

Equity and excellence: Liberating the NHS
BMA Response

Executive Summary

This response sets out the British Medical Association's (BMA) position on the key themes and overall direction of travel for the NHS described in the White Paper, as well as our views on specific reforms and initiatives. There are elements we broadly support, elements we support in part, elements we are unable to support and elements about which we require more detail before we can develop a fully considered position. Our response has been written to reflect the position of the BMA solely in the terms of the implementation of the White Paper's proposals in the English NHS, and should not be seen as representing the BMA's views more generally on the way forward for the NHS across the UK.

The direction of travel

The BMA has not supported the direction taken in the NHS in England in recent years, which is continued, and indeed accelerated, by the proposals set out in the White Paper, despite evidence showing that increased commercialisation has not been beneficial for the NHS or patients. Research¹ has found that Independent Sector Treatment Centres (ISTCs) could damage the local health economy, profiting from NHS funding by explicitly choosing to treat only less risky patients while being paid the same rate as publicly funded hospitals. In addition, a 2010 National Audit Office report questioned the long-term value for money of PFI hospital contracts and found that the lack of flexibility in repaying debts could make it difficult for trusts to make savings without cutting back on services.

There are aspects of the White Paper's proposals which have the potential to undermine the stability and long-term future of the NHS. The 'any willing provider' policy has the capacity to undermine local health economies by replacing existing multi-service natural monopolies with a plethora of smaller units providing more limited ranges of services. This would radically affect both the efficiency and value for money of the NHS. If the tariff system is to remain, we are anxious that tariffs should encourage high-quality care and value for money and not produce the unintended consequence of destabilising existing providers.

Changing the status of existing NHS providers to foundation trust status has already threatened the character and ethos of NHS provision. Further moves towards the development of corporate entities would threaten the stability of the NHS and the security of its employees and their terms and conditions of service.

We remain opposed to the commercialisation and active promotion of a market approach in the NHS, and to the very significant threats to national terms and conditions of service and education and training for doctors contained in the White Paper. Moreover, the wish, expressed frequently in the White Paper, to improve the patient experience and provide more seamless, integrated care, seems at odds with many of the policies which will, inevitably, widen the purchaser provider split. We wish to see an NHS that is a public service working cooperatively for patients.

The financial climate

The BMA notes that a large amount of money is being spent to make the changes proposed in the White Paper, whilst at the same time attempts are being made to release £15-20 billion of efficiency savings over the next four years. This is a very difficult climate in which to make substantial service changes and reconfigurations. We would question the value for money of such changes and whether a less disruptive, more cost-effective process could have been proposed to achieve similar aims of reducing bureaucracy and empowering clinicians. We are aware that cuts are already being planned or implemented that will have an adverse impact on doctors' ability to care for their patients. It is imperative that the costs associated with restructuring or reconfigurations are minimised and, where inevitable,

¹ Street A, Sivey P, Mason A, Miraldo M, Siciliani L. 'Are English treatment centres treating less complex patients?' *Health Policy* 2010; 94(2): 150-157.

separated from the ongoing provision of care in order to avoid adverse impacts on frontline patient services.

We urge the Government and NHS organisations to focus on those areas where they can truly eliminate waste and achieve genuine efficiency savings rather than adopt a slash-and-burn approach to health care with arbitrary cuts and poorly considered policies. Robust evidence must be gathered and proper processes put in place, and we welcome the commitment to actively involve clinicians, patients and local populations in decision-making processes.

The transition period

The winding down of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) must be managed carefully to avoid any confusion and inefficiency. Both should remain in place until the new structures are ready to operate. Steps must be taken to prevent the loss of significant numbers of skilled staff within both types of organisation, something which may already be occurring.

PCTs currently have many statutory functions and responsibilities that will still need to be undertaken after they are abolished. We are aware that a complete list of both statutory and non-statutory roles has been drawn up and sent to PCTs, and this should now be made publicly available. Functions that will no longer be required should be clearly identified so that consortia are able to operate effectively with their reduced budgets. We would like further details on where responsibility for the many non-commissioning functions of PCTs and SHAs will lie during the transition period and following abolition, and what will happen to PCT debts. These debts should not be passed on to consortia, as we believe this will prevent them from functioning to their full potential and will also discourage GPs from becoming involved in consortia.

Training and education

The BMA believes that effective national oversight of medical education and training is absolutely essential. We strongly oppose any moves that will increase reliance on local planning and management of education and training. As local employers unavoidably lack a broad overview of workforce requirements, we believe that the management and planning of the medical workforce can only be done at a national level, and more properly at a UK level. We believe UK cohesion and consistency, which enables medical graduates to move between national boundaries, is essential to ensuring that the same high standard of patient care is maintained throughout the UK. Without a uniform approach to training in terms of career progression and standards of qualification, there could be further instability to patient care, as it would become more difficult for the medical workforce to move around the UK.

Public health

We note with interest proposals for a new Public Health Service. Its success will depend upon the expertise of people with population health and public health skills, covering all domains of public health practice. The Public Health Service will not be effective unless it can fully support the delivery of public health functions at a local level. There is a danger that the centralisation of skills and expertise into the service might be at the expense of the capacity and capability within local departments. Under the new system of commissioning consortia there should be continued public health input into commissioning and, reciprocally, GP input into public health strategies.

Patient choice and control

The BMA supports meaningful choices for patients, free from political targets, but we do not believe that the patient choice agenda of recent years, which is continued in the White Paper, has improved clinical outcomes or offers patients the choices they actually want. We would suggest that most of all, patients want high-quality providers close to where they live and to receive timely, competent diagnosis and treatment and ongoing support when necessary.

NHS Outcomes Framework

While the BMA recognises that some waiting-time targets have helped to reduce headline waiting times in the NHS, we welcome the reduction in the number of top-down targets. However, we would not support the wholesale replacement of process targets and indicators with clinical and patient reported outcomes measures. There is clear evidence that the use of process measures is an effective management tool for judging and rewarding quality provided the process measures are valid, have professional support and are able to influence the process of care without having total control over the outcome of that care.

In developing the national outcomes goals, it will be essential that the Department of Health engages with, and utilises the skills and expertise of, the whole medical profession, patients, carers and representative groups to create indicators which are based on the best available evidence.

GP-led commissioning

The BMA is interested in exploring with the Government the proposals for GP-led commissioning consortia, which see GPs as an intrinsic part of the commissioning machinery within the NHS. Successful commissioning will only be achieved with GPs, secondary and tertiary care consultants and other clinical colleagues, working together. Public Health consultants will also have a significant role to play, as will clinical academics. It is absolutely essential that all these expert clinicians are able to play a central role in commissioning decisions and, as such, consortia must design local mechanisms that ensure consultants and other specialists are brought into the decision-making process.

Some patients may view GP-led commissioning with suspicion, particularly when their GP refers them for treatment from another GP provider. It will be essential to develop and implement a system that maintains patient trust and protects professional values. This system should be as transparent as possible and assure patients that their doctor is referring them to a particular provider purely because it will provide the best clinical outcome.

Foundation trusts

The BMA is concerned by the Government's determination for all NHS trusts to become foundation trusts, given the notably bad outcomes that have been seen in a number of cases and despite the fact that foundation trust status is supposed to be a mark of quality. We are concerned that intensifying the pressure on NHS trusts to achieve foundation trust status within the next three years will drive more of them to place the achievement of this target above all others, including safe patient care. The BMA would like NHS hospitals to be part of a collaborative publicly owned system of the provision of care for clinical need. We do not believe poorly performing hospitals will improve their standards by moving to a more autonomous system of financial regulation.

The BMA believes the abolition of the cap on the amount of income foundation trusts can earn from other sources has the potential to act as an incentive for foundation trusts to undertake more non-NHS activity at the expense of NHS provision. If unfettered, this could lead to a two-tier health service, as foundation trusts invest more resources in non-NHS facilities.

Social enterprise

The BMA is not aware of any evidence that could support the view that significant numbers of NHS staff wish to work in social enterprises and would question whether the benefits of the approach set out in the White Paper will be achieved. Attempts to force NHS staff into accepting a move to a social enterprise model without proper consultation or engagement will not produce successful social enterprises. Where they do exist, the Government should ensure access to the NHS pension for all social enterprise staff.

Economic regulation

The BMA does not support Monitor's role as promoter of competition in healthcare and believes its focus should be on ensuring quality. If Monitor does take on this role, it should seek the views of professionals and patients before making decisions about anti-competitive

behaviour, to find out which services they want in the area and if there are established pathways of care and existing collaboration, rather than force competition when it is inappropriate. Competition between hospitals can be wasteful and inefficient and so these powers should only be used when it can be demonstrated that introducing competition will benefit patient care.

NHS pay

The BMA supports a comprehensive and universal NHS with national contracts and conditions. It is essential that national terms and conditions are protected, to ensure an equitable spread of doctors across the UK irrespective of local differences in geography or economic wealth, and to safeguard against poor working conditions. Multiple instances of local pay negotiation and bargaining would be time wasting and inefficient. We therefore do not support the proposal to encourage individual employers to determine pay and local terms and conditions for their staff. We do not believe that the abandonment of national contract negotiations or pay review body arrangements would be in the best interests of the NHS, doctors or patients.

NHS pensions

The BMA believes that the NHS pension scheme is sustainable and represents value for money for the public. The scheme for NHS staff in England and Wales has already been subject to a recent major review and, contrary to common misconception, is financed by employees and employers, providing a surplus to the Treasury in recent years.

Cutting bureaucracy and administrative costs

Effective management is essential to the future of the NHS. Whilst we support measures to reduce unnecessary bureaucracy and administrative costs, some NHS management functions are necessary to ensure the smooth running of services and the NHS as a whole. It would be wasteful and inappropriate to delegate management tasks to clinicians who are neither trained for these tasks nor have time to do them.

Arm's-length bodies

The Government's proposals to downscale or close a number of arm's-length bodies have far-reaching implications. The BMA is particularly concerned about the impact of proposals on the Health Protection Agency and the Human Fertilisation and Embryology Authority. Our views are set out at Appendix B.

1. Introduction

1.1 The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 140,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

1.2 It is important to highlight that, with devolution, healthcare policy has become increasingly divergent across the four nations of the UK, and the BMA's response to the policies and priorities set by each administration will vary according to the particular national context. The NHS in England has already moved further towards competition and marketisation in health than the devolved nations, and is now significantly different from the service in the rest of the UK. This response has been written to reflect the position of the BMA solely in the terms of the implementation of the White Paper's proposals in the English NHS, and should not be seen as representing the BMA's views more generally on the way forward for the NHS across the UK.

2. Direction of travel in the NHS in England

2.1 Doctors are passionate supporters of the NHS and recognise the importance of playing a key role in shaping the future of the system. The BMA acknowledges that any health system needs to evolve, underpinned by full consultation with the healthcare professionals, patients and the public and a rational and agreed plan that has clinical leadership in partnership with patients at its core². We note the Government's commitment, as expressed in the underpinning principles of the White Paper, to an NHS which provides a comprehensive service free at the point of use, which puts clinicians in the lead and gives the NHS operational freedom from ministerial control. We recognise the Government's commitment to increase health spending in real terms for every year of this Parliament. We are also reassured by the White Paper's statement that the NHS will continue to be funded by the taxpayer.

2.2 However, the BMA remains profoundly critical of the direction that has been seen in the NHS in England in recent years, namely that of increased involvement of the commercial interests and the active promotion of a market approach in the NHS, which is continued by the proposals set out in the White Paper. This is despite evidence³ showing that increased commercialisation has not been beneficial for the NHS or patients.

