BMA

Scotland

BMA Scotland – A National Care Service for Scotland

BMA Scotland welcomes the opportunity to provide written evidence and comments to the Scottish Government consultation 'A National Care Service for Scotland'. Before addressing some of the main proposals in the consultation, as the doctors' trade union in Scotland, we are deeply concerned about the proposals to have Community Health and Social Care Boards (CHSCBs) manage GPs contractual arrangements. This proposal fails to understand the close and interlinked relationship between primary and secondary care and any moves to fragment this would not only risk altering the role and function of the GP but the proposals may lead to poorer outcomes for those patients who require healthcare.

As a nation we have witnessed over the last year the difficulties faced not only by some of the most vulnerable in our society but also by those who care for them and are employed within the social care sector. All care in the community, whether in care homes or in people's own homes, is an essential part of the integrated health and social care system, but services often operate without functional integration with NHS services.

If one measure of being a caring and effective society is our ability to care for our most vulnerable, on that measure we have been found sadly wanting at times because of the lack of attention on, and investment in, the care sector. Little consideration has been given to the needs of those employed within social care to enable them not only to do the job but to do the job well. BMA Scotland believes that the sub-optimal operational integration (irrespective of legislative and organisational integration), variable training, poor pay and employment conditions and a lack of career pathway progression opportunities has led to some of the shortcomings within this sector.

In recent decades, with changing demographics and improving healthcare, there has been a huge expansion in the demand for both home care and institutional care and this has put a different, but significant, strain on the systems and resources available to properly meet those needs. One of the original aims of the shift of care responsibility from NHS to local authorities in the 1980s, was to allow the NHS to focus on healthcare and rehabilitation needs rather than providing care, but it is clear that resourcing, staffing and care provision shortfalls in social care have major impacts on NHS services. Gaps in social care have led to increased demand on primary care, emergency medicine departments, acute admission units, geriatric and psychiatry services, as well as the issue of delayed discharge which reduces the efficiency and speed that patients move through the system and often means long unnecessary stays in hospital.

BMA Scotland welcomes the work being carried out to reform and improve care in the social care sector; it is important for society that we look to protect and care for our most vulnerable, in the best possible way and ensure their rights and needs are addressed and met. But it is also important for the sustainability of the NHS that we examine the relationship between the two sectors, to find better ways to integrate work and share data, when appropriate.

It is vital that plans for a National Care Service are viewed in this context – and are interrogated robustly to ascertain whether they will deliver the aims and improvements we have set out. The move to a National Care Service does have potential to deliver clearer lines of accountability for the sector, although it will need to be implemented carefully, avoiding the kind of arbitrary target driven approach we have seen in the NHS, which too often is responsible for poor culture and behaviours which focus on blame rather than openness and learning. An NCS also has the potential to create more comprehensive national planning for the sector and improved terms and conditions and training for staff. However, it will also be a complex and challenging programme of reform that will require considerable investment of time, resources and finances.

As a result, there are key questions and concerns that need to be considered as this proposal progresses and is considered further. There is no doubt that improvements in social care, and its links with both primary and secondary health care have the potential to improve anticipatory and preventative care provided in particular to older people and as a result considerably ease the pressure on the health service as a whole. However, any changes need to be allowed considerable time to bed in and they must not be allowed to compromise already hugely stretched NHS budgets. Of course, we need to move away from a siloed approach to funding – but equally we cannot avoid the conclusion that a considerable increase in funding is needed to the total provided across the whole system – and large programmes of reform can prove an expensive drain on resources. Equally to pursue that theme, there are no doubt improvements that can be made to the interfaces across health and social care – and primary and secondary care, but we must not allow any reforms to make these relationships more complex, hard to navigate and as result less effective and joined up for patients.

As these proposals progress we anticipate there will be more and fuller opportunities to expand on these points as more detailed proposals come forward. In the meantime, below we have responded to the specific areas in the consultation which are of particular concern to our members, or where BMA Scotland believes further consideration is required. This has been done in the order that the consultation has addressed each area and not in order of the importance of our concerns.

