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 welcomes the opportunity to respond to the Health and Social Care Committee’s inquiry into the Health and Care White Paper.
- The proposed legislative changes would deliver reform called for in the NHSE Long Term Plan which established that the NHS needs integration and collaboration over competition.
- The BMA is supportive of this overarching aim and has strongly advocated for the removal of enforced competition and the need for a more collaborative health and care system since the introduction of the Health and Social Care Act 2012. However, there are a number of areas where we believe the Bill must be strengthened to protect the NHS from outsourcing and privatisation and achieve the collaborative health and care system the reforms aim to attain with clinical leadership at its heart.
- It is important to note that the changes are coming at a time when the NHS is experiencing unprecedented pressures. Proposals for reorganisation on such a scale must be given time and space to get right and not be rushed through while doctors are still dealing with the aftereffects of a worldwide pandemic.
- The immediate and forthcoming 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, including extremely concerning increased incidences of child abuse, demand on domestic abuse services, and in particular, a rise in ill mental health and demand for mental health services. It is vital the Government ensure attention is not diverted away from addressing these critical challenges by reorganisations of the NHS.
- Improving integration – The BMA agrees with the aim of improving integration and supports placing ICSs on a statutory level to ensure they are transparent and accountable, as well as the introduction of a duty to collaborate.
- However, these measures on their own are insufficient to delivering better integrated care. We are concerned that integration will be undermined by Foundation Trust statutory requirements that encourage them to focus on their financial performance, hindering efforts to break down barriers between primary and secondary care.
- Integration must be delivered with consent to ensure it works. As such, the independent contractor status of GPs, which plays a vital role in the effective provision of primary care, must also be retained and GPs should not be expected to enter into any arrangements with other providers without agreement.

1 NHSE (2019) The NHS Long Term Plan
2 The BMA estimates that between April and December 2020 there were between 989,000 and 1.3m fewer first elective treatments than would normally have been expected, potentially costing the NHS between £4bn and £5.4bn to work through – BMA (2021) Pressure points in the NHS
3 BBC News (2021) COVID-19: Rise in suspected child abuse cases after lockdown
4 ONS (2020) Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales
5 The Health Foundation (2020) Emerging evidence on COVID-19’s impact on mental health and health inequalities
• Greater clarity is also needed over what the changes will mean in practice to ensure the necessary cultural change and work on the ground to develop integrated ways of working.

• In line with the paper's recognition that "every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met", it is vital that reform of these sectors is joined up.

• **Clinical leadership** – Those working within the system know best where the barriers to greater integration lie. A truly integrated healthcare system therefore must have strong clinical leadership, engagement and involvement at its heart.

• The White Paper states that CCGs will be absorbed into their local ICSs, however there is limited detail on what this will mean at this point. It is vital the positive functions of CCGs, namely a strong clinical voice; local expertise and knowledge; skill and experience in commissioning services; and accountability to clinicians and patients, are not lost in this process.

• Clinicians must be at the heart of decision making in the NHS, including those working in general practice, secondary care, community care and public health. This should include a formalised role for LMCs and LNCs, and public health doctors.⁶

• **Outsourcing and procurement** - We welcome that the White Paper removes Section 75 of the Health and Social Care Act and automatic competitive tendering, which should reduce the costly disruption caused by the present procurement process.

• Whilst this is a step in the right direction, the proposed legislation should be tightened to establish the NHS as the preferred provider of services to protect the NHS from instability and prevent further privatisation.

• It is vital that the new provider regime NHSE is consulting on establishes sufficient scrutiny and transparency over the tendering and awarding of contracts. We have seen the shortcomings of a lack of scrutiny for the public purse during the COVID-19 pandemic.

• **Workforce accountability** - The BMA believes the Government must be accountable for ensuring health and care systems have the workforce required to meet the needs of the population through legislation.

• The White Paper sets out action in this direction via a provision to create a duty for the Secretary of State to present a document to parliament at least every five years which details roles and responsibilities for workforce planning and supply in England.

