Health and Care White Paper: The BMA View

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The White Paper: at a glance

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- Significant reform of the 2012 Act
- Section 75 to be removed – ending mandated competitive tendering
- ICSs to be formalised as statutory bodies
- NHS bodies within ICSs bound by a Duty to Collaborate
- CCGs to be absorbed into ICSs
- Greater powers and (some) accountability for the Secretary of State

The road to the White Paper

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- Follows years worth of visions and strategies for the NHS – most prominently the Long Term Plan
- Proposals put forward by NHSE alongside the LTP and in late 2020 form a major part of the White Paper
- These are ultimately rooted in the view that the NHS needs collaboration and integration over competition
- They also reflect a clear recognition that the 2012 Act is not fit for purpose
- We have lobbied NHSE and the Government heavily throughout this process, especially with our CSC report

Key changes: NHS structure

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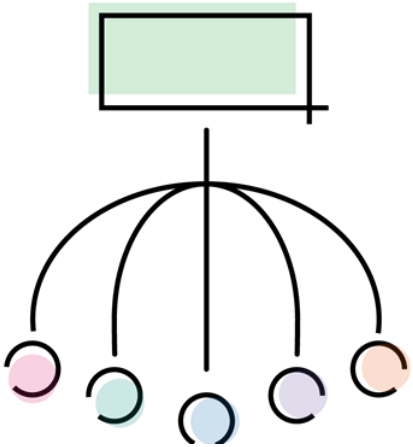

- ICSs will become statutory bodies – formalising their role and accountability for the planning and provision of care
- ICSs will be formed of two boards:

1) **ICS NHS body**, focused on core NHS services; and

2) **ICS Health and Care Partnership Board**, focused on wider issues e.g. public health and social care

- CCGs and their commissioning powers and responsibilities will be absorbed into ICSs
- Trusts and FTs will retain their independence
- But NHS bodies will be bound together by a Duty to Collaborate and a Triple Aim, focused on collaboration
- NHS England and NHS Improvement will merge formally

Key changes: CCGs

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- CCGs and their commissioning powers will be absorbed into ICS - follows NHSE's drive toward reducing the number of CCGs and encouraging mergers
- CCGs have been imperfect, but their loss could reduce local accountability, representation and clinical leadership
- Risk of losing vital local expertise and relationships too, though most staff are expected to carry over to ICS
- Clinical leadership and representation **must be embedded at every level of ICSs, including roles for LMCs** – as well as for LNCs and public health doctors
- We have also lobbied for existing CCG agreements with GPs and partners to be carried forward into future arrangement

The ICP Contract

- The White Paper doesn't refer to the ICP contract
- DHSC and NHSE are focused on the development of ICSs
- But SoS powers to create new Trusts could simplify the creation of ICP contracts (held by NHS Trusts)
- Currently **only one** ICP contract (Dudley) – which we are closely monitoring
- There are fundamental differences between ICSs and ICP contracts (see table)
- We oppose the ICP contract
- ICSs **could** deliver collaboration without the risks associated with the ICP contract

ICSs	ICP Contract
Integration by collaboration	Integration by contract
An 'alliance agreement' is held collectively by member bodies	Require a single contract, held by a single body, for the majority of health and care services
Do not necessarily require formal organisational change	Involves potentially major structural change
No change to GP independent contractor status	Incompatible with GP independent contractor status
No contract – so no increased risk of large-scale privatisation	ICP contract could theoretically be held by private provider

Key changes: competition and commissioning

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- Section 75 of the 2012 Act would be removed, ending the requirement for commissioners to competitively tender NHS and public health contracts
- The replacement system is under consultation, but would broadly give commissioners three options:

1) Renew contracts with existing providers without the need for tendering
2) Offer new or existing contracts to providers without tendering
3) Launch a competitive tendering process for contracts where appropriate

- This **should** see less wasteful competition and greater stability – but safeguards are needed to ensure proper scrutiny of commissioning
- We want to see the NHS recognised as the 'preferred provider' of NHS services

Key changes: power and accountability

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- The BMA criticised the removal of responsibility for the NHS from the SoS in the 2012 Act
- The White Paper would increase SoS responsibility - but this could mean more power for politicians over NHSE, not accountability for NHS performance
- SoS could set (or reset) the direction of the NHS
- ALBs could be amended or abolished by the SoS
- SoS could create new NHS Trusts
- SoS powers to intervene in service reconfigurations would be strengthened
- SoS to be required to publish a report on workforce planning every five years

Key changes: ‘additional proposals’

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- Making the HSSIB (Health Service Safety Investigations Body) statutory – with a focus on learning and safe spaces, which the BMA has supported
- Giving the SoS authority to introduce new restrictions on advertising high fat, salt, and sugar foods, as well as powers to alter food labelling requirements
- Streamlining the process of water fluoridation
- Allowing the SoS to make direct payments to social care providers
- Reforming patient discharge from hospitals to care settings – ‘discharge to assess’
- Extending professional regulation to include managers and senior leaders – as the BMA has called for

Funding, resources, and pay?

