BMA

BMA organisational submission - Change NHS: Your priorities for change (England)

14th April 2025

British Medical Association
bma.org.uk

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association that organises and campaigns with its members on matters of importance to the medical profession.

The BMA welcomes the opportunity to respond to this survey and we are doing so as part of our wider engagement with the development of the 10 Year Health Plan in England.

This response builds on our comprehensive submission to the initial Change NHS survey and reiterates that the eventual 10 Year Health Plan for England must place patients at its centre, by valuing the medical expertise of doctors and ensuring that the system properly trains, rewards, and retains them. In turn, doctors value the knowledge and skills of other healthcare professionals and support staff as part of the wider aim of building a healthier society, where treatment is available equitably to all regardless of the ability to pay.

As we have not been part of the 10 Year Health Plan working groups, we have opted to respond to this survey in writing rather than via the online portal, in order to address the questions asked in the most productive way possible and to best represent the views of our members. The views of our members should be crucial to the development of this plan, as they are tasked with planning and delivering medical care, teaching, and training the next generation of doctors and other health care professionals, and play a central part in public and occupational health, academia, research, and innovation in medicine.

This response has been developed collaboratively across the Association and has been submitted on the behalf of the entire BMA.

Please contact healthcare.delivery@bma.org.uk with any questions regarding the submission.

Section 1: Empowering you to make choices, throughout your life

Q1. Many of you have told us that more can be done to support people with their physical and mental health.

Which three things would help you most to stay healthy? *Please select up to 3.*

- Easier access to your health record with personalised information about any risks to your health and how to manage them
- Access to fitness and mental wellbeing apps which support you to stay healthy (Couch to 5k, mindfulness apps, etc.)
- Reminders from the NHS app to support you to manage your health (notifications to remind you take medicines, book follow-up appointments, follow medical advice, etc.)
- A healthcare professional signposting to activities in the community that can help your mental and physical health (exercise classes, nutrition and cooking classes, meditation, etc.)
- Easier access to tests and diagnostics to help spot any health issues you may have
- Regular check-ins with a health care professional on your physical and mental health
- Don't know
- None of these

BMA Response:

The BMA supports the ultimate goal of a more preventative model of healthcare, which we believe would, if approached correctly, benefit patients, doctors, and the health and care system as a whole. More effectively supporting patients to stay healthy will be important to achieving this shift, but we are sceptical about the viability of certain interventions suggested in this question, including how quickly or effectively they could be implemented.

Regular check-ins with a healthcare professional would be beneficial for many patients and would undeniably be a major step towards better enabling the public to stay healthy. However, achieving this will require significant investment in general practice, an end to GP under- and un-employment, and efforts to secure the necessary workforce. As part of this, we are calling in the first instance for an additional 11p per patient per day for essential services, increasing current investment to £152.50 per weighted patient per year for practices.

However, fundamentally, achieving this model necessitates the agreement of a new GP contract that restores the family doctor and allows for the continuity of care essential to delivering regular check-ins, as set out in GPC England's vision for general practice. Continuity of care has been shown to significantly improve patient outcomes – including morbidity and mortality – and to reduce hospital attendances and admissions.

Similarly, regular mental health check-ins would clearly be positive for many people, but there are immense practical limitations to how such a service could be delivered. This includes workforce shortages across the mental health sector that make regular check-ins extremely difficult to deliver, as well as long-term underinvestment in mental health services, and the ongoing failure to fully establish parity of esteem between physical and mental health. As the CQC (Care Quality Commission) has found, demand for mental health care continues to outstrip supply, with a third of people answering its survey stating that they had waited more than three months for their first treatment, and 42 percent saying that their mental health deteriorated while waiting for care.

The situation is particularly stark for children and young people, with the Royal College of Psychiatrists identifying that one in five child and adolescent consultant psychiatrist posts are vacant. Meanwhile, analysis by the charity Young Minds has found that in 2023/24 that the average wait to access CAMHS (Child and Adolescent Mental Health Services) following referral was 392 days, with 171,134 children and young people having their referrals closed before accessing support. These waiting lists – and the children and young people on them – are routinely overlooked in the discourse surrounding elective recovery and their experiences risk setting them up for worse ill health across the whole of their adult lives. Therefore, to make the aspiration of regular mental health check-ins a possibility, the plan must commit to ambitious goals on mental health funding and workforce development, including an explicit focus on CAMHS.

