The Surgical Workforce 2006

INTERIM REPORT AND POLICY UPDATE FROM
THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

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The Royal
College
of
Surgeons
of
England

1. Introduction

This short report aims to provide an interim review and policy update to the College's 2005 report *Developing a Modern Surgical Workforce*[1] and to give some indication of the current thinking around future workforce planning.

It is aimed primarily at surgeons, but also provides a useful summary of surgical workforce matters for Strategic Health Authority (SHA) workforce planners as well as workforce leads at trust level.

A full review of *Developing a Modern Surgical Workforce* is scheduled for January 2008.

2. Policy update

Since the 2005 publication, the government has enhanced its fast-paced reform programme. Many of the policy changes were described in the College's Reconfiguration Working Party's report *Delivering High Quality Surgical Services for the Future*[2]. Key policy themes which will have an effect on surgical workforce planning can be summarised as:

- A greater emphasis on high quality commissioning to achieve a patient-led NHS
- The continued 'marketisation' of the NHS and the drive to cut waste, achieve value for money, improve efficiency and increase productivity
- The availability of enhanced information to commissioners to facilitate the above and limit variations in practice
- Decentralisation of power - national standards with local implementation
- The extension of patient choice and payment by results as a means of promoting competition and contestability
- Proposals to shift care closer to home
- Service reconfigurations to facilitate safe, cost effective care provision
- The continued utilisation of ISTCs and the relaxation of 'additionality'
- Modernising Medical Careers (MMC) and the European Working Time Directive (WTD)
- A continued focus on safety and leadership
- Emphasis on public health – prevention of illness and health improvement

3. What changes will be required in service and training provision?

It is clear that the direction of travel is set drastically to change where and how surgeons work and train. The new NHS operates a supplier-market which is led by service commissioners. Surgeons need to understand the fundamental shifts in power and focus in order to safeguard patient safety, provide effective treatment in a timely way, and attain professional effectiveness.

The devolution of power from Whitehall will continue to give service providers and commissioners more freedoms. The push to extend payment by results (PBR) to cover all services and for all Trusts to achieve foundation status, coupled with the increased use of the independent sector (IS) means that eventually decisions about staffing, service and training provision will be made locally and will be based upon meeting local service needs, maximising profit and gaining a competitive advantage over other providers.

3.1 A consultant-delivered service?

The College has pressed, for many years, for consultant expansion in order to achieve a consultant-delivered service based in a combination of teaching hospitals and district general hospitals (DGHs). We have seen the surgical consultant workforce grow by almost 60% in the past ten years (1995-2005). In the same period, the number of SpRs has grown by 83% to prime consultant expansion. This growth was necessary and has been welcomed.

The specialist associations set consultant expansion targets for 2010 based on the traditional service models of regional teaching units and DGHs. Current projections suggest that these targets will be reached in most cases by or soon after 2010 and, in some instances, the targets will be exceeded. Concern has been expressed that the profession is training surgeons for whom there will be no consultant posts. In some specialties this is true (for example in cardiothoracics, where technological advancement has significantly reduced the need for surgical intervention). Other specialties have reported a lack of employment opportunity for Certificate of Completion of Training- (CCT)-holders, but further in-depth investigation is required to confirm the existence of this problem and to assess its seriousness.

Having increased the consultant workforce and the training grades, the government now wishes to see a return on its investment and has embarked upon a series of initiatives which focus upon productivity, efficiency and cost effectiveness.

Fundamental to the economics of ensuring cost effectiveness in service delivery is to use the lowest cost 'resource' to undertake the majority of the work – there is some sense to this argument. Freeing up consultant time to focus only on those tasks which require their breadth and depth of knowledge and skill makes good sense from both a fiscal and patient experience perspective. There must, however, be regulation in the system to make sure that the most appropriate resource or level of staff is used for each task in order to ensure patient safety and avoid the potential hidden costs of, for example, inappropriate admissions or increased length of stay which may be incurred by using less experienced decision makers at key points in the patient pathway.

In terms of productivity and efficiency, the Department of Health (DH) has, for the first time, made available to Trusts and commissioners information tools which enable the identification of outliers in terms of output and activity. The College believes that outcomes from healthcare should be measured in terms of better health, and not procedural activity. However, such process measures, especially of activity, are being used as a proxy and surgeons must be aware of this.

Recent consultant redundancies are said to have been primarily brought about by a mismatch in the number of consultants and the predicted workload. Primary Care Trusts (PCTs) and Trusts are becoming more able to identify such disparities and recognise the effect this might have on their potential to generate income. Trusts will wish to correct any over/under supply swiftly.

