

JRCPTB

Joint Royal Colleges of Physicians Training Board

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Liberating the NHS: Developing the Healthcare Workforce

Background

This consultation on the arrangements for planning and training the NHS workforce was launched on 20th December 2010, and complements the changes planned for the wider NHS in "Equity and Excellence: Liberating the NHS" which is currently going through Parliament. The consultation ends on 31st March, though earlier responses have been invited. In brief the changes include:

1. In future the DH wishes to have less direct involvement in planning and developing the healthcare workforce and wishes to transfer these responsibilities to healthcare providers
2. SHAs are to be abolished in 2012 (Health and Social Care Bill)
3. Postgraduate deaneries, as part of the SHAs will be abolished
4. Planning the healthcare workforce, and responsibility for its education, training and development will be delivered at local level by multiprofessional "skills networks" composed of groupings of healthcare providers (including GPs in their provider role), which will not have a centrally defined structure.
5. Skills networks will be legal entities, responsible for managing local workforce data and planning, and handling and allocating the funding for training the healthcare workforce (including medical and dental). They will be created by, funded, accountable to and audited by the healthcare providers.
6. An autonomous statutory board, Health Education England (HEE), lean and expert and free from day-to-day political interference will be created to focus on workforce issues at national level. It will take on the advisory role of Medical Education England (MEE) and the professional advisory boards for education and training. It will:
 - Provide national leadership for planning and developing the healthcare workforce
 - Ensure development of healthcare provider skills networks
 - Promote high quality education and training responsive to changing needs of patients and communities
 - Allocate and account for NHS education and training resources

Summary of JRCPTB response

- JRCPTB believes that the massive reorganisation of the NHS proposed in the current Healthcare Bill, and this consultation, combined with the need to make £20 billion efficiency savings, potentially threatens the quality and delivery of postgraduate medical training
- We are concerned that responsibility for medical training should be given to healthcare providers, which have a history of allowing service and research to dominate their agenda at the expense of education. Many trusts, for instance, persistently fail to support educational supervisors by recognising this activity in job plans, and increasingly fail to support their staff in

fulfilling important national roles related to standard setting and training. There is no mention of the safeguards which need to be put in place to protect the quality of medical training

- It appears to be implicit that Postgraduate deaneries should disappear, since the abolition of SHAs will make it mandatory that alternative arrangements are made. Postgraduate deaneries are currently pivotal in quality managing the delivery of medical training in trusts, but the planned replacements (skills networks), being answerable to, and funded by healthcare provider units would seem to lack the impartiality required to drive the quality agenda, at a time when this may be most needed, because of fiscal pressures and the associated threat to educational quality.
- Effective management of the complexities of postgraduate medical training requires professional leadership, skills and experience which take years to develop.
- Postgraduate medical training has been subjected to 3 or 4 massive organisational changes in the last ten years, with the advent and demise of educational consortia and workforce development confederations. These initiatives have been costly and unproductive
- There is no large resource which could be released from the £2 billion spent on training doctors without compromising healthcare delivery, because almost all of the budget is taken up with the salaries of those delivering the service
- JRCPTB believes that there are no gains to be made by inflicting massive change on medical training at a time when it is most in need of protection. Any changes which the DH desires should be delayed until healthcare providers show that they have a commitment to educational quality and the ability to deliver information which would allow workforce planning.
- Postgraduate deanery commissioning and quality management functions need to be preserved intact within any new organisational arrangement for at least a number of years until successor structures and expertise can be developed.
- When healthcare provider skills networks are developed, a mechanism will have to be found which will protect the quality management and workforce data functions currently based in deaneries.
- JRCPTB has played a key role in collaboration with the RCP London in providing national coordination of recruitment to 1200 posts per annum in core medical training, and in 2011, to ST3 posts in 12 medical specialties. Selection interviews are conducted by deaneries, and the coordinated processes have saved the service £millions, as well as saving hundreds of hours of consultant and trainee time. Transparency, efficiency and fairness of recruitment have been improved. Any re-structuring of deanery functions must be designed in such a way as to preserve the great progress which has been made with the national coordination of recruitment.
- HEE is supposed to be a lean and expert organisation. Its workforce functions will be challenging because of the need to set in place mechanisms to collect relevant data, and it will be dealing with an embryonic Centre for Workforce Intelligence (CfWI) which currently is not able to provide meaningful workforce intelligence or advice. JRCPTB is particularly concerned about workforce planning for its 12 small specialties, and is also concerned that the urgent need to reduce higher training numbers will get overlooked amidst transformational change. If skills networks are hastily put together to replace deaneries, the task of HEE in providing oversight of the networks will be challenging in view of their variable structure, and concerns about their fitness to undertake quality

management. It will be important to ensure that HEE is adequately resourced.

