

# Secondary care matters

Shaping the future of safe,  
sustainable hospital-based  
healthcare in Scotland



Caring, supportive,  
collaborative  a future  
vision  
for the NHS

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## Chair's foreword



Simon Barker

Since its inception the NHS has maintained an implicit contract with the people of Scotland that if your care cannot be provided in or near your home, there will be a bed in a hospital where we, the team of hospital doctors, alongside colleagues from other healthcare professions, will seek to restore your health. We all rightly assume that when health goes badly wrong, the best of care will be there for us in the GP surgery, in A&E, in hospital clinics and operating theatres, through investigations, wards and therapy centres, and in maternity, paediatric or geriatric hospitals. It's our need to deliver on this reasonable expectation that underpins our purpose and motivation as hospital doctors. The dream of comprehensive care free at point of delivery is realised in our NHS, something worthy of celebration and definitely worth cherishing.

Therefore, bearing witness to our hospital system struggle and creak under the pressures of ever-increasing demand in the face of tighter and tighter resource stringency is an unhappy situation for doctors alongside the patients we are striving to help. This cannot go on indefinitely without adverse consequences for patients, and we are prompted to seek a better way forward.

Hospitals are occasionally joyful, sometimes a place of relief, often a place of distress and usually somewhere to be avoided. It is perhaps this mixture of emotion they generate that contributes to the distinct lack of consideration the hospital sector experiences as a coherent entity. Put simply, we take our hospitals and those that work in them for granted. Above and beyond the patient in need, there are a plethora of committees, organisations and authorities that make demands of our hospital sector, yet frequently these are poorly or completely un-coordinated requirements to fulfil this or that 'priority', lacking a system-wide approach to ensure we are resourced to deliver on these expectations.

For those working at the front line, it is not difficult to identify the challenges our hospital sector faces in Scotland. We all went into medicine to provide the best care possible, yet it is an increasing and daily challenge to 'make it work' for our patients in a system which is increasingly blind to its shortcomings. We have highlighted some clear examples in this vision document, but we believe in moving beyond these problems to develop solutions. The answers will necessarily be situationally specific, but clear principles can usefully guide us to a better way forward: one that can be owned by the patients we serve alongside us as clinicians delivering their care; as well as by those who manage or commission our services.

Developing this vision for secondary care forms part of our professional response as senior doctors to draw appropriate focus to the stresses our hospitals now face and to appeal to our politicians to consider seriously and holistically the secondary care sector. It is only by taking a coherent and coordinated approach to secondary care alongside primary care that we can hope to deliver an integrated experience that optimises the care of patients across the nation. My sincere thanks are due to dedicated colleagues the length and breadth of Scotland who have helped to shape this vision, and to BMA staff who have helped to bring it together. We sincerely hope this contribution will be received positively and that we can look forward to open, honest engagement in the future between our profession, our employers, our politicians and the people of Scotland whom we all serve.

We owe it to our patients to get this right.

Simon Barker, Consultant paediatric orthopaedic surgeon  
Chair, BMA Scottish consultants committee, Summer 2019

## Key facts



Scottish BMA doctors surveyed in 2018 told us they believe current **staffing levels are not adequate to deliver quality patient care**

Most Scottish doctors feel that **financial targets are prioritised over quality of care**



The Scottish Government **health budget for 2017/18 was £13.2bn**, which represents 42% of its total budget

**Almost half of NHS expenditure is on staff costs: £5.7bn in 2017/18**



The projected NHS Scotland **funding gap** in 2023/24 based on 2018 Scottish Government analysis is **£159m**

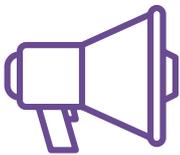
Since 2008, real terms take **home pay for consultants has declined by up to 30%**

The number of **patients in Scotland waiting for first hospital appointments has increased significantly** since 2014: by **26.9%** for outpatient appointments and **34.9%** for inpatient appointments



## Summary – key messages

1. Secondary care needs to be holistically and coherently planned, with sustainable funding to deliver equitable and comprehensive health care services to the people of Scotland regardless of location, personal characteristics or social situation.
2. Secondary care needs to cultivate a culture of open, honest, transparent working that values employees as its greatest asset, with services led by consultants who are responsible for the teams who deliver those services. Service plans should inform Board, Regional and National plans in a reversal and rebalancing of the traditional 'top down' approach.
3. The measures of success must be focussed around quality and outcomes that matter to patients.
4. Decisions around structures and care delivery need to be transparent, demonstrate awareness of consequence, and be responsive to actively-sought views of patients, staff and society.
5. We know from our 2018 survey that 93% of Scottish doctors are sometimes fearful of making a medical mistake, with 86% citing lack of capacity and workplace pressures as the main reasons that medical errors occur.
6. Hospital doctors currently comprise 8.5% of the total NHS Scotland workforce. Although consultant numbers have increased slightly, this is outweighed by the number of consultant vacancies – BMA figures indicate that the true vacancy rate is almost double the official NHS ISD figures.



**We are calling for a collaborative and sustainably funded structure, a supportive culture, and a valued workforce**

## Introduction

### What is secondary care?

Secondary care is specialist physical and mental health care. It focuses on specific health care conditions or parts of the body that require investigation and treatment that cannot be provided in general practice. It covers a wide range of specialties that are complementary to primary and community-based care. It is hospital-based and often, but not exclusively, provided in hospital settings.

### What is the purpose of this vision?

This vision for secondary care covers hospital services plus those specialist services provided outside a hospital setting, such as community paediatrics and community psychiatry. Developed by Scottish consultants, it sets out a principles-based approach to shaping the future of safe, sustainable secondary care in Scotland. It is intended to contribute to the debate on how to transform the planning and delivery of secondary care services in Scotland in a way that complements and integrates with services provided by colleagues in primary care.

