Consultation response

The King's Fund's response to the Department of Health's consultation *on Liberating the NHS: Developing the healthcare workforce*

31st March 2011

The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

Context

The King's Fund has a longstanding interest in workforce issues and the quality of workforce planning. Our recent work includes a review of workforce planning in this country (drawing on international evidence) (Imison *et al* 2009) and leading the consultation that framed the remit of the Centre for Workforce Intelligence (Dixon *et al* 2009) on behalf of the Department of Health. We have also actively engaged in the current consultation, participating in and offering support to a number of consultation events.

Introduction

Health care workforce planning is highly complex and multi-layered and involves different timelines for different professions and occupations. It is made particularly difficult by the long timelines associated with medical workforce planning. Our previous work suggested that these complexities make it is impossible to get workforce planning 'right', not least because depending on where you sit in the system you may have different views of what 'right' is. A key challenge for any workforce planning system is to reconcile these different interests to produce outcomes that are in the best interests of the patient and the tax payer.

Our 2009 review of the current workforce planning architecture in this country reached the following conclusions.

- The different dimensions of service, workforce and financial planning are not adequately co-ordinated.
- The divide between medical and non-medical planning is still to be bridged.
- The workforce plans of different strategic health authorities vary in approach and scope. Some strategic health authorities (SHAs) have supported the development of leadership and improvement skills in the current workforce that will be critical to addressing the productivity challenge. It was clear that a larger critical mass in terms of funding base gives more opportunity for a broader and more inclusive approach.

Summary

We welcome the attempt to address some of the current weaknesses in the current workforce planning architecture, in particular:

- supporting multi-professional workforce planning through the establishment of Health Education England
- greater engagement of health care providers within and outside the NHS through the skills networks
- continued support for the Centre for Workforce Intelligence and the proposed duty on health care providers to provide workforce planning data.

However, we would question whether the proposals will achieve the laudable goals set out within *Liberating the NHS: Developing the healthcare workforce.* In particular, it is difficult to see how the proposed skills networks will operate effectively given the size and diversity of

their proposed membership. We suggest that the governance and engagement model for the skills networks is reviewed to ensure the networks can effectively fulfil their functions, deliver value for money and avoid conflicts of interest.

We note a fundamental tension inherent in these proposals of mixing a market approach to services with a planned approach to the workforce. It is hard to see how services driven by a market fit with a workforce driven by planning, particularly when the planning is reliant on the collaboration of competitors. If services are to be driven by markets then maybe the health care workforce should be exposed to greater competitive pressures, as they are in other countries. This would suggest a more blended model in which the state focuses on the provision of workforce intelligence and targets its subsidy/support to high priority areas.

There are also two issues notable by their absence from the proposals.

First, support for re-skilling and developing the current workforce. This should be an integral part of the wider workforce planning. Not only will this be critical to achieving improvements in workforce productivity but there are significant savings to be made from greater collaboration between providers to deliver statutory, vocational and professional development training. There is a particular risk arising from the abolition of SHAs, as SHAs have provided a strategic human resources and development function that is not expected to be part of the skills networks' role.

Second, it is not clear how primary care providers will be engaged and who will take lead responsibility for commissioning education and training for this sector. If skills networks are to take this on too their engagement challenge becomes even greater (see commentary below).

Detailed commentary on proposals

In appraising the proposals laid out in *Liberating the NHS: Developing the healthcare workforce* we have commented on both the objectives and architecture of the system. We begin with objectives.

Objectives for workforce planning, education and design

The consultation lays out five objectives:

- security of supply - sufficient numbers of appropriately skilled health care staff in the right place at the right time
- responsiveness to patient needs and changing service models
- high-quality education and training to support safe, high-quality care and greater flexibility
- value for money
- widening participation.

These are laudable objectives, but we would question whether the workforce planning and broader system architecture proposed by *Liberating the NHS* will achieve them.

