BMA response to Labour health and care policy review

Summary of key points

- The BMA supports the concept of whole person care. It is vital that individuals can access the care and support they need, when they need it, in the best place for them. With an ageing population and increasing demand for services, now is the time to reassess our approach to how care and support is delivered.

- The BMA does not believe the full integration of health and social care (structures, budgets and staff) is either necessary or desirable. Rather, we believe that current structures should be retained, maintaining separate services, and existing mechanisms to facilitate coordination between health and social care should be used more widely to plan and deliver joined-up local services. What matters to patients and their families is not structures but that joined up care is a reality.

- Coordination is best achieved not by reorganising but by creating stability across the NHS and local authorities and allowing integrated care to become a priority.

- The NHS budget should be protected and should not be used to prop up underfunded social care services. The NHS should continue to be funded directly by general taxation and decisions about where to direct health spending should be free from party political influence.

- Local health commissioning should remain the duty of the CCG, to ensure it is carried out by people with expert and in-depth knowledge of local health services and the health needs of the local population. To avoid further reorganisation, the current model of GP-led commissioning should evolve into genuine clinically-led commissioning.

- It should be easier for CCGs and local authorities to share budgets where professionals have identified that doing so would be beneficial for patients and users of social care, either through existing mechanisms, or by creating new ways to pool budgets.

- Consideration should be given to the possibility of designing tariffs to cover pathways of care that include identifiable social care consequences of a health condition. Part of the local authority budget could be transferred to the clinical commissioning group to cover these consequences.

- The payment by results system should be reformed. In its current form it is ill designed to promote or support larger-scale shifts in care from hospitals to other settings. This is due to incentives facing hospitals to maintain income and the lack of flexibility to vary tariffs to reflect the different costs of providing care in different settings.

- It is important to remember that shifting the location of care, for example from hospital to the community, will not reduce the overall levels of staff, or funding, required to provide the whole range of care that patients need.

- Decisions to centralise services must be taken only where the evidence shows it would be beneficial for patient care. The BMA would be very concerned if decisions to centralise services were driven by any other criteria. Potential unintended consequences of centralising care must be considered before decisions are made.

- There should be a greater skill mix on hospital wards to coordinate care between health and social care services and to make sure the right care is in place to support individuals to return home. Consideration should be given to the potential to link social care professionals to primary care.

- The BMA supports the NHS as preferred provider. We are strong advocates for a publicly-provided health service and remain opposed to attempts to further increase competition in the NHS, which can fragment services and undermine the promotion of patient centred services. We would welcome

details on how the policy could be reinstated in a way that would avoid further legal claims from non-NHS providers.

- More work needs to be done to ensure that commissioners and providers of health and social care services install IT systems that can talk to each other. It is vital that they have access to the information they need in order to provide integrated care, particularly for individuals with multiple and complex conditions whose care crosses organisational boundaries.

- Of the options identified in the review for funding social care, we are more inclined to favour an 'all-in' system that requires all people to contribute regardless of present or future needs.

BMA response to Labour health and care policy review

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 152,000 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. Introduction

The BMA takes a close interest in areas that have the potential to impact on doctors' working lives and the way care is delivered to patients, including coordination and integration of services, reconfiguration of hospitals, skill-mix on hospital wards and in primary and community care and where care is best delivered. As such, we welcomed the Shadow Secretary of State's speech to the King's Fund on 24 January 2013, which launched Labour's health and care policy review, and touched on these and many other issues that are of significance to doctors. The review launches a timely debate about how the needs of people who use health and care services can best be met in the coming years.

This paper is a response to the key points in the Shadow Secretary of State's speech. We will also be submitting evidence to Labour's Health and Care Policy Commission and feeding into the Independent Commission on Whole Person Care, being chaired by Sir John Oldham OBE. We hope our input will offer a valuable contribution to the debate.

The BMA supports the concept of whole person care. It is vital that individuals can access the care and support they need, when they need it, in the best place for them. We know that people can experience difficulties and frustrations when trying to navigate local health and social care systems, for example having multiple separate assessments, having to repeat their stories to many people, inherent delays in the system due to the transmission of information across service boundaries and the complexity of the system. The BMA agrees that, with an ageing population and increasing demand for services, now is the time to reassess our approach to how care and support is delivered.