Regarding the future of the medical workforce, and as stated in our submission to the initial Change NHS consultation, we believe that it is critical that the 10 Year Health Plan includes a commitment to support and engage with medical academia and research. This is essential to ensuring we have the educators we need to train the doctors of the future, and to allowing doctors to undertake vital research into developing new treatments. Perpetuation of a university system where clinical academics are so poorly funded and an NHS where research and academia is so poorly valued cannot continue. It is time for the NHS to be front and centre of the provision of academic opportunities for research and innovation in medicine in particular and healthcare more generally.

Given the extent of waiting lists and their impact on patient care, easier access to tests and diagnostics is understandably appealing, but achieving this will also only be possible with significant investment in the capacity and staffing needed to deliver them. Furthermore, given the limited resources available within the NHS, any potential plan to

enable self-referral to diagnostics and testing may present significant challenges as there is a risk that the 'worried well' utilise capacity that is then unavailable for those with greater clinical need.

Giving patients easier access to their health record, including personalised information about health risks and their management, can be beneficial in empowering patients to better manage their own health. However, care must be taken to ensure that patients understand the information that is contained within their record and are protected from any potential risks – including, for example, information that might be distressing to view, or information that might be harmful or can be accessed by a third party, particularly in cases where domestic violence or other abuse is a risk factor.

The use of apps can be useful for many people and, if used correctly, could be a notable part of the move towards a more preventative system. For example, the BMA has strongly promoted the potential of increased physical activity as a means of improving physical and mental health for many people, which can be aided by the use of apps. However, this must also come with a strategy to support those people who are unable to utilise apps or other forms of technology, to avoid exacerbating digital exclusion. It is also important to note that creating the ecosystem for these apps would necessitate the NHS vouching for them and vetting any updates to confirm that they do not contradict NHS values.

Q2. We also heard that, whilst you see a big role for the NHS to help individuals stay healthy, you also think others in society have a role to play. Beyond the NHS, who should have the biggest role in helping people manage their health and wellbeing? *Please select all that apply.*

- Local government (councils, local services, elected local leaders)
- Voluntary organisations (charities that provide support on conditions and health e.g. cancer, etc.)
- My family and friends
- Employers (providing good working conditions, access to healthy food, access to health apps, wearable tech, access to a work-health advisor etc.)
- Public figures (sportspeople, social media influencers, etc.)
- Education organisations (schools/universities)
- Fitness organisations (gyms, personal trainers, sports clubs, parkrun, etc.)
- Other - please specify
- Don't know
- None of the above – it should mainly be the responsibility of the NHS and healthcare staff

BMA Response:

Doctors have invaluable insight and expertise in assessing and addressing the needs of patients and so are uniquely well placed to inform measures intended to help keep people healthy. Because of this, it is vital that doctors – and particularly GPs and public health specialists – play a leading role in devising new strategies for health promotion, both nationally and locally. To ensure this expertise is used effectively at a local level, it is essential that ICBs (Integrated Care Boards) are all required to include at least one GP and one independent, qualified public health specialist on their boards.

Alongside doctors and other clinical staff, a wide range of organisations, including those listed in the survey, also have roles to play in protecting, improving, and sustaining people's health. However, the absence of national Government or relevant departments, including DHSC, from this list is a significant omission. In order to be effective, the 10 Year Health Plan must acknowledge the wider determinants of health and the role that many parts of Government should have in addressing them. This includes through the allocation of funding and, where needed, the creation of legislation. The BMA believes that UK Government should adopt the health in all policies approach legislated for in Wales.

