

Summary report



**Caring, supportive,  
collaborative**

Doctors' vision for change  
in the NHS

Caring, supportive,  
collaborative



**a future  
vision**  
for the NHS



**What needs to change to  
improve care for patients  
and the working lives of  
doctors in the NHS?**

For more than a year the BMA has sought to answer this question. As the only medical organisation that represents all doctors and medical students in the UK, we can draw on the experience of over 150,000 members working in the UK's health services to find the answer.

Across the UK health services are struggling to cope after years of underinvestment, leaving doctors treating patients in an increasingly unsafe, unsupportive environment. One in which a persistent culture of fear and blame stifles learning, contributing to a vicious cycle of low morale and poor rates of recruitment and retention. All of this has a knock-on impact on patients and their care.

With nine in 10 doctors saying that safe staffing levels are not adequate and that they are fearful that systemic pressures and a lack of capacity will cause them to make an error, radical change is needed. This report sets out for governments, MPs, commissioners and those in leadership positions across the NHS our vision for change.



### A supportive culture

where doctors work in an environment that supports their wellbeing, promotes learning and encourages the development of systems to improve safety and quality of care – and where diversity is celebrated and there is equal opportunity and reward



### A valued workforce

where everyone who works in the NHS feels part of a properly resourced team working in harmony and with the right mix of skills to do the job



### A collaborative structure

where doctors and all NHS staff are empowered to work together across traditional organisational divides, so that patients receive seamless care

**Underpinned by adequate funding and terms and conditions for doctors to relieve system pressures**

# A system under pressure

## Any vision for the future of the NHS must consider the immense pressures facing health services across the UK

Doctors work in an NHS that is underfunded. It has insufficient medical staff, beds and vital equipment, as well as buildings that are often not fit for purpose. 78% of doctors have told us that this lack of resources is affecting the quality of patient care.

We are also seeing this in the rapid deterioration of performance levels where missed A&E waiting times across the UK is now considered 'normal', where 4.5m patients are waiting for elective treatment in England alone – the highest on record – and where the pressures on primary care are leading to waiting times of more than two weeks for a routine appointment.

Compared with similar EU countries the UK is falling behind in these key measures, and the gap is widening.

	UK	Average for similar EU countries <sup>a</sup>	UK position (out of 11)
Funding as % of GDP	9.8	10.1	8th
Doctors (headcount) per 1,000 people	2.8	3.8	11th
Hospital beds per 1,000 people	2.5	4.5	10th
MRI scanners per million people	7.2	19.3	9th (out of 9) <sup>b</sup>

To reverse this, urgent action is needed by **Government** to:

- address the funding gap by increasing spending by at least 4.1% per year to put the NHS on a sustainable long-term footing.<sup>1</sup> This equates to an extra £9.5bn across the UK by 2023/24
- invest in the NHS workforce – with the NHS currently short of over 100,000 staff<sup>2</sup> including at least 10,000 doctors. Page 10 of this report sets out steps we can take now, including ensuring safe medical staffing levels with accountability enshrined in legislation
- reverse recent cuts to beds, equipment and buildings – it's estimated that the NHS requires more than 10,000 beds to cope with rising demand. Investment is urgently needed to maintain hospital buildings and upgrade facilities in primary care
- boost funding for primary care, public health and social care so we can prevent ill health and care for people in or close to their own homes
- act swiftly to change NHS pension taxation rules that financially penalise senior doctors, ending the current situation in which experienced clinicians who decide to work extra hours are being hit with tax bills greater than the value of the hours worked.

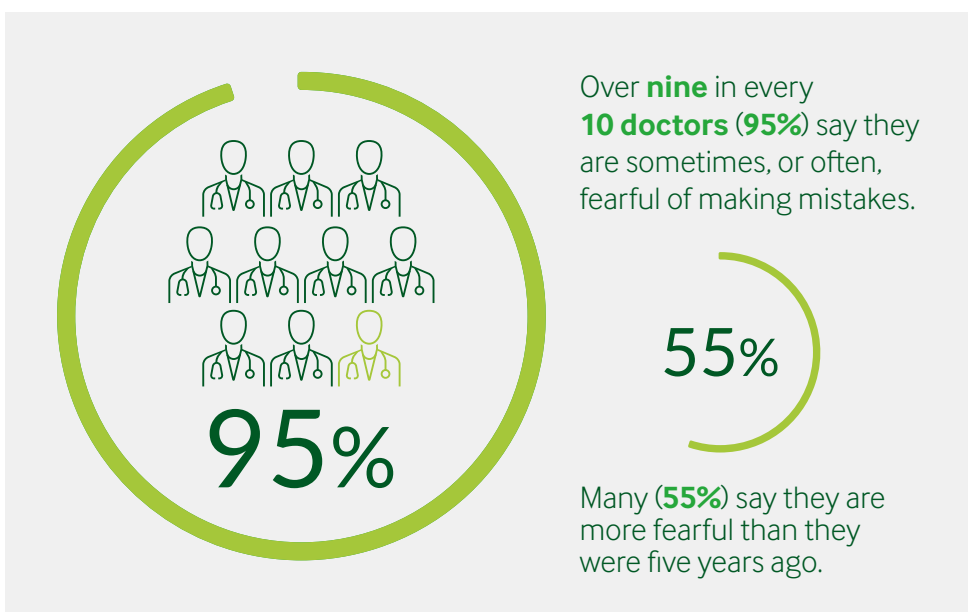
a Similar EU countries measured by GDP per capita. Excluding the outliers of Luxembourg and Ireland the top 10 leading EU countries are Austria, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Sweden and Spain.