2. Integration

Integration has been identified as one of the ways in which the design and delivery of health and social care services can be better tailored around the needs of the people who use them.

In 2012 we produced three reports looking at different aspects of integration. 'Integrating services without structural change' is a practical guide to help lead the integration of health services without the need for major structural or organisational change. It provides an account of the mechanisms and processes that can be used to improve the way different providers work together around the needs of patients, and the under-pinning evidence base. 'Doctors' perspectives of organisational mergers' shows that doctors are sceptical about the potential for mergers to be successful in bringing about integration. Their main concerns focus on the disruption caused during mergers and the fact that mergers, in themselves, do not achieve integration. Most relevant to this review, 'The integration of health and social care ' looks at historical attempts to integrate health and social care services and the role doctors can play in overcoming the barriers to integration. The report recommends that in order to convince doctors of the value of integration, strategies must be clearly based on the benefits being sought for patients and service users. The will to achieve greater integration exists among doctors, but more work needs to be done to overcome the plethora of existing barriers and promote integration in ways that will demonstrably support patients and enable doctors to get involved.

2.1 Why integrate?

To many, the case for coordinated service delivery is clear and convincing. The population of England is ageing and will continue to do so. The percentage of the population aged over 85 years is set to double over the next 20 years. Many will live with significant, often complex, health and social care needs. Alongside rising demand, the NHS and local authorities are facing severe financial constraints and being asked to make significant savings. There is growing recognition that the system needs to deliver better value through improving outcomes and cost-effectiveness.

Aside from meeting the financial and demographic challenges identified, literature tells us that integration if services can also be beneficial for individual patients and service users. National Voices has identified the lack of joined-up care as a source of huge frustration for patients, services users and carers, and that ''achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety''[1].

The BMA has long advocated for greater integration in the NHS, generally between the different elements of the health service. We support coordinated planning of primary, secondary and tertiary care and the development of clinical pathways, through collaboration between these services, to enhance the patient experience. We also believe that closer integration of health and social care should be encouraged, where evidence shows it can be beneficial to patients and service users. Doctors should be encouraged to play a leading role in any initiatives to integrate care.

It should be noted that pilot schemes to provide integrated care have not always shown the anticipated results, such as reducing demand for services or making cost savings. An evaluation of the first year of a major integrated care pilot in inner north west London has found little change in emergency admissions and in the wider use of health and care services. The scheme, which produces individual care plans for people with diabetes and those older than 75, found that patients did not show "any significant reduction in emergency admissions or significant changes in the wider use of services." However, the researchers involved have said that more time is needed to assess the longer term effect of the pilot[2].

2.2 Integration for patients and service users

The BMA agrees with the approach and language used in the recent report from the National Collaboration for Integrated Care and Support[3]. Integrated care should be defined through the experience of the patient or service user, rather than by the structures, organisations or pathways in place or the way services are commissioned or funded. Integration is about individuals and communities having a better experience of care and support, and therefore the individual must be the organising principle for services. Patients and service users should perceive no organisational barriers or bumps while interacting with the various providers of their package of care. We agree with report's headline definition of integration, from the patient's perspective: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me." We would highlight in particular the points in the accompanying narrative around transitions and the importance of plans being put in place when patients and service users move to a new service. We support the ambition for all national and local partners to adopt this definition and its accompanying narrative, to ensure that patients and service users are at the heart of integrated care and support. Given this definition, integration does not necessarily require high-level budgetary or structural integration, rather a refocusing of attention onto how to work together to ensure patients and service users experience as seamless a service as possible as they move through their treatment and care.

3. Commissioning care

3.1 Full integration of health and social care

The BMA does not believe the full integration of health and social care, as set out by the Shadow Secretary of State for Health, is either necessary or desirable. Rather, we believe that current structures should be retained, maintaining separate services, and existing mechanisms to facilitate coordination between health and social care should be used more widely to plan and deliver joined-up local services.

One of the main reasons behind this thinking is the risk of further disruption to the NHS. In our view, full integration as described in the speech cannot be achieved without major restructuring. It does not seem feasible that existing organisations can simply be refocused to deliver fully integrated commissioning. In a recent survey of BMA members, 60 per cent of respondents felt it would not be possible to create a fully integrated health and social care system without any major structural change for the NHS. On the contrary, it seems likely that the creation of one single commissioning body would require substantial structural change, including the relocation of staff and redundancies as a result of consolidating functions and removing duplication.

