**BMA submission to the Public Bill Committee on the Health and Care Bill**

**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.

**Summary**

* The BMA believes the Health and Care Bill is the wrong bill at the wrong time.[[1]](#footnote-2) It is wrong to implement wholesale reform of the health and care system at a time when frontline workers are still dealing with the COVID-19 pandemic and the huge backlog of care the NHS is facing.[[2]](#footnote-3) Doctors have not had the time necessary to discuss and scrutinise the details – legislative reorganisation on such a scale must be given time and space to get right and not be rushed through.
* The Bill does nothing to address the significant pressures on the NHS in terms of waiting lists, resources and chronic workforce shortages.
* The immediate challenge for the NHS will be addressing the greatest backlog of care our health service has ever faced, alongside the continued pressures of COVID-19. This includes addressing the increase in issues and conditions associated with the pandemic, a rise in mental ill health and demand for mental health services[[3]](#footnote-4), as well as highlighting and exacerbating health inequalities.[[4]](#footnote-5) Attention must not diverted away from addressing these critical challenges. It is unclear how the proposed changes would do anything to address these issues or better prepare the health and care system for any future pandemic.
* The BMA is calling for crucial amendment to the Bill to address our concerns with the legislation as it stands.
* **Protecting the NHS from wasteful and destabilising privatisation** - Enforced competition has led to unnecessary and costly procurement processes and the fragmentation of NHS services.
* The BMA supports the removal of Section 75 in Schedule 12 of the Bill, but we have significant concerns over the lack of safeguards to protect the NHS against unnecessary private sector involvement. The Bill could, under the new Provider Selection Regime, allow contracts to be awarded to private providers without proper scrutiny or transparency.
* To truly end disruptive, unnecessary competition within the NHS and to establish a joined-up, collaborative approach to delivering services – as the Government has stated is its intention – then the NHS should be 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.
* This would also prevent the Provider Selection Regime leading to increased and costly use of judicial reviews by providers not chosen for contracts by ICSs, something various provider organisations have warned against.[[5]](#footnote-6)
* **Private provider representation on ICS boards** – The legislation 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.
* 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.
* The threat of private health providers having a formal seat on new decision-making ICS boards, and wielding influence over commissioning decisions, must be ruled out within the Bill.
* **Clinical leadership -** Doctors know their local systems better than anyone and are best placed to make decisions about what is needed in the interest of patient care. A truly collaborative and integrated healthcare system must therefore have strong clinical leadership at its heart.
* The Bill sets out minimum membership of Integrated Care Boards, which includes one GP representative, a member nominated by the NHS or Foundation Trust and a member nominated by the local authority.
* This provision, and further detail set out in the NHSE ICS Design Framework, falls far short of ensuring clinical leadership and representation with no mention of Local Medical Committees or Local Negotiating Committees (established local medical representative bodies), or the need to involve consultants, SAS doctors, public health colleagues or junior doctors in the work of the ICB.
* The Bill must be amended to ensure clinical leadership and patient representation is embedded at every level of ICSs, including formalised roles for LMCs and LNCs, and Directors of Public Health.[[6]](#footnote-7)
* **Workforce accountability** – The Government must be accountable 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.
* The BMA estimates that the NHS is currently facing a shortfall of 49,162 full time equivalent doctors. Without significant and sustained action, staff shortages are expected to increase rapidly.[[7]](#footnote-8)
* To deliver accountability for safe staffing, the Bill must include a responsibility for the Secretary of State to produce ongoing, accurate and transparent workforce assessments to directly inform recruitment needs as well as responsibility for delivering these staff. The BMA and key stakeholders have proposed an amendment to this effect, which can be viewed [here](https://www.rcplondon.ac.uk/guidelines-policy/health-and-care-leaders-say-health-and-care-bill-must-be-strengthened-improve-workforce-planning)[[8]](#footnote-9).
* **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 focus more on securing power over the NHS for politicians rather than accountability for its performance.
* The Bill would afford the Secretary of State new powers to intervene in local service reconfiguration, to direct (or redirect) the NHS outside of the NHS Mandate, to establish new NHS Trusts and to modify or abolish Arms Length Bodies.
* Unchecked, these wide-ranging powers could result in increased political influence in NHS decision making and undermining long-term planning.
* We are calling for clear safeguards and limits on the use of these powers to be included in the Bill

**1. Procurement and outsourcing**

*Removal of Section 75*

1.1 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, in recognition that this has led to costly procurement processes, fragmentation and the destabilisation of services.