### Why does it matter?

NHS Scotland employs more than 140,000 whole time equivalent (WTE) staff across its 14 NHS local boards and eight national boards. This includes 5,282.7 WTE (5,705 headcount) medical consultants working in Scotland's 274 NHS hospitals and providing secondary care services outside a hospital setting.<sup>1</sup>

In addition, 924.4 WTE (1,232 headcount) specialty and associate specialist doctors and 5,748.6 WTE (5,961 headcount) junior doctors bring the number of NHS hospital doctors in Scotland to 11,955.7 WTE (12,898 headcount).



## We want our doctors to work in an NHS that recognises and values its employees as its greatest asset

Delivering safe, quality, person-centred care matters to Scottish hospital doctors, to the individuals who receive secondary care services and to their families. It matters to GPs, the providers of accessible local healthcare to Scotland's communities and in turn to those communities that collectively enjoy better life outcomes through improved population health.

Whilst we support a move to community-based care where possible, there will be limits to what can realistically be delivered in the community. General Practitioners need responsive referral mechanisms and access to adequate capacity for those requiring hospital-based assessment and treatment. In turn, patients moving out of hospitals and into the community need resources to meet their ongoing health needs. Blocked beds are a feature of a resource-starved system and will not be solved by shuffling existing scarce resource around. An 'either-or' approach to primary and secondary care is a false dichotomy. We need to strive for excellence across the whole NHS.

Therefore, it is vital that secondary care receives appropriate whole-system attention from those responsible for the funding, structure and workforce planning for Scotland's national health service.

Moreover, if we want this whole system approach to be responsive to what the service needs to deliver, it matters that doctors who are closest to service delivery and patient care take a central role in influencing the development of long-term strategies and system change. We need to ensure that secondary care planning and strategy in Scotland is not fragmented and driven by transient focussed attention on specific areas that is to the detriment of others. There has been no coherent expression of secondary care as an area that deserves holistic attention. As a result, it has suffered from conflicting and contradictory demands.

We believe it is time to change that approach.

## Our vision

*Our vision is a collaborative and sustainably funded structure that enables and nurtures a supportive culture, in which doctors feel they are part of a genuinely valued workforce delivering quality patient care*

## A collaborative, sustainably funded structure

### What needs to happen?

1. We are calling for a sustainable, long-term approach to funding that is realistic about the demand for hospital-based care over the next 5 to 10 years and fully committed to funding it to meet the needs of the people of Scotland for specialist care.
2. We are asking for an open, honest and creative conversation with Scottish Government and the public to address the challenges of fair and proportionate resourcing for primary, secondary and social care between 2020 and 2030 as we collectively work to rebalance aspects of care that can be provided in primary and community settings.
3. We seek a commitment that any reallocation of resource from secondary to primary or community care (or indeed vice-versa) will be managed through a transitional phase that ensures stability of services and quality of care, including an understanding that some double funding may be required until evidence is in place that service transfer is safely completed and delivering the best for patients. Quality outcome measures must at least suffer no detriment when compared to the preceding arrangements.
4. We challenge Scottish Government to progressively increase healthcare spending to 10% of GDP, which would clearly address the projected funding gap for health and social care of £159m<sup>2</sup> (2016/17 prices) and match comparator EU countries (that spent an average of 10.1% of GDP on healthcare in 2017)<sup>3</sup>. Investment in health is an investment in economic prosperity and inclusive growth. In 2017, overall UK health expenditure (including, but not exclusively the NHS) was 9.6% of GDP (79% of which was reported by the ONS to be government financed – i.e. An estimated 7.6% of GDP).<sup>4</sup> In 2017/18, the Scottish Government health budget of £13.2bn<sup>5</sup> represented 8.4% of Scotland's estimated onshore GDP of £157.6bn.<sup>6</sup> If Scotland's health budget had been 10% of estimated GDP (based on these 2017/18 figures) this would amount to £15.8bn, or additional spending of £2.6bn.<sup>a</sup>



## £159m projected NHS Scotland funding gap in 2023/24 based on Scottish Government analysis (Oct 2018)

5. We are asking for a 5-year plan to address current medical workforce shortages through the rollout of multi-disciplinary consultant-led teams designed to deliver the best possible patient care, supported by an effective strategy to fill consultant vacancies in the medium to long term. We propose principles to govern the management of vacancies and their impact on current services (see appendix 2).
6. We are asking for a commitment to prioritise equitable access to services for the whole Scottish population. We must serve the homeless, the frail, and the island dweller as much as the 'internet savvy' city resident. This must include:
  - strategic geographical consideration of the full range of service provision: where reconfiguration of hospital services is being considered, particularly when it involves centralisation around major extended urban areas, care needs to be taken that any changes do not inadvertently destabilise continuing local service provision without adequate mitigation.
  - active consideration of access to services for the disadvantaged or marginalised. For example, service planning should not anticipate that technological solutions will be accessible to all ages and social strata.

<sup>a</sup> The GDP figure referenced is calculated from figures for 2017Q2 to 2018Q1 to align with the annual budget period.

7. We are seeking national performance measures that prioritise quality as well as throughput indicators, with scope to analyse performance based on capacity and resourcing, including the limitations caused by ongoing consultant (as well as other staff) vacancies. Comparisons made between services and variation analysis must be based on a full analysis of contributory factors.
8. We are calling for the development of new services, and reform of services, to be carefully planned around existing provision to maintain stability and quality of care within an overstretched system. We welcome initiatives such as the expansion of resource through planned elective care centres, and potential easing of pressure on existing centres. However, we recognise that there is a risk that the more attractive daytime working hours and access to the latest technology could draw staff away from existing services. We are seeking coherent and collaborative planning across the whole system to make such plans viable and propose principles to underpin such considerations (see appendix 3).
9. We are seeking a commitment to invest in the full digitisation and interoperability of all patient records with a high-quality user-interface and investment in IT infrastructure to ensure that a patient's entire history is fully accessible in real time to clinicians working across the primary/secondary care interface.

