The British Medical Association (BMA) is a politically neutral professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. The BMA has a total membership of around 168,000 representing around two-thirds of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 members.

We welcome the opportunity to respond to the Health and Sport Committee’s call for views on whether NHS boards adhere to good governance.

Below are BMA Scotland’s responses to the questions posed.

- **Do you trust NHS Boards to make decisions that are in the best interests of the public?**

NHS boards in Scotland operate in the context of many, often competing, demands. The BMA believes that boards are forced to prioritise the challenge of meeting rising demand for services, with insufficient resources and the pressure to meet politically driven targets. This creates a system often stretched beyond its means, that does not always put the patient, or the best interests of the public, first.

Indeed, the BMA has warned for some time that there is still simply not enough money for the NHS in Scotland. We need a long term, sustainable plan that closes the growing gap between resources – in particular finances - and the demand for services. The BMA believe that multiple targets, an ageing population and the funding gap are creating a vicious circle, putting the system and NHS boards under increasing pressure.

This is already having an impact, with services beginning to deteriorate and patients suffering as a result. NHS boards are still faced with having to make considerable savings and being forced into decisions over where to direct insufficient resources, rather than being able to make choices that fully meet local needs.

The BMA believes that, in these circumstances, boards are often unable to prioritise what is best for the public. BMA members have indicated that they believe that as finances get further stretched, the public interest will be subsidiary to meeting targets and breaking even.

It is only through tackling this growing funding gap between resource and demand, and using NHS data in a more mature way that puts the emphasis back on the judgement of their own doctors, that NHS boards will truly be able to make decisions focussed entirely on what is in the best interests of the populations they serve.

NHS Boards also exist in a political and policy environment that dictates a lot of what is and isn’t possible. The overall policy context is set by the Scottish Government. So, for example, the
Scottish Government’s plans for elective centres across Scotland are something boards have to adapt to, and deliver, without necessarily starting from the perspective of what is best for the local population they serve. Similarly, boards need to be aware of the political climate in which they plan services. While there may be good reasons for altering service delivery to improve care, in some circumstances there could also be possible political resistance based on the interests of specific communities or local groups. These, of course, may be perfectly valid concerns, but they nevertheless illustrate the different demands and considerations boards face when making any decision, which may not necessarily coincide with what is best for the whole population they serve.

Equally, the BMA are clear that boards need effective ways of engaging with, and listening to the views of the public. Too often this can lead to the voices of those who are most vocal being heard, while the views of hard to reach members of the public often go unheard and are not considered. Effective engagement with the public on an ongoing basis, not simply when services are due to change, is crucial for boards to both understand and respond effectively to what is in the best interests of the public.

- Are NHS board decisions open and transparent?

At a board level, and through board meetings, decisions are generally open and transparent. They are published through board papers and meetings are open to the public. Local and national media coverage of board meetings often helps ensure that decisions are well publicised and that the public are informed and aware.

It is crucial that boards continue to work with local communities to ensure they are informed of, can offer views on, and participate in decisions relating to the delivery of the care they rely on.

However, below board level, BMA members believe the decision-making process is often less clear and transparent. Decisions taken at board level are high level and do not reflect the large number of decisions taken across all levels of a health board, which staff often do not feel they are consulted on, or are even aware have been taken.

This can involve spending decisions that are not included in the high-level financial choices often made at board level. For example, the differential resourcing of some services, and decisions to prioritise one service are often not clear or transparent to staff working in those services. Equally the public are often unaware of the choices being made. Of course, institutions need to balance the level of involvement in decision-making with the need to avoid systems that are too cumbersome to allow choices to be made. However, there is a clear requirement that boards, at all levels, are open and transparent about the decisions being made and the reasons behind them.
On that basis, it is not open and transparent to simply put a decision into the public domain and communicate it to staff. Instead, the reasoning and evidence for such decisions should be clear and easily available. Boards need to be open about the views provided when gathering evidence, both for and against decisions, so that those working at a health board, or living in the area, can understand the justification.

However, just as important is the involvement of clinicians and the public at an early stage of decision making. BMA members often report feeling consultation comes too late, when preferred options are already identified and the impression is decisions are already taken. This can often then feel like a tick-box exercise. Instead, meaningful consultation should start early in the process and involve staff and the public in finding the best possible solutions to improve care.

