Meeting the challenge of change

Report of the College Day on 6 July 1995

Following the success of the first College Day, a second was held on Thursday 6 July 1995, addressing issues of current concern under the title of 'Meeting the challenge of change'. These included research and development in the National Health Service (NHS), preparation for specialist training, and the interface between primary and secondary care. Each session covered the key issues in the area under debate and was followed by lively and informative discussion. Research and evaluation was a consistent theme throughout the day.

Research and development in the National Health Service

Analysis and recommendations

Professor Culyer (Chairman of the Research and Development Task Force) outlined the process of consultation leading to the publication of the Culyer Report in April 1994. This revealed widespread consensus about the problems of research and development (R&D) in the NHS (Table 1), though not their solutions, and as a result focused on the principles of change and not on the detail. R&D is a public good, so the benefits will in due course become available to the NHS as a whole. Market mechanisms are therefore inappropriate for the support of NHS R&D. Current internal market stresses include the perverse incentives of charging for referrals and the difficulties this presents for clinical trials. A levy will be imposed on purchasers in recognition of the opportunity cost of research to service provision and vice versa.

Funding problems include the temporary nature of project grants and the limitations this imposes on career development. The concentration of funding on teaching institutions and special health authorities has led to a lack of support for research in community and primary care; hence the recommendation to promote funding in these 'Cinderella' fields. It is important for non-teaching institutions to declare their own R&D activities so that purchasers can support local initiatives. A single stream of funding will meet direct and indirect costs, service costs to the NHS, and support facilities for research. The costs of establishing and maintaining the information systems and processes to prioritise and commission NHS research should not be underestimated.

The Task Force found that quality control in research was variable: much research was not peer reviewed, intrinsic quality assurance was not a criterion for funding nor were resources targeted to the short- and long-term needs of the NHS. In consequence, it recommended systematic peer review of research wherever feasible, and quality assessment based on the model of the Higher Education Funding Council for England.

There is a need for strategic planning to coordinate R&D, both in funding and in setting priorities, to reduce duplication and deficiencies in research, and to find an appropriate balance between local, regional and national activity. Mechanisms for achieving this which have already been implemented, include a national forum for top level integration of strategy, a central research and development committee (CRDC) to advise on priorities and overall patterns of funding, and a national project register to include all R&D. The Task Force also recommended a central organisation for facilitating clinical trials and for revising the Medical Research Council (MRC) concordat.

Implementation

Professor Holgate (until recently Regional Director of R&D) emphasised that the NHS R&D initiative must be needs-led, with national groups setting priorities in different areas. Achievements to date include the Cochrane Collaboration and the NHS Centre for Reviews and Dissemination. The latter aims to process and disseminate research information to purchasers and providers. The R&D initiative has highlighted the importance of a multiprofessional research base by sponsoring dedicated studentships for nurses and professions allied to medicine, and by establishing a national centre for R&D in primary care in Manchester, it has shown the need to expand research expertise in this area.

Professor Holgate pointed to a number of concerns: the need to maintain stability against a background of rapid organisational change; the future financial support of research facilities (infrastructure support); the temptation to shift from core to project funding; the potential loss of the independence of regional R&D

Table 1. Diagnosis of research and development problems

- poor policy coordination
- ownership issues
- diversity of funding
- patchy quality control
- internal market conflicts
- limited human resources (training and development)

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directors; and a prescriptive model of needs-driven research precluding innovative science.

He concluded by stressing the need for collaboration between organisations; the development of functional teams for research; and the translation of research findings into practice through training, education and continuing professional development.

Discussion

Sir Christopher Booth emphasised the need to support original research and questioned, first, the predictive ability of scientific committees, and, second, the link between research evidence and government policy, citing the smoking agenda. **Professor Turnberg** stressed that the academic community must unite behind the national initiative, but strive to avoid the separation of bioscience from NHS research. Professor Holgate expressed concern about the changing balance between health services research and bioscience, with potential for the erosion of the latter's funding. **Dr Box** confirmed that MRC support for biomedical research remained unchanged. Professor Culyer stated that NHS R&D was not responsible for funding bioscience, but service support for it would come within the remit of the CRDC. He commented that structures alone cannot create the synergies that need to be established between academics in institutions. The R&D strategy does not aim to predict future scientific success; its role is to set objectives and principles to facilitate research activity. Conducting research remains the responsibility of the academic community. **Dr Das** asked how innovations by individual consultants could be supported. Professor Culyer replied that this was probably service development rather than R&D, but reiterated the Task Force recommendations to identify and ring-fence funding for explicit district general hospital research.