b Data only available for nine of the 11 countries

## A supportive culture

NHS culture needs to change. Doctors want to care for patients in an environment that supports their wellbeing. One that promotes learning rather than blame, encourages the development of systems to improve safety and quality of care, and where diversity is celebrated and there is equal opportunity and reward.

### A learning culture where staff feel able to raise concerns without fear or blame, knowing they will be acted on to improve patient care



**Knaresborough GP Cath Dixon at a BMA member event** 'There's a big blame culture... unfortunately, in medicine, lots of things don't go to plan and that's not because anyone hasn't tried. As doctors, we are committed to trying to do our best for our patients.'

Learning from errors and improving quality can't happen unless staff feel safe to report errors and raise concerns. There have been steps to encourage greater openness and transparency in the NHS, such as the introduction of an organisational duty of candour, reporting systems for patient safety and organisational roles to support staff in speaking up (for example, the freedom to speak up guardians in England and whistleblowing champions in Scotland), but much more needs to be done.

- **Employer organisations** must:
  - acknowledge the role of system and human factors and consider these as part of any investigation
  - recognise the impact of a patient safety incident on staff and provide them with support
  - give sufficient protected time for learning and development, including in the GP contract, so doctors can develop professionally and support quality and safety improvements throughout their careers
  - adopt the NHS Resolution 'Just and Learning Culture Charter'<sup>3</sup> (England only).



- **Leaders in NHS organisations across the UK** must:
  - demonstrate openness by sharing learning from past incidents and where possible involve patients and carers too
  - share positive patient feedback to reinforce learning from positive behaviours and outcomes.

### Case study: a just and learning culture at Mersey Care<sup>4</sup>

Mersey Care is an NHS organisation that has realised learning cannot happen from mistakes if employees are too afraid to report them. Its work to embrace 'a just and learning culture' has centred on the desire to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. In the case of an adverse event it instinctively asks what was responsible, not who was responsible. It is not finger pointing and it is not blame seeking. But it is also not an uncritically tolerant culture where anything goes; that would be as inexcusable as a blame culture.

## A focus on improving patient care, not hitting financial or political targets

It should be patients – not numbers – which count, as Robert Francis QC said when introducing his report into failings at Mid-Staffordshire. He found that the organisation had placed a high priority on the achievement of targets.



Targets, directives or interventions need to consider the challenging and complex environment in which staff work and be effective in supporting them to maintain good quality care or deliver improvements. Reorganising the same resources to try to achieve more – and more challenging – targets yield diminishing benefits over time. When organisations are already struggling, more support is needed so they can reach ambitious goals.

The **Government** should:

- encourage all NHS bodies to adopt the 'quadruple aim' (see box below), including a commitment to 'enrich the wellbeing, capability and engagement' of their staff.

- **Employer organisations** should:
  - prioritise developing better metrics on quality of care, staff engagement and culture and encourage more of a focus on them
  - abandon crude targets and replace them with quality assessments that recognise the context in which local providers are working.

### The quadruple aim

The 2018 Parliamentary Review of Health and Social Care in Wales<sup>5</sup> recommended that the NHS in Wales adopt four aims to help it tackle the challenges of providing care to a growing and ageing population. These are based on the internationally recognised 'triple aim' first developed by the US Institute for Healthcare Improvement,<sup>6</sup> with one important addition: a fourth dimension is needed to reflect the growing consensus that the wellbeing and engagement of staff is vital to delivering safe care. The four aims are to:

1. improve population health and wellbeing by focusing on prevention
2. improve the experience and quality of care for individuals and families
3. increase the value achieved from funding health and care through improvement, innovation, use of best practice, and eliminating waste
4. enrich the wellbeing, capability and engagement of the health and social care workforce.

