## **NHSE Legislative Proposals – Outline BMA Response**

This document sets out a draft outline of the BMA response to NHS England’s consultation on [new legislative proposals](https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf).

Our submission will argue that **while the proposals include some positive steps forward in respect of delivering integration, they lack clarity in key aspects and fail to go far enough to build the system the NHS and its workforce needs.**

In support of this, our response will focus on the following central arguments:

* **We agree that ICSs should be made statutory:** aswe have argued previously, the lack of statutory footing for ICSs strictly limits their accountability and transparency. This would, in part, be resolved by making ICSs statutory bodies.
* **The positive elements of CCGs must be retained in any new model:** We endorse neither option set out in the consultation for the future of CCGs.The choice presented is not genuine, given the clear preference for option 2 in the proposals and the significant impact on CCGs caused by either approach. Instead we will call for the key, positive elements of CCGs, such as a strong clinical voice, local decision making, and accountability to clinicians to be retained in any new model.
* **Foundation Trusts should also be subject to legal reform:** current accountabilities and financial imperatives for Foundation Trusts create perverse incentives and hinder collaboration. As well as reforming CCGs, NHSE should take the opportunity to reform the role of Foundation Trusts, too.
* **A strong clinical voice within ICSs is essential:** the present system and the proposals fail to provide a clear, strong voice for clinicians. We will argue for a leading role for clinicians – across all branches of practice – and proper representation within all ICSs and their substructures (i.e. Place), including formalised roles for LMCs as representatives of provider GPs.
* **Changes to competition rules are positive but have to be reinforced by making the NHS the preferred provider of services:** we strongly believe that NHS services should not be subcontracted to private providers and have argued that removing Section 75 and competitive tendering is not enough, as this may lead to the use of other, equally undesirable approaches to tendering. We will argue for the NHS to be made the preferred provider of NHS services as part of the reforms.
* **Safe and adequate staffing is absolutely essential to integration:** increased ICS-level management of the local workforce has potential benefits, but will not matter if there is insufficient recruitment, training, and retention of staff. NHSE England should be clear about how this will be secured and explore the opportunity to pursue reforms such as safe staffing legislation.
* **Pooling certain funding streams makes practical sense but must come with safeguards:** present funding arrangements increase fragmentation and create perverse incentives. This can be overcome in part by pooling some budgets, but NHS funding, General Practice budgets – including GMS and PMS contract funding, and locally agreed arrangements (such as those between GP practices and CCGs) must be ringfenced.
* **Accountability is essential if ICSs are to be successful:** the present system lacks accountability and limits the ability of staff and patients to challenge decisions. We will call on NHSE to make clear how ICSs and their substructures will be held accountable, especially with the diminished role of CCGs.
* **The role of social care within ICSs – particularly in respect of funding – needs to be clarified:** the proposals do not present a vision for how social care will be integrated within ICSs. We will argue for greater clarity on social care involvement – particularly in respect of budgets.
* **Provider collaboratives present opportunities for clinical leadership but clarity is needed:** the proposals are unclear on how provider collaboratives will work in practice and particularly the role of PCNs and GPs within them. We will call for that clarity, as well as for clear recognition of the importance of retaining the independent contractor status and partnership model of General Practice.
* **The focus on improved use of data and technology is welcome but has to be supported with genuine investment:** the proposals around data and technology sound positive but are not new. We will argue that if the ambitions on this are to be met, then targeted investment is needed.
* **The timing and scope of the consultation limits the capacity of clinicians and their representatives to respond as thoroughly as possible, and undermines trust in the process:** carrying out this consultation both during a pandemic and over the festive period limits the opportunity for frontline clinicians to provide their views and significantly reduces the quality of this engagement exercise. We will call for further, more meaningful engagement on these proposals prior to their submission to Parliament.