Preparation for specialist training

Senior house officers need a better deal: how the Royal College of Physicians can help

Professor Shaw (Medical Coordinator, Joint Committee on Higher Medical Training) expressed his concern about the variation in educational opportunity and time spent in the senior house officer (SHO) grade. The Calman proposals for integrated training have potential for renewed neglect of this important early training period.

Professor Wass (Director, Training Office) listed the resources available to the College to improve SHO education and training: postgraduate deans, College regional advisers and tutors. Currently, 47.3% of junior doctors are SHOs; their ultimate career paths are diverse, emphasising the need for intercollegiate liaison.

He drew attention to the recent College document on general professional training, which outlines a core curriculum including induction courses, acceptable rotas and workloads, consultant supervision and educational programmes. An SHO action group will systematically assess current posts, review the introduction of log-books, and develop appraisal mechanisms to monitor individual progress. As part of this assessment each SHO will complete a questionnaire on the nature and details of their post, including education and training, supervision and support, together with a review of accommodation standards, out-of-hours catering and personal safety.

The College is aware of the need for SHO support, both educational and personal, the latter including career advice. Sources of information on these are not widely known, and available resources are probably underused. The recent formation of a network of associate tutors provides a mechanism for cascading information, although its primary role is to inform the Colleges on the educational content of posts.

The proposed portfolio of generic SHO skills includes communication and computing skills, an understanding of health service management, team work, audit, management of acute pain, and resuscitation.

In the future the education programme will include a survey of available teaching resources. A Royal Colleges' Education Department will provide educational material, learning courses, self-assessment exercises and a skills laboratory, facilitate intercollegiate coordination of teaching programmes, and provide an educational research facility. Possible topics for educational research are outlined in Table 2.

Table 2. Action areas for educational research

- evaluation of educating educators
- assessment of the effect of SHO input into teaching objectives and methods
- correlation between educational factors and MRCP examination success
- development of mechanisms for assessment of posts and factors influencing change
- comparison of different delivery methods for educational packages, eg 'SHO away days'

SHO – senior house officer

These proposals have implications for the financial and human resources of the College and other collaborating groups.

A senior house officer's perspective: present and future

Dr Valerie Fletcher (SHO) presented a personal view of 'life at the coal-face' and how it might be improved. The areas of concern are careers advice, individual performance appraisal and postgraduate medical

education. She expressed the opinion that careers advice diminished from secondary education onwards, and was practically non-existent at SHO level. There was no formal preparation for interviews or advice on CV presentation, nor an obvious alternative source of information. Acquiring these, like most other practical skills, continued to rely on the 'see one, do one, teach one' mentality. She argued for compulsory and pro-active careers guidance, with formal training for the consultant staff involved. The current disillusionment of junior doctors may in part reflect the lack of appropriate career advice, with career pathways not reflecting informed choice.

A more flexible approach to training was needed, with greater value placed on broadening experience through overseas work. On return to the UK, personal commitment to training should not be doubted, and overseas experience should be given equal credit in competition for career posts.

More emphasis should be placed on personal development. Assessment of individual strengths and weaknesses is important but is not valued; for most SHOs appraisal is neither formal nor systematic. Dr Fletcher argued that it should be compulsory and present at every level of training. Appraisers should acquire skills that encourage constructive feedback—a prerequisite for objective career development.

She criticised undergraduate medical education for being too information based and failing to prepare doctors for a lifetime of learning. Final examinations were perceived as the pinnacle of achievement, and the need for a continual process of education was recognised only after registration. She commented on the variability of locally organised postgraduate education and the absence of quality monitoring or evaluation. Practical problems included timing of sessions, which often coincided with other commitments, and a lack of protected 'bleep-free time'. Limited support and teaching in preparation for the MRCP were compounded by the 'study leave lottery', in which study leave was determined more by locum availability than by entitlement.