## A shift in culture to recognise that staff wellbeing is essential to good patient care

There is a wealth of evidence showing a link between staff wellbeing and the quality of patient care. It is critical in an NHS under pressure that this is recognised at every level of NHS organisations. Staff must be given the time to create strong and supportive working relationships with colleagues, which are key to ensuring staff wellbeing.

In addition, NHS bodies need to ensure that the physical environment supports staff wellbeing, eg access to rest facilities.

Many doctors say they struggle to find the time to meet with colleagues away from immediate work pressures and patient-facing environments, and their working relationships are more distant as a result.

- **Employer organisations** should:
  - create protected time for staff to meet and share experiences across hierarchies and professional boundaries, for example, through schwartz rounds.
- The **Government** should:
  - develop a professional code of conduct for NHS managers, strengthening compassionate and inclusive leadership (with accompanying regulation – see below).

### Schwartz rounds

Schwartz Rounds provide a unique forum for clinical and non-clinical healthcare staff to come together to reflect on the emotional and psychological impact of their work. They benefit participants through the process of sharing and reflecting on experiences increasing empathy for patients and each other, reducing feelings of isolation and improving communication with colleagues. People who attend rounds are less stressed and in better psychological health than their non-attending colleagues. It can create ripple effects in the organisation, reducing isolation, improving teamwork and improving communication.

## A compassionate working environment in which staff treat each other with respect

Bullying and harassment are endemic in some parts of the profession and NHS with serious consequences for patient care and safety. In workplaces where bullying is common, communication and team work suffer; staff are afraid to raise legitimate concerns and wellbeing is affected.

There needs to be greater clarity about values and expected behaviours, and more encouragement, support and multiple routes for raising concerns. A greater focus on early intervention should address unprofessional behaviour, and help staff and managers intervene effectively.

**Two-thirds** of doctors say that bullying and harassment is a problem in their main place of work because people are under pressure.



**Three-fifths** say such behaviour is difficult to challenge as it comes from the top.

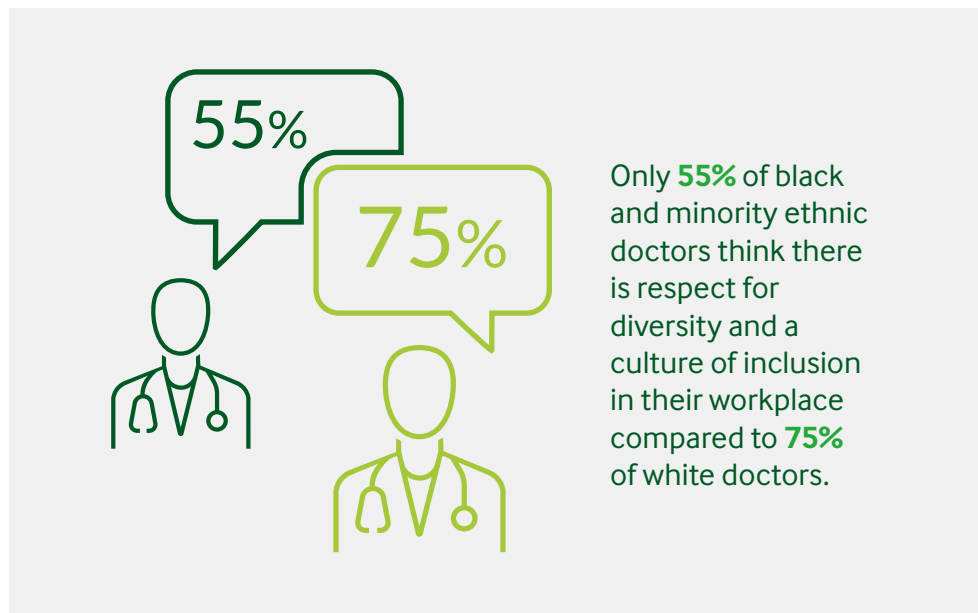
- The **Government/employer organisations** should set clear expectations from the very top of the NHS that bullying and harassment are unacceptable, and ensure all NHS bodies take steps to:
  - be clear about standards of expected behaviour, and when things like performance management or banter risk crossing the line into bullying and harassment
  - provide designated contacts within the organisation that people can speak to informally and confidentially if they have any concerns and use anonymous surveys and other feedback sources to gather information
  - improve how formal bullying and harassment complaints are handled in practice, ensuring sufficient resourcing and independence of investigations, and annual reports on the nature of complaints, responses, and outcomes
  - improve training and support for those with managerial and supervisory responsibilities to enable more effective early intervention
  - embed human factors in medical selection, education, training and work practices.
- **Regulators** of NHS organisations must take robust and proactive steps to ensure workplaces are fully inclusive and free from a culture of bullying, undermining and harassment.