1.2 The BMA has long called for and supported the removal of enforced competition, which has resulted in costly procurement processes, increased fragmentation of care and has destabilised NHS services. It has also seen private sector companies cherry picking some of the NHS’s most profitable contracts, terminating contracts early,[[9]](#footnote-10) as well as successfully “suing”[[10]](#footnote-11) the NHS for anti-competitive awarding of contracts or behaviour at a significant cost to the NHS.

1.3 A 2018 BMA [survey](https://www.bma.org.uk/media/1984/bma-privatisation-of-the-nhs-in-england-jan-2019.pdf) found that 73% of doctors were concerned by independent sector provision of NHS services and that 66.5% of doctors who work in sectors with high independent sector provision felt that it has had a negative impact on the quality of service provision those areas.[[11]](#footnote-12) The most common reasons for concern were the destabilisation of NHS services, the fragmentation of NHS services, value for money and quality of care.

1.4 Enforced competition has resulted in frequently drawn out and disruptive competition over NHS and public health contracts seen since 2012, such as the tendering of £1.2bn worth of [cancer and end-of-life care contracts in Staffordshire](https://www.bbc.co.uk/news/uk-england-stoke-staffordshire-38115713),[[12]](#footnote-13) the takeover of NHS contracts by Virgin in recent years, such as the [£104 million contract to run Lancashire’s 0-19 Healthy Child Programme](https://www.thelancasterandmorecambecitizen.co.uk/news/16188529.court-hearing-controversial-virgin-healthcare-deal/) – including school nursing, and Virgin Care suing the NHS after it lost out on an £82m contract to provide children’s health services across Surrey.[[13]](#footnote-14)

1.5 However, the BMA has significant concerns over the lack of safeguards to protect the NHS against unnecessary private sector involvement and that the Bill could, under the new Provider Selection Regime, allow contracts to be awarded to private providers without proper scrutiny or transparency.

*NHS Provider Selection Regime*

1.6 It is vital that the new provider selection regime provides sufficient scrutiny over the awarding of contracts. As seen in the Government’s response to COVID-19 so far, many high value contracts have been handed to private companies with little oversight and on the basis of relationships between those companies and the commissioners involved.[[14]](#footnote-15) The impact of this has led to performance issues, for example COVID-19 tests being lost or vital data not shared,[[15]](#footnote-16) problems in the delivery of high-quality PPE to frontline workers,[[16]](#footnote-17) and a lack of mechanisms through which to hold companies to account for their handling of these contracts.[[17]](#footnote-18) Failure to establish clear and robust commissioning rules could lead to similar mistakes being made in future.

1.7 The new provider selection regime[[18]](#footnote-19) would broadly give commissioners three options:

1. Renew contracts with existing providers without the need for tendering
2. Offer new or existing contracts to providers without tendering
3. Launch a competitive tendering process for contracts where appropriate

1.8 Whilst the ability to renew contracts with existing providers without the need for tendering could help reduce wasteful competition and lead to greater stability, the ability to offer new or existing contracts to providers without tendering could lead to contracts being awarded to private providers without proper scrutiny or transparency.

**1.9 The BMA believes, therefore, that to truly protect the NHS from instability, unnecessary tendering and fragmentation, whilst ensuring adequate scrutiny, the Bill must be amended to enshrine the NHS as the default option for NHS contracts.** This would not mean that private or non-NHS providers could no longer hold or be subcontracted to fulfil NHS contracts, but would establish the NHS is the default option for NHS contracts and commissioners would be required to present a case as to why a non-NHS provider would be better placed to hold any such contract. As seen with the rollout of the vaccine programme, where the NHS is the preferred provider, it delivers high quality results that the public can not only see, but also rely on.

