Royal College of Physicians of Edinburgh

Scottish Parliament
Health and Sport Committee
Call for views on issues affecting the health sector in Scotland

The Royal College of Physicians of Edinburgh (RCPE) is pleased to respond to the Committee's call for views on issues affecting the health sector in Scotland. For further information about the RCPE's healthcare policy priorities, please see our Health Priorities[i] document, prepared in advance of the Scottish Parliament elections 2016.

The Royal College of Physicians of Edinburgh is an independent clinical standard-setting body and professional membership organisation, which aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties.

Recruitment and retention

The RCPE considers that the recruitment and retention of high quality staff to NHS Scotland, particularly with regards to the acute specialties, is a very pressing issue and should be a high priority for the Committee's consideration.

The RCPE supports increased availability of consultant-delivered care, including at evenings and weekends, where there is potential to improve quality of care for patients with the appropriate staff and services in place. It is essential that an evidence-based approach to extended working is taken, recognising the importance of a multi-professional approach and an appropriately phased implementation. It is also essential that there is recognition that this cannot be delivered without additional resource, increased medical staffing, clinical time, and increased support from services such as radiology, pathology and allied health professionals (AHPs). Collaboration is vital between Government and clinicians to build upon the emerging evidence in this area, such as the findings of the RCPE's expert workshop on extended working[ii].

The medical workforce faces a number of challenges and the RCPE recognises the need for safe and sustainable staffing levels throughout the NHS. We need to ensure that we continue to recruit and retain a world class workforce to deliver the best possible patient care[iii]. The RCPE is committed to working with the Scottish Government and other allied organisations to address issues around recruitment and retention such as consultant vacancies, rota gaps and trainee attrition rates, as a matter of priority.

We are also committed to working with partner organisations to promote innovative ways of working in the NHS. The roles of Physician Associates, Advanced Nurse Practitioners and other examples of physician extenders should be further examined to create a workforce fit for the future.

Political parties must commit to developing and implementing safe staffing levels for all professions within hospital settings, based upon best evidence[iv], along with improved workforce planning which reassesses the size and structure of the consultant workforce taking account of such changes as the rise of part-time working, extended working, and the needs of an ageing population.

The College is committed to promoting the highest clinical standards and implementation of robust, evidence-based medical practice. Standards must be measurable and the associated scrutiny proportionate, in order to be effective. Improving patient flow across health and social care remains vital in this regard, both in terms of patient safety and quality improvement[iv]. Patients must be treated in the right place, and as quickly as possible. This requires the right numbers of staff and mix of skills across health and social care.

Medical training: Successive independent Inquiry reports and a number of surveys conducted by the Royal Colleges throughout Scotland and the UK have highlighted major difficulties within medical training which have the potential to undermine the future provision of high quality and safe patient care. Heightened by the impact of the European Working Time Regulations, many doctors in training to become consultants are currently receiving an inadequate level and quality of training. The balance between service needs and learning has been adversely altered and it is essential that the importance of providing high quality medical training is more widely recognised and that trainees and their trainers are better supported. Against this background, the Charter for Medical Training[v] was developed by the RCPE Trainees & Members' Committee and has the full support of the RCPE. The purpose of the Charter is to improve the quality of training by targeting areas where there is a need for improvement.

Data from the Foundation Programme Annual Report 2015[vi] shows that, of those who satisfactorily completed the Foundation Year 2 programme in August 2015 and provided information about their next career destination, only 52.0% were appointed to specialty training in the UK (from the 7,168 responses). This figure is lower than reported in 2014 (58.5%) and demonstrates the scale of the attrition rates facing medicine.

Consultant contract: Despite the uncertainty surrounding the consultant contract in England, RCPE Fellows have stated that the "9:1 contract" in Scotland is still significantly impeding the ability to recruit new staff to high intensity specialties such as acute medicine. Many NHS boards have unfilled consultant acute physician posts and, whilst "9:1" contracts remain, it is difficult to see them being filled. The growth of 9:1 consultant contracts in Scotland has been underpinned by a desire to increase levels of Direct Clinical Care by Consultants. However, this means that all training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal,

research, clinical management and local clinical governance activities must be completed in just one session out of ten.

The number of Consultant medical posts vacant for more than 6 months in Scotland has increased in the last year, from 44 (3.5% of all posts) in March 2015 to 54.4 (4.2% of all posts) in March 2016[vii]. The specialties which nationally have the most vacancies (by number) are general (acute) medicine with 21.5 vacancies, geriatric medicine with 15 vacancies and respiratory medicine with 12 vacancies.

