Parliamentary brief
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BMA

Health and Care Bill

House of Lords, Report Stage
March 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 nearing 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 100 health and care organisations, including colleagues in the Royal Colleges, influential think tanks and charities, is calling on peers to speak in support of, and vote for, the amendment to Clause 35 tabled by Conservative peer Baroness Cumberlege, co-signed by Baroness Thornton, Baroness Walmsley and Lord Stevens.**
    - **The amendment would place a much-needed 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, the Bill should establish the NHS as the default option for contracts to avoid unnecessary outsourcing and the destabilisation and fragmentation this can bring.
- This would also guarantee that contracts would not be awarded to corporate providers without proper scrutiny or transparency.
- The Government has tabled amendments that would require regulations specifying steps that need to be taken when following a competitive tendering process and that these should ensure transparency, fairness, that compliance can be verified, and manage conflicts of interest.

- Whilst this shows recognition of the potential problems caused if contracts are awarded without adequate transparency, it falls short of guaranteeing that contracts will only be awarded to the private sector if necessary or setting out the parameters for ensuring transparency and fairness.
    - **The BMA urges peers to vote in favour of amendments that would establish the NHS as the preferred provider for NHS contracts and guarantee any contracts that do end up being put out to tender are subject to adequate transparency and scrutiny.**

- **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 amendments 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 ICB 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.**
    - **We have also been 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 urge peers to vote in favour Baroness Meacher's amendment that would ensure the ICB membership includes:**
        - At least one clinical member nominated jointly by persons who deliver NHS secondary, medical services within the integrated care board's area
        - At least one clinical member nominated jointly by persons who deliver NHS mental health services within the integrated care board's area
        - At least one member appointed directly by the ICB to provide public health advice as a registered consultant in public health

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

- **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. **We encourage peers to vote in favour of Baroness Thornton's amendment that would remove Clause 40 from the Bill.**
        - 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.

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. 43% of respondents to the BMA's September 2021 Viewpoint survey[2] said they were now more likely to take early retirement, while 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. Projections by the Health Foundation and REAL Centre show that the NHS workforce would need to grow by over a fifth by 2024/25, on top of current growth, to reduce current staffing shortages.[3] The growth would need to be even higher if the NHS sought to reduce bed occupancy to provide more resilience to health shocks. They estimate that by 2030/31, the NHS workforce would need to grow by 40% and the adult social care workforce by 55%, meaning over 1 million additional full-time equivalent staff.[4]

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 3.7 doctors per 1,000 people that is the average in OECD EU nations today. Our doctor to population ratio is already nearing 50,000 FTE doctors short of where it would need to be to meet this average of 3.7 per 1,000 people. 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, retention 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 in 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

[2] BMA Viewpoint survey, Sept 2021: https://www.bma.org.uk/what-we-do/viewpoint-surveys
[3] Health Foundation, 2021. Health and social care funding projections 2021. Available at: https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021
[4] Health Foundation, 2021. Health and social care funding projections 2021. Available at: https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021

believe it will be sufficiently meaningful unless the Bill also addresses *what* must be delivered – we still will not know whether we are training enough people to meet demand now and in the future. Given the scale of the workforce crisis, the current duty in the Bill falls short of what is needed; the 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.

Despite compelling cross-party support and backing from a coalition of almost 100 sector organisations, MPs rejected an amendment to strengthen workforce planning, tabled by the Rt. Hon. Jeremy Hunt MP, during the final Commons' debates on the Bill. The amendment has now been championed in the Lords by Baroness Cumberlege, supported by peers from across the House.

During questioning in oral evidence sessions, the Prime Minister[5] and Secretary of State for Health and Social Care[6] both agreed to engage with this amendment. However, to-date the Government has so far dismissed amendments on workforce planning on the basis that 'Framework 15', which DHSC has commissioned HEE to refresh, will "provide a framework for the health and regulated social care workforce… [and] look at the key drivers of workforce supply". Whilst greater clarity on these drivers is welcome, Framework 15 was first published in 2014, last updated in 2017, and there is still no agreed, publicly available assessment of workforce numbers now nor into the future – the framework does not address what would be achieved by the amendment but could, instead, feed into those regular publications of workforce modelling.