*1.10 Membership on ICS boards*

The legislation 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.

1.11 Although Clause 13 of the Bill includes 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.

**1.12 The Bill must be amended to rule out the possibly of private providers being able to have a formal seat on new decision-making ICS boards, and wielding influence over commissioning decisions.**

**2. Clinical engagement and leadership**

2.1 Doctors who know their local systems are best placed to make decisions about what is needed in the best interest of patient care. A truly collaborative and integrated healthcare system must therefore have strong clinical leadership at its heart.

2.3 The BMA has consistently called for meaningful clinical leadership, engagement and representation at every level of Integrated Care Systems to ensure the right voices are heard when it comes to commissioning decisions, but we are concerned that this is not reflected in the legislation.

2.4 Whilst placing ICSs on a statutory footing should improve their accountability and transparency, the BMA is concerned that the measures proposed in the Bill undercut truly representative clinical leadership by failing to retain some of the positive elements of CCGs. This includes their vital function in ensuring accountability to clinicians and patients as a body of elected, local GPs; their invaluable local knowledge; their role in providing a strong clinical voice; and their skill and experience in commissioning services.

2.5 In their new statutory form, ICSs will be formed of two bodies – the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP). The BMA is clear that the Bill must be amended to ensure clinical leadership and patient representation is embedded at every level of ICSs.

2.6 Membership of the ICB, which will be responsible for the commissioning and provision of NHS services and distributing funding within their footprints, will be up to local determination, barring a core, minimum membership set out in the Bill. These include:

* a Chair (appointed by NHS England and approved by the Secretary of State)
* a Chief Executive (appointed by the Chair and approved by NHS England)
* at least three other members, including:
  + one nominated jointly by NHS Trusts and Foundation Trusts (trusts)
  + one nominated jointly by GPs and primary care
  + one nominated by local authorities.

The Bill makes no further prescriptions regarding ICB membership.

2.7 The legislation is even less prescriptive when it comes to the membership of Integrated Care Partnerships, which will be required to take a broader view than ICBs and involve a wide-ranging set of partners. The Bill establishes that each ICP will need to have at least one member appointed by the ICB and one appointed by each local authority, but beyond that all other members will be appointed by the ICP itself.

2.8 The BMA understands that only limited specifications around ICS governance arrangements are included in the legislation to enable local leaders flexibility over approach. However, this provision, and further detail set out in the NHSE ICS Design Framework, falls far short of ensuring clinical leadership and representation with no mention of LMCs or LNCs (established local medical representative bodies), or the need to involve consultants, SAS doctors, public health colleagues or junior doctors in the work of the ICB.

2.9 Whilst one representative from primary care is required on ICBs, far greater and broader representation of doctors is needed throughout ICSs, ICBs, and ICPs. It is also essential that ICSs include registered specialists in public health, on ICBs and ICPs not as representatives of their employers, but as independent voices. The importance of this has been laid bare by the pandemic.

2.10 The BMA is calling for amendments to the Bill to ensure clinical leadership and patient representation is embedded at every level of ICSs, including ensuring there is a formalised role for local medical committees, local negotiating committees and public health doctors.

2.11 This includes an amendment to ensure every ICS board has at least one clinical representative from secondary and primary care, as well as a registered public health specialist.

**3. Workforce accountability**

3.1 The BMA believes the Government must be accountable, through legislation, for ensuring that health and care systems have the workforce required to meet the needs of the population, now and in the future. We estimate that the NHS is currently facing an alarming shortfall of around 50,000 full time equivalent doctors[[19]](#footnote-20). Pre-pandemic, nine in 10 (91%) doctors responding to a UK-wide BMA survey[[20]](#footnote-21) told us that current staffing levels are ‘inadequate to deliver quality patient care’ and most doctors (74%) felt that situation had worsened within the previous year.

