

Liberating the NHS: Developing the Health Care Workforce

Consultation Response

Introduction

Cambridge University Health Partners (CUHP) is the partnership organisation for the Cambridge Academic Health Science Centre (AHSC). CUHP also holds the contract for delivery of the Cambridgeshire and Peterborough Health Innovation and Education Cluster (HIEC).

The members of Cambridge University Health Partners are:

- The University of Cambridge;
- Cambridge University Hospitals NHS Foundation Trust;
- Cambridgeshire and Peterborough NHS Foundation Trust;
- Papworth Hospital NHS Foundation Trust.

In addition to the members of CUHP, the Cambridgeshire and Peterborough HIEC also includes the following member organisations involved in the education, training and development of the healthcare workforce:

- NHS Cambridgeshire
- NHS Peterborough
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Hinchingsbrooke Healthcare NHS Trust
- Cambridgeshire County Council
- Anglia Ruskin University

CUHP is thus able to represent the view of a wide range of organisations, spanning sectors and all occupational groups, in response to the consultation.

Overarching comments

1. We strongly support the policy of creating an employer-led system, which we anticipate will lead to greater responsiveness to local needs. This will support the re-shaping of the workforce that is essential if the health and social care sectors are to meet the QIPP challenge.
2. The employer-led policy is also consistent with the direction of travel towards greater autonomy for NHS Foundation Trusts. Healthcare providers are ready to take on responsibility for planning and developing their own workforce.
3. This move towards greater provider autonomy needs to be balanced against three further considerations:
 - i) the need for scale in provider networks that balances efficiency, effectiveness and economy;

- ii) the need to protect investment in education and training against short term responses to financial pressures; and
 - iii) the imperative of ensuring business continuity during the transition period.
4. In our view, the Department of Health has so far placed insufficient emphasis on the imperative for business continuity. The consultation document employs negative commentary on the current system as a rhetorical device to justify change (3.19). This needs to be balanced with greater recognition of the positive aspects of the service provided by Deaneries and the need to maintain this service through transition. There is considerable risk to the reputation of the NHS if this is not made a priority.
5. An obvious way of mitigating transition risk and achieving right-scale for networks would be to build on existing partnerships. In this context, we welcome the reference to both AHSCs and HIECs as potential platforms for Skills Networks in the consultation document (5.25).
6. The position of the universities in relation to skills networks needs to be clarified. The consultation document is ambiguous on this point. In some places, where the emphasis is on partnership and inclusion, there is a suggestion that HEIs should be included in networks (5.22). Elsewhere, where the emphasis is more on competition, the suggestion is that this would not be appropriate (5.24). In practice, complete separation of provider and purchaser roles is difficult to achieve in this field (many NHS Trusts also play a significant role in provision) and greater clarity is needed about the balance between competition and collaboration envisaged, especially – but not exclusively - in relation to HEIs.
7. In this connection, we note that there is a desire by the University of Cambridge to increase its involvement in postgraduate medical education and to extend its role in the postgraduate education of other professions. In our view, there would be much to be gained from such a development in terms of greater integration of research, education and service provision, which is at the core of our role as an AHSC. The means to achieve this would be through the Deaneries, which could be hosted in future by AHSCs where these exist. Provided the Deaneries are seen as providing an advisory role to the Skills Networks, which would be the commissioning organisation, this would be consistent with the desire to preserve a purchaser-provider split (if that is policy intent – see comment 5).
8. We welcome the principle of an education levy as this is probably the most reliable means of ensuring sufficient investment in education, training and development by healthcare providers (8.2). Given our comments on transition risk, we support the suggestion that any reforms to funding should be introduced at a cautious pace. Simultaneous reform of both structures and funding will compound risk.

9. The proposed new national body, Health Education England, is also welcomed on the basis that its role is focused on the four areas set out in the consultation document: strategic leadership; development of Skills Networks; promoting quality; resource allocation. Arrangements will be needed that balance co-ordination with the NHS Commissioning Board with a suitable degree of autonomy for HEE and protection of education and training funding.

Response to specific consultation questions

Chapter 2

Q1: Are these the right high-level objectives? If not, why not?

We agree that these are appropriate objectives.

Q2: Are these the right design principles? If not, why not?

We agree that these are appropriate design principles for the new system.

Chapter 3

Q3: In developing the new system, what are the key strengths of the existing arrangements that we need to build on?

The best Postgraduate Deaneries have established excellent systems for quality monitoring and improvement. This infrastructure needs to be sustained and developed within the new Skills Networks.

The current system successfully handles contracts and financial management for some £5bn of public money. The transparency and effectiveness of financial governance needs to be maintained.

