Securing the future of Scotland’s health service

BMA Scotland briefing to accompany its manifesto for health in the Scottish Parliament elections 2016
Introduction

The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 154,000, which continues to grow each year. In Scotland, the BMA represents around 16,000 members.

The BMA Scotland manifesto for the 2016 Scottish Parliament elections sets out doctors’ priorities for the future of the health service in Scotland. It forms our contribution to the public debate on the challenges facing the NHS and how these challenges should be met.

We believe that our manifesto policies will deliver a high quality health service for the future and we encourage political parties to reflect on these as they consider their priorities for health.

Address the funding shortfall for health

All parties must be honest with the electorate and state clearly in their manifestos whether they will close the funding gap faced by NHS Scotland or set out what range and models of health services they will realistically pursue with currently planned resources.

The NHS is facing a number of pressures which impact on NHS boards:
– An ageing population and an increase in the number of older people with complex care needs
– More people living with long term conditions and multiple conditions
– More people seeking emergency and urgent care
– More people being treated in outpatient and day-case settings
– Recruitment and retention of health professionals (including medical staff)
– Improving patient flow from admission to discharge back into the community.
Figure 1 – Changing profile of population in Scotland, 1911 – 2031

Figure 1 shows clearly how the profile of the population has changed already, and how much more it is expected to change over the next 15 years. It is projected that there will be an 86% increase in the population age 75 years and over between 2012 and 2037 and a 151% increase in the population aged 85 years and over.  

Analysis of the impact of this ageing population on demand for hospital beds was carried out for NHS Forth Valley, and is illustrated in Figure 2. It shows a projected increase in demand for bed days for those aged 65 or over from around 2500 in 2014, to over 4600 by 2035 – a new, additional hospital would need to be built unless care is remodelled and provided in a different way, in a different setting.


Figure 3 provides a different view of the challenge, illustrating the relentless increase in multimorbidities with age, across all socioeconomic groups, with over 70% of people aged 75 and over living with multimorbidities. Clearly as the number of people aged over 75 almost double between 2012 and 2027, the number requiring care and support to manage multimorbidities could be expected to increase at the same rate.

Whilst there are pressures arising from increased demand, NHS Boards are required to achieve annual financial and performance targets amid rising cost pressures such as staff pay costs, the growing costs of drugs and other health technologies. Figure 4 demonstrates that despite increasing costs, the combined NHS Scotland capital and revenue has seen a slight decline of 0.7 per cent since 2008/09.

3 NHS Forth Valley [accessed 20 August 2015] Shaping Services for the Future
5 On socioeconomic status scale 1= most affluent and 10= most deprived
As well as meeting these rising cost pressures, NHS boards will be expected to achieve 3.5% efficiency savings in 2016/17. Audit Scotland has reported\(^6\) that in order to achieve financial targets in 2015, many NHS boards relied on one-off savings, and two boards required extra financial support from the Scottish Government to break even, demonstrating that there is very little scope to achieve further savings without impacting on service delivery. The requirement to meet annual performance and financial targets can divert NHS boards away from longer term planning to be able to respond to the known future pressures.

**FIGURE 4 – NHS Scotland budget changes in real terms 2008/09 to 2014/15\(^7\)**

In order to maintain services to patients, existing NHS staff are working harder to fill gaps and maintain quality of care but this is not sustainable as a long term solution to the pressures.

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6 Audit Scotland (October 2015) *NHS in Scotland 2015* Audit Scotland: Edinburgh  

7 Audit Scotland (October 2015) *NHS in Scotland 2015* Audit Scotland: Edinburgh  
Recruit, retain and value doctors

There must be immediate action to make Scotland a more attractive place for doctors to work and ensure that vacant posts are filled.

All NHS boards must be required to adhere to nationally agreed contracts to ensure that Scotland attracts and retains doctors in a global market.

Doctors are dealing with rising demand, unmanageable workloads and increasing pressure in a service that is clearly struggling to cope with shortages. This situation is not sustainable and doctors in Scotland are working under significant pressure and increasingly having to cover gaps in the face of rising vacancies. There are a number of actions which could be taken by government to address disincentives for doctors to work in Scotland including addressing the problem of health boards not adhering to nationally agreed contracts, and removing unnecessary hurdles which stand in the way of doctors returning to work.