2.3 Research has found that patients treated in Independent Sector Treatment Centres (ISTCs) are more likely to need further care, often in NHS hospitals, and that ISTCs could damage the local health economy, profiting from NHS funding by explicitly choosing to treat only less risky patients, while being paid the same rate as publicly funded hospitals⁴.

2.4 Furthermore, a 2010 report from the National Audit Office questioned the long-term value for money of PFI hospital contracts, which will cost the NHS £65.1bn over their lifetime. It also found that the lack of flexibility in repaying debts could make it difficult for trusts to make savings without cutting back on services⁵. This inflexibility could increase the

² *A rational way forward for the NHS in England*. BMA, 2007.

³ Fotaki *et al.* (2008) 'What benefits will choice bring to patients? Literature review and assessment of implications'. *Journal of Health Services Research and Policy*, 13, No. 3, pp.178-184.

⁴ Street A, Sivey P, Mason A, Miraldo M, Siciliani L. 'Are English treatment centres treating less complex patients?' *Health Policy* 2010; 94(2): 150-157.

⁵ *The performance and management of hospital PFI contracts*, NAO 2010. Available at http://www.nao.org.uk/publications/1011/pfi_hospital_contracts.aspx

financial pressures on trusts, creating financial instability in the NHS, and ultimately make cuts and closures more likely⁶.

2.5 Therefore, this response should be viewed in the context of our continuing opposition to the commercialisation and promotion of the market in the NHS and to the threats to national terms and conditions of service and education and training for doctors contained in the White Paper. Moreover, the frequently expressed wish to improve the patient experience and provide more seamless, integrated care, seems at odds with many of the policies which will, inevitably, widen the purchaser-provider split. We wish to see the NHS restored as a public service working cooperatively for patients. We are committed to an NHS that:

1. Provides high quality, comprehensive healthcare for all, free at the point of use.
2. Is publicly funded through central taxes, publicly provided and publicly accountable.
3. Significantly reduces commercial involvement.
4. Uses public money for quality healthcare, not profits for shareholders.
5. Cares for patients through cooperation, not competition.
6. Is led by medical professionals working in partnership with patients and the public.
7. Seeks value for money but puts the care of patients before financial targets.
8. Is fully committed to training future generations of medical professionals.⁷

2.6 There are aspects of the White Paper's proposals which have the potential to undermine these principles and about which we are extremely concerned. Foremost amongst these are the policy of 'any willing provider' and the proposal that all NHS trusts should become, or become part of, foundation trusts.

2.7 The 'any willing provider' policy has the capacity to undermine local health economies by replacing existing multi-service natural monopolies with a plethora of smaller units providing more limited ranges of services. This would radically affect both the efficiency and value for money of the NHS. Allied to the treatment of the payment by results tariff as a maximum, this also threatens to introduce price competition with undesirable effects on the quality of care. If the tariff system is to remain, we are anxious that tariffs should encourage high quality care and value for money and not produce the unintended consequence of destabilising existing providers.

2.8 Changing the status of existing NHS providers to foundation trust status has already threatened the character and ethos of NHS provision. Further moves towards the development of corporate entities would threaten the stability of the NHS and the security of its employees and their terms and conditions of service.

2.9 Although the proposals in the White Paper apply to doctors working in the NHS in England, we are aware of the concerns of doctors in the devolved nations that they could yet have an adverse, knock-on effect in their countries. We have addressed these concerns in the appropriate sections of our response.

2.10 The BMA notes that a large amount of money is being spent to make the changes proposed in the White Paper, whilst at the same time attempts are being made to release £15-20 billion of efficiency savings over the next four years. This is a very difficult climate in which to make substantial service changes and reconfigurations and places an inappropriate burden at the door of those individuals expected to make both changes and savings simultaneously. We would question the value for money of such changes and whether a less disruptive, more cost-effective process could have been proposed to achieve similar aims of reducing bureaucracy and empowering clinicians.

⁶ *Inflexibility of PFI damaging to NHS*. BMA, 2010. Press release, Thursday 17 June 2010. Available at <http://web2.bma.org.uk/pressrel.nsf/wlu/SGOY-86GDYW?OpenDocument&vw=wfmms>

⁷ *Look After Our NHS*. BMA, 2009. Available at <http://lookafterournhs.org.uk>

2.11 Despite the Government's best assurances that front-line services will be protected, our data⁸ shows that cuts are already being planned or becoming reality and that these will have an adverse impact on doctors' ability to care for their patients. Even changes to back-room functions or administrative processes have consequences for front-line staff who, in many cases, may have to pick up the work themselves, meaning less time for patients. Although guaranteed growth in spending, in real terms, has been promised, this is likely to be minimal and efficiency savings will still have to be made. NHS trusts are already under pressure to make their funding go even further, eliminate waste and improve on productivity. It is imperative that the costs of change are minimised and, where inevitable, separated from the cost of provision of care if change is not to adversely impact further on frontline patient services.

2.12 There are likely to be areas where there is a genuine need to examine ways of working and services being offered to ensure they are delivered in the most cost-effective manner. However, where this does happen, it is vital that robust evidence is gathered and there are proper processes in place, rather than savings being delivered through indiscriminate cost-cutting exercises. Clinicians, other healthcare professionals, patients and local populations should be actively involved in decision-making processes and there should be genuine devolution of appropriate decision-making to a local level. We urge the Government and NHS organisations to focus on those areas where they can truly eliminate waste and achieve genuine efficiency savings rather than adopt a slash-and-burn approach to health care with arbitrary cuts and poorly considered policies⁹.

3. The transition period

3.1 The winding down of PCTs and SHAs must be managed extremely carefully if confusion and inefficiency is to be avoided in the current system's final years and months. The task of PCTs and SHAs will be made additionally difficult because, as well as their normal functions, they will be required to take on additional short-term work to support the transition. Staff within both types of organisation will, rightly, be thinking of their future careers and there is a risk that, if too many of the best managers leave their current employment too soon there will not only be a reduction in workforce numbers, but also a loss of corporate memory which will leave those staff left at PCTs and SHAs struggling to cope effectively with an increased workload. We are extremely alarmed at the potential vacuum and loss of skilled staff that could occur. If handled poorly, there is a real risk of PCT implosion, which would require a dramatic shortening of the proposed timeline, even if consortia were not fully capable of stepping into the role. The BMA has grave concerns over the possibility that PCTs may be phased out before consortia are properly established and would suggest that PCTs should be retained until consortia are fully operational.

3.2 The Government has outlined its commitment that SHAs and PCTs should seek to devolve leadership of the Quality, Innovation, Productivity and Prevention programme (QIPP) to GP-led consortia and local authorities as soon as possible. With the requirement that SHAs and PCTs have an increased focus on maintaining financial control during the transition, we are concerned that SHAs and PCTs will be empty of talent as the skilled people leave to take new positions or set up as advisers to consortia before PCTs and SHAs are actually abolished.

3.3 PCTs currently have many statutory functions and responsibilities that will still need to be undertaken after they are abolished. These include holding performers lists, emergency planning, child protection, the allocation of premises and practice IT funding, administration of GP appraisals. Plans for revalidation, as currently constituted, will also rely on PCT involvement in providing the responsible officer function to oversee the process at a local level and ensure that governance systems are sufficiently robust to support it. We are aware

⁸ A total of 361 LNC chairs were sent the survey on 15 June 2010. The survey was closed to further responses on 24 June 2010. A total of 92 responses had been received by this date - a response rate of 25.5%.

⁹ *Front line services already feeling the pressure of front line services*. BMA, 2010. Press release, Sunday 27 June 2010. Available at <http://web2.bma.org.uk/pressrel.nsf/wlu/CMUN-86TCSA?OpenDocument&vw=wfmms>

that a complete list of both statutory and non-statutory roles has been drawn up and sent to PCTs, and which should now be made publicly available. Functions that will no longer be required should be clearly identified so that consortia are able to operate effectively with their reduced budgets.

3.4 The BMA requires further details on where responsibility for the many non-commissioning functions of PCTs and SHAs will lie during the transition period and following abolition. Further, we do not believe PCT debts should be passed on to consortia, as we believe this will prevent them from functioning to their full potential and will also discourage GPs from becoming involved in consortia.

3.5 At present PCTs administer many aspects of GP's pensions and those of their staff. PCTs also pay the employer's contribution in respect of GP locums. We would request details on how these arrangements will be fulfilled in the future.

3.6 The BMA notes this year's 20 per cent reduction in local authority funding with significant concern¹⁰. The White Paper proposes closer working between health services and local authorities, to create integrated systems of care and support. However, it is likely that care services provided by local authorities will be affected by budget cuts in the coming months and years, which will make it more difficult to commission integrated care pathways and services and meet the wider support needs of patients and the public. Local authorities need to be properly funded and appropriate services need to be in place before commissioning responsibilities are handed over to consortia.

3.7 We would like clarification on the definition of the term 'frontline' as used in the White Paper, and reassurance that this includes those in training posts. There is reference to a rebalancing of NHS staff towards 'clinical staffing and frontline support' but we would urge the Government to also protect training explicitly, to ensure that NHS patients get the best possible service both now and in the future. In order for the NHS to remain the envy of the world, it is imperative that it continues to provide world-class training for the doctors of tomorrow at undergraduate and postgraduate level. Training must not be overlooked in the process of change.

4. Training and education

4.1 The BMA notes the lack of detail given in the training and education section of the White Paper. This gives us huge concerns, given the central importance of training and education in providing a world class health service. We would expect to play an integral part in the further development of proposals around education and training and look forward to inputting in more detail to the consultation on these areas due to be published later in 2010.

4.2 The BMA believes that effective national oversight to medical education and training is absolutely essential. More detail on our view is available in Appendix A.

4.3 We would strongly oppose any moves towards local planning and management of education and training – and by extension, of workforce. As local employers unavoidably lack a broad overview of workforce requirements, we believe that the management and planning of the medical workforce can only be done at minimum at a national level, and more properly at a UK level. We believe UK cohesion and consistency, that enables medical graduates to move between national boundaries, is essential to ensuring the same high standard of patient care is maintained throughout the UK. We would be extremely concerned at a loss of this important UK perspective. Additionally, without a uniform approach to training in terms of career progression and standards of qualification, there could be further instability to patient care as it would become more difficult for the medical workforce to move around the UK. We therefore do not support the proposal for healthcare employers and staff, locally, to agree plans and funding for workforce development and

¹⁰ 'Local government to bear brunt of £6.2bn cuts', The Guardian. Monday 24 May, 2010. Available at <http://www.guardian.co.uk/society/2010/may/24/cuts-local-government-loses-2bn>

training. Instead, we believe that medical workforce planning should sit within a collaboration of the postgraduate deans, medical schools and the medical royal colleges, in consultation with employers and informed by the Centre for Workforce Intelligence (CfWI).

4.4 We acknowledge the need for Medical Education England (MEE) to evolve into a body that can lead on the planning of education and training of doctors in England, in conjunction with the devolved nations.

4.5 We believe that determination of required medical school intake should be made by MEE, working backwards from suitably-informed proposals from Medical Programme Board (MPB) of requirements for the workforce and in conjunction with discussions in the other three UK nations.

4.6 We would urge that postgraduate deaneries continue with their current structure and functions following the abolition of SHAs. Most deaneries were separate entities prior to merger with SHAs and we would strongly advocate their continuation after SHAs cease to exist.

4.7 We note the focus on the profession in deciding the structure and content of training. We envisage the medical royal colleges retaining their current educational role with regard to setting specialist standards and curricula, as well as providing workforce information based on local specialty-based knowledge. The General Medical Council (GMC) should continue to approve training programmes and undergraduate training, as well as quality assuring deaneries. This will require ongoing commitment from the GMC and the medical royal colleges to consult the profession over the content, structures and costs of training.