Security of supply - sufficient numbers of appropriately skilled health care staff in the right place at the right time.

Sixty per cent of the staff who will be working in the NHS in 10 years' time are currently working in it. This objective will not be achieved without significant investment in re-skilling the current workforce.

Responsiveness to patient needs and changing service models

An ageing population and the epidemic of chronic disease make a new model of care an imperative. However, the professional bodies and many health care providers may have difficulty in providing the necessary impetus for the change, as the new service models could threaten the acute providers' viability and challenge the current status of some professional groups. There is a potential missing element in the jigsaw. Who will be responsible for specifying innovative service models which underpin workforce planning models? Currently, the Centre for Workforce Intelligence is attempting to do

this within their work on pathways. We would question whether they are the appropriate organisation to undertake this work.

High-quality education and training to support safe, high-quality care and greater flexibility

The quality of education and training will be highly dependent on the commissioning skills of the proposed skills networks. We have significant concerns about the capacity and effectiveness of the skills networks (see below).

Value for money

It is not clear to us how the proposed model delivers value for money in terms of the planning architecture. There will be many more organisations with a leadership role – current estimates suggest at least double the number. There will also be significant opportunity costs arising from the necessary engagement of stakeholders in the skills networks.

Widening participation

This is an important aspiration, and a provider-led model may be better equipped to address than the current model.

The new system will also be designed under the guidance of 12 principles. We would endorse all of the principles, but as above, we have concerns about whether they will be achieved.

Alignment with the wider system design for commissioning and providing services.

Until funding for training flows via commissioners there will continue to be risks that workforce planning is disconnected from service commissioning. The engagement of commissioners in the skills networks is problematic given the numbers of GP commissioning consortia that are likely to fall under each network; for example, a London-wide network would relate to 40 GP commissioning consortia.

Ensuring that fairness and transparency is at the heart of the new framework and in decision-making.

Transparency will be critical to proposed system's effective governance. It is very important to establish at the outset how information will be gathered and shared, particularly given commercial interests.

Ensuring the capability to plan effectively for both current and future workforce requirements.

This is a critical aim, but it is very dependent on the wider system for commissioning and provision delivering service plans that can underpin workforce plans.

Taking an integrated and multi-professional approach to workforce planning and education and training where possible, with stronger whole workforce approaches.

A major opportunity presented by these proposals is a stronger multi-professional approach to workforce planning, education and training.

Doing at a national level only what is best done at a national level, leaving flexibility for employers to maximise local innovation and implementation.

We would agree. It is not clear from the proposals exactly what will be done at national level and therefore whether this ambition will be achieved.

Ensuring effective professional engagement at local and national levels, with the professions having a lead role on safety and quality issues.

For this aspiration to be achieved it will be important for the professional regulators to have close links with the skills networks and Health Education England.

Ensuring that arrangements for planning and developing the healthcare workforce have appropriate integration with the approaches to planning and developing the public health and social care workforce.

This is important but challenging. The social care workforce of 1.7 million exceeds that of the NHS, is largely unregulated and works within thousands of very small employers. The means by which they can be meaningfully and effectively engaged needs to be thought through. In our view, solely relying on engagement in the skills networks will not be adequate.

Ensuring strong partnerships with universities and education providers to make the most effective use of the skills of educators.

There are opportunities through the skills networks to strengthen the partnerships between service and education providers for mutual benefit. It is important that the partnership at local level is mirrored at national level. Proposed changes to higher education funding have significant implications for health care education and training, in terms of both the decisions taken by the education providers over the provision of courses and the future student take-up.

Making sure there is sustainable and transparent investment in education, training and development to provide the skills needed, so that funding allocated for the purposes of education and training is only spent on those activities.

This is key to effective governance of the skills networks, ensuring resources allocated to them are used only for education and training and do not act as a hidden subsidy to service costs.

Streamlining processes and structures to ensure they are simple, cost effective and efficient.

This is clearly important but we would question how achievable this is, give the proposed membership and structures of the skills networks.

