

Re-engaging the consultant workforce: the role of local medical advisory structures

Background

Work¹ commissioned by BMA Scotland, and undertaken by the universities of Dundee and Glasgow, has confirmed that while consultants in Scotland are highly engaged with their jobs, their clinical colleagues and with the values of the NHS, they are also experiencing significant frustration and disengagement. Consultants are struggling to input effectively to local service development and clinical priority setting, and this is having a profoundly detrimental impact on their sense of professionalism and autonomy. This has a potentially significant impact on the NHS, as it means the wealth of experience, knowledge and motivation of the consultant workforce cannot be fully utilized for the benefit of the service.

While the research does not suggest current risks to patient safety, this type of disengagement has been identified as a driver of devastating patient safety issues elsewhere within the NHS².

We regard these research findings as an 'early warning', and believe that NHS Boards and consultants have a joint responsibility to work together locally to re-engage in a way that all concerned can have confidence in.

Barriers to engagement

The key barriers to meaningful engagement between NHS Boards and their consultants are:

- The pressures of immediate service demand, forcing consultants to crisis manage rather than work with NHS Boards to plan strategically for service development and improvement.
- The perception by consultants that NHS Boards lack a route for them to deliver purely clinical advice independent of management pathways. This lack of confidence in the current mechanisms is perhaps evidenced by the increase in concerns being expressed publicly direct to the media.

Re-engaging the consultant body

NHS Boards need expert input from their consultant body to inform both strategic planning and the ongoing implementation of safe and efficient patient services. To achieve this, NHS Boards and their consultants need to work together to redevelop the necessary climate of mutual trust, respect and understanding to allow meaningful clinical conversations to take place.

All NHS resources, including consultant and senior management time, should be used as efficiently as possible. We should avoid creating additional bureaucratic structures, but should use the current available mechanisms in a more effective way. As a first step, we recommend much better use made be made of the existing statutory

¹ The changing experience of work of consultants in NHS Scotland, G Martin, S Siebert, B Howieson, S Bushfield, May 2015

² <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf> para24, page 13

local medical advisory structures (ie the AMC, Consultants subcommittee, specialty subcommittees etc).

While these structures function well in some NHS Board areas, the overall picture is patchy. However, where these committees do work effectively, they bring significant benefits: they sit side by side with the management structure, and allow consultants to provide medical advice and opinion independent of those pathways; they allow NHS Boards to be confident that they clearly understand the concerns, hear the advice, and benefit from the expert input of experienced senior doctors who are working at the front line of service delivery; they allow senior management and consultants to meet in an atmosphere of mutual trust and respect, which can help drive the overall culture of an organization.

Practicalities of re-invigorating medical advisory structures

Medical advisory committees are not and should not be BMA committees. However we believe that this research identifies serious early warning signs that must be addressed. We have therefore written to consultant representatives on medical advisory structures where they exist and to representatives of medical staff committees and of LNCs where these advisory structures do not exist. We have asked them to encourage consultant engagement, and where necessary to contact NHS Boards to initiate local discussion.

We have also produced as a useful resource and starting point for local activity a list of principles (Appendix A) and a possible framework (Appendix B) to help facilitate these discussions.

Conclusion

The research we commissioned indicated that consultants in Scotland, despite their commitment to their patients, their colleagues, and the health service, are worryingly disengaged from NHS Boards and their management structures.

We believe that this disengagement is to the detriment of both consultants and the health service, that it is an early warning that cannot be ignored, and that consultants and the NHS have a joint responsibility to engage with seeking solutions.

We believe that the most effective initial step to address this, without creating additional unnecessary bureaucracy, is to make proper use of the existing statutory medical advisory structures.

In many areas, it will take real effort and commitment by both management and the consultant body to rejuvenate and reinvigorate these structures. We will continue to encourage and facilitate consultants at local level to work with NHS Boards to develop and engage with effective and appropriate medical advisory structures. We invite NHS Boards to join us in this commitment.

SUPPORTING CONSULTANT ENGAGEMENT IN LOCAL MEDICAL ADVISORY STRUCTURES**- PRINCIPLES TO INFORM DISCUSSION AT LOCAL LEVEL**