GP vacancies
The increasing intensity and complexity of GP workload, the shift of more specialist care from hospitals into local communities and extended access initiatives means that general practice has reached saturation point. Without additional resources and capacity, it will be impossible for general practice to respond to the rising demand of an ageing population.

We are hearing increasingly from members about local issues of recruitment and retention and in some areas, such as Grampian and Dumfries & Galloway, this has resulted in practices having to close. The closure of GP practices affects the provision of local patient care and is a situation that nobody wants to see, but there is a real risk that it will happen more and more frequently if action is not taken to improve the recruitment and retention of GPs.

The BMA is working with the Scottish Government to develop a new GP contract for 2017 that once again makes becoming a GP an attractive career option, but until then the priority must be ensuring that GPs in communities across Scotland have the support they need to provide the care patients rely on.

A recent BMA survey found high vacancy rates in GP practices in Scotland, which are leaving practices struggling to cope. 20% of the practices who responded had at least one GP vacancy.

The survey also revealed the difficulties practices face in trying to secure locum cover, with 75% of respondents stating that they were unable to secure a locum on at least one day over a one month period. In more extreme cases, practices had been unable to secure locum cover for 15 days or more within the one month period.

Scotland is facing significant GP recruitment problems which are being further exacerbated by difficulties in securing locum cover. An ever increasing workload, combined with falling resources, has led to a reduction in the number of doctors choosing to train as GPs, while senior GPs are choosing to retire early or work abroad for a better work-life balance. A high vacancy rate translates into a decline in the number of available appointments – reducing access to general practice at a time when we are trying to treat more people in their communities.
Consultant numbers and vacancies

National figures suggest that there are around 4943 WTE consultants working in the NHS in Scotland.\(^9\) The data also shows that consultant vacancies are rising, with a rate in June 2015 of 8.3%, compared with a rate of 6.9% in June 2014. Of these, 188.0 WTE were vacant for more than six months, an increase of 95.1 WTE on June 2014.

Vacancies not filled through the recruitment process and posts that are not yet cleared for advert are not always included in the official figures. Moreover ISD figures do not fully reflect the heavy reliance on locum doctors that boards are using to cover vacant consultant posts. The use of locums is a temporary solution and does not provide long term sustainability. It is therefore vital that these posts are included in vacancy data to enable proper workforce planning.

Vacant posts place immense pressure on the service. When NHS boards cannot fill a post other doctors within the team have to cover the workload or the service provided may be reduced. Staff are asked to work increasingly longer hours and more intensely to fill the gaps. Audit Scotland has reported\(^10\) that vacancy rates, staff turnover rates and sickness absence levels have all increased during 2014/15. Recruitment and retention of staff on permanent contracts remains a significant problem for many boards. As a result boards are now hiring more temporary staff to help keep services running. This is not a viable long term solution.

Trainee and specialist posts

Unfilled trainee posts are a further source of pressure on the health service that can leave services struggling to cope with gaps in healthcare teams. This problem is particularly pronounced around certain training specialties.

For example, in 2015 just 24% of emergency medicine trainee specialty vacancies were filled and only 78% of GP trainee vacancies were filled. Meanwhile mental health specialties have faced particular problems in filling trainee vacancies for a number of years.

Ensuring that trainees are attracted to work in Scotland needs to remain a priority. The Scottish Government’s announcement that it will not unilaterally impose a new contract on junior doctors in Scotland is a positive step in this direction and all parties should commit to taking the same approach.

Adhering to nationally agreed contracts

Consultants have always been leaders in developing and improving the delivery of patient care. Since 2004, a clear and specific amount of time has been allocated in consultants’ job plans to recognise this work, which is called SPA time (Supporting Professional Activities). SPAs are at the heart of what it means to be a consultant and exemplify the added value that consultants bring to the NHS. It is during the time made available through SPAs that consultants are able to improve and hone their skills through auditing their practice, research and innovation, developing new techniques and building new services. Such activities are essential to the long term maintenance and improvement of the quality of the service provided to patients alongside more readily recognisable direct, hands-on patient care.

The consultant contract sets out the standard number of supporting professional activities, 2.5 per week on average or 10 hours (paragraph 4.2.2\(^11\)), that should be made available to a full time consultant, with variation from this standard being subject to agreement between the employer and the individual consultant.

