Member briefing: Government health White Paper

The UK Government has now formally published its white paper on NHS reform - *Integration and Innovation: working together to improve health and social care for all* – which sets out a range of proposals that would see dramatic changes for the NHS in England.

This briefing provides a summary of those changes, the BMA's initial analysis of them, and outlines how the BMA is working to influence the proposed legislation on behalf of members.

The BMA issued a press response to the publication of the White Paper, highlighting the unfortunate timing of the proposals and saying clinicians must be front and centre in plans for NHS reform.

Introduction

The Government is proposing changes to NHS legislation after several years of informal changes to NHS structures and amid a growing consensus that the 2012 Health and Social Care Act is ill-suited to the needs of the health service. This is reflected both in the white paper itself 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 has put forward its plans as, in part, a means of 'giving the NHS the changes it has asked for' – by removing existing competition rules and formalising the collaborative workarounds developed in recent years, such as ICSs (Integrated Care Systems). However, the white paper goes significantly further than NHS England's requests, particularly in the authority it would grant to the Secretary of State for Health and Social Care over the health service.

Quick overview of the proposed changes

- Establishing Integrated Care Systems (ICSs) in statute, and transferring the commissioning duties of Clinical Commissioning Groups (CCGs) to them
- Requiring ICSs to set up an ICS board and an ICS Health and Care Partnership Board
- 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 to collaborate' on all NHS bodies
- 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 Arm's Length Bodies (ALBs)
- A new duty for the Secretary of State to publish a report each Parliament on workforce planning
- Establishing the Health Service Safety Investigations Body (HSSIB) in statute, which will be tasked with encouraging the spread of a culture of learning within the NHS through promoting better standards for investigations into safety incidents
- Possibly giving Ministers the power to extend professional regulation to NHS managers and senior leaders

Why is the government proposing new legislation?

In its white paper, the Government presents several arguments for why it feels legislation is needed. These include: the need 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 does the Government intend to implement changes?

The white paper establishes that, subject to Parliamentary business, the Government wants the legislative proposals it has set out to begin to be implemented from April 2022 – a relatively tight timescale. The BMA has argued that the timing of this process – in the midst of a global pandemic - risks undermining the confidence of clinicians in any future legislation. We've called for more time to be given so that clinicians can scrutinise the proposals and will continue to raise concerns around the timing of changes throughout the legislative process.

The changes set out in the white paper

The white paper breaks down its proposed legislative change into four themes, which will be summarised below. These themes are:

- working together and supporting integration
- reducing bureaucracy
- improving accountability and enhancing public confidence
- additional proposals (public health, social care, safety and quality)

Working together and supporting integration

A core aim of the white paper and the proposals it sets out is establishing ICSs in statute. This would make their currently informal roles formal and enshrine them with powers and accountabilities they presently lack – particularly in respect of managing and distributing NHS funding at a system level. In so doing, the Government would also legislate for every area of England to be covered by an ICS, in line with NHS England's plans. ICSs will also be expected to be coterminous with local authorities, presenting a potential challenge for the many developed ICSs already working across multiple local authority boundaries.

In their new statutory form, ICSs would be made up of two core components – an ICS NHS body and an ICS Health and Care Partnership – which would be collectively referred to as the ICS. Essentially, the ICS NHS body would represent and be responsible for NHS services and provision, whereas the Health and Care Partnership would be focused on broader issues such as social care, public health and the wider determinants of health.

Every ICS NHS body will be required to have a unitary board, which will be directly responsible for the NHS spend and performance of the system. These boards are expected to include, as a minimum, representatives from NHS trusts, general practice, and local authorities, as well as locally-determined representation from other services such as community health (CHS) and mental health trusts. Importantly, the ICS NHS body would also take on the majority of the duties currently held by CCGs as well as many of the commissioning functions undertaken by NHS England, such as commissioning some specialised and primary care services. Furthermore, they would also have the ability to delegate functions to individual providers or groups of providers.

