

Mr Ian Dodge
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Friday 8th January 2021

Dear Ian,

BMA response to ‘Integrating care: Next steps to building strong and effective integrated care systems across England’

Please find attached the BMA’s response to *Integrating care: Next steps to building strong and effective integrated care systems across England*. However, I must be clear that we believe the timescales given to respond meaningfully to these proposals, which have far-reaching consequences, have been unrealistic and inadequate.

Coming as it does amid the ongoing global pandemic and the immense pressures the NHS is facing this winter, our members have understandably been focused on the provision of vital care and the implementation of the vaccination programme. This has meant that many have been unable to give these plans the consideration and scrutiny they require which, in our view, risks undermining confidence in this process and the proposals themselves.

Consequently, while the BMA has engaged in this process in good faith, it is worth noting that our response represents only our initial views on certain aspects of the proposals.

We believe it is therefore imperative that this engagement exercise should be followed by further consultation, either through a formal consultation process which provides clinicians, the public, and all interested stakeholders proper time to submit their views or via comprehensive pre-legislative scrutiny.



In respect of the proposals themselves, the BMA supports the principles of integration and of a collaborative NHS – which we called for in our document [*Caring, Supportive, Collaborative. Doctors vision for change in the NHS.*](#) We recognise that some elements of your proposals aim to help achieve this. However, we also have significant reservations about other aspects of the plans, which are either unclear or which we believe could have adverse consequences for clinicians and local NHS services.

The BMA hopes that our response is constructive and would welcome the opportunity to further discuss these proposals with NHS England, to help deliver the changes our members and the NHS need.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Chand Nagpal'. The signature is written in a cursive style with a large initial 'C' and 'N'.

Dr Chaand Nagpaul
Chair of Council, British Medical Association

Enc.

BMA Response - Integrating care: Next steps to building strong and effective integrated care systems across England

Executive Summary

Overall points

- The engagement process itself risks undermining confidence in the proposals and must be revised – with a formal consultation carried out over an adequate period of time, or if that is not possible proper pre-legislative scrutiny.
- The BMA supports the aim of integration and of fostering a collaborative NHS, and some aspects of the proposals put forward by NHS England could help achieve this
- However, we have profound reservations about other elements of the proposed changes – not least due to a serious lack of clarity regarding the practical implications of transferring CCG powers to ICSs and the introduction of provider collaboratives, as well as the notable absence of references to general practice, public health and prevention, and social care from the proposals

Integrated Care Systems

- We agree ICSs should be made statutory, to ensure they are transparent and accountable bodies
- A strong clinical voice is essential within ICSs and their substructures and must be enshrined within any legislative change – including formal representation for LMCs and LNCs
- Safe and adequate staffing is essential to integration, so NHS England must be clear how ICSs will be supported to deliver the recruitment and retention programmes needed to achieve this
- NHS England and Government should also take this opportunity to include new legal requirements on safe staffing within the proposed reforms
- Clarity is needed on how ICSs will be held accountable to clinicians and the public

Clinical Commissioning Groups and Foundation Trusts

- Whatever the future of CCGs, their positive elements – including the strong clinical voice they have helped facilitate, local decision making, and accountability to clinicians – must be retained in some form
- NHS England should look to alter the fiscal accountabilities of NHS Foundation Trusts, which hinder integration and alignment within systems, and not focus only on CCGs

Competitive tendering and commissioning

- The removal of Section 75 and end to competitive tendering must be reinforced by making the NHS the preferred provider of NHS services
- General practice funding – including GMS and PMS contracts as well as locally agreed arrangements – should be more clearly ringfenced in any pooling of NHS finances, and clarity is needed on who will be responsible for commissioning general practice

Other issues

- Social care is notable in its absence from the proposals and clarity on its role is urgently needed, particularly in respect of its funding
- Provider collaboratives hold some promise, especially in bringing organisations together, but NHS England must clarify their expected membership and how they will operate in practice
- The focus on data and technology is welcome, but has to be backed with genuine investment

Introduction

The BMA supports the principle of integration and has campaigned strongly for a collaborative NHS, free from competitive models that have built artificial boundaries between services and clinicians. This stance is reflected in the BMA's report [Caring, Supportive, Collaborative. Doctors vision for change in the NHS](#) which, through a comprehensive survey of BMA members, showed the clear support amongst doctors for an NHS which breaks down those barriers and brings services and staff together.