Patients and the people who work in the NHS are still dealing with the impact of the Coalition Government's most recent reorganisation, which has proved hugely disruptive and divisive, despite pre-

election promises of no more top-down reorganisation of the NHS. It has been estimated that the cost of the Coalition's reforms will be £2bn-£3bn[4]. It does not seem sensible to embark on another potentially expensive reorganisation, particularly given the ongoing efficiency savings being asked of the NHS.

The suggestion of such a major change will itself be enough to raise concerns and suspicions that the NHS is to experience yet more politically-driven upheaval. Patients and NHS staff are unlikely to welcome more change and it will be difficult to gain their support for another reorganisation, whether real or perceived. We would urge any future Labour government to allow health and social care commissioners and providers to focus on planning and delivering care, rather than tie them up in yet more restructure and reform. As we have stated, we support refocusing attention to make the patient and service user experience the organising principle for integrated services, rather than focusing on structures and organisations.

A Labour government should enable integration to become properly established not by reorganising but by creating stability across the NHS and local authorities and allowing integrated care to become a priority.

As well as focusing on the patient and service user experience, we believe that integration will be better achieved by creating a stable environment, stronger incentives and greater flexibilities for the NHS and local authorities to explore how best to work together for the benefit of their local populations. The King's Fund has identified that successfully achieving integration is a long and arduous process. Leaders need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy[5]. They need policy and system stability in order to do this. It is possible that one of the reasons integration has been slow to take off so far is because there has not been a significant period of policy and system stability in the NHS in recent years. New ideas and ways of working have seldom had time to become established before a raft of new initiatives has been introduced. It is unsurprising that professionals working within the NHS have been unable, or unwilling, to prioritise integration in the face of other, higher profile priorities such reducing waiting times, and in the knowledge that further change in policy direction or structure might render any efforts pointless. A period of stability, to facilitate long-term planning and the development of clear strategy, is vital.

It is essential to the success of integration that leaders and people working in the NHS and social care services are supportive of any proposals. Any integration project needs a strong collective vision, built on a foundation of evidence-based thinking, the benefits being sought for patients and service users, and staff involvement and engagement. We believe that the main benefits of integrated care are achieved by breaking down barriers between services and professionals and allowing them to focus on the experiences of patients and service users, not by merging organisations.

Furthermore, stronger incentives to encourage organisations to work in partnership should be utilised more frequently. Measures to align incentives could be effective, for example by requiring health and social care organisations to work together to deliver specific outcomes before funding is awarded to any of the organisations involved. This creates a strong incentive for the different organisations involved to work together to deliver the integrated care that patients and service users need.

3.2 Lead commissioner

We believe local health commissioning should remain the duty of the CCG, to ensure it is carried out by people with expert and in-depth knowledge of local health services and the health needs of the local population.

High-quality commissioning is essential to improving the standard of health services available to patients and ensuring the best possible use of limited NHS resources. This is best undertaken by clinicians working with patients and so, keeping in mind the need to avoid any further NHS reorganisation, CCGs should be retained as the lead commissioners of health services. Health and wellbeing boards should play an important role in bringing together the CCG and the local authority as well as other local stakeholders, but would not in a position to take on health service commissioning to the same standard as CCGs. Similarly, local authorities will have an essential role to play in identifying local priorities and opportunities for integrated working, but are not experts in health commissioning. As such, we strongly recommend that CCGs are retained as the lead commissioners of NHS services. Recent findings from the HSJ CCG Barometer survey reinforce the importance of commissioning remaining the responsibility of CCGs. When

asked about the likely effects of transferring their budgets and making CCGs advisory bodies to councils, 63 per cent of respondents said they were likely or very likely to leave their CCG position. Eighty-five per cent said it was likely or very likely some of the CCG's GP leaders would leave. This would have a damaging effect on the continuity of local commissioning and create yet more upheaval and confusion at a time when CCGs need stability in order to start implementing longer term plans for the benefit of their local population.