## A supportive culture

### What needs to happen?

10. We are asking for a genuinely supportive working environment where doctors are not fearful of being unfairly blamed for wider systemic failings. This will require a fundamental shift in NHS culture that recognises that some errors may result from the challenging working environment in which doctors provide patient care.
11. We are calling for recognition that care providers perform best when empowered to do so. This will require a significant organisational shift within NHS Scotland towards trusting and enabling the teams responsible for an area of service delivery to do precisely that. Constraints must change from stifling ideas and innovation to allowing freedom to act, within clearly delineated, proportionate governance and oversight.



## We want to work in an NHS that welcomes innovative thinking and enables doctors to directly influence and shape strategic priorities

12. We are calling for the Scottish Government to take responsibility for rationalising, coordinating and managing the diverse reporting requirements placed upon health boards and their constituent services. The conflicting demands of mutually incompatible goals creates an impossible situation for health boards. Rationalised measures of performance should be introduced which do not make failure the likely outcome.
13. We are calling for a move towards embracing the Era 3 'Moral Culture' supported (among other things) in the 2013 Berwick review into patient safety.<sup>7</sup>

For secondary care in NHS Scotland the focus of the Berwick Principles should:

**Stop excessive measurement** – the target culture has brought some services into sharp focus, yet it has led to the relative neglect of other areas. Arbitrary time limits are poor surrogates for quality of care and they trap many under-resourced services into a perpetual sense of failure. The political enthusiasm for targets needs to be redirected towards quality outcomes that matter to patients.

**Abandon complex incentives** – Board funding must be equitable, predictable, and not dependent on opaque and obscure mechanisms. ‘Extra funds’ hypothecated for particular purposes tie the hands of those who know where those funds are most needed. Perverse incentives to spend residual budgets by artificial deadlines lest they are ‘clawed back’ are not helpful. A transparent approach to funding that is genuinely informed by clinicians, based first and foremost on patient safety and improved clinical outcomes, is imperative.

**Reduce the focus on finance** – presuming that the historical financial settlement is a sound base for future resourcing is fundamentally flawed. Similarly, the perpetual drive for efficiency savings delivers patently unhelpful outcomes for patients as services are constrained by frantic cliff-edge budgetary cuts. The health budget must be realistic to the aspirations placed upon it by the public and politicians.

**Avoid professional prerogative at expense of the whole** – the professions working in NHS Scotland have already made this change themselves; multidisciplinary care is the norm not the exception. There is recognition that we need to continue this and ensure time and resource is available to facilitate it.

**Recommit to research** – there is a long tradition of research in NHS Scotland in collaboration with our universities. Current consultant contracts do not adequately demonstrate that research involvement by consultants is valued. This needs to change if we want to continue to seek a better future for the lives of our children in Scotland. A renewed commitment to incentivise research excellence is required.

**Embrace transparency** – this is fundamental to confidence in the system, and it applies across the system; from governance and decision-making to funding and local budgets.

**Protect civility** – this needs and relies on the contribution and commitment of all participants. Endorsing leadership that prioritises listening to and service of others over and above transactional command and control systems would go a long way to create an inclusive and supportive culture in the NHS.

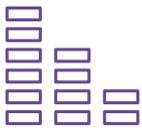
**Listen, really listen** – encouraging team dialogue (with time to do so) and shared approaches to problems is fundamental to finding shared solutions that prioritise patient care.

**Be realistic** – the NHS can only provide within the envelope of its budget. It is vital that the public are educated to value the services they use, and to recognise the limitations of a system under increasing demand. Promising more than we can deliver must end to build honesty and trust between government, service and patient.

## A valued workforce

### What needs to happen?

14. We are seeking a commitment from Scottish Government to achieve and then maintain an appropriate ratio of hospital doctors per 1,000 inhabitants, with ongoing consideration of population expansion and vacancy figures. Recognising the political focus on shifting the balance of care, we invite a robust discussion about the number of hospital doctors required until there is a significant and stable reduction in the number of referrals from primary to secondary care.
15. We are asking for a fair system of pay and reward that better reflects the challenges and pressures faced by Scottish doctors, improves recruitment and retention, recognising the global recruitment marketplace, and begins to restore pay to appropriate levels after a decade of real terms decline.



## Since 2008, real terms take home pay for consultants has declined by up to 30%

Figure 1: Hospital doctor pay erosion 2008/9 – 2017/18



16. We need a culture that enables and supports consultants and other senior hospital doctors to undertake the continuing professional development required to ensure they are at their very best when caring for their patients. We need to ensure their skills are maintained, quality of care is monitored, and service improvements are developed and tested. They also need to have the time and resources to ensure that future generations of doctors have their training appropriately prioritised to provide care of the highest standard to patients.
17. We are calling for workforce planning that includes a clear and unambiguous focus on positive physical and mental health and well-being for NHS staff. We need an NHS that looks after its doctors and other healthcare workers so that they can look after the people of Scotland to the very best of their abilities. This must include a programme of positive forward investment and planning of facilities for the NHS workforce across Scotland. The commercial world has long recognised that investment in a healthy and happy workforce will bring a dividend well beyond its cost. Providing attractive sport, recreation and social space infrastructure for staff; adequate investment in parking; provision of nursery places; fair relocation packages; and support for disabled staff should be re-prioritised from the status of 'optional extra' to that of fundamental to the recruitment and retention strategy for our NHS.
18. We are asking Scottish Government to work with us in managing patient and public expectations of the NHS as the demand for its services continue to increase. We support the delivery of person-centred realistic medicine, but we invite Scottish Government to lead and engage in a genuine national conversation with the public about their expectations of the NHS in a period of ongoing financial constraint and complex system pressures that make it increasingly difficult to deliver consistently high-quality services.