Using data to support care

BMA Scotland strongly agrees that with appropriate safeguarding and resourcing, there should be a nationally-consistent, integrated and accessible electronic social care and health record. We also strongly agree that with secure access agreements and audit trails, information about health and care needs being shared across the service that support an individual, would improve co-ordination.

Consideration must be given to the potential for public concerns about the wider sharing of what is often very sensitive data. Measures will need to be taken to alleviate any impact that these concerns might have on a patient's willingness to share information even with clinicians who need it in order to deliver appropriate health care.

As it stands, much of the information and data recorded in social care is done so in silos and not shared across the system. Before we are able to identify clear gaps within that, we need to have a better understanding across the board of what data is collected and how: only then can we consider what the gaps are and the most appropriate way of filling them. Any additional data that needs recorded, while useful, will require additional resource and agreement on who will be able to assume that role. BMA Scotland believes that there needs to be further consideration about whether legislation is required, we would be concerned that some "required" information may not be appropriate or needed for all service users within the system, any legislative requirement for recording data or information may become a bureaucratic burden and create additional pressure, that in turn would take resource away from other activities or functions that are not required in statute but appropriate for individual needs.

Healthcare

BMA Scotland does not believe that Community Health and Social Care Boards managing GPs contractual arrangements would be beneficial to patients, primary care services or how primary care works within the NHS. It is important that health and social care providers communicate and collaborate for the benefit of patients but this does not require moving GP contractual arrangements from health boards to CHSCBs. Doing so risks altering the role and function of the GP and changing the emphasis on what general practice would be expected to deliver. It is vital that general practice remains the integral part of the NHS that it is. These proposals may lead to poorer outcomes for those patients who require healthcare which is not also associated with delivery of social care services.

Under current arrangements, GPs are a central part of the NHS and to remove them from their integral place as part of that model would only undermine the clinical links and relationships that they have as part of that service. It has often been said that general practice is the backbone of the National Health Service; to remove it from the NHS would seriously jeopardise the complicated interface and collaborative working with secondary care and acute services, which is by far the biggest stakeholder of primary care. The majority of patients that come through primary care, that need further referral are to secondary care and acute services, and we are very clear that nothing must undermine that relationship or damage the clinical care governance arrangements.

Much work has been done in recent years between BMA Scotland's GP committee and the Scottish Government to create and work towards implementing the 2018 GMS contract – agreed with the Scottish Government, the new contract sees the role of the GP as that of an 'Expert Medical Generalist' (EMG), this involves interfacing and leading multidisciplinary teams (MDTs) which includes some social care services but the GP does not provide social care. One of the primary aims of the new contract is to encourage recruitment to, and increase the attractiveness of, general practice. There has been real concern that if the role of the GP was being seen as the poor relation within the medical profession, excessive bureaucracy, increasing workload pressures, with much of their time being spent managing social as opposed to medical issues and not being respected for the overarching expertise in managing a long list of medical conditions, illnesses and sickness in the community, then doctors may stop choosing it as a career. A considerable focus of the 2018 contract was for Integrated Joint Boards (IJBs) and health boards to establish themselves as alternative service providers in primary care – for example in vaccinations and pharmacotherapy – thus allowing GPs to use their skills, training and experience as EMGs to focus on complex care and whole system quality improvement and clinical leadership, among other priorities. There is a very real concern that the proposals set out in this consultation would undermine that role and damage the parity that general practice has with acute care returning the

GP to being a poor relation within the health care structure. And while we expect that the new contract will go a long way to improve community health care management, we still are far from implementing the contract in its entirety. The new contract needs time to take shape and to implement the change needed by allowing GPs to work within MDTs, to ensure that patients access the right person for their needs. That model demands good relationships and integration with Social Care services, a process that has begun through the new contract partly through the introduction of community link workers, but it requires general practice to be part of the NHS.

