

## BMA Member briefing: Health and Care Act

### Foreword

The UK Government has now formally passed the Health and Care Act, which introduces significant changes for the NHS in England. The BMA was clear from the outset that this was the [wrong Bill at the wrong time](#). Not only have these changes been pursued at a time when healthcare workers have been busy tackling a global pandemic – the final Act fails to address the critical challenges facing the NHS of too few resources, too little funding, a crisis in social care and a huge shortage of staff across the system.

In July 2021, the Government brought the Health and Care Bill with the stated aims of embedding the co-operation seen across the NHS in response to the COVID-19 pandemic; removing longstanding barriers to collaboration by reversing competition rules that forced commissioners to put their services out to tender; and increasing political accountability for the NHS.

However, the Bill that was presented to Parliament instead risked further private sector interference in the NHS by failing to rule out corporate healthcare providers from sitting on NHS-decision making boards, or safeguarding against NHS contracts being awarded to the private sector without adequate scrutiny; failed to place clinical leadership at the heart of the NHS; and set out overarching powers for the secretary of state to intervene in the day-to-day running of the NHS.

We called for significant amendments to the Government's proposals to address our key concerns, including [a new duty to increase government accountability for safe staffing](#) by requiring the Secretary of State to provide regular, transparent workforce assessments; making sure there are genuine and transparent protections against privatisation; embedding clinical leadership throughout Integrated Care Systems (ICSs); and limiting new powers for the Secretary of State to avoid unnecessary political influence in NHS decision-making.

[We worked with other organisations, peers](#) and [MPs](#) across the House in calling for these changes, as well as [drawing on the support of our members and activists](#) to [campaign for change](#). It [is hugely disappointing](#) that the Government did not listen to the concerns of frontline staff and failed to address the critical issues the NHS and our members are facing.

However, with your support [we put up a strong fight](#) and the Government faced multiple challenges and delays in getting the Act through. Our lobbying helped force the Government into making concessions in other critical areas, including greater protections over private providers influencing commissioning decisions via membership of NHS decision-making bodies and safeguards over undue political interference in decisions over local health and care services.

We also joined organisations, peers and MPs in placing pressure on the Government to accept other important amendments that would strengthen research duties within the Bill, include regulations to restrict unhealthy food advertising before 9pm and ensure the NHS is not buying or using good or services produced by or involving any kind of slave labour.

Whilst the legislation we have before us may be improved from the one that was first presented, it still [fails to legislate for the action needed](#) to address the key challenges facing the NHS – most crucially, the [crippling workforce shortages](#).

Despite a coalition of over 100 organisations – co-founded by the BMA – [politicians from across the political divide](#), and [former NHS leaders](#) *all* backing an amendment to ensure regular, transparent workforce assessments that would hold the Government legally accountable for safely staffing the NHS, the Government [rejected vote after vote](#) on the issue. Their [refusal to act](#) and provide these assessments begs the question: [what does the Government have to hide?](#)

This briefing sets out what the Act means for our members, and the BMA analysis of this. As the Act begins to be implemented, we will continue to campaign for a publicly funded, publicly provided and publicly accountable NHS that gets the investment it needs, is properly staffed and protects the health and wellbeing of its workers so they are able to provide the high quality and timely care that patients deserve. – **Dr David Wrigley, Deputy Chair, BMA Council**

## Introduction

The Government's new Act 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 Act 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 justified the Act as 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 Act goes significantly further than NHS England's requested changes, particularly in the authority it grants the Health Secretary over the NHS and proposals relating to the future model for financing social care.

### **An overview of the changes**

- establishing [ICSs](#) in statute, and transferring the duties, staff, and resources of CCGs (Clinical Commissioning Groups) to them
- requiring each ICSs to set up a statutory 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.
- a new £86,000 cap on the amount anyone in England will need to spend on their personal care their lifetime. Only personal contributions to the cost of care will count towards the cap. Means-tested payments made by the local authority will not be counted.
- measures to help ensure the NHS is not buying or using good or services produced by or involving any kind of slave labour
- new duties on ICBs and NHSE to take steps to both promote and facilitate research regulations to restrict unhealthy food advertising before 9pm.

### **Why has the Government passed a new Act?**

The Government presented several arguments for why it felt the Act is needed. These include: the desire 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 will the changes be implemented?**

The changes set out in the Act can begin to be put into action now the Act has received Royal Assent. Whilst some of the changes have already begun implementation, others will take time for healthcare systems to develop and embed. The BMA questioned the timing of the legislation given it was introduced when the NHS was in the midst of responding to a global pandemic and facing severe backlogs of care.

### The changes set out in the Act

The Act covers a range of issues and will 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, social care, regulation and research).

### *NHS Structures*

A core purpose of the Act is to establish ICSs in statute. This would enshrine them with powers and accountabilities they presently lack – particularly in respect of commissioning and managing NHS funding. There are currently 42 ICSs, covering every area of England.

