If workforce is the problem – why isn't it the solution?

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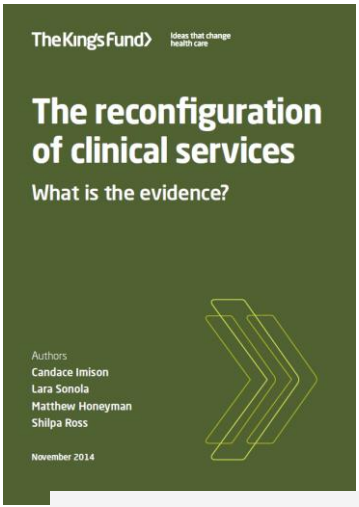
Drawing on evidence from



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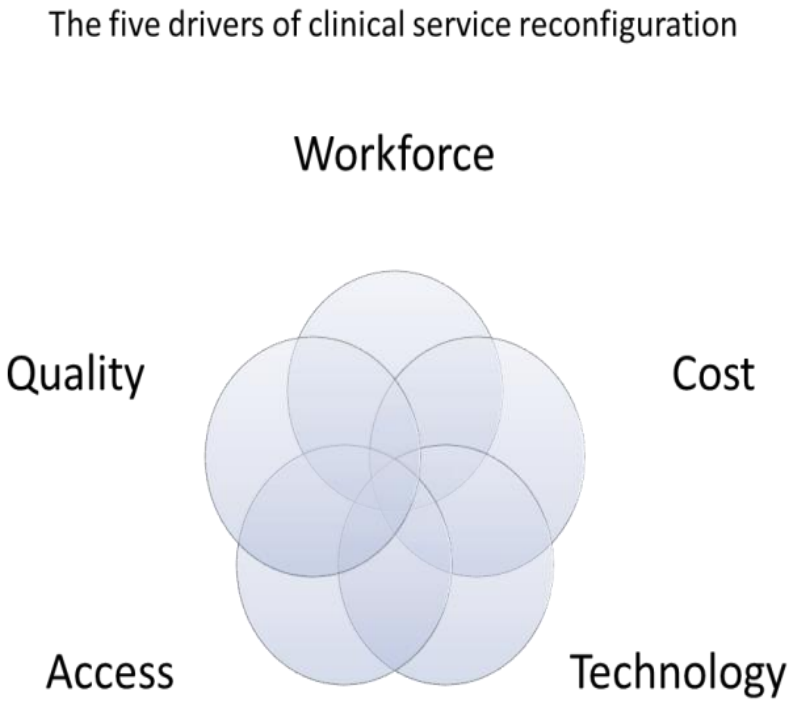
Key drivers of reconfiguration

Drivers of reconfiguration	Number of reconfiguration proposals (total = 108)	Clinical services
Finance	62	All except trauma, stroke, vascular surgery
Estates (often linked to finance)	16	Community services, mental health, A&E and urgent care, elective surgery
Workforce	53	All except stroke and vascular surgery
Safety	20	A&E and urgent care, maternity, neonatal, paediatrics
Quality	19	Vascular surgery, stroke, trauma
National policy (linked to quality and access)	14	Community services, mental health, vascular surgery
Access	10	Community services, mental health

Imison et al , 2014, The Reconfiguration of clinical services

Five forces in tension



Little evidence reconfiguration will save money

- Diseconomies of scale
- Lack of spare capacity to absorb additional activity => high capital costs
- Costs retaining access to less acute services
- Heroic demand management assumptions
- Poor benefits realisation
- If driven by workforce shortages – unlikely to see reduction in staffing costs

