

## BMA Briefing: Implications of the Health and Care Bill for General Practice

The UK Government has now formally published its [Health and Care Bill](#), which, if enacted, will result in significant changes for the NHS in England and for General Practice. This paper provides a summary of the major changes set out in the Bill as they impact GPs as well as the BMA's initial analysis of them.

A [BMA-wide briefing](#) has also been produced on the Health Care Bill, which is available on the [BMA's dedicated webpage](#).

### An overview of the Bill's key changes

- establishing [ICSs](#) in statute, and transferring the duties, staff, and resources of CCGs (Clinical Commissioning Groups) to them
- requiring ICSs to set up an Integrated Care Board and an Integrated Care Partnership
- enabling ICSs to set up joint committees between NHS bodies and providers
- repealing Section 75 of the Health and Social Care Act 2012, meaning NHS commissioners will no longer be compelled to put services out to competitive tender
- placing a new duty on all NHS bodies to adhere to a 'triple aim' of assuring the health of wellbeing of the population, quality of care, and sustainable use of resources
- removal of duties to promote autonomy, with a wider focus on collaboration
- the formal merger of NHS England and NHS Improvement
- expanding the power of the Secretary of State for Health, including increased power to direct NHS England/Improvement, create new NHS Trusts, intervene in reconfiguration disputes, and amend/abolish ALBs (Arm's Length Bodies)
- a new duty for the Secretary of State to publish a report each Parliament describing the system in place for assessing and meeting the workforce needs of the NHS in England
- establishing the HSSIB (Health Service Safety Investigations Body) in statute, which takes a no-blame approach to investigations into safety incidents.

### Key implications for General Practice

A number of the changes set out in the Bill have specific impacts on General Practice, GPs, and primary care more widely, these are summarised here.

#### *Integration, collaboration, and system working*

##### **ICSs (Integrated Care Systems)**

A core purpose of the Bill is to establish ICSs in statute. This would make their currently informal roles formal and enshrine them with powers and accountabilities they presently lack – particularly in respect of commissioning and managing NHS funding.

In their new statutory form, ICSs will be made up of two core components – an ICB (Integrated Care Board) and an ICP (Integrated Care Partnership) – which will be collectively referred to as the ICS. The ICB will take on the duties, resources, and staff of CCGs and will be responsible for NHS functions within each ICS. The ICP takes a broader focus, covering issues such as social care, public

health, and housing, and will develop an overarching ICS strategy. For further information on how ICBs and ICPs are expected to operate, see our [BMA briefing on the ICS Design Framework](#).

Local authorities are likely to have a particularly prominent role in the ICP and Health and Wellbeing Boards are expected to provide scrutiny of ICS, ICB, and ICP planning and decision making. Additionally, ICSs will need to pay regard to local JSNA's (Joint Strategic Needs Assessments) in their planning.

While the Bill does not include specifics on the transparency of ICB and ICP board meetings, the ICS Design Framework – NHS England's guidance underpinning the development of ICSs as statutory bodies – does establish that both will need to meet in public, to publicly publish their board papers, and to communicate with the public in an inclusive manner.

### **CCGs (Clinical Commissioning Groups)**

The Bill will abolish CCGs. The existing duties, resources and functions of each CCG will be carried over into the relevant ICB as well as any contracts they presently hold, including GP practice contracts where relevant.

### **Triple aim and the duty to co-operate**

Under the Bill, the ICB, ICP, and all NHS Trusts will be expected to adhere to the triple aim, of –

1. better care for all patients
2. better health and wellbeing for everyone
3. sustainable use of NHS resources.

In addition, they will also be bound by a Duty to Cooperate - previously billed as the Duty to Collaborate in the White Paper – which requires NHS Bodies and local authorities to work together. Alongside this, the Bill also removes existing duties on the Secretary of State and NHS England to promote autonomy, as part of the broader focus on system-wide working.

### **Joint committees and joint appointments**

The Bill will also allow NHS bodies to create joint committees between them, both within the ICS and more broadly. Likewise, some joint appointments will also be possible - across different NHS bodies, or between the NHS and local authorities, for example - with the apparent intention of fostering closer collaboration.

#### **Implications for General Practice and the BMA's analysis**

- the transfer of CCG's commissioning role to ICSs will significantly alter the role of GPs in NHS decision making at a local level – which will not be fully replaced with a single role on the ICB
- as ICSs – and ICBs specifically – take on the duties of CCGs, GPs and practices will also need to build relationships with them and shift the focus of any local lobbying
- the focus on collaboration and cooperation is something the BMA has supported previously, however, the Bill lacks specific detail on how GPs would be involved in this
- GPC and the BMA also remain clear that any reforms must protect and respect the independent contractor status model of General Practice.