4.8 It is vital to ensure that undergraduate and postgraduate education and training is integrated within, and a fundamental part of, local health economies¹¹. Whilst we believe that providers should recognise the needs of their patients in the future as well as today, and view training as a necessary cost, we have difficulty reconciling this general approach with the role of the GPs as providers.

4.9 We also have concerns that employers are subject to short-term drivers which prevent them from being able to take the long view. This will erode the principle of producing well-rounded, appropriately skilled doctors and will ultimately have an adverse effect on patient care. We therefore believe that funding for postgraduate training posts and medical schools should flow from MEE in its commissioning function. We would welcome the opportunity to discuss this further with employers, especially those who do not currently contribute to the costs of training healthcare staff.

4.10 The BMA wholly agrees that funding flows need to be transparent. Alongside this there must be transparent rules as well as clear mechanisms to ensure that the measurement of quality is used in the determination of funding.

4.11 Local oversight of providers' funding plans for training and education should be provided by the deaneries, who should then report to MEE. We would seek clarification on how the NHS Commissioning Board fits with the plan to give the Multi-Professional Education and Training levy budget to MEE.

4.12 The planning decisions by MEE and MPB need to be informed by long-term projections regarding the shape and nature of the medical workforce. We therefore acknowledge the White Paper's commitment to the CfWI and its role in providing a consistent source of information and analysis. However, we request greater clarity about the function, membership and aims of the CfWI in order to have confidence that it will be able to achieve this.

¹¹ *A rational way forward*. Op cit.

4.13 The BMA seeks confirmation that the development funding for Staff and Associate Specialist (SAS) doctors in England will not be withdrawn or the funding allocation decreased given the Department of Health's commitment to reducing its role in overseeing education and training.

5. Improving public health

5.1 As the leading professional organisation for doctors in the UK, the BMA represents the collective voice of the profession in improving and protecting public health. We believe doctors are in a unique position to be able to speak out for their patients and to identify areas where resources can be targeted to prevent disease. Reducing health inequalities and improving public health will remain a priority for the BMA in the coming months and years. We support some of the proposals for a new Public Health Service and have set out below several aspects that need to be considered in the creation of the service, including public health involvement in commissioning and the independence of the Director of Public Health.

5.2 Effective delivery of the Public Health Service will be crucially dependent upon the expertise of people with population health and public health skills covering all domains of public health practice. The Public Health service will not be effective unless it can fully support the delivery of public health functions at a local level. There is a danger that the centralisation of skills and expertise into the service might be at the expense of the capacity and capability within local departments. These skills give public health specialists the ability to deliver cost-effective, population-based and patient-oriented outcomes. It is imperative that all these functions are retained and linked together, ensuring that the focus of an independent voice for the population is not lost as the new commissioning model emerges. The unique role of public health specialists as advocates for the entire population needs to be recognised and utilised.

5.3 It is imperative that there is continued public health input into commissioning and, reciprocally, continued GP input into public health strategies. We believe public health specialists are uniquely placed to work in partnership with and assist GPs to make the best value commissioning decisions, given their bird's eye view of healthcare needs and ability to analyse health services information from a population perspective. In addition, public health doctors are experienced at working closely with secondary and tertiary care clinicians, to ensure best quality clinical outcomes, which will be of great value in the commissioning process. Furthermore, they have skills in developing an evidence based approach, in comparative effectiveness approaches and in the effective prioritising of services within a cash-limited budget. It is vital that public health is embedded in the commissioning process and not seen as a last minute addition.

5.4 The Director of Public Health should be an accredited specialist in public health. As such, they should be recognised by the local authority as the principal officer accountable for all matters related to population health and the principal advocate in local health systems for health improvement and reducing health inequalities. The BMA would like the office of Director of Public Health to be given a legally constituted status, that is, to be a statutory appointment, as an independent advocate for the health of a defined population¹². This would ensure that, in the exercise of their functions, they have a separate legal existence from the local authority or the Public Health Service. Directors of Public Health need to have the power to advocate on behalf of the community without needing the authorisation of others. Furthermore, the Director of Public Health should be an executive appointment reporting directly to the chief executive of the local authority.

5.5 There are many areas, including planning, transport and environmental issues, where we believe the Director of Public Health should be a statutory consultee. The Director of Public Health should have the freedom to participate in such processes in accordance with their professional judgement.

¹² BMA (2010) ARM Emergency Motion 2

5.6 The job description of medically qualified consultants in public health requires them to play a part in local medical leadership. Medically qualified Directors of Public Health must engage with this role and non-medical Directors must arrange for it to be carried out. This is an important element of the public health contribution to the health and wellbeing process and the BMA would be concerned if it were lost or became merely a bureaucratic role.

5.7 The BMA requests that the Government make explicit what is included within the public health funding stream, what part of the public health budget will be ring-fenced and that funding should come from local authorities as well as the NHS¹³.

5.8 The focus of the Public Health Service should include looking at how to better meet the health needs of minority groups and to seek greater understanding of diseases more prevalent in minorities, with an emphasis on early identification and prevention, which will save money in the long-term.

5.9 The BMA has concerns regarding the future of academic public health and seeks assurances that its future will be secure if responsibility is transferred to local authorities. In order to retain important links with the NHS, we suggest that medically qualified Directors of Public Health could be given honorary consultant contracts, modelled on the contract for consultant clinical academics.

5.10 The BMA looks forward to inputting in more detail to the Public Health White Paper, due to be published in Autumn 2010.

6. Reforming social care

6.1 The BMA believes reform of the chronically under-funded and complex social care service is needed and notes the Government's commitment to continue to play a vital role in setting adult social care policy and to setting out a vision for adult social care. We would urge the Government to provide a clear definition of social care in its vision. It is vital that the public, commissioning groups and local authorities are aware which services will be provided by the NHS, free at the point of delivery, and which services will not, under a new social care system. This would enable better joint commissioning, help GP-led consortia to see the value of investment in preventative services and clarify, to an extent, the sorts of services people might need to save to pay for.

6.2 We support greater collaboration between health and social care services¹⁴ and the breaking down of burdensome barriers between health and social care that do not benefit patients. In order to create seamless integration between health and social care, new pathways will be required to link services to facilitate movement of patients between different care sectors.

6.3 We would like to see a more strategic approach to the challenges facing health and social care services in terms of life expectancy and current health trends. Due to the increase in long-term conditions and co-morbidity, particularly amongst older people, we believe there are dangers in creating discrete services that separate their management from others within the system¹⁵.

6.4 We note the establishment of the independent commission on the funding of long-term care and support, and its commitment to report within a year. We look forward to engaging with the commission in the coming months. We are concerned about the establishment of an insurance scheme that we do not believe would improve the current situation. We would prefer the introduction of a funding model based on a partnership of state and individual funding, ensuring that premia were related to ability to pay.

¹³ BMA (2010) Op cit.

¹⁴ ARM 126. BMA, 2000.

¹⁵ *Response to the Green Paper 'Shaping the Future of Care Together'*. BMA, 2009.

6.5 In addition, we would strongly recommend a wider policy review on the social determinants of health, whose effects determine morbidity and mortality outcomes, as set out in the recent Marmot Review report 'Fair Society, Health Lives'. Policies in other areas, such as education, income support and transport, impact on health in a wider sense. A coherent policy on prevention and public health becomes far more sustainable if the social determinants of health are given more consideration.

6.6 We look forward to engaging with both the commission on the funding of long-term care and Government's White Paper on social care reform, expected in 2011, where we will set out our view on these issues in more detail.

7. Putting patients and the public first

7.1 Doctors are wholly committed to putting patients and the public first. The doctor's code of practice states "*Make the care of your patient your first concern ...be honest and open and act with integrity; never abuse your patients' trust in you or the public's trust in the profession*". The individual doctor is trusted to serve the individual patient, but doctors also have a duty to whole families, and whole communities, treating illness and promoting health. It is commitment to this cause which defines their professional role¹⁶.

Shared decision-making: nothing about me without me

7.2 The BMA supports shared decision-making between patients and doctors and an increased emphasis on patient involvement. In recent years patients have acquired greater empowerment and autonomy, impacting on the doctor-patient relationship¹⁷. Patients increasingly request more information about treatment options and expect to be more involved in making the decision about what option to follow¹⁸. As a result, the doctor-patient relationship has moved towards a two-way interaction with a growing emphasis on a partnership approach to decision-making¹⁹.

7.3 Enabling patients to make informed choices through supporting shared decision-making is central to the role of today's doctor. Trust has always been the bedrock of the doctor-patient relationship and central to the doctors' code of practice. The BMA believes that trust is nurtured in partnership with patients, through meaningful communication, patience and empathy, with doctors acting as interpreters of information, translating complexities and supporting decision-making about health choices²⁰. Where appropriate, some of the best healthcare outcomes can be achieved when patients have an understanding of their care, and are able to actively participate in the decision making process. As such, we accept the principle of *no decision about me without me*.

7.4 However, we note that shared decision-making does introduce the risk that doctor and patient may have conflicting views as to the best course of treatment, particularly if patient expectations have been raised beyond the available funding for services. These will need to be carefully managed. Evidence on good outcomes will be key to providing patients with more detailed, evidence-based and accredited information to support their care, which will also take time, leading to longer average appointment times with GPs and other health professionals.

7.5 These aspirations need to be balanced against the drive for service productivity and efficiency. Delivering these principles will make the NHS appear less efficient as fewer patients will be seen in the time available as they will need to be guided through the decision-making process in a much more detailed way. However, this approach should create

¹⁶ *The Role of the Doctor: Building on the Past, looking to the future*. BMA, 2008. Available at http://www.bma.org.uk/careers/becoming_doctor/roleofdoctor2008.jsp

¹⁷ *Ibid.*

¹⁸ *Public and Patient Involvement in the NHS*. BMA, 2009. Available at http://www.bma.org.uk/healthcare_policy/nhs_system_reform/ppimarch2008.jsp

¹⁹ *Role of the Doctor*. *Op cit.*

²⁰ *Ibid.*

long-term gains, such as improved patient satisfaction, possibly fewer follow-up appointments and possibly improved health outcomes.

8. NHS Information revolution

8.1 The BMA supports provision of information, advice and support that could help patients improve and better manage their health. The continuing development of online services offers patients and the public new opportunities to access information and communicate with health professionals, but it also brings significant risks. Patient surveys and feedback can be useful tools in helping services improve, but careful consideration must be given to the design and implementation of such tools. Similarly, patient ratings and peer comparison can provide greater transparency and information for patients but must be meaningful and fair for providers. With greater transparency comes a need to support staff to foster a culture of active responsibility. The BMA notes the White Paper's commitment to require that staff feedback on the quality of patient care provided is made publicly available. The BMA seeks assurances that whistleblowers will be better protected and supported than under the current system, so they can safely raise concerns without being penalised. The BMA has previously published guidance on whistleblowing for doctors and reported on the low awareness of official whistleblowing policies in the workplace and confidence in the outcomes of such processes²¹. Patient confidentiality and accuracy of data must be at the heart of any new initiatives.

Online communication

8.2 The NHS should continue to develop clearly accredited information for patients to access in a range of media. If the information provided by the NHS is appealing to the public, it may reduce the number of visits to websites which provide unaccredited misleading information.

8.3 The BMA recognises the potential benefits of patients being able to communicate with clinicians online in certain circumstances. We believe there is value in certain administrative functions being processed online, such as ordering repeat prescriptions. There may also be times when appointments are saved by answering a quick question from a patient, although this often already occurs over the telephone. However, online communication will not always be appropriate or safe.