**East of England GP Health Service Clinical Lead Lucy Henshall at a BMA member event:** 'Somewhere along the line, not just our profession but the NHS itself has forgotten kindness, civility, and good behaviours toward each other... my call to action to my colleagues is: look sideways, look across the room in your workplace, take care of your colleagues because what you give you will get back, in spades.'



## An NHS where everyone feels included, where diversity is celebrated and there is equality of opportunity and reward

The medical profession and wider NHS workforce are increasingly diverse, but the experiences of staff and opportunities for development are not equal. Environments that are diverse and inclusive have greater professional satisfaction and better outcomes for patients. The NHS needs to take action to ensure these benefits are fully realised.



### Equality matters

The BMA's recently announced programme of work – *Equality matters* – promotes a workplace culture, both within the BMA and the NHS, where equality, inclusivity and respect really matter, and where any signs of discrimination are directly challenged.

- The **Government** should radically improve the way the NHS supports doctors of all backgrounds by:
  - making inclusivity a core competency for NHS leaders, something they are expected to demonstrate and be held accountable for
  - developing and promoting more flexible career pathways, improving support for less than full-time working options, and for those returning to practice after career breaks
  - developing effective training for all doctors, medical students and non-medical managers on the value of diverse teams and the importance of inclusion
  - providing proper inductions to doctors new to the UK or those in isolated roles and ensuring there is ongoing accessible support
  - making peer support and mentoring routinely available to all medical students and doctors, ensuring those from minority or under-represented groups have access to appropriate mentors who can support them through particular challenges.

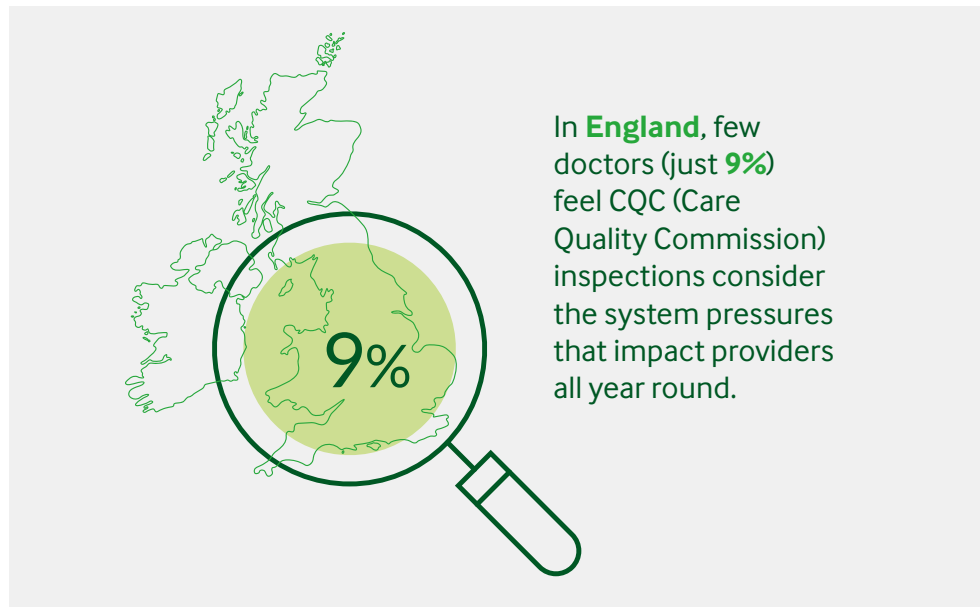
## Regulation needs to encourage improvement and support a learning culture

The current approach to regulation in the NHS – both of individual doctors and the organisations they work in – contributes to the culture of blame that many doctors have said negatively affects patient care and in particular the CQC system in England.

The GMC (General Medical Council) has acknowledged<sup>7</sup> that its fitness-to-practise processes are slow, inflexible and heavy-handed. Regulatory reform is necessary to deliver improvements, but more could be done to reduce the burden and fear that comes with being regulated.

- The **GMC** should continue its programme of work to ensure its processes and procedures are fair, timely, and proportionate and streamlined to reduce the personal impact of investigations on doctors. It must also fulfil its commitment that all GMC fitness to practise decision makers, case examiners and clinical experts will receive human factors training so that the role systems and workplaces play in events is fully considered
- The **Government** should make amendments to the Medical Act to ensure professional regulators have the flexibility they need to adapt their approach to the needs of the profession they regulate.

The regulation of employer organisations also needs to change. They must reduce the time doctors and other staff have to spend away from patient care, and place more emphasis on staff wellbeing as a vital ingredient in providing good care. Current approaches focus too narrowly on the performance of individual organisations, without sufficiently accounting for the impact of problems in the wider health system.