**We believe that honest communication will ultimately lead to better decision making and higher quality outcomes for doctors and patients**

19. We are seeking a clear, accountable and proactive strategy, both nationally and regionally, for involving clinicians 'in the front line' in the future direction of the NHS: strategic planning, service redesign, and local delivery plans. This requires a shift away from a central, top-down managerial approach to better reflect the diversity and expertise within secondary care at local service levels (see appendix 1).
20. We welcome the Scottish Government's legislation on minimum safe staffing levels, which has the potential to provide real quality safeguards around patient safety if appropriately implemented and enforced. We are asking Scottish Government to work with us to recognise these safe staffing principles must be considered for all doctors. We propose principles for vacancy management to regain confidence in the oversight of medical workforce planning (see appendix 4).

## The scale of the challenge

The NHS is facing some of the most difficult challenges of its 70-year history. Increasing demand for NHS services, drugs and treatments, and the challenges presented by a growing and ageing population living with multiple long-term conditions, mean that securing a sustainable future for the NHS in Scotland is critical.

The Scottish Government has a vision for healthcare in Scotland where everyone is able to live longer, healthier lives at home or in a homely setting by 2020, supported by an integrated health and social care system that provides the highest standards of quality, safety and person-centred care. Although life expectancy figures in Scotland have risen over the last 35 years to 77 years for men and 81 for women, Scotland has the lowest life expectancy of any UK nation.<sup>8</sup> There are significant discrepancies in some areas of Scotland, highlighting the importance of addressing public health issues and avoidable health conditions that add pressure to the NHS. Public health issues linked to obesity, smoking and misuse of alcohol and drugs are frequently cited as major population health risks in Scotland, with associated mental health implications. Child obesity has increased, with children from more deprived areas significantly more likely to be overweight or obese than children from more affluent areas.<sup>9</sup> Obesity itself represents a health problem and is also linked to other associated health problems, such as heart disease, osteoarthritis and cancer.

Combined with the pressures of a tight financial environment over the past decade, rising public and political expectations, the availability of new and expensive drugs and treatments, and difficulties recruiting and retaining staff, the scale of the challenge for secondary care is very significant.

Despite this, the commitment to deliver high quality, safe patient care appropriate to the needs of the individual has remained the at the core of what motivates doctors, and the foundation for hospital care in Scotland. This vision describes the scale of the challenge to help set the context for what needs to change.

### Rising demand

The number of patients waiting for secondary care treatment is increasing. In 2017/18, the number of people waiting more than 12 weeks for their first outpatient appointment rose by 6 per cent on the previous year. Over the past five years, the number of people who waited more than 12 weeks for their first outpatient appointment or planned inpatient procedure has increased by 215 per cent.<sup>10</sup> At the same time, funding pressures mean that although health funding in Scotland has increased over the past decade, funding has increased at a slower rate than demand.

We know that Scotland's population is ageing. Over the past 20 years, the increase in the population of older age groups has been much higher than younger age groups. The largest increase was in the over 75 age group, which saw an increase of 31% between 2007 and 2017, while the population of children aged 0-15 decreased by 9%.<sup>11</sup> By 2041, the number of people aged 75 or over is expected to increase by 79% (from a 2016 baseline).<sup>12</sup> This will have a significant effect on the demand for secondary care services that relate to the multiple complex conditions often associated with living longer.



**305,754 patients waiting for first outpatient appointment → 26.9% increase since 2014**

**72,837 patients waiting for first inpatient appointment → 34.9% increase since 2014**

### Funding

In Audit Scotland's October 2018 report on the NHS, one of the key messages was that the NHS in Scotland is not in a financially sustainable position, with boards struggling to break even. By May 2018, NHS boards in Scotland were predicting a total deficit of £131.5m in 2018/19.

NHS boards made unprecedented savings in 2017/18 in an effort to close the gap between the funding they receive and the cost of delivering services. But achieving savings through non-recurring measures coupled with increasing annual costs is unsustainable – the question we need to answer is how can we address this and maintain safe, high-quality, person-centred care?

The significant funding difficulties within the NHS impact both patients and those working to deliver health and care services. In 2018, BMA conducted an all-member survey to gather doctors' views on working in the NHS today. Nearly all doctors in Scotland who responded to the survey believe that NHS resources are inadequate and affecting the quality and safety of patient services (97%). Two thirds believe that quality and safety is significantly affected by lack of resources.



**£13.1bn Scottish Government health budget 2017/18. £6.6bn spent within hospital sector in 2017/18**

The Scottish Government health budget of £13.2bn for 2017/18 represented 8.4% of GDP (based on estimated onshore GDP for 2017/18 of £157.6bn).<sup>13</sup>

In 2017, UK health expenditure was 9.6% of GDP (79% of which was reported to be government financed – i.e. 7.6% of GDP). The 10 EU countries with highest GDP per capita<sup>b</sup> spent an average of 10.1% of GDP on health.<sup>14</sup> Scotland currently allocates less for healthcare than all of the 10 comparator countries, who spent between 8.8% (Spain) and 11.5% (France) of GDP on healthcare in 2017. If Scotland's healthcare expenditure was increased to 10% of Scottish GDP, based on 2017/18 figures this would amount to an approximate additional £2.6bn each year. We believe Scotland should aim to make this commitment to the current and future health of the nation.