• We believe it is crucial that this duty is supported by the Government providing an ongoing population-based assessment of the NHS workforce’s ability to meet patient need in England, now and in the future. The Government must then deliver the necessary funding and resource based on this assessment of NHS staffing need.

• **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.

• To avoid increased political influence in NHS decision making and undermining long-term planning if political imperatives change, we would want to see clear safeguards and limits on the use of these powers included in any legislation.

• **Regulation of NHS managers** : The BMA welcomes proposals to move towards the regulation of NHS managers in the future, by clarifying the scope of Section 60 of the Health Act 1999. We called for the regulation of senior NHS managers and leaders in our Caring, Supportive and Collaborative work⁷ to help improve the culture of NHS organisations, staff wellbeing and patient safety.

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⁶ BMA (2019) Briefing: Integrated Care Systems
⁷ BMA (2019), Caring, Supportive, Collaborative: a future vision for the NHS
The BMA supports the principle of integration and has campaigned strongly for a collaborative NHS, 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: a future vision for the NHS*, which sets out how to incentivise NHS bodies, including hospitals, GP practices, public health, and community services, to work together as one system.

A 2018 *survey* of 7,887 BMA members showed clear support amongst doctors for an NHS 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.

The ICS model is an opportunity to deliver better collaboration, but as recognised in the White Paper, the lack of a statutory footing, formalised role and accountability has hindered ICSs to date. Our five *principles for integration* call for ICSs and any related models for organising healthcare to:

- protect the partnership model of general practice and GPs’ independent contractor status
- ensure the pay and conditions of all NHS staff are fully protected
- only be pursued with demonstrable engagement with frontline clinicians and the public, allowing local stakeholders to challenge plans
- be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
- be operated by NHS and publicly accountable bodies, free from competition and privatisation.

On this basis, and examining the White Paper’s proposals against our principles, we feel that while they do include positive steps toward delivering integration, they lack clarity in critical areas.

The BMA supports placing ICSs on a statutory footing, which should help create a structure across the health and care system that enables better integrated care by formalising their roles and enshrining them with powers and accountabilities they presently lack, particularly in respect of managing and distributing NHS funding at a system level.

However, it is important that thorough processes are put in place to deliver integration in practice. Simply making ICSs statutory bodies is not enough, particularly given the proposed changes to CCGs which currently provide an important role in ensuring the NHS is accountable at a local level.

Greater clarity is needed over what the proposed changes will mean in practice and what other measures will be proposed to ensure the necessary cultural change and work on the ground to develop integrated ways of working.

*Duty to collaborate*

It is positive that the White Paper establishes a duty to collaborate on NHS bodies. This is underpinned by measures to improve data sharing and a ‘triple aim’ duty on NHS organisations that would require them to simultaneously pursue the aims of better integrated care for all patients, better health and wellbeing for everyone and sustainable use of NHS resources.

Currently, the proposal are a high-level duty to collaborate, so that organisations aren’t overly or solely focused on their individual responsibilities. However, this duty is simply ‘laid over’ existing responsibilities of individuals to their individual organisations (e.g. trusts) which are not being changed and currently lacks any formal enforcement. The White Paper states that the Secretary of State will have the ability to issue guidance on what the delivery of the duty means in practice ‘in recognition of the fact

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8 BMA (2019), Caring, Supportive, Collaborative: a future vision for the NHS
9 BMA (2018), Caring, Supportive Collaborative Survey Report
10 BMA (2019) Briefing: Integrated Care Systems
that collaboration may look very different across different kinds of services.’ We therefore need to see this further detail to understand whether the duty will achieve a more collaborative and integrated system.

**Statutory duties on individual organisations**

As the BMA argued in our [Caring Supportive Collaborative report](#) and our [response](#) 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.

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.¹³

Unless the statutory requirements on Foundation Trusts that encourage them to focus on their financial performance above all other priorities are removed, the duty to collaborate will be insufficient to break down the barriers between secondary and primary care.