In respect of CCGs themselves, the white paper states that they will be absorbed into, or 'become', their local ICSs. In practice this appears to mean that much of the existing form and functions of the CCG will be carried over into the newly statutory ICS. However, only limited detail has been provided on this point to date.

ICSs will also be given a consistent but small set of requirements to meet under the new legislation. This is in line with the Government and NHS England's aim of establishing some consistency in the development of ICSs while retaining the permissive culture in which they have progressed so far.

The development of ICSs and integration will be supported by formally requiring all health bodies to abide by both a new duty to collaborate and a triple aim duty – which would mean they must simultaneously pursue the aims of:

1. better care for all patients
2. better health and wellbeing for everyone
3. sustainable use of NHS resources.

Alongside this, NHS England will take on some powers with respect to NHS Foundation Trusts and their capital spending limits, but exactly how this will work remains unclear. The proposals are, though, explicitly clear that NHS Trusts and Foundation Trusts will remain independent, statutory bodies and that an ICS board will not have the power to direct them. This raises questions about the capacity for ICSs to develop and deliver a joint plan when certain member bodies have such clearly defined independence from it.

The Government proposals also include changes to allow NHS bodies to:

- create joint committees, designed to improve collaboration between them
- make joint appointments of Executive Directors, to facilitate shared decision making
- share data across organisational boundaries.

ICSs are also positioned as the core facilitator of collaborative working across and between the NHS, local government, the voluntary and third sectors, and the private sector in delivering health and care services. Within this, the white paper reasserts the focus on the role of 'place' that featured heavily in NHS England's proposals, but states that legislation will not be prescriptive about how ICSs will be expected to work at Place level.

The Government have set out an intent to include data sharing in its legislation, to facilitate and reinforce integration at a local level. However, little detail is provided on this point and it is imperative that data security and systems are robust if data is to be shared on such a wide footprint.

Initial analysis:

- The BMA has strongly supported the principle of integrated care (including in our *Caring, supportive collaborative* project)
- However, we made clear in our response to NHS England's consultation that any future system must have strong clinical leadership, engagement and involvement at its heart. While it is therefore positive that representatives from NHS Trusts and general practice are required on ICS NHS bodies, there remains a risk that the proposals outlined could reduce clinical involvement in decision making (eg with the loss of formal clinical leadership enshrined in GP-led CCGs)
- Any future system must safeguard the independent contract status of GPs.

Reducing bureaucracy

In line with NHS England's recommendations, the paper proposes the repeal of Section 75 of the 2012 Health and Social Care Act and ending the role of the CMA (Competition and Markets Authority) within the NHS.

The creation of a new provider selection regime that would - the paper argues - give commissioners greater flexibility in how services are arranged has also been proposed. This regime is now subject to an NHS England consultation, but remains a hugely important issue to consider alongside the legislative proposals themselves.

The proposals would also see NHS Improvement's specific duties around competition and the prevention of anti-competitive behavior abolished, in favour of its formal absorption into NHS England as an improvement agency, rather than a regulator. Likewise, NHS England's duty to refer contested licence conditions or National Tariff provisions to the CMA will be removed.

Under the reforms, the Secretary of State will also be given the power to create new NHS Trusts, to facilitate the reorganisation of care. The cited examples for this include creating emergency provision for specific care needs, such as the Nightingale Hospitals introduced to support Covid-19 treatment. ICSs will also be able to apply to the Secretary of State to create new Trusts.

In respect of workforce, the proposals also establish that LETBs (Local Education Training Boards) will be abolished to provide HEE (Health Education England) with greater flexibility to adapt its regional operating model. Moreover, the Government also plans to introduce a duty for the Secretary of State to publish a report during every Parliament (ie at least once every 5 year session) which is intended to provide greater clarity around workforce planning responsibilities.

