the NHS from wasteful and destabilising outsourcing** – Although the BMA supports the removal of Section 75 in Schedule 12 of the Bill, under the new Provider Selection Regime, contracts could be awarded to private providers without proper scrutiny or transparency.
    - **The BMA urges peers to vote in favour of Amendments 207 and 208 that would establish the NHS as the preferred provider for NHS contracts and ensure any contracts that do end up being put out to tender are subject to adequate transparency and scrutiny.**

  This would provide necessary safeguards for ensuring the private sector is only used when absolutely necessary and that there is adequate scrutiny and transparency when contracts are tendered.

- **Rule out private sector companies wielding influence over commissioning decisions** – The Bill leaves open the possibility for corporate healthcare providers to gain seats on ICS boards, which would allow them to influence ICSs strategies and risk conflicts of interest in commissioning decisions.
- Although it is welcome that the Government, during the Commons' stages, has recognised the risk of conflicts of interest as a consequence of private providers sitting on ICBs, the amendment would leave this to the discretion of the ICS constitution when making appointments and doesn't go far enough to rule out private company influence across NHS decision-making boards and sub-committees.
- To truly safeguard ICS decision-making bodies from conflicts of interest, we are calling for amendments to the Bill that would rule out corporate health providers as members of NHS decision-making bodies.
    - **The BMA does not believe the Government Amendment goes far enough to rule out the threat of private providers wielding influence over commissioning decisions or the wider ICS strategy.**
    - **To truly safeguard ICS decision-making bodies from conflicts of interest, we are calling for amendments to the Bill that would rule out corporate health providers as members of both ICBs and ICPs.**
    - **We urge peers to vote in favour of Amendment 29 tabled by Baroness Merron, that would restrict certain persons with an involvement in promoting private healthcare from being appointed to an integrated care board.**

- **Embed clinical leadership within ICSs** – A truly collaborative and integrated healthcare system must have strong, independent clinical leadership at its heart, but the Bill as written risks undercutting local clinical engagement and leadership.
- The BMA calls on peers to amend the Bill to ensure independent clinical leadership from across primary, secondary and public health care is embedded at every level of ICSs, including formalised roles for Local Medical Committees (LMCs) and Local Negotiating Committees (LNCs).
    - **The BMA believes the Bill should be amended to ensure there is a qualified and registered[1] public health consultant appointed by the ICS as a member of the Board to provide public health leadership and a professional view on the health of the whole ICS population and how to improve it.**
    - **The BMA is calling for amendments to the Bill that would strengthen minimum membership of ICBs to include more than one GP and a clinical representative from secondary care.**
    - **We are supportive of Lord Hunt's Amendments 117 and 147 to Clause 20 that would require the ICB, partner trusts and NHS Foundation Trusts to consult the relevant primary care Local Representative Committees when publishing their forward plan and to Clause 21 that would ensure that primary care professions have mandated roles within Integrated Care Partnerships with a member appointed by each of the practitioner committees.**

- **Balance Secretary of State powers with responsibility –** The BMA is concerned that the Bill's proposals focus more on securing power over the NHS for politicians, rather than accountability for its performance.
    - **The BMA is calling on peers to support amendments that would:**
        - **introduce safeguards over the Secretary of State's ability to influence reconfiguration decisions**
        - **reinstate the Secretary of State's responsibility for providing comprehensive healthcare**
        - **strengthen safeguards over the Secretary of State's ability to redirect the NHS outside of the NHS mandate by ensuring any revision is laid before parliament and subject to the affirmative resolution procedure.**

[1] Registered with either the General Medical Council or the UK Public Health Register

Improve Government accountability for safe staffing

What is the current problem with the Bill?

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[2] 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.[3] 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 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. Any legislation must be used as an 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 35 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 – this data gap must be closed to strengthen accountability for workforce planning.

What is the BMA Calling for?

Regular transparent workforce assessments 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. These reports 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.

MPs rejected an amendment to strengthen workforce planning, tabled by the Rt. Hon. Jeremy Hunt MP, during the final Commons' debates on the Bill, despite compelling cross-party support and backing from a coalition of almost 90 sector organisations. The amendment has now been re-tabled in the Lords by Baroness Cumberlege, supported by Lord Hunt of King's Heath, Baroness Brinton and Lord Stevens of Birmingham.