Providers will be examining their staffing and workload closely, mainly in response to pressure from commissioners to contain costs and employ tight utilisation management techniques (that is, ensure that surgical intervention rates are in line with national levels as outlined in the Chief Medical Officers' Annual Report[3]). This, combined with the transfer of activity to the IS in some areas may mean that Trusts will look to reduce their expenditure on medical staff in order to avoid financial crisis.

What this means for surgeons is:

- Trusts will start to think about less expensive ways to staff their units, and this may mean different types of staffing models which may not include the current ratio of consultants to service grade and trainee surgeons.
- The old adage of 'a job for life' and being linked to one employer throughout one's career is no longer a reality.

a) Staffing models

Historical staffing models where one or two consultants managed the surgical team are outmoded. Trusts will seek to profile the surgical services they provide and examine translation rates and modes of activity to decide upon the best staffing model. Large numbers of consultants are not always required to deliver a service. Service grade doctors responsible to a consultant have for many years made a major contribution to service work. Ratios of consultants to service grade staff vary considerably amongst the surgical specialties – for example, according to Department of Health workforce data, in cardiothoracic surgery and neurosurgery, service grade doctors make up approximately 7% of the non-trainee workforce, in general surgery, 20% and in trauma and orthopaedics and urology, the figure is closer to 23%. In oral and maxillofacial surgery, meanwhile, 42% of the non-trainee workforce is made up of service grades. These figures provide evidence to employers and commissioners that reliance on service grade doctors is an acceptable method of staffing the hospital whilst ensuring patient safety and reducing expenditure. MMC will likely expand the service grades significantly, and Trusts will seize upon this additional staffing resource to run essential services within the hospital, sustain service reconfiguration and support initiatives to move care closer to home.

Non-medically qualified staff substitution has been in operation for some time. Practitioners of various sorts have been used to reduce the burden of unnecessary non-medical work on junior surgeons to enable them to concentrate on their training. In many instances these have been successful (for example, the night nurse practitioner roles used in Hospital at Night teams). Whilst using non-medically qualified personnel to free up the time of medical staff appears to make good economic sense, there are concerns that substitution might not be a cost effective solution in the longer-term. Practitioners may deal with previously unmet needs or actively generate new demand for healthcare. If this is the case, such role substitution will not reduce the surgeon's workload or reduce care costs. It remains a fact, however, that the IS is looking to expand their non-medially qualified personnel and contract their medical staffing and the NHS may follow suit.

Consultant expansion has meant that, in many units, there are a large number of consultant surgeons within each specialty. It is impossible for them all to manage the service and so some of them will have responsibility for managing staff, others for training, and so on. In order to provide a safe and efficient service, the surgical team must be well managed and led and appropriately resourced.

Consultants have an important role to play in senior decision making and service design and they must be free to effectively utilise the skills and experience they have developed over a number of years. In order to achieve this, they must be adequately supported to work in teams and to focus on managing uncertainty, effective triage, critical decision making, training, and achieving better outcomes. Consultants involved in clinical directorship must be more closely aligned with the business and financial aspects of the unit and wider organisation and should have influence over the provision of an appropriate workforce.

b) A job for life?

Trusts have already started to engage surgeons on a short-term basis to protect the employer's interests – this may mean higher costs initially (to attract the appropriate calibre of surgeon), but will enable flexibility in recruitment and retention and cut the longer-term costs of pensions, sickness, etc.

Competition in surgery has always been strong and rightly so. It has never been the case that each and every SHO went on to attain a national training number (NTN) and that each and every CCT-holder went on to become a consultant. It is certain that, in the new world of PBR and a commissioner-led service, the attainment of a CCT will not guarantee any surgeon a consultant appointment. In order to be appointed and to function effectively as a consultant additional abilities and attributes, including leadership and management skills will be required.

Surgeons must start to think differently about their employment prospects. A CCT will be a valuable commodity, in that it will assure that a surgeon has attained a level of competence that will ensure patient safety in a given field. Trusts will be mindful of the fact that they must provide a safe and efficient service in order to attract patients under the 'choice' initiative.

Some surgeons will not wish to work as a consultant, preferring instead the sometimes more predictable working arrangements of the service grade which may allow an agreeable work/life balance.

c) A hospital for life?

Surgeons must also move away from the current idea that they will work at one hospital/Trust throughout their career. In reality, they may be more regionally-based, a return to the position prior to the late 1970s/early 1980s, or they may work across the traditional boundaries of primary and secondary care. Such employment structures are based on networks and not single locations.

The recent White Paper *Our health, our care, our say*[4] will be instrumental in changing the way in which professionals and patients think about hospital buildings. There is a need to move away from traditional thinking about the 'bricks and mortar' of the hospital. More lateral thinking is required about how services might be provided in the safest and most appropriate location for patients and this must be the driver for the creation of different models of service provision and employment. Commissioners will be looking for innovative methods of delivering services. Both concentration of some specialist services and networking of more generalist services may be required to make the best use of resources and provide appropriate access.