In their new form, ICSs will be made up of two statutory 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 is also required to have its own constitution, which will be subject to approval from NHS England. These constitutions, while based on a core national template, can vary significantly and will and reflect NHS England's policy of allowing ICSs and ICBs to develop with a high degree of freedom.

Barring a core, minimum membership set out in the Act, the wider membership of the ICB will be up to local determination and will be set out in each respective ICB constitution. The statutory membership of an ICB will be:

- 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 Chair of the ICB will also be expected to ensure at least one of the ordinary members has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

ICBs will also be required to keep the skills, knowledge and experience of their members under review and take action to address any gaps identified.

The Act 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.

This includes measures to help rule out private providers gaining a seat on ICBs or their sub-committees, in order to avoid them holding influence over commissioning decisions and the wider ICS strategy. These amendments to the Bill were brought by the Government following significant concerns raised by the BMA and others that, as initially drafted, the legislation left open the possibility of corporate healthcare providers wielding influence over commissioning decisions.

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

Critically, ICBs will also 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 and circumstances, 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 Act 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.

### **Clinical Commissioning Groups**

The Act abolishes 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 – for example, it will now be possible to submit an FOI (Freedom of Information) request to an ICB or ICP
- 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, we lobbied for greater and broader representation of doctors throughout ICSs, ICBs, and ICPs.
- this has included calling for ICSs to include independent public health experts on ICBs and ICPs serving not as representatives of their employers, but as independent voices able to provide a professional view on the health of the whole ICS
- whilst we were unsuccessful in getting the Government to accept amendments that would achieve these changes, the Government has introduced a duty on ICBs to review their skills mix and take action to address any shortfall in expertise on its board. It is vital that any guidance on the ICB skills mix reflects these key concerns and the need for strong, independent clinical leadership at the heart of the NHS – we will also continue to lobby NHS England and individual ICSs and ICBs on this issue
- 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. Our lobbying was key to securing Government concessions that help rule out private providers from sitting on ICBs or their sub-committees - we will continue to monitor how these measures are expanded on in guidance and enacted to ensure there is no room for misinterpretation.

#### *Collaboration*

The Act 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 Act 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 Act does not set out any reduction in existing Foundation Trust powers or legal duties. However, the Act 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 Act 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 Act 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 Act 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 Act itself, commissioning and service procurement will be governed by NHS England's Provider Selection Regime. The regime was subject to a consultation in 2021, [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.

Further detail on the [application of the Provider Selection Regime](#) was released alongside a technical consultation launched by DHSC in February 2022.

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

The Act 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 Act 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 remain concerned that 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
- we are continuing to lobby DHSC and NHS England on the development of the final Provider Selection Regime, to ensure that it includes robust and comprehensive scrutiny of commissioning and contracting decisions.

## *Workforce*

The Act 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 Act 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 Secretary of State.

### **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 Act.

**Our analysis:**

- the BMA has consistently lobbied for greater government accountability for ensuring health and care systems have the workforce required to meet the needs of the population, now and in the future
- during the Bill's passage, we were a leading voice in a coalition of over 100 healthcare organisations all lobbying for the Act's reporting requirement to go beyond just routinely describing the system in place for assessing and meeting the workforce needs of the NHS
- having harnessed extensive support from cross-party parliamentarians, the Health & Social Care Select Committee, and former NHS leaders, we lobbied for a new duty that would



require the Secretary of State to produce ongoing, accurate and transparent workforce assessments to directly inform recruitment needs across the healthcare system

- the Government was confronted with three separate votes in the House of Commons on this issue; despite the huge consensus for an amendment to the Bill, they refused to engage and whipped its MPs to vote against the amendment each time
- beyond this Act, we will be calling for the new NHS workforce strategy (which DHSC commissioned NHS England to undertake in collaboration with HEE earlier this year) to be based on an assessment of the workforce, including projections over the next 5-15 years, with a commitment to further assessments of a minimum of every two or three years.

### *Data and information sharing*

The Act 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 or in what way they may precede or compliment the proposed merger of NHS Digital's statutory functions with NHS England.

#### **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 monitor the impact of the legislation to ensure that developments in technical standards or infrastructure do not undermine existing high standards of patient confidentiality.

### *Powers and accountability*

A substantial portion of the Act 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.

#### **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 Act, 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 Act will allow the Health Secretary to proactively intervene in service reconfigurations and do so earlier in the process.

Following lobbying from the BMA, NHS Confederation, The Kings Fund and others the Government brought amendments to the legislation that provide additional safeguards and limitations to the

Secretary of State intervening in service reconfigurations to help ensure decisions over services are made in the interest of patient need rather than for political reasons. These will mean that:

- Both NHS organisations and local authorities affected by an intervention on local services by the Secretary of State will have to be consulted and their responses published
- The Secretary of State will only need notification and be able to intervene in complex and substantial reconfigurations
- The Secretary of State will need to publish the reasons for any intervention and be required to make a decision on a proposed service change within six months of ‘calling it in’ for consideration

### **Arm’s Length Bodies**

The Act gives the Secretary of State 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 will also allow the Health Secretary to amend the roles of other ALBs, including NHS England itself. As per the Act, 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.