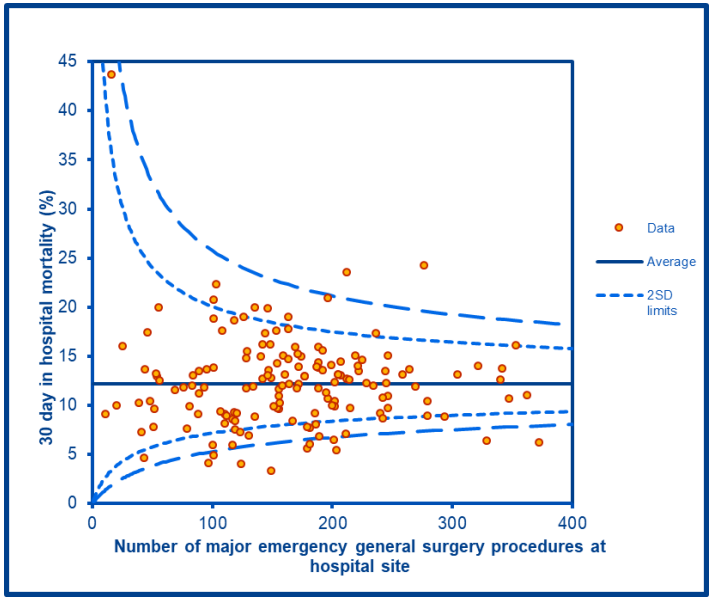
Quality drivers poorly understood

""ten per cent of patients admitted acutely suffer harm and in at least half this harm is avoidable…..It is now clear that the prevention of these service failures depends on far more than the effort and skills of individuals and that organisational, cultural and systems defences are some of the most influential preventative factors.

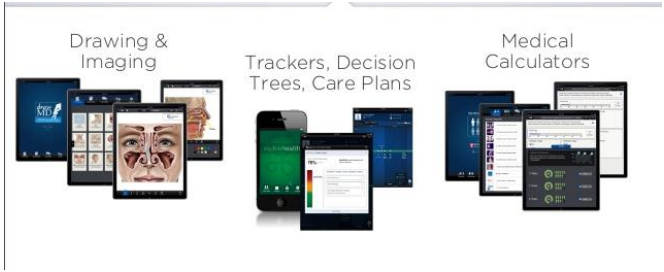
It is also probable that events outside of the main sites of acute care are far more influential in determining the health and wellbeing of populations. Despite this knowledge the focus for improvement tends to be predominantly on strategic reconfiguration of acute sites. This is an important but ***insufficient*** *approach." NCAT Reviewer*

Volume is not always the primary driver

- Marked national variation in outcomes for EGS presentations:
  - Emergency laparotomy
  - Appendicectomy
  - Cholecystectomy
- Stark variation in compliance with key standards (NELA 2015):
  - Senior input
  - Timely antibiotics
  - Documentation of risk



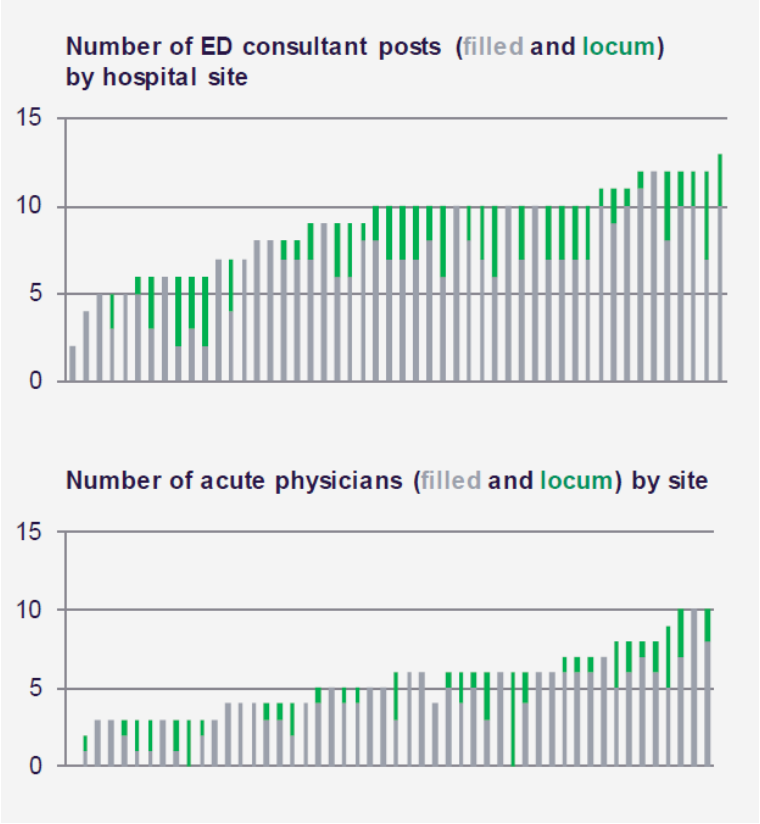
Technology – limited exploitation to date - could help overcome geographical barriers



