

Mr Ian Dodge
National Director, Strategy and Innovation
NHS England
PO BOX 16738
Redditch
B97 9PT

25 April 2019

RE: Consultation on proposed legislative changes

Dear Mr Dodge,

The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The BMA welcomes the opportunity presented by the Long Term Plan to review and assess the legislation governing the health system in England. This is an important opportunity to address some of the underlying structural issues currently impeding the delivery of the highest quality care to patients. These include:

- Removing unnecessary administrative and bureaucratic barriers to collaboration within the NHS.
- Mitigating the counter-productive effects of competition and procurement requirements on the delivery of high-quality patient care by the NHS.
- Ensuring transparency and accountability in the way the NHS is structured and organised.

In principle, the BMA supports the stated aim of NHS England's proposed legislative changes to facilitate the development of integrated and collaborative care. The BMA has consistently highlighted the detrimental impact to patients of fragmented and disjointed care. Successful integration of care has the potential to deliver benefits to both patient care and doctors' working lives. The BMA's *Caring, Supportive, Collaborative*¹ project, a long term piece of work aiming to

¹ *Caring, supportive, collaborative: a future vision for the NHS* www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/future-vision-for-the-nhs



be an honest conversation with our profession about the sort of NHS doctors want to work in, explores how the fragmentation of care can be overcome. A recent BMA survey of 8,000 doctors, conducted as part of this project, found that 94% of doctors agree that greater collaboration between primary and secondary care will improve patient services, and that 93% agree GPs and hospital doctors should work together more closely. In addition, only 16% of doctors believe that there currently are clear channels of communication between primary care and secondary care. The effect of this is that just 9% of doctors believe patients experience co-ordinated care between hospitals and general practice.

The BMA is encouraged to see that NHS England has rightly identified the competition and procurement requirements within the NHS as a key barrier to the delivery of integrated care. The BMA has expressed longstanding opposition to the role of competition within the NHS. We are, therefore, pleased to see that the detrimental and wasteful impacts of competition within the NHS have finally been acknowledged. We specifically support the proposal by NHS England for NHS contracts to be exempted from the Public Contract Regulations 2015, and for section 75 of the Health and Social Care Act 2012 to be revoked.

There are many areas in which more detail is needed than is currently given in the consultation document in order to understand the full implications of the proposals. We have set out in detail below our views on each of the proposals in turn, following the structure of the consultation document.

Promoting collaboration

As stated above, the BMA does not believe that it is appropriate or helpful for the NHS to be subject to the competition requirements that apply to the rest of the economy. In accordance with this position, we believe that the CMA's (Competition and Markets Authority) role within the NHS is unnecessary, as the CMA's duty can act as a deterrent to collaboration, as well as leading to an unnecessary use of already limited time and resources by NHS providers to satisfy the requirements of a CMA investigation.

We would appreciate greater clarity from NHS England on the process which will govern proposed mergers or acquisitions. Specifically, we would ask what methodology NHS Improvement will use to determine whether there are "clear patient benefits" when reviewing proposed mergers or acquisitions. This is particularly pertinent as NHS Improvement's primary role is not just to support improvements in quality of care, but also the use of NHS resources. The BMA does not believe that financial savings alone should be used as the criteria for reviewing such mergers or acquisitions. Instead, we believe there must be demonstrable benefits to service delivery and patient care that can be achieved from any merger or acquisition for it to be approved.

We would also welcome NHS England's assurance that the assessment by NHS Improvement of any proposed merger or acquisition would be made publicly available. In addition, opportunities must be made for the public and clinicians to engage with NHS Improvement when any mergers or acquisitions are being reviewed.

Getting better value for the NHS

The BMA has long highlighted the counter-intuitive and wasteful impact of competition and procurement requirements within the NHS. We therefore support proposals to revoke section 75 of the Health and Social Care Act 2012, and the exemption of the NHS from the Public Contract Regulations 2015.