- All **systems regulators** should ensure employing organisations:
  - put in place measures that support the culture change necessary to encourage staff wellbeing
  - demonstrate that doctors are aware of, and feel comfortable in using, mechanisms for raising concerns (eg exception reporting and safe working guardians in England)
  - respond to errors in a culture of learning rather than blame.

- In England, the **Government and CQC** should:
  - fully reform the CQC’s approach to regulation and inspection, and remove aggregate ratings
  - overhaul the bureaucratic nature of the CQC’s registration system, which unnecessarily duplicates much of the work GP practices are required to report to NHS England – regulatory registration requirements and processes must be tailored to the specific services being delivered.

It is vital that medical error is not criminalised – to do so risks strongly discouraging doctors, teams and the organisations they work in from identifying and learning from mistakes to continuously improve patient safety. Current proposals in Northern Ireland to introduce a statutory duty of candour with criminal sanctions are particularly worrying and go against developments elsewhere in the UK. Given the importance of their role, individuals working in senior management positions should also be subject to appropriate scrutiny.

- All **governments** should:
  - fully implement the recommendations of the Williams and Hamilton reviews<sup>8</sup> into GNM (gross negligence manslaughter) and culpable homicide in healthcare
  - resist any attempts to introduce an individual duty of candour with criminal sanctions as proposed in Northern Ireland and establish a national guardians office to lead on culture change
  - introduce a regulatory mechanism for holding senior non-clinical managers to account.

## A valued workforce

The NHS is facing a workforce crisis. With at least 10,000 medical vacancies,<sup>c</sup> there are currently too few doctors to meet the growing needs of patients. Doctors want to work in an NHS with safe staffing levels, where everyone feels part of a properly resourced team, working in harmony with the right mix of skills and tools to do the job. Yet there are not enough doctors to look after patients safely. Of the European OECD countries only Poland and Slovenia have fewer doctors per head of population than the UK.

### No one should have to work in a consistently under-staffed and under-resourced environment



To ensure safe medical staffing levels, we need more doctors. This means doing a better job at retaining current medical staff and investing in more medical schools places. By precisely how much depends on comprehensive workforce planning and accurate real-time data. We must also create an immigration system and an environment that encourages doctors from across the world to come and work in our NHS.

Where staffing levels have fallen below a level that they believe is safe, it is important that doctors can call this out. There must also be clear lines of accountability for staffing levels in NHS organisations right up to health ministers across the UK – this must be enshrined in safe staffing legislation, following Scotland's lead.

Doctors' scarce time must also be used more effectively. Too much time is wasted on unnecessary bureaucracy, complying with targets or regulatory requirements. Compounding this problem is a not fit-for-purpose IT infrastructure which is a significant source of added workload. Investing in better IT alone could free up over 8.15m medical hours per week, equating to 4,870 FTE (full-time equivalent) doctors working 37.5 hours a week over the calendar year.

<sup>c</sup> [NHS Digital data.](#)



Nearly six in every 10 doctors (**56%**) report that current IT infrastructure significantly increases their day-to-day workload, with over a quarter (**27%**) reporting more than four hours per week lost due to inefficient hardware/ systems (BMA IT survey).

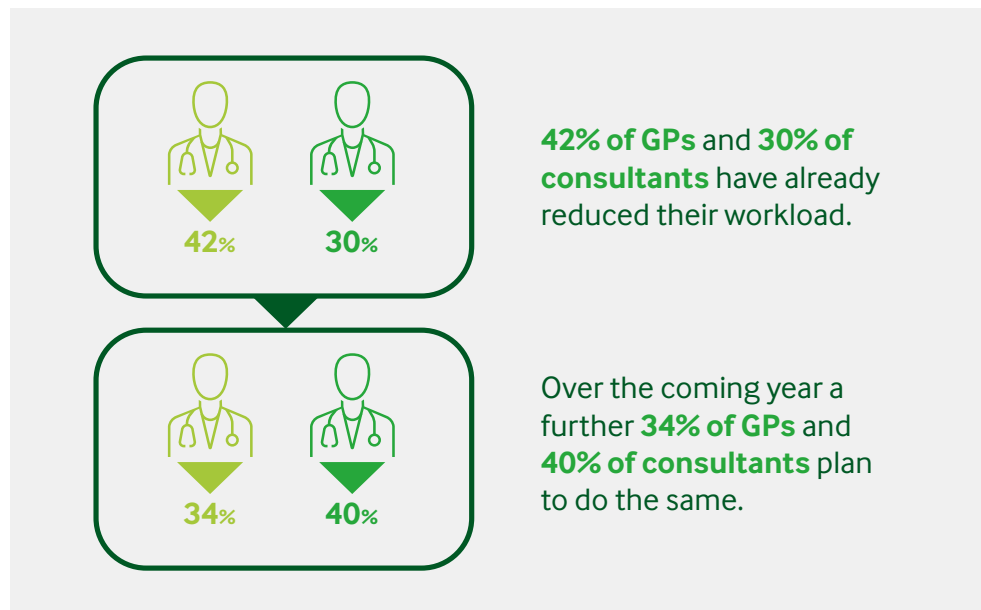
- The **Government** must:
  - invest in further expansion of medical school places in line with need based on comprehensive workforce planning
  - create an immigration system and promote an environment that encourages doctors from across the world to come and work in the NHS
  - invest in better IT infrastructure and modern technology that reduces doctors' workload
  - create mechanisms for doctors across the UK to speak out when staffing has fallen below safe levels
  - create clear lines of accountability for safe staffing levels through safe staffing legislation.
- **Healthcare regulators** should ensure all NHS organisations provide accurate pictures of staffing needs so that issues can be addressed quickly and effectively.

