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Liberating the NHS: Developing the Healthcare Workforce

Consultation response by the Faculty of Pharmaceutical Medicine

The Faculty of Pharmaceutical Medicine welcomes the opportunity to comment on the consultation paper 'Liberating the NHS: Developing the Healthcare Workforce'. The Faculty of Pharmaceutical Medicine is a Faculty of the three Royal Colleges of Physicians of the UK, and represents the specialty of Pharmaceutical Medicine. It is also a member of the Academy of Medical Royal Colleges.

Pharmaceutical Medicine is a medical specialty concerned with the discovery, development, evaluation, licensing and monitoring of medicines, and the medical aspects of their marketing. The Faculty exists to advance knowledge and promote the science of pharmaceutical medicine by working to develop and maintain competence, ethics, integrity and the highest professional standards of practice in the specialty for the benefit of the public. In short it concerns itself with postgraduate education of pharmaceutical physicians and with standards of practice of pharmaceutical medicine in medicines development.

Pharmaceutical Medicine practitioners in the UK are approximately 1,500 doctors (approx. 1.5% of the medical workforce), who work with the pharmaceutical industry, employed in pharmaceutical companies, regulatory authorities and contract research organisations, and in independent consultative roles. Each year 100-120 doctors join the pharmaceutical industry as pharmaceutical physicians, after completing at least four years of post-graduate clinical training and reaching the competences of S2; further training & education is undertaken in the industry through a 4-year workplace-centred, competency-based programme of Pharmaceutical Medicine specialty training (PMST), resulting in a Certificate of completion of Training (CCT) or a CESR-CP, and a place on the GMC Specialist Register. PMST is regulated by and works within the Quality Improvement Framework of the GMC. Approximately 60% of pharmaceutical physicians are from physician specialties and 40% from all other specialties in medicine including general practice.

The work of pharmaceutical physicians in the development of medicines involves them very much in liaison with clinicians and many other appropriately trained, experienced and expert healthcare professionals in the organisation and conduct of clinical research (clinical trials) on new medicines and on receiving expert advice on diseases, patients and treatments. Later, following the licensing and introduction of the new medicine(s) the pharmaceutical physician, both directly and indirectly, works with and through clinicians and healthcare professionals to monitor the use, and undertake the continuing development, safety monitoring and risk management of the medicine(s).

For the reasons above, the content of the present consultation, relating in general to healthcare policy and specifically to medical education and medical workforce planning are of direct interest to the Faculty. The Faculty's understanding of the proposed changes which are at the heart of the consultation concern the devolution of planning and development of the healthcare workforce from the centre (DH) to healthcare providers, with responsibility for education & training and development to be delivered locally by multi-professional Skills Networks (legal entities), replacing postgraduate deaneries. Skills Networks, accountable to, funded and audited by healthcare providers, will in turn manage local workforce data and planning as well as the funding for training. A new board, Health Education England (HEE) will replace all current bodies to focus on workforce matters (coordination, harmonisation) at the national level.

In responding to specific questions in the consultations, the Faculty would like to comment as follows:

Q1: Are these the right high-level objectives? If not, why not?
These proposals are appropriate to meet the objectives and values laid down in the reforms for the NHS as applied to the workforce: security of supply, responsive to patient needs and to change, high-quality E&T supporting safe high-quality care, flexibility, value for money and widening participation.

The caveats to this are that it represents a seismic shift in organisation and delivery of E&T in a time of austerity (cuts & savings) just a few years after the previous upheaval of postgraduate training (still ongoing) which could further impact standards and quality of postgraduate medical training. The rate of change at the expense of allowing teams to settle down, work together and develop is a real concern.

Q2: Are these the right design principles? If not, why not?
The design principles follow the objectives appropriately: the wider system for commissioning and service provision at local level, fairness & transparency, effective current & future workforce planning focussed locally, integrated & multi-professional approach to E&T and workforce planning, integration in planning & development with public health and social care, strong local partnerships with universities and education providers.