3.2 The demands on the NHS workforce have been highlighted and exacerbated by the COVID-19 pandemic. Burnout has led to significant numbers of medical professionals [considering leaving the profession](https://www.bma.org.uk/bma-media-centre/year-of-unparalleled-pressure-leaves-staff-exhausted-and-on-the-brink-bma-survey-shows) or reducing their working commitments. Twenty-six per cent of respondents to the BMA’s February 2021 [COVID-19 tracker survey](https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-bma-actions-and-policy/covid-19-analysing-the-impact-of-coronavirus-on-doctors) said they were now more likely to take early retirement, and 47% reported being more likely to reduce their hours.

3.3 Stubbornly high NHS staff vacancies existed even before the pandemic (88,347 FTE staff) across staff groups.[[21]](#footnote-22) As of June 2021, however, the overall number of NHS vacancies was 93,806 FTE staff – an increase of 6% since March 2020. In terms of doctors, the number of medical vacancies increased by 46% - from 6,634 to 9,691 – between March and June 2021[[22]](#footnote-23). These figures indicate that temporary staff who returned to support the pandemic effort are not being retained, *and* existing staff are burning out and either changing their working patterns or leaving the health and care workforce altogether. This comes at a time when the care backlog threatens to quickly overwhelm our services.

3.4 Without significant and sustained action, 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 trusts in England could reach almost 350,000 FTE posts.[[23]](#footnote-24)

3.5 We have consistently lobbied for government accountability for safe staffing of health and care services across the UK, and we are calling for any legislative reform to be used as a vehicle for the Government to take sustainable action to alleviate issues relating to workforce supply and demand in England. Overcoming unsafe staffing levels is an essential measure to ensure patient safety and to boost the wellbeing, morale, tenure, and productivity of staff working in health and care services.

*3.6 Delivering accountability*

The BMA and key stakeholders[[24]](#footnote-25) believe that the Bill’s existing duty for the Secretary of State to report on the system in place for assessing and meeting the workforce needs of the health, social care, and public health services in England must be complemented by an additional duty: published assessments every two years of the workforce numbers required to deliver the work that the Office for Budget Responsibility estimates will be carried out by the healthcare system in future.

3.7 Numerous reviews have impressed upon Government the importance of assuring that sufficient staff are available to meet NHS need, now and in the future.[[25]](#footnote-26) NHS England and NHS Improvement’s own recommendations for this legislation were that ‘*the Government should now revisit with partners whether national responsibilities and duties in relation to workforce functions are sufficiently clear’.*

3.8 To this end, Clause 33 of the Bill currentlyrequires 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, the BMA and key stakeholders believe that the Bill must also include a responsibility for the Secretary of State to produce ongoing accurate and transparent workforce assessments, independently verified, which will directly inform recruitment needs. Without this amendment, we do not believe that provisions in the Bill will deliver the clarity needed as to whether the system is training and retaining enough staff to deliver safe health and care services now and in the future.

3.9 The independently verified workforce modelling we are calling for[[26]](#footnote-27) must be publicly available, and presented to parliament, to enable proper scrutiny and debate of what policies and investment are needed to inform local and regional training and recruitment needs.  Whilst such workforce projection data will not solve the health and care workforce crisis, we believe it would provide a better foundation on which to take long-term decisions about workforce planning, regional shortages, and the skills mix needed to help the system keep up with patient demand and to prevent unsafe levels of staffing from continuing to occur.

3.10 The BMA has joined key healthcare organisations, including the RCN, RCP, AoMRC, Health Foundation, Kings Fund, Nuffield Trust, NHS Providers, Macmillan and NHS Confederation, in calling for a duty on the Secretary of State to provide this ongoing, transparent workforce assessment. The Health and Social Care Select Committee, too, has been clear[[27]](#footnote-28) that objective, transparent, and independent reporting on workforce is needed.