### Case study: how legislation is being used to tackle unsafe staffing

On 2 May 2019, the Scottish Parliament passed the Health and Care (Staffing) (Scotland) Bill, which places a legal requirement on NHS boards and care services in Scotland 'to ensure appropriate numbers of suitably trained staff are in place, irrespective of where care is received'. The legislation includes a clear requirement for a system of escalation of concern for any member of staff who is working in what they believe are unsafe levels of staffing; and risk monitoring. The Act includes a duty for boards to have real-time staffing assessment in place, and a duty to have risk escalation processes in place.

## Doctors feeling valued, supported and fairly rewarded throughout their working lives

Damaging tax legislation including the annual allowance and lifetime allowance rules are leading to a rise in the number of doctors reducing their hours or retiring early. The workforce crisis is exacerbated as experienced clinicians are being forced to reduce their working commitments in the face of significant and often unexpected charges on their deemed pension growth.



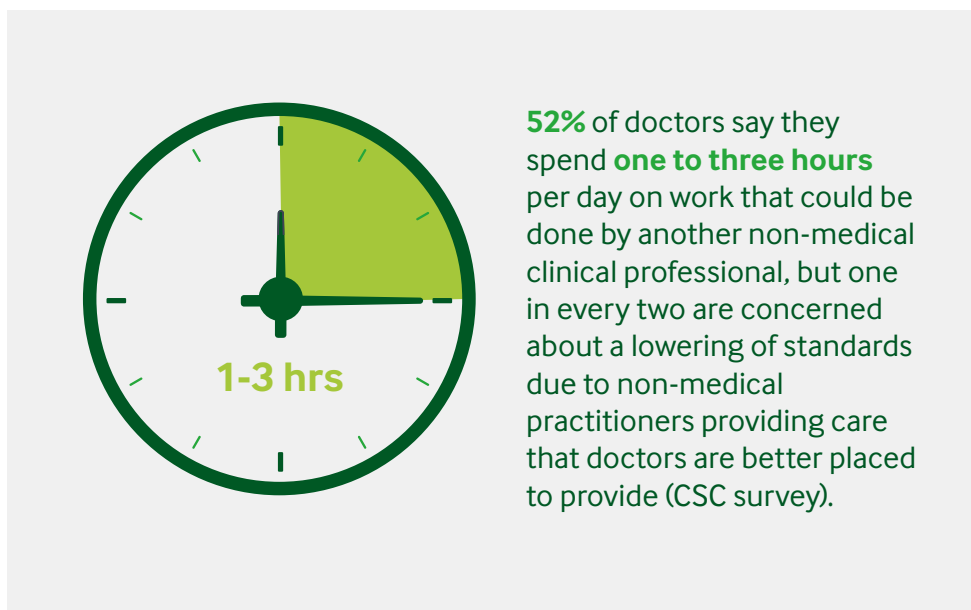
Action is also needed to ensure doctors receive fair pay for the work they do. A decade of austerity and pay caps in the public sector have eroded doctors' pay levels by as much as 30%.

- The **Government** must:
  - act swiftly to change NHS pension taxation rules that financially penalise senior doctors ending the current situation in which experienced clinicians who decide to work extra hours are being hit with tax bills greater than the value of the hours worked. This means wider pension taxation reform, including urgent scrapping of the tapered annual allowance
  - take urgent action to address the real terms pay cut most doctors are experiencing.