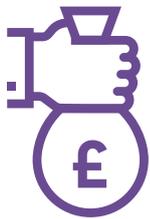
We recognise that decisions about public funding involve compromise and competition for limited funds. However, when we lag behind other countries in terms of public investment in healthcare, we disadvantage patients, NHS staff and the wider communities in which we all live and work. The good health of a country's population is linked to better economic performance, quality of life, educational attainment, greater social cohesion and lower rates of violent crime.

<sup>b</sup> Austria, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Sweden and Spain

To reverse the trend in declining NHS performance, it is imperative that healthcare spending decisions for Scotland are focused on the best ways to meet patient need and provide sustainable good quality services now and in the future.

This may require difficult decisions, but doctors need more recognition from government and health boards that efficiency does not simply mean cutting costs and working more; it can also mean maintaining existing delivery with stretched resources and rising demand. To be able to deliver better, more innovative healthcare fit for the future, matching investment is needed along with more clinician-informed and led decisions regarding service provision and change.

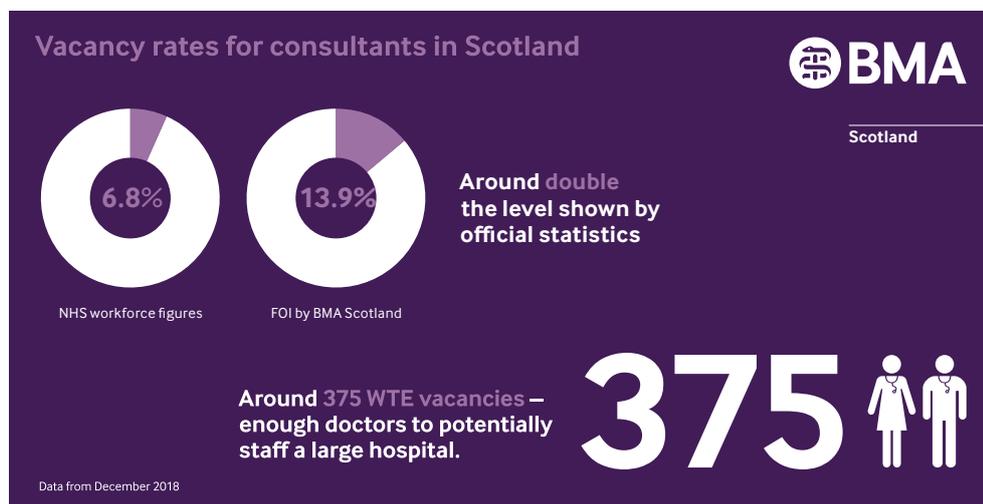
At the same time, doctors need more honesty from local and national politicians about what alternatives they would propose and what hard choices they would make when they're campaigning for or against closures and service reconfiguration – at their core, the political arguments must focus on patient care and better individual and population health outcomes.



**After a decade of underfunding, coupled with rising demand, we need urgent investment in secondary care or doctors will not be able to meet demand because of system and funding constraints.**

### Workforce and workload

An experienced and expert workforce is at the heart of the NHS. The biggest single investment that the NHS makes is in its staff, which means that public spend in healthcare in Scotland is mostly on the workforce. Almost half of NHS Scotland expenditure in 2017/18 was on staff (47.6% or £5.7bn).<sup>15</sup> Although there have been incremental increases in consultant numbers in recent years (3.1% increase on previous year in 2018) when considering the whole time equivalent numbers (adjusted for part-time working) of all hospital doctors (Consultant, SAS and Trainees), and the welcome reduction in junior doctor working hours, the overall whole time equivalent numbers of hospital doctors in post are less impressive. Put simply, there are not enough hospital doctors to meet current, far less projected demand, with long term vacancies across many geographies and specialties to which we are unable to attract suitably qualified applicants. The official vacancy figures significantly underestimate the scale of the problem as they do not count some types of vacancy.



We welcome Scottish Government plans to increase the number of medical graduates, but it takes a long time to train a doctor, requiring an increase in medical school places but also postgraduate training places and re-prioritising the capacity of existing consultants to help train the consultants of the future. At the moment that training time is continually under pressure from the need to keep services afloat. Our senior doctors of the future deserve better.

It also requires that we make the job attractive enough to recruit and retain these trained doctors to the permanent workforce. To support a pipeline of future hospital doctors, current system pressures and challenges need to be urgently addressed in the short term.

**The scale of the workforce and workload challenge is immense:**

- We know from our 2018 all-member survey that doctors are concerned about excessive workloads, unmanageable working hours, and the pressures associated with lack of cover for absences and long-term vacancies. To make working in Scotland attractive to current and future doctors, it is vital that these pressures on the workforce are recognised and tackled with robust solutions. Part of this involves demonstrating that the workforce is valued, through fair pay and real improvements in doctors' working lives. The need to create an attractive working environment must be prioritised and not seen as an 'optional extra', since it will enable Scotland to compete not only with other parts of the UK but also internationally for doctors where there are shortfalls in specific specialties.
- The median age of the NHS Scotland workforce increased from 43 to 46 between 30 September 2008 and 31 March 2018. The proportion of staff aged 50 and over has increased from 29% to 39% over the same period. Whether we can retain this ageing workforce is in significant doubt.
- The retention of the secondary care medical workforce has been a largely neglected issue which is likely to come into sharp focus in light of the punitive UK pensions tax regime that now impacts mid to late-career stage consultants alongside other senior NHS staff. The NHS in Scotland cannot afford to lose the significant contribution of senior medical staff who are increasingly finding that they face an impossible choice to cut their hours or retire altogether in order to avoid quite literally 'paying for the privilege of working'. We are calling for the Scottish Government to recognise this very significant factor and engage with us in seeking solutions.
- We recognise that medical workforce planning is difficult and complex given the long lead time and the uncertainties around future demand and models of care. It is also difficult to predict what the wider employment market will be like, including competition from overseas or rest of UK employers and other career choices that might attract potential doctors. We are working with Scottish Government to tackle this difficult issues as it develops workforce plans. We would caution that it is not just about planning for the long-term future; we also need a better understanding of the current picture – where the workforce gaps are and why, and what we can do to address them now.