The caveats to this are that healthcare providers do not have a great record for prioritising education & training against service provision and healthcare research; so, investing them with all the high principles and high expectations of devolved responsibility for E&T without many safeguards built into the plan may at best see many delays to implementation, and at worst see the whole plan falter irretrievably.

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

The growing strengths (over many years) of the present system are: (a) a realisation that multi-professional dialogue and transparency are at the heart of effective workforce planning; (b) that post-graduate deaneries have proved to be effective in delivering complex educational needs, in listening and responding to trainees and others and (c) in fostering a multi-disciplinary medical expertise to support their work. These strengths must somehow be transferred to the Skills Networks.

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

For local healthcare providers to demonstrate that E&T are on their agendas, and do not fall at the first hurdle.

(a) To coordinate both local and national requirements for recognition of trainees' needs for workplace-centred opportunities for E&T, training time, and fulfilment of the new specialty-based curricula and assessments, including the many general and transferable skills and medical leadership

(b) Educational supervision (ES) to be prioritised, with ES roles recognised in job plans

(c) Accurate workforce planning to avoid under- or over-supply; this might be better done at local level than national and avoid the traumas of e.g. MTAS.

(d) Recognise the value of innovation in developing a new approach. For example there does not appear to be enough mention of information technology (IT) in the proposals to. Particularly, increasing effective use of IT represents automation of activity and often can reduce the numbers of people needed in a workforce. IT also provides continuity of knowledge and care in the NHS, which is value to the workforce. IT also allows monitoring of performance.

(e) Encourage E&T and workforce planning and deployment to re-incentivise experienced and expert professionals to engage in innovative medicines R&D (especially development), by allowing time for this activity which does not conflict with service requirements.

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?

Yes

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

Yes

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

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

Q9: Are there other or different functions that healthcare providers working together would need to provide?
Opportunities for local and national IT training (see Q4 above).
Opportunities for local staff to fulfil national roles relating to standards and training;

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

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?
They should do. However, these duties and responsibilities do have to be actively embraced, and problems owned. Only then can local healthcare providers recognise the continuity of their role, not only in future workforce planning, but in improving educational opportunities and standards.

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?
Financial incentives for cooperation, teamwork and joint undertakings, including national as well as local consultation and collaboration must be the key to ensure progress towards success. This will undoubtedly be a complex and fraught issue, particularly in the economic circumstances that, if not cause, are part of this reorganisation.

Q13: Are these the right functions that should be assigned to the Health Education England Board?
Yes, in principle.

Q14: How should the accountability framework between healthcare provider skills networks and HEE be developed?
Through effective dialogue between Skills Networks and HEE. If HEE is not established before Skills Networks are implemented, then it will be up to the Skills Networks to help develop the relationships, roles and responsibilities, framework for joint working and accountabilities with and for HEE. In turn this will be an opportunity for Skills Networks to have an oversight body that they can work with and that delivers for them the benefits of a national advisory body without the

bureaucracy and lack of local involvement which could eventually weigh on them adversely.

Q15: How do we ensure the right checks and balances throughout all levels of the system?
There is little in the consultation about governance and quality management, but the right arrangements for these throughout the whole system, local and national, will be crucial to this question.

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?
No response.

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?
No response.

Q18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?
No response.

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?
Education and training must meet designated standards, which must be adhered to and compliance assured. Whilst healthcare providers themselves have a responsibility for this (QC), there must also be external bodies to bring fair assessment of adverse findings, remediation and compliance to bear. The first stop for this will be the Skills Networks (QM). Oversight of the whole, as mentioned in the consultation, will be through regulators (e.g. GMC for medical education matters), CQC and Monitor. It is also believed that Colleges and Faculties can play a role in this matter through early intelligence and identification of problems; this information must then be routed appropriately and responsibility for the necessary action taken.

Q20: What support should Skills for Health offer healthcare providers during transition?
No response.