## Funding

Funding is not addressed in detail within the Bill, but it is clear that ICBs will control NHS funding within their footprints. This includes the distribution of that funding across the relevant providers – though NHS England guidance has been clear that national GP contracts will not be affected.

ICBs will also control capital funding and will be able to delegate certain functions, including to Provider Collaboratives, Place-Based Partnerships (i.e. the ICS ‘place’ level), and other partners.

Alongside this, as also set out in the [ICS Design Framework](#), the Bill will allow for the creation of pooled funds and budgets, including across health and local authorities, subject to further guidance.

### **Implications for General Practice and the BMA’s analysis**

- GPC has been clear that General Practice funding needs to be protected amid the transition to statutory ICSs
- this includes nationally agreed GP contracts, as well as locally agreed arrangements between CCGs and practices, which we believe need to be carried over to ICBs to ensure continuity and security of income
- it will be important for LMCs, practices, and PCNs to engage with their local ICSs and ICBs regarding funding arrangements, particularly where population needs may require specific interventions and support
- the fair distribution of capital funding is essential and GP premises must be supported by ICSs
- the BMA has been wary of pooled funds previously, given the possibility of NHS funding being used to plug gaps elsewhere within the ICS – this remains a concern and reinforces the need for GP funding to be safeguarded.

## GP Voice

GPC and the BMA have been clear that a strong GP voice is essential if ICSs are to be successful. We have reiterated this in response to the Bill, as well as to the guidance underpinning it.

ICBs will have a mandated seat for a representative of General Practice, nominated by the GPs and providers of primary care services within the ICS – we are seeking clarity on how the nomination process will operate, but it is likely to be established locally by each ICS. This member will sit along a single mandated representative nominated by the trusts within the ICS and one nominated by the relevant local authorities.

Beyond this, the Bill does not establish any further representation for GPs – or other clinicians – within ICSs. Although wider NHS England guidance does stress the need for clinical leadership at each level of the ICS. ICBs will also be able to make additional appointments to their boards at their discretion (subject to approval by NHS England), which could potentially include further GP representation. Notably, the Bill neither proposes nor opposes the potential for corporate private providers to sit on ICBs, leaving the possibility of their involvement open.

The Bill makes no further prescriptions regarding ICB membership, but processes will need to be put in place by each ICB to manage any potential conflicts of interests for its members. Notably, the Bill neither proposes nor opposes the potential for corporate private providers to sit on ICBs.

LMCs are also referred to within the Bill, though only in confirming that an ICB may recognise more than one within its footprint.

#### **Implications for General Practice and the BMA's analysis**

- a guaranteed GP representative on the ICB is welcome and has been a key call for GPC
- further GP involvement within ICSs is still needed though, including formal roles for LMCs as well as GP leadership at system and place level
- clarity is also needed on how the GP representative on the ICB will be chosen and who will be eligible for the position
- corporate private providers must have no place on ICBs or ICPs, to prevent conflicts of interest and any undue influence over the use of vital NHS and public resources
- the role of LMCs as the statutory voice of GPs remains vital and needs to be recognised by the Government, NHS England, and ICSs themselves
- LMCs will also need to focus on building or reinforcing their influence within their local ICSs, this could include working together to present a single voice – [Humberside LMCs and the Humber Primary Care Collaborative](#) provide a strong example of how this can be done
- primary care representation will also be needed within the ICP – particularly regarding its work on the wider determinants of health
- it is also essential that ICSs support clinical leadership and involvement with resources and funding, to allow GPs to attend and contribute to key meetings for example
- further clarity is also needed on the role of PCNs within the new system, but this is expected to be addressed in NHS England guidance rather than legislation.

### *Workforce*

The Bill includes a number of measures in respect of the NHS workforce, which may alter existing approaches to long-term planning and training, as well as the regulation of some NHS staff.

#### **Workforce reporting**

The Bill mandates the Secretary of State, at least once every five years – i.e. every Parliament, to publish a report describing the system in place for assessing and meeting the workforce needs of the health service in England. NHS England and HEE (Health Education England) will be expected to assist in the development of this report, if asked by the Health Secretary.

#### **Local Education Training Boards**

LETBs will be abolished under the changes set out in the Bill, with their roles and responsibilities returning to HEE. The stated intention of this change is to give HEE flexibility to adapt its regional operating model over time.

