STRATEGIC AGENDA FOR MEDICAL DIRECTORS

Discussion paper 2

April 1995

KINGS FUND COLLEGE

STATE OF FLUX
Creating Capacity for Change

Taking the longer view

Ray Flux reports on a workshop addressing future clinical staffing

A major change has taken place in our society (and many like ours) which means that people and professions are re-thinking the ways in which they work and contribute. For more than a decade our government has been committed to deregulationary policies and undermining restrictive practice whether in the industrial sector, the public sector or the professions. But the current challenge in healthcare is not predominantly a government-driven issue: technical capability, public expectations and costs are far more significant. These challenges may threaten established practices and career paths but also offer an opportunity to develop a national health system which is viable for the 21st century.

Medical Directors need to be at the forefront in taking the longer term and broader perspective in the development of healthcare in this country. But many are struggling to clarify the particular contributions that they should be making and to free the time and energy to undertake this work.

Here, we consider one possibility: Medical Directors can make a special contribution to shaping the future medical and clinical staff of their Trusts and thereby, shape a major part of the healthcare employment market in this country. Several considerations make this an important strategic issue at this time:

- Nationally, the pressure is on to align our clinical training with other European countries, so that qualifications are equivalent and there can be a free flow of doctors and other clinicians throughout the European market.

- We need to reduce the hours worked by junior medical staff for their benefit and for the safety of patients.

- Junior medical staff need to learn through systematic training and education with staff in other healthcare disciplines as well as by gathering experience.

- The boundaries between primary and secondary care and between medical and other clinical professions are being
:hnologies and approaches to caring for

- Rapidly changing clinical practice requires that Trusts have the opportunity to challenge and alter the profile of the clinicial services that they are offering, and all staff will need to upgrade their skills throughout their careers.

As a result the training, skills, work patterns and career paths of doctors and other clinical people are likely to change significantly in the next decade. Future medical staff training and local pay bargaining are being considered nationally while Medical Directors and Trusts for the most part do not have a very coherent input to the process (see panel). Yet they are, potentially, the major shapers of the future employment market for doctors.

> Roy Lilley, one of the Government's most ardent supporters of the NHS Reforms has warned that hospitals are not ready to introduce local pay bargaining for doctors and nurses within the timetable set down by the Department of Health. Mr Lilley wrote to every Trust chairman in the country. Only a small minority had addressed the issue. Most of them said that they did not want to pick a fight with the BMA and had put the problem in the "too hard basket."
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> *Daily Telegraph 5.2.95*

Can a Medical Director, working with colleagues, design better ways to train staff, develop and use clinical skills, support continuous learning, create flexibility and opportunities within careers and deal with people who struggle (or refuse) to change? How much flexibility is there for local leaders to plan or reorganise for the future or are the strings attached to central professional bodies and government too useful to ignore, too tightly restrictive to escape, too dangerous to challenge and too complex to unravel?

The strategic agenda of Medical Directors has enormous potential, but each individual needs to choose the contribution that they can best make. Shaping the future clinical staff profile is an essential task for Trusts. It involves both working with people inside the organisation and being aware of national interests and imperatives. This discussion paper may suggest some ways to get started.

Workshop Design

At a one-day workshop for medical directors and board level colleagues, the challenge was given to create viable future medical and clinical staff profiles from the baseline of staff presently employed in four different types of Trust from around the country. Sixteen invited participants worked in groups of four, each group focussing upon how the medical/clinical staff of one of their Trusts could develop over the next 5-8 years in the face of a raft of influences. Members of each group came from broadly similar types of Trust.

With four different types of Trust and with this methodology, we hoped to explore how each Trust could profile its future to illustrate some specific options and to identify which of the many influences upon clinical staffing they reckoned to be most significant. Many influences are possible, for example:

* the markets that they might wish to develop,

* their commitment to research and education,

* retirements and the availability of new skills,

* technologies which would come on-stream,

* their use of staff grade doctors,

* locally determined pay and conditions,

* doctors' involvement in management,

* new boundaries to professional practice,

* multidisciplinary approaches to education and training.