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9 ISD Workforce report, September 2015 http://www.isdscotland.org/Health-Topics/Workforce/Publications/index.asp#1465
11 4.2.2 Unless otherwise agreed, a full-time consultant will devote 7.5 programmed activities per week to direct clinical care, and 2.5 programmed activities to supporting professional activities. Part-time consultants will require an allocation for supporting professional activities that is higher than the pro-rata allocation.
However, SPA time is being eroded in some areas, and many consultants are on contracts with fewer than 2.5 SPAs a week, such as a split of 8.5 to 1.5 or even 9:1. The understandable driver for this is to ‘get more hands on time’ from a consultant. The logic of this falls down if we want a health service which continues to excel and develop with the next generation of doctors properly trained.

SPAs are not an allowance for the comfort of consultants, nor are they time away from the wards at the expense of patient care. Rather they are vital in allowing consultants the time and space to develop their skills, train junior staff and maintain and improve services and techniques which directly benefit patient care and safety.

SPAs form a key part of the job plan and the BMA is clear on the issue – any deviation from 2.5 SPAs should be questioned by the consultant concerned and the consequences fully understood. By maintaining appropriate SPA levels the BMA seeks to defend the quality and safety of care we can offer to patients.
Prioritise the clinical needs of patients

*Action needs to be taken locally to ensure that senior doctors are able to speak out on behalf of patients, and influence how the services patients need are best provided and sensibly prioritised.*

*A review of the now outdated approach to targets should be undertaken to ensure that resources in the NHS are not skewed, and that clinical judgement is prioritised.*

The changing work experience of consultants

Research from the Universities of Dundee and Glasgow\(^1\)\(^2\) suggests that whilst consultants remain “highly engaged with their jobs, their clinical colleagues and with the values of the NHS”, it also identified a high level of frustration at their “lack of opportunity to express their ideas and feelings, and to participate in decision-making over issues that directly affected their working lives”. Consultants are concerned that the dominance of business and political rationales in key decision-making is at the expense of effective and efficient patient care.

NHS Boards need expert input from their consultant body to inform both strategic planning and the ongoing implementation of safe and efficient patient services. To achieve this, NHS Boards and their consultants need to work together to redevelop the necessary climate of mutual trust, respect and understanding to allow meaningful clinical conversations to take place.

All NHS resources, including consultant and senior management time, should be used as efficiently as possible. We should avoid creating additional bureaucratic structures, but should use the current available mechanisms in a more effective way. As a first step, we recommend much better use be made of the existing statutory local medical advisory structures (i.e. the Area Medical Committee, Consultants subcommittee, specialty subcommittees etc.).

While these structures function well in some NHS Board areas, the overall picture is patchy. Where these committees do work effectively, they bring significant benefits. They sit side by side with the management structure, and allow consultants to provide medical advice and opinion independent of those pathways.

They also allow NHS Boards to be confident that they clearly understand the concerns, hear the advice, and benefit from the expert input of experienced senior doctors who are working at the front line of service delivery. Importantly, they allow senior management and consultants to meet in an atmosphere of mutual trust and respect, which can help drive the overall culture of an organisation. Senior doctors must feel able to speak out on behalf of our patients and the services they need, and influence how they are best provided and sensibly prioritised.

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\(^1\) The changing experience of work of consultants in NHS Scotland, G Martin, B Howieson, S Bushfield, May 2015
Health and social care integration
Integration of health and social care is already being taken forward in the form of Integrated Joint Boards (IJBs) and their associated localities. The BMA did not call for these new structures but they are now established in law and will have oversight of a considerable portion of the health budget.13

Effective engagement of doctors is a key factor in the success of the integration agenda. A major component of this will be the engagement of general practitioners in the integration authorities. We have suggested the creation of GP cluster groups working closely with Local Medical Committees within integration localities. IJBs should provide practical (administrative) support and sufficient financial assistance to allow at least one GP from every GP practice to participate. The GP cluster group would be the locus for:

Peer review of quality within general practice
1. Practice collaboration
2. Developing best practice
3. Through GP Clusters, identifying and improving patient outcomes, experience and service quality within local NHS and social care service delivery
4. Enabling and empowering primary care medical managers to take practical action to seek improvements to service delivery and address GP concerns about patient outcomes, experience and service quality

In simple terms, we believe that GPs need to be in a position of influence, working to help make health and social care organisations, and the services they provide to patients, a success.