#### **Regulation of NHS staff**

The Secretary of State will also gain the authority to move certain health care professionals into, or out of, regulation, and to abolish regulators under certain circumstances. These changes are extremely unlikely to impact doctors and their existing model of professional regulation. The

Government's White Paper referred to these powers potentially being used to expand regulation to senior NHS managers, but this is not explicitly addressed in the Bill.

#### **Implications for General Practice and the BMA's analysis**

- 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
- as highlighted in the BMA's staffing report [Medical staffing in England: a defining moment for doctors and patients](#), there are currently 1,307 fewer qualified FTE GPs now than in September 2015
- we do not believe that the bill's existing requirement for the Health Secretary to report only on the system in place for assessing and meeting the workforce needs of the NHS every five years is sufficient to tackle this, or the wider challenges of recruitment and retention
- while it is important that the Health Secretary does take on further responsibility for workforce numbers and needs, the Bill must go further
- in the BMA's view, the Bill must include a responsibility for the Secretary of State to produce ongoing, accurate and transparent workforce assessments to directly inform recruitment needs - we have worked extensively with other stakeholders to align bodies across the profession behind this recommendation, which is also endorsed by the health and social care select committee and key think tanks
- the removal of LETBs could see a loss of a dedicated, local support system for GP trainees – though clarity is needed on how HEE intended to replace or replicate their functions
- the BMA would be supportive of extending regulation to senior NHS managers, were the Government to pursue this.

#### *Competition and procurement*

In line with NHS England's recommendations, the Bill will make a number of changes aimed at reducing competition and bureaucracy in commissioning and procurement decisions.

#### **Section 75 and the new Provider Selection Regime**

The Bill will repeal Section 75 of the 2012 Health and Social Care Act – with commissioners no longer required to competitively tender all contracts above a certain value. This has been posited as a means of avoiding costly and disruptive tendering processes.

While not detailed in the Bill itself, commissioning and service procurement will in the future be governed by NHS England's Provider Selection Regime. The regime was subject to a consultation earlier this year, [which the BMA responded to](#), and will give commissioners three options:

1. renew an existing contract without competitive tender
2. award a new contract, or an existing contract to a new provider, without competitive tender
3. hold a competitive tendering process, if necessary.

#### **Anti-competitive behaviour**

The Bill will also see NHS Improvement's specific duties around competition and the prevention of anti-competitive behavior abolished, making it easier for organisations to work together.

#### **Implications for General Practice and the BMA's analysis**

- the BMA has consistently and strongly opposed Section 75 and competition within the NHS
- the exact implications of the change on General Practices remain unclear and GPC are monitoring this issue closely
- it is possible that ending mandated competitive tendering could lead to less churn in providers, as commissioners will be able to keep existing providers in place more easily, which may reduce the scope for private providers of NHS GP services to enter the market
- but it is also possible that contracts could be offered to existing private providers, such as Operose, without tender, potentially solidifying their existing presence in the market
- we believe the proposed reforms are insufficient to fully protect the NHS and General Practice from unnecessary private sector involvement and could, under the Provider Selection Regime, allow contracts to be awarded to private providers without proper scrutiny or transparency
- we fundamentally believe that, in order to protect the NHS and prevent fragmentation of services, the NHS should be made the default option for NHS contracts, with competitive tendering used only where an NHS provider cannot provide a given service.

#### *Medical examiners*

The Bill will also establish a statutory medical examiner system within the NHS in England and Wales, to scrutinise those deaths which do not involve a coroner. While not addressed in the Bill itself, NHS England is also intending to [extend medical examiner scrutiny into primary care](#).

#### **Implications for General Practice and the BMA's analysis**

- the operational and financial impacts of extending the medical examiner system into primary care have not been finalised but we believe that, in their current form, they will result in a significant increase in unscheduled and urgent workload
- GPC and the BMA are actively lobbying NHS England on this issue and are monitoring developments closely.

#### *Powers and accountability*

A substantial portion of the Bill is focused on establishing new and greater powers for the Health Secretary which would significantly increase their direct power over the NHS. The Government has characterised this as ensuring greater Parliamentary accountability over the health service.

While these powers have no specific impact on General Practice per se, they will have consequences for the NHS as a whole if they are implemented and are therefore important to consider.

#### **Directing the NHS and the NHS Mandate**

Currently, the overarching direction of the NHS is set annually via the NHS Mandate. This provides a broad set of expectations for NHS England to follow over the course of a year. Under the Bill, the Health Secretary would be able to set or reset the direction of the NHS outside of the mandate and at their discretion, allowing them to make reactive and rapid changes to NHS England's priorities.

