hscreform@dhsspsni.gov.uk
HSC Reform, DHSSPS

12 February 2016

Health and social care; reform and transformation, getting the structures right

Dear Sir: Madam

Please find enclosed BMA Northern Ireland’s response to the above consultation. We welcome the opportunity to respond to this consultation. BMA Northern Ireland believes that the voices and experiences of doctors are essential to this debate. It is vital that our members are involved at all stages and we look forward to having discussions with you and your officials as this progresses. If you need any further clarification on any of the issues raised, please do not hesitate to contact, Judith Cross, Senior Policy Adviser, on 02890269687 or jcross@bma.org.uk.

Yours sincerely

[Signature]

Dr John D Woods
BMA NI council chair
Health and social care; reform and transformation, getting the structures right

Introduction

BMA Northern Ireland is both a professional association and a trade union which represents the medical profession in Northern Ireland across all branches of practice. Our mission is “we look after doctors so they can look after you”.

BMA has 169,000 members worldwide, and 75% of doctors and medical students are members in Northern Ireland.

BMA Northern Ireland welcomes the opportunity to respond to ‘Health and social care; reform and transformation, getting the structures right.’ BMA Northern Ireland members fully support the move from commissioning to a planning model as previously outlined in our response to the Donaldson Report, ‘The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland’. We believe that health and social care should remain a public service working for the benefits of patients in Northern Ireland.

The consultation document poses a number of questions based on the Ministers vision delivered in November 2015. In essence the question being asked is whether Northern Ireland needs to have a purchaser/provider commissioning model or would a planning function be better suited given the size and characteristics of Northern Ireland.

In preparation for responding to this consultation document, we held a workshop with Northern Ireland Council members to ascertain their views, some of whom were involved in previous reviews such as the Hayes Review (2001). Our members, similar to the general public, are only too aware that there have been several previous reviews
with similar findings and recommendations, particularly around the delivery of acute care and the need for more resources in community/primary care, with very little change following these. They are increasingly frustrated at the lack of progress in implementing the well-documented changes that are needed. For example, within this Assembly mandate we have had 2 significant reviews, Transforming Your Care and the Donaldson Report both of which have re-stated the known problems and reiterated the recommendations of previous reviews. Our members are aware of how political constituency interests often act to resist change. However, the lack of urgency to strategically implement how our health and social care services are delivered and managed, particularly in light of the reducing budgets is deeply concerning to our members.

Our response will provide comment on the principles that should underpin clinical involvement and a planning model, and the particular circumstances of managing the GMS contract under a planning model. We will also comment on population planning, medical workforce planning, payment models and service reconfiguration.

Context

Northern Ireland, like the rest of the UK, is experiencing demographic shifts in terms of ageing, life expectancy and a growing population. Unhealthy lifestyle behaviours, such as poor nutrition, smoking and alcohol consumption have a significant impact on quality of life and life expectancy and place a huge burden on an already overly committed health and social care service. In Northern Ireland today, , 1 in 5 consume alcohol above the recommended limits, 22% of adults smoke and 5% of 11-16 year olds smoke\textsuperscript{iii} and it is estimated that 40% of the population will be obese by 2025. Despite efforts by government and the public health strategy, ‘Making Life Better,’\textsuperscript{iv} health inequalities have remained stubbornly persistent and those who live in deprived areas face the worst health outcomes across a number of health measures.\textsuperscript{v}

- The population of Northern Ireland is increasing and is projected to reach 2 million by mid-2034\textsuperscript{vi}
• From 2012 to 2022, the population aged 65 or more will increase by 26% (71,000 people)\textsuperscript{viii}

• The number of people aged 65 and over is projected to increase by 44% in the next fifteen years (2012-2027)

• It is estimated that there were 33,300 people aged 85 and over living in Northern Ireland at 30 June 2013, 40 per cent more than was the case ten years previously in 2003\textsuperscript{viii}

• The number of persons aged 85 and over is projected to increase by nearly 50% in the next decade, whilst by 2029 there are projected to be twice as many people aged 85 and over than there are today\textsuperscript{x}

In addition, public expectations and attitudes towards their care are changing but support for a universal NHS remains high in Northern Ireland at 73\%\textsuperscript{x}.