Consultant expansion has not resulted in an efficient or equitable distribution of doctors across geographical or specialty boundaries. It may be that the government will start to use incentive mechanisms to encourage doctors into locations and specialties which are most in need. In order to take advantage of this, surgeons will need to be flexible in their approach to practice.

3.2 Training

One of the consequences of payment for activity in the NHS is that, inevitably, trainees will become 'expensive' – they will reduce the throughput of the unit and thus affect the potential for income generation. Consequently not all hospitals will wish to take on trainees

unless appropriate reimbursement is provided to make up for the loss in earnings. Training is a valued activity and one which should be appropriately rewarded. The DH is currently examining the funding mechanisms for training to achieve the right incentives to modernise training and service provision, potentially making the training levy consistent with PBR so that it is adequately funded and recognised.

Not all hospitals will undertake training and those without trainees will need to recover the shortfall in service commitment and therefore we may see a further expansion of the service grades, along with perhaps moderate consultant expansion. It is possible that, in hospitals with trainees, service staff will expand such that the trainees may become supernumerary and therefore able to meet their training requirements within the reduced working hours limits required by the WTD.

4. Facilitating quality and patient safety in the new NHS

The government is keen to modernise the way healthcare services are delivered in the UK. This is an opportunity for surgeons to be at the forefront of redesigning services and ensuring patient care.

In order to do this, surgeons must:

a) Understand the commissioning process

As surgeons, we are in a unique position to advise on appropriate service delivery mechanisms to ensure patient safety and quality of outcome. We can:

- Engage with commissioners and offer our services to maximise the benefits to patients of surgery
- Advise on outcomes and effectiveness
- Develop services which will generate income for the Trust and also help to maintain other services (for example, the provision of paediatric ENT services which are relatively low risk and high volume, in order to safeguard other paediatric services and resources on site)

b) Understand employability issues

Since the future of the service cannot be predicted (because of the rapidly changing technological, pharmaceutical and clinical landscape) the workforce will be increasingly defined by competencies and not divided by professions. Surgeons must be flexible in their practice and able to respond to service change. MMC will go some way towards assisting with this. Movement between specialties will be made easier by the competence-based approach of MMC – trainees may be able to transfer their skills to another specialty without having to fully retrain. This approach would be particularly helpful in specialties such as cardiothoracic surgery, whereby cardiothoracic surgeons could undertake minimum retraining to enable them to become cardiothoracic physicians, who themselves are undertaking an increasing number of minimally invasive procedures analogous to surgery.

The achievement of a CCT provides a route to enter the specialist register. It will not guarantee consultant appointment. Local financial expediency will lead hospitals to look for innovative staffing solutions which may not include employing large numbers of consultants.

Surgeons must develop skills that make them employable in the new NHS. Some examples might include:

> Leadership, safety and managerial skills
> Clinical skills for specific disease-oriented practice
> Trainer skills

c) Understand new employment models

Moving away from institutional boundaries of primary and secondary care and thinking about moving care to the most appropriate and safe location for the patient will help to focus the mind on new employment models.

It may be that innovative working arrangements take the place of traditional employment contracts. The National Leadership Network report[5] outlines some possible models:

> Managed clinical networks
> Principal provider models
> Joint-venture arrangements

In addition, the DH is also looking at social enterprise arrangements.

Such models of employment offer the opportunity for clinicians to take the lead in designing services and to liaise with commissioners to ensure the best services are offered for patients.

5. Conclusion

Clearly, the status-quo is not an option. The surgical workforce is changing dramatically and will continue to change over the coming years. Surgeons must step up to the challenges which now face them and ensure that, to protect patient safety, they are in a position to design, manage and provide safe and efficient services in an environment which is agreeable to the patient. The commissioner-led market will force service providers to examine more closely their outputs, costs and quality. To do this well, service providers must engage clinicians and this will be an excellent opportunity for surgeons to be at the forefront of designing and delivering services for patients. Changing workforce strategies will also provide opportunities for the better use of consultant time, improvements to team-working and the prospect for surgeons to design and develop services at clinical director level. This will involve, for example, a change in the traditional role of the consultant who should be more immediately available as the senior decision maker for emergency patients.

Flexibility in approach is required, as is a re-evaluation of the traditional methods of working and employment. Our role must be to embrace change whilst ensuring patient safety and the effective use of surgical resources and surgical teams.

The College will be publishing a series of guidance notes for fellows and members on the issues raised in this paper. If you have any queries, please contact us at: workforce@rcseng.ac.uk.

Further information on workforce can be found on our website at: http://www.rcseng.ac.uk/service_delivery/workforce.

References

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