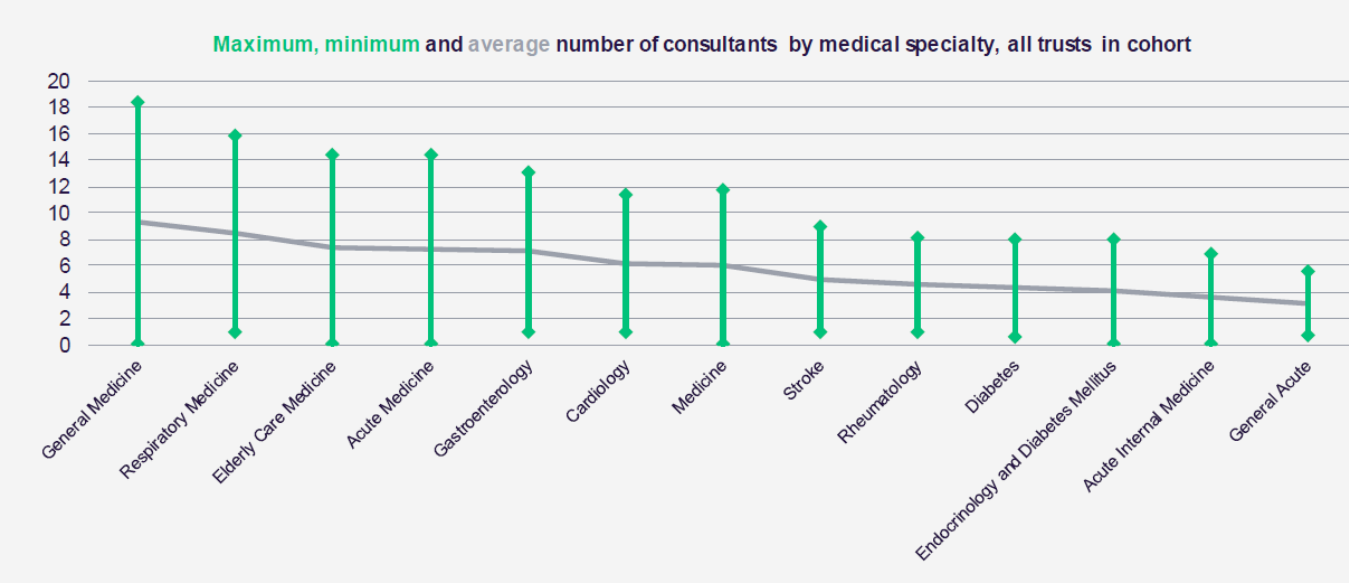
- Care across networks and teams
- Supports care closer to home
- More consistent care
- Working to top of license

Workforce pressures are significant - gaps and growing reliance locums

- Challenges in filling junior doctor rotas – **80% sites**
- Growing dependence on internal and external locums - **45%** of advertised consultant posts unfilled (RCP, 2018).
- **£5bn** spent on temporary staff (2017/18)



Lack of workforce strategy + wide variation in consultant staffing across sites => no "one size fits all" solution