A number of other challenges will further intensify the pressure on the financial stability of health and social care in Northern Ireland. Issues such as patterns of disease and disability, medical advances, information technology and the workforce will need to be factored in. For example, we know that in order to curb the rising demand for diabetes services, we need to reduce the incidence of diabetes through significant preventative measures. Likewise, healthy ageing is the best way to address the increasing costs of an ageing population. Again, investing in preventative measures protecting long term health and well-being will create savings in the longer term. Reductions to the public health budget are short-sighted and will increase costs further down the line.

**Clinical involvement**

BMA Northern Ireland met with the commissioning review teams last year and outlined our concerns across primary and secondary care. Our members have consistently called for more genuine clinical involvement and engagement in delivering safe and effective care for patients and we welcome the recognition of this in the consultation document.
Successful planning can only be achieved with GPs, secondary care consultants, junior doctors and speciality doctors working together. There is also a significant role for our public health consultants as well as clinical academics as education, research and training are important elements. It is absolutely essential that all these expert clinicians have a role in planning.

There are a number of ways to promote clinical engagement, but these can be quickly over-shadowed by disincentives which discourage involvement. We are aware of numerous examples of service “closure by collapse” in Northern Ireland, where a service is run to the point where immediate closure is the only safe option.

Clinicians in both primary and secondary care can be discouraged by targets being set which are unrealistic and / or unachievable. In order to promote clinical engagement, the terms of involvement should be fair, equitable and reasonable. Adequate resources should also be available to support clinical involvement, including enabling doctors to develop the appropriate and necessary skills.

Our members outlined a number of key principles that should support clinical engagement:

- Clinicians’ input to be trusted, valued and respected
- Align incentives across primary and secondary care
- Proposals must be evidence based
- Proposal should be patient centred
- Based on clear need and appropriate funding
- The system needs to be flexible and adaptable
- Minimal bureaucracy
- Avoid needless duplication
- Information sharing with the right systems in place
- Time and resource allocated for clinical engagement
Principles for planning of services

In our response to the Donaldson report in 2015 we recommended ‘ending the inappropriate redefinition of commissioning as a procurement method and instead returning to a planning function that is clinically led and based on collaborative relationships between primary, community and secondary care and public health’. We therefore welcome the intention to end the commissioning model and to simplify the system for planning and delivering services.

Northern Ireland requires a sustainable health and social care system, and this must be delivered in the face of unprecedented financial and social challenges. In our vision for the health service in Northern Ireland, published in 2010, we argued for HSC organisations to produce 5 year plans for service delivery with 5 year budgets aligned to ensure that short, medium and long-term planning can be achieved\footnote{xi}. We note that the budget for 2016-17 refers to ensuring that innovative approaches can be funded by a dedicated transformation fund\footnote{xii}. We believe that 5 year budgets aligned with 5 year plans can ensure that medium and long-term plans can be accommodated in this fiscal environment.

BMA believes that the role of a planning model should be about balancing the clinical needs of patients with available resources and improving the range and quality of health services. The following principles should underpin any such planning model:

- Promoting clinical engagement: clinicians should be involved in decisions to ensure services are planned on the basis of patient needs
- Enabling cross-sector collaboration: clinical networks should be established across primary and secondary care, with a significant input from public health, to deliver patient-centred outcomes
- Ensuring an appropriate balance between cost-effectiveness and quality: decisions must not be based solely on cost
• Effective dialogue with patients and the public: there must be an open and honest debate with the public about what services can be delivered and where

• Development of information systems: data upon which to base planning decisions must be accurate, robust and timely

• Longer planning and budgetary cycles to promote innovation and planning

**Assessing local needs***

The consultation document refers to Trusts assessing local needs for planning services in their area. BMA Northern Ireland does not have a difficulty with this proposal but this needs to be based on an epidemiological approach to assessing local needs and unnecessary duplication must be avoided.