- All involved in or with local medical advisory structures³ should respect NHS Scotland's core values of care and compassion; dignity and respect; openness, honesty and responsibility and quality and teamwork. There is an explicit responsibility on both NHS Boards and medical staff to engage with each other in line with these values.
- Local medical advisory structures should be representative of doctors across all sites and specialties within an NHS Board. The Area Medical Committee (AMC) in each area should determine appropriate representation and how this is achieved, including the establishment of a consultant subcommittee, and the consideration of specialty committees, if necessary. The local structures and their functioning should be clearly 'visible' to the local consultant body and to management.
- Both NHS Boards and members of local medical advisory committees should recognise that the role of the advisory structure is to deliver medical advice that is independent of medical management pathways. To avoid perceived or actual conflict of interests, consultants with a significant management component in their job plan should not play an active role in their NHS Board's AMC or its subcommittees, unless the membership of the AMC requests their input on a specific issue or issues.
- Not all advice need always be given at NHS Board level. The benefits of specialty subcommittees etc being able to give specialty specific advice at other levels within an organisation should be recognised.
- The provisions of the Staff Governance Standard with regard to involving staff in decisions that affect them mean that local medical advisory structures must be involved from the outset in discussions regarding matters of significant change in strategic direction, clinical service delivery plans and redesign, and in matters of similar significance devolved to integrated joint boards or other agencies. There is also a responsibility on the advisory committees to engage with such matters in a timely and constructive manner, and they should work in a way that facilitates this.
- If an NHS Board decides to act contrary to the clear advice of its local medical advisory structures, then to maintain mutual respect and confidence, the Board should explain that decision in appropriate detail. Similarly, consultant members of advisory structures have a duty to convey Board decisions and reasoning to their constituents, even if they disagree with the final decision.
- All consultants with roles as members of medical advisory committees should have the necessary time and resource made available to allow them to fulfil their responsibilities. This should be agreed through the job planning process. Senior managers whose role it is to engage with the medical advisory committees should also have the necessary time and support. Medical advisory committees in themselves will require support (including appropriate secretariat facilities and IT support) and this should be discussed and agreed with the NHS Board.

³ I.e Area Medical Committees and their subcommittees

SUPPORTING CONSULTANT ENGAGEMENT IN LOCAL MEDICAL ADVISORY STRUCTURES - FRAMEWORK FOR LOCAL STRUCTURES

Appropriate local medical advisory structures must be agreed by doctors and their NHS Boards working together. This framework can be adapted for local use.

1. Area Medical Committee

Each NHS Board is required to have an Area Medical Committee as a statutory representative body for doctors under section 9 of the 1978 NHS (Scotland) Act as amended in 1990 by the NHS & Community Care Act

The functions of the Area Medical Committee include:

- provide professional medical advice to the NHS Board and its structures
- advise the NHS Board on strategic matters
- advise the NHS Board of concerns
- provide effective liaison between doctors and the NHS Board and its structures
- provide a forum for discussion between doctors
- support effective medical leadership within the NHS Board

The Area Medical Committee will normally have:

- a Consultant sub-committee (plus speciality or site-specific sub-committees where appropriate)
- a GP sub-committee

It is crucial that these structures retain the confidence of their constituents and maintain independence from management. They are completely separate from the LMC and LNC.

2. Consultant subcommittee

The consultant subcommittee (CSC) is an autonomous subcommittee of the AMC and the principal vehicle for consideration of matters of specific relevance to secondary care within the NHS Board. It should:

- have the power to determine its own constitution subject to the approval of its constituents.
- meet regularly to consider items brought before it by the NHS Board, the AMC, or by its constituents.
- meet separately and regularly with management (a follow-on meeting after the members' meeting may be appropriate). The Medical Director and appropriate secondary care management representatives should attend these meetings ex-officio.
- have the right to refer back any nominated representative to the specialty subcommittee concerned if there is a significant job planned managerial component for that nominee.
- comprise:
 - a chair elected from the committee by its members
 - a secretary elected from the committee by its members
 - members elected by the constituents of specialty groupings – as determined by the committee and subject to their review. The underlying principle should be to secure appropriate representation from all specialties/departments
 - representation from geographically discrete hospitals or sites
 - an LNC observer

- an SAS observer
- refer on (with relevant input) Items of relevance across primary and secondary care to the AMC.
- have reciprocal representation with the GP subcommittee.
- be provided by the NHS Board with appropriate support for its committee members.

3. Specialty specific subcommittees

The CSC should set up speciality or site-specific subcommittees where necessary:

- The consultants in a given speciality (or grouping of specialties) should constitute a specialty subcommittee of the CSC.
- The SAS doctors in a given speciality (or grouping) should have right to attend meetings of their specialty subcommittee.
- The service manager for a given speciality should have invited observer status to specialty subcommittee meetings at the chair's discretion.
- The specialty subcommittee should elect a chair and secretary from their number who does not have significant management responsibilities.
- Each specialty committee should have a representative seat at the CSC, recognising the requirement of CSC that the representative should not, wherever possible, have significant (job planned) managerial responsibilities.
- The geography of an NHS Board may require site-based consultant or specialty sub committees. The interrelationship of these committees and their route to the AMC should be explicit.
- The NHS Board should provide appropriate administrative support for members of the committee.