We would like to see more detail on what commissioning processes will replace the current competition and procurement framework in the NHS, and, specifically, what shape NHS England's proposed 'best value test' will take. Greater clarity is needed on the following points, in particular:

- Greater detail on eligibility requirements for a provider to be given an NHS contract under the proposed best value test.
- Confirmation of whether an independent NHS provider will be able to receive an NHS contract via the application of the proposed best value test – any new test cannot lead to a situation where commissioners award NHS contracts to private providers without due transparency or regard for the impact on wider NHS provision. In addition, we believe there should be a requirement for an NHS provider to be considered as the preferred provider for any contract being awarded via the best value test.
- Confirmation of whether a best value test will adopt the principles and methodology of the existing public sector best value test, or if a new test will be developed specifically for the NHS. Currently the consultation only mentions that the aim of the new regime would be to ensure the delivery of good quality care and value for money. It is important that the new best value test does not lead to contracts being awarded to private providers overestimating the amount of savings they can deliver only for provision to revert back to now destabilised NHS providers once the private provider has handed back the contract. This is a situation which has often occurred under the current competition and procurement regulations.

We would also welcome an assurance that there will be a consultation exercise on the development of the statutory guidance to support the application of this best value test.

Where best value tests are used to award contracts, clear safeguards must be in place to ensure transparency and accountability, as well as ensuring adequate and meaningful public consultation is included as part of the commissioning process. Therefore, detail is urgently required from NHS England as to how provisional assessments resulting from the best value test will be scrutinised by the local community and NHS workforce.

Increasing flexibility of national NHS payment systems

Based on our understanding of these proposals, they appear to be sensible and practical suggestions which will address current deficiencies within the NHS payment systems.

We would like to see further detail on how the setting of national prices by a formula would enable prices payable to more accurately reflect local factors than the current application of a provider's market forces factor to a national price. In addition, we would like to see explanatory guidance released as to how this proposed formula will operate and what principles it will be based on.

We would also like to know what safeguards would be put into place to protect providers from any detrimental financial impacts resulting from an adjustment to the national tariff within a tariff period.

Integrating care provision

The BMA is in agreement that there is a need for more integrated and collaborative health services. However, the BMA has previously publicly stated our concerns about the ICP (Integrated

Care Provider) model, the creation of which, changes in this area are intended to facilitate. Further detail on our position on ICPs can be found [here](#)². Our concerns include:

- That creating a single contract for NHS care risks creating a situation where in the future a private company could be given that contract, which would represent a significant increase in private involvement in the NHS. Although NHS England’s proposals could help mitigate this risk (by removing the requirement to tender contracts) more detail is needed to understand whether it would still be possible for such a contract to be awarded under the proposed best value test (see section 2 above).
- A fully integrated ICP model would involve a move away from the independent contractor status of GPs, which the BMA strongly opposes.

The NHS England consultation document states that prior to a new integrated care trust being established by the Secretary of State, there will be “appropriate local engagement”. We would like to see more detail as to how the public and clinicians will be engaged on such a proposal, and how this local engagement will be formalised prior to the creation of such a trust.

Secondly, the consultation document states integrated care trusts would be accountable to their commissioners for their performance. However, a further legislative change proposed in the consultation would enable commissioners and providers to establish joint committees to exercise collective decision-making. In such a scenario, where the integrated care trust and the commissioner are on a joint committee, we would like greater clarity on where accountability for the performance of this trust would sit and the mechanisms in place to make this accountability transparent. As currently, we believe the commissioner is likely to be conflicted in managing the performance of the provider due to their joint working with the provider through the committee.

Furthermore, we would like to see greater detail on what process will be followed if an integrated care trust is failing to deliver on its ICP contract. Specifically, what action would be taken to address the failure and whether it would be possible for such a trust to be dissolved, if the failure were severe enough to warrant such a step. This process should be consistent across ICP trusts and be clearly set out during the consultation phase prior to the establishment of such a trust to ensure the public and clinicians are aware of how the performance of these trusts will be managed. Detail should also be provided on how the CQC (Care Quality Commission) and NHS Improvement will assure system-wide performance within an ICP contract, along with ensuring service failings are not overlooked in this assessment.