Dr Fletcher urged the College to define a core curriculum and monitor this through the use of log-books. These should also document career counselling and any external courses attended. She requested that courses be nationally organised and funded, and backed by a strong College commitment to study leave entitlement. She concluded by recommending that the College handbook *Training to be a physician* [1] should be compulsory reading for SHOs and their consultants. The pressures for improved training will increase when a reduction in working hours results in less tired and more enthusiastic junior doctors.

Discussion

Professor Richards remarked that current barriers to appropriate primary care for junior doctors include mobility and concerns over confidentiality. He suggested a designated panel of general practitioners (GPs) to provide an accessible and confidential service. He challenged proposals for compulsory career guidance, arguing that SHOs should take the initiative. Professor Wass welcomed these comments and suggested that information on personal health care could be included in induction packages and evaluated in the proposed SHO questionnaire. **Professor Edwards** emphasised the importance of role models, and stressed the need for inspiration and leadership. **Professor Williams** questioned whether the College could cope with the increasing number of SHOs. Professor Wass also expressed concern about a mismatch between rising SHO numbers and the predicted post-Calman reduction in career-grade trainees. This may restrict the proposed expansion of the consultant grade, with implications for the future availability of high quality SHO training.

Professor Haq Nawaz described the role of associate tutors and log-books in the auditing of training and careers advice in Pakistan. He supported Dr Fletcher's opinion that overseas training is valuable, and urged the creation of international accreditation systems. A speaker from the floor noted that it was 30 years since the Porritt Report had recommended service abroad, but concurred with Dr Fletcher about career barriers on return. He pressed for the College to take a strong lead on this.

In response, **Professor Turnberg** stated that the College was aware of the problems of junior doctors in training, and felt that the relentless increase in consultant workload was a contributory factor. The Calman proposals had placed training on the policy agenda and provided the College with a further opportunity to raise the financial and human resource implications with the Department of Health.

Professor London made the point that the UK and Eire had the lowest ratio of doctors to population in Western Europe, and asked whether the College was arguing for an improvement in this measure. Professor Shaw replied that the increasing number of training posts and the expansion of the undergraduate intake were encouraging. The final comment was that much SHO teaching is undertaken by registrars who have no formal training for this, and have competing pressures such as their own research.

The interface between primary and secondary care

Bridging the gap

Professor Turnberg (President, RCP) defined two interfaces: one intersectoral between primary and secondary care, the other interprofessional between medical, nursing and other health care professions. He emphasised that the UK has one of the best developed primary care systems in the world. The GP, in the role of gatekeeper, has traditionally provided

a high quality service on a limited budget. Recent NHS changes have devolved purchasing power to primary care, generating potential conflict across the primary/secondary care interface. This conflict has, however, failed to materialise, but patients are confused by the language of the new NHS and need reassurance that primary and secondary care are working together to provide them with high quality care. Barriers to this are outlined in Table 3.

Professor Turnberg deplored the current annual contract round, together with problems arising from differing demands of multiple purchasers, and the risks inherent in the provision of high cost/low volume services. He argued for longer-term rolling contracts to provide stability in service planning and recruitment, purchasing consortia to reduce transaction costs, and service planning for rare conditions based on populations of 3 to 5 million. Strategies for education, training and research need a longer time scale and a national perspective.

The actual—or potential—two-tier system created by fundholding is of concern. Suggested ways forward are either extension of the model to all GPs or its abolition—a discussion paralleled in the political arena. However, the feasibility of universal fundholding, its management burden and transaction costs have not been assessed. Budget holding also offers the perverse incentive to limit or delay referral and to use the emergency route for admissions, although there is no evidence that this is happening.

It was questionable whether major resource shifts from secondary to primary care would improve service to patients, but there was currently no evidence either for or against the policy. Increased investment in primary and community care in inner cities is expected to result in reduced secondary sector use, though it is possible that an increase in demand will follow as unmet need is identified. The impact on emergency admissions has yet to be determined. The resultant growth in primary care workload was likely to increase the numbers of GPs needed, but both the current rise in early retirement and the fall in recruitment may cause difficulties.