- JRCPTB deals with trainees from the devolved nations. We are concerned to ensure that standards are maintained across the nations, and that training arrangements are coordinated to ensure freedom of movement between countries. Scotland, Wales and Northern Ireland will maintain deanery structures to coordinate and deliver training. We must ensure that developments in England do not threaten this coordination between the 4 countries, and the lack of defined structure for skills networks appears to pose a threat to this ambition.

Introduction

The JRCPTB welcomes the fact that the importance of workforce planning is recognised in the consultation, and the further recognition that high quality education and training is a critical factor in both developing the existing workforce and preparing the future workforce.

The consultation document rather disappointingly, does not attempt an evidence-based assessment of the current arrangements, nor any attempt to identify the weaknesses which need to be addressed, but consists largely of sweeping (mostly unreferenced) statements.

The proposed “Skills Networks” are tasked with both workforce and training and education responsibilities, but from the point of view of this critique, these are best dealt with separately:

Postgraduate Medical Training and Education

Postgraduate deaneries currently quality manage the provision of training in provider trusts as part of the GMC Quality Framework. In the past, one of the great barriers to driving up the quality of training was to persuade provider trusts that high quality training was a worthwhile goal. Too often, they failed to recognise training activity in job plans of supervisors, and failed to make proper provision for the impact of training on clinical service delivery. This was in spite of the fact that healthcare delivery in the UK is highly dependent on the trainee workforce. JRCPTB believes that there are inherent dangers in making the quality management of medical education a responsibility of a network funded by and accountable to healthcare providers. There must be conflicts of interest, either overt or covert which would threaten the ability of a skills network to quality manage a provider trust. We expect that the GMC will have concerns as to whether such an arrangement could deliver its quality management framework. The JRCPTB believes that this is a crucial issue which relates directly to questions of patient safety.

We can see no safeguards in the proposals which would protect the quality of medical training. In order to achieve this, we think that it would be sensible to develop a sub-national first tier of HEE, which would be interposed between HEE and skills networks in order to focus on the training/quality management /workforce planning functions of the latter. Such a first level component of HEE would need to have the necessary governance to hold skills networks to account for their workforce data and plans, to channel the strategic workforce decisions of HEE to the skills networks (especially in relation to smaller specialties), and to quality manage training and act as focal point for the GMC and other regulators. The number of such sub-national units which might be required would depend to some

extent on the number of skills networks which are approved. Based on current deanery arrangements, one might suggest 7 units with responsibilities for: 1) Northwest and Mersey, 2) Northern and Yorkshire, 3) East and West Midlands, 4) London, 5) Eastern and Oxford, 6) KSS and Wessex, 7) South West and Peninsula.

If this type of safeguard is not put in place, Colleges may need to prepare themselves once again to take on the quality management role which latterly has been delivered by deaneries. Colleges (and the JRCPTB) are likely to have difficulty in dealing with skills networks which will not have defined structures. Currently, we have multiple and complex interactions at many levels with deanery staff, and disruption of these relationships would require months or years to repair.

Workforce Planning

JRCPTB would like to highlight the following points:

- Data: We welcome the acknowledgement (6.8-6.10) of the vital need to have high quality workforce information. Attempts to plan the medical workforce in recent years have been hampered by the lack of reliable information about the numbers and location of doctors in training. Colleges collated accurate data on trainee numbers until 2005, when responsibilities for approving training shifted to PMETB. PMETB chose to focus on programme approval, rather than posts, and centrally held data has deteriorated since this time. For workforce planning, we need to know the distribution and training level of all trainees. This is currently not known, and JRCPTB feels that the situation must be urgently remedied by concerted action of Colleges, deaneries and the GMC, with the data being shared with the Centre for Workforce Intelligence (CfWI).
- Multiprofessional workforce planning: This is proposed again as the answer to avoiding shortages of, for instance, intensive care and renal nurses. There is no mention of previous failures to improve the planning of the healthcare workforce via multiprofessional initiatives such as Educational Consortia or Workforce Development Confederations. One reason for this recurrent failure might be the fact that fundamental differences in the training of different professional groups have been ignored. Most healthcare professional training is at undergraduate level, whilst healthcare scientist and medical training is postgraduate, and in the case of medical graduates, prolonged and complex. Medical specialty training requires about 5-10 years of postgraduate training, in one of 62 specialties (and up to 34 subspecialties). The complexity and prolonged length of training mean that workforce needs have to be identified well in advance, and that errors are costly in terms of the wasted human and educational resources. JRCPTB does not believe that moving to a multiprofessional workforce organisation will lead *de facto* to improved planning and training, and recent experience would suggest the opposite. The complexities of postgraduate medical training require skilled professional leadership, and highly trained administrative and support staff. Dismantling of deanery structures and functions would hamper workforce planning and data gathering and would take years to repair. Having said that, we recognise that there are certain areas where training of other professional groups could be linked to medical training. Advanced Nurse Practitioner, Operating Department Assistant and perhaps midwife training might benefit from this approach.
- Distribution of the training (trainee) resource: In spite of attempts to improve the situation, the majority of medical care in the NHS, especially