**3.11 Specifically,** [**we are calling for an amendment**](https://www.rcplondon.ac.uk/guidelines-policy/health-and-care-leaders-say-health-and-care-bill-must-be-strengthened-improve-workforce-planning)**[[28]](#footnote-29) to Clause 33 that would place a duty on the Secretary of State to present a report to parliament at least every two years. This will contain an assessment of the workforce numbers required to deliver the care that the Office for Budget Responsibility estimates will be needed in the future (over the next five, 10 and 20 years). The assessment would be based on projected demographic changes, the growing prevalence of certain health conditions, and the likely impact of technology. The proposed amendment from the BMA and others can be viewed** [**here**](https://www.rcplondon.ac.uk/guidelines-policy/health-and-care-leaders-say-health-and-care-bill-must-be-strengthened-improve-workforce-planning)**, accompanied by a more detailed explanatory note.[[29]](#footnote-30)**

*3.12 Duty to report on roles and responsibilities - considerations*

Under the new legislative system, there would be increased ICS-level management of the local workforce. It is vital that in setting out the roles and responsibilities for workforce planning and supply in England that the Secretary of State consider:

* Expectations for ICSs to deliver both local recruitment and retention initiatives must be clarified, and what specific powers will be given to systems to allow them to do so. This should include clarity regarding the role of HEE in respect of local health and care systems (including in medical training and education at a system level), as well as national and regional workforce planning modelling; and what any changes to this may mean for medical students and junior doctors. Further, if ICSs do adopt the responsibilities of CCGs in this area, the BMA would want them to also take on their legal obligations regarding education and research, as laid down in the Health and Social Care Act (Section 26, paragraphs 14X – 14Z
* Regarding ICS-wide management of the NHS workforce, it is essential that LNCs remain fully involved in any discussions about changes to patterns and places of work, as well as any potential contractual changes – including changes to locum rates, for example. Furthermore, the autonomy of the clinical workforce must be respected, and job plans and redeployment in secondary care be fully agreed, not imposed from the centre. Integration by imposition will not be successful.

*3.13 LETBs*

Local Education Training Boards LETBs will be abolished under the changes set out in the Bill, with their roles and responsibilities returning to HEE. The Explanatory Notes[[30]](#footnote-31) set out that the intention of this change is to give HEE flexibility to adapt its regional operating model over time. However, the BMA would be concerned if the change resulted in any loss of locally driven training programmes or support for local recruitment, in favour of a nationally focused approach that fails to address the specific needs of each locality.

As set out above, clarity over HEE’s role with regards to medical training and education is essential, as is reassurance that this will not result in the nationalisation of workforce planning, or loss of local support structures for trainees.

**4. Secretary of State powers**

4.1 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.

4.2 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.

4.3 Unchecked, these wide-ranging powers could result in undue political influence in NHS decision making and undermine long-term planning. For example, the power, contained in Clause 3 of the Bill, to direct (or redirect) the NHS proactively and outside of the existing system of the NHS Mandate, could also increase political influence in NHS decision making and undermine long-term planning, if and when political imperatives might change.

4.4 Schedule 6 of the Bill, would give the Secretary of State new powers to intervene in service reconfigurations, which could leave the Secretary of State more vulnerable to pressure from local politicians to intervene in planned service reconfigurations.

4.5 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.

**4.6 We are calling for clear safeguards and limits on the use of these powers to be included in the Bill and for a reinstatement of the specific duty of the Health Secretary to provide and secure comprehensive healthcare.**

**4.7 We are supportive of amendments proposed by NHS Confederation, the Local Government Association and the Centre for Governance & Scrutiny that would ensure the Secretary of State has regard to, and publishes, clinical advice (from the ICB Medical Director) on a reconfiguration decision; that the Secretary of State must demonstrate a decision has been made in the public interest; and to ensure the relevant Health Overview and Scrutiny Committees have been consulted as part of the decision.**

**4.8 We are also calling for the duty for Secretary of State to lay before parliament any revised version of the NHS Mandate to be strengthened 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.**

**5. Integration and collaboration**

5.1 The BMA supports the principle of integration and has campaigned strongly for a collaborative health and care system, free from competitive models that have built artificial boundaries between services and clinicians. This stance is reflected in the BMA’s report [Caring, Supportive, Collaborative](https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-future/caring-supportive-collaborative-a-future-vision-for-the-nhs): a future vision for the NHS[[31]](#footnote-32), which sets out how to incentivise NHS bodies, including hospitals, GP practices, public health, and community services, to work together as one system.