Bridging the gap between primary and secondary care requires collaboration and cooperation, not competition. Informal communication is known to occur, but may be sporadic. Professor Turnberg commended an example known to him of GPs who meet regularly with consultants. He advocated formal fora for professional discussion, suggesting the Joint Consultative Committee, the General Medical Services Committee, and the Conference of Colleges as vehicles for this purpose. Other opportunities were provided nationally by committees for intercollegiate guideline development, and locally through outreach clinics. Whilst the benefits of outreach clinics are apparent in theory, they have yet to be appraised in practice, so he cautioned against their unevaluated development or expansion. He highlighted the importance of considering the opportunity cost and relative cost-effectiveness of shifting diagnostic and minor procedures into primary care, and of promoting the early discharge of patients to the community. On the issue of early discharge, he questioned the availability of the necessary community services and whether the process was as efficient and effective as claimed. To bridge the gap, Professor Turnberg suggested joint research and the evaluation of pilot projects.

Table 3. Barriers to providing high quality patient-focused care

- nature of the contracting process with its short time-scale
- separation of general practice into two tiers: fund-holding and non-fundholding
- redeployment of resources from secondary to primary care
- likely shortage of general practitioners

Research and development at the primary/secondary interface

Professor Haines (Department of Primary Health Care, University College London Medical School) described the primary/secondary interface as dynamic, with 7.5 million referrals annually. It is a site of technological innovation, such as near patient testing and telematics, and also an area where evidence-based medicine is likely to change professional practice. He cited the demand for direct-access echocardiography generated by the effective treatment of cardiac failure with angiotensin-converting enzyme inhibitors. This interface is a priority for NHS R&D (Table 4) and can be studied at three points: the entry into and exit from secondary care, and during shifts in the balance of care between the two sectors.

Professor Haines outlined the method of awarding funding, and highlighted the importance of multidisciplinary team bids. A total of £6 million was committed to 54 proposals which comprised 8% of those submitted and 50% of those shortlisted. Changing skills and training requirements at the interface appeared to be a difficult target for research, and this priority area was not funded in the first round.

Hospital-at-home schemes, as a model of intermediate care, were covered in some detail. He described international examples, ranging from high technology care at home facilitating early discharge (France, Netherlands and Australia) to a focus on palliative care (Italy and Sweden). In most countries, this is an area of service development, but the volume of care and the rapidity of throughput varied between the different schemes. Evaluation required agreement on, and definition of, key outcome measures such as change in the level of physical disability, patient and carer satisfaction, and cost-effectiveness.

Table 4. Priority areas for research and development at the primary/secondary care interface

- transfer of information across the interface
- evaluation of clinical guidelines
- appropriate access, use and location of diagnostic facilities and new technologies
- impact on referrals and discharge of involving patients and carers in decision making
- appropriateness of outpatient follow-up
- evaluation of treatment by referral versus management in primary care
- impact of purchasing arrangements on the interface
- aftercare rehabilitation and community care for priority groups
- prescribing across the interface
- models of intermediate care
- evaluation of specialist outreach schemes

Professor Haines emphasised the need for greater collaboration between primary and secondary care, and echoed Professor Culyer's approach to funding focused on people—individuals and teams—rather than on institutions.

The value of nursing—pushing at the boundaries of care

The Royal College of Nursing (RCN) has 100 specialist membership groups and 300,000 members. **Ms Hancock** (General Secretary, RCN) made the point that there was a direct relationship between pay and quality of patient care which was central to the nurses' recent action. Examples were cited where nursing care had contributed to faster patient recovery, more cost-effective care, better communication and patient satisfaction, reduced prescribing costs and GP workload.

Nursing has the potential to offer solutions to a number of current NHS problems including the shortfall in junior doctors and the reduction in junior doctors' hours. She drew attention to the joint Royal College of Physicians and RCN statement on skill sharing [2]. In acute hospitals, nursing skills enabled a greater throughput of cases, despite rising levels of patient dependency. In the USA it was estimated that nurse practitioners could meet 60–80% of health care needs and provide the majority of health promotion, whilst improving the quality of both.