Recruitment and retention to general practice is still a huge concern and it has been further exacerbated by the COVID19 pandemic. BMA Scotland is concerned that rather than tackle the issues around increasing recruitment and making general practice attractive, this attempt to reorganise primary care not only won't resolve the issues, but it will do irreversible damage to the integrity of general practice as part of the NHS. Doctors feel very strong loyalty towards a National Health Service and being a part of that institution. Removing GPs from that is very likely to erode that relationship and decrease the attractiveness of general practice to medical students. We have already had concerns raised by our membership that having this discussion and the manner in which is being conducted, is already causing damage to the attractiveness of the specialty.

If we want CHSCBs to better support integration with hospital-based care services then there needs to be established fully supported local interface groups between social, primary and secondary care, to agree end-to-end patient care pathways. For that to work then there needs to stop the fear of a loss to budgets. Any shift to care or ways of working will initially require stability across budgets before it can be identified where the shifts to spending flow need to move.

Mental Health Services

Many of the elements of mental health care outlined for delivery under the National Care Service work closely with in-patient mental health services within the NHS. For example, many psychiatrists work between both community and in-patient mental health services, having a single contract with the health board. This allows for much easier and more efficient movement between the services, ensuring better outcomes for patients and cross departmental working. Our members have highlighted concerns with tensions that might arise should community mental health move to the NCS and fragment the relationship between community and in-patient mental health service. Similar to the point outlined with moving GPs to CHSCBs, moving doctors who work in mental health to be managed by social care rather than NHS would most certainly change how those specialties are regarded by the medical profession and potentially make them less attractive. COVID19 has highlighted to society the great pride that people working in the NHS have in that institution and there is a very real fear that moving people out of that employment structure will damage the desire to work in that field.

Moving the management of community mental health services into NCS and splitting it from in-patient services in NHS will not be an effective way of ensuring that mental health service under the NCS is linked to NHS. This is particularly important for psychiatrists, many of whom work in both services, with a single contract with the Health Board. The creation of local interface care pathways groups, that meet regularly to agree how patients' needs are best met would have the greatest affect.

Reformed Integration Joint Boards: Community Health and Social Care Boards

BMA Scotland has significant concerns about the proposals to reform IJBs into 32 CHSCBs, each with what we understand from the consultation document to be a full complement of executive officers and directly elected members. This would be a huge exercise in reorganisation, with massive financial and opportunity cost, when we should be focusing on the problems that need solved with the existing bodies. There needs to be clear evidence that any solution proposed will be deliverable, affordable and will provide better outcomes than structures already in place (including the existing NHS Boards). Resources are clearly scarce (this is not simply a 'perception' as described in the consultation document) and the BMA's view is that these precious resources should be focused on delivering better joined-up care to the people of Scotland. Furthermore, the experience in the NHS of introducing direct elections to Boards was expensive, time consuming and was not successful.

Commissioning of Services

BMA Scotland is supportive of the NCS creating and managing a professional development programme for all those working in social care. Improving the skillset and assuring continuity of care by investing in those that work within adult social care would have very positive and far reaching consequences. The COVID-19 pandemic highlighted the lack of incentive, training and career progression that needs to be addressed, not just to improve the quality of life of those receiving care from this sector but also to improve the quality of life of those working in this sector. Better terms and conditions with job security, pension security and clear opportunities for training and advancement will provide better continuity and quality of care. Consideration should also be given to safe staffing levels for care homes. Many of those residing in care homes live with complex needs and may have multiple comorbidities and demands on staff can be similar to the demands to those working in hospital wards.

We are also supportive of the NCS being responsible for the commissioning, procurement and contractual management of national social care contracts, particularly for residential care home provision. The location of care homes is currently not regulated and where they exist is determined as much by the economic viability as where they are needed to meet population demand. This has resulted in some areas having no residential care homes and some having more than are required. In the latter scenario this creates an additional incoming population with complex care needs and therefore an addition pressure on local community health services including general practices. Consideration should be given to the immediate vicinity and accessibility of the site of any new care homes and to the already existing healthcare structure in that area. Strengthening links between care homes and the NHS is vital if we are to improve the health outcomes of those service users who depend on the care sector.