CARE GROUP WORKFORCE PLANNING: A CASE STUDY IN CORONARY HEART DISEASE

1. Introduction

Background

1.1 This case study of a CHD workforce scoping exercise has been written for someone who intends to either undertake a care group workforce plan themselves, or to commission someone else to do so. It explains the steps undertaken, and how the various issues that arise from a piece of work of this type were addressed. This case study reviews the stages of the project and then finally covers the competencies needed to undertake such work.

1.2 It is based on a CHD workforce report commissioned by the Birmingham and The Black Country Cardiac Networks from George Blair of Shared Solutions Consulting.

Project stages

2.1 There are four main stages to undertaking such a project, which in turn entail a series of steps. The stages are: project planning and stakeholder engagement; background research; data collection and analysis; report presentation and implementation.

2.2 Firstly, we explored how to minimise the biggest threat to a workforce project, which is that the key stakeholders are insufficiently committed to the exercise to implementing the findings. This was addressed through clarifying the purpose of the project and engaging the key stakeholders through presentations and interviews.

2.3 Secondly, once firm foundations have been laid, the next phase is to capture existing knowledge to avoid wasting time by rediscovering what is already known. This was achieved through a literature search, contacting professional bodies, and organisations such as the Modernisation Agency and clinical networks.

2.4 Thirdly, we gathered and analysed data, which took the most time. It involved undertaking many interviews, running workshops and analysing workforce data.

2.5 Fourthly, we finally reached the moment of truth when the report was circulated for comment. The real test was not the immediate response, but whether the recommendations were implemented. This in turn depends on an action plan that has the support of stakeholders.

2. The Project Phases

Project Planning and Stakeholder Engagement

2.1 This entails laying the foundations for a successful project. The following steps are essential for success and are to be ignored at your peril. They are:

Clarity of purpose

2.2 It is amazing how many projects could benefit from a sharper focus. One way to overcome this is to ask the client, if the project were brilliantly successful, what would have happened, who was involved and how was it achieved?

Scope of the project

2.3 Producing a workforce plan for a care group is very different from producing plans for a staff groups. It is relatively straight forward covering the few staff groups who are dedicated to a specific care group, such as heart failure nurses and cardiologists for CHD. However, there is a major problem in allocating generic staff to specific care groups. This is because they work across many care groups, e.g. GPs, district nurses, medical and surgical nurses and many diagnostic staff, such as diagnostic radiographers.

2.4 It may well be useful to obtain staffing information for these staff groups from other sources, such as the Workforce Development Confederation or the Office of Manpower Economics. WDCs can also advise when it might be a bad time to ask trusts for information, as it might clash with other data collection exercises.

2.5 It is rarely worthwhile to find out how much time generic staff spend with patients of a specific care group, as this takes a huge amount of effort for very little benefit. A more useful question is, how important is a specific staff group with regard to either outcomes or patient quality? For instance, GPs may spend a very little time with patients of a specific care group, yet they may have an important role in initial diagnosis, which may warrant additional training. Therefore, it would be more accurate to describe a care group project of this type a workforce strategy, rather than a workforce plan.

2.6 In our CHD project, the object was to produce an overview of the key staff groups in coronary care and identify issues regarding staff roles, workforce supply and training issues. This was to take into account the impact of new procedures and the increased focus on improving care provided in the community, for patients with chronic heart disease. The outputs were to be a report and an action plan based on the recommendations.

Project sponsor

2.7 Who is the **project sponsor**? This is someone in a very senior position who wants the project to succeed. A minimum requirement is for them to give their name to the project, for instance by signing correspondence to launch the project and to assist in enabling the report recommendations to be implemented, by assigning managers to undertake specific tasks. If the project sponsor is not senior or not committed to the likely outcomes, do not proceed; otherwise the report will be destined to gather dust in a bookcase.

2.8 In the CHD project this role was performed by the lead consultants from the two networks. In addition, the PCT Chief Executives who chaired the networks were also very focused on the topics to be addressed and in producing a robust implementation plan.