The Secretary of State recently told the health and social care select committee (Jan 2022) that he had commissioned NHS England to deliver a long-term workforce strategy – but since then, no detail has been forthcoming about what time-period it will span, whether it will be regularly published, or if it will include modelling on the numbers of staff needed across the health and care system to meet population demand for services. A one-off plan doesn't get us very far; this commitment is not sufficient to negate the need for this amendment. We urge peers to heed Baroness Harding's warning at the Bill's second reading that, from her experience of leading the development of the Interim People Plan, "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 and vote for Baroness Cumberlege's amendment to take forward a proposal that has such compelling cross-party and cross-sector support.

How would the amendment work?

The amendment tabled by Baroness Cumberlege to clause 35 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.

This amendment would mean that such assessments are dynamic – 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.

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[5] 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)

[6] 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)

Regular, independent public workforce projection data will not solve the workforce crisis. But having a collective national picture of the health and care staff numbers needed now and in future to meet demand *will* provide the strongest foundations to take long-term strategic decisions about funding, regional and specialty shortages, and skill mix.

The non-legislative approach taken so far has not worked. Deferring to Framework 15, the NHS England/HEE merger, or the recently commissioned long-term NHS England long-term workforce strategy will not provide this foundation if there is no grounding in legislation to ensure accountability and provide transparent oversight of the state of staffing numbers – this amendment is necessary to ensure that workforce modelling is routinely published to inform system-wide planning now and into the future. Without which, history tells us – as outlined by Lord Stevens – that the Government's workforce planning will continue to omit this vital component and perpetuate a lack of accountability for unsafe staffing.

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.[7]

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.
- 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.

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

The Government has tabled amendments that would require regulations specifying steps that need to be taken when following a competitive tendering process and that these should ensure transparency, fairness, that compliance can be verified, and manage conflicts of interest.

Whilst this shows recognition of the potential problems caused if contracts are awarded without adequate transparency, it falls short of guaranteeing that contracts will only be awarded to the private sector if necessary or ensuring there is robust guidance and regulations for ensuring transparency and fairness.

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[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.

The BMA urges 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

We recognise that the Government wants to allow for local flexibility and judgement, as well as the suggestion that additional requirements could be retrospectively introduced through regulations if necessary. However, we are clear that to guard against conflicts of interest and undue influence in decision-making, corporate providers should not be involved in the leadership of ICSs or any commissioning decisions they make.

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

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.

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.

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. 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.

Furthermore, it is vital that any public health representative provides solely a professional view of the health of the whole ICS population, and that their recommendations are not influenced by any employing organisation, their politics or budget. If ICS's are to fulfil their partnership, care, social and economic potential they must have unbiased, and 'clinical' (i.e. not solely "medical" but population health-informed) advice on how to improve the health of all members of their population. This professional public health advice would support the other board members and ensure improved and equitable health outcomes are achieved.

Whilst we recognise ICBs will have a duty to seek clinical advice, and tabled Government amendments that would include a requirement to keep membership under review, we remain concerned that without guaranteed strengthened clinical representation on the ICB itself, the legislation will fail to ensure meaningful clinical leadership in practice. The duty to review ICB membership will also have little impact if there is no clear guidance or regulations setting out what skills, knowledge and experience is necessary for the board to possess to effectively carry out its functions.

What is the BMA calling for?

The BMA is clear that clinical leadership and representation must be embedded at every level of Integrated Care Systems, including formalised roles for doctors working in primary care, secondary care, and public health.

This must include ensuring there strengthened primary care representation and a guaranteed role for a secondary care clinician on the ICB.

There must also be a qualified and registered[9] 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.

We strongly believe strengthening these minimum legislative requirements would help ensure a necessary level of consistency and guaranteed clinical representation across ICSs, whilst allowing local areas the discretion to build on these in a way that best meets the needs of their populations.

We urge peers to vote in favour of amendments that would help strengthen clinical leadership and representation within ICSs.

In particular, we call on peers to support Baroness Meacher's amendment as essential to guaranteeing necessary minimum clinical leadership on the ICB by ensuring the board includes at least one clinician of secondary care; at least one qualified and registered public health consultant appointed by the ICS to provide public health leadership and a professional view on the health of the whole ICS population; and at least one mental health clinician.

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.

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, NHS Providers, the Kings Fund and others in calling on peers to support Baroness Thornton's amendment to remove Clause 40 from the Bill.**
- **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.**

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