Effective working in the primary health care team demanded flexibility of practice, appropriate training and clear definition of roles and responsibilities. These skills were being successfully developed at the interface. Good examples are the patient satisfaction expressed with nurse-led minor injuries units and a paediatric hospital-at-home scheme preferred by children and their parents. Moving towards a wider appreciation of health than the public perception of hospital sickness services, nurses were increasing their role in chronic disease management, patient education, health promotion, profiling health needs and purchasing.

In the complex area of elderly care, Ms Hancock was concerned that a silent revolution had shifted individual care from long-stay NHS beds to the private sector. The delivery of primary health care may be disrupted by the different settings in which social care is provided—residential or home—but equality of access needed to be ensured. An individual's needs are often multiple and vary over time, so that admission to a nursing home may not be an irreversible process. The quality of care needed close monitoring by an integrated inspectorate of residential and nursing homes, and appropriateness of placement should periodically be reviewed. She urged the establishment of local resource centres for continuing care advice for local agencies, individuals and their carers, and primary health care teams.

Ms Hancock argued that nursing care must remain part of a national health service delivered according to need. Nurses should develop a culture of flexible and autonomous practice. She concluded with a plea to recognise the contribution of nursing to long-term care and the needs of individual patients. If nurses are to take on this new role, workload, pay, flexibility of staffing and resources needed to be urgently addressed.

Discussion

The ensuing discussion fell into three categories: hospital at home, the primary/secondary care interface, and the development of the nursing role. Professor Turnberg enquired about international experience of hospital-at-home. In response, **Professor Tiller** stated that in Australia it cost at least as much as hospital care and there was increasing disillusionment with this model of care. He commented that nurses—or the nursing hierarchy—were not meeting the challenge of change. A speaker from Pakistan said that in his country the converse occurs, with the home environment being taken into hospital. **Professor Dinsdale**, from Canada, had no direct experience of the New Brunswick project, but commented that professionals were in favour—although it was seen primarily as a fiscal matter. From the UK, **Dr Das** described a team caring for up to six patients with cancer or stroke in South London, and said that the cost was equivalent to nursing home care. Professor Haines remarked that the size of the service was a critical issue, and that the South London team might be too small to be cost-effective. Ms Hancock noted that comparisons should be made on an equal basis, taking into account all costs and benefits, including those borne by the carer.

A speaker from the floor questioned whether patients were adequately reassured by a consultation in

primary care or whether their expectation was for specialist referral. He commented that increasing consultation time may be needed to clarify patients' expectations. Ms Hancock was more optimistic about patients' wishes, stating that they often opted for cheaper treatments when given an informed choice. She questioned whether some referrals resulted from professional uncertainty or inexperience. Professor Turnberg stated that good communication was central to the gatekeeper role which required clear reasons for referral. Professor Haines commented that problems often occurred in conveying the notion of probability and risk, and that new technologies such as interactive video systems may help with this task. **Professor Godfrey** (College Adviser, Israel) suggested that there was a need for a gatekeeper in secondary care ('a bouncer') to ensure appropriate bed-use, to which Professor Turnberg replied that the pressure on beds ensured that inappropriate use was kept to a minimum.

The development of the nursing role was raised by a speaker from the floor. He noted that a formal training was needed for nurses fully to develop their skills in clinical trials and epidemiological research. Ms Hancock agreed, but noted that demands for teaching diminished the time available for research. She remarked that it was difficult to obtain funding from the NHS R&D programme. Professor Haines replied that the situation was slowly improving and that non-medical research fellowships were available. Professor Turnberg urged nurses to participate in research through multidisciplinary team working.

Ms Hancock concluded by stating that new models of care needed to be developed. However, it was natural to be cautious in the face of current anxieties about workload and the opportunity costs that new roles may entail. She foresaw an expanding role in the inner cities for nurse practitioners with diagnostic skills.

Professor Turnberg closed the day by highlighting the need to train professionals to meet the challenge of change and for development work to define the appropriate boundary between primary and secondary care.

References

1 A handbook compiled by the Standing Committee of Members of the Royal College of Physicians of London. *Training to be a physician* (2nd edn). London: RCP, 1993.
2 Joint statement from the Royal College of Physicians of London and the Royal College of Nursing. Skillsharing. *J R Coll Physicians Lond* 1996;**1**:57.

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