Q21: What is the role for a sector skills council in the new framework?
No response.

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

By encouraging clinicians to be engaged in leadership matters at all stages and their participation shown to relate to improved outcomes in both care and, if possible, the economics of care. In turn Medical Leadership is now embedded in specialty training curricula. The Faculty, through its specialty training programmes, now PMST, has fostered Interpersonal and Management Skills as part of the training, and this has now been enhanced by the addition of the Medical Leadership 'curriculum' as part of this.

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?

Leadership and management skills must be developed in clinicians and their practice encouraged. Medical leadership training (via Medical Leadership Forum and continued through new initiatives such as the Faculty of Medical Leadership & Management) is now built into the specialty curricula, and its demonstration through acquisition of competency and assessment must be actively encouraged. Both HEE and Skills Networks will have to play a part in bringing this about.

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

Yes. This would be an opportunity to bring together the development of medical and managerial leadership.

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?

Skills Networks and HEE have multi-professional and full responsibilities across all of medical education, an integrated approach across all these divides might be the next step.

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?

No response.

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?

No response.

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?
No response.

Q29: What should be the scope for central investment through the Multi-Professional Education and Training budget?
No response.

Q30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?
No response.

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?
No response.

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?
No response.

Q33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?
No response.

Q34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?
No response.

Q35: What is the appropriate pace to progress a levy?
No response.

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?
The Faculty takes the view that the doctors (and other healthcare professionals) working within the pharmaceutical industry, whilst operating wholly outside the NHS, are nevertheless part of the medical workforce that is delivering healthcare for the benefit of patients and the public health. The postgraduate training of these doctors, through the 4-year CCT programme, PMST, is paid for largely by the employer, and thus indirectly through the taxpayer (public purse) through sale of the industry's medicines. The collaborative work between these non-NHS doctors and NHS healthcare professionals brings great benefits, through the provision of new medicines and other treatments, to the NHS and patients in the

UK, as well as to the nation through a net exporting industry. There should be no consideration of a levy on those UK-trained doctors working outside the NHS, but in the interests of the NHS, patients and the nation.

Q37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?
No response.

Q38: How can we introduce greater transparency in the short to medium term?
No response.

Q39: How can transaction costs of the new system be minimised?
No response.

Q40: What are the key quality metrics for education and training?
The Faculty, and its PMST programme, through its governance structures and its adherence to QMS and QIF is now subject to developing and providing quality metrics. We believe that these must be based on an assessment of experience of both trainees and trainers (educational supervisors) as well as of performance and quality of the educational offering. This view could be extended to all stakeholders in the E&T process and cycle (and workforce planning and implementation).

Q41: What are the challenges of transition?
These are massive. Postgraduate medical education and training linked to workforce planning and effective implementation has been in flux for the last 6-7 years, and perhaps only now is beginning to settle again; this has been largely due to changes in the nature and content of education linked to the early years of professional life. Now this fundamental reorganisation of the structures and processes of education and workforce planning through devolution to local healthcare providers is a major upheaval on top of the content changes. This will be compounded by the financial considerations, and the change of fiscal arrangements (from top-slicing to tariffs and levies). At best this will all take a long time to work through, and it is to be hoped that during this time, the standards and quality of PG E&T are not diminished.

Q42: What impact will the proposals have on staff who work in the current system?
Presumably the functions of the current deaneries must continue, even if SHAs are abolished, so there will have to be effective transfer of functions, activities and staff to the Skills Networks.

Q43: What support systems might they need?
The expertise of the deaneries should be maintained and not lost.

Q44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?
No response.

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

The proposals alone will not bring this about. This will depend on the new bodies working alone and together appropriately, locally and nationally.

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?

The new arrangements should not affect any particular group one way or another. The new bodies, like any others, will have to be aware of both the law and of issues arising in this area from time to time and be prepared to react and intervene to ensure no one is disadvantaged.