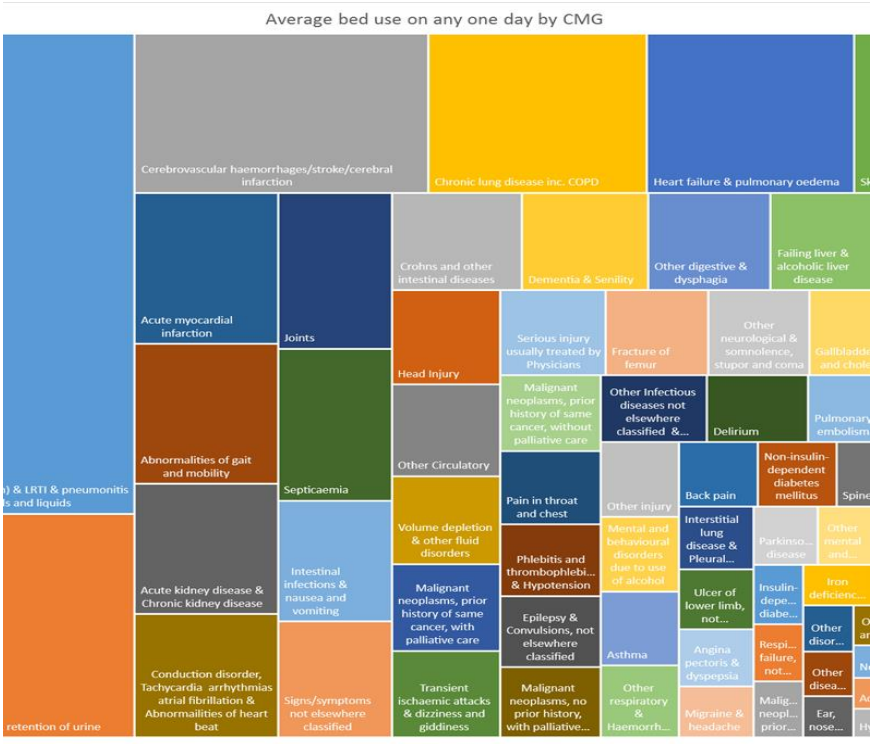
Source: Nuffield Trust analysis of NHS Digital data

40% of the acute medical workload is accounted for by just 10 diagnostic categories.

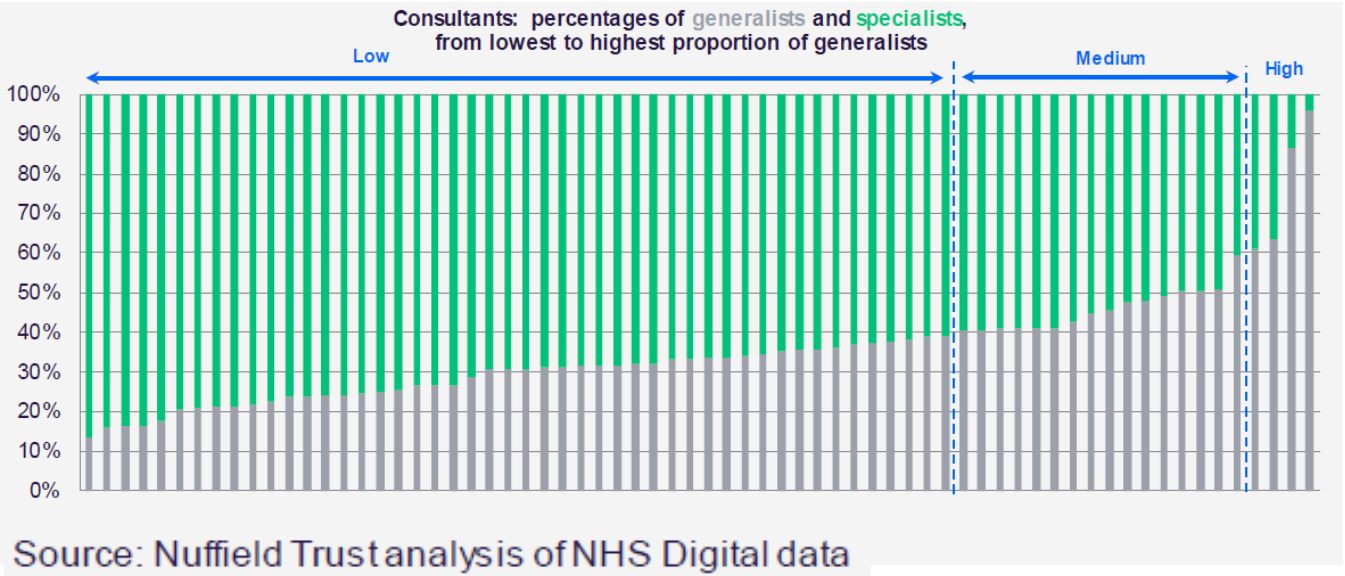
- The acute medical caseload is dominated by older people, many with multiple conditions.

