

Assuring Adequate Specialists, Generalists and a Health Workforce Where it's Needed: How Do We Balance Demands to Improve Quality, Expand Access and Contain Health Care Costs?

England and the United Kingdom – Professor Peter Kopelman

How can generalism and practice flexibility be supported and encouraged through education, policy, regulation and compensation? Are there models in the different countries that could provide insights for the others?

In 2007 an independent inquiry into Modernising Medical Careers, chaired by Sir John Tooke, made a number of recommendations about the shape and structure of medical education and training in the UK. It called for a more flexible and broad based approach to medical training, integrating both training and service objectives into workforce planning. The inquiry raised issues about the roles of trainees and consultants and the implications of the Certificate of Completion of Training (CCT) on training and practice. Subsequent inquiries have highlighted the need to develop the current structure of postgraduate medical training so it continues to provide consistent, high quality training for doctors throughout the UK. They also highlighted the importance of more flexible training in order to equip doctors to respond better to changing needs of patients and the service.

This was underlined by the Health Foundation's commissioned report for the Royal College of General Practitioners:

“Medical training needs to become much more generalist in content, with more of it taking place in primary care settings. A placement in general practice should be compulsory during the two-year foundation programme for medical graduates. There should be an immediate extension of the length of specialist training for GPs from three years to five. This must include specific provision for training in disciplines particularly relevant in general practice, including paediatric care, learning disability, mental health, care of people with life-limiting conditions, and end-of-life care for patients and their families.....All medical undergraduates should have greater experience of these core disciplines, and opportunities for shared training modules across health and social care should be pursued”. (RCGP & The Health Foundation, 2011)

In 2011, Medical Education England (MEE) reconfirmed the issues facing postgraduate medical training which included:

- The tensions between the needs of the service and the demands of training;
- The balance between *generalists and specialist* care;
- Flexibility and value for money;
- The need for innovation set against the risks of de-stabilisation if current arrangements are changed.

In February 2012 Professor David Greenaway, Vice-Chancellor Nottingham University, was appointed as an independent chair of the Shape of Training Review. The review is presently considering the following themes:

- *Workforce needs*: specialist or generalists. The review is likely to challenge an underlying assumption that there is only one appropriate outcome of successful training, which all doctors must meet, with any other outcome being failure. It will consider whether there are

alternatives models for training including the balance between generalism and specialism, the timing of sub-specialty training and exit points within training.

- *The breadth and scope of training:* The review will consider how trainees may gain the right mix of knowledge, skills and behaviours to prepare them for the range of environments in which they may need to provide care in the future.
- *The needs of the Health Service:* the tension between service and training when working in a system based on trainees delivering the service, particularly at nights and weekends.
- *The needs of the patient:* addressing the current lack of transparency for patients and the service about the standard of practice that both trainee doctors and trained doctors have attained.
- *Flexibility of training:* considering the difficulty doctors may face moving from one specialty to another.

Professor Greenaway is scheduled to publish his report towards the end of 2013 (see <http://www.shapeoftraining.co.uk/>)

Recent work by the Centre for Workforce Intelligence (CfWI) in reviewing future medical and dental school takes (DH, 2012) highlights the issues of balance between generalism and specialism. The work demonstrates the tensions between the potential oversupply of a trained hospital doctors in all the scenarios explored if there is no rebalancing from some specialties to general practice. However, it makes important assumptions about career choices, part-time working and flexible careers.

What patterns, policies and initiatives are being experienced by each country to promote higher quality and specialized care while balancing the need to meet the range of services required by their populations when and where they need them (without increasing costs)?

The Future Hospitals Commission has been established by the Royal College of Physicians of London to review all aspects of the design and delivery of inpatient hospital care. It is increasingly clear in the UK that a radical review is required of organization of hospital care is required if the National Health service is to meet the challenge of rising acute admissions, an ageing population and an increasing number of patients with complex, multiple conditions. Hospitals also need to continue to adapt in order to take advantage of new technologies, drugs and innovations and manage pressures on budgets. These all affect hospitals' abilities to deliver:

- high quality care sustainable 24 hours a day, 7 days a week
- continuity of care as the norm
- stable medical teams for patient care and education
- optimised relationships with other teams
- appropriate balance between care by *specialists and generalists*
- discharge arrangements which realistically allocate responsibility for further action

A key element of the review is the staffing of hospitals. The "people workstream" within the Commission is looking:

- What is the ideal size and make-up of teams to deliver care to acutely unwell patients;
- How medical consultants should work in the next 10 years;
- The development of new types of medical staff;
- How to make the better use of the current non-consultant medical workforce.