Acute medicine: workload intensity: Acute Medicine Units (AMUs) are perhaps the most pressured workplaces within the hospital. Activity is increasing due to a combination of public expectation, increasing numbers of referrals from primary care, and artificial variation stemming from the need to meet the four hour emergency access standard. There is a need to focus on patient flow (out of AMUs to downstream wards and beyond) that has the same political imperative as the emergency access standard.

A significant contributor to this workload intensity (for both medical and nursing staff) is the highly complex landscape regarding targets and standards. Fellows feel that it is not always clear which organisations are responsible for improvement and which are responsible for scrutiny. For frontline clinicians this can result in an array of 'must-dos' for each patient, voluminous and time-consuming paperwork, and complexity in how this is captured, recorded, and reported.

Obesity

65% of all adults in Scotland were overweight in 2014[viii], compared to 39% globally[ix] and 62% of the UK.[x] Prevention is both better for patients and more cost-effective than treatment. However, action is also necessary to assist those who are already overweight or obese. The costs of obesity to both the NHS and patients are high[xi], financially and in terms of avoidable suffering. Being overweight increases the chances of developing diabetes, heart disease, cancer and arthritis, and has the potential to lead to reduced mobility, disability and social isolation. It is vital that the public can make informed choices about food. While a balanced diet will help avoid obesity, a poor diet which does not meet recommended dietary requirements and results in overweight/obesity could be described as 'modern malnutrition'.[xii] Preventative measures such as reduced food portion or pack sizes must be considered along with policies such as the sugary drinks tax.

The RCPE supports fully embedding physical activity for health into primary care, secondary care, social care and health education,[xiii] as well as in the health and social care workforce and workplace. This would include ensuring that secondary care staff provide guidance on the recommended minimum levels of physical activity for health, offer brief advice and brief interventions, and signpost to community resources fully supporting the aims of the Health Promoting Health Service.[xiv] The RCPE also asks that the Scottish Government renews and prioritises the current obesity route map.

Mental health

There is a well described link between mental and physical health and wellbeing,[xv] and we therefore call for an integrated and holistic view to be included in the next mental health strategy. Around 30% of people with a long-term physical health condition also have a mental health problem. The evidence also shows that people with mental health issues are dying early due to associated physical behaviours and that, for example, stopping smoking improves mental as well as physical health.[xvi] Mental health promotion should be given more prominence with respect to physical health due to the burden of morbidity and reduced life expectancy.

Specifically looking at cognitive mental health, there has been a major focus on dementia and some good work has been done in this area nationally. One downside of this focus has been the lack of appreciation that, for the majority of patients, physical and cognitive frailties co-exist. We therefore need to bring older adult mental health and elderly medicine services much closer together to allow a person centred approach to truly work.

Health and social care integration budgets

Collaborative working is essential to make integration a success, and active support to enable primary and secondary care to work effectively in partnership with social care will be vital. Managing patients with long-term or chronic conditions is one of the biggest challenges facing the NHS in Scotland, and health and social care integration has great potential in this regard. It is important that, where appropriate, patients are treated in a community setting and are empowered to be active participants in their own care where possible.

GPs and GP hubs

The crisis in GP recruitment has been well reported recently and is having a major impact on primary care. There is concern that this is having a significant knock on effect to the whole national clinical strategy and 20:20 vision which is working towards more health care in the community. In order to deliver this we need a robust workforce which includes, e.g. advanced nurse practitioners with skills in frailty assessment, GPs with an interest and skills in managing older people and frailty (beyond which they currently routinely have) and consultant geriatricians working in the community alongside their primary care colleagues – this would likely be via GP hubs or clusters.

Delayed discharges

Delayed discharges directly influence 'front door' pressures at the hospital, including emergency waiting times and Acute Medicine Unit capacity and flow. Ongoing investment is required to help overcome the hurdles often encountered - which may include waiting for packages of care and transport. The former should be improved by better health and social care and integration, and RCPE Fellows have reported that in locations such as Fife where there have been trials of commissioning packages of care at 'the front door' for patients presenting in social crisis; this enables patients to go directly home from the AMU where a period of reablement focuses on improving independence and has resulted in only a minority requiring long term packages. Health economics have indicated that impressive savings could be made by taking this approach and this is worth further exploration.

There is a perception that there is poor integration with the Scottish Ambulance Service (SAS). The SAS must respond to priorities and this often means downgrading downstream hospital discharges, particularly for less mobile patients requiring two man crews, or bariatric services. Further work needs to be done on making this a joined up service, with review of how this is prioritised.

Delayed discharges have a huge impact on secondary care services but more importantly have a huge personal impact on patients who are delayed in hospital waiting on community health and care services. For an individual patient, the risk of delirium, falls, healthcare associated infection, dependency and institutionalisation are real and very concerning. One major issue is the question of age: services for 'adults' under 65 are very different from 'older people'. There should be a system based on need without the often artificial boundaries around age limits.