Social care services are central to supporting the health and wellbeing of those who use them, as well as their families and carers. It is essential for the 10 Year Health Plan to recognise this and for it to include a focus on social care reform, to ensure these

services are fit for purpose and to help tackle the serious issues, like poor patient flow through patient pathways across the healthcare system and delayed hospital discharges, that insufficient social care provision compounds in the NHS. This sorely needed reform must include significant change to social care funding as well the pay and conditions of the sector's workforce.

Q3. One suggestion is that early conversations about people's preferences for their future care, including end of life care, may help ensure people's wishes are respected.

How do you feel about having an early conversation about palliative care with a healthcare professional, including an opportunity to discuss what a good death would mean for you? *Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this*.

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

And:

Q4. What, if any, concerns would you have with discussing your preferences for palliative care? Please select all that apply.

- I would rather not talk about palliative care while I am healthy
- I am uncomfortable talking about palliative care with a healthcare professional
- I do not have enough information to have this conversation
- This does not feel relevant to me at the moment
- Other – please specify
- Don't know
- None

BMA Response:

The BMA has repeatedly highlighted major concerns regarding palliative care services, which we believe have been persistently underfunded and subject to serious unwarranted variation across the country. We believe that palliative care commissioning must be backed up with proper funding for comprehensive hospice, community, and hospital specialist palliative care services nationwide, alongside the

introduction of a duty on all NHS commissioners to ensure these services are made available to all who need them. Any inclusion of palliative care policy within the 10 Year Health Plan must include recognition of this as well as a plan to address it, otherwise any broader changes to when and with whom a person discusses palliative care plans will be severely undermined.

We would encourage all members of the public to have conversations with their loved ones about their future care as they grow older and potentially sicker, to normalise and plan for the inevitability of the end of life while they are in relatively good health.

Section 2: Delivering care where it's needed

Q5. Accessing care is one of the top concerns you've shared during the engagement so far. One suggestion to address this could be seeing other healthcare professionals for specific issues to be seen sooner, instead of going to your GP first.

Which other healthcare professionals would you be happy to speak to first instead of a GP, if it meant you were seen sooner? *Please select all that apply.*

- A pharmacist to discuss a prescription to treat common health conditions and/or check and review a prescription
- A nurse to discuss a minor illness
- A relevant specialist (consultant, dietitian, etc.) instead of waiting for a referral
- A mental health practitioner to discuss your mental health
- A physiotherapist to discuss an injury
- Other – please specify
- Don't know
- None – I would want to speak to a GP first

BMA Response:

The BMA is clear that patients being able to see a GP when they need to is the gold standard, but that this requires general practice to be better funded, orientated around a model of the family-doctor, and empowered by a new contract negotiated within the term of this Parliament. The 10 Year Health Plan must include a serious commitment both to achieving this outcome and to the future of general practice.

We recognise that enabling patients to access support from a broader range of sources and appropriately qualified professionals would be a broadly positive move and could

allow for improved access to GPs for patients who need it. However, this process needs to be managed carefully, with the recognition that improved access to care will only be beneficial if that care is safe and high quality.

For this approach to work effectively, it must be provided as part of an integrated system that has general practice at its heart. This is essential to ensure patients are well informed about the services open to them and advised about which would be most applicable to them, rather than being left to choose from an array of options, some of which may be wholly inappropriate for their specific circumstances.

Many GP practices also host or employ, including via ARRS (Additional Roles Reimbursement Scheme) funding, a number of the healthcare professionals named in this question. This reaffirms the need for general practice to be at the heart of this kind of proposed model but also raises wider issues around investment into GP premises. Many GP practices are physically too small to accommodate additional staff, including those covered by ARRS, and so are unable to properly incorporate those roles. Much needed investment in GP premises would help to resolve this issue while also allowing patients to access a wider range of healthcare professionals more conveniently.

The list of professionals given includes those with separate and specific skills and expertise, although some of these do overlap, which enables them to give advice and treatment within their professional scopes of practice.