Clinical priorities and targets
NHS boards are required to meet a number of performance targets and standards that the Scottish Government sets each year. Audit Scotland reports that in 2015, the NHS in Scotland missed seven of its nine key waiting time targets.14 The report concluded that an ageing population and higher activity levels makes achieving targets more difficult.

Failure to meet certain targets can increase pressure elsewhere in the service and can impact on the effective management of patient flow. It can also mean that priority is given to specific services to meet targets at the expense of other services, which do not have to meet targets.

The Scottish Parliament’s health committee recently questioned whether NHS Scotland performance targets are an efficient use of public money and called for flexibility in the way they are applied.15 The committee warned that there is currently no way to assess how much health boards are spending to meet performance targets.

BMA Scotland believes that targets can skew clinical priorities, and that the clinical needs of patients should always be the driving force behind patient care. We also believe that the current approach to pursuing targets at all costs is contributing significantly to the managerial culture reported by consultants.

We support a review of the current approach to setting and implementing targets and the development of an evidence based approach to driving quality by changing how we measure and set targets so that we do not skew clinical judgement and allow the flexibility to prioritise patients with the most urgent clinical need.

13 Integrated Joint Boards will control £7.6 billion of the total health and social care budget, which is £12.3 billion p.a. (2012/13 figures).
14 Audit Scotland (October 2015) NHS in Scotland 2015 Audit Scotland: Edinburgh
http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/92814.aspx
Prevent ill-health and support self-management

Personal responsibility for health should be encouraged and adults and children should be educated on the appropriate and best use of healthcare services.

An entitlement to a free portion of fruit or vegetable on every school day should be introduced for all primary school pupils in Scotland.

Health inequalities
Although Scotland’s post-devolution policy approach to addressing health inequalities has generally been well received, health inequalities have remained stubbornly persistent. There are still significant challenges to improving overall population health in Scotland. It is widely recognised that the most important policy levers to address health inequalities are outwith the realm of health policy. If real progress is to be made, significant efforts will have to be made across a raft of policy areas outwith health and by different agencies collaborating and working more effectively together.

Use of healthcare services
The BMA believes that children and adults should be given more information about how to get the best value from the NHS for themselves and their families to maximise health outcomes and minimise wasted use of resources. We believe that schools should teach the responsible use of public services to pupils, alongside other health choices and behaviours.

Early years
More than 8,000 babies every year need specialist hospital care at birth in Scotland.16 The main reasons for requiring this care are premature birth and low birth weight and there are strong links between these and social deprivation. Giving children the best start in life begins before birth and into early years of childhood:

Alcohol
FASD (Foetal Alcohol Syndrome Disorder) is a term used to encompass a wide range of physical, mental and behavioural effects that can occur in the children of mothers who consume alcohol during pregnancy. There has been limited work on FASD in the UK, however as data on incidence begin to emerge, it is clear that the most at risk are those who experience a high degree of social deprivation and poverty.

Smoking
Maternal smoking during pregnancy is the largest preventable cause of neonatal and infant ill health and death in the UK.17 In 2013, almost one third (29.8%) of pregnant women in the most deprived quartile of the population report smoking, compared to just 6% of the least deprived quartile.18

Exercise/obesity
Figures for 2013/14 report that in the least deprived areas 17.8% of children were classified as at risk of overweight and obesity compared to 25.9% in the most deprived areas.19 Consumption of fruit and vegetables amongst children in Scotland is poor, with the average portions consumed per day remaining at around 2.8 since 2003.20

16 BLISS – http://www.bliss.org.uk/
17 BMA Board of Science and Education. Breaking the cycle of children’s exposure to tobacco smoke. 2007 http://bma.org.uk/working-for-change/improving-and-protecting-health/tobacco
18 ISD Births in Scottish Hospitals – smoking at booking by SIMD, year ending 31 March 2013 http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/index.asp#1285
19 ISD Primary I BMi Statistics 2013/14, Published February 2015 http://www.isdscotland.org/Health-Topics/Child-Health/Publications/index.asp#1359
Currently, 11 of Scotland’s 32 local authorities have some form of free fruit & vegetable scheme in place in addition to what is provided as part of a school lunch. This is down from 16 local authorities that had schemes in place as recently as 2013/14.