For all doctors, the specific risks around fatigue and the availability of adequate rest and catering facilities impact significantly on the attractiveness of working in Scotland. In the short to medium term, practical steps must be taken to mitigate the impact of rota gaps on service provision and doctors' workload and wellbeing. The BMA is actively promoting better rest and catering facilities for doctors and invites the Scottish Government to join us in prioritising this.



**NHS Scotland needs to be able to recruit and retain doctors from other countries to continue to provide the highest levels of patient care**

- If the NHS in Scotland is to continue to provide safe and reliable healthcare services, and to remain globally competitive in the life sciences, it must be able to recruit and retain doctors and other staff from the rest of the UK, Europe, and elsewhere in the world. General Medical Council (GMC) data shows that almost six per cent of doctors working in Scotland obtained their primary medical qualification in a non-UK EEA country. The Scottish Government estimates that 4.4 per cent of the total health and social care workforce in Scotland are non-UK EU nationals (around 17,000 people).<sup>16</sup> The difficulty in attracting and retaining these staff is expected to exacerbate with Brexit; a BMA survey of EEA doctors working in the UK found that more than four in ten are considering leaving following the EU referendum result. In this regard we welcome the Cabinet Secretary's supportive letter to the NHS workforce.<sup>17</sup>
- Given that current medical workforce shortages will not be corrected soon, the NHS must consider other strategies to support doctors to deliver the best patient care. Other healthcare professionals cannot replace the highly specialist work that doctors do and should not be seen as a complete solution to a professional recruitment and retention problem. We want to ensure that our NHS supports sustainable, rewarding careers for specialist hospital doctors. However, multi-disciplinary consultant-led teams, appropriately resourced and funded, can help address current workforce shortages.
- A valued workforce is closely equated with excellence of care. It creates a positive environment that encourages innovation, develops expertise, and secures the future of the NHS. We know that many doctors working in Scotland do not feel valued – this includes those who are Scottish-trained, those who've come to work in Scotland from elsewhere in the UK, and those who've come from overseas. Our members report that excessive workload pressures (77%), the system not supporting work life balance (49%) and a negative workplace culture with lack of valuing and respect for staff (48%) are the top reasons there are difficulties retaining medical staff.
- Valuing doctors includes but goes beyond the issues of pay, workload and fatigue. Providing excellent training and opportunities for career development and influencing are crucial to maintaining staff morale and motivation over the course of a doctor's career. We need an NHS that ensures doctors can contribute to wider service planning and use their knowledge and expertise to help positively influence decision-making at all levels in the NHS, confident that their voice will be heard.
- Good staff health and wellbeing benefits the NHS by improving staff engagement, reducing costs associated with turnover and absences, and improving patient outcomes. When the NHS is under-resourced, over-stretched and facing significant recruitment and retention problems, it is even more vital that the health and wellbeing of hard-working NHS staff is prioritised. This requires strong leadership and a culture of care that recognises staff as an asset to be valued, recognising the crucial contribution that good staff health and wellbeing makes to delivering NHS core objectives.



**93% of Scottish doctors are sometimes fearful of making a medical mistake. 86% believe the main reasons for medical errors are lack of capacity and workplace pressures**

- Doctors want to work in supportive learning environment free from blame and fear. Patient safety is at risk if doctors do not feel able to raise concerns about patient care without fear of blame and negative repercussions. 53% of doctors working in Scottish hospitals told us that they are fearful of being unfairly blamed for errors that are due to workplace pressures or system failings. To support the delivery of safe, high-quality care the NHS must develop a genuinely supportive learning environment for staff, in which doctors feel safe to routinely raise concerns about quality and patient safety, and where bullying and harassment is not tolerated. The BMA have produced guidance for raising concerns in systems 'under pressure'<sup>18</sup>. Additionally, BMA Scotland is undertaking a major project on promoting a positive workplace culture looking to address issues such as bullying and harassment and propose solutions to ensure doctors feel properly supported.

## Finding a common voice

Patients and their families, clinicians and managers all have valuable perspectives and expertise to bring to the NHS. Their contributions should all have an important and explicit role in deciding how NHS services are planned and delivered. Clinicians want to work in an NHS where they can contribute to discussions and decisions at a local, regional and national level - where decisions regarding finance, planning and delivery are informed by clinical expertise, underpinned by a focus on effectiveness, quality and safety and directed at excellent equitable care. Too often decisions seem to be taken remotely, consultation is 'tick box' or lacks a sense of genuine interest in non-management perspectives. The advent of regionalisation and health and social care integration should not be reasons for this to deteriorate further.

The knowledge, skills and experience of the NHS clinical workforce and the perspective that frontline staff offer should be seen as key to successful service delivery and patient care. We would welcome a more collaborative approach that represents a shift away from dominant top-down managerial culture towards a more representative approach that includes frontline clinicians and the public. A clear, accountable and proactive strategy – nationally, regionally and locally – for engaging the diverse consultant workforce in the future direction of the NHS is needed. This should set out how clinicians from all specialties will be informed about plans for national and local reform, and how their opinions and expertise can and will be used to shape and drive that change. Doctors work on the frontline in the NHS every single day and night – they are key to improving the NHS and future-proofing it for the next generation of doctors and patients. This is a planning resource too valuable to ignore.