There are also clear local mechanisms through which staff can be consulted, that boards choose to by-pass, or not pay sufficient attention too. Area Medical Committees and local staff groups such as BMA Local Negotiating Committees (LNCs), and Local Medical Committees (LMC’s) for GPs are clear means for boards to engage their medical staff and ensure they are sighted on decisions. Boards need to ensure this is done consistently and in a way which provides staff with a genuine chance to influence and understand decisions, to ensure they deliver effectively for the public.

- How accountable do you believe NHS boards are?

The BMA believes that it is not clear how NHS boards are accountable to the local populations they serve.

Boards are primarily accountable to the Scottish Government and the Cabinet Secretary for Health. As a democratically elected politician, this provides a link to the public in terms of accountability, but this is only at a high-level, that will make little difference to the kind of local issues and accountability that are so important to areas that health boards serve.

While non-executive members of NHS Boards can hold the board’s Executive Team to account via board meetings and scrutiny of performance, it is not clear:

- how consistently effective this is;
- whether non-executives are representative of their local population;
- or whether systems and reporting are always sufficiently open and transparent enough to allow the level of scrutiny required.

Accountability is also often intrinsically linked to performance against the current set of targets that exist for healthcare in Scotland. The BMA believe that this can mean that judgement and accountability is only made against certain high-profile measures, often centred around waiting
times and often not providing a full picture of how a health board is serving its local population, or the outcomes it is delivering. The BMA believes a more mature approach to targets, that places more faith in the judgement of doctors, will help bring greater focus to outcomes, and whether boards are taking the right measures to improve health of their local populations. Fundamentally, a greater focus needs to be placed on whether high quality is provided to individual patients, that helps their specific circumstances, rather than simply how long they waited. Only through this kind of accountability will the delivery of health services better reflect the needs of individual patients and the populations that health boards serve.

A further consideration concerns the Integration Authorities (IAs) now operating across Scotland. These bodies also lack direct accountability and concerns have been highlighted over the current levels and standards of engagement that IAs have with stakeholders and their local communities (including by the committee itself). With an apparent lack of knowledge, understanding and engagement at a local level over what is done by an IA, or a health board, the lines of accountability to local populations are likely to become even less clear. As the committee itself has pointed out, there is a need for better, high quality engagement from IAs. Health boards also must have a role to play, in setting out clearly to the public which bodies are responsible for their care, and decisions about provision of that care.

- **How effective are NHS boards at delivering health services and improving the health of their population?**

This is an extremely wide-ranging question and is essentially too broad to provide a comprehensive response. As the BMA has set out in responses to the questions already asked, we believe a combination of insufficient funding to meet demand, a workforce that is overstretched, and an arbitrary set of politically driven targets means that health boards are often unable to provide the high-quality services that local populations demand and deserve. That leads to variable delivery of health services across the country. Where this pressure is greatest, it is clear to see that patient care is deteriorating already.

On that basis, boards and the national Government need to improve how they plan care both in the short and long term. While the pressures experienced this winter may have been considerable, they are also a symptom of a system where demand is continuing to outstrip resource, and the gap between the two is growing. With the challenge presented by an ageing population and more people suffering from multiple and complex illnesses, there is a clear need for change, based on improved planning and forecasting of demand. Regional planning is being introduced across Scotland, meaning boards must work more closely together to plan to meet demand. While fundamentally, there is a requirement for more resources and more staff across the system, any regional plans brought forward must be used as an opportunity to model the needs of local communities more effectively and ensure services are designed to deliver the best possible outcomes at a local, regional and national level.
Even if this is the case, it should be noted population health is about far more than the services that health boards deliver. Wider factors, such as housing, education and poverty are all key determinants of population health over which boards have no control. Judging boards on improving the health of the population is futile, unless wider social trends and determinants are taken into account.

Finally, the urgent pressures described throughout this response, can often divert attention and resources from any long-term goal health boards may have in terms of improving the health of their population. With considerable pressure in place simply to meet the day to day demands of their local population, it is not clear that health boards either consistently have the capability or resources to deliver a fully effective public health function.