We also recommend that consideration be given to including voluntary and community sector organisations on health and wellbeing boards where appropriate. Some organisations, such as those providing support for people with dementia or diabetes, have a high level of insight into how local services could be arranged to better meet the needs of people with these conditions. It will be important to capture these views.

The current model of GP-led commissioning should evolve into genuine clinically-led commissioning. All types of clinicians should be enabled to engage fully with CCGs, which should in turn be enabled to implement pathway-driven commissioning. The focus of a CCG should be to design effective care pathways which are in the best interests of patients and which cross between GPs, local hospitals, local authorities and community services. It is essential that clinicians from secondary care, and others such as medical academics and social care professionals, are able to get involved with CCGs, to enable integrated decision-making and ensure integrated care pathways are in place. This could be achieved by encouraging secondary care doctors to sit on CCG boards, to enable a more collaborative approach between commissioners and providers. All CCGs should also have access to specialist public health advice to ensure that commissioning is evidence-based, appropriate to the needs of the local population, aims to reduce inequalities and represents best value for money. There are existing examples of excellent partnership working between public health and CCGs, for example where public health professionals, whilst employed by the local authority, are embedded within CCGs to enable effective commissioning. This achieves proper clinically-led commissioning without requiring any further reorganisation of public health. The Labour health team should explore whether this and other good practice could be applied across the country.

3.3 Integrated budgets

The NHS budget should not be used to prop up underfunded social care services. The NHS should continue to be funded directly by general taxation and decisions about where to direct health spending should be free from party political influence.

The BMA is committed to an NHS which is publicly provided and free at the point of need. Fully merging health and social care will inevitably have implications for the NHS budget, which will be difficult to manage in the current financial climate. We are concerned that integration may lead to the transfer of health budgets to cover social care services traditionally funded by local government, at the expense of healthcare services.

A fully integrated single budget for health and social care risks introducing local politics into health spending, if local authorities were to take overall control of the budget. Whilst putting local authorities in charge of the NHS budget would provide electoral accountability for health spending, it would also make the local NHS vulnerable to short-term political decision-making. This could risk the stability of essential services such as mental health services, which are not always highly valued by people who do not use them and so might be neglected by locally elected officials in favour of more universally popular services such as maternity services. For many years the BMA called for the NHS to be given independence from party political influence and to be able to operate on the basis of a long-term strategy. We would not want to see decisions about local health services put back into the hands of politicians.

There is also the risk that NHS funding would be subject to the cuts that are affecting other public services as local authorities attempt to make significant savings. A recent survey of 81 local authorities revealed that arts and sports budgets will be cut, youth centres closed and other support withdrawn as authorities struggle to deal with a growing financial crisis. Almost half said they were planning to reduce spending on care services for adults, affecting those with learning difficulties or disabilities. Eight have cut care for those deemed to have 'moderate' needs. It has been reported that local authorities will have lost a third of their budget by 2015.[6] Given this backdrop, it is even more essential that the NHS continues to be funded directly by general taxation, pooled centrally, and then allocated regionally through a fair and

robust allocation formula. This will help to maintain a broadly similar service across the country, fulfilling the fundamental principle that the NHS provides a comprehensive service available to all. We accept that difficult decisions have to be made about where to direct health spending, but this should be done by clinicians supported by public health specialists. While local authorities will have a valuable contribution ot make to the debate, they are not best placed to make these decisions.

In this economic climate, it is important that any savings are retained by the health service to be reinvested where needed, including in integrated health and social care services. In the past two years, nearly £3 billion of NHS funding has been handed back to the Treasury with just £316m of the £1.4bn Department of Health underspend in 2011-12 carried over for it to use in 2012-13[7]. Rather than being returned to the Treasury, any savings should be redirected to areas where funding is most needed, such as prevention services to keep people out of hospital and integrated health and social care schemes to help people return home from hospital as soon as possible.

Commissioners should also be required to reinvest the 70 per cent saving they can make on the emergency readmissions tariff, as it is meant to be. Savings should be directed to reablement services, in order to reduce rates of admission following discharge, which will require an integrated approach across health and social care. Further investment in prevention could also result in significant savings, enabling existing services to be used more efficiently. We believe this investment is best implemented through increasing all local authority ring-fenced public health allocations to the level of the best.