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

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

The BMA, alongside our colleagues in the Royal Colleges, influential think tanks and charities, is jointly calling on peers to support Amendment 170 tabled by Baroness Cumberlege to clause 35 to place a duty on the Secretary of State to publish regular, independently verified assessments of the workforce numbers needed now, and in the future, to meet the growing needs of the population.

Importantly, this amendment would mean that such assessments are informed by projected demographic changes amongst the patient population, demographic changes amongst health and care staff (e.g. change in working patterns), changes to the cost of healthcare, new and emerging patient pathways and evidence-based treatments, and the prevalence of different health conditions. The coalition has set out the key principles for amending the Bill here.

During questioning in oral evidence sessions, the Prime Minister[4] and Secretary of State for Health and Social Care[5] both agreed to engage with this amendment; we hope the Lords' scrutiny sessions will make progress on a proposal that has such compelling cross-party and cross-sector support. We note Baroness Harding's contribution at the Bill's second reading, from her experience of leading the development of the Interim People Plan, that "unless expressly required to do so, government will not be honest about the mismatch between the supply and demand of healthcare workers" – we urge peers to seize the opportunity to address this accountability gap without further delay.

Safeguard the NHS from wasteful and destabilising outsourcing

Why is the amendment needed?

The BMA supports the removal of Section 75 of the Health and Care Act 2012 via Schedule 12 in the Bill. However, this is not enough to protect the NHS from the fragmentation and destabilisation seen as a consequence of unnecessary outsourcing of NHS contracts to private providers.

Doctors are concerned about the impact this has had on patient care:

- 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%) of responding doctors who work in sectors with high independent sector provision felt that it has had a negative impact on the quality of service provision.[6]

Although the Bill repeals enforced competition, the new Provider Selection Regime, would enable contracts to be awarded to private sector companies without scrutiny and transparency. The last few years have shown repeated examples of the damage done by outsourcing NHS services to private companies has had over the last decade:

- Circle's disastrous takeover of Hinchingbrooke Hospital in 2012 saw the company pulling out just three years into its 10-year contract, with the CQC determining the service inadequate, and leaving the NHS footing the bill - the deficit created during Circle's stewardship of the hospital was far in excess of the £7 million that the company was contractually liable to cover
- Serco ended its contract to provide out of hours GP services in Cornwall in 2013 - 18 months early. The Public Accounts Committee finding the service to be falling "unacceptably short" of essential standards of quality and safety.

[4] Prime Minister's oral evidence to the Liaison Select Committee, 17 Nov 2021, available at: https://committees.parliament.uk/oralevidence/3007/default/ (see page 39)
[5] Secretary of State for Health and Social Care's oral evidence to the Health and Social Care Select Committee, 2 Nov 2021, available at: https://committees.parliament.uk/oralevidence/2942/pdf/ (see page 9)
[6] BMA (2019) Independent Sector Provision in the NHS revisited

- The Practice Group in Brighton, terminated its contract to run five GP surgeries in the city in 2016, leaving thousands of patients forced to move practice.

By contrast, the NHS provides a reliable, accountable service and ensures public money is invested back into NHS services.

What is the BMA calling for?

To truly end disruptive, unnecessary competition within the NHS it is essential that the Bill establishes the NHS as the default option for services. If the intention of the Bill is to establish a joined-up, collaborative approach to delivering services – as the Government has stated – then the NHS should be enshrined as the default option for NHS contracts.

This amendment would provide necessary safeguards for ensuring the private sector[7] 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.

The BMA urges urge peers to vote in favour of Amendments to the Bill that would establish the NHS as the default option for NHS contracts and ensure there is adequate transparency and scrutiny when contracts are put out to tender.

Rule out private providers on NHS Boards

Why is the amendment needed?

The Bill 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.

In response to amendments tabled by the Opposition and supported by the BMA, the Government brought an amendment to the Bill at Report Stage in the Commons that would prevent the appointment of a member of an integrated care board if they "could reasonably be regarded as undermining the independence of the NHS because of their involvement in the private healthcare sector or otherwise".

Whilst the Government clearly recognises the risks posed by private sector companies sitting on NHS decision-making boards, the amendment does not go far enough to address this. It fails to rule out private sector companies sitting on NHS decision-making boards or sub-committees and therefore wielding influence over decisions and the overarching strategy of the ICS.

What the BMA is calling for?

The BMA is clear that, 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.