Providing clarity of roles, responsibilities and accountabilities.

It will be important to clarify roles and responsibilities and ensure these are understood across the system, not just to those engaged in workforce planning.

Reinforcing values and behaviours that recognise the wider benefit to society of developing the health workforce and skills, and the need for cooperation and collaboration.

This is critical but challenging in the context of growing competition and moves towards a more market based system.

Architecture

Health Education England

The proposals centre on the development of a new independent statutory body, Health Education England, which will coordinate national workforce planning, training, and education in the NHS. In 2012, Health Education England will take over from Medical Education England, and the professional advisory boards for education and training. It is expected to provide national leadership on planning and developing the health care workforce, ensure the development of local skills networks of health care providers, promote high-quality education and training that is responsive to the changing needs of patients and local communities, and allocate and account for NHS education and training resources.

We welcome the move to extend the remit of Medical Education England to encompass the whole health care workforce. We see the following as being key to Medical Education England's success:

- strong links to the NHS Commissioning Board , which should provide on service aspirations
- strong links with the professional regulators
- the levers and capacity to influence and improve the operation of the skills networks
- effective support from the Centre for Workforce Intelligence – providing intelligence on current workforce and education supply.

Centre for Workforce Intelligence

The King's Fund earlier work on the potential remit for (insert ref) suggested the following key activities underpin the analytical function of the Centre:

- collate and synthesise data on labour market dynamics and workforce supply and where necessary collect data to supplement that which is routinely available
- regularly update projections of workforce supply
- commission research to establish and validate key assumptions underpinning the projections
- present risk and sensitivity analysis for all projections, estimates, and forecasts
- ensure that high-quality labour market intelligence is made regularly available, where possible broken down by region.

The Fund recommended that it would be important for the Centre to provide a whole-system perspective. This means having data not only on NHS providers but also on independent and voluntary sector providers of health care. In social care, where the majority of providers are small to medium-sized enterprises, gathering data may rely on data from commissioners (ie, local authorities) or will require data from a representative sample of providers.

The Centre will need to scan the horizon for future workforce and labour market issues, but also identify issues in the wider context such as political, economic, societal and technological changes which are likely to have an impact on the health and social care workforce. The Centre will need to interpret these trends alongside potential changes to health care workforce and service models and describe their prospective impact on health and social care workforce supply and demand.

In our view, all of the above recommendations still hold, but looking forward, we suggest that it will also be important for the Centre to also gather information on education as well as workforce supply. The recent changes to tuition fees suggest that gaps may emerge in training provision as education providers cease to deliver non-profitable courses.

The Centre will also need to forge strong links with Health Education England and the skills networks. The information produced by the Centre will be a key enabler for both to undertake their functions.

Local skills networks

The workforce functions allotted to SHAs will, following their abolition in 2012, transfer to local skills networks of health care providers and clinicians, local authorities and education providers. As legal entities, they will be able to enter into contractual agreements with education providers. The networks offer the opportunity for a localised, whole-systems approach to workforce planning, but there is also a significant risk that the skills networks will be unwieldy and unresponsive. If networks cover a region, or even a third or half of a region, the numbers of potential number of members is huge.

Estimated numbers of skills network members in London

- More than 100 different NHS, private and voluntary health care providers ranging from Imperial College Healthcare NHS Trust with a turnover of more than £900 million to small private therapy centres and hospices, less than 1/100 as big.
- 40 GP commissioning consortia
- Several hundred social care providers.
- More than 1000 GP practices, dental practices and optometrists.
- It hard to quantify the number of self-employed social and health care practitioners but one might expect numbers in the hundreds.

The network will act as conduit for significant resources – without strict financial controls there are possible governance risks. Establishing the networks as separate legal entities suggests a huge governance challenge. How can they be effectively held to account?

