Royal College of Physicians

Submission

Health and Social Care Bill 2021-22 | Public Bill Committee

Written evidence submitted by the Royal College of Physicians (HCB62)

About the Royal College of Physicians

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We represent doctors from over 30 medical specialties from cardiology and gastroenterology to infectious disease and respiratory medicine. We provide physicians in the UK and overseas with education, training and support throughout their careers. As an independent body representing over 40,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Summary

- The RCP supports the general direction of travel to put Integrated Care Systems (ICSs) on a statutory footing to facilitate more integrated care. But to deliver on the promise of better joined up care and improved population health, the government must strengthen several areas of the Bill.

- Workforce is, and will be, a key limiting factor in delivering high quality integrated care. The government must use the Health and Care Bill to improve workforce planning. The current duty on the Secretary of State in Clause 33 falls short of what is needed given the scale of the challenge facing the health and care system. The non-legislative approach taken so far to workforce planning has not been sufficient to ensure the system can keep pace with growing demand. **Clause 33 should be strengthened so that every two years the Secretary of State must also publish independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections.**

- Many of the duties that previously existed for Clinical Commissioning Groups (CCGs) have been transferred into this legislation to be placed on Integrated Care Boards (ICBs). Two key transferred duties are the duty to promote research, and the duty to have regard to the need to reduce inequalities. The Health and Care Bill is an opportunity to strengthen both of these duties.

- The pandemic has underlined the health inequalities. **General duty 14Z35 under Clause 19 should be amended to include the requirement to implement systems to identify and monitor inequalities in health between different groups of people within the population of its area.**

- The pandemic has also shown the potential of clinical research in the UK. Following the success of the COVID-19 vaccine, the Bill is an opportunity to prioritise clinical research and cement the UK's place as a global leader

in that space. **The Bill should mandate that ICSs ensure that NHS organisations for which they are responsible conduct and resource clinical research.**

Clause 19 – General Functions of Integrated Care Boards

1. 14Z35: Duties as to reducing inequalities

1.1 Although we welcome the provisions in the bill for Integrated Care Boards (ICBs) to "have regard to the need to reduce inequalities" in access and outcomes, this is no significant change from the duties on CCGs currently in place as a result of previous legislation. Despite the NHS Act 2006 mandating the secretary of state to "have regard to the need to reduce inequalities", the least deprived people can expect to live in good health for two decades more than the most deprived.

1.2 The current duty on CCGs that will be transferred onto ICBs will lead to some action by ICBs to reduce inequalities in access and outcomes. But given the impact of the pandemic on widening health inequalities, it needs to be strengthened. The existing duty will only be effective if systems can identify where local inequalities exist and monitor any changes to them. The data will support targeted service improvement and evaluation. **The 'duties as reducing inequalities' (14Z35) should be amended to include a requirement to for ICBs to set up systems to identify and monitor inequalities in health between different groups of people within the population of its area.**

1.3 But more must be done beyond legislation to reduce health inequalities - access to services and outcomes once someone has become ill are a small part of the picture. Our health is a product of our environment, which is why as convenors of the Inequalities in Health Alliance we have been **calling for a cross-government strategy to reduce health inequalities,** led by and accountable to the prime minister.

2. 14Z40: Duty in respect of research

2.1 Currently, research is not mandatory, and is therefore often seen as an optional extra, rather than a key part of routine patient care. Yet the success of the COVID-19 vaccine trials in Oxford shows what can be achieved when research is prioritised.

2.2 Research benefits patients, improves outcomes and reduces mortality rates. 67% of doctors surveyed by the RCP said dedicated time for research would make them more likely to apply for a role. CQC analysis shows that NHS staff working on sites with higher clinical research activity levels are more likely to recommend their own organisation.

2.3 14Z40 in Clause 19 proposes that ICBs should have a duty to 'promote…research on matters relevant to the health service'. **The RCP, alongside the ABPI Cancer Research UK, Association of Medical Research Charities and others, believe the Bill should mandate that ICSs ensure that NHS organisations for which they are responsible conduct and resource clinical research.**

2.4 An amendment of this kind would support the government's Clinical Research Vision *"to make access and participation in research as easy as possible for everyone across the UK, including rural, diverse and under-served populations".* Addressing staff shortages will be key to harnessing the benefits of research in the NHS, so clinicians have time to conduct clinical research. Government should ensure the NHS health and care workforce has the right workforce capacity in place, including through increasing medical school places and publishing regular independent assessments of future workforce requirements, to reduce pressure and allow more time for staff to take part in research.