5.2 A 2018 [survey](https://www.bma.org.uk/media/2035/bma-caring-supportive-collaborative-survey-report-sept-2018.pdf) of 7,887 BMA members showed clear support amongst doctors for a health and care system which breaks down those barriers and brings services and staff together. Within England, 94% of respondents answered that greater collaboration between primary and secondary care will improve patient services, and 93% thought that GPs and hospital doctors should work together more closely.[[32]](#footnote-33)

5.6 The Bill includes a focus on ensuring collaboration and co-operation within the NHS and between it and local authorities, public health, and social care.

5.7 As part of this, the triple aim within the Bill will introduce a duty on all NHS bodies – including ICBs, ICPs, and trusts – to simultaneously pursue:

1. better care for all patients

2. better health and wellbeing for everyone

3. sustainable use of NHS resources

5.8 It is notable that this falls short of the [quadruple aim](https://qualitysafety.bmj.com/content/24/10/608) where the value of a well and motivated workforce is recognised, by “creating the conditions for the healthcare workforce to find joy and meaning in their work and in doing so, improving the experience of providing care.”

We believe the Bill should be amended to include this fourth aim.

*5.9 Foundation Trust powers*

**As the BMA argued in our** [**Caring Supportive Collaborative**](https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-future/caring-supportive-collaborative-a-future-vision-for-the-nhs) **report[[33]](#footnote-34) and our** [**response**](https://www.bma.org.uk/media/3650/bma-consultation-response-integrated-care-systems-england-jan-2021.pdf)**[[34]](#footnote-35) to NHS England’s legislative proposals, we believe that the aim of delivering collective, system-wide plans will be undermined by the continued need for individual organisations to focus on meeting their own individual accountabilities regarding finances.**

5.10 A 2018 BMA survey found that seven in 10 doctors felt organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs, and 60% felt these barriers result in compromised quality and safety of patient care.[[35]](#footnote-36)

5.11 Whilst the Bill grants ICBs the authority to freeze capital spending for specific trusts, to be used if it is determined that a trust is operating outside of the ICS’ wider plans or is not working co-operatively, it does not set out any reduction in existing Foundation Trusts powers or legal duties. Unless the statutory requirements on Foundation Trusts that encourage them to focus on their financial performance above all other priorities are removed, we are concerned these measures will be insufficient to break down the barriers between secondary and primary care.

5.12 A collaborative approach that shifts focus away from these rigid boundaries and responsibilities in favour of working together is needed, not one that retains them.

**6. Social care**

6.1 As highlighted in the Government’s White Paper on the Bill, social care is a central pillar of integration. Although we are beginning to see detail of how the government plans to raise additional funding for social care, there is nothing in the Bill on what is being done to support the sector in the longer term.

6.2 The social care sector has been overstretched, underfunded and understaffed for far too long. The devastating impact[[36]](#footnote-37) of the COVID-19 pandemic on the sector has emphasised the need for well-funded, integrated services and the crucial role social care plays in the care of patients.

6.3 Greater, long-term reform of social care as well as a significant boost in funding is desperately needed.[[37]](#footnote-38)

**7. Public health measures**

7.1 As recognised in the White Paper on the Bill, the COVID-19 pandemic has highlighted the importance of public health. Alongside the population health duty in the “triple aim”, the bill includes measures to bring in new restrictions on the advertising of high fat, salt and sugary foods, as well as powers for Ministers to alter food labelling requirements and moving responsibility for water fluoridation to the Secretary of State.

7.2 Whilst measures to strengthen public health legislation in these areas are positive, most important to delivering strong public healthcare services is ensuring they receive the funding and workforce they so desperately need. This includes both health protection functions to allow us to cope with the impact of COVID-19, deliver the necessary measures to help us be better prepared for future pandemics, tackle persistent health inequalities, and support health promotion and public healthcare services.[[38]](#footnote-39) This must be in addition to ensuring public health doctors have a formalised role within ICSs, including a requirement for an independent registered specialist in public health on the ICB.

**8. Data and technology**

8.1 Clause 79 in the Bill 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.

8.2 The BMA broadly welcomes efforts to improve information standards, but clarity on powers given to the Secretary of State to enforce information standards may need to be established, particularly regarding what this could mean for healthcare providers and staff.

