Dear Acting Convenor,

Leadership and workforce challenges: health and social care sectors

Thank you for the opportunity to provide an update to the evidence BMA Scotland gave to the Public audit and post-legislative scrutiny committee earlier this year.

When I appeared in front of the committee at the start of March we were all very much aware that COVID-19 was going to impact on our health and social care sector, but what wasn’t clear was how far and how deep that impact would be felt. We hoped for the best but many across the NHS were already preparing for the worst. Two weeks later we entered a national lockdown, many NHS services were halted, and staff redeployed in order to cope with the expected influx of COVID-19 patients. Many doctors did quick retraining and refresher courses to allow them to help in areas that were likely to be overloaded. Hospitals were divided into two zones; green zones to allow essential services to continue to operate as much as possible, and red, where operating theatres were repurposed into ICU beds. Our primary care sector was redesigned virtually overnight, continuing to provide care to those in the community who needed it most, as well as massively supporting COVID-19 community assessment centres. In many areas strong relationships based on mutual trust were forged between GP leaders and Health and Social Care Partnerships (HSCP)/Board management to urgently deliver the shared aims of COVID-19 community assessment centres and new ways of working. The response of our NHS to the coronavirus pandemic has been nothing short of miraculous.
It was clinical leadership that drove the successful, rapid and necessary reconfiguration of services and not the top-down hierarchy of the NHS that we have grown inured to. Clinical leadership worked well in the pandemic, inter-departmental, inter-speciality, across both primary and secondary care as well as multi-disciplinary team working all worked well in the pandemic. And it can continue to work if clinical leadership is allowed its rightful place alongside management and they continue to work collaboratively as we return to something more normal.

But the previous normal is not the place we want to return to. Pre-COVID-19 the NHS was already running at full capacity. Services were stretched and as we approached winter 2019 we warned that staff resilience and ability were near breaking point. Last winter was difficult for everyone in the NHS, what has followed has caused that to pale in comparison. There was no slack in NHS Scotland, no additional capacity and decisions made in the early days of the pandemic reflect that the NHS was in a perpetual state of running “hot”.

In my original evidence session I talked about the lack of proper strategic workforce planning,

“always trying to fix the now and, because we are so busy trying to do that, it is very difficult to plan for the future”

Doctors have been working with the background of constant vacancies and understaffing. We are consistently told that there are more doctors than ever before, but the demand is more than it has ever been, and that demand outstrips what we can provide with what we currently have. Planning to remedy those workforce shortfalls needs to be one of the first priorities as we move forward from the pandemic. As the NHS continues to remobilise services and deal with the increased waiting lists, doctors must be allowed to use clinical judgement in the prioritisation process, working with their colleagues across specialties and between primary and secondary care.

Earlier this year in my speech to the BMA’s annual representative meeting (ARM) I talked about the target culture that dominated the NHS pre-COVID-19. It was not fit for purpose and did not focus on assessing whether the NHS delivers on what it needs to. It was clear from the Sturrock report that target culture has been one of the major factors in fostering and allowing poor behaviours towards doctors and other healthcare staff.

The current system and narrative around measuring NHS activity is based on an oversimplified view of what constitutes ‘success’ and more often ‘failure’, and fails to reflect the complexity, range and sheer scale of all the NHS does. Monitoring the performance of the NHS and measuring what it does is a vital part of running the whole system. It can help identify pressures, gaps in resource, increased demand and if data from that is used properly that will help to produce targeted solutions that benefit both patients and healthcare professionals.
It is neither realistic or desirable to propose that we should stop measuring, recording and assessing NHS activity. Indeed, setting evidence based goals and aims and associated targets has helped deliver improvements in resources and treatment pathways. There is also no argument that patients should be given a transparent and realistic indication of how long it will take for them to get treatment and that such a system should strive to eradicate inappropriately lengthy waits for investigation or treatment. However what is needed is a wholesale shift in approach which moves away from a blunt focus on targets which doesn’t take account of clinical need, and a simplistic narrative that either considers waiting times targets in total for all conditions, or focuses on only one clinical area in a “cherry picking” fashion. BMA Scotland believes that focus needs to be on measuring the quality of care a patient receives and their overall care journey. More information on this can be found in the BMA Scotland paper – ‘Measuring our NHS: Transforming Scotland’s approach’.

Many initiatives have been introduced over the last year to address the basic needs of NHS staff as they go above and beyond, such as the local introduction of wellbeing spaces, the removal of parking charges and provision of hot food. These basic needs were not being met before the pandemic which only goes to highlight the unacceptable place the NHS was in as regards to protecting the mental and physical health of its staff. It is vital going forward that these improvements are not lost or seen as something that is just required for facing a pandemic. NHS staff have always worked in high pressured situations and sadly it has taken a pandemic to realise that we need to protect and take care of their wellbeing.

There needs to be a proper short, medium and long term plan for Scotland’s medical workforce, focusing not just on numbers but also staff wellbeing and empowering clinical teams to lead. This will not just lead the NHS to deliver better care but also maintain a more stable and motivated workforce.

Yours sincerely

Dr Lewis Morrison
Chair of BMA Scotland