The networks are charged with assuring the quality of education and training that they commission. We are concerned that a conflict of interest arises from skills networks commissioning from their own constituents for training placements. Some SHAs appear to be proposing models that retain a purchaser–provider split and envisage retaining the deanery function as a 'commissioner' arm. It is not clear to us whether this fits with the proposed model for skills networks.

Further, we would pose the following questions:

- How will the voting and decision-making rights of the network's constituent organisations be determined?
- How will Health Education England manage skills networks' performance? Will they be expected to arbitrate if disputes arise? If so, Health Education England won't be a lean organisation.
- Is it realistic to expect GPs to actively engage in the networks? One can't expect one GP per cluster – how will representatives be identified and then realistically engage with others?
- Once the levy and tariff are in place, how will funding be allocated and on what basis will relative contributions of different organisations be calculated?
- The consultation mentions skills networks for small professional groups – who will sit in these networks? How will they be held to account?

We would suggest that there is a need for a formal process to accredit training providers with agreed national standards.

Health care providers

Aside from entering into skills networks, health care providers will be expected to:

- consult patients, local communities, staff and commissioners of services about how they plan to develop their workforce
- provide data about their current workforce and future workforce needs
- co-operate in planning the health care workforce and in planning the provision of professional education and training.

Consultation on workforce plans

It is not clear which providers would be expected to do this. As can be seen above, the size and scale of provider is hugely varied. It is also not clear to us what the added value of this consultation would be. If the patient and public voice is to be heard it would seem more effective to require consultation and engagement by the skills networks.

Duty on providers/Networks to provide data

Provision of data is a critical foundation of robust workforce planning; we believe this duty should be embedded in licensing requirements. As noted earlier, significant attention needs to be paid to specifying the data requirements including quality and frequency.

Duty to co-operate

The duty to co-operate will be very important if the skills networks are to achieve consensus. However, in a market-based economy a key competitive lever is workforce. There will be particular pressures from the increased scarcity of junior medical staff as training numbers fall. This could present a significant challenge – what are the incentives for providers to cooperate?

We would also question what incentives/sanctions will be in place to ensure the engagement of providers in the skills networks. If it is not mandatory, what are the implications for their operation if a significant proportion do not participate, leaving others to carry the load?

Finance and incentives

Levy on providers

Funding for the next generation of health care professionals will be sourced from a centrally imposed levy on providers. In principle this should create a more level playing field between NHS and non-NHS providers. However, devising a formula perceived to be fair by all is likely to be very difficult.

Multi Professional Education and Training Budget

The inequitable distribution of the training budget in previous years has been widely criticised. There is a separate review that considers the specifics of the Multi Professional Education and Training budget.

Tariffs

The government also intends to introduce tariffs for medical and other clinical placements. This will, it is believed, provide a level playing field for the flow of funds. We support greater transparency in this area, but the system should learn from the experience with the service tariff – it should not be tariff for activity but have an element linked to quality. There will also be a need to recognise scale issues for providers.

Benchmarking

Benchmarking performance can also be a powerful lever for change and could also be a valuable part of the governance framework. The Centre for Workforce Intelligence could be charged with benchmarking providers and skills networks across a number of key dimensions, for example:

- Skills networks
    - management costs expressed as a percentage of the total training budget
    - training places commissioned annually, by professional group, expressed as a percentage of current workforce leavers
- Providers
    - Percentage of total budget invested in current workforce development
    - trainee satisfaction scores.

The transition

The workforce planning reforms are set to be in place by 2012. SHAs will hold and allocate the Multi Professional Education and Training budget for 2011/12. Partnerships between employers and local partners will need to be developed in 2011, for skills networks to be separate legal entities able to commission education and training from April 2012. The Health Education England board will be established in shadow form during 2011, and become a 'special health authority' from April 2012.

The anticipated pace of change is ambitious, especially given that at the time of writing there is no clarity about the legal form and governance of the skills networks. We also have concerns about the potential loss of scarce workforce planning expertise during transition from SHAs.

References

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