8.3 The changes in the Bill mean providers of health or adult social care to whom the new mandated standards apply will have to comply with them, rather than merely having regard to them. However, the BMA is concerned that this puts the onus on NHS providers to procure software is able to functionality meet standards, rather than on commercial suppliers to the NHS to exclusively sell software that meets standards. This is what currently happens and is problematic as market forces have not driven suppliers to develop software based on open standards. Consequently, NHS providers have only a limited number of suppliers to choose from meaning that in some cases, they feel forced choose software that does not meet standards because it is the best for the job.

8.4 To address this, the BMA believes national standards should be enforced within the commercial sector to ensure that all new software procured by the NHS and eventually social care is interoperable by design. This additionally requires investment in IT infrastructure sufficient to ensure interoperability between all primary and secondary care providers as a matter of urgency.

8.5 The focus on data sharing and technology must be supported by the targeted investment needed to deliver improvements at scale. An urgent audit of the IT estate in the NHS should be carried out with a view to proposing a clear investment standard in legislation, to provide ICSs and their member bodies with the resources they need to work better together.

**9. Medical examiners**

9.1 Part 5 of the Bill would establish a statutory medical examiner system within the NHS in England and Wales, to scrutinise those deaths which do not involve a coroner. While not addressed in the Bill itself, NHS England is also intending to extend medical examiner scrutiny into primary care.[[39]](#footnote-40)

9.2 The operational and financial impacts of extending the medical examiner system into primary care have not been finalised but the BMA is concerned that, in their current form, they will result in a significant increase in unscheduled and urgent workload at a time of extreme GP shortage. Further detail is needed on proposals for bringing the medical examiner system into primary care to ensure it doesn’t result in increased work for already overstretched doctors.

1. BMA [press release](https://www.bma.org.uk/bma-media-centre/wrong-bill-at-the-wrong-time-bma-council-calls-on-mps-to-reject-health-and-care-bill) (July 2021) ‘Wrong bill at the wrong time’ – BMA Council calls on MPs to reject Health and Care Bill [↑](#footnote-ref-2)
2. The BMA estimates that between April and June 2021 there were 3.66m fewer first elective treatments than would normally have been expected, whilst the total waiting sits at a record high 5.45 million – BMA (2021) [Pressure points in the NHS](https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs) [↑](#footnote-ref-3)
3. # The Health Foundation (2020) [Emerging evidence on COVID-19’s impact on mental health and health inequalities](https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-mental-health-and-health)