In many cases SHA Workforce Directorates and Deaneries have utilised their sizeable budgets and autonomy to commission innovative programmes in areas such as leadership. It is important that the Skills Networks are able to build upon this flexibility and are not subject to additional constraint.

Q4: What are the key opportunities in developing a new approach?

- Integrate workforce planning and education at a local level.
- Link workforce development to local innovation and service improvement activity.
- Strengthen the partnership between universities and NHS providers.

Chapter 5

Q5: Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce?

We agree that the Skills Networks should consult widely on their plans to invest MPET resources, (and in future the provider levy). It should be left to individual providers to determine how best to engage with stakeholders on developing their workforce overall.

Q6: Should healthcare providers have a duty to provide data about their current workforce?

Healthcare providers will need to share data with CfWI and HEE to inform national workforce planning and negotiations with DH and HMT concerning resources. The use and publication of these data should be subject to strict agreements concerning confidentiality. Much of this information is likely to be sensitive at an individual provider level in relation to service contracting and price setting.

Q7: Should healthcare providers have a duty to provide data on their future workforce needs?

Yes, but with similar reservations to the answer to Q6 above.

Q8: Should healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?

This is implicit within the design of the proposed system. Healthcare providers will only be able to benefit from the Skills Networks by working cooperatively within them.

Q9: Are there other or different functions that healthcare providers working together would need to provide?

Networks may wish to collaborate in other areas of joint interest such as service improvement skills. These sorts of activities should be discretionary and locally initiated, not mandated.

Q10: Should all healthcare providers be expected to work within a local networking arrangement?

Same answer as for Q8.

Q11: Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?

Yes.

Q12: Are there other incentives and ways in which we could ensure that there is an appropriate degree of cooperation, coherence and consultation in the system?

The key incentive for providers to engage actively in the new system is real autonomy for the Skills Networks. While the networks will need to be properly accountable for their actions and plans, if their freedom of action is excessively constrained by DH, HEE or regulators then senior staff will not be prepared to give up the time required to participate in network activity and development.

Chapter 6

Q13: Are these the right functions that should be assigned to the Health Education England Board?

Overall these are the right functions to be assigned to HEE. It will be important to ensure that the *modus operandi* in relation to the Skills Networks is to hold the latter to account for commissioning appropriate education across the board. We are unsure whether the needs of small/specialist staff groups would be best served by consortia/lead commissioner arrangements between Skills Networks or by national commissioning through HEE. We are certain that safeguarding education arrangements for small specialities/specialist roles in Medical, Nursing and Healthcare Scientist training must not be overlooked. This question needs exploration in the light of whatever evidence, perhaps from other national models, is available.

Q14: How should the accountability framework between healthcare provider skills networks and HEE be developed?

Skills Networks will need some national co-ordinating secretariat to negotiate the accountability framework with HEE. This process needs to start during 2011/12.

Q15: How do we ensure the right checks and balances throughout all levels of the system?

It is in all parties' interests, including healthcare providers', to ensure that the system delivers the objectives set out in Chapter 2 of the consultation document. Skills Networks should be held to account by both HEE and the providers themselves, HEE should be held to account by DH and by a balanced board representing the professions, the public and also the providers and commissioners of both healthcare services and education.

Q16: How should the governance of HEE be established so that it has the confidence of the public, professions, healthcare providers, commissioners of services and higher education institutions?

See answer to Q15 above.

Q17: How do we ensure that the Centre for Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?

CfWI is still in early days. It will need to engage widely with relevant organisations, particularly with regard to smaller specialties for which some

national oversight is needed. Some mechanism will be needed for the oversight of CfWI.

Q18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?

Skills Networks will need to demonstrate that their workforce plans are consistent with the service commissioning intentions of NHSCB.

Q19: Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and cooperation in planning the workforce and in the planning and provision of professional education and training?

Providers will only be able to engage with, influence and receive funding from their Skills Network if they operate by its rules. This should be the focal relationship for individual providers in relation to workforce development.

Q20: What support should Skills for Health offer healthcare providers during transition?

We have no comment to make on this question.

Q21: What is the role for a sector skills council in the new framework?

We have no comment to make on this question.

Q22: How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?

This should be a matter for local determination. In establishing Skills Networks healthcare providers will need to satisfy the outgoing SHA that clinical leadership has been addressed in their proposals.

Q23: In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?

This should be a matter for local determination.

Q24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?

Yes and it should then devolve responsibility for implementation to the Skills Networks.

Q25: What are the key opportunities for developing clinicians and managers in an integrated way both across health and social care and across undergraduate and postgraduate programmes?

As well as nationally funded programmes it is essential that Skills Networks have the flexibility to utilise elements of MPET funding for this purpose just as many Deaneries have done hitherto.