We believe it would be worth considering whether part of the social care budget could be transferred to the local clinical commissioning group (CCG). It might be possible to design tariffs to cover pathways of care that include identifiable social care consequences of a health condition, which would be funded by the CCG with its enhanced budget. The Labour health team should work with key stakeholders to explore the potential for this type of tariff.

In the meantime, it should easier for CCGs and local authorities to share budgets where professionals have identified that doing so would be beneficial for patients and users of social care, either through existing mechanisms, or by creating new ways to pool budgets.

Local authorities and the NHS have had the ability to pool, or share, budgets and delegate resources from one to another for many years, but there has been little uptake. In 2011, less than five per cent of the combined NHS and public social care budget was spent through joint arrangements[8]. The additional £1bn per year by 2014/15 to be set aside from NHS budgets for partnership working offers a real opportunity for local authorities and the NHS to begin discussions about sharing resources, taking improving the patient and service user experience as the starting point. Sharing budgets does not require the integration of organisations but rather the will and ability of local partners to make it happen and agreement about the aims of partnership working. Clarity about desired outcomes is more important than the specific mechanisms used to bring resources closer together. An important aspect of this is having good quality information about local spending, costs and outcomes and the experiences of local people who use health and social care services[8]. This enables a better understanding of the needs of the local population and, therefore, a better idea of where to focus efforts to share resources to achieve the greatest impact. Initial focus should be given to pooling budgets in defined areas where specific pressure points have been identified, for example, prevention services and early discharge from hospital. The Labour health team should look at what support central government and Public Health England could offer to local authorities and CCGs to help them develop systems to collect information locally and how government could better disseminate examples of good practice in pooling budgets.

4. Providing care

4.1 Hospitals as integrated providers of whole person care

The BMA is interested in the idea that hospitals should grow into integrated providers of whole person care. There are a number of barriers to this that would need to be tackled before it could become a reality, some of which were identified in the shadow Secretary of State's speech to the King's Fund.

The current payment by results system is ill designed to promote or support larger-scale shifts in care from hospitals to other settings, due to incentives facing hospitals to maintain income

and the lack of flexibility to vary tariffs to reflect the different costs of providing care in different settings.

In its current form, it does not provide a financial framework that supports or directly incentivises new ways of delivering care for people with long-term conditions and it creates divisions between primary and secondary care. This model makes integrated care much more difficult to provide as it incentivises hospitals to undertake in-patient activity, to maintain their income, rather than incentivising the shift of care into non-hospital community settings. If hospitals are to expand further into the community the payment method for care will need to be revised. Under the current system, providers would not be able to maintain financial viability if they were paid less for admitting patients.

Other payment mechanisms, such as the year of care model for long-term conditions, may be a solution. Pilot schemes, which ran in 2012-13, enabled commissioners to pay providers to care for patients with long-term conditions for a year, rather than receive payment each time a patient was admitted to hospital. The aim was to incentivise trusts to deliver the best care for patients rather than maximise hospital activity. The Labour health team should investigate whether the year of care tariff, or other similar models, could be comprehensively applied across the country to incentivise non-hospital based care and also maintain adequate funding for providers. Tariffs for in-patient care and care delivered away from the hospital should be properly balanced to reflect the true nature of a provider's work. There will always be some patients who need to be admitted to hospital and providers need to be adequately reimbursed for this vital activity as well incentivised to work more in the community.

Encouraging hospitals to grow into integrated providers would necessitate changes in where and by whom care is delivered. Some secondary care services are already delivered in community settings, with secondary care doctors and other healthcare professionals working away from their hospital. This would need to increase, with larger numbers of secondary care doctors treating patients in the community, often in collaboration with primary care. It is essential that this includes more geriatricians working in the community and visiting residential and nursing homes to help keep older people out of hospital where appropriate. There would need to be a corresponding expansion of district nursing, which is already under significant pressure and would need significant extra resource to be able to manage a more substantial workload shift. This pattern of care delivery would be more convenient for patients and would also help to break down the divide between primary and secondary care, as doctors and other healthcare professionals would be working much more closely together in the community.