   [↑](#footnote-ref-4)
4. ONS (2020) Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 May 2020 [↑](#footnote-ref-5)
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8. Joint explanatory briefing from the BMA and other key stakeholders, available at: [www.rcplondon.ac.uk/guidelines-policy/health-and-care-bill-must-be-strengthened-improve-workforce-planning](http://www.rcplondon.ac.uk/guidelines-policy/health-and-care-bill-must-be-strengthened-improve-workforce-planning) [↑](#footnote-ref-9)
9. See page 5-6 of [BMA response to NHS Provider Selection Regime](https://www.bma.org.uk/media/3975/bma-response-to-nhs-provider-selection-regime-consultation-apr21.pdf) consultation for examples of cost and disruption from ISPs winning NHS contracts [↑](#footnote-ref-10)
10. The Financial Times (2017) Virgin Care sues the NHS after losing Surrey services deal [↑](#footnote-ref-11)
11. BMA (2019) Independent Sector Provision in the NHS revisited [↑](#footnote-ref-12)
12. BBC (2016) [Staffordshire £1.2bn cancer contract given green light](https://www.bbc.co.uk/news/uk-england-stoke-staffordshire-38115713) [↑](#footnote-ref-13)
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14. BMA (2020) The role of outsourcing in the Covid-19 response [↑](#footnote-ref-15)
15. BBC News (October 2020) Covid: Test error ‘should never have happened’ – Secretary of State, Matt Hancock [↑](#footnote-ref-16)
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17. NAO (November 2020) Investigation into government procurement during the COVID-19 pandemic [↑](#footnote-ref-18)
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19. [*Medical staffing in England*](http://www.bma.org.uk/staffing), British Medical Association (July 2021) [↑](#footnote-ref-20)
20. [*Future vision for the NHS: all member survey*](https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-future/caring-supportive-collaborative-a-future-vision-for-the-nhs), British Medical Association (2018) [↑](#footnote-ref-21)
21. [*NHS Vacancy Statistics England April 2015 – March 2021 Experimental Statistics*](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey), NHS   
    Digital (June 2021) [↑](#footnote-ref-22)
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23. [*The health care workforce in England: make or break?*](https://www.nuffieldtrust.org.uk/research/the-health-care-workforce-in-england-make-or-break), The Nuffield Trust, Health Foundation and King’s Fund (2018) [↑](#footnote-ref-24)
24. For more information, please see the joint stakeholder briefing here: [www.rcplondon.ac.uk/guidelines-policy/health-and-care-bill-must-be-strengthened-improve-workforce-planning](http://www.rcplondon.ac.uk/guidelines-policy/health-and-care-bill-must-be-strengthened-improve-workforce-planning) [↑](#footnote-ref-25)
25. For example, The Berwick Review (2013) included amongst its ten recommendations that ‘Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS’ needs now and in the future’, and that ‘healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported’. [↑](#footnote-ref-26)
26. For example, the patient demand and staff supply modelling that Health Education England already carries out internally on an ongoing basis. [↑](#footnote-ref-27)
27. 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). [↑](#footnote-ref-28)
28. Joint explanatory briefing from the BMA and other key stakeholders, available at: [www.rcplondon.ac.uk/guidelines-policy/health-and-care-bill-must-be-strengthened-improve-workforce-planning](http://www.rcplondon.ac.uk/guidelines-policy/health-and-care-bill-must-be-strengthened-improve-workforce-planning) [↑](#footnote-ref-29)
29. [↑](#footnote-ref-30)
30. DHSC (July 2021) [Health and Care Bill: Explanatory Notes](https://publications.parliament.uk/pa/bills/cbill/58-02/0140/en/210140en.pdf) [↑](#footnote-ref-31)
31. BMA (2019), Caring, Supportive, Collaborative: a future vision for the NHS [↑](#footnote-ref-32)
32. BMA (2018), Caring, Supportive Collaborative Survey Report [↑](#footnote-ref-33)
33. BMA (2019) Caring, Supportive, Collaborative: a future vision for the NHS [↑](#footnote-ref-34)
34. BMA (2021) BMA response to ‘Integrating care: Next steps to building strong and effective integrated care systems across England’ [↑](#footnote-ref-35)
35. BMA (2018), Caring, Supportive Collaborative Survey Report [↑](#footnote-ref-36)
36. Research by the Health Foundation found that by 19 June 2020, there had been more than 30,500 excess deaths among care home residents in England, 4,500 additional deaths in domiciliary care and social care staff have been around twice as likely to die from Covid-19 than other adults. [↑](#footnote-ref-37)
37. A BMA paper published in 2020 – [Calling for action for social care in England](https://www.bma.org.uk/media/3216/bma-calling-for-action-for-social-care-in-england-report-sept-2020.pdf) – sets out the BMA’s vision for social care [↑](#footnote-ref-38)
38. The BMA is [calling for](https://www.bma.org.uk/media/3854/bma-letter-to-the-chancellor-budget-feb-2021.pdf) an increase of £1bn to the public health grant to return funding to 2015/16 levels, with additional investment year on year increasing to £4.5bn by 2023/24, as well as a commitment to ensuring that the newly formed ‘National Institute for Health Protection’ (NIHP) is adequately resourced to ensure that our response to COVID-19, future pandemics and other hazards is as robust as possible. [↑](#footnote-ref-39)
39. NHSE (June 2021) [System letter: Extending medical examiner scrutiny to non-acute settings](https://www.england.nhs.uk/publication/system-letter-extending-medical-examiner-scrutiny-to-non-acute-settings/) [↑](#footnote-ref-40)