out-of-hours, is delivered by trainees. Many trusts regard approved training posts as a valuable resource, and a means to fill posts and to deliver service at relatively low cost. The inequitable distribution of training posts, with more than 30% of posts in London, providing care for 12% of the population is unacceptable, and means that under-provided areas suffer disproportionately when percentage reductions of the MPET levy are applied.

Prior to 2005, Lead Deans had control of training post numbers, and distributed new resources in an equitable way, respecting training capacity and capitation. The effective end of tight management of medical trainee numbers came in 2004, with the central well-intentioned, but ill-thought-through initiative which allowed the creation of ad libitum additional registrar posts to meet the requirements of the EWTD (“Hutton” numbers). This process effectively sacrificed planning of the medical trainee workforce to the needs of the service, and the subsequent workforce responsibilities allocated to SHAs and their workforce directors has not improved the situation.

- Funding of postgraduate medical training: There are frequent references to the MPET levy, which approaches £5 billion, and appears to be a tempting resource. £2 billion of the levy is taken up by postgraduate medical and dental education, although these groups account for only 10% of the NHS workforce. There is little mention, or perhaps realisation, that more than 90% of this sum is taken up by the salaries of doctors who are actually providing the service for the NHS. Around 75% of the sum flows directly to trusts, so the idea that there is a major untapped resource may be illusory. If the trainee posts are removed abruptly, the service collapses. This is not to say that there is not a need to explore new ways of working. Many of the tasks undertaken by junior trainees can be dealt with by appropriately trained other staff. There will be increasing pressure to develop service delivery in this way as surplus medical training posts are removed. Trusts have not sufficiently responded to pressures which already exist, related to such things as EWTR, perhaps because there is little or no financial incentive to replace medical trainees.
- Centre for Workforce Intelligence: The consultation variously has the following to say about the CfWI:
 - Provides objective evidence and insight for use by the NHS in planning and developing the workforce (Annex A)
 - Provides objective analysis and evidence for the planning and development of the workforce at both national and local levels (Annex B)

These are aspirational statements. The CfWI is a fledgling organisation, working in a complex field of which it has no direct knowledge, and with a dearth of reliable information. It is currently hugely dependent on Colleges, deaneries and the DH for guidance and support. It will take some time for the CfWI to provide useful guidance on major specialties, but many of the 62 specialties are small, and many belonging to the JRCPTB are “niche” specialties for which planning entails sophisticated professional knowledge. These specialties will all require planning at national level, and the data and expertise to do this are currently lacking. All medical workforce planning will need national oversight to ensure that collated plans are coherent and in line with national strategies and horizon scanning. It is intended that CfWI should provide this for HEE. The JRCPTB is concerned that the consultation does not adequately reflect the amount of

developmental work required, and the amount of resource which will be needed to plan and develop the NHS medical workforce.

Conclusion

JRCPTB recognises the aims of the consultation to empower healthcare providers and to give them greater responsibility for planning their health professional workforce and the way in which it is trained.

However, the length and complexity of postgraduate medical training, and the small size of many specialties make it imperative that there is national strategic planning and scrutiny of local plans. To be effective, this has to be backed up by the appropriate governance and accountability of skills networks.

To safeguard the quality of medical training, we feel that quality management must be based in a management tier to which skills networks would also be accountable.

We suggest that the appropriate safeguarding of both workforce planning and education could be achieved by creating a first tier of HEE at a sub-national level, and consisting of around 7 discrete units.

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