8.4 The breadth of the spoken word and personal interaction cannot be encompassed when communicating electronically and it can be easy to misinterpret meaning. The clinical information that can be conveyed online is extremely limited and health issues, which can be picked up when seeing and examining a patient, may be missed. We are concerned that an online conversation could take place without any certainty that either party is who they claim to be, risking a breach of confidentiality or mistaken advice being given. Delays could occur if a patient sends a communication to their doctor outside normal working hours and online consultations could lead to reduced satisfaction for patients as they receive an impersonal service. We therefore believe that online communication needs further piloting and should be introduced on a voluntary basis before being implemented more widely. This should take into account the experiences and lessons learnt by Connecting for Health and should be cost-effective.

8.5 It is important that the increasing use of online services does not disenfranchise those people who do not have internet access. It is often the case that those with the greatest health needs are those with the least access to up-to-date technology and so increased IT use can deepen inequalities between those who have internet access and those who do not. People who do not wish or who are unable to use the internet must not inadvertently miss out on care.

Patient surveys and feedback

8.6 The BMA welcomes the opportunity to engage with patient experience surveys and realtime feedback. We believe that surveys of this kind should be locally led, and relevant to

²¹ *An NHS beyond the market*. BMA, 2010. Available at http://www.bma.org.uk/healthcare_policy/nhsnewdirectionjune2010.jsp

individual practices and groups of practices, so that they can provide feedback that is genuinely useful in improving local services. National surveys, such as the Patient Experience Survey, are an expensive and inefficient way of gathering these data.

8.7 The BMA supports the use and promotion of validated and representative patient feedback surveys. Patient rating of services can be useful, provided it can be done fairly and meaningfully, within the context of available funding. Any rating system must take into account the local context, to help patients interpret the results, and services should not be compared with others in simplistic terms when demographics and structures may vary hugely. The BMA's view on patient feedback and ratings is set out in more detail at Appendix A.

8.8 As with the introduction of the rating systems on NHS Choices, care must be taken to ensure that malicious comments and deliberate manipulation do not skew overall ratings. It must be acknowledged that all online feedback systems exclude those who are not IT literate or do not have access to the internet.

8.9 In terms of primary care specifically, the BMA would not wish to see any direct link between patient surveys or rating of services and GP practice funding, as removing resources from practices found wanting is likely to exacerbate rather than improve the situation for patients.

8.10 The BMA accepts the extension of national clinical audit but would stress the need for this to be properly funded and the importance of ensuring clinicians have adequate time for this activity.

8.11 The BMA has particular concerns about the proposed expansion of Patient-Reported Outcome Measures (PROMs). Only a small number of PROMs have been properly validated at this time. As such, we do not believe that the use of PROMs should be expanded until there is peer-reviewed evidence to show how they benefit patient care. It is our view that a significant amount of work remains to be done to gather this evidence. It is vital to pilot and evaluate the use of PROMs in new areas before they are rolled-out more widely.

Comparative data

8.12 The BMA recognises the need for transparency in the health service with patients having access to data about services. We would recommend a focus on improving and safeguarding the accuracy and quality of data captured across the NHS so that patients are not misled, results cannot be manipulated and services do not suffer due to poor quality data.

8.13 We have some concerns about how information showing providers' performance against their peers will be used, as it is unclear if this means national and regional league tables and/or outcome figures in non-league table format. League tables generally focus on overly simplistic figures and are not the best way to accurately compare provider's performance. Presenting individual outcome figures in any overly simplistic format without guidance on how they should be interpreted could create reluctance among clinicians to take on patients whose care will be seen to impact negatively on their performance. A more detailed view on these issues is set out at Appendix A.

8.14 We are concerned that peer competition between NHS providers based on patient feedback could result in penalising staff in areas of the NHS that are understaffed due to budget cuts. Healthcare professionals may be working very hard but not be able to attend to each patient in the way they would wish through sheer volume of workload, leading to negative feedback and loss of staff morale.

8.15 The BMA would like clarification as to the meaning of 'risk-adjusted' performance, how this will be done and by whom, as we are unaware of it taking place successfully on a widespread basis.

8.16 The BMA is pleased to see a commitment to undertaking an evaluation of Quality Accounts before potentially extending the scheme, as we believe the framework will need to evolve following the experiences of healthcare providers over recent years. Our detailed position on Quality Accounts is set out at Appendix A.

Access to health records

8.17 The BMA agrees that patients should have easier access to their health records. Although this sounds like a simple proposal there are many practical problems and therefore this should be considered as a long-term strategic aim with implementation in stages. The BMA has supported a discussion paper on patient access²² which highlights some of the complexities. Any arrangements for accessing patient records must have a focus on seeking explicit patient consent for sharing healthcare information for purposes which go beyond direct contributions to the care or treatment of the patient, with the doctor acting as the record guardian. We support proposals to make aggregate data available to patients and for health research purposes but it is important to ensure that the information is an accurate reflection of the care provided, is not obscured by variables which could mislead patients and that patients are involved fully in decisions about how their identifiable data are used.

8.18 The BMA's views on this area are set out in more detail at Appendix A. We look forward to contributing to the forthcoming consultation on patient records to ensure that patients have greater control but are supported in their sharing decisions when required.

Accessing data

8.19 The BMA believes there should be improved governance when accessing health data. Discussions need to continue to ensure that patient confidentiality is not undermined by central collection both in terms of patient consent for the collection of the data and future use of the data. Whilst we agree that there should be greater control over the flow of data within the NHS, patients and medical professionals need reassurances that once held centrally the information will not be used inappropriately, for example by attempting to implement information sharing clauses similar to those included in the initial draft of the 2009 Coroners and Justice Bill (now Act).

8.20 The BMA agrees that standards to ensure that data are fit for purpose and comparable are essential. The time and resources required to ensure data are of an appropriate standard should not be under-estimated.

8.21 We look forward to contributing further to the forthcoming Information Strategy.

9. Patient choice and control

9.1 The BMA supports meaningful choices for patients, free from political targets, but we do not believe the patient choice agenda of recent years, which is continued in the White Paper, has improved clinical outcomes or offers patients the choices they actually want²³. We would suggest that most of all, patients want a high quality provider close to where they live and to receive timely, competent diagnoses and treatment and ongoing support when necessary. Too much choice can lead to confusion and inaction due to uncertainty. The choice agenda has been viewed by some as a 'matter of process that has grave opportunity costs - those who are good at exercising choice benefit at the expense of those who are not'²⁴. For many patients it is appropriate that their doctors use their skill and experience to make these choices for and with them. The BMA's position on patient choice is set out in more detail at Appendix A. We have set out our views on the specific elements of choice identified in the White Paper below.

²² *Enabling Patients to Access Electronic Health Records: Guidance for Health Professionals*. BMA, 2010. Awaiting publication.

²³ *ARM 022*. BMA, 2007.

²⁴ Oliver, Adam. 'Promoting quality in the NHS'. *Health Policy Monitor*, April, 2009.

Extending choice

- Choice of any willing provider

9.2 The BMA does not support the choice of any willing provider for patients. We believe that the NHS should remain the principal provider for primary and secondary care, to ensure continuity of care and financial sustainability. The 'any willing provider' policy assumes that cost is the primary motivation for commissioners and that, therefore, introducing competition, via choice, will lead to cost savings. However, doctors do not make commissioning decisions based on cost alone, but consider the impact of decisions on patients, the public and providers in the area. For instance, if the decision to commission a particular service from an alternative, cheaper provider would destabilise the equally high-quality main provider of services in the area, the doctor may often choose not to commission the cheaper service, in order to maintain a level of stability. Services are not commissioned in isolation and decisions are not based solely on cost.

9.3 We do not support the creation of further opportunities for private sector companies to provide health services or back room support or the promotion of competition in healthcare, except where the NHS does not provide a service or existing services are inadequate to meet patient need. Multiple routes to obtain a single service may lead to confusion among patients, and risks fragmentation of the service that will increase costs and complexity and could impact upon patient safety. Research has already shown that patients treated in ISTCs are more likely to need further care, often in NHS hospitals, and that, as previously stated, ISTCs could damage the local health economy, profiting from NHS funding by explicitly choosing to treat only less risky patients while being paid the same rate as publicly funded hospitals²⁵.

9.4 We are also concerned that the 'any willing provider' policy could threaten national terms and conditions of service for healthcare professionals, as non-NHS employers become more prevalent and introduce local terms and conditions for staff. Furthermore, the BMA seeks clarification on how the 'any willing provider' policy can operate alongside the vision of more integrated services promoted elsewhere in the White Paper, given that choice and competition risk creating greater fragmentation, are likely to increase costs, are probably more likely to increase than decrease inequalities and may or may not increase efficiency²⁶.

- Choice of named consultant-led team

9.5 The BMA supports the choice of named consultant-led team for elective care, but has concerns that it would not be appropriate for all services. A universal introduction of choice of named consultant-led team could result in some patients having to wait longer to be seen, as it would not be possible to spread referrals across teams. In the case of elective surgery, this could lead to restrictions on when patients could be admitted, for example if the named consultant was on annual leave. In other situations, patients would need to be directed to a certain subspecialty, so choice of named consultant-led team would not be appropriate. The growth in sub specialisation means that it is easier for patients to be directed towards the wrong sub speciality, which can be avoided by using more generic referrals. Furthermore, it would be unsuitable for patients being treated in sectorised services with community components, such as psychiatry, to be able to choose a named consultant-led, team as this would break the sectorisation and harm the continuity of care being received.

9.6 A number of SAS doctors work independently. In order to ensure that their expertise is used efficiently, Associate Specialist-led teams could provide some elective care.

9.7 It is also important to recognise that, while some patients will find it relatively easy to exercise choice in this area, there will be other groups of patients who have little knowledge of the NHS or how it works and do not have the time or the skills to make

²⁵ Street A, *et al.* (2009) 'Are English treatment centres treating less complex patients?' *Health Policy*, doi:10.1016/j.healthpol.2009.09.013

²⁶ Fotaki *et al.* (2008) 'What benefits will choice bring to patients? Literature review and assessment of implications'. *Journal of Health Services Research and Policy*, **13**, No. 3, pp.178-184.

these sorts of informed choices. It will be essential to provide patients with support and guidance on what these choices mean for them. Consideration will also have to be given to how information on named consultant-led teams will be delivered to patients and who will be responsible for this.

- Choose and Book
9.8 The BMA has noted that in many areas significant implementation problems have been encountered with Choose and Book and, as such, we would not support its mandatory use.
- Maternity choice and provider networks
9.9 The BMA notes the proposals to extend maternity choice. We believe that maternity care should be led by specialists (both obstetricians and midwives). When offering choice of home births and births in stand-alone midwifery-led units, appropriate systems must be in place to ensure timely transfer to a hospital if needed, as unexpected emergencies can arise during labour, even in uncomplicated pregnancies, and in most cases, will require immediate transfer to hospital²⁷.

9.10 We have also been concerned over policy changes in recent years that have led to the gradual withdrawal of district nurses and health visitors from GP practice teams, and the consequent loss of continuity of care. We believe GPs and GP practice staff have an important role to play and patients should be able to access this, both through their GP and through local midwifery services. Recent research by the King's Fund highlighted that GPs' lack of involvement in maternity care is undermining the care of pregnant women and their families and suggested that shared care, between GPs and midwives and obstetricians, could result in better co-ordination of care, particularly for women with ongoing medical conditions and complicated medical histories²⁸. We do not believe that maternity care should be commissioned differently from any other kind of care: it should be commissioned through local consortia rather than as a separate national contract. We would request further details as to why maternity care has been excluded from GP-led commissioning.
- Choice of treatment and provider in mental health services
9.11 The BMA cautiously welcomes the introduction of choice of treatment and provider in some mental health services from April 2011. However, the standard of mental health services in many areas is unacceptably low and must be improved before the introduction of choice which could potentially fragment care further. The implications of introducing choice for this most vulnerable group of patients need careful consideration by commissioners, providers and mental health charities, alongside an examination of potential ethical issues that could arise. The BMA would prefer to see this choice offer piloted and evaluated before being implemented more widely.
- Choice for diagnostic testing and choice post-diagnosis
9.12 The BMA agrees with the introduction of choices for diagnostic testing and post-diagnosis, in principle. However, it is important to recognise that it will sometimes be most clinically appropriate for a patient to be treated by the team that made the diagnosis, or within that Multi-Disciplinary Team, rather than to be seen by a new team altogether. This should be clearly communicated to patients.
- Choice in long-term conditions and end-of-life care
9.13 The BMA supports proposals to introduce choice in care for long-term conditions and end-of-life care.

