

Strategic Clinical Manpower Planning in the Defence Medical Services Beyond Op HERRICK

DA Rew

Consultant Surgeon, Southampton University Hospitals, Colonel L/RAMC & Officer Commanding Specialist Theatre Teams, 2 Med Bde and Council Member of Association of Surgeons of Great Britain and Ireland

Introduction

Time lends perspective to the view. Over 35 years, the Defence Medical Services (DMS) has been transformed from a Cold War-orientated, Rhine-centred Army Medical Service, to a much smaller and more agile tri-service organisation. The three single service health systems are broadly integrated functionally and with their NHS partner hospitals. The DMS has been highly innovative in the management of complex trauma, and by relentless focus on the quality of care for individual trauma cases, it has produced dramatic gains in the numbers and quality of survivorship.

The past decade has seen an extraordinary reversal in the fortunes of the DMS, with continuous operational engagement on Operations TELIC and HERRICK. This followed a low point in the late 1990s, with an outflow of clinical staff following Defence Cost Study 15 [1,2]. The Regular clinical cadre is well recruited and dispersed in peacetime employment around a number of NHS hospitals in the UK; the Reserve clinical cadre has made a substantial and well integrated contribution whilst the Royal Centre for Defence Medicine (RCDM) and the University Hospitals Birmingham (UHB) and the rehabilitation services are working well under a heavy workload of complex casualties.

As with all things military, change is continuous, and there are a number of ongoing factors which oblige us to now focus on the longer term, particularly when given the long time lines required in clinical manpower planning [3].

The draw down of Op HERRICK by 2015 will almost certainly mark a scaling down of the requirement for medical support for brigade and divisional scale warfighting for many years to come, although there will always be a continuing requirement for high readiness clinical support for small scale and Special Forces operations.

Severe financial constraints and their material consequences will limit the macro-economic scope for overseas operations, and will oblige a detailed examination of costs and cost effectiveness at the micro-economic level. We will thus be challenged to maintain corporate memory and hard won clinical experience and skills into the distant future, with a relatively small cadre of regular clinicians plus the reserve cadre, which will provide a range of different challenges in recruitment, retention and professional leadership.

**Corresponding Author: David A Rew TD MA MB MChir
FRCS, Consultant Surgeon, Southampton University
Hospitals
Email: d.rew@soton.ac.uk**

Clinical Currency and NHS Trauma Centres

The challenges of restricted specialist training within narrow career pipelines, in respect of producing well rounded and broadly trained military and emergency clinicians have been well rehearsed in numerous professional fora.

The NHS has belatedly acted to improve standards in trauma care, and the implementation of a plan for regional NHS trauma centres is in progress. Nigel Tai, in a recent Editorial in this Journal [4], has given voice to various discussions about the option of placing regular cadre clinicians within these centres. A number of regular and reserve clinicians have been closely involved in the implementation of Level 1 NHS Trauma Centres around the country. However, we must be careful about placing too much faith in these centres as the panacea to our training and skills maintenance problems. The clinical arrangements and high volume of penetrating trauma workload in London are not necessarily or readily replicated in the Provinces, where District General and Teaching Hospitals are more widely dispersed.

Unlike the USA, where gunshot trauma accounts for up to 30,000 deaths and 300,000 major injuries every year [5], such injuries are very uncommon in the UK. With the exception of inner city knife and gun crime in a few urban centres, the pattern of NHS trauma is very different to military trauma, and the frequency of complex, multi-system trauma is much lower than that in Basra or Helmand. It could thus be difficult for individual military clinicians to sustain a fulfilling career which met their professional expectations or ambitions in such a centre, and it is not yet clear that the funding will be available to allow recruitment to such posts in the present financial turmoil.

Moreover, outside the major urban centres, the Regional Trauma Centres are wholly untested, and indeed the two southern regional centres with which I am familiar are both on the very periphery of their intended catchment areas. There will remain a need for distributed high level trauma management skills in NHS hospitals across the UK if the law of unintended consequences is not to be writ large. There is a real risk that we could see a paradoxical increase in delays and adverse outcomes as casualties in the provinces bypass trauma-neutralised local hospitals for distant specialist centres with uncertain resourcing.

We will thus need to assume that the majority of Regular and Reserve clinicians will continue to be drawn from institutions other than Level 1 Trauma Centres. We need to consider how best to sustain in the long term a cohort of clinicians with the technical skills and judgement to mobilise and staff operational hospitals on demand. These individuals will be characterised clinically by a higher degree of specialisation than in the past, and

a considerable proportion will be reservists. They will possess a core of military training, ethos and historical operational insight. They will need the adaptability to operational environments and circumstances which may be very different from the circumstances of Iraq and Herrick.

Maintaining Corporate Knowledge

We have accumulated a remarkable corporate knowledge of the management of complex trauma in the past decade. Corporate knowledge always fades with time, and we will have to find ways of sustaining it. We need now to be writing the books, making the educational videos and stocking the libraries with the unique contemporary clinical knowledge to be passed on to our successors.

Individual and Cadre Clinical Training

One of the most significant corporate achievements of the DMS has been in the modernisation of individual and collective clinical training, such that we are able to place well drilled and well rehearsed clinical teams on the ground, using a variety of short professional skills courses such as Definitive Surgical Trauma Skills and the Military Operational Skills Training and the Hospital Trainer at Strensall. These will need to be adapted and refocused with time as the immediate operational imperative disappears and the personal operational experience which has driven recent course fades with time and retirement. It seems likely that specialist centres such as the Royal London Hospital and the RCDM/UHB will remain repositories of current experience and drivers for trauma teaching and education.

Conclusion

All who have served in a medical capacity on TELIC or HERRICK will acknowledge the enormous sense of professional satisfaction from a job well done. There have been substantial personal and collective achievements in the most emotionally and physically demanding circumstances, in terms of effective teamworking and clinical outcomes, and across the entire spectrum of simple and complex trauma. Those who have served with distinction in Iraq and Afghanistan will need to recalibrate to a different pace of life and clinical casemix. For some, this will represent a major personal upheaval.

We are obliged to start organisational and career planning for what is likely to be a lean period of large scale military activity following the draw down of Op HERRICK. This may last for years or decades, during which there is a real risk of stagnation in organisational thinking such was a feature of the long Cold War standoff between 1945 and 1990. It will be difficult to justify and sustain the continued employment of a large regular clinical cadre, and many individuals may need to recalibrate their career plans and expectations.

The role of the Reserve will remain that which it has been for several centuries; to maintain geographically and socially diverse citizen engagement in the Armed Forces, and to provide the capability and capacity for rapid expansion in time of need, as it has done very creditably in the past decade. The national focus of Army Reserve Manning and Training on 2 Med Bde at Strensall should help in this respect.

The challenge of professional leadership will be to integrate the experience of the past decade into a sustainable knowledge base and career programme which will prove attractive for Regulars and Reservists; which will drive recruitment and retention of clinicians in tight financial times and which will ensure that our hard won corporate knowledge is not allowed to slip through our fingers with the sands of time.

References

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