Expecting other occupational groups to act as first line diagnosticians outside their areas of expertise poses serious potential risks to patient safety, as has been seen with cases of serious misdiagnosis by physician associates (PAs). Allowing cheaper, less qualified clinicians to carry out first line diagnostics has been a failed and dangerous experiment, with tragic and fatal consequences. It is essential that a clear, nationally determined scope of practice is established for PAs working in the NHS more broadly, but we believe that the PA role in general practice as previously defined by NHSE is fundamentally unsafe and should be phased out. There must be a clear scope of practice for any clinician who acts as a first line diagnostician in general practice, avoiding any blurring of the lines between the work and responsibility of these clinicians and that of a doctor.

More broadly, many of the alternative services mentioned in this question have also suffered from long-term underfunding and may lack the capacity necessary to fulfil an expansion to their role. It is therefore important for the 10 Year Health Plan to also consider how to ensure services like community pharmacy, dentistry, and out-of-hours (OOH) services have the resources they need.

Q6. Which settings would you be happy to speak to a healthcare professional in, outside of a GP surgery or hospital? *Please select all that apply.*

- A mobile screening clinic (for cancer tests, blood tests, etc.)
- A community centre (a pop-up clinic)
- Faith buildings (a pop-up clinic)
- Your home
- Schools and colleges
- Pharmacies
- By digital appointment (on your phone, tablet, laptop, etc.)
- Don't know
- None – I want to be seen in a GP surgery or hospital

BMA Response:

While we appreciate the value of convenient access to healthcare professionals for patients, the BMA would have concerns regarding any major expansion of healthcare services into a number of the proposed settings.

Speaking to a healthcare professional in a mobile screening clinic, in a pharmacy, via a digital appointment, or, in certain circumstances, at home are appropriate and established means of accessing support. Likewise, dedicated community care teams are well-placed to engage with patients and the public in a wider range of settings.

However, significantly expanding those services poses risks that need to be addressed. Principally, we are concerned about the safety of staff, who could be at greater risk of verbal or physical abuse when operating outside of traditional settings. Placing a larger number of staff in non-clinical, community spaces will necessitate providing them with greater support and security, to ensure their safety.

Action will also be needed to ensure that staff other than doctors working in these settings have appropriate oversight and support from doctors or other relevant professionals, particularly if they are expected to provide diagnostic advice. However, we recognise the potential to reduce inequalities – in health, engagement with health health education, and preventative services - when novel access schemes engage local populations within particularly 'hard-to-reach' communities, as was seen during the COVID-19 pandemic.

Clarity will also be needed on who organises, funds, and oversees these services. Namely, whether they will they be operated by primary care or secondary care providers, or as collaboratives between different sectors, and how resources will be allocated accordingly.

Q7. What, if any, concerns would you have about speaking to a different healthcare professional instead of a GP? *Please select all that apply.*

- Care not feeling joined up between different healthcare staff and services
- Receiving worse care
- Unfamiliarity
- Lack of availability
- Other – please specify
- Don't know
- None

BMA Response:

Seeking advice on health issues from sources other than doctors is by no means new. Patients have traditionally sought informal advice from family and friends in local communities and, more recently, have consulted the internet on a wide range of health issues. While the increased availability of information online can be helpful at times, it can also be dangerous as the posting, validation, and appropriateness of on-line content is largely unregulated. Similarly, seeing other clinicians as a direct substitute for GPs can comes with risks regarding the safety of the advice, diagnosis, or treatment they receive outside of 'minor' ailments, injuries and conditions. There are no circumstances where another clinician should be deployed in place of a GP to provide an equivalent service to a fully qualified GP, as we have seen with tragic consequences in the deployment of PAs. Where other clinicians are deployed to provide a first line care the care provided must be entirely with in their area of expertise, it must be heavily informed and guided by the patient's GPs, have comprehensive oversight measures in place, and that staff providing this service must be subject to a clear, nationally agreed scope of practice.

Q8. We heard that to feel confident using services in new settings and with new healthcare professionals you need to know that there will be proper safeguards in place and that this will benefit you.