Chapter 7

Q26: How should Public Health England, and its partners in public health delivery, be integrated within the new framework for planning and developing the healthcare workforce?

In the same way as other professional groups/bodies, through participation in HEE and the Skills Networks.

Q27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities; and what funding mechanisms should be employed with regard to the public health workforce?

Local Authorities would make a welcome contribution to the Skills Networks. It should be remembered, nonetheless, that the proportion of the healthcare workforce employed by Local Authorities is extremely small and will remain so even after the bulk of public health staff transfer to local authority employment.

Chapter 8

Q28: What are the key issues that need to be addressed to enable a strategic, provider-led and multi-professional approach to funding education and training, which drives excellence, equity and value for money?

Skills Networks will stand or fall by the extent to which they prove effective in their role. It is essential that their authority is not circumscribed more than is absolutely necessary. If this becomes the case then providers will simply not engage.

Q29: What should be the scope for central investment through the Multi-Professional Education and Training budget?

Skills Networks should receive allocations, (in future levy payments) on the basis of a transparent, equitable and responsive formula that balances maintenance of the current workforce with opportunities for strategic investment in workforce re-design. We suspect that the principles behind this should be quite different to those applied in determining allocations for servicing commissioning.

So long as they can satisfy HEE that their plans address both short and long term requirements for the whole workforce they should be free to determine what education and training is commissioned from the MPET budget.

Q30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?

See answer to Q29 above.

Q31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?

The introduction of tariffs should be accompanied by transitional arrangements for capping potential gains and losses to individual institutions. Careful thought needs to be given to the interplay between tariff and levy introduction with a view to avoiding unintended consequences or provider de-stabilisation.

Q32: If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?

Not necessarily – see answer to Q29.

Q33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?

We have no comment to make – this question is too detailed for this stage of the consultation.

Q34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

See answer to Q33.

Q35: What is the appropriate pace to progress a levy?

Slowly – see overarching comments on transition and risk.

Q36: Which organisations should be covered by the levy? Should it include healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse?

All providers employing significant numbers of staff trained through the public purse. The private and voluntary sectors should not enjoy ‘free-rider’ status in these arrangements, especially if their role is set to grow as a consequence of ‘any willing provider’ policy.

Q37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?

A levy on NHS service providers should be based on current and future need for staff. This would be most fairly and easily introduced as a proportion of service income. For this to incentivise investment it will be essential that an explicit assumption about educational funding is built into tariff and other price setting. Moreover, payment of the levy should be directly into the local Skills Network of which the provider is a member. This will enable proper local control and

accountability while ensuring that investments are made in the public interest according to clear, published plans.

In addition to developing a levy to fund future workforce development needs, the Government may also wish to establish a separate levy on organisations who rely on staff trained by the NHS but who do not provide NHS services. This would go some way to recouping the public investment in these staff. This would need to be a separate system working alongside the levy on NHS service providers.

Q38: How can we introduce greater transparency in the short to medium term?

HEE and Skills Networks should publish their plans along with the agendas and minutes of meetings.

Q39: How can transaction costs of the new system be minimised?

By right-sizing Skills Networks and by eliminating any discretionary activities unless they can demonstrate added value.

Q40: What are the key quality metrics for education and training?

We assume that the SHA/Deaneries already have an evidence-based view on the connection between education and training investment and QIPP and that this knowledge-base will be brought through into whatever new system emerges.

Chapter 9

Q41: What are the challenges of transition?

Maintaining business continuity, with particular regard to staff morale in the current Deanery function will require early determination of matters such as the geography and structure of Skills Networks and plans for implementation, so that the staff can be given certainty about their future. The risk is that during the transition period, experienced personnel may leave the NHS as a response to uncertainty. Early certainty and effective communication are the most obvious strategies for reducing this risk.

Setting up Skills Networks as legal entities. It is essential that a national model for the form of incorporation and constitution is developed at an early stage. The alternative will be considerable cost and delay that will escalate the existing risks to business continuity.

Q42: What impact will the proposals have on staff who work in the current system?

Substantial impact given that they will face a change of employer and, over time, a likely change in role. This needs to be managed by giving early certainty of future arrangements.

Q43: What support systems might they need?

This is a question for the SHAs as current employers.

Q44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?

No comment to make.

Chapter 10

Q45: Will these proposals meet these aims and enable the development of a more diverse workforce?

This could be made a requirement of local proposals.

Q46: Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender, gender identity (including transgender people), religions or belief; pregnant women, people who are married or in a civil partnership, or disabled people) will be advantaged or disadvantaged by these proposals or have greater difficulties than others in taking part in them? If so, what should be done to address these difficulties to remove the disadvantage?

See answer to Q 45.