Targets

The impact of targets on recruitment and retention of medical staff to acute specialties (in particular acute medicine) is significant. Whilst there is no doubt that the four-hour emergency access standard (previously target) has transformed the quality of acute care over the past decade, the associated negative impacts should not be ignored. Patients are frequently admitted just to 'avoid a breach' and consequently attract unnecessary paperwork and time in hospital. Patients may even be admitted to 'any bed' in order to avoid breaching – resulting in direct boarding from the emergency department. Frontline staff in such pressurised environments work extraordinarily hard, but often feel that they are not providing any recognisable level of care. Relationships between clinicians and managers can break down; such is the scrutiny over performance. Elective targets can impact on pressure at the front door in more subtle ways – resources are diverted away from acute medicine units to fulfil the treatment time guarantee – such as substantive consultants no longer undertaking general medicine 'on-call' and being backfilled by locums.

There is concern that the greatest merit of the emergency access standard – its simplicity – is also its greatest downfall. Patients either breach the standard or do not, and this leads to many maladaptive

strategies as described above, which increase pressure on AMUs. Consideration should be given to replacing this with a target based on when a patient is ready to move from an emergency department with a maximum wait time to reach an appropriate bed.

Data: NHS Scotland has been described as "data rich but information poor." High quality, electronically gathered data is a powerful tool for improvement and engaging with staff. Although these data may exist in health boards it is seldom shared with clinicians, and there is a real lack of clinician ownership of their own data, and organisational data.

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

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[i] RCPE Health Priorities 2016 http://www.rcpe.ac.uk/sites/default/files/files/rcpe-health-priorities-2016-booklet-final.pdf

[ii] S Dunn, M Jones, T Woodcock, F Cullen, D Bell, J Reed. Consistent services throughout the week for acute medical care. J R Coll Physicians Edinb 2016 46: 77–80 http://dx.doi.org/10.4997/JRCPE.2016.202 http://www.rcpe.ac.uk/sites/default/files/jrcpe_46_2_dunn.pdf

[iii] Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Academy).*Learning from Serious Failings in Care*. May 2015. http:// www.scottishacademy.org.uk/documents/final-learning-from-seriousfailings-in-care-exec-summary-290615.pdf

[iv] RCPE UK Consensus Conference statement. *"Acute Medicine: Improving quality of care through effective patient flow – it's everyone's business!"*15–16 November 2013. http://www.rcpe.ac.uk/sites/default/files/files/final_statement_patient_flow_.pdf

[v] RCPE Charter for Medical Training.http://www.rcpe.ac.uk/sites/default/files/files/rcpe-charter-for-medical-training_0.pdf

[vi] P.20, Foundation Programme Annual Report 2015 http://www.foundationprogramme.nhs.uk/download.asp?file=FP_Annual_Report_2015_-_FINAL.pdf

[vii] ISD Scotland: Consultant vacancies (published 07 June 2016) http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=1662#1662

[viii] Scottish Government.*The Scottish Health Survey 2014 edition*.National Statistics Publication for Scotland. September 2015. http://www.gov.scot/Resource/0048/00485546.pdf

[ix] WHO Factsheet. *Obesity and overweight*. January 2015. http://www.who.int/mediacentre/factsheets/fs311/en

[x] SPICE briefing. *Obesity in Scotland*. 7 January 2015. p.20. http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_15-01_Obesity_in_Scotland.pdf

[xi] NICE. *Preventing obesity and helping people to manage their weight*. NICE advice [LGB9]. May 2013. https://www.nice.org.uk/advice/lgb9/chapter/economic-impact

[xii] Faculty of Public Health.*Food Poverty and Health*. May 2005. http://www.fph.org.uk/uploads/bs_food_poverty.pdf

[xiii] The Scottish Academy of Medical Royal Colleges and Faculties Pledge on Physical Activity.http://www.rcpsych.ac.uk/pdf/SA%20Position%20Statement.pdf

[xiv] The Scottish Academy of Medical Royal Colleges and Faculties Pledge on Physical Activity. p.5. http://www.rcpsych.ac.uk/pdf/SA%20Position%20Statement.pdf

[xv] Faculty of Public Health.*Relationship with physical health and healthy lifestyles*.http://www.fph.org.uk/relationship_with_physical_health_and_healthy_lifestyles

[xvi] ASH Scotland.*Smoking and mental health: a neglected epidemic*. June 2015. http://www.ashscotland.org.uk/media/6418/ASHScotlandSmokingandmentalhealth.pdf