"90% of our take is elderly patients coming in with multiple comorbidities."
Consultant Physician, Site 12

Average bed use on any one day in a single acute trust



Few "specialist" generalists => mismatch to patient needs



Source: Nuffield Trust analysis of NHS Digital data

Generalist: Acute Internal Medicine, Acute Medicine, General Acute, General Medicine, Elderly Care Medicine, Medicine

Specialist: Cardiology, Diabetes, Endocrinology, Gastroenterology, Respiratory Medicine, Rheumatology, Stroke

Regulatory requirements can exacerbate workforce challenges

"problems with staffing are further exacerbated by the imposition of minimum staffing levels, specific rota designs and other standards by external regulators. In many cases these rules are based on guidance developed for larger (often urban) centres, and there is limited evidence that these standards translate into improved outcomes. Smaller and remote hospitals need to befree to design the acute medical service in a less rigid way."

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International strategies to support services in rural areas

Regulation and policy

- Defined access times (< 60 mins)
- Role delineations for emergency services
- Reimbursement policies

Services

- Clinical Networks
- Air transport
- Rural “health hubs” + increasing role of primary care

Workforce

- Small numbers of consultants delivering long hours/low intensity “on call”
- Medical outreach/in-reach between urban and rural hospitals
- Changes in medical training including placements in rural settings
- A&E, medical and surgical teams combine to provide cover

Technology

Telehealth

Source: Rechel et al – Health Policy 2016

Rethinking acute medical care recommendations

Workforce

- Develop innovative approaches to staffing – *team working and new and extended roles*
- Shift from models, based on professional boundaries, to models based on *skills, expertise and experience*.
- More effort to create *continuity of care* for patients

Help workforce go further

- **Rapid assessment** at front door – establish diagnosis
- Consider **pooling clinicians** – single front door team
- **Remove carve out** – eg separate units for frailty, ambulatory care etc.
- **Networked arrangements** for some high risk patients – eg treat and transfer GI bleeds overnight
- More **flexible on call** – recognise – frequency/intensity trade off

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Staffing the hospital

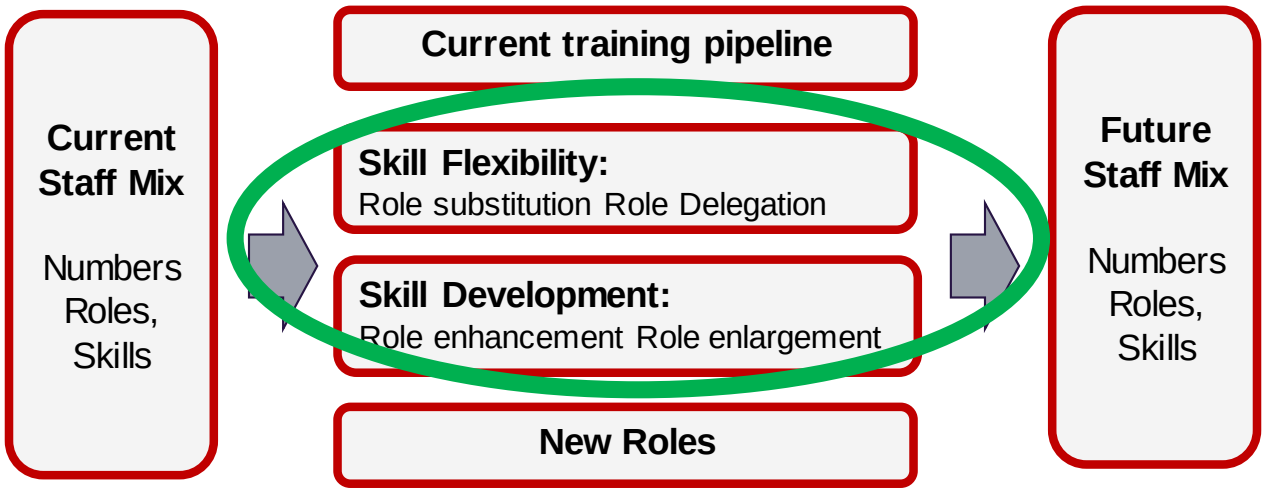
The success of an interdisciplinary team approach to the front door is heavily dependent upon the construction of cover by task/job rather than by specialty. This requires:

- A deep understanding of the requirements of local service provision
- An understanding of the skills, expertise and limitations of individual clinicians
- Support from other professional groups with key skills eg. GPs, ANPs, Physicians Associates etc.
- Tolerance of complexity in construction of cover – eg. pairs of clinicians working together may be needed to provide the required skills in certain cases
- Increasing skills in existing staff rather than hiring additional staff
- Negotiation of best practice/pathways for common and/or life-threatening conditions, reducing variability between individual clinicians

Putting the hospital to bed

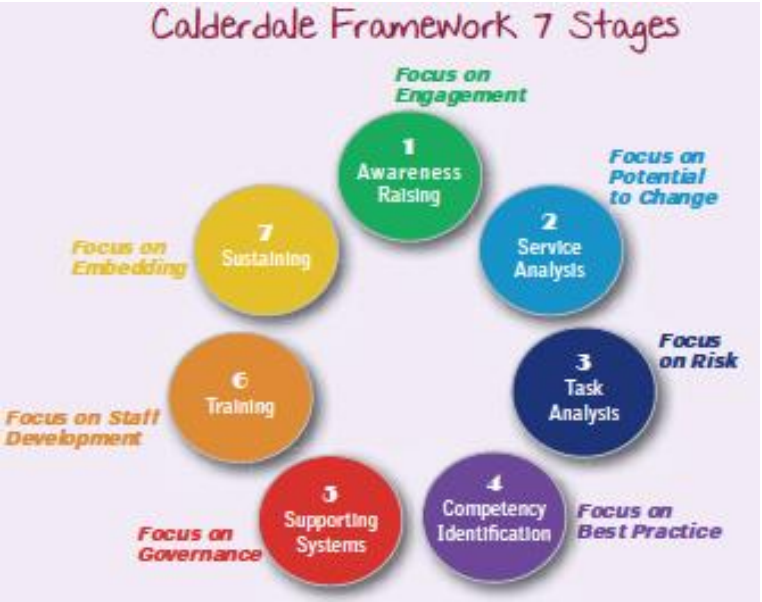
- Patterns of ED and ward activity are predictable; staff working patterns should match these
- Switch from full service to ‘night mode’ at a consistent time
- Use of a single unified team to cover whole hospital based out of ED or ICU
- Team constructed according to skills-mix and expertise; workload distributed accordingly
- Should not be doing ‘day jobs’ overnight
- Clear pathways for patients requiring transfer overnight

Significant workforce development challenge - most of the workforce in 10 years time – here today



Systematic approaches to workforce redesign will be needed

- Build roles on a *detailed understanding of patient needs* and necessary skills
- Strong communications and *change management* strategy
- Invest in the *team* not just the role
- Support *task delegation* - you may need to de-commission old roles if commissioning new ones
- Build sustainability through clear *career pathways* and evolve to make the best use of new skills
- *Evaluate* the impact of your workforce redesign



Source: http://www.calderdaleframework.com/the-framework/

A vision of the future workforce

Where we have been	Where we may go
Care models driven by professional role boundaries	Care models driven by patient needs and goals
Professional qualifications - high barriers to entry, narrow specialisation	Career pathways that widen participation and support progression
Training focus on most expensive professionals	Professionalisation of health and home support roles
Professionals working in specialist isolation	Professionals working as part of multi-disciplinary team with a shared goal
Individual skills development	Team skills development
Professionals as "authority"	Professionals as "coach"
Patient / carer as recipient	Patient / carer as team member

Workforce redesign - delivers benefits staff as well as patients

- More patient focused care
- Improved health outcomes
- More rewarding roles & happier staff
- Improved collaboration and support
- Improved recruitment and retention
- Addressing workforce gaps
- Better use of resource

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