We have also previously published [five principles for integration](#), against which we have judged the development of ICSs and other related models. These call for any such model to:

- protect the partnership model of general practice and GPs' independent contractor status
- ensure the pay and conditions of all NHS staff are fully protected
- only be pursued with demonstrable engagement with frontline clinicians and the public, allowing local stakeholders to challenge plans
- be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
- be operated by NHS and publicly accountable bodies, free from competition and privatisation.

On this basis, and examining the proposals against our principles, we feel that while they do include positive steps toward delivering integration, they lack clarity in critical areas and fail to build the system the NHS and its workforce needs. We have suggested several ways in which these shortcomings may be addressed, but fundamentally see the published proposals as in need of revision and much more extensive consultation before they can become viable.

In addition, we have significant concerns regarding the timing of this exercise, which we feel risks undermining the validity and value of the process. While we have produced this submission to meet the timescales for response, we believe it is essential that a further, formal consultation is launched to provide clinicians, the public, and all interested stakeholders proper time to submit their views. In this is not possible, we would expect proper pre-legislative scrutiny of any legislative proposals. In April 2019, the [BMA submitted a comprehensive response](#) to the prior iteration of NHS England's legislative proposals, much of which remains valid and we hope remains of use. However, as this consultation took place some time ago and the proposals have evolved since, more engagement is needed.

Therefore, this response is naturally limited and, consequently, in certain sections represents only our initial views. However, in the below, we present the core points we believe NHS England must address:

The timing and scope of the consultation limits the capacity of clinicians and their representatives to respond as thoroughly as possible to the proposals, and undermines trust in the process

As reports over the festive season have shown, hospitals across England are stretched to the limits of their capacity and GP practices are dedicating much of their time to preparing and delivering the vital Covid-19 vaccination programme. Unfortunately, conducting a consultation at this time means few doctors will have time to properly consider the proposals. The short deadline for responses to be submitted has exacerbated this. It is also notable that the proposals have been shared as an engagement exercise rather than a formal consultation.

If these proposals are to have the confidence of clinicians, the public, and stakeholder organisations, they absolutely must be subject to formal consultation before being put to Parliament. This should not only provide proper time for the proposals to be considered in full, but also include meaningful engagement with frontline clinicians and patients in particular.

We agree that ICSs should be made statutory

As the BMA has argued previously, the lack of statutory footing for ICSs has severely limited their accountability and transparency and, in so doing, has reduced confidence in them as nascent institutions. We believe that enshrining ICSs in statute would, in part, help to resolve these issues, particularly in respect of ICSs' transparency and their accountability to clinicians, patients, and the public.

However, it is important that thorough processes are put in place to deliver this in practice. Simply making ICSs statutory bodies is not enough, particularly given the proposed changes to CCGs which currently provide an important role in ensuring the NHS is accountable at a local level. This should include formal systems of accountability for ICSs, such as representative bodies or forums, which allow clinicians, patients and others to meaningfully question and challenge the plans of their local ICSs, as well as clinical representation within ICS decision making structures.

Further, the present status of ICSs has reduced the capacity for genuinely aligned system-wide plans for services, finances, and workforce development as each member organisation retains its present statutory responsibilities which override any system-level considerations. In making ICSs statutory, we agree that that all member organisations and strata within the system should have clearly defined responsibilities and accountabilities, both as individual organisations and as part of the collective ICS.

The positive elements of CCGs must be retained in any new model and clarity provided on where their present responsibilities will be transferred

We endorse neither option set out in the consultation for the future of CCGs. Instead, we call for positive elements of CCGs to be retained in any new model. This includes their vital function in ensuring accountability to clinicians and patients, their invaluable local knowledge, their role in providing a strong clinical voice, and their skill and experience in commissioning services. The staff and leaders of CCGs are pivotal to this. While we welcome NHS England's commitment to retaining CCG employees, we believe further clarity is needed on where these staff and GP commissioners will be transferred and assurances that their vital expertise will be retained by local Places and ICSs on a long term basis.