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Submission

Clause 33 - Report on assessing and meeting workforce needs

3.1 The past 18 months have very clearly demonstrated that our health and care system has little capacity to deal with emergencies while still delivering routine care. A lack of staff is a key cause of burnout among healthcare workers, and is why the Nightingale hospitals were not used. Even before the pandemic **43% of advertised consultant posts in England and Wales went unfilled due to lack of suitable applicants (2019 RCP census).** Recent data from the RCP shows that **more than a quarter of consultant physicians expect to retire within 3 years**, while the **majority (56%) of medical trainees entering the NHS are interested in working part-time.**

3.2 Clause 33 sets out a new duty for the secretary of state to publish a report once a parliament 'describing the system in place for assessing and meeting the workforce needs of the health service in England'. While this new duty will bring additional clarity on the process of workforce planning, it falls short of what is needed. Workforce is a key limiting factor in delivering high quality integrated care. The bill is a vital opportunity to establish greater accountability and transparency on workforce planning to ensure we can meet patient demand now and in future.

3.3 **Clause 33 should be strengthened so that every two years the Secretary of State must also publish independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections.** This should cover the health, social care and public health workforce. The RCP, alongside the British Medical Association, the Health Foundation, King's Fund, Macmillan Cancer Support, NHS Providers, NHS Confederation, Royal College of Nursing and others have outlined a proposed amendment. This has been circulated to committee members in a joint briefing, and is copied at the end of this document.

3.4 The OBR predicts likely healthcare spending by projecting likely healthcare activity, accounting for demographic changes and other factors including the changing cost of healthcare, the likely impact of technology and the rising prevalence of health conditions. Tying independently verified assessments of future health and care requirements, including staff numbers, to these OBR projections means we will understand what staff numbers will be needed to deliver the work that the OBR estimates we will carry out in future. We recommend these are assessments are done biennially, rather than at least once a parliament, to ensure they are responsive to potential societal shifts.

3.5 **We recommend that these projections of current and future workforce requirements span 5, 10 and 15 year periods.** The pandemic has demonstrated how unforeseen events can have significant impacts that change over time. Building in a range of time periods for projections means workforce planning can be responsive to immediate changes, while considering long-term ongoing changes such as an ageing population and environmental factors. Over the next 20 years, the patient population and the drivers for workforce planning are going to change significantly. For example, the majority (56%) of medical trainees entering the NHS are interested in working part-time which will have significant implications for workforce planning in 10 years, when that cohort begin to qualify as consultants. At the same time, the ONS estimates that by 2040 there will be over 17 million UK residents 65 and above, meaning the cohort of people potentially requiring geriatric care will make up 24% of the population.

3.6 Clause 33 also currently proposes that Health Education England (HEE) and NHS England (NHSE) must assist in the preparation of reports 'if required to do so by the Secretary of State'. **The RCP believes that the Secretary of State must have to consult with HEE and NHSE because of their overview of the system, and that a wider group of bodies including – but not limited to – health and care bodies and employers, medical royal colleges and should also be consulted because of their involvement in workforce planning.**

3.7 Regular workforce projection data will not solve the NHS workforce crisis, but it will give us the best foundations to take long-term decisions about funding, workforce planning, regional shortages and the skill mix to help the system keep up with patient need. It should inform local and regional training and recruitment needs. It should underpin a long-term workforce implementation strategy that sets out how we can improve recruitment and retention to meet the number of health and care professionals we need. HEE's current consultation seeks to develop a shared understanding of the changing drivers for workforce planning. This is welcome, and its findings could be fed into the regular published assessments of the future health and care numbers required, **but the non-legislative approach taken so far to workforce planning has not been sufficient to ensure the system can keep pace with growing demand.** Transparent projections enables the system to plan and policy makers to scrutinise.

3.8 Only describing the system in place for assessing and meeting workforce needs – as the bill currently does – means we still will not know whether we are training enough people now to deliver health and care services in future. Any other organisation would make regular assessments of how many staff it has and how many more it needs. The government must do the same for our health and social care system if we want to keep providing the care that patients need and expect.

Proposed amendment

"After section 1G of the National Health Service Act 2006 (but before the italic heading after it) insert—
1GA Secretary of State's duty to report on workforce systems

(1) The Secretary of State must, at least once every two years, lay a report to parliament describing the system in place for assessing and meeting the workforce needs of the health, social care and public health services in England.

(2) This report must include
  (a) an independently verified assessment of health, social care and public health workforce numbers, current at the time of report publication and the projected supply for the following 5, 10 and 20 years

  (b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care needs of the population for the following 5, 10 and 20 years, consistent with the Office for Budget Responsibility long-term fiscal projections

(3) NHS England and Health Education England must assist in the preparation of a report under this section.

(4) The organisations listed in subsection (3) must consult with health and care employers, providers, trade unions, royal colleges, and any other persons deemed necessary for the preparation of this report, taking full account of workforce intelligence, evidence and plans from local organisations and partners within integrated care boards."

Explanatory notes
This amendment would require published assessments every 2 years of the workforce numbers required to deliver the work that the Office for Budget Responsibility estimates will be carried out in future, based on projected demographic changes, the growing prevalence of certain health conditions and likely impact of technology.

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