BMA Member briefing: Health and Care Bill

The UK Government has now formally published its Health and Care Bill, which, if enacted, will see dramatic changes for the NHS in England. This briefing provides a summary of those changes, the BMA's initial analysis of them, and outlines how the BMA is working to influence the legislation on behalf of members.

The BMA has issued a press response to the publication of the Bill, highlighting our concerns – not least regarding its timing and the powers it would confer to the Health Secretary – as well as where we think it must be strengthened, including genuine protections against privatisation, embedding clinical leadership throughout ICSs (Integrated Care Systems), and political responsibility for staffing levels.

Introduction

The Government's new Bill follows several years of informal changes to NHS structures and a growing consensus that the 2012 Health and Social Care Act is ill-suited to the needs of the health service. This is reflected in much of the content of the Bill and in the separate proposals put forward by NHS England in late 2020, which form a substantial part of the Government's own plans. The BMA response to NHS England's proposals is available here.

It is on this basis that the Government has justified its Bill is a means of 'giving the NHS the changes it has asked for'. Namely, this refers to removing existing competition rules and formalising ICSs in statute. However, the Bill goes significantly further than NHS England's requests, particularly in the authority it would grant to the Health Secretary over the health service.

An overview of the proposed 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.

Why is the government proposing new legislation?
The Government has presented several arguments for why it feels legislation is needed. These include: the need to embed the co-operation seen across the NHS in response to the Covid-19 pandemic; the need to remove longstanding barriers to collaboration; reversing competition rules that create unnecessary bureaucracy by forcing commissioners to put their services out to tender; and a desire to clarify and increase political accountability for the NHS.

When does the Government intend to implement changes?
Subject to Parliamentary business, the Government wants its legislation to be implemented from April 2022 – a tight timescale. The BMA has questioned the timing of this process given that the NHS remains in the midst of a global pandemic and faces severe backlogs of care. Likewise, given the expected pace of the Bill's journey through Parliament and its intended implementation, it is essential that sufficient time is allowed for full scrutiny of the Bill, including by doctors.

The changes set out in the Bill

The Bill covers a range of issues and, if enacted, would introduce a number of significant changes to the way the NHS is structured and how it operates. For the purposes of this briefing, these changes have been broken down into broader themes:

- NHS structures
- collaboration
- competition and procurement
- workforce
- data and information sharing
- powers and accountability
- wider proposals (public health and social care).

NHS Structures

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 so doing, every area of England will need to be covered by an ICS, in line with NHS England's plans.

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. For further information on how ICBs and ICPs will be expected to operate in practice, see our BMA briefing on the ICS Design Framework.

Integrated Care Boards
The ICB will be responsible for the commissioning and provision of NHS services, as well as allocating and distributing funding within their footprints. Essentially, they will take on all the existing responsibilities, contracts, and resources of CCGs, as well as the majority of their staff.

ICBs will be required to publish a five year plan for services each financial year, updating it each year if necessary. Alongside this, they will also be expected to publish an annual report each year. Each ICB will also be required to develop their own constitution, subject to approval from NHS England, and, in line with wider guidance, will be able to develop with a high degree of freedom.

Membership of the ICB will also be up to local determination, barring a core, minimum membership set out in the Bill of:

- a Chair (appointed by NHS England and approved by the Secretary of State)
- a Chief Executive (appointed by the Chair and approved by NHS England)
- at least three other members, including:
    - one nominated jointly by NHS Trusts and Foundation Trusts (trusts)
    - one nominated jointly by GPs and primary care
    - one nominated by local authorities.

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 (Local Medical Committees) are cited within the Bill, with confirmation that ICBs will be able to recognise multiple LMCs within their given footprint – if appropriate.

ICBs will control NHS funding flows within their footprints, including capital funding. They will also be able to delegate certain functions, including to Provider Collaboratives, Place-Based Partnerships (i.e. the ICS 'place' level), and other partners.

Integrated Care Partnerships
Each ICB will be required to form a joint committee with the local authorities within its footprint (including any that only partially fall within that footprint), known as an ICP. They are intended to be developed locally and in response to local need, with little national direction or intervention.

ICPs will take a broader view than ICBs and will involve a wide-ranging set of partners, with the aim of acting collectively on issues such as public health, social care, and the wider determinants of health. As part of this, ICPs will be expected to develop an overarching strategy for the ICS as a whole, which ICBs will need to take into account when making their own decisions and plans.

The Bill does establish that each ICP will need to have at least one member appointed by the ICB and one appointed by each local authority. Beyond that, all other members will be appointed by the ICP itself. Again, the Bill neither proposes nor opposes corporate private providers holding membership positions within ICPs.

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.

Our analysis

- the BMA has supported the principle of integrated care (including in our Caring, supportive collaborative project), though we have not endorsed ICSs or any other model
- we have been critical of ICSs operating outside of statute to date, so their new status should be an improvement, particularly in ensuring their accountability and transparency
- we are clear that ICSs – as well as ICBs and ICPs – must have strong clinical leadership, representation, and engagement embedded throughout their structures, including primary care, secondary care, and public health doctors, and with formal roles for LMCs and LNCs (Local Negotiating Committees)

- while it is positive, therefore, that a representative from primary care will be required on ICBs, greater and broader representation of doctors is needed throughout ICSs, ICBs, and ICPs
- it is also essential that ICSs include public health experts, including Directors of Public Health, on ICBs and ICPs not as representatives of their employers, but as independent voices
- corporate private providers should 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.