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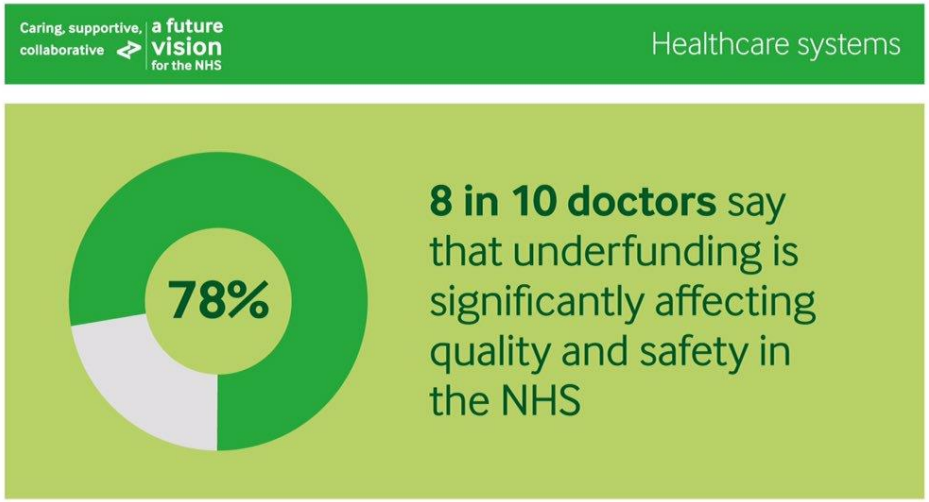

- While it sets out significant changes to the way the NHS works, the White Paper fails to address the underfunding and lack of investment in the NHS pre-COVID-19
- No new commitments are made within the White Paper on long-term funding for the NHS
- Equally, no focus on staff pay or resolving years of stagnant pay
- The future of the NHS depends on proper resourcing – ICSs, integration and collaboration need it to succeed

Key implications for GPs and LMCs

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- **Clinical voice** – loss of CCGs risks losing/reducing GP leadership within ICSs and may change who and how LMCs lobby locally, the role of PCNs is also a key consideration
- **CCGs** – while most staff will transfer into the ICS, there is a risk that leadership and commissioning expertise may be lost
- **Funding** – we have lobbied for ringfencing of GP funding, but as ICSs and Places take on more financial control current funding flows may change
- **Integration** – 'Place' will play a major role within ICSs with significant powers be devolved to them, but this isn't expected to be set out in legislation (to ensure local flexibility), so it's essential clinicians shape NHSE guidance

Positive Signs

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There a number of proposals within the White Paper that broadly align with our vision for the NHS – including key points we set out in the Caring, Supportive, Collaborative project:

- The broad progress towards a more collaborative NHS
- The removal of Section 75 and end to enforced competitive tendering, which has resulted in costly procurement processes, private provider takeovers and the fragmentation of services
- Creating ICSs on a statutory footing, which **should** ensure they are properly accountable and allow for greater clarity on their role
- The initial moves toward both regulation of NHS managers
- Support for a more flexible approach to the application of the NHS tariff and payment models, which could see a broader shift away from payment by results

Campaign Priorities

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- Whatever system replaces Section 75 should ensure there is sufficient scrutiny of commissioning decisions and that the NHS is the preferred provider of NHS services
- Clinical leadership and representation must be embedded at every level of ICSs – with roles for LMCs and LNCs, as well as for public health doctors
- Clarity is needed on how ICSs will work in practice and how their two boards will interact and co-ordinate their efforts fully
- The acknowledgement of SoS responsibility for workforce planning is an important step, but needs to be strengthened – with a firm commitment to safe staffing
- The powers set to be handed to the SoS must come with accountability to Parliament and the public as well as clarity over when and how they are to be used
- The duty to collaborate must have teeth to overcome perverse incentives

Next steps

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- The Bill is expected to be tabled soon – in April or May – to meet the Government's target of implementation by April 2022
- We are currently lobbying DHSC and NHS England to influence both the coming Bill itself and the guidance that is expected to underpin it
- Likewise, we are carrying out extensive engagement with external stakeholders, including the RCN, RCGP, RCP and others
- We are also actively engaging with BMA Council, committees and Regional Councils to update members and hear your views on the White Paper
- The BMA will also be responding the NHS England consultation on its future Provider Selection Regime – the replacement for Section 75

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