Although the proposals do stress that the Place level will play a pivotal and potentially leading role in the work of an ICS, the proposals are currently vague on how decision making at Place level will work in practice. This includes what accountability structures will be in place and, particularly importantly, how local clinicians will be involved in this process. Clarity is urgently needed on this issue, to provide reassurance that power will not be concentrated at ICS level – which remains remote from frontline doctors.

Additionally, there is a desperate need for clarification of how existing CCG responsibilities for primary care commissioning will be transferred to an ICS, if that is the eventual outcome. This includes CCGs delegated powers to agree and 'hold' GP contracts – following changes to NHS England's previous responsibility for this duty. This lack of clarity means that the potential changes to CCGs are a source of significant concern for GPs and GP partners, who may face significant changes to their working lives as a consequence, and NHS England must provide complete clarity on where and to which bodies CCG powers may be transferred.

Finally, the proposals set out an important role for PCNs ((Primary Care Networks) in the future development of ICSs. However, it remains unclear how they will be expected and supported to fulfil these functions, particularly given the many roles already ascribed to PCN clinical directors. We believe one way of providing this support would be repurpose some CCG management resources to PCNs, in order to support their development. However, it is important to stress, as set out below, that PCNs are not representatives of GPs or general practice and should not be treated as such.

Pooling certain funding streams makes practical sense but must come with safeguards

As the BMA has argued, existing funding arrangements increase fragmentation, create perverse incentives, and encourage competitive behaviour, all of which hinder integration and collaborative working. We agree that this can be overcome in part by pooling certain budgets, particularly in secondary care where Trusts have previously been forced into a competitive model.

We welcome the requirement within the proposals for ICSs to maintain national investment standards, particularly for general practice. However, we remain clear that core general practice budgets – including core GMS and PMS contract funding, as well as locally agreed arrangements such as those between GP practices and CCGs – must be protected. The partnership model of general practice and GPs' independent contractor status both play a vital role in the effective provision of primary care and it is imperative that their funding remains secure. Likewise, local arrangements between CCGs and GP practices can provide vital additional funding targeted at those communities most in need, so should be retained if and when ICSs take on CCGs duties.

Foundation Trusts should also be subject to legal reform

The present proposals focus almost entirely on the roles and responsibilities of CCGs; however, this appears to overlook the ways in which the existing statutory powers of other NHS bodies can and do hinder integration.

NHS Foundation Trusts hold considerable power and accountability over their finances above and beyond their responsibilities to their given ICS. This means that it is possible that Foundation Trusts will understandably need to consider their own financial performance, in line with their legal duties, before the overarching financial state of the local health and care system. In addition, this may force Foundation Trusts to place their financial requirements before the wider needs or wants of the ICS, including their desire for collaboration, commissioning of services and long term plans for reconfiguration. Ultimately, the current accountabilities and financial imperatives for Foundation Trusts can create perverse incentives and hinder collaboration.

Therefore, NHSE should take this opportunity to consider reforming the role of Foundation Trusts, as well as that of CCGs. This should include the option of altering their financial responsibilities and, in so doing, allowing for a genuinely and legally collaborative approach across each system.

Provider collaboratives present opportunities for clinical leadership, but clarity is needed

As proposed, provider collaboratives appear to have potential to improve collaboration and may, as we have called for previously, reduce the siloes prior reforms have constructed around provider organisations. However, the proposals are unclear on the membership of these collaboratives, how they will work in practice, and on the role of general practice within them. This lack of clarity is a source of major concern for the BMA and our membership.

The membership of the proposed provider collaboratives will undoubtedly be pivotal to their development and eventual operation, yet it remains largely unclear which organisations will be expected to be a part of them. To some extent this is understandable, as it will depend to a degree on the needs and composition of individual health and care systems. However, this leaves the makeup and, as a result, the influence of the collaboratives open to question. Equally, those details set out in the proposals raise the prospect that private providers, depending on the contracts they hold, may be prospective members of provider collaboratives and, consequently, may have a significant influence over those groups which would be unethical given their requirement to focus on the profit of their business rather than what is best and most affordable for the local healthcare system. This is a source of significant concern for our members and urgently requires clarification in the final proposals.