Managing the NHS’s resources better

Part of the proposals in this section follow on from the proposals set out in the “Promoting collaboration” section of the consultation document and we repeat our call for clarification to be provided as to how NHS Improvement would determine where there were “clear patient benefits” to be achieved from a merger or acquisition.

The consultation document states that NHS Improvement’s ability to direct mergers or acquisitions would require “appropriate safeguards”. The BMA agrees, but we believe further detail is required from NHS England as to how these safeguards would work. We would

² Integrated Care Providers, BMA – available at: <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/nhs-structures-and-integration/integrated-care-providers-icps>

recommend that a publicly available, standard framework be created setting out when it is appropriate for NHS Improvement to direct a merger or acquisition.

NHS England must also provide clarity over how the contracts of staff employed in organisations involved in such mergers or acquisitions will be protected, including relevant TUPE arrangements.

Although we understand the reasoning behind the proposal to provide NHS Improvement with the ability to set annual capital spending limits for foundation trusts, we would appreciate reassurance that foundation trusts will not be restricted in spending funds received through the Provider Sustainability Fund, a potential issue highlighted by the Nuffield Trust.³ Therefore, we believe measures, such as raising the Department of Health and Social Care's capital spending limit should be pursued. This would ensure that foundation trusts are able to use the funds they earned through cost-saving measures. If foundation trusts are prevented from using these funds as they see fit, then this will likely undermine clinical trust and engagement with initiatives from NHS England, if promised incentives are not honoured.

Every part of the NHS working together

In accordance with our support for integrated care, we are broadly supportive of the proposals set out in this section of the consultation document. These proposals appear sensible as they break down the unnecessary barriers to collaboration between commissioners and providers – provided NHS England can give clarification on a few key points.

We are particularly encouraged by the proposal to allow the designated nurse and secondary care doctor on CCG governing bodies to be clinicians in a local provider. This change will help ensure local clinical expertise and experience is able to shape and influence the design of local services. This change would also create parity, in terms of the restrictions that apply, between secondary care doctors and GPs. Current best practice on managing conflicts of interests should be applied to nurses and secondary care doctors on CCG governing bodies.

Regarding the proposal to allow joint committees of commissioners and providers to be created to exercise collective decision-making we would like to see more detail on how, if at all, the independence and individual duties of commissioners and providers will be maintained. Furthermore, NHS England needs to provide a clear mechanism for how these joint committees will be scrutinised and held to account as a whole by the public, rather than as two separate constituent parts of commissioners and providers. However, we believe this proposal is a step in the right direction. This is because we are of the view that the purchaser-provider split is an unnecessary division existing only to meet the requirements of the competition and procurement requirements within the NHS, which we are staunchly opposed to.

Considering the trend towards greater collaboration and mergers between CCGs, and the clear desire for integration among providers, these joint committees have the potential to be responsible for the organisation and delivery of care across large areas of the country. Given this all-encompassing role for the committee across a large population, the BMA would be keen to know how NHS England plans to ensure there is sufficient public and clinical engagement with these committees, beyond the clinical and patient representatives on the governing bodies.

Thus far, there does not appear to be a satisfactory desire to engage with local clinicians and members of the public. This has been demonstrated in the South West London merger of six

³ Gainsbury S (2019) "Having your fudge and eating it", Nuffield Trust comment

CCGs, where there have been inadequate levels of engagement with local GP member practices. This is despite NHS England's own guidance stating this is key criteria for CCGs to demonstrate in any application for a merger.⁴ Therefore, we would be grateful if this requirement was highlighted to CCGs as a matter of urgency and that the fulfilling of this requirement was prioritised by NHS England when reviewing merger applications. Without such engagement and local clinical support, these mergers could undermine the key principle of CCGs of being clinically-led organisations.