We believe it would also be beneficial for ward nurses and other healthcare professionals based in secondary care settings to rotate into community services throughout the working year. This would further encourage closer working between primary and secondary care professionals and enhance the level of integration between services. It would also help embed knowledge of the services that are available and how care is provided in the community across the secondary care workforce.

If hospitals were to expand significantly into the community, trusts and individuals would need to be supported to take on new ways of working. Providing substantially more services in the community will change the nature of some medical roles. The reasons behind shifting provision of care into the community and the benefits of the new approach need to be clearly communicated to staff, particularly those who may be required to work in a different location. We would not want to see the loss of any medical posts as a result of a hospital expanding into the community. Where a reduction of in-patient workload is predicted, existing staff should be redeployed to community-based services. In addition, it is important to remember that shifting the location of care will not reduce the overall levels of staff, or funding, required to provide the whole range of care that patients need.

Substantive workforce planning will be required to manage these shifts of care. It is vital that proper planning is done now, to ensure that the future healthcare workforce is sufficiently staffed and has the flexibility to be able to deliver care in different locations as required, without leaving parts of the health service inappropriately or under staffed.

4.2 Centralising services

Decisions to centralise services must be taken only where the evidence shows it would be beneficial for patient care.

The BMA would be very concerned if decisions to centralise services were driven by any other criteria. Consideration of the local infrastructure and the potential impact of centralisation on health inequalities, particularly in rural areas, must be central to any proposals. It is vital that any future centralisation does not create inequalities or disadvantage those people who are less able to access services further away from their homes.

It is important to remember that there can be unintended consequences of centralising services. Patients who do not want to travel to specialist sites end up visiting a provider in their area, so the burden on local services can actually increase. Decisions around centralising specialist services must take into consideration the potential impact on the entire local health economy.

> In Lincolnshire, the removal of the spinal surgery unit resulted in an unexpected and significant increase in the number of patients accessing the local chronic pain service. Patients who could not or preferred not to travel further to receive treatment at the specialist spinal service visited the local chronic pain service instead. The chronic pain service did not have the capacity to cope with the unexpected and unplanned increase in activity and so a significant number of patients had to wait longer than 18 weeks for treatment.

The views of patients, the local population and local leaders will also have an impact on decisions to centralise services. The influence of local MPs and councillors on health service configuration is well documented, with many publicly opposing proposals to reconfigure hospital services in their area even where there is a clinical case to do so. We do not believe it is realistic to think that local people and politicians will be convinced of the need for widespread change to local hospitals without much more meaningful, early, well planned and sustained dialogue between commissioners and providers, the public and local politicians.

4.3 Skill mix on wards

The BMA supports the concept of having a greater skill mix on hospital wards to coordinate care between health and social care services and to make sure the right care is in place to support individuals to return home.

In his speech to the King's Fund, the Shadow Secretary of State highlighted the example of Torbay, where care workers provide support for older people on hospital wards and ensure the right package of care is in place to help them get back home as soon as possible. In Northern Ireland social care professionals are also present on hospital wards where necessary and it has been reported that the system works well for patients and professionals. Health and social care staff are able to work together to consider a patient's health and social care needs outside hospital and share assessment information in order to avoid duplication and delays. This helps to provide patients with coordinated and consistent services as they return home.

The BMA strongly believes that individuals should not have to remain in hospital if they are clinically well enough to return home. In 2011 it was revealed that, after a decade of improvements, the number of days of delays for patients leaving hospital had risen to 128,517 during August and September 2011, an 11 per cent increase on the previous year[9]. If patients are unable to access home help for vital tasks, such as eating and washing, they are forced to stay in hospital unnecessarily. As a consequence some patients with pressing medical conditions cannot be admitted immediately because healthy patients are occupying beds. The situation is distressing for individual patients, of great concern to the medical profession and an organisational problem for the NHS. Patients who have a prolonged spell in hospital face an increased risk of suffering complications associated with healthcare, such as infections, blood clots, and social isolation. In terms of the NHS, the Commons Public Accounts Committee has previously estimated that delayed discharge costs the NHS £170m a year[10].

