Health and Care Bill | House of Lords’ committee stage, January 2022

Summary

• The provisions on workforce planning should be amended to establish greater accountability and transparency on workforce numbers. The RCP is one of almost 90 health and care organisations asking Peers to speak in support of the amendment tabled by Baroness Cumberlege to mandate the secretary of state for health and social care to publish independent assessments of current and future workforce numbers every 2 years. All successful organisations rely on long-term workforce planning to meet demand - the NHS and social care are no exception. A dedicated briefing on this amendment is available on the RCP website, along with the full list of supporters.

• The triple aim should be amended to explicitly reference health inequalities. The pandemic has exposed and exacerbated health inequalities that have long existed in our society. Amending the triple aim to include health inequalities would mean NHS bodies have to take account of health inequalities when making decisions, sending a clear signal about this being a priority at all levels.

• NHS England should be given a statutory duty to publish guidance for NHS bodies on collecting, analysing, reporting and publishing data on factors or indicators relevant to health inequalities.

• The ‘duties as reducing inequalities’ should also be amended to include a requirement for ICBs to set up systems to identify and monitor inequalities in health between different groups of people within the population of its area. The existing 14235 duty will only be effective if systems can identify where local inequalities exist and monitor any changes to them. The data collected will support targeted service improvement and evaluation.

• Following the success of the COVID-19 vaccine, the bill is also an opportunity to prioritise clinical research and cement the UK’s place as a global leader. The current duty for ICBs to promote research should be strengthened so that the bodies for which ICBs are responsible have a duty to ‘conduct’ research. We are asking Peers to speak in support of the amendment tabled by Lord Sharkey, Lord Kakkar and Lord Patel on conducting research.

Health and care workforce

Workforce is one of the biggest limiting factors for the government’s ambitions on health and care and sustainably delivering NHS care in the long-term. A lack of staff is a key cause of burnout among healthcare workers, and is why the Nightingale hospitals were not used. According to the most recent RCP Census, last year 48% of advertised consultant posts went unfilled across the UK. This is the highest proportion of unfilled posts in almost a decade – a 33% increase in the proportion of unfilled consultant posts since 2013. Posts mostly went unfilled due to a lack of applicants (49%), followed by a lack of suitable applicants (34%) or candidates withdrawing (17%). We simply do not have enough doctors to fill the number of consultant posts advertised. With a record 5.98 million people now on waiting lists for treatment, the recent funding allocated by the government to bring down waiting lists is key. But it can only go so far because we have too few staff to undertake additional checks, scans and appointments. The bill is a vital opportunity to strengthen workforce planning so we understand how many staff will be required now and in future to meet patient demand.
Clause 35 places a duty on the Secretary of State to publish a report describing the system in place for assessing and meeting workforce needs. While this will bring clarity to workforce planning, it does not go far enough given the scale of the challenge facing the health and care workforce.

Throughout the passage of the Health and Care Bill so far, the RCP has argued that the bill should be strengthened to improve transparency and accountability on workforce planning. The RCP is one of almost 90 health and care organisations calling for the bill to be amended to mandate independent assessments of current and future workforce numbers to be published regularly. We are encouraging peers to speak in support of the amendment tabled by Baroness Cumberlege, Lord Hunt of King’s Heath, Baroness Brinton and Lord Stevens of Birmingham when debated in committee which would mandate these assessments.

The coalition of almost 90 health organisations represents service users and patients, doctors, nurses, and health and care employers and providers in the NHS and the voluntary sector. This broad spectrum of the health and care sector has issued a set of principles it believes any amendment or clause tabled on workforce needs to meet to close the data gap on how many staff we need and improve the current system on workforce planning.

Government has so far dismissed amendments on workforce projections on the basis that ‘Framework 15’, commissioned by the Department of Health and Social Care (DHSC), will look at the drivers of workforce supply and demand and ‘help to ensure’ we have the right numbers of staff. But Framework 15 was first published in 2014, last updated in 2017, and yet there is no agreed, publicly available assessment of workforce numbers now nor into the future. The findings of the Framework 15 consultation could be fed into the assessments the amendment asks for so that they take account of changing drivers, but we do not believe that the Framework alone will not solve the ongoing data gap on health and care staffing numbers to inform strategic workforce planning decisions at all levels.

Integrated Care Boards (ICBs) will be given responsibility – set out in draft guidance – to develop system wide plans to address current and future workforce supply locally and to undertake supply/demand planning based on population health needs. A local only approach would not increase government accountability or transparency on workforce planning, and would fail to ensure a collective understanding of current and future workforce numbers across health and care. ICBs also do not have access to the levers that government does, such being able to increase training places or change immigration policies, that are required to take action to fill current and future staffing gaps. Locally driven assessments have a place but should come alongside a national picture and direction of travel.