²⁷ Royal College of Obstetricians and Gynaecologists Statement on the Maternity and Early Years document, Wednesday 17 March 2010. Available at <http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-maternity-and-early-years-document>

²⁸ *Maternity care in general practice*. Kings Fund, 2010. Available at http://www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/maternity_care_in.html

9.14 We firmly believe that all patients are entitled to high quality care and for their wishes to be taken seriously, regardless of their condition or age. Many people wish to die at home and improvements in palliative care mean more patients are now able to do so with dignity than in recent years.

9.15 However, we are concerned that there is neither the available funding nor infrastructure to enable a significantly increased number of people to choose to die at home. The tough financial environment in the years ahead is a difficult backdrop against which to introduce a potentially very costly choice offer for patients, many of whom will require high levels of nursing care in their own homes for an undefined period of time. Some savings will be made at hospitals if more patients choose to die at home, but it is not clear if this will match the costs of providing widespread terminal care at home.

- More information on research studies

9.16 The BMA supports the commitment to giving patients more information on research studies that are relevant to them and more scope to join if they wish. Education and research are at the heart of world-class healthcare, so it is vital that patients have increased awareness and opportunities to be involved in the work of medical researchers.

9.17 We would wish to see further details on plans to increase patient access to research and remove barriers to participation. We believe that expert information for both patients and clinicians is needed to ensure wider participation. We would suggest that the NHS Commissioning Board takes on the role of championing this issue.

9.18 We would urge that this work be accompanied by a halt in the decline in the medical academic workforce that has been seen over the past decade. An improvement in the supply of senior clinical academics is necessary to maintain the delivery of research and education. This can only be achieved by raising the profile of academic medicine amongst students and ensuring parity of pay and conditions of service between NHS doctors and those employed by universities. Higher education must continue to be supplied with the necessary resources to achieve this²⁹.

- The right to register with any GP practice

9.19 It is right that patients should be able to choose which GP practice is best for them. However, removing practice boundaries entirely may have a large number of unintended and unwanted consequences. It will increase the cost of providing care, complicate resource allocation, make home visiting, currently a contractual obligation for GPs and a vital service for many chronically sick, immobile and elderly patients, impractical, and will damage continuity of care. It may widen health inequalities and will make commissioning care difficult for patients who do not live locally³⁰.

- 24/7 urgent care service

9.20 The BMA notes the plans to develop a more coherent 24-hour urgent care service, and hopes this will reduce unnecessary duplication of services and efforts, as well as increase quality. We believe that GPs are at the heart of urgent primary care and do not think that patients will get an improved service if this crucial element is moved to another part of the NHS.

Patient and public voice

9.21 We note the intention to increase patient and public engagement through the development of HealthWatch England and local HealthWatch. Many GP practices have already taken the initiative in this area and encouraged the development of Patient Participation Groups. This has been of considerable benefit to both patients and practices,

²⁹ *The BMA Manifesto*. BMA, 2010.

³⁰ *Reforming General Practice Boundaries*. Available at http://www.bma.org.uk/images/reformgpboundaries_tcm41-193919.pdf

and we would hope that the roles of independent Patient Participation Groups and local HealthWatch groups would be complementary.

9.22 However, it will be important to provide local HealthWatch groups with appropriate funding, training and support to ensure they are properly equipped to provide the range of services identified under their remit in the White Paper.

9.23 The BMA would like clarification on when local HealthWatch will be able to recommend that poor services are investigated and whether this will include individual doctors, teams, departments and hospitals.

10. The NHS Outcomes Framework

10.1 The BMA believes the primary purpose of the NHS should be to provide comprehensive, high quality healthcare for the population. Broadly speaking this encompasses prevention, diagnosis and treatment, and long-term care. It is always vital to strive to achieve the best outcomes, and to improve these where possible, but, due to the complexity of healthcare, measuring outcomes in isolation is not always a reliable indicator of overall quality.

10.2 While the BMA recognises that waiting-time targets have helped to reduce headline waiting times in the NHS, we welcome the reduction in the number of top-down targets, which had the potential to distort priorities. However, we would not support the wholesale replacement of process targets and indicators with clinical and patient reported outcomes measures³¹. It is generally accepted that the quality of care received by patients should be integral to the assessment of whether or not that care has been successful. There is clear evidence that indicates how quality of care can be best measured, showing that the use of process measures is an effective tool for judging and rewarding quality, provided the process measures are valid and able to influence the process of care but do not have total control over the outcome of that care. More detail on our views on these issues is available at Appendix A.

10.3 The BMA will be contributing to the consultation on the development of the national outcomes goals. It will be essential that the Department of Health engages with, and utilises the skills and expertise of, the whole medical profession, patients, carers and representative groups, to create indicators which are based on the best available evidence. The meaningful involvement of clinicians and the deployment of evidence-based decision-making at every stage of service design and development are central to achieving successful change in the health service and to the delivery of high-quality care to patients³².

Developing and implementing quality standards

10.4 The BMA broadly supports the continued role for the National Institute for Health and Clinical Excellence (NICE) and the introduction of quality standards in health and social care. It is useful to have authoritative standards to ensure that there is a clear patient pathway and to avoid inequalities in care. However, a careful balance needs to be reached in order to allow clinicians to do more than follow protocols and avoid unintended consequences, and we have some concerns about the potential problems of introducing 150 new standards. Taken in isolation each will be valuable, but when considered as a whole, 150 standards, each with a potential 10 quality measures, may be a challenge for providers to implement safely and may lead to a renewed focus on achieving national targets. We would like to see emphasis when creating standards on an approach that can be quickly understood and implemented by all providers, including those that are smaller.

Research

10.5 The BMA acknowledges the Government's commitment to 'the promotion and conduct of research as a core NHS role'. However, it is unclear how this is to be done in the newly-structured NHS and what funding is to be made available to support it. The BMA would recommend consideration of the roles of networks, Health Innovation and Education

³¹ *An NHS constitution for England*. BMA, 2008.

³² *Caring for the NHS: A way forward*. BMA, 2007.

Clusters and the National Institute for Health Research and how these will fit into the Government's overall plans. We would suggest that consideration also needs to be given to Health Technology Assessment and to the importance of medical devices in addition to pharmaceutical research.

10.6 We further note the emphasis given in the White Paper to comparing the performance of the NHS with healthcare systems from around the world. We would like to highlight that evidence from outside the UK is not always applicable for this sort of comparison and that sufficient investment in UK health research and a more coherent approach to investing in and designing long-term research programmes is required to ensure that robust evidence and recommendations can be obtained.

Incentives for quality improvement

10.7 The BMA remains concerned about the system of payment by results. The current system does not reflect the relative true cost of treatment, is bureaucratic and costly to implement and creates perverse incentives³³. In particular, payment by results creates a tension between primary and secondary care, as GPs are encouraged to refer less, while secondary care providers are incentivised through the national tariff to carry out more procedures in hospitals. This discourages the collaboration that is needed to develop integrated services. The system also discourages networking of secondary care services, and so discourages collaboration between clinicians working for different secondary care trusts³⁴. We would like to see a system that properly rewards efficiency and promotes fairness by making payments for the effectiveness of work done and that offers a way of ensuring that money flows effectively within the system.

10.8 We support placing emphasis on avoiding hospital readmissions. However, simply using financial disincentives is likely to result in unforeseen and potentially perverse consequences. One risk is that decisions about discharge are based not on a judgement about what is best for the patient, but on an attempt to avoid additional costs. This could result in patients being kept in hospital longer than necessary, when it might be better for them to be at home. It is also essential to remember that there can be a range of reasons that a patient is readmitted. Many of these are beyond the control of the hospital³⁵, such as a lack of appropriate social care or community-based services. Furthermore, some readmissions are inevitable due to the nature of the health condition. The best outcomes are always likely to be achieved when primary and secondary care professionals are allowed to work together to achieve what is best for patients and the BMA supports models of healthcare and funding that encourage co-operation rather than competition.

10.9 We agree that it is essential for improved patient outcomes that health and social care services are better integrated. However, we have concerns that local authorities may need to use health funding to meet the costs of a significant amount of social care provision, long before the expected benefits of a new approach to the public saving for their social care will be realised.

10.10 We note the commitment to seek to establish a single contractual and funding model for primary care in which funding follows the patient on a weighted capitation basis. We would caution that there is a risk of practice destabilisation if this is implemented too quickly, without additional funding, with a new formula and loss of correction factor and/or Personal Medical Services (PMS) funding. It would be particularly perverse to destabilise and alienate GPs through rushed and poorly thought out contract negotiations whilst trying to engage them in the added burden of commissioning. We welcome the commitment to incentivise ways of improving access to primary care in disadvantaged areas, as we believe quality improvements are best reached through incentives, rather than the threat of penalties, which can deprive practices of the resources necessary to achieve targets in the future and be

³³ ARM 242. BMA, 2010.

³⁴ *Consultant involvement in commissioning*. BMA, 2009.

³⁵ BMA comment on plans to reduce hospital readmissions, Tuesday 08 June 2010. Available at <http://web2.bma.org.uk/pressrel.nsf/wlu/RWAS-868HGH?OpenDocument&vw=wfmms>

demoralising, particularly when the failure to reach a specific target may not have been within the practice's control in the first place.

10.11 We support the decision to introduce the latest version of the International Classification of Disease (ICD) 10 coding system. Improved coding will be vital to enable GP led consortia access to the data they will need to effectively deliver high quality commissioning.

11. Commissioning consortia

11.1 High-quality commissioning is essential to improve the standard of health services available to patients and to ensure the best possible use of limited NHS resources. The BMA strongly supports greater clinician involvement in the design and management of the health service. The BMA is interested in exploring with the Government the proposals for GP-led commissioning consortia, which sees GPs as an integral part of the commissioning machinery within the NHS. Successful commissioning will only be achieved with GPs, secondary and tertiary care consultants and other clinical colleagues working closely together. Public Health consultants will also have a significant role to play, as will clinical academics, not least because commissioning needs to take into account education, research and training requirements. It is absolutely essential that all these expert clinicians play a central role in commissioning decisions and, as such, whilst GP-led, consortia must nevertheless design local mechanisms that ensure consultants and other specialists are brought into the decision-making process. It is clear that 'real and meaningful clinical engagement in commissioning is crucial'³⁶. However, there appear to be few incentives in the White Paper to encourage such cooperation: indeed the emphasis on continuing and even widening the purchaser-provider split seems to actively discourage this.

11.2 The 'any willing provider' policy has the potential to undermine the development of these pathways if it means that, in order to promote competition, multiple providers would have to be in place for each one. If this multiplicity of potential providers is indeed the intention, it would be impossible to achieve the goal of integrated pathways. This would also be inefficient, as each pathway would need to have multiple providers in place, despite the fact that they would definitely not be awarded the work.

11.3 The concept of GPs leading many of the NHS's commissioning decisions is not widely understood. Patients and the public may initially find it difficult to understand, particularly if an increasing number of services are to be provided in a general practice setting. One of the GP's primary roles is to act as a patient's independent advocate, organising patient care based on the patient's individual needs. It is possible that some patients may view GP-led commissioning with suspicion. As such, it will be essential to develop and implement a system that maintains patient trust and protects professional values. The system should be as transparent as possible and assure patients that their doctor is referring them to a particular provider purely because it will provide the best clinical outcome. Clear probity and scrutiny rules will need to be drawn up and patients will need to be educated about the way that commissioning works.