It is essential that action is taken to help patients return home once they no longer need the clinical care provided in hospitals. The BMA supports the concept of having a greater skill mix on hospital wards to coordinate care between health and social care services and to make sure the right care is in place to support individuals to return home. In a recent survey of BMA members, 67 per cent agreed that there should be a greater presence of non-healthcare professionals in the hospital environment to help patients return home as soon as possible, once clinically appropriate. It is important, though, to take care when

considering skill mix on wards. It is essential that the right people are on the ward to do the right things. If a nurse is needed, a nurse should be available. Equally, if a social care professional is needed a social care professional should be available. The different roles and responsibilities should not be confused or used inappropriately.

We believe that consideration should be given to the potential to link social care professionals to primary care. In Torbay, work was allocated to staff teams in adult social services on the basis of GP registration rather than home address. This aligned social work with community health and linked it to clusters of GP practices. As the King's Fund report on Torbay states, "it is hard to see how integration could have progressed so rapidly without this decision." These clusters later became zones and ultimately proved to be the facilitators of bottom-up change[11]. Community nursing could also be based around GP practices, to further enhance the integrated nature of services. A shift in many areas to organise services around geographical areas has led to community nursing becoming remote from practices. It would be beneficial to re-establish closer working between general practice and community nursing. The Labour health team should consider whether these arrangements could be replicated across the country to enable better coordination of local services.

4.4 NHS as preferred provider

The BMA welcomes Labour's commitment to the NHS preferred provider model. We are strong advocates for a publicly-provided health service and remain opposed to attempts to further increase competition in the NHS, which is not in the interests of patients. We continue to favour an NHS based on cooperation and collaboration rather than driven increasingly by markets and competition law because of the risk of fragmentation, transactions costs and scope for legal challenge. We favour a system in which the NHS is the preferred provider of care, giving the NHS an opportunity to improve any underperforming services before any non-NHS procurement of services was considered. We continue to believe that the high transaction costs of procurement, the contractual inflexibility it builds into the system and the wider fragmentation that the dependence on competition brings to the service can all affect the ability of the NHS to deliver the most seamless and cost-effective care to patients. NHS contracts used between NHS bodies would avoid huge cost and complexity.

However, we are unclear as to how it would be possible to reintroduce the concept of preferred provider in the future. We are aware that the model was challenged by representatives of private and voluntary sector organisations who took the case to the Cooperation and Competition Panel (CCP)[12]. Although we have not seen the result of the CCP's investigation, the preferred provider policy was withdrawn before the 2010 General Election. We would welcome details on how a Labour government would reinstate the policy in a way that would avoid further legal claims from non-NHS providers.

5. Access to patient records

It is widely, though not universally, held that full and accurate information about a patient's needs and care should be available to everyone involved in that care, and to the patient themselves. The NHS Future Forum workstream on information identified poor flow of information about patients and service users as one of the key barriers to ensuring that people receive a safe, effective, joined-up service[13]. Commissioners and providers have reported that they do not have access to the kind of information they need to provide integrated care journeys, particularly for individuals with multiple and complex conditions whose care crosses organisational boundaries. Delays, inaccuracies and gaps in information are commonplace[14]. The Future Forum recommended that the NHS move to using IT systems to share data about individual patients and service users electronically and that systems must be interoperable. This does not mean having a national programme for IT, but installing IT systems that can talk to each other. At the same time, safeguards must be put in place to prevent unplanned access to personal medical records and to protect vulnerable individuals from exploitation by third parties. Patient confidentiality must be paramount and proper consent processes for the use of information must be in place. The Labour health team should press the Government on what progress has been made on this important issue and investigate how achievements could be made more quickly.

6. Social care funding

Of the options identified in the review for funding social care, we are more inclined to favour an 'all-in' system that requires all people to contribute regardless of present or future needs.

The BMA believes that funding arrangements for social care should be fair and transparent and open to wide public debate. In the past, the BMA expressed a preference for funding the social care system through a comprehensive model, based on a partnership of state and individual funding, ensuring that premia were related to ability to pay. We were also in favour of local flexibility in the scheme, to take account of differences in costs and preferences at the local level.

The Government announced its intention to cap the cost of social care in the Queen's Speech on 8 May 2013. The Care Bill proposes a limit on costs in 2016, to prevent individuals having to sell their home to pay for their care. The Government had previously announced that this would be set at £72,000. This legislation will likely be in place at the time of the next General Election and so the Labour health team will need to account for its impact in any plans for reforming social care funding.

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