The White Paper does go some way toward addressing this concern, in seeking powers for the Secretary of State to set legally-binding CDEL (Capital Departmental Expenditure Limits) for individual FTs, where they may risk breaching either system or national limits, or be working outside of the wider plans or the interests of their ICS. However, the paper is also clear that FT autonomy will be retained and that FTs and Trusts will continue to hold their functions and duties broadly as established in current legislation. We need a collaborative approach that shifts focus away from these rigid boundaries and responsibilities in favour of working together, not one that retains them.

**Funding arrangements within ICSs**

Greater clarity on how funding arrangements will work within the proposed new statutory ICSs is also necessary, and this must include explicit protections for general practice funding. Whilst we agree there is a need to better coordinate and integrate health services, the BMA does not believe new contractual models, such as the ICP contract are necessary to achieve this. The Secretary of State’s new powers to create new Trusts could simplify the process of creating ICP contracts and we would be concerned if ICP contracts are included as part of the Government’s more detailed proposals, as combining multiple services into one contract risks the potential for non-NHS providers taking over services for entire areas. There is also a risk ICP contracts could undermine the independent contractor status and the partnership model of general practice, which is essential in allowing GPs to advocate independently for what is best for their patients.

The independent contractor status of GPs must remain at the heart of primary care and the NHS, and GPs should not be expected to enter into any arrangements with other providers without agreement.

**Clinical involvement and leadership**

The White Paper states that CCGs will be absorbed into, or ‘become’ part of, their local ICSs. In practice, this appears to mean that much of the existing form and functions of the CCG will be carried over into the newly statutory ICS. However, only limited detail has been provided on this point to date, which raises the question of how system leaders and board members, at both ‘Place’ and ICS level, will be chosen and how leaders will be held accountable. This includes what accountability structures will be in place and, particularly importantly, how local clinicians will be involved in this process. Clarity is urgently

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¹² BMA (2021) BMA response to ‘Integrating care: Next steps to building strong and effective integrated care systems across England’
¹³ BMA (2018), Caring, Supportive Collaborative Survey Report
needed on this issue, to provide reassurance that power will not be concentrated at ICS level – which
remains remote from frontline doctors. This lack of clarity means that the potential changes to CCGs are
a source of significant concern for GPs and GP partners, who fear losing the ability to be involved in local
decision making.

Only limited specifications around ICS governance arrangements are proposed for inclusion in legislation
to enable local leaders flexibility over approach. However, each ICS NHS body will be required to have a
unitary board accountable for NHS spend and performance within the system. This board will be
expected to include, as a minimum, representatives from NHS Trusts, general practice and local
authorities, as well as locally determined representation from other services such as community health
and mental health trusts. There is no further detail on the composition of membership in the White
Paper, and it is important this allows for independent scrutiny.

The ICS Health and Care Partnership Board will bring together the NHS, local government and other
partners to focus on wider issues, such as public health and social care, but membership is not specified
beyond this. Greater clarity is needed over how these two boards will interact and coordinate their
efforts fully and it is vital that clinical leadership and representation is embedded at every level of ICSs,
including roles for LMCs, LNCs and public health doctors.

Whilst it is positive that representatives from NHS Trusts and general practice are required on ICS NHS
bodies, there remains a risk that the proposals outlined could reduce clinical involvement in decision
making if there is any loss of formal clinical leadership enshrined in GP-led CCGs, which currently play an
important role in ensuring the NHS is accountable at local level.

The positive elements of CCGs must be retained in any new model and clarity provided on where their
present responsibilities will be transferred. 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.

There must also be a formalised role for Local Medical Committees (LMCs) and Local Negotiating
Committees (LNCs) and public health doctors to ensure clinicians who know their local healthcare
systems best are able to influence changes.

Reducing bureaucracy

Removal of Section 75

The BMA welcomes the proposed removal of Section 75 and automatic competitive tendering of
contracts, 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, as well as successfully “suing” the NHS for anti-competitive awarding of
contracts or behaviour at a significant cost to the NHS.

A 2018 BMA survey 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. The most common reasons
for concern were the destabilisation of NHS services, the fragmentation of NHS services, value for money
and quality of care.