11.4 We will be responding to the 'Commissioning for patients' consultation, where we will set out our views on commissioning in more detail, and we look forward to commenting further as commissioning is developed over the coming months.

- **Size of consortia**

11.5 The way that consortia are formed will be critical to their future success, as it is likely that choices made now will be difficult to change at a later date. Careful consideration will need to be given to issues such as size, composition and structure.

³⁶ Smith J *et al* (2004) *A review of the effectiveness of primary care led commissioning in the UK NHS*. London: The Health Foundation.

11.6 The BMA does not believe there should be a 'one size fits all' solution, as consortia will vary considerably in size depending on local circumstances. Issues of practicality are likely to dictate upper and lower size limits. We anticipate that the majority of consortia will have a population of between 100,000 - 750,000 patients (as risk pooling becomes more reliable above 500,000 population size). We do not wish to see a specified maximum or minimum size for each consortium. Consortia should be of a sufficient size to be able to deliver the core functions currently undertaken by PCTs but also to maintain their local identity. In some circumstances, for example when commissioning low-volume services, consortia could join together in regional consortia federations with a single lead consortium. The lead consortium would commission services on behalf of the group, while the member consortia would share the risks associated with these services by joining together. An alternative to creating lead consortia would be a new organisation that acted on behalf of consortia, similar to a primary care group arrangement, and also hosted the regional functions.

- Management support

11.7 Each consortium will need sufficient numbers of management and administration staff to do the work required, and small consortia are unlikely to be able to afford to employ sufficient staff on their own. Consortia will need a management allowance that is sufficient to attract qualified candidates, and to ensure that those involved are remunerated for their involvement. We remain convinced that consortia should rapidly recruit and retain good managers from the local NHS, who have the experience to manage the local commissioning process. Prior to the formation of consortia, care should be taken to ensure that uncertainty over their futures does not lead to good managers leaving the NHS.

11.8 One possible way of enabling consortia to retain the flexibility and local touch that comes with being small, while at the same time allowing them to make use of economies of scale when commissioning and employing staff, may be for consortia to group together into federations. Alternatively, large consortia could be created with some form of local sub-consortia that remain locally accountable.

- Integrated working

11.9 It will be essential for consortia to include colleagues from secondary care and public health, as well as others such as medical academics and social care professionals, to enable integrated decision-making and ensure integrated care pathways are in place. Some of the most frequently quoted examples of successful healthcare provision – such as Kaiser or the Veterans Administration in the USA – have very close integration between primary and secondary care clinicians.

11.10 Commissioning is a sophisticated process and is not just about price. Local consultants will have a valuable input into commissioning decisions and ensuring commissioning plans are clinically relevant. Advice about new technologies and service developments will be critical in helping service planning for the future, as will research evidence and knowledge of clinical effectiveness and capacity planning. In areas where there is significant research activity spanning primary and secondary care, it will also be particularly important to seek advice from clinical academics on ensuring commissioning plans incorporate appropriate safeguards to protect, and, if possible, enhance, clinical research activity³⁷. Similarly, public health consultants are specialists in critically appraising the evidence base, in translating evidence into protocols and pathways, in comparing the effectiveness of groups of treatments and in prioritising treatments within and across care pathways and as such they will play an essential role in assisting commissioners in reaching objective, defensible and sustainable commissioning decisions.

11.11 It will be important that all those involved in commissioning decisions declare any conflicts of interest, to help ensure transparency and confidence in consortia. Consortia

³⁷ *Consultant involvement in commissioning*. Op cit.

will be looking to involve clinicians from provider units in commissioning decisions, to utilise their expertise and create integrated pathways. This could create a conflict of interest for these clinicians who will be competing for the work.

11.12 The focus of a commissioning consortium will be to design effective care pathways which cross between GPs, local hospitals, local authorities and community services. The commissioning population will therefore depend primarily on the natural clinical community of the local hospitals and local health economy. Where a consortium overlaps with more than one hospital and potentially other groups, these will have to work together to coordinate their efforts and possibly appoint a lead commissioner as PCTs do at present. By involving clinicians from secondary care and other healthcare professionals, safe and effective pathways for appropriate patient management can be developed.

11.13 A further barrier to integrated working will be the separation of budgets for primary and acute care under the new commissioning system. This will make it more difficult to transfer resources between primary and secondary care, in order to accommodate the shift of secondary care to the primary care setting, which is not the case with existing PCT unified budgets.

11.14 Consortia will also need to ensure that patients and the public are involved and that the population perspective is embedded in all levels of commissioning to ensure that minority groups are not marginalised and to try to gain public acceptance of difficult decisions.

- Geographical area and formation of consortia

11.15 If the proposal to allow patients to register with any GP practice, regardless of location, goes ahead, it will be difficult to justify requiring GP practices to join consortia within a rigid geographical area. However, it would be difficult to justify a situation where a GP practice joined a consortium that was primarily based elsewhere. One possible way to address this could be to require GP practices to join a consortium within their local authority boundary area, or in cases where a practice is near a local authority boundary, to join a consortium within the boundary of a neighbouring local authority, even if this does not necessarily fit neatly with a pre-existing natural health economy. Consortia may wish to consider acting coterminously with the local authority, to enable easier joint working with the public health services and the Director of Public Health.

11.16 It is critical that consortia do not practice adverse selection to exclude practices that have naturally high referral costs, over fears that the performance of these practices will damage the consortium's overall performance on paper. Instead, at this stage, practices should be discussing what formations will make the most sense with regard to natural clinical communities.

11.17 While we accept the power of the NHS Commissioning Board to assign a practice to a consortium if necessary, we believe that this power must be used sparingly, and that practices and consortia should be encouraged to come to an agreement where possible. Where the NHS Commissioning Board exercises this power, any allocation must still be made in consultation with the practice, the consortium and the Local Medical Committee (LMC), and care must be taken to find a consortium that is acceptable to the practice (and vice versa) if at all possible. If it will be possible for a practice and consortium to part ways it will also be necessary to consider what temporary arrangements should be put in place during the period when a practice is between consortia. More thought needs to be given to the implications of expelled practices and how it would be practical for them to become part of another group if there was no other natural geographic, local authority or health economy link. We would oppose the removal of a practice's PMS/GMS contract should their commissioning involvement cease.

- Consortia leadership
11.18 The relationship between a consortium and its members will need careful consideration. If a consortium's leadership is to be truly effective, it is vital that the consortium has not just a formal mandate from its members, but that its leaders have the respect of the consortium's members. We would not want to see a situation where initial enthusiasts take on leadership roles almost by default, by virtue of being first movers.

11.19 Electing the leaders of consortia carries the risk that those elected may be more popular than competent. Conversely, simply appointing consortia leaders carries the risk that those appointed may be competent but lacking the respect of consortia members. One potential way of addressing this problem would be to recommend that consortia elect a Board of Appointment that is empowered to appoint key positions within the consortia, such as accountable officers or finance officers, competitively. Governance arrangements must also be put in place to allow for a change of leadership, if thought necessary by members.

11.20 It will be important that consortia leadership represents the interests of the local health economy as a whole, to ensure that the needs and views of all sections of the population and healthcare providers are included in the decision making process.

- IT
11.21 The General Medical Services (GMS) contract transferred funding and ownership of IT systems from GP practices to Primary Care Trusts (PCTs). With the abolition of PCTs, consideration needs to be given as to who will be responsible for owning, funding and upgrading IT systems and ensuring that GP practices have systems which can fulfil all purposes, particularly at a time when greater emphasis is being placed on data collection.

- Local Medical Committees
11.22 We believe that the long-term future of NHS commissioning will be secured by ensuring that Local Medical Committees (LMCs) have a role that is both complementary to and occasionally critical of consortia, allowing them to support consortia where possible, but also to make sure that the viewpoint of their members is heard. It is unclear from the White Paper how LMCs will fit into the new NHS structure. Their current role and function is a statutory one, and PCTs are obliged to consult with them on a range of matters. We believe that LMCs must have a statutory role in relation to consortia and their relationship to constituent practices, and that the NHS Board and consortia must be required to recognise them and consult and engage with them as the local representative body of GPs. They will also have an important role in dealing with poor performance and be in a position to provide a corporate memory at a time of significant organisational change.

11.23 In the shorter term, we believe that LMCs could play a role in supporting the creation of consortia, for example, by facilitating debate and communication, and by acting as a broker during discussions and disputes. LMCs will undoubtedly play a large role in supporting consortia once they are operational but this should not absolve PCTs of their role in supporting the transition.

An autonomous NHS Commissioning Board

11.24 The BMA has been calling for an independent board to run the NHS with a long-term strategy, free from party political influence, for some time³⁸, but, as yet, we have insufficient information to be able to welcome the creation of the NHS Commissioning Board. The role of the NHS Commissioning Board in supporting the development of commissioning consortia will be vital. In a time of uncertainty, the production of timely guidance and regulations will be appreciated by those forming consortia. However, we would urge that any regulations and guidance issued should, wherever possible, facilitate local planning, rather than direct it.

³⁸ *A rational way forward for the NHS in England*. Op cit

11.25 The way in which the NHS Commissioning Board allocates resources to GP-led consortia will need to be considered in greater detail, as will the way in which model contracts are developed, and the BMA would expect to be consulted on these issues. While we agree that the NHS should strive to 'secure equivalent access to NHS services relative to the burden of disease and disability', it must be recognised that a simple move to a 'fair share' budget may be counterproductive. The allocation of resources to consortia should be on the basis of need, but it should be noted that the definition of 'need' will vary depending on local circumstances. Historic NHS funding is entrenched in local health economies and any sudden move away from this would destabilise local health systems that are vulnerable to small shifts in funding.

11.26 The practicalities of the relationship between the NHS Commissioning Board and consortia will also need to be considered in detail. We are concerned that the gap between a national board and locally based consortia will be too great, and there is a risk that the Board could be too remote from individual consortia for the two to be able to liaise effectively. This will become even more of a concern if many small consortia are formed. It may be appropriate for the NHS Board to have local outposts of some kind, to liaise with consortia, provided this does not compromise efficiency savings gained through the abolition of SHAs and does not replicate the bureaucratic performance management functions of SHAs.

11.27 We note the Government's commitment to discussing the way that primary care contracts can best reflect contemporary responsibilities for individual GP practices, and look forward to discussing this in more depth. We do not believe that there needs to be contractual change within PMS or GMS to deliver this, as alteration of the NHS Act in England would have the same effect without altering the UK GP contract.

11.28 The White Paper states that some services cannot be commissioned solely by GP-led consortia. As stated previously, we believe that consortia should be able to commission maternity services and must be able to commission Local Enhanced Services (or equivalent) from GP practices, with the involvement of the LMC. We would welcome clarity on this section of the White Paper.

11.29 We would like to take this opportunity to reiterate the suggestion that the Board also champions patient access to research and the removal of barriers to participation.

A new relationship between the NHS and Government

11.30 The BMA has previously advocated for the NHS to be removed from direct governmental and Ministerial control³⁹ and so supports the White Paper's commitment to reducing the Secretary of State's ability to micromanage and intervene in the NHS.

11.31 We accept the Secretary of State's continued statutory role of arbiter of last resort, but would seek clarification as to whether this will apply only to disputes between NHS commissioners and local authorities, or if it will also extend to other disputes such as those involving GPs and commissioning consortia.