The BMA has called for a range of action to improve diets and reduce obesity, including the provision of a portion of free fruit and vegetables to every primary age child on each school day. This proposal was backed by 79% of parents across the UK in an Ipsos MORI opinion poll for the BMA.

Ensuring that children in particular are eating enough fruit and vegetables is especially important at a time when they are forming habits that will last throughout their lifetimes.

**Adults**

The major public health challenges of alcohol, tobacco and obesity remain major financial burdens on the NHS and society more generally. Investing in measures that can help to change behaviour in these areas can help to significantly reduce the pressure being put on the health sector.

**Alcohol**

The cost of alcohol to Scottish society has been estimated at £3.6 billion a year and there were 1,152 alcohol-related deaths in 2014, an increase of 5% on the previous year.

Although the introduction of minimum pricing continues to be delayed in the courts, it remains a key policy that will help to reduce consumption amongst the most harmful drinkers. Maintaining support for this policy across the political spectrum must remain a key priority.

**Smoking**

In Scotland, tobacco use is associated with more than 13,000 deaths and around 56,000 hospital admissions every year. The Scottish Health Survey found that in 2014, 22% of adults in Scotland were smokers.

Smoking remains one of the major causes of preventable disease and premature death and is a source of major financial pressure on the health service.

While smoking prevalence has been gradually declining over the years, achieving further progress must remain a priority for public health if Scotland is to meet its target of a tobacco free generation by 2034.

**Obesity**

Scotland has one of the worst obesity records in the OECD and the costs of coping with the conditions associated with obesity are increasing. The most recent Scottish Health Survey found that 65% of adults were overweight, 28% of whom were classed as obese.

While recent years have seen action on reducing trans-fats and salt intake, less attention has been paid to the need to reduce intakes of sugar, fat, saturated fat and calories. Addressing sugar-sweetened beverages in particular should be a priority as they are high in calories but contain little nutritional value.

Taxation has consistently been shown to have the potential to improve health and the introduction of a tax of 20% on sugar-sweetened drinks could help to achieve significant progress in reducing obesity.

Scotland has made good progress in introducing mandatory food standards for schools and hospitals in recent years, but less progress has been made in care homes. Addressing the inconsistent standards of food that care home residents receive should be addressed through new mandatory national standards.

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22 Scottish Government [accessed 26 October 2015] [http://www.gov.scot/Topics/Health/Services/Alcohol](http://www.gov.scot/Topics/Health/Services/Alcohol)


Support Scottish general practice

All parties should commit to working with the BMA to ensure that patients have access to a range of health professionals and to allow GPs to focus their time on those patients with the most complex care needs.

In August 2015 the Scottish GP Committee and the Scottish Government put in place a period of contractual stability until April 2017 to reduce the burden of yearly contractual change on practices and allow time to develop a new GP contract in Scotland. With this period of stability and broad support for change there is a window of opportunity to pursue real and meaningful change to the contract in Scotland.

General practice is under considerable pressure from compounding problems of workforce shortage and unsustainable workload. Unfortunately, the evidence to support this is very clear – a growing number of practices are struggling to remain viable under the national contract because of recruitment and retention problems. The role of the general practitioner in the future must best utilise the experience and skills of these doctors to address the health needs of the community and improve recruitment and retention to strengthen general practice.

Demographic change brings increasing numbers of elderly patients that require complex care. This is having, and will continue to have, a profound impact on demand on the NHS. Scottish Government policy is clear – the bulk of additional patient demand will need to be met and managed within the community. It is unlikely there will be additional hospital beds.

General practice can help to meet the challenge of demographic change but to enable GPs to do so will require sweeping change to the structure of the contract and the role and responsibilities of GPs.

BMA Scotland is proposing a revised role for the GP from 2017, where GPs as senior clinical decision makers will focus on:

- Complex care in the community
- Undifferentiated presentations
- Whole system activity – quality improvement and clinical leadership teams

We want to build and support the practice based primary care team to ensure that patients have access to a range of services and to allow GPs to focus their time on those patients with the most complex care needs.

This is an opportunity to make general practice a more attractive career option for doctors in the longer-term.