The removal of enforced competition could avoid the 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, the takeover of NHS contracts by Virgin in recent years,

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15 BBC (2016) Staffordshire £1.2bn cancer contract given green light
such as the £104 million contract to run Lancashire’s 0-19 Healthy Child Programme – 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.\(^\text{16}\)

Removing automatic tendering means it will be easier for current contract holders to retain their contracts and there is likely to be less scope for private sector providers to increase their foothold in the UK market.

**NHS Provider regime**

It is vital that the new provider regime provides for 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.\(^\text{17}\) The impact of this has led to performance issues, for example tests being lost or vital data not shared,\(^\text{18}\) problems in the delivery of high-quality PPE to frontline workers,\(^\text{19}\) and a lack of mechanisms through which to hold companies to account for their handling of these contracts.\(^\text{20}\)

Failure to establish clear and robust commissioning rules could lead to similar mistakes being made in future.

NHSE is currently consulting on proposals for the regime, but they 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 through a formal (and previously notified) process falling short of formal tendering
3. Launch a competitive tendering process for contracts where appropriate

This should see less wasteful competition and greater stability. However, safeguards are needed to ensure proper scrutiny of commissioning. We are also concerned that services will remain open to any qualified provider leaving the option to tender out services in local commissioners’ hands.

The BMA believes the most comprehensive means of protecting the NHS from instability, unnecessary tendering and fragmentation, whilst ensuring adequate scrutiny, is to enshrine the NHS as the preferred provider of services. This would not mean that private or non-NHS providers could no longer hold or be subcontracted to fulfil NHS contracts, but rather would make the NHS the default option for NHS contracts, with commissioners 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.

**Enhancing Public Confidence and Accountability**

*Workforce accountability*  

The BMA believes 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, through legislation. The NHS does not currently have enough staff to cover patient demand, and the number of overall vacancies in England, including clinical and non-clinical roles, at 88,801 FTE unfilled posts (a 7% vacancy rate), is deeply concerning. Nine in 10 (91%) doctors responding to a UK-wide BMA survey\(^\text{21}\) told us that current

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\(^{16}\) The Financial Times (2017) [Virgin Care sues the NHS after losing Surrey services deal](https://www.ft.com/content/155887a5-c22e-11e6-aac8-6f4ad88c8249)  
\(^{17}\) BMA (2020) The role of outsourcing in the Covid-19 response  
\(^{18}\) BBC News (October 2020) Covid: Test error ‘should never have happened’ - Hancock  
\(^{19}\) The Guardian (May 2020) How a decade of privatisation and cuts exposed England to coronavirus  
\(^{20}\) NAO (November 2020) Investigation into government procurement during the COVID-19 pandemic

staffing levels are ‘inadequate to deliver quality patient care’ and most doctors (74%) felt that situation had worsened within the previous year.

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 or reducing their working commitments. Twenty-six per cent of respondents to the BMA’s February 2021 COVID-19 tracker survey said they were now more likely to take early retirement, and 47% reported being more likely to reduce their hours. 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.

In the forthcoming legislation, the BMA believes there is a real opportunity for 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 the NHS. As such, the BMA has consistently lobbied for government accountability for safe staffing of health and care services across the UK.

Numerous reviews have also impressed upon Government the importance of assuring that sufficient staff are available to meet NHS need, now and in the future. 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’.

We welcome the Government’s commitment in the White Paper for the Secretary of State to take accountability for providing clarity on roles and responsibilities regarding workforce planning and supply in England. The White Paper’s proposal of a new reporting duty to this end is important progress to address the existing national accountability gaps regarding workforce planning in England.

Delivering accountability

The BMA believes that the Secretary of State’s duty to report on roles and responsibilities must be complemented by open and transparent modelling on national, population-based demand to inform local and regional recruitment needs.

In order to ensure that levels of staffing meet the needs of patients, now and in the future, it is crucial that the Government provides, openly and transparently, an ongoing assessment of the NHS workforce’s ability to meet patient need in England. This modelling must be publicly available, and presented to parliament, to enable proper scrutiny and debate of what policies and investment are needed to prevent unsafe levels of staffing occurring.