If Trusts are to develop services based on assessing local needs, this must determine the health of the population, how and why diseases occur in different groups of people and areas, with a view to planning and evaluating strategies, not only to prevent illness but as a guide to management of illness.

BMA Northern Ireland believes public health should remain a function that is medically led, and part of the health and social care system. It must also be pivotal in how services are planned and delivered. Public health input into planning at local and regional level must be put onto a statutory footing. This will ensure that population approaches to public health are built in from the outset, are effective and can tackle persistent health inequalities.

It is vital that any structures or processes that are developed within the department, the trusts and the public health agency do not simply re-create layers and repeat the complexity that are all too evident today.

The consultation document gives no indication on how regional services will be planned for and how this would work in practice. We accept that further detailed work is needed but we would appreciate clarity on this as soon as possible. We would recommend however that this role should lie with DHSSPS.
Management of general medical services

BMA Northern Ireland notes that whilst the document recognises that family practitioner service contracts are managed by the health and social care board (HSCB), there is no further discussion on where the management of this independent contract would sit within a new planning system.

The Department will be aware of the development of the federation model for general practice and how this can support the aspirations of Transforming Your Care while at the same time addressing the workload and workforce issues contributing to the crises in general practice.

GP federations are a network of 17 not-for-profit collaborative partnerships covering Northern Ireland. Each federation will cover about 100,000 patients, averaging about 20 practices. The primary aim of GP federations is to provide better care and to deliver this in a more responsive way to meet patients’ needs. GP federations are in a position to utilise the expertise and knowledge of GPs and other health professionals in the federation. This increases the range of services available within that locality and reduces demand on secondary care services. How this interacts and interfaces with trusts assessing local needs also needs further consideration.

BMA Northern Ireland GP members are of the view that the general medical contract needs to be managed centrally and it would be inappropriate for this to be managed at local trust level.

Medical workforce planning

BMA Northern Ireland considers that good medical workforce planning is essential to enable clinicians to deliver care that is both safe and of high quality to their patients. We continue to outline our concerns that despite review after review of the medical workforce, the lack of implementation has resulted in shortages across a number of specialties. We are currently experiencing serious medical staff shortages in Northern
Ireland particularly within specialties such as radiology, anaesthetics, psychiatry, laboratory medicine, emergency medicine, and general practice. Whilst we welcome the recent announcements of additional GP trainee places and an increase in the number of foundation programme places, this in itself will not address the fundamental challenges identified by the reviews if no further or sustained action is taken.

Our members see and feel the consequences of a lack of effective workforce planning which impacts on service delivery and patient care:

- General practice has a major workforce crisis
- Gaps exist in specialties across secondary care
- Poor and ineffective rota design
- Over-use of locums

We believe that the continued failure to recognise and adjust to the changing health needs of Northern Ireland, particularly in areas such as general practice and emergency medicine, has resulted in crises within these areas of medicine.

BMA Northern Ireland believes that an over reliance on locums is a very clear symptom and consequence of the absence of effective workforce planning. This may have a direct impact on patients as they do not have the continuity of care that they need. The use of locums is also significant in terms of cost to the NHS and we believe that this money could be more effectively invested in training sufficient numbers of doctors in appropriate specialties rather than addressing the issue in a short term way.

New models of care will require the necessary shifts in workforce happening in parallel. BMA Northern Ireland is recommending that the medical workforce required to support the reform of the HSC and the outcomes of the expert panel are planned for and executed as a matter of urgency with the allocation of appropriate funding.
Commentary on payment models

BMA Northern Ireland believes that as a result of changes to commissioning, it is important that payment systems are created that encourage and facilitate a coordinated approach to patient care that focuses on outcomes and improves the quality of patient care. We note that the block contract model is crude and can result in perverse incentives which leads to stagnation and fragmentation in the delivery of health and social care. As block contracts are made in advance of a service being delivered, unexpected pressures such as patient demand and costs are not taken into account. In addition, there is a lack of transparency and accountability once the payment has been made. Providers have limited mechanisms to mitigate these pressures and as we have seen in Northern Ireland, has resulted in trusts rationing services or a decline in quality of care as they manage resource constraints through the contingency plans.