Which of the following is most important to you? *Please select the top 3 that are most important to you.*

- That my personal data will be handled safely and securely
- That my concerns and issues will be taken seriously
- That healthcare professionals will have access to my records, so they know how to treat me and what my history is
- That my GP should have a record of every appointment and conversation, so nothing gets missed
- That I will be seen sooner than if I went to a GP
- That I will be seen at a more convenient time and/or location
- That healthcare professionals that are not GPs are trained to spot things that could be signs of more serious illness
- Other – please specify
- Don't know
- None of these

BMA Response:

In addition to the issues highlighted above, patients must have confidence in the security and confidentiality of their personal data, but this could be undermined if a wide array of staff with varying roles, qualifications, and legal responsibilities all have access to it. Additionally, the storage of that data on systems or in locations outside of traditional settings may also pose further risks that will need to be mitigated.

Section 3: Supporting staff to care for patients

Q9. A common challenge people face is having to book lots of separate appointments with different healthcare professionals if they have multiple health conditions or concerns.

How do you feel about all healthcare staff having more information about your overall health and your health risks to give you broader advice instead of focusing on one specific health issue? *Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this.*

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

BMA response:

As highlighted above, the BMA would be concerned that significantly widening access to patient data – while it may enable better integration of care and increase convenience – carries significant risks around the safety and confidentiality of that data. Access to data should be contingent on it being directly relevant to a given treatment plan or care pathway.

In our view, the ideal format for patients to receive care and advice on multiple issues, rather than one specific problem, would be within general practice itself. If general practice was properly funded and GPs were enabled to provide longer, more holistic appointments via a new contract then this proposal could be achieved. This would take advantage of the significant benefits provided by the continuity of care within general practice and, crucially, would allow for more comprehensive appointments to be delivered without relying on alternative healthcare staff taking on responsibilities they may not be fully qualified for.

Q10. What concerns, if any, would you have with healthcare staff taking a broader approach to your health, and not just the specific health issue or concern you have?

- I am uncomfortable with healthcare staff having access to all of my health information and would prefer to talk only to specialists about specific issues
- Healthcare staff should focus on developing expertise in their specialist areas rather than giving general advice
- I am concerned about health professionals telling me what to do when it comes to my overall health
- Other – please specify
- Don't know
- None of these, I am comfortable with staff taking a broader approach to my health

BMA Response:

Any shift towards more generalist medical specialities, including a much needed increase in GPs in General Practice, must not come at the expense of adequate staffing in secondary and acute care settings, including specialist staff that continue to face high numbers of vacancies. To understand what is needed, the Government must ensure that it's refreshed long-term workforce plan includes modelling of demand for individual specialities. To deliver this, it must commit to rapidly expand the number of speciality training places and, subsequently, the number of consultant posts.

Q11. How do you feel about dedicated staff helping you to use the NHS and to access the right services and information? *Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this.*

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

BMA Response:

While the BMA is not opposed to signposting or care coordinator roles, the limitations of this approach must be taken into account – it is not a panacea and is not a substitute

for the adequate provision of care and comprehensive services. The staff responsible for signposting will also need to be properly trained and supported to provide the best quality advice, otherwise this service could risk misdirecting patients and potentially wasting time and resources. Navigating the complexity of the NHS could also be simplified with the provision of adequate hospital and care beds, staff, and capacity to reduce waiting times.

Section 4: Improving health for everyone, especially those with the greatest need

Q12. One suggestion to improve health for everyone is to target resources to people and areas that have the greatest need. This could include prioritising more spending in specific areas, such as pop-up or mobile clinics in areas of need to make healthcare more accessible in communities, and to provide more outreach to communities.

How do you feel about targeting more resources on prevention and healthcare to people and areas who are more in need than others? *Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this.*

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

BMA Response:

The BMA supports the concept of allocating funding equitably and we believe that this could be highly beneficial for those areas with greatest need, particularly where there are structural barriers limiting access to healthcare. As part of this approach, the Public Health Grant allocation formula should be reviewed, to ensure those areas with the greatest need are funded accordingly. Linked to this, as we called for in our response to the initial Change NHS survey, the Public Health Grant must also be restored in real terms per person to at least 2015/16 levels.