Importantly, these powers are set to be used in order to merge NHS Digital into NHS England, ending the relative independence it currently holds as the safe haven for patient data.

### **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, we were concerned that the proposals in the legislation appeared 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
- in particular, we were concerned 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
- the BMA joined NHS Confederation and others in calling for additional safeguards over powers for the Secretary of State to intervene in local service reconfigurations, with the aim of ensuring that any decisions over services are made in the public interest and not for political reasons
- This led to the Government bringing their own amendments to limit the Secretary of State’s powers to intervene in service reconfigurations, which should help address these concerns.
- we have raised specific concerns over the plans to use these powers to merge NHS Digital into NHS England, too, particularly where extracted patient data will no longer be held by NHSD and subject to the checks and balances currently in place for dissemination
- 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 Act includes specific plans to give the Secretary of State the authority to bring in new regulations to restrict unhealthy food advertising before 9pm on television, on demand services and online. The regulations are due to come into effect on the 1<sup>st</sup> January 2023, although the Secretary of State for Health and Social Care retains the power to extend this. Secondary legislation to support these regulations is expected imminently.

Powers to amend EU food labelling requirements are also included.

#### **Our analysis:**

- the BMA has long advocated and therefore welcomes the advertising restrictions of unhealthy foods and will now be focused on making sure the successful passage of necessary secondary legislation
- the BMA will also focus on seeing that the remaining policies outlined in the Government's 2020 obesity strategy, such as calorie labelling on alcohol, are implemented in full.

### **Social care**

The Act introduces a new £86,000 cap on the amount anyone in England will need to spend on their personal care their lifetime.

Only personal contributions to the cost of care will count towards the cap and means-tested payments made by the local authority will not be counted.

It also includes 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 Act 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.

#### **Our analysis:**

- the care cost cap has come under significant criticism for only applying to personal contributions to the cost of care, meaning less wealthy people in receipt of means tested support will take longer to reach the care cost cap and would need to meet a much higher level of need to benefit from the cap
- it was also criticised for being introduced to the legislation halfway through the legislative process, meaning MPs did not have as long or as much opportunity to scrutinise the changes
- the BMA has called for more social care services, including personal care, to be free at the point of need to increase the availability of and access to care, as well as reduce the pressure on the NHS by reducing delays in finding care packages for vulnerable patients
- we have also called on the Government to invest in the social care workforce, including ensuring there are opportunities for salary and career progression, and it is disappointing that the Act takes no action to address the workforce crisis facing social care.

### **The Health Services Safety Investigations Body**

The Act 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.

The Bill previously proposed an exception for coroners from the HSSIB safe space so they could access information on investigations for their reviews. The BMA and others raised concern over this exception from the safe space, arguing that the approach should be universal. Following amendments made by the House of Lords, this exception was removed from the legislation.

Our analysis:

- 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
- it is right that the exception for coroners from the safe space was removed, which should help ensure confidence among healthcare professionals in the approach.

### **Medical examiners**

The Act 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 Act itself, NHS England is also intending to [extend medical examiner scrutiny into primary care](#).

Our 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.

### **Research duties**

The Act now places a duty on each ICB, NHS England and the Secretary of State to “facilitate or otherwise promote research.” This duty was strengthened from the original duty to promote research. ICBs will also now be required to consider how the duty has been met in their forward plans and annual reports, whilst NHS England’s will be required to do the same in their business plan and annual report. The ICB research duty will also need to be considered in NHS England’s annual performance assessment of each ICB.

**Our analysis:**

- through direct meetings with DHSC and joint briefings with research organisations, the BMA called for the research duty on ICBs to be strengthened from one to promote research to one to conduct research – in order to help ensure research is carried out
- the Government responded by strengthening the duty to one to facilitate research to clarify that “promote” is a spectrum of activity that includes actively facilitating research
- further amendments were also made to require ICBs and NHSE to give the duty particular consideration in annual reports, plans and performance reviews with the aim of ensuring promoting research is seen as central to good performance.

## Further guidance and consultations

In addition to the White Paper on the Bill 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.

In February 2022, the Government published a new white paper – [Joining up care for people, places, and populations](#) – which sets out its high level plans to better connect health and social care services. This appears, in part at least, to signal the future direction of ICSs and their involvement in coordinating health and care services, as well as their funding. [Read the BMA briefing on the integration white paper](#).

## Conclusion and next steps

Following the Act receiving Royal Assent on 28<sup>th</sup> April, the focus is now on its implementation.

The BMA will continue to closely engage Government Ministers, NHSE, civil servants working on the implementation of the Act and the guidance underpinning it, as well as directly engaging with ICSs on how they are implementing the measures in the Act locally.

Separately, we continue to campaign for a publicly provided and publicly accountable NHS that gets the investment it needs, is properly staffed and protects the health and wellbeing of its workers so they are able to provide the high quality and timely care that patients deserve.

You can find our more on the BMA's work on the Act [on our dedicated webpage](#).