To truly safeguard ICS decision-making bodies from conflicts of interest, the BMA urges peers to support Amendment 29 tabled by Baroness Merron that would restrict certain persons with an involvement in promoting private healthcare from being appointed to an integrated care board.

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

Clinical engagement at the heart of the NHS

What is the current problem with the Bill?

Given the integral role doctors play within the health system, 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.

The Bill sets out core, minimum membership of Integrated Care Boards (ICBs), which includes at least one 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 far short of ensuring clinical leadership and representation needed. ICSs are currently finalising their draft constitutions, including the proposed membership of their ICBs, with many failing to provide adequate representation for clinicians. This is particularly apparent in respect of public health expertise on ICBs, with some constitutions making no reference at all to public health or roles for directors of public health.

The BMA is concerned the Bill risks undercutting truly representative clinical leadership by failing to retain some of the positive elements of Clinical Commissioning Groups. This includes their vital function in ensuring accountability to clinicians and patients as a body of elected, local GPs. There is also no requirement for doctors from secondary care or public health on ICBs as independent representatives acting on behalf of the local population need. Without this, there is a real concern that postcode lotteries could emerge with regards to clinical engagement at ICB level. We have already seen with the consultations on constitutions currently under consideration that some have included a public health representative, for instance, whilst others have not.

Given the hugely important role of public health doctors throughout the COVID-19 pandemic, and the expectation that ICSs will act as population health organisations, this is a shocking omission that needs to be addressed.

What is the BMA calling for?

The BMA believes the Bill should be amended to ensure there is there is a qualified and registered[8] public health consultant appointed by the ICS as a member of the Board to provide public health leadership and an independent professional view on the health of the whole ICS population and how to improve it.

The BMA is also calling for amendments to the Bill that would strengthen minimum membership of ICBs to include more than one GP and a clinical representative from secondary care.

We are also supportive of Lord Hunt's amendments 117 and 147 to Clause 20 that would require the ICB, partner trusts and NHS Foundation Trusts to consult the relevant primary care Local Representative Committees when publishing their forward plan, and to Clause 21 that would ensure that primary care professions have mandated roles within Integrated Care Partnerships with a member appointed by each of the practitioner committees.

Public accountability and Secretary of State powers

The Bill introduces wide-ranging new powers for the Secretary of State to intervene in local service reconfigurations, to direct (or redirect) the NHS outside of the existing system of the NHS Mandate, establish new NHS Trusts and to modify or abolish Arms Length Bodies.

[8] Registered with either the General Medical Council or the UK Public Health Register

Whilst the BMA supports clear lines of political accountability for the NHS at Secretary of State level, power must be balanced with responsibility, and we are concerned the measures in the Bill focus much more on affording new powers to the Secretary of State without the necessary accountability. Unchecked, these wide-ranging powers could result in undue political influence in NHS decision making and undermine long-term planning.

Whilst limited safeguards are included in the bill in relation to some of the proposed Secretary of State's powers, there are areas where 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.

What is the BMA calling for?

The BMA calls on peers to vote in favour of amendments that would:

- **Reinstate the specific duty of the Health Secretary to provide and secure comprehensive healthcare.**
- **Introduce safeguards over the Secretary of State's ability to influence reconfiguration decisions. We have joined NHS Confederation and others in supporting Baroness Cumberlege's Amendments 179-183 to this effect.**
- **Strengthen the duty for the Secretary of State to lay before parliament any revised version of the NHS Mandate by ensuring it is also subject to the affirmative resolution procedure. This would help improve parliamentary scrutiny over the revised mandate by ensuring it is actively approved by both Houses of Parliament.**

Additional calls – research and tobacco control measures

- **Strengthen the duty to promote research with a duty to conduct research -** The BMA, alongside organisations and charities including the ABPI, AMRC, RCP and CRUK, is calling for an amendment to the Bill that would strengthen the current duty to promote research to a duty to *conduct* research. We support Lord Sharkey's Amendment 79 to this effect.
- The BMA is clear that this must apply to all organisations providing NHS services. This would support patients, clinicians and NHS organisations across the country having equal access to the well-documented benefits brought by research participation.
- **The BMA also supports Amendments to Part 5 of the Bill to strengthen tobacco control measures** with the aim of increasing the rate of decline in smoking prevalence and uptake to put the UK on track to make smoking obsolete.

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