We aimed to share thinking from the workshop (where this did not breach confidential issues) with Medical Directors around the country. The ideas contained here by no means solve a very complex problem, but this discussion paper is intended to broaden this debate (see panel 2) and add some urgency to it.

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Stephen Hunter, Medical Director
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Challenges of describing the workforce

In future, NHS Trusts will have much greater control over the balance, mix and focus of their clinical staff than before. Whilst this responsibility will be an essential part of a Trust's ability to respond to new service requirements, it is no part of our recent past, and systems and expertise to manage it in future need to be put in place.

In one sense the task for our workshop was a simple one: Members were asked no more than to imagine (with some detail) what the future staffing of an organisation might look like, with no particular requirement to say how that could be achieved. Given this task, a Medical Director needs useful ways of describing the workforce, groups within it and individuals.

How would Medical Directors want to describe their present workforce? Would the data be available to create that description and would new dimensions be required to describe the workforce needed for the future?

The data most probably available now would enable someone to describe the age profile of staff, their levels of qualification, the distribution of grades and part-time/full time contracts, years of service, years to retirement, etc.

In three of our four client Medical Directors' situations, the data which they sought from their organisation to describe the present situation was readily available and they had some confidence in its accuracy.There were problems of definition and consistency in the way that data about clinical staff are collected, and less confidence in data for medical staff in rotational training posts. The adequacy of data in the fourth Trust was clearly not satisfactory, to the extent that it was not possible even to be sure how many people were employed or what they were contracted to do!

In addition to this quantitative data, each Medical Director also has a range of anecdotal information and impressions about the characters who make up the staff, their strengths, weaknesses and aspirations. This knowledge is rich and colourful in some places, thin and pale in others. Such knowledge of individuals on the staff can be made much more robust through good appraisal and workplanning procedures.

Each type of data has its value. Combining these sources of data usefully and making both more reliable is a challenge for the present. But even if a full and balanced picture of the present were available, how would this need to be extended as one planned for the future? Would some of the following dimensions be considered important:

- experience of or aptitudes for learning multiple technologies?
- trained in the Trust or imported?
- employment contract type eg full, part-time or staff grade and with what types of security?

Human Resource issues was believed to offer the greatest scope for local control and flexibility within the organisation. Options involving significant change and maintaining the status quo were considered. The status quo option seemed a passive and erosive one, whilst the alternative represented a huge challenge to carry forward. Within the Service Commitments area changes involved,

- an increase in the number of nurses and professional practitioners,

- an increase in the scope of their work,

- recruiting younger and committed consultants who are more specialised,

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The approach to Education and Training called for a reduction in the number of trainees providing services and an increase in CME with more of this conducted in a multi-disciplinary context. If Research and Development work were to be developed as a specifically commissioned area of business it would require specialist research supervisers and committed professional researchers.

The New Balance

Reflecting upon this challenging day, some substantial messages and questions remain:

The NHS Reforms offer the opportunity for a significant repositioning of the publically funded service in the wider system which addresses the health of the British population. This involves recognition that the wider system has more players and partnerships than before and the NHS has to clarify and negotiate its proper future role within that system. Skills, confidence and flexibility within the workforce are important parts of being able to negotiate that role.

Increasing flexibility within organisations involves working at an individual level with people who have personal, professional and advocacy interests which they wish to promote or defend. It also means working with government and national bodies who have proper interests in standards and professional practice within local systems.

Finding a productive and safe balance of influence between central national bodies and local management is a delicate and crucial matter and the options for clinical staffing in future offer a complex example, perhaps one of the first test cases of finding this balance.

NHS Healthcare is now delivered through some 430 Trusts who will create the major part of the training, research and employment market for doctors and other clinicians. Our workshop suggests that significant changes in the way that health care is delivered are both necessary and desirable.

The service designs for the future seem to require considerable local freedoms to achieve and the complexity of communicating with all the important players, satisfying their interests and orchestrating their behaviours over a protracted period is a huge task for local leaders to pull off. This will seem the more so, because some aren't able or powerful enough, many have other complex issues to deal with and because any one of several central powers may act to bring innovators or risk-takers back into line, for example, in relation to local pay and conditions or recruitment practices.