Regarding the proposal for new provisions on the formation and governance of joint committees, we would welcome assurances from NHS England that there will be a consultation and engagement exercise on the development of these new provisions. These provisions should also ensure there is adequate opportunity for the public and clinicians to engage with these joint committees.

Although we can see the benefits of allowing joint appointments across organisations, and we appreciate that NHS England has highlighted the need for guidance on managing conflicts of interest, there is a need for further information as to how these conflicts will be managed. We would appreciate confirmation that information will be made publicly available on any conflicts of interest that a person has who holds a joint appointment.

Shared responsibility for the NHS

We welcome the aspiration that NHS England has set out in its proposed shared duty for those who plan NHS services and NHS providers. The "triple aim" of "better outcomes; better experiences for patients and staff and better use of resources" is one that we endorse, and something that we would hope NHS commissioners and providers already meet.

We are further encouraged that NHS England is seeking to make this 'triple aim' a statutory duty. However, we are keen to know how this shared duty will be implemented, especially in cases where it may conflict with an individual organisation's statutory and financial duties. We would also like to know whether organisations will be compelled to comply with this duty; and, furthermore, whether organisations would be open to challenge if they were perceived to not be compliant with this duty.

We would appreciate clarification as to whether independent NHS providers would have to adopt this duty to continue providing NHS services. We believe they should, as it would ensure that no part of the NHS had differing aims to another and help to encourage collaborative working.

Planning our services together

Overall, we are supportive of the main aim of this section of the consultation document; to remove legal barriers to organisations collaborating and making decisions jointly. We are supportive in part due to the need for integrated and collaborative care, but we also believe decision-makers should be empowered to exercise their professional judgement when designing services for patients.

⁴ Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution, NHS England (2019) – available at: <https://www.england.nhs.uk/wp-content/uploads/2019/04/procedures-ccgs-constitution-change-merger-dissolution-april-2019.pdf>

We are particularly supportive of the intention to allow section 7A public health services to be commissioned at a local level, as any measures which promote a more integrated and holistic approach to public health are commendable.

Regarding the proposal to provide NHS England with the ability to allow groups of CCGs to collaborate to arrange services for their combined populations, we would appreciate further detail on where accountability will lie for commissioning such services. Specifically, whether in such instances there will be individual accountability for the services delivered in a local area; collective accountability between all the CCGs who are collaborating together; or whether the lead CCG will be individually accountable for the services delivered across the combined populations.

We would also appreciate confirmation as to whether the proposal to allow NHS England and CCGs to enter into formal joint commissioning arrangements and pool budgets is restricted to just specialised services.

Joined-up national leadership

We are in agreement with NHS England that the leadership structure of the NHS is currently unclear and confusing for the public, as well as clinicians. This confusion can often lead to a lack of accountability within the NHS and government, hampering the scrutiny of NHS performance and support for its workforce. In line with this desire for simplicity and transparency, we agree that there is a good case for creating a single organisation responsible for all the existing functions of NHS England and NHS Improvement.

However, despite our support for the principle behind the proposal in this section, we are not able to offer our support to either options proposed until further information is provided by NHS England. Specifically, this requires setting out how it is envisioned these options will work in practice and what the new lines of accountability would be.

The proposal to provide the Secretary of State with the ability to transfer, delegate or create functions for Arm's Length Bodies appears worthwhile. However, we would appreciate further detail as to how the Secretary of State would utilise such a provision, along with what consultation exercise would be undertaken prior to any changes.

We hope our response to these proposals indicates our willingness to engage meaningfully with them and demonstrates our support for the principles behind these proposals. However, as highlighted throughout our response, in some areas we believe far greater detail is required on these proposals before we can fully endorse them. We look forward to engaging further with NHS England on these proposals to aid them in their development.

Yours sincerely



Raj Jethwa
Director of Policy