12. Local democratic legitimacy

12.1 In principle, the BMA welcomes the aim of increasing local democracy in health and recognises the importance of health services and local authorities working more closely together for the benefit of patients and the public. However, it is essential that any transition is careful and measured and that local authorities have the capacity, resources, depth of understanding and long-term responsibility to carry forward changes.

12.2 We note the creation of health and wellbeing boards to take on the function of joining up the commissioning of local NHS services, social care and health improvement. We hope

³⁹ *A rational way forward for the NHS in England*. Op cit

that these boards will allow local authorities to take a strategic approach and promote integration across health and care services, including safeguarding. We support the necessary simplification and extension of powers that enable joint working between the NHS and local authorities and hope these arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care. However, we would be concerned if health issues became the subjects of local politicisation and distortion by local politicians as a result of these changes.

12.3 The BMA seeks clarification on the strategic leadership and governance around equality and diversity in new structures and approaches. There must be clear accountability and strong leadership on equality and diversity otherwise it will be marginalised in the system.

12.4 There is also a need for clarity about accountability on challenging discrimination. Our experience to date has been that monitoring agencies have struggled to impact on equality and diversity issues meaningfully or equitably across the six diversity dimensions. It is essential that persisting inequalities and discrimination within health and the NHS are identified and acknowledged, and that systems are put in place to eliminate them.

12.5 We will be responding to the 'Local democratic legitimacy' consultation, where we will set out our views on these issues in more detail.

13. Freeing existing NHS providers

13.1 The BMA supports freedoms being given to providers where it can be shown that change will benefit services and local NHS economies but not where it will cause destabilisation and is undertaken with inadequate regulation. We do not believe that the promotion of competition and commercialisation set out in the White Paper will lead to higher quality and more efficient care or, in the most cases, be in the interests of patients, the taxpayer or NHS staff.

Foundation trusts

13.2 The BMA has serious concerns about the Government's determination for all NHS trusts to become foundation trusts, given the notably bad outcomes that have been seen in a small number of cases and despite the fact that foundation trust status is supposed to be a mark of quality. We are concerned that intensifying the pressure on NHS trusts to achieve foundation trust status within the next three years will drive them to place the achievement of this target above all others, including safe patient care⁴⁰. At a time of huge change and financial pressure across the whole NHS, it could be that cutting staff and reducing overheads are judged as the best way to achieve foundation trusts status, putting patient safety and care at risk. The BMA would like NHS hospitals to be part of a collaborative publicly owned system of the provision of care for clinical need⁴¹. Furthermore, we do not believe poorly performing hospitals will improve their standards by moving to a more autonomous system of financial regulation.

13.3 It is imperative that only those trusts that achieve 100 per cent compliance with the New Deal are granted foundation trust status. Furthermore, we believe it should be a prerequisite for achieving foundation trust status that trusts are in full compliance with European Working Time Directive regulations⁴². We note that the proposals regarding foundation trusts make no mention of the importance of collaboration between NHS organisations for the purposes of research and education, nor the need for foundation trusts to provide training and education for medical students and junior doctors where appropriate. We would urge that the omission of these essential issues is addressed. We are extremely concerned that the emphasis on gaining foundation trust status in a short space of time will mean these standards are not met or properly implemented.

⁴⁰ ARM 160. BMA, 2010.

⁴¹ *Consultants Conference 038*. BMA, 2010.

⁴² ARM 142. BMA, 2004.

13.4 The BMA believes the abolition of the cap on the amount of income foundation trusts can earn from other sources has the potential to act as an incentive for foundation trusts to undertake more non-NHS activity at the expense of NHS provision. If unfettered, this could lead to a two-tier health service, as foundation trusts invest more resources in non-NHS facilities.

Social enterprise

13.5 The BMA is not aware of any evidence that could support the view that significant numbers of NHS staff wish to work in social enterprises and would question whether the benefits of the approach set out in the White Paper will be achieved.

13.6 Existing social enterprises point to the importance of staff buy-in and meaningful opportunities for staff to participate to ensure success. Attempts to force NHS staff into accepting a move to a social enterprise model without proper consultation or engagement will not produce successful social enterprises.

13.7 Successful social enterprises rely on strong and consistent leadership. Managers must be visibly committed to policies to increase staff participation if they are to succeed and the approach to staff involvement must be consistent. Tokenistic issuing of shares or rebranding as foundation trusts will not provide the incentives staff need to work more efficiently or innovatively if leadership at a local level is not fully supportive of employee participation⁴³. We can envisage a situation in which staff merely recognise 'employee ownership' as the latest NHS restructuring exercise and do not engage with the changes, which will not benefit patient care.

13.8 The BMA would also question the policy of creating social enterprises in the current uncertain financial climate. In the past, social enterprises set up to provide healthcare have failed, forcing the NHS to step in to protect frontline jobs and ensure that patients continued to receive medical services⁴⁴. We do not believe this is a sensible course of action given the need to reduce spending in these tough economic times.

13.9 One of the major concerns we have with the social enterprise model is access to the NHS pension scheme. While staff who are transferred to social enterprises currently have access to the NHS pension under Transfer of Undertakings (Protection of Employers) Regulations, new starters do not. This has the potential to create a two tiered workforce and disadvantage future staff.

14. Economic regulation and quality inspection

14.1 The BMA has developed a constructive working relationship with the Care Quality Commission (CQC) since it came into being. We are currently in discussions with the CQC about the evidence required for compliance with the registration requirements for general practice and will continue to work with them to make sure that the system put in place is appropriate.

14.2 However, we do have concerns that the joint role of CQC and Monitor in operating a joint licensing regime may lead to unnecessary bureaucracy and cost, and recommend that consideration be given to alternatives. We are concerned that the costs of monitoring may be passed to providers of all sizes. We oppose this cost being visited on smaller providers directly when the state will pick up the costs for all others. Additionally, we believe that there should be a right of appeal against any proposed licence modifications in most if not all cases.

⁴³ *NHS Mutual: Engaging Staff and Aligning Incentives to Achieve Higher Levels of Performance*. The Nuffield Trust, 2009.

⁴⁴ 'An ill wind blows for social enterprise', The Guardian. Wednesday 18 October, 2009. Available at <http://www.guardian.co.uk/society/2009/nov/18/prison-healthcare-nhs-social-enterprise>

The scope and power of Monitor

14.3 The BMA does not support Monitor's role as promoter of competition in healthcare and believes its time would be better spent ensuring quality. We do not believe that healthcare should be treated in the same way as other industries and are alarmed at the clear suggestion in the White Paper that competition in healthcare should resemble that in the telecoms or energy industries.

14.4 We would urge caution over the use of powers to prevent anti-competitive behaviour. If Monitor is given a role in relation to promoting competition, then before making decisions about anti-competitive behaviour, it should seek the views of professionals and patients, to find out which services they want in the area, and if there are established pathways of care and existing collaboration, rather than force competition when it is inappropriate. Competition between hospitals can be wasteful and inefficient and so these powers should only be used when it can be shown that introducing competition will benefit patient care. The BMA supports an NHS that cares for patients through cooperation, not competition, and is opposed to any new opportunities for the private and independent sectors to deliver healthcare. Further, we would like clarification that where a private provider has a local monopoly of service, the NHS will be able to use its facilities, as described in the White Paper.

14.5 We do agree that Monitor should have powers and funding to support continued access to essential services that it can use when it is appropriate and necessary.

14.6 In its proposed role of setting prices for NHS services, we agree that Monitor should consult the NHS Commissioning Board and take into account the interests of the taxpayer but would argue that professionals and patients should be actively consulted as well. The right of providers to appeal against Monitor's pricing methodology should also exist.

14.7 We will be responding to the 'Regulating healthcare providers' consultation, where we will set out our views on these issues in more detail.

15. NHS pay

15.1 The BMA supports a comprehensive and universal NHS with national contracts and conditions. It is essential that national terms and conditions are protected to ensure an equitable spread of doctors across the UK irrespective of local differences in geography or economic wealth, to safeguard against poor working conditions and avoid the creation of barriers to doctors moving around the UK. We therefore oppose the proposal to allow individual employers to determine pay and local terms and conditions for their staff. We do not believe that the abandonment of national contract negotiations or pay review body arrangements would be in the best interests of the NHS, doctors or ultimately patients. The efficiency of national negotiations compared to many local negotiations should also be recognised.

15.2 We would also like to see the continued requirement for all employers of salaried GPs to offer terms and conditions that are at least as good as those outlined in the model contract for salaried GPs.

16. NHS pensions

16.1 The BMA believes that the NHS pension scheme is sustainable and represents value for money for the public. Contrary to common misconception, the NHS scheme is financed by employees and employers, and in recent years has provided a surplus to the Treasury. We would also highlight that the scheme for NHS staff in England and Wales has already been subject to a recent major review. In 2008 the normal pension age for new staff increased from 60 to 65, and employers' contributions were capped, while contributions from doctors increased by up to 2.5 per cent. GP members of the scheme also pay further employer

contributions of 14 per cent. Our submission to the independent commission into public sector pensions sets out the BMA's position in full⁴⁵.

17. Valuing staff

17.1 The BMA welcomes the White Paper's commitment to implementing Dr Steve Boorman's recommendations to improve staff health and wellbeing. The BMA supports good employment and working practices, engagement and support for all workers.

17.2 Clinical academic staff, who also provide patient care, are not employed by the NHS but by higher education institutions. We would urge the Department of Health to work with the Department for Business Innovation and Skills and individual higher education institutions to ensure that the commitments to empowering staff are translated to the higher education sector.

18. Cutting bureaucracy and administrative costs

18.1 The BMA believes that effective management is essential to the future of the NHS⁴⁶. Whilst we support measures to reduce unnecessary bureaucracy and administrative costs, some NHS management functions are necessary for the smooth running of services and the NHS as a whole. It would be wasteful and inappropriate to delegate management tasks to clinicians who are neither trained for these tasks nor have time to do them.

18.2 GP-led consortia will not be able to function if they are expected to pick up the current roles and activities of PCTs. We request that the Department of Health clarify which management functions will no longer be required, bearing in mind the anticipated 45 per cent reduction in management costs.

18.3 The White Paper states that the replacement of PCTs and practice-based commissioners with GP-led consortia should save a significant proportion of the billion pounds spent by PCTs on administration each year. We would like to see evidence for this estimate. While we recognise the need to make immediate savings, it is essential to retain good management and administrative support during the transition period, to enable the successful creation of GP-led consortia. The reasons for any decisions must be made clear, and costs should not be deferred until consortia begin operation.

18.4 The BMA recognises that there will need to be cuts to centrally managed programmes. In relation to IT, we would have concerns if elements of the National Programme, which are delivering benefits or have potential, are terminated without consultation with the profession. The BMA has produced a Health Informatics Strategy which presents a clinical perspective on the priorities for investment in IT⁴⁷. We would welcome further detail about NHS services being customers of a more plural system of IT and how this will fit in with existing contractual arrangements.

18.5 We note the Government's publication of its review of arm's-length bodies and have set out our concerns relating to several of the proposals at Appendix B.

Enhanced financial controls

18.6 The White Paper states that 'there will be no bail-outs for organisations that overspend public budgets'. Whilst we agree that organisations should manage resources wisely, there can be genuine reasons why organisations that have tried and failed should be supported. An advantage of a coordinated NHS is the risk pooling and risk sharing that is possible, which has enabled Primary Care Organisations to survive previous financial challenges. This should continue, as a rigid 'no bail out' approach would be harmful to local commissioning.

⁴⁵ *BMA evidence to the Independent Public Service Pensions Commission*. BMA, 2010. Available at <http://www.bma.org.uk/employmentandcontracts/pensions/ipspevidencejuly2010.jsp>

⁴⁶ *Junior Doctors Conference*. BMA, 2010.