The temptation for many will be to remain passive or powerless until a national lead is taken or a pattern emerges. There may be sense and safety in this approach for many. But there is great danger for government and for the service in leaving the problem to national agencies: the government, Royal Colleges and BMA, alone: Our past tendency has been to deal with complexity by holding key elements in planning near to the centre where most authority and integration can occur. Command and control authority which can coordinate the actions of diverse players has resided in central government, accrediting bodies and trades unions each of which set rules which are applied to all the country unilaterally.

This expectation that central bodies can organise sensitive responses to complex situations is seriously flawed. The planning models on which this thinking was based were largely developed in wartime when local people and agencies were prepared (temporarily) to subjugate their goals, interests and energies to the national interests which were relatively simple (or could be made to seem so). Without this, governments and national bodies do not maintain such a dominant and integrating position but become part of the pluralistic system where goals, interests, powers and energies become distributed among many players.

In this pluralist sytem, shared visions and values, needs and opportunities, negotiation and charismatic people shape and pull the system, within the framework of the law, in particular directions from time to time. This is the market.

Over the next relatively short period, we shall see a new balance emerge between the nationally laid down standards and laws for organising staffing of healthcare and the locally determined responses. It will take astute and courageous people to lead on the local scene to ensure that models of staffing are not determined by national imperatives by default. It will take astute and courageous people at national-level allow this to happen also.

Some Medical Directors must be among them.

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Each type of data has its value. Combining these sources of data usefully and making both more reliable is a challenge for the present. But even if a full and balanced picture of the present were available, how would this need to be extended as one planned for the future? Would some of the following dimensions be considered important:

- experience of or aptitudes for learning multiple technologies?
- trained in the Trust or imported?
- employment contract type eg full, part-time or staff grade and with what types of security?
- match of ethnic and gender mix with the community served?
- experience of and willingness to work in primary care or community care settings?
- preferences and aptitudes for audit, teaching, market research, public relations etc?
- enthusiasm for moving procedures towards capable but less qualified staff?

In the first instance, this approach did not much catch the imagination of the group! However, they were enthusiastic and challenged by trying to imagine different or radical kinds of service. Their pictures of the future described changed boundaries and ways of working between professional and informal carers, between different clinical professions, between local government and NHS agencies, between those in primary care, community care, secondary and tertiary centres, between Accident and Emergency centres and inpatient facilities. These changed boundaries would certainly involve different roles, different training and different participant numbers in each of the areas compared with now.

The vision of future services is an important and powerful step towards identifying the people, skills and attitudes that might be needed in future. The group's approach accords with the strategic imperative: "Function before Form!" and since they were working through these steps, the workforce profiles would have developed had more time been available.

We have also noted that designing the future workforce is an unfamiliar task for leading clinicians but closely related to picturing the future service which is much more their domain. It was therefore possible to slip into the familiar task. Given these familiar and unfamiliar tasks, an important alliance may need to be developed in many Trusts: a strategic link between the Clinical Executive Directors (Nursing and Medical) and the Human Resource specialists who can help in describing the future workforce.

For Medical Directors reading this, here are two challenges:

How helpful would our staffing information systems be to describe my Trust's present workforce and what additional information would I need to give an acceptably balanced picture from which to build models of the future?

Do I have any strategic projects where I work closely with the Director of Human Resources?

How the participants saw the Future

THE GENERAL ACUTE HOSPITAL TRUST

In this Trust, traditional personnel data about the medical and clinical staff are available and its' accuracy was felt to be adequate, although there was less confidence expressed about data concerning staff in rotational training. It was not easy to describe what people are employed to do or who pays for them, so that trying to get a picture of the relative return on investment for different types of staff was difficult. This lack in the data did not imply that the system does not work on the ground or that people were employed without purpose, but rather that the managerial capacity to analyse how staff are employed was some way behind.