Project lead

2.9 Who is the **project lead**? This role involves carrying out many practical tasks, such as identifying key people to interview, describing the context of the project. This could include whether a similar project was undertaken previously and what was the outcome. It is very helpful when the project lead is well established and has a wide network and a good grasp of the issues.

2.10 This role was carried out by the StHA CHD lead who liaised closely with the two network managers.

Timescale

2.11 Quite often clients have unrealistically tight timescales. If respondents were available at a drop of a hat, then that would not be a problem. However, it takes about six to eight weeks to get into the diary of some senior staff and workshops need two months notice to attract them. If the report needs the approval of a network board or similar, that can be a further source of delay as they are often meet on a monthly basis. A three month project can easily become a six month one.

Communication

2.12 How often will progress be reported, in what format and to whom? We undertook this by means of phone calls, progress reports, and presentations to the network boards and to a workforce sub group.

Sign off arrangements

2.13 Who will approve the report? This group should include all the influential people who could support the implementation of the recommendations. It should also include staff from the different staff groups covered by the project. This was undertaken by the workforce sub group in the first instance and then by the network boards.

Client contribution

2.14 This might specify the level of seniority of the person who would sign correspondence to launch the project.

Resource implications

2.15 The proposal was based on 42 days of consultant resources. However, to this needs to be added the time given by the 30 people who attended the workshops and also by those who were interviewed.

Risk issues

2.16 This would cover what could go wrong, why that might be the case and the action needed to militate against it happening. There should be no surprises in a well run project. A frequent risk is a low level of engagement by key stakeholders who have a large and rapidly changing agenda.

2.17 Addressing risks is also a very good means to ensure that the stakeholders do not hold the consultants/researchers accountable for issues which are not their responsibility. An example might be if influential medical consultants do not see the value of the project, which should be addressed by the project sponsor before the project starts in earnest.

Background Research

2.18 The most powerful way to engage senior decision makers is to go out to interview them in their own offices. This would also reveal how much scope there is for change, the state of organisational politics and the extent to which resource issues might be a constraint. Another technique is to run workshops, which has less impact, but is a cheaper way of reaching a wider audience. Ideally, both approaches should be used together. We interviewed many network board members, which included clinicians, commissioners, managers and patient and user representatives.

Literature review

2.19 This can be useful where there is plenty of published information. Good sources are the Health Service Journal, The Department of Health and

Modernisation Agency websites. Google can be very helpful to gain at least a superficial understanding of acronyms may be new to you. When we started the project we heard much talk about BVP. BVP what? This is where Google came to the rescue. It gave the answer on its first page, as bi ventricular pacing, which led to some very informative articles. However, this was after several responses for a German Catholic centre party that shares the same acronym!

Telephone interviews

2.20 However, if you are interested in the latest developments it is likely to be necessary to telephone project leads, as the results of their work may not yet be published. Sources of contacts can be found in the Update, which is published each month by the Modernisation Agency. Other useful sources are fliers advertising speakers and conferences.

2.21 Organisations such as the Royal College of Nursing have professional advisers who are very willing to help you over the phone and may suggest policy documents, other literature or people to contact. Smaller organisations may refer you to their lay members who might be a lead for a specific topic. It is impressive how many such dedicated people there are who will phone you back with useful information.

Gathering the Main Data

2.22 This takes up the largest amount of project resources.

Workforce data

2.23 Workforce data for consultants and nurses was provided by the Strategic Health Authority. However, information on heart failure nurses and cardiac physiology numbers were provided by their professional leads. This was because there are no occupation codes for heart failure nurses, while in the case of cardiac physiologists some wrong occupational codes invalidated the data in the eyes of the staff concerned. A 100 per cent response rate was achieved by shaming trusts that failed to supply information by publishing blank lines for them in the draft report.

2.24 The Strategic Health Authority quarterly monitoring report now publishes information on the bigger staff groups on a care group basis for CHD and cancer. Thus the project encouraged the routine provision of relevant workforce information.

2.25 The section on workforce made mention of a couple of its crucial components that are often unacknowledged, namely users and carers. The Expert Patient Programme enables patients to obtain better targeted care and can result in a reduction in demand, once they stabilise their condition.