#### **Service reconfiguration**

The Secretary of State will also be granted increased powers to intervene in local service reconfigurations. Currently, the Secretary of State can only become involved if plans are referred to their office. The Government sees this as a hindrance to the effective resolution of disputes, as

referrals tend to come only very late in the process. The Bill will allow the Health Secretary to proactively intervene in service reconfigurations and do so earlier in the process.

### **Arm's Length Bodies**

Under the Bill, the Secretary of State is also given greater authority over ALBs (Arm's Length Bodies), including powers to alter and abolish them. This is partly intended to facilitate the formal merger of NHS England and NHS Improvement. However, it would also allow the Health Secretary to amend the roles of other ALBs, including NHS England itself. As per the Bill, the Health Secretary would need to consult on any changes made to ALBs and, in respect of NHS England specifically, they would not be able to make any changes to its duties or functions that would render it redundant.

### **New Trusts**

The Health Secretary will also take on the power to create new NHS Trusts. This is framed as a means of facilitating the rapid reorganisation of care when needed to support emergency provision, such as with the establishment of the Nightingale Hospitals. ICSs will also be able to apply to the Secretary of State to create new Trusts.

#### **Implications for General Practice and the BMA's analysis**

- the new Secretary of State powers would not necessarily have a specific impact on GPs, but will have potentially significant implications for the NHS as a whole
- the BMA has advocated for clear lines of political accountability for the NHS – however, these changes appear to be far more about accumulating power than responsibility
- there is a risk that a lack of safeguards in the use of many of these powers could lead to greater power for the Secretary of State without sufficiently robust accountability
- currently, the Bill only outlines limited safeguards regarding the Health Secretary's powers to amend and abolish ALBs – more stringent measures are needed to limit the use and scope of these powers to prevent major changes being made to health bodies without due scrutiny
- the power to create new NHS Trusts could also ease the introduction of Integrated Care Provider Contracts – which GPC oppose – although it is notable that there is no reference to them in the Bill, White Paper, or NHS England guidance
- while Ministers should ultimately be accountable in Parliament, the pandemic has shown how much can be achieved by putting NHS clinicians in the driving seat - doctors must be trusted to lead, to deliver for the good of their patients and the whole health system.

### [BMA position and amending the Bill](#)

Following a vote by UK Council, the BMA's position is to actively oppose the Health and Care Bill currently before U.K. Parliament. Although there are aspects of the Bill which the Association agrees with, we believe that, as proposed, it is likely to do more harm than good.

Implementing wholesale reform while the country is still fighting Covid-19 is unwise, especially when we consider the extensive backlog of care the NHS is facing and how little time doctors have had to scrutinise the details.

We have indicated that, without amendment, the BMA cannot support the Bill. Amendments the Association will be calling for include:

- ensuring there are genuine and transparent protections against privatisation, including enshrining the NHS as the preferred provider of NHS services
- embedding clinical leadership throughout Integrated Care Systems (ICSs) – with formal roles for LMCs, LNCs, and Public Health doctors
- ensuring political responsibility for staffing levels
- limiting the scope and use of the Secretary of State’s powers.

See **Annex 1** for the press release regarding the Council vote and the updated BMA position.

### Further guidance and consultations

In addition to the White Paper itself, a number of consultations have been carried out on how elements of the proposed changes will work in practice. These include consultations on NHS England’s new [Provider Selection Regime](#), which would replace current rules on commissioning and competition, and its new [System Oversight Framework](#) which will govern the regulation of statutory ICSs.

The [BMA response to the Provider Selection Regime](#) was clear that while moving away from the present model of enforced competition is an important step forward, it must come with clear safeguards, transparency, and a commitment to the NHS being the default option to hold NHS contracts.

In [response to the proposals for the new System Oversight Framework](#), we stressed the need for the degree of clinical leadership, representation, and engagement within ICSs being used as measure of their performance.

NHS England has also published a new ICS Design Framework, setting out how ICSs are expected to develop over the next year and prepare for statutory status. We have [produced a member briefing on the framework](#), including our analysis of its potential implications.

### Next Steps

Following its introduction in the House of Commons on Tuesday 6<sup>th</sup> July, the Bill received its Second Reading on Wednesday 14<sup>th</sup> July, which was the first opportunity for a full debate on the proposals it sets out.