At the same time, despite the importance of patient voice being recognised as a priority by Scottish Government and NHS boards, in reality the opportunities for patients and the wider public to genuinely influence decisions about service design and configuration are extremely limited. It is imperative that we work together to ensure that the views of patients and the public are heard in a way that normalises seeking their views in all aspects of the health service, not limited to reporting only failure, and not mediated via local and national politicians, pressure groups, and the media.

We challenge the Scottish Government to embed appropriate patient feedback opportunities into all NHS patient experiences. This should build on the feedback opportunities already provided, such as the on-line Care Opinion website<sup>19</sup>, to ensure there is a clear and well publicised and automatic opportunity for everyone who is cared for by the NHS to give direct feedback on their experience. This should be both digital and by more traditional means, to ensure no one is excluded.



**Finding a common voice involves honest conversations about challenges facing the NHS – and what is achievable with the available resources**

The public needs to be better communicated with and involved in discussions regarding the challenges within the NHS and how we can work together in Scotland to improve our population health. There's now a real opportunity – and need – to genuinely engage with patients and the wider public. Scotland faces significant public health challenges that place considerable pressure on the NHS workforce, with an increase in demand on secondary care for conditions associated with preventable ill-health. Honesty about the scale of the challenge and range of options available is important, but also a genuine commitment both to inform and to guide, and to listen and respond to patient and public feedback and work with other organisations (such as local authorities) before important decisions are made.

## Quality, safety and improving outcomes

Improving the quality of healthcare and individual patient outcomes underpins our vision for secondary care in Scotland. It is critical that the drive to move towards and embed integrated health and social care in Scotland recognises the crucial role of local delivery partners. Like other UK countries, Scotland has so far struggled to effectively move care out of hospital into community settings.

Satisfaction rates with the Scottish hospital sector remain high, with 90% of Scottish inpatients saying NHS hospital care and treatment was good or excellent.<sup>20</sup> However, more than 70% of doctors surveyed in 2018 felt that overall patient services had worsened in the previous year.

Among doctors in Scotland, there is a majority view that health boards have been forced to prioritise financial over clinical targets. Of the members surveyed by BMA, 72% felt that national targets and directives are prioritised over quality of care. 68% felt that financial targets were prioritised. We know that the targets are not being met and that performance against the targets is declining, which creates a cycle of increasing pressure to achieve unrealistic targets with limited and overstretched resources. Inevitably, quality of care is at risk of suffering.

We support the aim to provide care in the home or a homely setting wherever possible. However, this aspiration is not currently matched by the demand for hospital services and delayed discharge statistics. It is important that we acknowledge that for many acutely ill patients, in-patient hospital care is what is needed. There is an assumption that delivering care in a primary care setting will save money. There is no evidence to support this and it is an assumption that carries considerable risk.

Delayed discharge cost NHS Scotland £125m in 2016/17. In Sep 2017-18 delayed discharge figures increased 8% on the previous year. We need to ensure that when someone is medically ready for discharge they are not delayed by lack of appropriate care provision in a community or home setting. Coordination with and realistic funding for social care are essential prerequisites for effective patient flow through the system.

Reducing in-patient acute bed numbers in the face of increasing patient demand merely worsens backlogs in the system and has a knock-on effect of longer waiting times, both of which negatively impact the overall quality of care. In all settings, making savings before they have been proven to – at the very least – not negatively impact on the quality of care will be unlikely to generate a satisfactory outcome for patients. The Scottish Government should require of itself and Boards that the case for a saving is proven before it is implemented.

There is a strong appetite amongst doctors in both primary and secondary care for finding better ways to work together to improve patient experience and outcomes. Better coordination of care between GPs and hospitals requires identifying and removing barriers to effective joint working and making better use of technology, such as single and accessible electronic records across the patient journey.

Not all patient records are currently in digital format and not all are accessible by the clinicians who need to see them to offer the best possible care to patients. This undermines any system which relies on knowing a patient's entire history and inhibits better collaboration between clinicians working across the primary/secondary care interface. Doctors should be able to see patient records, observations, results and background notes from any location, ideally in real-time. There would be clear benefits in emergency situations, and the ability to remotely access information to a patient's record would save time and reduce workloads.

The current lack of interoperability between digital systems can mean unnecessary duplication of effort and time asking patients to repeat information already provided in other care settings. More than half of respondents to BMA's 2018 survey (53%)<sup>21</sup> said they wanted to see more effective IT systems that are interoperable and that this would improve their day-to-day working life.

Investing in basic technological infrastructure must now be a priority. This would allow doctors to dedicate more of their time to patient care, supported by effective IT systems. Doctors should have the opportunity to influence the development and implementation of new systems, with dedicated funding and time allocated for training in the use of new technologies.

## Moving forward

Scottish consultant doctors want to help shape and lead the future of safe, sustainable hospital-based healthcare in Scotland. It matters to us, it is the underlying reason that we have each spent a significant part of our lives in training. We have set out our vision for a supportive culture, a valued workforce, and a collaborative structure. Our main priority at all times is patient safety and quality of patient care. This underpins all that we do.

We want patients and their families to feel genuinely heard, engaged and empowered to contribute to the discussion about the future of healthcare in Scotland. We want to attract, nurture and support a diverse, vibrant, motivated and committed specialist hospital doctor workforce that is adequately funded and fully equipped with the tools it needs to deliver world-leading hospital-based care across the wide range of specialisms within Scottish hospitals. We want to train the next generation of senior doctors to continue this legacy and to encourage and support research and innovation in health care. We aspire to interact with colleagues in primary care and other sectors to deliver optimal and seamless care to our patients.