The Comptroller and Auditor General in his report in 2015 pointed out that there is already a real terms reduction with health and social care trusts carrying underlying deficits into 2014-15 of £115 million\(^v\). Block contracts allow no flexibility for capital finance or innovation where upfront investment is required, as this would directly take away from delivering a service\(^vi\). We welcome the intention of the health minister to establish a transformation fund for innovation as outlined above, but believe that this by itself will not address the limitations of the current payment model. We have recommended 5 year budget cycles aligned with 5 year plans and believe that the continuation of the block contract will hinder the intentions behind ‘de-layering,’ more streamlined, accountable and responsive services.

Health and social care in Northern Ireland has the potential to lead the way in service change, but this will only happen if methods of funding allocation work to promote genuinely person-centred care, rather than create barriers to it. A payment system should support the delivery of effective care outcomes, not dictate approaches to care or hinder integrated working between services. DHSSPS must give serious consideration to utilizing a payment system that best delivers outcomes for patients and communities, even if this approach may look very different to the current one.
**Principles of service re-configuration**

BMA Northern Ireland accepts that service redesign is inevitable and necessary and indeed has been calling for change. However, reconfiguration of hospital services must stand up to scrutiny in terms of clinical gains and patient outcomes.

There has been a notable lack of frontline clinical engagement in the process of reconfiguration reported by some BMA members to date and this has inevitably caused both misunderstandings and unnecessary conflict. Where there is good evidence of patient benefit, or where safety and standards can be preserved and enhanced, reconfiguration in some areas may be desirable.

BMA believes that, in all service reconfigurations, the following conditions must be met to avoid compromising the quality, range and efficiency of care:

*Service change must*

- Be preceded by a thorough impact assessment, particularly addressing the safety of the proposed changes
- Be collaborative and transparent, involving all affected sectors and patient representatives
- Be led by clinicians - ‘Clinically-led’ acknowledges the ideas and expertise of front-line staff caring directly for patients who often have a wider local knowledge of what works and what obstacles and barriers exist to more cost-effective care. It is neither ‘clinician-fronted’ rhetoric of a managerial imperative nor just the views of employed clinical directors,
- Be based on good clinical evidence that quality of care will be enhanced, or at least not compromised
- Protects those least able or most deprived from a change of service that would otherwise widen inequalities, worsen outcomes or increase user dissatisfaction
- Be monitored, following implementation, for effectiveness and safety
It must not

- Be driven only by financial pressure without proper consideration of patient safety and quality of care
- Be imposed without prior consultation and discussion with those affected (staff and patient representatives)
- Lead to duplication of existing services.

The UK consultants committee and BMA Cymru Wales\textsuperscript{vii} have produced guides for hospital re-configurations for doctors and these can be found on our website.

Conclusions

BMA Northern Ireland believes that clinical leadership is fundamental to how health and social care is designed and delivered and we reiterate our call for doctors to be meaningfully involved in service development and leadership.

Furthermore, the recommendations from this consultation exercise must not be considered in a vacuum and the results from the political summit and the expert panel must also be considered and included in any proposed change to structure and accountability arrangements. Additional factors must be taken account of, such as the Stormont House Agreement, the administration review in health and social care, the unscheduled care taskforce amongst other public policy initiatives.

BMA Northern Ireland urges our politicians to listen to, and engage with, doctors working on the front line of health and social care. Only then will we secure the health and social care system that is fit for purpose for the 21\textsuperscript{st} Century.

ENDS

ii Hamilton outline ambitious vision for health and social care in Northern Ireland, 4 November 2015.
Speech by Simon Hamilton, Minister for health, social services and personal safety


xii NI Executive (2016) Budget 2016-17, pg 74 Belfast: NI Executive

xiii http://www.bmj.com/about-bmj/resources-readers/publications/epidemiology-uninitiated