Determining the extent of need at a local and national level necessitates expert leadership and input from doctors and especially from public health specialists, who have a key role to play. Additionally, secondary care staff and consultants in particular

should also have a major role in this process, given their expert understanding of the hospital and acute services in these areas, many of which are especially challenged in respect of demand, capacity, and workforce. In order to address this, we believe it is critical that ICBs include a consultant doctor on their boards to provide essential clinical guidance and advice on the needs of secondary care.

It is vital that the plan acknowledges that many areas with greater health and care needs also require support with the wider determinants of health, including action on their local economy, housing, the environment, and more. This reinforces our previous call for the plan to incorporate a commitment to pan-Government action and to avoid a blinkered focus on the NHS and health services alone.

Rural, remote and coastal communities face a range of particular health challenges and additional barriers to accessing healthcare. These barriers include under-doctoring due to recruitment and retention challenges, increased distances to healthcare settings, poor transport links, poor digital infrastructure, and digital exclusion. Yet England has no strategy to address these issues, and consequently the needs of these communities are at risk of being inadequately accounted for in NHS reforms. Without due consideration of the unique healthcare challenges faced by rural, remote and coastal communities, NHS reforms risk exacerbating existing inequalities faced in these areas. It is crucial that the 10 Year Health Plan explicitly addresses the needs of rural, remote, and coastal communities, including how care for these communities will be delivered and funded.

Q13. Another suggestion is that staff are encouraged to work in areas of the country with the greatest needs or that have higher levels of staff shortages. This could be though getting a higher wage or having their student loan repayments reduced.

How do you feel about giving staff higher wages or reductions in student loan repayments to encourage them to work in places where they are most needed?
Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this.

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

BMA response:

The BMA is not fundamentally opposed to the use of incentives to encourage recruitment and retention in areas with greater need, or into areas that might otherwise struggle to attract doctors and other staff, but our position on any model will depend wholly on the terms of the specific proposal.

In contrast to the aspiration set out in this question, the targeted enhanced recruitment scheme has been cut by NHS England for 2025/26 which could in fact reduce the number of GPs working in remote, rural and coastal areas. This will need to be addressed as part of any specific strategy within the 10 Year Health Plan for recruitment into these areas.

To secure the retention of staff in these areas an effective policy providing continuous incentives is needed, as one-off payments could ultimately only keep doctors in these areas temporarily.

Q14. People with complex needs could be prioritised for appointments to get the right healthcare as early as possible. This could mean that people with complex needs may have access to longer appointments with a GP and could be seen sooner, while there is a standard offer for everyone to see a healthcare professional as soon as possible.

How do you feel about people with more complex needs being prioritised for appointments? *Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this.*

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

BMA response:

We have concerns about this proposal as written and believe that additional clarity is needed on how this would work in practice. In particular, whether or not this is referring to clinical and health needs, or wider needs encompassing the wider determinants of health.

Furthermore, doctors are concerned that national mandates to prioritise patients on this basis could undermine their clinical independence and their role in working with patients to determine need and prioritise accordingly.

This approach could, however, be beneficial in respect of waiting list initiatives that target areas with acute needs. This could, for example, help to ameliorate multi-morbidities and support efforts to improve the health and wellbeing of particularly challenged communities.

Section 5: Using technology to improve your care and experience

Q15. How do you feel about having the NHS app as your main way to access NHS services and information? *Please select a number from 1-5 where 5 means you strongly support this, and 1 means you are strongly against this.*

- 1 – Strongly against this
- 2
- 3
- 4
- 5 – Strongly support this
- Don't know

BMA Response:

Expanding the functionality and use of the NHS App could be a major positive step, but we remain sceptical about how quickly this expansion can be implemented with current levels of investment. In our view, achieving this level of functionality would require significant improvement and development, which could take longer than is currently being implied.

It is important to be realistic about this and frank with the public, in particular to avoid presenting the NHS App as a direct means of improving access, which it is unlikely to achieve.

Maintenance of a comparable non-digital means of accessing the same range of services will also be needed, so as not to exacerbate digital exclusion and inequalities more generally.

Q16. How likely would you be to use the NHS app if it became the main way to access NHS services and information?

