BMA

Pre-ARM briefing – Health and Care White Paper (England)

May 2021

This briefing provides background information on the Health and Care White Paper. The White Paper is a preliminary document to legislation being introduced in the coming weeks. At time of writing the corresponding Bill is yet to be published.

Background

On 11 February 2021, the government published a White Paper setting out proposed reforms to health and care in England. The White Paper follows significant consultation since the development of the NHS long-term plan, which set out the need for legislation to support progress towards a better integrated, more collaborative health and care system.

Significantly, the legislation will abolish measures introduced under the Health and Social Care Act 2012 including Section 75 which enforced mandatory competitive tendering of services above a certain contract value threshold. The BMA has long supported the removal of enforced competition, which has resulted in costly procurement processes, private provider takeovers and the fragmentation of services in England. It has also resulted in private sector companies successfully "suing" the NHS for anti-competitive awarding of contracts or behaviour.

Another core aim of the proposed legislation is placing ICSs (Integrated Care Systems) on a statutory footing, which should improve accountability and transparency of ICS'. The White Paper also proposes a "Duty to Collaborate" between providers and sectors that is counter to the 2012 Act as another step towards a more collaborative NHS.

While these and a number of other areas align with BMA policy, there are other areas where we believe the White Paper needs to go further or change. The BMA will therefore lobby for significant changes in the legislation.

Overview of the proposed changes

The white paper is structured around four key themes:

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

These set out the following proposed changes:

- Establishing 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

Key considerations

Outsourcing and privatisation

The introduction of Section 75 through the Health and Social Care Act 2012 has resulted in enforced competition, which in turn has led to costly procurement processes, the fragmentation of care and the destabilisation of NHS providers across England through accelerating private sector provision.

The Health and Care White Paper proposes to remove Section 75 and automatic competitive tendering, which should mean less opportunity for outsourcing and privatisation. This could avoid the frequently drawn out and disruptive competition over NHS and public health contracts seen since 2012, such as the tendering of £1.2bn worth of cancer and end-of-life care contracts in Staffordshire, and the increased takeover of NHS contracts by Virgin in recent years, such as the £104 million contract to run Lancashire's 0-19 Healthy Child Programme – including school nursing, and Virgin Care suing the NHS after it lost out on an £82m contract to provide children's health services across Surrey.

Removing automatic tendering means it will be easier for current contract holders to retain their contracts and there is likely to be less scope for private sector providers to increase their foothold in the UK market, undermining the long-term sustainability of the NHS by outsourcing profitable services to the private sector.

However, the BMA has raised the importance of ensuring robust transparency measures are in place in NHS England's Provider Selection Regime, the proposed replacement for Section 75 to avoid contracts being handed out without scrutiny, as has been seen during the COVID-19 pandemic. In addition, including in our response to NHS England's consultation on the Provider Selection Regime, we have called for the NHS to be established as the default option for contracts as the most comprehensive way of preventing privatisation.

The BMA has called for the removal of Section of 75 and the competitive reforms introduced in the 2012 Act for many years. There are a number of existing ARM policies in support of this, including:

- **1705**.Health and Social Care Bill/Act: That this meeting calls for repealing the competition regulations in the Health and Social Care Act which is wasting significant sums of monies in procurement processes, fragmenting care and destabilising NHS providers through accelerating private sector provision.(2018)
- **1708**.That this Meeting believes that Section 75 of the Health and Social Care Act 2012 and its regulations remain incompatible with assurances given during the passage of the Act and subsequently; and:-
  - i) will obligate competitive tendering for NHS services;

  - ii) will fragment patient care;
  - iii) will increase privatisation of NHS care;
  - iv) calls for a campaign to repeal Section 75 of the Act and its regulations.(2013)
- **1715**.That this Meeting believes that the exposure of the NHS to competition law will embroil commissioners in endless legal action at the hands of unsuccessful bidders for NHS services. Such legal action will either waste consortia resources if contested or result in capitulation to bidders supported by large legal resources. This Meeting therefore calls on the BMA to campaign against the application of competition law to the NHS.(2011)

Workforce accountability

The White Paper sets out proposals for a new duty on the Secretary of State to present a document to Parliament at least every 5 years detailing roles and responsibilities for workforce planning and supply in England.

Whilst this would make it clearer who is responsible for workforce planning, the BMA has called for the Bill to also address what must be delivered by those who are responsible. A shared knowledge of what needs to be delivered would help hold to account those responsible for delivering the levels of staffing needed to meet population need, now and in the future.

The BMA - alongside key organisations representing healthcare professionals (including the RCN, NHS Confederation, NHS Providers, and the Academy of Medical Royal Colleges) - is calling for a duty in the Bill to provide open and transparent modelling of staffing requirements. This assessment would lead to a shared understanding of the levels of staffing needed to meet national, population-based demand and should inform local and regional recruitment needs. It should be made publicly available and presented to Parliament to enable proper scrutiny and debate about what policies and investment are needed to prevent instances of unsafe staffing occurring.