The preliminary conclusions support the concept of greater generalism within the medical staff, extended roles for nursing (but balancing this with the importance of basic nursing care) and the development of the role of physician associates. The importance of specialized care is acknowledged but the challenge is to create a better balance between generalism and specialism that will facilitate safe, high quality and sustainable care for all (see: <http://www.rcplondon.ac.uk/projects/future-hospital-commission>).

The costs of implementation are discussed in the next section. The issue is how better to use resources in an environment where resources are constrained

Why and where is greater specialization of the health workforce needed? What factors impede needed specialization?

Increasing concerns about the affordability of the medical workforce in the UK has resulted in a series of reviews by the CfWI. The technique of horizon scanning combined with Delphi techniques and analytical modeling is providing insight into possible workforce needs for the future. The analysis will inform workforce planners about particular requirements for specialization by professions other than medicine in order to address areas of patient care formerly served by doctors.

The CfWI review of medical and dental school intakes (DH, 2012) forecast (full-time equivalent basis) an increase of 29 per cent in GP supply and 64 per cent in trained hospital doctor supply between 2010-11 and 2039-40. The 64 per cent increase is near the top of the projected increase in the NHS budget across a range of scenarios, and, if it materializes, will have serious budget implications. An increase of this magnitude “may necessitate substantial offsetting cost savings to be made in other areas”. It begs also the question about how current costs are applied and opportunities for greater productivity and efficiency in utilizing the workforce.

Another major factor that impedes such work is a continuing dependence on a traditional approach of planning by profession rather than perceived patient need. CfWI has begun to address this by evaluating the likely needs of an ageing population with multiple morbidities but this requires greater “buy in” from all health professions (see: <http://www.cfw.org.uk/resources/ipc-care-pathway-study-for-older-people-admitted-into-care>). Work is also underway on workforce modelling around skills and competences, and across multiple professions rather than individual ones. This should provide a better understanding of how we might shape existing resources and use them to best advantage.

What are the incentives to produce health care providers that deliver a wide range of services and/or provide services across multiple settings?

Integrated care – patient care that crosses the health boundaries between primary and secondary care and social care – has been long proposed in the NHS. It is again topical in a context of an increasingly ageing population with increasing prevalence of long term conditions such as diabetes, cardiovascular and respiratory diseases and musculo-skeletal problems. Diabetes is an excellent

example where integrated care (shared between primary and secondary care providers) results in enhanced standards of care, improved patient outcomes (and satisfaction) and financial economies.

The incentive for better care is evident to health professionals as well as patients. The major counter determinants are twofold:

- Health professional training rarely includes training to work across boundaries and the necessary additional skills;
- Funding/ commissioning of care pathways remains focussed on traditional schemes of care: primary or secondary rather than integrated care.

See: <http://www.nuffieldtrust.org.uk/our-work/projects/developing-national-strategy-promotion-integrated-care?gclid=ClyMsr2XtLYCFS7KtAodPnwA3A> for further information.

Under recent changes in the health system in England, general practitioners have been given more power to plan services appropriate to local needs, including much of the commissioning. (RCGP, 2012).

'Super' specialist services are provided in relatively few centres, treating rarer conditions, or those that need a specialised team working together at a single centre. The NHS Commissioning Board (now NHS England) has set out a single, national system for commissioning specialised services in a new operating model, to achieve consistent high quality services across England (NHS Commissioning Board, 2013a). NHS England aims to commission the provision of specialised care that is productive, efficient, patient-centred, outcome based and accessible to all regardless of location (NHS Commissioning Board, 2013b).

The NHS Commissioning Board has held a consultation into service specifications and clinical policies and will publish a response soon. Specialised clinicians, expert patients and public health representatives were involved in this process, developing core standards to ensure that providers offer evidence-based, safe and effective services (NHS Commissioning Board, 2013c).

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