- Very likely
- Fairly likely
- Neither likely nor unlikely
- Fairly unlikely
- Very unlikely
- Don’t know

BMA Response:

We are increasingly concerned that the NHS App and its potential expansion is being framed as a direct expansion of access to care, which it is not. Greater access to personal data, appointment information, and other details will be useful for many patients, but it will not address the fundamental, underlying crises around waiting lists, corridor care, a lack of GPs, and wider workforce gaps.

Q17. What concerns do you have, if any, with making greater use of the NHS app? Please select all that apply.

- I don’t have access to the right technology to access services through an app (for example a smartphone or tablet)
- I don't feel I have the digital skills to access NHS services through an app
- I wouldn't feel comfortable entering personal information online
- I would have concerns about data sharing and privacy
- I don't want to use an app to access NHS services
- Other – please specify
- Don’t know
- None – I don't have any concerns about using an app to access the NHS

BMA Response:

As set out throughout this response, our view is that rigorous safeguards are needed to ensure the security and confidentiality of data accessed or shared via the NHS App, which will be critical to building public confidence in using it.

As also established above, we believe it is essential that any expansion in the use of technology and apps for patients is accompanied by robust measures to prevent and address digital exclusion and the exacerbation of health inequalities. As part of this, it is

crucial for the plan to acknowledge and accommodate that there will be many people who are less able, if able at all, to utilise the NHS App or other tools. Specific consideration also needs to be given to potential language and literacy barriers to using the NHS App.

Q18. A single patient record is a way of bringing together all health and care data about a person in one place, that all the people who care for you can access. What do you think should be prioritised when it comes to rolling out a single patient record? *Please select your top priority.*

- Staff having access to all your records from across different services so you don't have to repeat yourself
- Giving you access to your entire record, tailored health advice and access to testing and diagnostics on the NHS app or website based on your health and any health risks
- Being able to choose to integrate the record with other apps and wearable technology to help you manage your own health
- Saving staff time and freeing up staff resources by making processes more efficient
- Other – please specify
- Don't know
- None of these

BMA Response:

The correct balance must be struck between making the relevant information available to health and care staff when they need it and ensuring the confidentiality of the records are maintained along with public trust in the way the NHS manages health records. There are additional sensitivities around several specialties such as mental health, sexual health and gynaecological conditions, for example, as well as situations where there are concerns about being a vulnerable child or adult. The number of people experiencing domestic violence has been estimated as one in five, for example.

Therefore, a role-based access model is needed to control:

- Who has access to information;
- What information can be accessed; and
- Under what circumstances information can be accessed.

This model needs to:

• Allow health and care professionals relevant and proportionate access to relevant information in the patient healthcare record where needed, and only when they are involved in their care; and

• Create a robust audit trail that records when a patient healthcare record is accessed and by whom, so that inappropriate access can be challenged or investigated, and further action taken if necessary.

Additional reflections:

In addition to the above, we would also like to submit the below points for consideration.

NHS clinical negligence reform:

The current adversarial nature of the NHS clinical negligence compensation scheme does not work for doctors, patients or the NHS and reform of this system should be a key part of future plans for the NHS. The House of Commons Health and Social Care Committee and the Times Health Commission share our call for reform.

The current system is:

Unsatisfactory for patients

- The current clinical negligence system is adversarial and based around litigation, which is invariably extremely stressful for patients.
- The process can take many years, sometimes even decades to achieve resolution and compensation. For example, with birth injuries in England the current average time between notification of a claim and settlement with payment of damages is approximately 6.5 years.
- The sole focus on compensation for the injured patient takes the focus away from the incident, and from learning how to improve systems and processes to ensure patient safety.
- The current system also fosters a defensive culture, rather than a candid and transparent one, which limits its ability to learn lessons and improve service quality and safety.
- Around a quarter of the total money awarded for clinical negligence in England is paid to lawyers rather than to the injured patient.

Unsatisfactory for doctors

- The system is also very stressful for health professionals who feel their professional integrity has been undermined, and for whom the emotional consequences can be very severe.