An underpinning assumption of the future options considered was that the recommendations of the Calman Report would be implemented in some form. The favoured response to this was a radical development of roles across the professional and primary/secondary care boundaries. For the Acute hospital this would involve:

- thinking about the development of the role of specialists rather than consultants;
- trainees having reduced service commitments.
- some common core of training for all health professionals: doctors, nurses and paramedical staff;
- staff expecting to have several roles during the course of a lifetime career;
- seperating diagnosis and treatment with more care and treatment being managed by people other than doctors, for example by expanding the role of nurse practitioners;
- the development of computer based records of patients' care so that hand over of care plans, monitoring of progress and consultation on difficulties will be easier;
- the boundaries of primary and secondary care being fuzzier and the core business of acute hospitals being better focussed, so that for example, GPs would manage more care in the community and responsibility for referral to community hospitals;

This list raises enormous questions about how long-established attitudes and expectations of professional staff will be challenged and how they will be supported through such changes. What balance of central government action and local initiative will bring about work environments where staff engage with these changed ways of working, where they feel safe with so much flexibility and continue to deliver safe and high quality services to patients?

THE COMBINED ACUTE & COMMUNITY TRUST

Compared to others of similar configuration, this Trust was lacking consultant staff and was dependent on a significant number of middle grade medical staff for service delivery. Expenditure on medical staff was estimated to be £4m. With the implementation of the Calman Report recommendations, up to 1/3 of middle grade staff would be lost and 1/3 of the time of the remaining staff would be spent on more formal training. As the Trust considers Education and Training as an integral part of its future, the impact upon staff required for service provision is significant.

One option explored would require a massive investment (nearly double) in consultant staff to deliver a consultant-led service. To recruit to this level at consultant grade would probably require local discretion in terms and conditions offered to candidates and active recruitment outside the UK. The Trust may also need to consider cooperative ventures/partnerships with other Trusts to create attractive jobs and ensure successful recruitment. Though the workload for doctors would remain the same, the nature of the work undertaken by consultants would change. This would involve an explicit redefinition of the role of each consultant and this explicitness may result in loss of flexibilty of staff as people work to contract.

A more favoured option for this Trust would require some increase in the number of "specialists" but to a lesser extent than the first option. The aim would be to change the definitions of primary and secondary care, engaging and working more closely with General Practitioners, extending the understanding of nursing and the role of clinical nurse specialists and developing guidelines and protocols of care. This would also require a definition of the role of specialists as well as of the current consultants, a review of the work they undertake and identification of the skills required to deliver services safely and appropriately. These new ways of working across the boundaries of primary, secondary and tertiary care should be designed with patient focussed care at their core and should be piloted. Examples of piloting Hospital at Home and Hospital Aftercare systems were given.

In either scenario, the pace and nature of the implementation of the Calman Report were seen as significant factors in which the Trust might become more proactive.

THE COMMUNITY/PRIORITY SERVICES HEALTHCARE TRUST

In this Trust, the balance of influences upon its future shape seemed to shift from within the organisation to forces outside. Inside, there is a smaller and more disparate group of doctors whose services need to cross the boundaries of the organisation and integrate with services outside. Externally, the long term credibility of the joint Health and Social Services mental health strategy and the substantial strength of local GP fundholding create most uncertainty.

The present strategy for mental health could create substantial staffing problems in future if conventional roles are maintained. These problems were of such import that they require either refining the approach towards a more radical staffing and service model or compromising the strategy in successive commissioning rounds.

An alternative staffing model involved more focussed consultant and junior medical staff input to mental health services with a substantial increase in the numbers and scope of associated staff, psychologists, counsellors and community psychiatric nurses, in the service. Various models of community based mental health services exist. The favoured model in discussions was the development of Community Treatment Teams, but it was held that development should proceed incrementally to ensure the safest service for patients. Establishing the credibility of these models with key people and agencies would be the single most important factor.