Collaboration

The Bill includes a focus on ensuring collaboration and co-operation within the NHS and between it and local authorities, public health, and social care. As part of this, previous duties on the Secretary of State and NHS England to promote the autonomy of individual NHS bodies have been removed.

The triple aim
Likewise, the Bill will introduce a duty on all NHS bodies – including ICBs, ICPs, and trusts – to the triple aim, of simultaneously pursuing:

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

Foundation Trust powers
The Bill does not set out any reduction in existing Foundation Trust powers or legal duties. However, the Bill does grant ICBs the authority to freeze capital spending for specific trusts, to be used specifically if it is determined that a given trust is operating outside of the ICS's wider plans or is not working co-operatively.

Joint committees, pooled funds, 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.

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.

Our analysis:
- the BMA has long called for a more collaborative healthcare system and one which allows for NHS bodies and their staff to work together across current, artificial boundaries
- as such, the broad focus on supporting collaboration over competition is welcome, as is the introduction of a formal duty to the triple aim
- however, we remain concerned that the significant legal responsibilities held by NHS Foundation Trusts presents a potential hindrance to this collaboration
- while we are broadly supportive of the concept of joint committees, joint appointments, and, in certain cases, pooled funds, we strongly believe that any pooling of funding must not lead to NHS funding being used to plug gaps in other services, such as social care.

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.

The Competition and Markets Authority
Likewise, the Bill will end much of the CMA's (Competition and Markets Authority) current role within the NHS. As part of this, NHS England's duty to refer contested licence conditions or National Tariff provisions to the CMA will be removed.

Our analysis:
- the BMA has consistently and strongly opposed Section 75 and competition within the NHS
- however, we believe the proposed reforms are insufficient to fully protect the NHS 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.

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.

Our 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
- 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
- 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 BMA would be supportive of extending regulation to senior NHS managers, were the Government to pursue this.

Data and information sharing

The bill outlines new powers for the Secretary of State to mandate standards for how data is collected and stored with the intention that this will allow a greater range of data sharing from a technical standpoint.

It is unclear how far these powers will extend, specifically in relation to the use of data extracted from GP records for planning and research under the recently launched programme of the same name (GP Data for Planning and Research, GPDPR).

Our analysis:
- the BMA broadly welcomes efforts to improve information standards, but clarity on powers given to the Secretary of State to enforce information standards may need to be established, particularly regarding what this could mean for healthcare providers and staff
- we will be carefully considering the impact of the legislation to ensure that the appropriate safeguards for patient confidentiality are not undermined.

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 the over the NHS. The Government has characterised this as ensuring greater Parliamentary accountability over the health service.

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.

Our analysis:

- 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
- it is vital that the day-to-day running of the NHS is free from excessive political control and that long-term planning is not disrupted by changing political priorities
- 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 to Parliament, or to the public
- 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
- 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.

Wider proposals (public health and social care)

The Bill also includes a range of other, broader changes that will impact the NHS and doctors.

Advertising high fat, salt, and sugar foods
In line with the Government's Obesity Strategy, the Bill includes specific plans to give the Secretary of State the authority to bring in new restrictions on the advertising of high fat, salt, and sugar foods on television, video on demand services, and online. Powers to alter food labelling requirements are also included.

Social care
The Bill, like the White Paper, includes very limited reference to, or reform of, social care. However, a number of operational changes are included, including giving the Secretary of State powers to make payments and provide financial assistance to all social care providers. The Bill would also give the Health Secretary power to set or revise the CQC's objectives and priorities regarding the assessment of social care in Local Authorities – including indicators of quality.

The Health Services Safety Investigations Body
The Government's Bill will make the HSSIB (Health Service Safety Investigations Body) a statutory body. The HSSIB is currently in operation, but as a non-statutory organisation. It aims to take an approach to investigating safety incidents that focuses on learning and does not apportion blame, liability, or individual responsibility.

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.

Our analysis:
- we support the measures set out to limit the advertising of certain foods
- the paucity of genuine social care reform within the Bill is a major concern, given its ever-growing interdependence with the NHS and the urgent need for action
- the establishment of the HSSIB and its focus on fostering a learning culture in the NHS aligns with the asks set out in our *Caring, supportive, collaborative* report
- 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.

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.

Conclusion and next steps

Following the introduction of the Bill in the House of Commons on Tuesday 6th July, the Bill will now go on to receive its Second Reading which will be the first opportunity for a full debate on the Bill's proposals. We then expect Committee Stage – the stage at which amendments will begin to be brought to the Bill – once the House returns after summer recess in September.

The BMA will continue to closely engage Government Ministers, NHSE and civil servants working on the Bill and the guidance that will underpin it, as well as meet and brief parliamentarians at every stage of the legislative process with the aim of amending and strengthening the Bill, and to ensure the voice of clinicians is front and centre in decisions about the future of the NHS.

Follow the BMA's work on the Bill on our dedicated webpage.