## Using doctors' skills in the most effective way, as part of multidisciplinary teams

Doctors increasingly work as part of multidisciplinary teams with different clinical and non-clinical professionals. Yet this could be done by other healthcare professionals and staff. A huge amount of doctors' time is taken up by administrative tasks, including TTOs, filling in forms, dealing with correspondence, writing discharge summaries and completing mandatory coding and compliance sections on computer systems. Given the current medical workforce shortage and that increasing the numbers of doctors will take time, other staff taking on appropriate work from doctors could allow doctors to have more time to provide safe, quality care.





New clinical roles must not jeopardise the training of future doctors. Being employed in permanent roles within teams, MAPs (medical associate professionals) naturally over time earn the confidence of senior doctors and are often chosen over junior doctors to assist on work that would be essential experience for a doctor in training. All departments and care settings must take measures to balance the service provision benefits of MAPs, such as PAs (physician associates), with the training priorities of doctors in training.

Every member of the multidisciplinary team should have a clear understanding of their colleagues' scope of practice, lines of accountability and supervision responsibilities. The public and other clinicians need a better understanding of the roles that MAPs perform.

All clinicians must be regulated appropriately for the tasks they perform. PAs and AAs (anaesthesia assistants) are now set to be regulated by the GMC, but other MAPs are still to be regulated. To ensure new clinical roles can genuinely take the pressure off doctors, they must also be awarded prescribing rights where appropriate.



- The **Government and regulators** must:
  - set clear definitions and lines of responsibility for new clinical roles, so they can be introduced in a way that relieves workload and allows doctors to focus on tasks where their expertise is most needed
  - ensure all MAPs, not just PAs and AAs, are regulated and awarded prescribing rights where appropriate to ensure they can work safely as important contributors to their clinical teams
  - introduce non-clinical roles such as doctors' assistants and medical scribes to help reduce doctors' workload and allow doctors to focus on tasks where their expertise is most needed.

### Case study: can doctors' assistants free up time for secondary care?

In East Sussex, a trial is under way in secondary care for a new doctors' assistant role designed to support junior doctors clinical and administrative tasks. The role is being trialled in direct response to the fact that junior doctors spend 40-70% of their time on administrative tasks. In the role, tasks such as discharge summaries, patient notes and booking follow-up clinics sit alongside basic clinical tasks, such as phlebotomy, intravenous cannulation, ECG recording and dementia screening.

## A collaborative structure

Despite a growing need for care to be integrated around the needs of patients, doctors are prevented from providing joined-up care by bureaucratic barriers, communication gaps and competing organisational priorities.

Working in silos is bad for patients and doctors. Removing obstacles to collaboration can help reduce doctors' workloads and the unnecessary waste of time and resources.

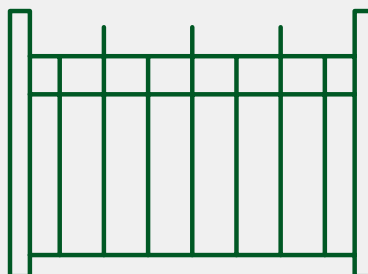
A new, more collaborative approach is needed in all four nations of the UK, so that doctors and all NHS staff are empowered to work together across traditional organisational divides.

### Design care around patients, not organisational boundaries

Too often, current NHS structures focus on individual providers meeting their own immediate organisational – often financial – priorities. Doctors say this increases costs and can affect quality and safety of patient care.

**Seven in 10 doctors** say current organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs (CSC survey).

**60%** say these barriers result in compromised quality and safety of patient care.



Despite repeated initiatives to promote more integrated working, the experience for both patients and doctors is often that different parts of the NHS do not pull together to work towards a common goal, and don't communicate effectively.

Pockets of good practice do exist, but funding and support are needed to ensure frontline clinicians can collaborate more as groups of professionals involved in the same care pathway (eg care of the elderly, paediatrics, diabetes care), regardless of where in the system they are based.



Only **16%** of doctors feel there is currently clear communication between primary and secondary care and just **9%** say patients experience coordinated care between hospitals and general practice (CSC survey)

**Barnsley and Yorkshire paediatric consultant and regional council chair**

**Rajeev Gupta at a BMA member event:** 'Doctors – whether hospital consultants or GPs – want to work together because we have a common motive of achieving better patient care. However, due to political reasons... there has been a division. To make the situation even worse, the computer systems of the two places don't work together.'