We do not believe the ambition set out in the White Paper to demarcate government accountability for workforce planning will be sufficiently meaningful if there is no benchmark by which to ensure those roles and responsibilities are being delivered. Legislating for who is responsible is the first step, but giving greater structure in the Bill as to what they are responsible for delivering – through a requirement to publish modelling that demonstrates supply versus demand – is a vital accompanying provision that we hope the committee will press for inclusion in the Bill.

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21 Future vision for the NHS: all member survey, British Medical Association (2018)
23 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’.
24 For example, the patient demand and staff supply modelling that Health Education England already carries out internally on an ongoing basis.
**Escalation reporting**

The BMA would like to see formal reporting mechanisms in place, as in Scotland\(^{25}\), that compel providers, commissioners and government to record and periodically publish concerns about unsafe staffing levels raised by doctors, nurses, and other health and care staff. Where low staffing levels persist, a perception held by health and care professionals is that their concerns often fall on deaf ears and are not properly recorded. The issue is also that those in management roles often do not have the power to change the situation, as they either do not have the money to employ additional staff or the power to increase the future pipeline of staff by increasing medical training numbers. This has led to a sense that things cannot and will not change. This is severely detrimental for staff morale, wellbeing and retention, not to mention patient safety. When no improvements appear likely, this breeds moral distress\(^ {26}\) and a sense of futility.

We believe mandating procedures between employers and staff, for reporting incidences of unsafe staffing, would further help us hold to account those responsible for quality and safety. This information would also feed into the ongoing national assessment of staff supply and patient demand.\(^ {27}\)

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

The White Paper proposes increased ICS-level management of the local workforce, which has potential benefits, particularly in allowing for a more co-ordinated and system-wide approach to workforce planning (including recruitment and retention). In setting out the roles and responsibilities for workforce planning and supply in England, we think the Secretary of State should 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.

**Secretary of State powers**

The White Paper proposes increasing the direct power and responsibility the Secretary of State has over the NHS to ensure greater parliamentary, and therefore public, accountability of the health service and its operation. Whilst the BMA supports clear lines of political accountability for the NHS at Secretary of State level, we are concerned that some of the proposals focus more on securing power over the NHS for politicians rather than accountability for its performance.

\(^{25}\) The Health and Care (Staffing) (Scotland) Act 2019

\(^{26}\) BMJ (2020) Covid-19 has amplified moral distress in medicine

\(^{27}\) The Francis Report recognised this back in 2013 recommending that ‘reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon’. It goes on to say that staff should also be ‘entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting’.
A principle example of this is the power to amend or abolish ALBs (Arms Length Bodies) via a statutory instrument following consultation, which while presented as a means of formally merging NHS England and NHS Improvement (along with Monitor and the TDA), would also potentially allow the Secretary of State to disband NHS England itself and without robust parliamentary scrutiny.

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

Increased powers to intervene in local service reconfigurations, whilst enabling reorganisations to occur earlier, could also leave the Secretary of State more vulnerable to pressure from local politicians to intervene in planned service reconfigurations. We would want to see clear safeguards and limits on the use of these powers included in any legislation.

**Additional proposals**

In addition to the White Paper’s three core aims – integration, reducing bureaucracy and improving public confidence and accountability – the paper includes a broad range of additional proposals.

**Social care**

Despite mentioning social care, and highlighting it as a central pillar of integration, there is a lack of detail within the White Paper on what is going to be done to support the sector in the longer term, other than a reference to plans for separate proposals on social care reform to be brought forward towards the end of 2021. The White Paper states that improved accountability through an enhanced assurance framework and data collection will be introduced within social care “allowing us to better understand capacity and risk in the social care system”.

The social care sector has been overstretched, underfunded and understaffed for far too long. The devastating impact 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.

Greater, long-term reform of social care and a significant boost in funding is desperately needed. Whilst the White Paper makes reference to this coming later this year, the Government must not delay long-awaited action. In line with the paper’s recognition that “every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met”, it is vital that reform of these sectors is joined up.