All successful organisations rely on long-term workforce planning to ensure they can meet demand and the NHS and social care system are no exception. The non-legislative approach that has been taken so far has not worked. The Prime Minister said in his session with the liaison committee in 2021 that he would ‘look at’ the amendment, and the Secretary of State for Health and Social Care told the health and social care select committee in November 2021 that ‘we need a much longer-term approach’ to workforce planning. We hope progress will be made on including regular workforce projections in the bill given the strong cross-party and sector support.

It takes time to train a doctor or a nurse, so we need to take action now to feel the benefit in future. The ONS estimates that by 2040 the cohort of over 65s potentially requiring geriatric care will make up 24% of the population. At the same time, there is a growing trend for part-time working, with a July survey of RCP members showing that the majority (56%) of medical trainees entering the NHS are interested in working part-time. This will have significant implications for workforce planning in 10 years when they begin to qualify as consultants. It’s also estimated that over the next decade 41% of UK consultants will retire (taking average retirement age of 62.4 years).

For more information, please contact Louise Forsyth, Public Affairs Manager | louise.forsyth@rcp.ac.uk
Regular, independent public workforce projection data will not solve the workforce crisis. But having a collective national picture of the health and care staff numbers needed now and in future to meet demand will provide the strongest foundations to take long-term strategic long-term decisions about funding, regional and specialty shortages, skill mix and underpin a long-term workforce strategy.

**Reducing health inequalities**

The pandemic has exposed and exacerbated health inequalities that have long existed in our society. Research from the Health Foundation estimates that working age adults in England’s poorest areas were almost four times more likely to die from COVID-19 than those in the wealthiest areas.

The provisions in the bill to “have regard to the need to reduce inequalities” in access and outcomes are no significant change from the existing duties on CCGs – and not enough progress has been made on tackling health inequalities under those duties. 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. The bill is an opportunity to make it a much higher priority in NHS decision-making.

The RCP supports calls for the triple aim to be amended so that it explicitly includes health inequalities. The triple aim as currently drafted means NHS England, ICBs and other NHS organisations will have to consider the effects of their decisions on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. These shared aims will provide a framework for decision making. Amending the triple aim to include health inequalities would mean NHS bodies have to take account of health inequalities when making decisions, sending a clear signal about this being a priority at all levels. The government has so far said that addressing inequalities is implicit in the first aspect of the triple aim where bodies have to consider ‘the effects of their decisions on the health and wellbeing of the population’. If reducing inequalities is a priority it should be made explicit in the triple aim.

The ‘duties as reducing inequalities’ under ‘14Z35’ to reduce health inequalities in access and outcomes for patients will only be effective if systems can identify where local inequalities exist and monitor any changes to them. The RCP would welcome Peers speaking in support of the amendment tabled by Lord Patel, Baroness Tyler, Lord Kakkar and the Lord Bishop of London for this duty to be amended to include a requirement for ICBs to set up systems to identify and monitor inequalities in health between different groups of people within the population of its area. The data collected will support targeted service improvement and evaluation.

The RCP also supports calls for NHS England to be given a statutory duty to publish guidance for NHS bodies on collecting, analysing, reporting and publishing data on factors or indicators relevant to health inequalities. Consistency on what data NHS bodies should collect and how it should be analysed and reported will improve understanding of health inequalities both at a local and national level. We hope Peers will support the amendment tabled by Baroness Thornton, Lord Patel and Baroness Walmsley.

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 the RCP as convenor of the Inequalities in Health Alliance has been calling for a cross-government strategy to reduce health inequalities. To improve health, we need to tackle employment and unemployment, low pay, poor housing, inadequate education, air pollution, unhealthy food, smoking, alcohol, homelessness and more.

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14Z40: Duty in respect of research

The success of the COVID-19 vaccine trials in Oxford shows what can be achieved when research is prioritised. Research benefits patients, improves outcomes and reduces mortality rates. Research also benefits clinicians and the NHS: 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. Currently, research is not mandatory, and is therefore often seen as an optional extra, rather than a key part of routine patient care.

The RCP, alongside the ABPI, Cancer Research UK, Association of Medical Research Charities and others, is calling for the bill to mandate that ICBs ensure that the NHS organisations for which they are responsible conduct clinical research. We hope Peers will consider speaking in support of the amendment tabled by Lord Sharkey, Lord Kakkar, Baroness Blackwood and Lord Patel.

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