Initial analysis:

- The BMA strongly opposed the competition elements of the 2012 Act and supports removing these
- However, we need to see much more detail on what would replace the current competition regime, currently subject to a separate consultation
- The BMA would not be able to support an approach that enabled commissioners to award contracts without sufficient scrutiny
- We have also made clear that we would like to see an 'NHS preferred provider' mechanism
- A new duty for the Secretary of State to report to Parliament on workforce planning is an important and positive step, but alongside this we would like to see greater accountability by the Secretary of State for ensuring safe staffing

Public confidence and accountability

This section of the white paper proposes to increase the direct power and responsibility the Secretary of State has over the NHS, something the paper characterises as ensuring greater Parliamentary (and therefore public) accountability of the health service and its operation.

This includes altering the present approach to the NHS Mandate – which is currently set annually– to essentially give the Secretary of State the power to set (or reset) the overarching direction of the NHS more easily (although Parliament will still need to be consulted).

In addition, 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 issues with such plans, as referrals tend to come only very late in the process. This reform would essentially allow them to proactively intervene in service reconfigurations much earlier than currently possible. However, the white paper does include a specific requirement on the Secretary of State to seek appropriate advice prior to making their decision on any reconfiguration, and to publish that advice transparently.

Finally, the Secretary of State will take on greater authority over ALBs, allowing them to alter and abolish them. This is, in part, intended to facilitate the immediate formal merger of NHS England and NHS Improvement, as well their various component parts (Monitor, the NHS Trust Development Authority, for example), into a single unified organisation known as NHS England. However, while immediately practical it remains unclear how and on what basis these powers would be used in the future.

Initial analysis:

- The BMA has long advocated for clear lines of political accountability for the NHS at Secretary of State level
- However, alongside this it is also vital that the day-to-day running of the NHS is free from excessive political control
- The BMA will be scrutinising this aspect of the proposals carefully. Although some of the measures proposed may increase political accountability, for others (such as the power to change/abolish Arm's Length Bodies without primary legislation) there is a risk that a lack of safeguards could lead to greater power for the Secretary of State without sufficiently robust accountability to Parliament.
- While ministers should ultimately be accountable in parliament and at the ballot box, the pandemic has shown how much can be achieved by putting NHS clinicians in the driving seat, as witnessed by the GP-led vaccination programme. Doctors must be trusted to lead, in order to deliver for the good of their patients and the whole health system.

Additional proposals

The white paper bundles a broad range of proposals under the umbrella of 'additional proposals'.

In respect of **public health**, specific plans are set out to give the Secretary of State the authority to bring in new restrictions on the advertising of high fat, salt, and sugar foods, as well as powers for Ministers to alter food labelling requirements.

Social care receives a prominent mention and is recognised as a central pillar of integration, but with little detail on what is going to be done to support it in the long term other than that separate proposals on social care reform will be brought forward in 2021. However, a number of operational changes are put forward, including giving the Secretary of State powers to make payments to all social care providers, and broad reforms to provide greater flexibility when discharging patients from a hospital to a care setting for assessment.

On **professional regulation**, the Government intends create powers that will enable it to extend the scope of professional regulation to NHS managers and senior leaders in future – although it doesn't commit to doing this immediately.

Finally, regarding **safety and quality**, the Government wishes to bring forward measures to make the Health Service Safety Investigations Body (HSSIB) a statutory body, to streamline the current regulatory landscape for healthcare professionals, and establish a statutory medical examiner system within the NHS to scrutinise those deaths which do not involve a coroner.

Initial analysis:

- The proposals in this section were not part of the original consultation by NHS England, so we will scrutinise them in detail
- The establishment of HSSIB and its focus on fostering a learning culture in the NHS aligns with the asks set out in our *Caring, supportive, collaborative* report
- In *Caring, supportive collaborative* we also called for professional regulation of NHS managers and senior leaders, so the steps towards that set out in the paper are welcome

Conclusion and next steps

Given the Government's relatively narrow timescales for the implementation of its proposals, it is expected that legislation will be put to Parliament by Summer 2021 at the latest. The BMA will be closely engaging with the Government, DHSC, NHS England, parliamentarians and various stakeholders over the next few months and at every stage of the legislative process to influence the draft bill and ensure the voice of clinicians is front and centre in decisions about the future of the NHS. Alongside this, we will be responding to the NHSE/I consultation on the proposed competition regime, which is open till April.