Opposition parties tabled motions in opposition to the Bill at its Second Reading, focusing on its timing and its failure to address the pressures facing the NHS, as well as highlighting the ability for the private sector to sit on ICBs and the Bill’s failure to reinstate the NHS as the default provider.

However, the Bill did pass and will progress onto the Committee Stage. This is the stage at which amendments will begin to be brought to the Bill and it is expected to begin once the House returns after Summer recess in September.

Follow the BMA’s work on the Bill [on our dedicated webpage](#).



Annex 1:

**BMA press release: immediate release, Wednesday 14th July 2021**

**‘Wrong Bill at the wrong time’ – BMA council calls on MPs to reject Health and Care Bill**

BMA council has overwhelmingly passed a resolution calling for the Health and Care Bill to be rejected, arguing that it is the wrong time to be reorganising the NHS, fails to address chronic workforce shortages or to protect the NHS from further outsourcing and encroachment of large corporate companies in healthcare, and significantly dilutes public accountability.<sup>1</sup>

The BMA is also concerned about the wide-ranging excessive powers the Bill would confer on the Health Secretary.

The Association believes the Bill carries significant risks and fails to address the problems the NHS is currently facing. Implementing wholesale reform while the country and NHS is still fighting Covid-19 is especially unwise when we consider the extensive backlog of care the NHS is facing and how little time doctors have had to discuss and scrutinise the details. Despite its title, the Bill does nothing to address the serious failings in social care that needs urgent attention.

Without significant amendment, the BMA will indicate that it cannot support the Bill. Parliamentary amendments the Association will be calling for include making sure there are genuine and transparent protections against privatisation, embedding clinical leadership throughout Integrated Care Systems (ICSs), addressing the ‘power grab’ by the Secretary of State and ensuring political responsibility for staffing levels.

**Dr David Wrigley, deputy chair of BMA council, said:** “This is not the right time to be making such widespread changes to our health service. What’s more the Bill addresses none of the problems the NHS is currently facing - too few resources, too little funding, a crisis in social care and a huge shortage of staff. It does not address the problem of a workforce that is exhausted and depleted by the pandemic and is now facing yet another wave.

“Healthcare workers have led from the front throughout this pandemic, but the Bill in its current form undercuts truly representative clinical leadership. The BMA has consistently called for meaningful clinical leadership, engagement and representation at every level of Integrated Care Systems, including from primary and secondary care as well as public health doctors to ensure the right voices are heard when it comes to commissioning decisions, but this has not been adequately addressed in the legislation. The threat of private health providers having a formal seat on new decision making boards, and wielding influence over commissioning decisions, must be ruled out.

“What should also have been ruled out is extending the powers of the Health Secretary. Of course, the Health Secretary should be accountable for the NHS, but it would be totally wrong for Government to have the power to abolish arm’s length bodies without due scrutiny, approve or reject ICS chairs, or interfere with local decisions – all of which risk political interference for political gain, and do not have the interests of the NHS, or its patients, at heart.

“The BMA has long supported collaboration and called for the removal of enforced competition through Section 75, which the Bill would achieve. The most effective way of doing that is to make

the NHS the default option for NHS contracts and to only tender competitively where this is not possible. This is also vital to avoid the awarding of contracts without scrutiny to private providers at huge expense to the taxpayer, as was seen with the procurement of PPE and Test and Trace during the pandemic.

“Fundamentally, the legislation is a missed opportunity to truly boost the NHS workforce. We entered the pandemic on the backfoot, with a historic workforce crisis that has only worsened over the last year. This Bill does nothing to address the huge staffing shortages facing the health service. The NHS is the people who work in it, and having a fully-fledged workforce is vital to safe patient care, which is why Government must be accountable for ensuring adequate numbers of staff. The Bill must include a responsibility for the Secretary of State to produce ongoing accurate and transparent workforce assessments which will directly inform recruitment needs, now and in the future.

“We don’t want Government to stick with the status quo but it has unfortunately not learned lessons from the failures of the 2012 Lansley Health and Social Care Act. It could have restored a collaborative NHS, properly funded and staffed, publicly delivered and publicly accountable but it has failed to do so. Instead we have the wrong Bill at the wrong time.”

**ENDS**

#### **Notes to editors**

The BMA is a trade union and professional association representing and negotiating on behalf of all doctors in the UK. A leading voice advocating for outstanding health care and a healthy population. An association providing members with excellent individual services and support throughout their lives.

1. The full wording of the motion was:

That Council calls on the British Medical Association to actively oppose the Health and Care Bill currently before UK Parliament.