The BMA has policy on the scoping of safe staffing levels of doctors across the health system:

- 1346.That this meeting recognises that there is a chronic understaffing problem in the NHS and:-
  - i) demands the detailed scoping of staffing levels of doctors is carried out individually across all the disciplines of healthcare in the UK to highlight the shortage;
  - ii) proposes the introduction of enforced and published safe staffing levels applicable to doctors in primary and secondary care;
  - iii) demands a universal, robust system by which doctors can immediately alert senior management to unsafe staffing and working conditions prior to, at the commencement of, or during any given shift. (2018)

ICS structures and clinical representation

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, thereby ensuring they can be held accountable - something which the BMA has called for throughout their development. Existing ARM policy is clear that the BMA opposed the development of ICSs under the 2012 Act and called for all new healthcare systems to be created via primary legislation:

- 1519.That this meeting:

- i) is opposed to the introduction and imposition of insurance-based healthcare systems in the UK;
- ii) commends the BMA's position of opposing accountable care organisations and integrated care systems operating within the current competitive framework in England;
- iii) calls for a collaborative universal healthcare system free from market forces and competition;
- iv) is concerned that healthcare systems are being created in the UK using non-statutory vehicles without appropriate parliamentary and public scrutiny;
- v) insists that there is full consultation with the medical profession, the public and parliamentary representatives on any new healthcare systems for the UK;
- vi) demands that any new UK healthcare systems in any nation of the UK are created only through primary legislation in parliament or national assembly.(2018)

The Government has also established an expectation for ICSs to be coterminous with local authorities, presenting a potential challenge for a number of 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. Essentially, the ICS NHS body would represent and be responsible for NHS services and provision, whereas the HCP (Health and Care Partnership) would be focused on broader issues such as social care, public health and the wider determinants of health. The membership of the HCP will be determined locally by each ICS, but the White Paper suggests that it could include Health and Wellbeing Boards, Healthwatch, voluntary and independent sector partners and social care providers, and housing providers.

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. The BMA has been clear that, to remove potential conflicts of interest and ensure effective governance arrangements, private providers should not be directly involved in commissioning decisions made or approved by ICSs – in either their NHS ICS Body or HCP. In response to this, the DHSC has clarified that the bill is set to include specific rules on potential conflicts of interest, to ensure providers are not able to unduly influence commissioning decisions.

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, or the ICSs 'places' – where a significant amount of their work is expected to take place.

The White Paper states that CCGs will be absorbed into their local ICSs, with their commissioning powers and the majority of their staff becoming part of the ICS NHS Body. There are concerns that local clinical leadership and accountability via CCG boards will be eroded. Further clarity on accountability structures and how clinicians will be involved at ICS and local level is needed.

The BMA is clear that any future system must have strong clinical leadership, engagement and involvement at its heart. A robust clinical voice within ICSs and their substructures is vital to ensure clinical and staff expertise and knowledge is reflected in changes and that, ultimately, the patient

experience is improved. This includes ensuring LMCs and LNCs, as well as public health professionals and patients, are included in local decision making in any future system.

Secretary of State powers and accountability
The White Paper proposes granting the Secretary of State a range of powers over the operation of the NHS, presented as a means of increasing political accountability for the NHS. These include powers to intervene in service reconfigurations, to amend or abolish arms-length bodies' and to set or re-set the overarching direction of the NHS outside of the current annual Mandate.

The BMA has advocated for clear lines of political accountability for the NHS at Secretary of State level, and we were critical of the removal of responsibility for the NHS from the Secretary of State in the 2012 Act as per ARM policy, including:

- **1539**.That this Meeting calls for the restoration of the statutory responsibilities of the Secretary of State for Health to secure and provide universal healthcare. (2014)
- **1524**.That this meeting mandates council to lobby for the restoration of the duty of provision of universal health care to the secretary of state for health. (2017)

However, we have called for clear safeguards and limits on the use of these new powers to be included in any legislation to avoid increased, unaccountable political influence in NHS decision making and undermine long-term planning if political imperatives change.

Data
The white paper contains a short section on data outlining the intentions of government to introduce measures necessary to allow greater data sharing within the NHS, between NHS and Social Care and between the NHS and third parties (research organisations for example). This section also outlines new powers given to 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, specifically in relation to the use of data extracted from GP records for planning and research under the recently launched programme of the same name (GP Data for Planning and Research, GPDPR). Whilst the BMA welcomes efforts to improve data sharing, we have expressed concern about any powers that would circumvent or make null the protections put in place regarding the dissemination of this data and intends to seek assurances to that end.

The paper proposes that NHS Digital's legal framework is changed to introduce a duty upon it to 'have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions.'

As with any other new powers endowed to the Secretary of State, Department of Health and Social Care and Arm's Length Bodies by the white paper, BMA strongly believes that clarity over the reach and nature of these powers should be included within the bill so as to avoid any confusion and ensure that where powers are seen to be excessive, attempts to bring amendments to the bill can be made to limit them.

Additional proposals

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

Public health: On 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. The White Paper also proposes that central government takes responsibility for the process of water fluoridation, currently held by local authorities. The BMA supports these proposals and has called for greater action on the advertising and labelling of food (ARM: 754 and 756), as well as the pace of water fluoridation (ARM: 773 and 774), for some time.

Social care: Social care 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.

The Government has confirmed in the Queen's Speech that it will bring forward proposals on social care later this year (2021), but long-awaited action on social care must not be delayed. BMA policy is that social care should be provided free at the time of need as part of a national system (ARM: 1677 and 308). **Professional regulation**: The Government intends to 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. The BMA called for the regulation of senior NHS managers and leaders in our Caring, Supportive and Collaborative work to help improve the culture of NHS organisations, staff wellbeing and patient safety.

Health Service Safety Body (HSSIB): 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. The establishment of HSSIB and its focus on fostering a learning culture in the NHS aligns with the asks set out in the BMA's 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.

Timeline and activity around the Bill

The White Paper sets out the Government's intention to begin to implement legislative proposals for health and care reform from April 2022.

Through high-level meetings with Ministers, politicians and civil servants; joint work with organisations with shared objectives; and consultation responses on ICS reform, the new provider selection regime, the new system oversight framework and the white paper itself, the BMA has communicated our analysis and key calls to DHSC, NHSE and politicians.

Following the publication of the bill (expected May/June 2021) we will continue to actively lobby for the bill to be amended and strengthened to reflect BMA policy positions.