- There have been cases which have highlighted the fear by doctors that they can end up taking the blame for organisational failings beyond their control.
- Compensation can sometimes be paid to patients without the knowledge of the health professionals involved so they have no opportunity to learn from the incident.
- Healthcare professionals leaving the NHS because of clinical negligence claims has been recognised as "a hidden but real cost of litigation".

Unsatisfactory for the NHS

- In the NHS, the cost of litigation comes from the overall NHS budget thus reducing the money available to spend on treating patients.
- Over the last 10 years the number of claims and the cost of litigation has increased significantly -in England in 2023/24 this was £4.7 billion.

Our proposals for reform:

1. Reform the current adversarial clinical negligence system to tackle the rising number and cost of clinical negligence claims and enable a move away from a 'blame' culture to a culture of learning to deliver high quality, safe services across the NHS.
2. Make a gradual move to a no-fault scheme, based broadly on the New Zealand model, starting with one specialty as a pilot to learn lessons and refine the system. The no-fault scheme would remove the need for legal representation for the parties, with attendant legal costs. However, each potential claim would be submitted for evaluation, and review by a panel of trained independent clinical experts to determine whether the injury was a result of the treatment, and to ensure, as far as possible, that exaggerated and fraudulent claims are excluded from the process.
3. Introduce a national system to investigate clinical errors and systemic failings to make findings and recommendations that will improve safety and learning, both locally and nationally, and to ensure that patients are provided with appropriate apologies, explanations, and assurance that improvements will be made.
4. Amend S2(4) of the Law Reform (Personal Injuries) Act 1948 so that it no longer applies to public bodies. This would remove the current provision which requires that compensation is calculated to cover the cost of private treatment, with no obligation to use the money in this way. Other properly funded arrangements would need to be put in place, however, to ensure that patients who are harmed by treatment in the NHS do not face long delays accessing the treatment and social care they need.
5. Standardise the loss of earnings claims for children and young people under the age of 18 (the current system differentiates between high and low earning parents).

Reform of patient safety culture and doctors raising concerns:

The BMA has consistently called for reform to the NHS culture surrounding patient safety issues and doctors raising concerns about safety – including via whistleblowing. We believe this should be addressed within the 10 Year Health Plan, as we set out briefly in our submission to the initial Change NHS consultation, for the benefit of patients and all NHS staff.

This reform must involve the creation of a genuinely supportive learning environment for staff, with the acknowledgement that errors may result from the environment in they work rather than being the fault of an individual. This is especially important given the extent of the pressures on the NHS, including vast waiting lists and the corridor care crisis.

Steps also need to be taken to ensure all grades of doctor and doctors from all kinds of backgrounds feel confident in raising safety concerns. Crucially, rigorous steps must also be taken to support and protect whistleblowers who put themselves at risk to report safety concerns.

The role of the private sector:

The BMA also has broader concerns regarding the potential place of private provision of NHS care within the 10 Year Health Plan, which we wanted to highlight here.

The Government's elective reform plans in particular, but also elements of its broader health policies, have included a notable focus on the role of the private sector. We are concerned that this has the potential to bake-in private sector involvement throughout the NHS and, in so doing, could see scarce resources directed to for-profit companies and undermine the long-term financial stability of the health service.

These concerns are in part driven by longstanding problems linked to 'cherry-picking' – whereby private providers of NHS services concentrate on less complex cases that generate greater profit, while leaving the NHS to manage more complex and more expensive care.

Therefore, while the BMA has recognised the need to use all available capacity to help bring down waiting lists, we believe it is critical that any inclusion of the private sector within the 10 Year Health Plan is time limited, fully transparent, provides rigorous value for money, and that long-term investment in the NHS remains the priority.

Reform to data handling in general practice:

In order to ensure that GPs can most effectively support new government programmes that change how data is handled in general practice, central information governance liability cover – equivalent to NHS Resolution's clinical liability cover, should be provided. This would cover any issues arising from GPs compliance with centrally led and novel data programmes. Extension of this coverage would absolve practices of the financial risk (resulting from ICO fines and/or civil cases) that comes with changing how data are handled and would ensure that GPs could much more easily comply with instructions set out by the secretary of state.