Exactly what responsibilities and accountabilities will be held by provider collaboratives remains unclear which, as a result, renders their prospective roles within ICSs opaque. Given the apparent importance of the collaboratives within the proposals, this is a significant issue. As the NHS adjusts to its new normal, staff and patients must be able to understand which element of the system is responsible for what. Therefore, before pursuing with the provider collaborative model in earnest NHS England must be clear about what it is expected to achieve and how.

The notable absence of reference to general practice - including GP partners, GP partnerships and GP practices - within the proposals is especially troubling, especially given its role as a cornerstone of local health systems. PCNs and their member GP practices will be vital to the work of ICSs at the 'neighbourhood' or 'locality' level, which should be reflected within provider collaboratives in such a way that gives general practice parity of esteem with larger secondary care providers. It is imperative that these collaboratives facilitate co-operation and a strong interface between primary and secondary care, which can only be achieved if general practice, as well as secondary care, has the recognition, representation, and equality it warrants within them. However, it should again be noted that PCNs do not serve a representative function for general practice or for GPs – LMCs (Local Medical Committees) provide this vital function and must be actively engaged in any discussions regarding the role of general practice in provider collaboratives.

A strong clinical voice within ICSs is essential

The present system and the proposals themselves fail to provide a clear, strong voice for clinicians within ICSs and their substructures. This minimises the ability of doctors, who ultimately know their local healthcare systems best, to influence changes within their systems and means that, for many, ICSs remain remote and disengaged entities. In line with our principles for integration, we believe this must be remedied urgently and comprehensively.

We remain clear in our view that integration should be led from the bottom up and by clinicians themselves. Therefore, we call on NHS England to enshrine within these proposals (and DHSC in any legislation), a leading role for doctors – across all branches of practice – within all ICSs and their substructures.

This should include not only representation of frontline clinicians on relevant boards and committees at system and Place level, but also formalised roles for LMCs. LMCs have a statutory role as representatives of general practice and provide a vital function in ensuring provider GPs have a strong voice at a local level, so their absence from the proposals as they stand is troubling and must be corrected. Equally it is important to note that while PCN Clinical Directors should and do play an important role within ICSs and at Place level, they are not GP representatives and should not be seen as such by NHS England.

Secondary care is too often represented by managers alone who, while playing an important role, cannot and do not provide a voice for clinicians themselves. Therefore, LNCs (Local Negotiating Committees) should also be given formal representative roles within ICSs and their Place level decision making structures. LNCs are important representatives of secondary care and hospital doctors, giving Consultants, SAS, and Junior doctors an essential voice, which must be included within ICSs.

Public Health doctors must also play a key role within ICSs, given their responsibility for the health of their local population. NHS England should require ICSs to work closely with Local Authorities to facilitate this.

Changes to competition rules are positive, but have to be reinforced by making the NHS the preferred provider of services

We very much welcome the clear move away from competitive tendering outlined in the proposals, a change that the BMA has campaigned for consistently. However, as argued in our response to NHS

England's 2019 legislative proposals, we do not believe that the removal of Section 75 of the 2012 Health and Social Care Act and the other changes set out thus far go far enough.

We strongly believe that NHS services should not be subcontracted to private providers and that simply removing present competitive tendering rules will not be sufficient to deliver this. Eliminating present tendering rules without establishing a clear replacement could ultimately lead to the use of other, equally undesirable approaches to the contracting of NHS services. As seen in the Government's response to Covid-19 thus far, many high value contracts have been handed to private companies with little oversight and on the basis of relationships between those companies and the commissioners involved. While we hope that this would not occur within ICSs, the vacuum created by diminishing the role of CCGs and a failure to establish clear commissioning rules could lead to similar mistakes being made.

It is imperative any such approach should be avoided. We believe the most comprehensive means to doing so would be to enshrine the NHS as the preferred provider of all NHS services in any prospective legislation.

Safe and adequate staffing is absolutely essential to integration

Increased ICS-level management of the local workforce has potential benefits, particularly in allowing for a more co-ordinated and system-wide approach to workforce planning, including recruitment and retention. However, at the heart of this must be a commitment to achieving safe staffing levels and valuing staff in tangible, meaningful ways.

