

Doctors and nurses

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No one needs reminding of the challenge facing the NHS, not just for this Parliament, but to deliver quality and good value in the decades ahead. Many agree on what a sustainable new model of care, designed to meet the changing health needs, would look like. Modern medicine and technology have the potential to transform how healthcare is delivered and organised. The innovations that can improve quality and reduce cost are well known. However the pace of change in the NHS cannot keep up with demand. For all the talk of the NHS being the most “reformed” healthcare system in the OECD, Ministers have failed to tackle the one thing that is at the centre of the health system: the workforce.²⁴

For any given hospital, 70 per cent of the costs are in the workforce and the vast majority of staff are in clinical roles.²⁵ England’s doctors and nurses are uncommonly expensive and inflexible. Inputs – particularly more doctors and nurses – absorbed much of New Labour’s unprecedented investment in the NHS. The health service has seen the biggest rise in staff numbers in the last decade of all public services, with headcount growing by nearly a third between 1999 and 2011.²⁶ National workforce planning saw targets set for recruiting clinical staff. However, with the time lag in recruitment and training, the full effect of the rise of medical school places has yet to come through, creating imbalances in the medical workforce between medical grades and specialities.²⁷

Pay has grown even faster. The King’s Fund has shown that pay in the NHS outstripped pay in the whole economy by around 15 per cent between 2002 and 2007.²⁸ Senior staff have benefited most from rising pay, with the latest consultant contract increasing annual earnings by £17,500.²⁹ But professionalism was undermined, doctors got paid more for fewer hours, yet morale went down and turned the best paid and well trained doctors into clock watchers. Merit awards

for consultants and the Quality Outcomes Framework were designed to reward excellence but have not delivered value for money.³⁰ England’s doctors have done even better by international standards. English GPs are the second best paid in the world, with salaries 3.6 times the average in the OECD.³¹

While pay has increased, the quality and financial performance of clinicians remains variable. It is no secret among the medical community that there are good doctors and bad doctors. The response from the Royal Colleges is more of the same, while the resistance to effective performance management continues. Greater flexibility would not only improve the quality of care and productivity but would unleash the innovations that will transform healthcare.

Workforce reform will unlock the service redesign that is needed to integrate care and move services into more cost effective settings. In the past there has been too much emphasis on personnel inputs and silos, without creating flexibility to innovate with different types of clinician, team based care or moving medical staff into the community. Along as consultants are connected to the income stream of hospitals, they will defend their turf and clinically led service redesign will remain a contradiction in terms. Creating integrated clinical pathways will continue to be frustrated by the different professional cultures of doctors in hospitals and primary care, and between specialities.

Meanwhile, clinical and medical education is still not fit for purpose.³² The innovations that will transform medicine, new technology, population health, team based care, are only slowly entering curricula. The Royal Colleges have “locked” the NHS into traditional models of care, with training based on meeting national accreditation standards rather than what employers need. Making greater use of junior doctors in hospital wards, is a useful first step, but over time the established progression of a medical career, from senior house officer, to registrar to consultant, has to be re-examined.

Medical education was organised to train doctors to work individually and intuitively in a hospital setting. Yet while medicine has changed we still train doctors in the same way. The move from intuitive medicine – dependent on highly trained and expensive problem solving professionals – to precise medicine will disrupt the medical profession.³³ Rather than directly providing care, the role of the doctor is changing to be organising and supervising other caregivers.

Innovators in healthcare are delivering productivity and quality through reforming the skill mix and challenging traditional assumptions of medical abilities. In Narayana heart hospital in India, surgeons perform 1 to 5 operations and 70 to 100 consultations a day.³⁴ Consultant productivity is maximised through the support of lower skilled staff and junior surgeons who open and close

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25 Appleby, J. et al. (2010), Improving NHS productivity: More with the same not more of the same, The King’s Fund.

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27 Haldenby, A. et al. (2009), The front line, Reform.

28 Wanless, D. et al. (2007), Our Future Health Secured? A Review of NHS Funding and Performance, The King’s Fund.

29 Bassett, D. et al. (2009), Back to black, Reform.

30 Bassett, D. et al. (2011), Reformers and wreckers, Reform.

31 OECD (2011), Health at a glance 2011

32 Cawston, T. (ed.), (2011), A lot more for a lot less: disruptive innovation in healthcare, Reform.

33 Christensen, C. et al. (2009), The innovators prescription: The disruptive solution in healthcare.

34 Bassett, D. et al. (2011), Reformers and wreckers, Reform.

operations. “Task shifting” and greater focus on team based care is allowing innovators to overcome workforce shortages and extract maximum value out of the most highly trained members of staff. In Aravind eye hospital, surgeons only perform cataract operations, while specialist assistant staff do the more routine pre-operative and post-operative tasks.³⁵

However, attempts to supplement the traditional clinical workforce in the NHS through non-medical consultants and assistant practitioners have only had limited success.³⁶ Professional groups have resisted new types of clinicians, while providers have often struggled to integrate new roles into the workforce or reach a “critical mass” to transform the ward.