**Regulation of NHS managers**

The BMA welcomes proposals to move towards the regulation of NHS managers in the future, a reform we have called for in our [Caring, Supportive and Collaborative](https://www.bma.org.uk/caring-supportive-collaborative) work. Developing a professional code of conduct and accompanying regulation for NHS managers should help improve the culture of NHS organisations, and there is a wealth of evidence showing a link between staff wellbeing and the quality of patient care. Regulation would help improve accountability throughout every level of NHS organisations for patient outcomes and should help foster collaborative working environments that support staff wellbeing. The legislation lays the foundations for regulation in the future by including

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28 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.


30 BMA (2019), Caring, Supportive, Collaborative: a future vision for the NHS

senior managers and leaders in regulation via clarifying the scope of Section 60 of the Health Act 1999. This marks a positive step in the right direction towards delivering regulation at manager level.

**Public health measures**

As recognised in the White Paper, the COVID-19 pandemic has highlighted the importance of public health. Alongside the population health duty in the “triple aim”, specific plans are set out to give the Secretary of State the authority 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. Most importantly, public health services must receive the funding 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 leave lockdown restrictions and be better prepared for future pandemics, as well as health promotion and public healthcare services.32

**Data and technology**

Elements of the White Paper that focus on data sharing and technology are positive but need to be supported by the targeted investment needed to deliver them at scale. In addition, further detail is required on the scope and scale of changes proposed to NHS Digital’s legal framework and what, if any new powers this would bestow on the Secretary of State to compel NHS organisations to share data.

The response to COVID-19 has seen impressive and rapid transitions to digital working which has made excellent use of available IT and technology.33 It has also, though, seen many doctors left to try and work remotely using out of date hard and software. Digital transformation can also benefit patients in terms of improving self-management of long-term conditions and empowerment over personal care. For example, the rollout of more than 300,000 home pulse oximeters will enable patients to measure their own blood oxygen levels at home.34

An urgent audit of the IT estate in the NHS must 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. Furthermore, responsibility for decision making on IT procurement within ICS’s should be clearly outlined to guarantee greater coordination between healthcare providers. To support this, national standards should be developed and enforced to ensure that all new software procured by the NHS and eventually social care is interoperable. This requires investment in IT infrastructure sufficient to ensure interoperability between all primary and secondary care providers as a matter of urgency.

Significant investment in and reform of diagnostic services is also needed, as highlighted in the NHS Long Term Plan35 and Professor Mike Richards’ subsequent review of diagnostic services for NHSE.36 In particular, the rapid rollout of community hubs, as recommended in the Independent Review, would enable hospital doctors to request investigations in the community, enabling a rapid diagnostic model closer to home for patients. This would also directly support the integration agenda by obviating the need to pass on hospital requests to GPs.

As with all decisions relating to the provision of care, meaningful and comprehensive clinical input should be sought on any IT decisions to ensure they reflect the needs of users. Where investment is needed to

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32 The BMA is calling for 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.
34 DHSC press release (2021) Driving digital in the NHS
bring all members of an ICS up to a common level, it should be provided as a priority to better enable system working to take place.

HSSIB

Finally, regarding safety and quality, the White Paper outlines measures to make the Health Service Safety Investigations Body (HSSIB) a statutory body, to streamline the current regulatory landscape for healthcare professionals, and establish a statutory medical examiner system within the NHS to scrutinise those deaths which do not involve a coroner. The BMA was supportive of the 2019 HSSIB Bill\(^{37}\), which the legislation would take forward, as it should help improve accountability for patient safety at system level and foster a learning culture, as called for in our Caring, Supportive work.\(^{38}\) That report found doctors want to see an NHS with a culture not rooted in blame, but that supports and encourages learning and improvement. The HSSIB’s learning approach to improving safety is therefore particularly welcome and we hope will help foster an environment that supports doctors to provide the best care for their patients.

March 2021

\(^{37}\)BMA Council Chair Dr Chaand Nagpaul (2019) Oral Evidence to the Joint Committee on the draft Health Service Safety Investigations Bill

\(^{38}\)BMA (2019) Caring, Supportive, Collaborative: a future vision for the NHS