**We invite Scottish Government to work with us, support us, listen to us, and help us build a better NHS for Scotland.**

## Appendices

### 1. BMA Principles for good medical engagement

Our vision is based on the BMA's 10 principles for good medical engagement:<sup>22</sup>

- Inclusive
- Given time and resource
- Open and transparent
- Timely and ongoing
- Active and collaborative
- Use a range of engagement methods
- Receptive to new ideas and to challenge
- Evidence based
- Part of a learning culture
- Regularly monitored and evaluated

### 2. Principles for service planning

We offer the following principles in support of the planning processes around departments and services. We believe such service plans should inform and underpin each Board's plans and strategies.

Service plans should:

- Be developed on an inclusive basis by the clinicians responsible for delivering the service
- Be fully supported by management for that service with appropriate administrative support
- Set out clearly the need (and/or demand) alongside current capacity with gap analysis and a realistic plan for addressing unmet demand
- Include clarity over scope of services to be provided and explicit pathways for areas of care that cannot be delivered in-Board (or in region)
- Include detail of how and where services are to be provided, with consideration of access by all potential patients (actively seeking to address unmet need) and with patient input
- Include clarity over resources required to deliver services including IT, training, staff, infrastructure
- Include reference to safe staffing legislation to inform workforce numbers
- Include clarity over the processes for any excess demand beyond capacity
- Include consideration of forward planning
- Include consideration of lateral planning – regional working, cross-regional working and national services
- Include explicit resilience planning (including clear Standard Operating Procedures (SOPs) for contingency and escalation planning – for example, for staff sickness)
- Clearly set out current and desired interfaces with primary care; to be explicit in terms of routes to engage and communicate – involving primary care colleagues in secondary care service planning
- Clearly set out what Patient Reported Outcome Measures (PROMs) will be published per service per quarter
- Be subject to at least annual review and represent a mandatory quality indicator in secondary care
- Together, across a Health Board, be collated to provide an accurate picture of the scope of care on offer
- Should inform the IT solutions and planning for health boards
- Should in turn inform a Scottish strategy for Secondary Care which identifies gaps and vulnerabilities in advance of them occurring.

### 3. Principles for service redesign

We offer the following principles in respect of proposals for significant changes to services offered at departmental, board, regional or national level.

In any service reconfiguration:

- Proposals must have a clearly stated aim – be that quality, safety or economic – set out without ambiguity
- Should be focused on at least maintaining or, in preference, improving patient safety, clinical outcomes and the quality of care
- To succeed, must be based on sound clinical grounds, evidence-based and never on short-term political expediency
- Needs to be professionally led: for secondary care medical services, this means consultants who are responsible for delivering a given service leading the process.
- Needs to engage politicians, the public and the medical as well as other health care professions
- Should always examine the unforeseen consequences through a thorough analysis of benefits and risks
- Must involve meaningful and open debate, including genuine proportionate consultation with patients and the public at an early stage before any decision on proposed options has been taken.
- Must balance views of the public with clinical considerations, sustainability, safety and affordability.
- Must be conducted in a transparent way with reasons for the decisions taken being recorded unambiguously.

### 4. Principles for vacancy escalation

We offer the following principles concerning the appropriate handling of vacancies to restore confidence in the management of vacancies and the increased burden that has on staff that remain.

There should be clear Board-level policy on the escalation of vacancies which should include:

- Appreciation of current and anticipation of emerging issues in service plans (see 2 above) including a requirement for resilience planning.
- Recognition of any vacancy as soon as it is anticipated or occurs and initiation of an explicit plan concerning replacement &/or mitigation
- Requires clear reasoning for decisions around filling a vacancy vs service redesign
- Requires a plan to be generated in close cooperation with the team who will face the consequences of the vacancy in a timely way and facilitate their input to that plan before it is finalised
- Requires an alert to be brought to the LNC / Area Medical Committee if not filled, with ongoing updates on progress
- Requires an alert to be brought to Board level if not filled at 2nd advert with clear implications for service delivery
- Requires a Board member to be designated with responsibility for monitoring Board performance on the true extent\* of vacancies with particular attention to those of more than 6 months duration and to actively seek feedback from the service who are working with the vacancy in place.
- Requires an annual report to SG and BMA nationally on efforts at Board level to address vacancies in excess of 6 months in addition to the ongoing current vacancy statistic gathering.

- See also 'Services under pressure' BMA SCC guidance
- \*The Scottish Government definition of vacancies does not necessarily include:
  - Vacancies which are not currently being advertised
  - Vacancies which have been advertised but there has been a failure to appoint
  - Vacancies which are being occupied by locum doctors

A full appreciation of the situation requires greater transparency by including these categories. The BMA supports the inclusion of all posts that are not occupied by a substantive post holder. Only then can we understand the extent of the workforce gap.

## Further reading

Kings Fund report Reconfiguration of Clinical Services, 2014

State of the Estate, 2018

NHS ISD Delayed Discharges in NHSScotland, Sept 2018 (full report)

NHS ISD Delayed Discharges in NHSScotland, Nov 2018 (summary report only)

NHS ISD Bed numbers: <http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds>

R Kline & D Lewis: The price of fear: estimating the financial cost of bullying and harassment to the NHS in England

M Dayan & N Edwards: Learning from Scotland's NHS Nuffield Trust, July 2017

Reports of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis, QC: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

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- 18 BMA UKCC guidance: <https://www.bma.org.uk/advice/employment/raising-concerns/guide-to-raising-concerns-for-consultants-in-a-system-under-pressure>
- 19 NHS Care Opinion online feedback tool: <https://www.careopinion.org.uk>
- 20 Ibid 2
- 21 Caring, supportive, collaborative? – Doctors' views of working in the NHS, Report of 2018 BMA all-member survey, September 2018
- 22 Principles for medical engagement within the NHS, BMA, 2018: <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/nhs-structures-and-integration/medical-engagement/principles-for-medical-engagement>

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