While standardisation is seen to threaten clinical autonomy, it is making medicine safer and cheaper around the world. The specialist maternity care provider in India, LifeSpring, has provided consistent quality through standardising all clinical and non-clinical tasks in 180 protocols. These are rigorously enforced; both doctors and nurses have been fired for not following them.³⁷ MinuteClinic in the United States has developed strict protocols for diagnoses and treatment, and like LifeSpring are able to use less expensive, less experienced and less qualified clinical staff to deliver the same quality of care.³⁸ “Airline style checklists” have been championed by the Boston based surgeon Atul Gwande and the World Health Organisation and seen complication rates fall from 11 per cent to 7 per cent in eight global cities, while death rates fell by 40 per cent.³⁹

Clinical leadership has championed new forms of delivery and driven improvements across health systems. Clinicians are responsible for using medical resources, but rarely accountable for the costs of delivery. English doctors bemoan the thought of financial incentives interfering with clinical decision making, but this works around the world. In Valencia, private providers have taken over health services and moved clinicians onto new contracts, with new pay and conditions.⁴⁰ Salaries are performance related, doctors are paid less before, work more and morale and productivity is higher. Partners Healthcare in Massachusetts has a pioneering approach to training physician as leaders. Doctors develop an overarching goal for the organisation to improve value for patients, while accurate and up to date data on cost and outcomes is used to benchmark performance. Peer pressure and financial incentives are combined to improve results.⁴¹

Standardisation, performance measurement and transparency are

essential to take the NHS from a cottage industry to postindustrial care.⁴² Doctors defend their autonomy, yet need help to keep up with the explosion in medical science. Clinicians resist public reporting of data, yet transparency on performance will harness the competitive nature of doctors. Senior doctors were trained to excel in their art, now health systems need a new generation of leaders that can become convenors of care in a team-based approach. The corollary of autonomy and clinical leadership is meaningful accountability. Tomorrow’s health system needs a different kind of doctor.

Promising developments are now on the horizon. Despite the Government’s retention of national planning in its workforce strategy, NHS hospitals are gearing up to exploit the flexibilities they have always had, and start to slip out of the straightjacket of Agenda for Change. Even more promising could be the review of national pay announced by the Chancellor, which will consider how to make Agenda for Change more “market facing in local areas.” Rather than “managing experts” NHS leaders need to innovate with pay, terms and conditions to effectively manage doctors and nurses, genuinely rewarding excellence and tackling poor performance. Service Line Management and Patient Level Costing have been installed but never turned on. Some hospitals are now starting to benchmark clinically-led business units on precise quality measures and young consultants are eager to take the lead in quality improvement initiatives.

Looking across Whitehall, some Departments have lost no time in reforming the workforce. Tom Winsor’s review of police officers’ staff’s pay and conditions is the only independent review of a public sector workforce commissioned by the new Government.⁴³ The workforce is even more expensive and inflexible for the police than it is for the health service, and the Winsor Review could give much greater freedom for chief constables to modernise their workforce. A review of the clinical workforce is long overdue and the Department of Health now needs to follow the lead of the Home Office. Without improving flexibility of the workforce the disruption innovation that the NHS needs for the next ten years will be left in the waiting room.

35 Ibid.

36 Ibid.

37 Johar, G. (2010), “LifeSpring Hospitals”, Columbia Business School.

38 Blair, R. (2005), “Make mine McMedicine”, Health Management Technology, April

39 Haynes, A. et al. (2009), “A surgical safety checklist to reduce morbidity and mortality in a global population”, New England Journal of Medicine, Vol. 360.

40 Bassett, D. et al. (2011), It can be done, Reform.

41 Lee, T. (2011), “Training physician as leaders”, Harvard Business School.

42 Swansen, S. et al. (2010), “Cottage industry to postindustrial care – The revolution in health care delivery”, New England Journal of Medicine, Vol. 362.

43 Bassett, D. et al. (2011), Reformers and wreckers, Reform.