THE TEACHING HOSPITAL TRUST

The Teaching Hospital Trust was perhaps the most complex organisation to imagine in future because of size, prominence on the political horizon, number of interested parties and its multiplicity of roles within the healthcare system. The group even found that location within or outside a metropolis made a significant difference! In this case, the metropolitan University teaching hospital Trust comprised some 1000 beds, located on several sites and 6000 staff, nearly 1000 of whom are dentists or doctors (450 consultants and >500 staff in training). The Trust has local and remote competitors for almost all of its services. Data to provide an adequate overview of this complex situation was difficult to access and unlikely to be accurate or reliable.

Like the Community/Priority Services Trust, the balance of forces which control the direction and shape of clinical staffing seemed to be outside the organisation. Not that the clinical staff are an insignificant force but their very numbers and diversity militate against a concerted view or voice, and this occurs in the face of powerful forces in the environment. It seemed that the bigger questions about the future of the Trust would be addressed in a wider political and national context. To get some grasp of this complex situation, the group seperated out three areas of business for the Trust, namely, Service commitments, Research and Development, and Education and Training. For each area the group looked ahead focussing upon Business, Human Resource and Capital options expressed in terms of revenue, workforce and sites respectively.

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W O R K S H O P S

The role of Medical Director is still developing as Trusts and individuals sort out what is required and what is possible. Opportunities for Medical Directors to meet and to find that others are grappling with similar opportunities, confusion and frustrations is reported as being of the great benefit. The variety of circumstances in which Directors can meet is growing, but many are still isolated. Through this bulletin we hoped to share some of the discussions occurring in our programme, to stimulate further thinking and debate, not just for Medical Directors but also for senior colleagues who work alongside them. Our discussions will continue throughout 1995 with two scheduled programmes exploring four themes:

work on current problems

speculations about future demands on health systems

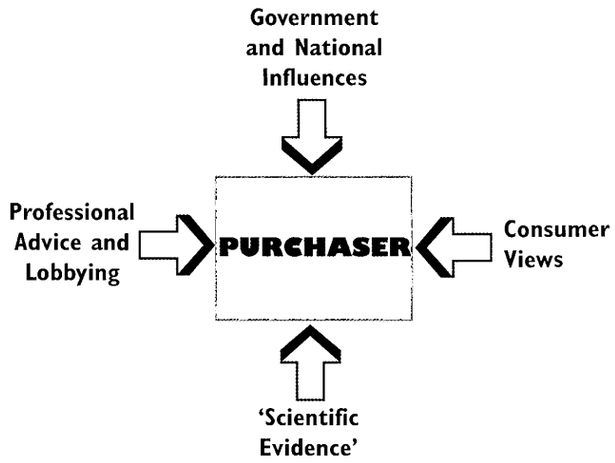
priorities for Medical Directors

models for more effective inter-personal work

If you would like to participate in these workshops with others close to your own experience, please contact Ray Flux to discuss the 1995 programmes or apply directly to the King's Fund College on 0171 - 727 0581. We hope that further issues of this bulletin will follow.

Evidence-based Practice

The seperation of purchasers and providers of health care, has brought to the fore a major intellectual challenge for both parties. What should our health services be doing and how should they best be configured to serve the population? Ron Zimmern, Director of Public health in Cambridge and Huntingdon Health Commission describes the influences upon his planning function thus:



The long established influences: pressure and advice from government and the clinical professions are, in part being balanced with scientific evidence where this can be marshalled, and with the preferences and concerns of service users.

From a low base, the scientific evidence available to support purchaser decisions has undergone a surge of interest and investment. This has been characterised by the commissioning of new research in a concerted way, the organisation and dissemination of past research results, more commitment to audit, the development of clinical protocols based upon professionally-determined best practice, and the publication of guidelines for organising economic analysis alongside clinical trials.

An improvement in the quality of scientific evidence to influence and support purchaser decisions is only one part of the shifting balance of influences. There is considerable concern about the access of professional clinical advice to purchasers. How do doctors working in Trusts advise purchasers about their services and their patients' needs? Would a workshop focussed upon local organisation of evidence-based practice in a wide sense ie to include evidence from clinical specialists, consumers and their advocates and from scientific sources be of interest? If so, contact Ray Flux expressing interest or ideas for an event in July.

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