- The **Government** must:
  - incentivise NHS bodies, including hospitals, GP practices, public health, and community services to work together as one system. This will involve bringing together clinicians, other healthcare professionals and patients to design systems built on trusting relationships between previously isolated parts of the NHS
  - reform how individual NHS providers are held to account, focusing on encouraging behaviours that improve patient care in the health system as a whole rather than narrow organisational priorities. In England, the Government should abolish the statutory requirements on foundation trusts that currently encourage them to focus on their financial performance above all other priorities. All NHS trusts should be encouraged to work collaboratively as part of the local health system they work in
  - in England, redesign the way NHS bodies are allocated money, moving away from 'pay for activity' models that incentivise hospitals to increase their workload and towards mechanisms that encourage health systems to work together to prevent ill health and reduce the need for patients to be admitted to hospitals wherever possible
  - group together teams of doctors and other health professionals based on specific care pathways so that services are designed around patients' journey through the system rather than organisational divides
  - hospital doctors should be able to request investigations in the community and prescribe medications that can be collected in a community pharmacy, including provision of electronic prescriptions
  - greater funding and support should be made available for schemes designed to build professional and social connections between clinicians across traditional working divides.

### Case study: developing multidisciplinary primary care teams in Northern Ireland

In Northern Ireland there is a recognition of the pressures on the primary care workforce and the need to extend the team to help increase capacity, but also to free GP time to deal with the increasing demand and complexity of an ageing population. GP federations allowed the development of the first practice-based pharmacist scheme in Northern Ireland with every average sized practice soon to see a full-time pharmacist available. The approach has already led to progress in safety and quality and the freeing of GP time.

## Compatible IT systems that support safe sharing of patients' data to improve care

While the Government's focus is on new technologies and the deployment of artificial intelligence within the NHS, it is the lack of adequate IT infrastructure that is one of the biggest barriers to creating a more collaborative NHS. Just like patients, doctors report frustrations with not being able to quickly and securely share vital information between primary and secondary care, and with other parts of the health service.

Different parts of the NHS have developed IT systems largely in isolation, with the resulting lack of interoperability meaning that patients often report a disjointed experience in navigating parts of the NHS. This can affect the quality and safety of care they receive.

For collaboration to work, clinicians must be able to see patients' records, observations, results and background notes ideally in real time. This would be possible if doctors had secure access (with appropriate information governance in place) to an up-to-date IT infrastructure with fully functioning kit and material and reliable broadband connectivity across the country.

### Box 24: virtual e-clinic for kidney disease, Tower Hamlets

Specialist kidney doctors based at Barts Health Trust and GPs in Tower Hamlets, east London, are using a pioneering e-clinic approach to provide more effective joined-up care to patients suffering from chronic kidney disease. Clinicians in both primary and secondary care have worked together to develop an interoperable IT system that gives consultants access to all patients' health records, and sends automatic trigger alerts to GP practices about patients most at risk following routine blood test results. Under the new system, outpatient appointments have reduced significantly and waiting times for patients who require a face-to-face appointment have also dropped from an average of 64 days in 2015 to just five by 2017.

- **Governments** should:
  - commission and publish an assessment of the likely cost of achieving safe and secure IT interoperability and a plan to deliver this over the next five years. As part of this governments should produce an 'interoperability map' to track progress
  - make broadband available in all care settings and ensure the NHS is an early adopter of 5G technology
  - invest in basic technological infrastructure as a priority to improve workload, morale, retention and patient outcomes.

### **The NHS should be free from wasteful competition rules**

Current competition rules in England are incompatible with our vision of a collaborative NHS. Rules requiring NHS services to be put out to competitive tender create unnecessary waste and encourage different health providers to see each other as competitors, rather than collaborators. The rules make it more difficult for health systems to develop the trusting long-term relationships needed for integrated ways of working.

- The **Government** should:
  - amend legislation to revoke section 75 of the Health and Social Care Act 2012, remove rules in England requiring CCGs to put contracts out to competitive tender and make NHS providers the preferred provider of services
  - legislate to guarantee that integrated models of care cannot be run by the private sector.



## References

- 1 Charlesworth. A, Johnson. P, (2018) *Securing the future: funding health and social care to the 2030s*, Institute for Fiscal Studies, The Health Foundation  
<https://www.ifs.org.uk/uploads/R143.pdf>
- 2 The King's Fund (2018), *The Healthcare Workforce in England: Make or Break?*  
<https://www.kingsfund.org.uk/publications/health-care-workforce-england>
- 3 Just and Learning Culture Charter
- 4 A just and learning culture at Mersey Care
- 5 Parliamentary Review of Health and Social Care in Wales (2018)  
<https://gweddill.gov.wales/topics/health/nhswales/review/?lang=en>
- 6 Institute for Healthcare Improvement, *The IHI Triple Aim*.  
<http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>
- 7 The act needs action
- 8 Williams review – Hamilton review





**British Medical Association**

BMA House, Tavistock Square,  
London WC1H 9JP  
[bma.org.uk](http://bma.org.uk)

© British Medical Association, 2019

BMA 20190479