2.26 The British Cardiac Society produced[1] a very helpful evaluation of new procedures and their associated workforce requirements. This was based on a recommended number of procedures per million that compared current English rates with those in other countries. The next step was to estimate the time taken by staff such as cardiologists for each procedure, then it was a matter of calculating the number of staff required to deliver a given number of procedures. This gave an upper estimate based on ten clinical sessions per

[1] Hackett, Dr David (2003) *Cardiac Workforce Requirements in the UK*, British Cardiac Society

week of 3.5 hours and a lower estimate factored on 7.5 sessions of 3.5 hours. Another assumption was that consultants were available for 81 per cent of the year (42 weeks).

Running workshops

2.27 In addition, three workshops were run to obtain input from many more clinicians at all levels. As well as providing invaluable input, the approach generated a high level of engagement. The topics for the workshops were selected by one of the network chairs, which integrated the project even more closely with the future agenda of the networks. The subjects selected covered both acute and primary care and were of interest to all the stakeholders, namely: the impact of GMS2; the Kaiser approach to heart disease; the workforce implications of primary angioplasty. A keynote speaker spoke at the start of each workshop for about half an hour to explain the context of the topic and to pose some thought provoking questions. Well-respected local people were specifically chosen to be the speakers, which helped attract delegates to the workshops.

Report presentation and implementation

Report structure

2.28 The report was divided into five main sections. They explored policy issues, models of care, innovations in procedures that provided that are key drivers for the demand for workforce and the development of new roles, before addressing specific workforce issues, as follows:

- Introduction and background – this set the scene by making reference to national policy, statistics on the prevalence of heart failure and the national growth in the number of catheter laboratories that has a direct impact on the demand for staff

- Innovations in models of care – this covered a very wide range of initiatives such as chronic disease management, modernisation projects, the Expert Patient Programme, the General Medical Services contact, patient involvement, Kaiser Permanente and Evercare. These issues are of great interest to commissioners and clinicians and have a huge impact on workforce requirements.

- Innovations in procedures and acute service developments – this focused on the acute procedures that tended to lend themselves more readily to evaluation than longer term public health interventions.

- The workforce – this started with integrated care pathways, which are vital to providing seamless care for the patient journey between providers. The bulk of this chapter covered individual staff groups both in terms of establishment and staff-in-post, along with changes in staff roles.

- Future CHD workforce planning framework – this explored how to improve the collection and presentation of workforce information to Network Boards.

Draft reports

2.29 Drafts were circulated and recipients were invited to suggest amendments by means of insertions and deletions. This reduces the number of vague comments to which it is difficult to respond.

2.30 It is easy to make errors in the use of language with regard to medical procedures, for instance an initial draft referred to pacemakers being inserted rather than implanted. If you can find someone with a good understanding of such terms to proof read your draft, so much the better.

2.31 It is sometimes necessary to permit a project to be delayed in order to maintain a high level of stakeholder commitment. For instance, when the draft report was presented to a network board an influential clinician raised a criticism. He had been unable to participate in a workshop and was not selected for interview, so his views were not fully addressed in the report. It was decided to interview him, which resulted in valuable additional information being obtained and also gained his support to the project. This was more important than delaying the project by one month.

Action plan

2.32 Network members were asked to rate the recommendations as of high, medium or low importance, in order to decide what to include in an implementation action plan. This enables a scoring system to be used with three points for high, two for medium and so on. This is a very productive approach and involves many more stakeholders than who could actively participate in a discussion. The findings of the survey could be discussed at a meeting and be altered slightly if necessary.

3. Competencies Required

3.1 To produce a care group workforce plan requires a wide range of competencies, such as:

- Project planning
- The capacity to rapidly learn the medical issues and terms related to a care group
- Questionnaire design
- Interviewing skills
- Data analysis
- Organisation development
- Workshop facilitation skills
- Reporting writing
- Presentational skills

3.2 While the above competencies are essential, however, they do not necessarily need to be held by one individual and could be provided by a team working together on the project. Without all these competencies, the project could fail, making any future work with that care group extremely compromised.

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