⁴⁷ *Health Informatics Strategy*. BMA, 2010. For further information see http://www.bma.org.uk/ethics/health_records/itstrategy.jsp

18.7 Consideration will need to be given to the rules surrounding risk-pooling, stop-loss insurance and reconciling this with the position of 'no bail outs'. Clarification will also be needed on which organisations will be required to participate, whether un-used pooled funds can be carried forward to future years and whether a deficit can be offset by the subsequent year's funds. Clear rules also need to be set out to specify what will happen if risk-pooling fails, or if Monitor assesses that a provider is not financially viable.

Appendix A

Patient surveys and feedback

Careful consideration must be given as to which indicators are collected and why, while inherent data collection biases, such as less feedback coming from patients of lower socio-economic status, must be overcome. It is essential that ratings differentiate between the quality of experience that the patient perceives and the quality of care that the expert observer might consider has been delivered. It is far more common for people to report bad experiences than good experiences and so any form of patient rating system has to be interpreted with great care. Furthermore, we would like to see a move away from the use of the term 'ratings', which simplifies the multiple dimensions of care offered by many providers, which might provide good care in some areas but less good care in others. A ratings system does not sufficiently demonstrate this and runs the risk of creating a system similar to homogenous star ratings.

Surgeons and other clinicians may become reluctant to take on higher risk patients, patients with co-morbidities and patients who are likely to need a longer stay in hospital, if their individual outcome figures were made publicly available without proper guidance on how they should be interpreted. This could impact on the care offered to certain groups of patients who could be deemed higher risk, such as older people.

In any league table there will be a 'normal distribution' and so half of all providers will be below average. This may be due to random fluctuations in small numbers outside the control of the provider that may result in a provider falling to the bottom of the table, through no fault of their own. League tables also disincentivise providers from taking on higher risk patients with complex health issues, as they have poorer outcomes that will affect a provider's league table position. These patients may find new barriers to their care being created through institutional resistance to the negative impact they would have on outcomes should they be presented in league table form.

Significant statistical expertise is required to construct league tables and to make sense of the data in the context of the particular case mix for that provider, and so on. Any organisation that takes on the role of generating league tables or presenting comparative data must be properly monitored and regulated to ensure its statistical analyses are accurate, fair and meaningful.

Quality Accounts

We continue to have significant doubts over the format and use of Quality Accounts and would stress the importance that they should not inflict a heavy cost or administrative burden on healthcare providers. We are unconvinced that the format is of interest to clinicians and therefore, whether in practice they act as a stimulus for service improvement, particularly given that Quality Accounts report on relatively few clinical areas. We would suggest that in order for Quality Accounts to 'provide a spur for providers to focus on improving outcomes' some further work outside the Quality Accounts process itself will be necessary, for example, in the form of embedding the use of the Indicators for Quality Improvement. We are also concerned about using Quality Accounts to encourage peer competition, as their content does not lend itself to such an approach⁴⁸.

Further, there are various perverse incentives and unintended consequences that may arise, partly due to Quality Accounts focusing on relatively few areas when compared with the overall scope of services delivered by providers, and partly from the likelihood of the media and third parties using the information in a way which might skew providers' approaches to producing Quality Accounts in future years⁴⁹.

In order that Quality Accounts are transparent and useful tools for commissioners of NHS services, we would ask that Quality Accounts published by private providers clearly define

⁴⁸ Response to 'The framework for Quality Accounts'. BMA, 2009. Available at http://www.bma.org.uk/healthcare_policy/responses_consultations/framequalaccount.jsp

⁴⁹ *ibid.*

whether the treatment was wholly funded by the NHS, partially funded by the local authority or privately funded.

Access to health records

The BMA has supported a discussion paper on patient access⁵⁰ which highlights some of the complexities. These include ensuring that patient access does not affect the quality of clinical information by making clinicians feel reluctant to record certain information, removing third party information to ensure that patients do not inappropriately access third party information, which will incur a significant and recurring cost, and ensuring that patients have access to counselling when viewing distressing results or information.

This ensures that the implications of sharing decisions can be explored with patients so that only relevant information is shared and patients understand the implications of withholding certain information. This is important as there is a risk that patients may experience pressure from some third parties (for example, an abusive partner, a parent, an employer or insurance company) to share more information than they wish to.

The BMA supports proposals to make aggregate data available to patients and for health research purposes but, as highlighted previously, it is important to ensure that the information is an accurate reflection of the care provided, is not obscured by variables which could mislead patients and that patients are involved fully in decisions about how their identifiable data are used.

Bodies with which patients share their records must comply with the same ethical standards expected of doctors and these standards must be rigorously enforced. We would be particularly concerned if private companies were to be able to use data from records to advertise health products and services to patients. The BMA would like to work with the Government to find a way to maintain a balance between the interests of safeguarding the confidentiality of patient information and researchers' controlled access to data in order to continue the medical research for which the UK is so highly regarded⁵¹.

To implement consistent medical record sharing in an era when some patient records are electronic and others are available on paper only will be a major technical challenge. Most hospital records are still paper based and experiments with completely electronic healthcare records in hospitals are in their infancy. Those records that are electronic are contained in a number of different systems and in a non-standard format. It will require a substantial amount of time and resource investment to develop and enable interoperable systems.

Patient choice

The choice offered to patients has been skewed by 18 week targets and has been subject to local manipulation to manage capacity and meet demand. The provision of comparative data as part of the patient choice agenda has proved unpopular, with research showing that only four per cent of patients said they had accessed NHS Choices information on performance when choosing a hospital⁵². This echoed work undertaken by Ipsos-MORI on behalf of the Department of Health, which revealed that only 6 per cent of hospital patients had consulted NHS Choices⁵³. This limited use of the comparative data on NHS Choices suggests that patients and the public do not make their healthcare choices based on other people's reviews and ratings, as they might when choosing things such as holidays.

Personal health budgets

The BMA awaits the outcome of the evaluation of the personal health budgets pilots with interest. We would not support the rolling out of the personal health budgets programme before robust analysis of the pilots has taken place. We have previously noted our concerns

⁵⁰ Enabling Patients to Access Electronic Health Records. Op cit.

⁵¹ Standing up for doctors, Standing up for Health: The BMA Manifesto. BMA, 2010.

⁵² Robertson, R. Dixon, A. *Choice at the point of referral; early results of a patient survey*. The Kings Fund, 2009.

⁵³ *Report on the National Patient Choice Survey - March 2009 England*. Department of Health, 2009.

about the initiative in general, as we believe that it could lead to NHS patients receiving different levels of care, raising significant equity concerns, and that it has the potential to add a new layer of bureaucracy and administrative burden onto the NHS⁵⁴.

NHS Outcomes Framework

The 18-week and four-hour waiting time targets resulted in pressure on staff to make inappropriate decisions and had the potential to distort clinical care. Similarly, the guaranteed access target in primary care had an adverse effect as it demanded that practices had enough appointments available on the day or the following day to meet the target, so patients who wished to book in advance found there were fewer appointments available. The scrapping of this target will give GPs greater flexibility to organise their appointment booking system in a way that best suits their local patient population⁵⁵.

The Quality and Outcomes Framework (QOF) in general practice, allows GPs to provide treatments and services that are important in improving a patient's health, but which, if judged on an end-point outcome alone, may not appear effective. This is particularly useful where the end-point outcome is felt to be unachievable in the shorter term. The QOF is regarded as a world leader in primary care standards, is leading to a reduction in health inequalities, and the BMA continues to support this approach.

When measuring outcomes, it is important to note that there are many other factors, external to the care given, that can affect outcomes and that the further the distance from the consultation and treatment, the less relevance of any data obtained in assessing the quality of care. A study from the University of Birmingham found that 'Clinical outcomes are likely to be affected by factors other than the quality of care' and that there is a 'poor correlation between outcome and quality'⁵⁶.

Training and education

The three elements of medical education and training - undergraduate medical education led by medical schools, postgraduate medical education led by the postgraduate deans in partnership with employers and the medical royal colleges, and continuing professional development, led by the individual doctor in partnership with their royal college and employers - require different levels of funding and support and may need to be commissioned in different ways. The system, therefore, needs to be flexible and responsive to different needs.

⁵⁴ For further detail see BMA response to Department of Health consultation on 'Direct payments for health care: a consultation on proposals for regulation and guidance'. Available at http://www.bma.org.uk/healthcare_policy/responses_consultations/directpayconsjan10.jsp

⁵⁵ *Comment on the NHS Operating Framework*. BMA, 2010. Available at <http://web2.bma.org.uk/pressrel.nsf/wlu/STRE-86MHPD?OpenDocument&vw=wfmms>

⁵⁶ Lilford, R. J., Brown C. A. and Nicholl, J. (2008). Use of process measures to monitor the quality of clinical practice. *British Medical Journal*, 335: 648-650.

Appendix B

The proposals to downscale or close a number of arm's-length bodies have far-reaching implications. While we agree that it may be possible for some functions, for example IT, finance and human resources, to be shared between arm's-length bodies, the BMA seeks assurances that the essential work currently undertaken by these bodies is not damaged.

The Health Protection Agency (HPA) has been a very effective body in helping England to respond effectively to public health threats, including Sars, pandemic flu and polonium poisoning. The fact that the HPA has been a standalone body has always been seen as beneficial to public health as messages are often more effective coming from this agency than government. We are concerned at the potential loss of expertise and experience as a result of the changes to the HPA. We are also concerned about how the abolition of the HPA might affect junior doctors in public health rotations and training and would welcome further discussion on this.

We would stress the importance of stability for the future and would urge the Government to extend its planning frame up to 2020, rather than 2015 as is currently the case, to allow the new system to become properly established and to make it as immune as possible to further change that might undermine its effectiveness.

The HPA does not, however, exist in isolation. It is dependent upon medical microbiology and virology laboratories, currently at trust level. The requirement imposed upon SHA's to implement a reduction in expenditure of £500 million from pathology in England will inevitably reduce manpower, which will make it more difficult to fulfil the legal requirement of laboratories to report notifiable and other infections. Together with the continued emphasis on control of infection, this disconnects resource and statutory duty. The cooperation and communication demonstrated to have been effective in recognition and investigation of developing infection challenges will reduce as competition and isolation inherent in disparate provision increase. The destructive effect on existing referral and consultation between pathology laboratories will not enhance patient care, despite the requirements for accreditation and compliance with central information demands.

The BMA has very serious concerns about the recommendation that the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA) be abolished and their regulatory functions transferred primarily to the CQC and other organisations.

In 2007, the BMA considered in detail the previous Government's proposals to amalgamate the HFEA and HTA into a single body, the Regulatory Authority for Tissue and Embryology (RATE). The BMA, along with other medical bodies, strongly opposed this move. The BMA's previous arguments opposing the formation of RATE are directly applicable to these most recent proposals, namely the risk of diluting the specialised expertise of these organisations. The BMA remains firmly convinced of the need to retain two distinct regulatory bodies to oversee the areas of human tissue and assisted reproduction. The UK has been well-served by the HFEA and HTA, and both have been used as models for other jurisdictions⁵⁷.

The BMA also has concerns at the proposed abolition of the Alcohol Education and Research Council. We believe protecting the health of the nation must remain a priority for the Government, especially as recession has a negative impact on health. Tackling alcohol-related harm should be one of the key areas for action⁵⁸ and we are concerned that efforts to achieve this will suffer with the loss of the Alcohol Education and Research Council. We would require further details on how the essential functions of this arm's-length body will be continued.

⁵⁷ *Response to the Human Fertilisation and Embryology Bill*. BMA, 2007. Available at <http://web2.bma.org.uk/pressrel.nsf/wlu/SGOY-78SG6Q?OpenDocument&vw=wfmms>

⁵⁸ *The BMA Manifesto*. Op cit.