NHS England should provide clarity about how it expects ICSs to deliver both the local recruitment and retention initiatives necessary, and what specific powers will be given to systems to allow them to do so. This should include clarity regarding the role of HEE (Health Education England) in respect of local health and care systems, including in medical training and education at a system level, as well as national and regional workforce planning modelling, and what any changes to this may mean for medical students and junior doctors. Further, if ICSs do adopt the responsibilities of CCGs in this area, then we would want them to also take on their legal obligations regarding education and research, as laid down in the Health and Social Care Act ([Section 26, paragraphs 14X - 14Z](#)).

Regarding ICS-wide management of the NHS workforce, it is essential that local LNCs remain fully involved in any discussions about changes to patterns and places of work, as well as any potential contractual changes – including changes to locum rates, for example. Furthermore, the autonomy of the clinical workforce must be respected and job plans and redeployment in secondary care be fully agreed, not imposed from the centre.

Finally, the BMA believes that NHS England should also take this opportunity to pursue wider legislative reform in order to secure workforce supply and ensure patient safety, both now and in the future. Namely, NHS England and Government should take this opportunity to include new legal requirements on safe staffing within the proposed reforms, such as those now in place in Scotland, for the benefit of patients and NHS staff. It is our view that these reforms, including formal reporting mechanisms for staff in the case of any incidence of unsafe staffing, compelling providers, commissioners, and regulators to record and publish any unsafe staffing concerns raised by doctors, nurses and other health and care staff, real-time monitoring of staff levels and short, medium and long-term workforce planning, and provisions for responding quickly to risks and challenges, are badly needed and could be well managed operationally at ICS level. First, however, we must re-establish in statute hierarchical accountability for overcoming the challenges and risks that persistent unsafe staffing brings. This should create a line of accountability stemming from Government and Parliament, as publicly elected arbiters of public policy and spending, to national and regional health and care commissioning bodies, to regional providers, so that resources can reach ICSs and be distributed to local providers swiftly and as required.

The focus on improved use of data and technology is welcome but has to be supported with genuine investment

Those elements of the proposals focusing on data and technology are positive but, importantly, are not new. Promising aspirations and commitments around greater use of IT and access to data have been made before, but not been supported by the targeted investment needed to deliver them at scale.

The response to Covid-19 has, as widely reported, seen impressive and rapid transitions to digital working which has made excellent use of available IT and technology. It has also, though, seen many doctors left to try and work remotely using out of date hardware and software.

It is, then, essential that these laudable aspirations are followed by adequate investment. To ensure this, NHS England should consider, as a matter of urgency, carrying out/requesting an audit of the IT estate in the NHS with a view to proposing a clear investment standard in its legislation, to provide ICSs and their member bodies with the resources they need. Furthermore, responsibility for decision making on IT procurement within ICSs should be clearly outlined so as to guarantee greater coordination between providers. As with all decisions relating to the provision of care, meaningful and comprehensive clinical input should be sought on any IT decisions to ensure they reflect the needs of the users. Where investment is needed to bring all members of an ICS up to a common level, it should be provided as a priority to better enable system working to take place.

The role of social care within ICSs – particularly in respect of funding – needs to be clarified

As is now widely recognised, one of the greatest challenges faced by the NHS and the future integration of health and care services is the current state of social care in England. It is, therefore, surprising and significant that the proposals fail to address social care or how ICSs will interact with it in their prospective statutory role.

If these proposals are to present a clear and lasting vision for integration and for ICSs as its primary vehicle, they must include real detail on how they will interact with and potentially manage social care services. Moreover, NHS England and Government must consider and clarify how the funding issues that plague social care will be resolved.

Conclusion

The proposals put forward do contain several positive steps and potential reforms that closely align with the BMA's longstanding calls regarding competition, collaboration, and the future of the health service. However, as noted throughout this response, we have a significant range of concerns regarding specific elements of the proposals which, in their current form, are not sufficient to deliver the NHS staff and patients need.

Beyond this, we do not consider this exercise – in its form, timing, and scope – appropriate for proposals of such gravity for our members, or for the NHS at large. Therefore, for this process to have credibility, we believe it should be revised to include a full consultation which provides enough time to all stakeholders to submit their views to NHS England - or if this is not possible at the very least proper pre-legislative scrutiny.