NHS

Liberating the NHS:

Developing the Healthcare Workforce

Executive Summary

DH Department of Health

Executive Summary

Chapter 1 – Purpose & Scope

1. The vision set out in the white paper *Equity and Excellence: Liberating the NHS* can only be achieved if healthcare providers employ staff with the skill mix appropriate to deliver a high quality service to patients in every circumstance. That blend of skills will change repeatedly to satisfy the evolving healthcare needs of local communities.

2. Public investment is central to securing high quality services and training. However, we cannot continue to expect top-down workforce planning to respond to the bottom-up changes in patterns of service that will be required by GP consortia. In future the DH will have progressively less direct involvement in planning and development of the healthcare workforce, except for the public health services.

3. So, it is time to give employers greater responsibility for planning and developing the healthcare workforce. Local 'skills networks' of employers will take on many of the workforce functions currently discharged by Strategic Health Authorities, while the quality of education and training will remain under the stewardship of the healthcare professions, working in partnership with universities, colleges and other education and training providers.

4. This consultation document sets out proposals to establish a new framework for developing the healthcare workforce and seeks views on the systems and processes that will be needed to support it. The **final date for responses is 31st March 2011**, but earlier expressions of view would be helpful.

Chapter 2 – Vision

5. The current system of workforce planning has grown in a piecemeal way. There is an opportunity now to fundamentally reshape it.

6. This chapter sets out five objectives the new framework will need to deliver:

    - security of supply, having people with the right skills in the right place at the right time;

    - responsiveness to patient needs and changing service models;

    - high quality education and training that supports safe, high quality care and greater flexibility;

- value for money;
- widening participation.

7. This chapter also proposes 12 principles that should shape the design of the new system. They include:

   - doing at national level only what is best done at national level – leaving maximum opportunities for flexible, local implementation and innovation;
   - security of supply, having people with the right skills in the right place at the right time;
   - ensuring effective professional engagement at local and national levels, with the professions having a leading role on safety and quality issues;
   - ensuring strong partnerships with universities and education providers, to make the most effective use of the skills of educators;
   - sustainable and transparent investment in education and training.

Chapter 3 – Context

8. About 1.4 million people in over 300 different roles make up the NHS workforce. More than half of them are healthcare professionals, including doctors, nurses, midwives, healthcare scientists, pharmacists and a wide range of Allied Health Professionals.

9. Currently Strategic Health Authorities (SHAs) determine where to invest the £5bn central budget for education and training. Most of the money is spent on developing the skills of the next generation of professionals, including clinical placements and other work-based learning through healthcare providers. The Department of Health will continue to ensure this core investment is available to make the sector more self-sufficient and less reliant on international recruitment.

10. Led by SHAs, the current system has made significant progress, notably in improving security of supply of healthcare professionals. However, there are deficiencies:

    - the current system is too top-down;
    - service development planning is often poorly integrated with financial and workforce planning;
    - medical workforce planning and education is managed by postgraduate deaneries within SHAs, largely in isolation from the planning and commissioning of education for other healthcare professionals;

- there are persistent shortages of particular skills, including insufficient specialist skills in theatre, renal and intensive care nurses, which causes over-reliance on expensive agency staff and recruitment overseas. The agency bill for healthcare staff is more than £1.9bn;

- ways of working often follow a traditional pattern of looking at supply and demand within single professional silos;

- the costs of running the current system are high and vary greatly among SHAs.

11. There is scope to design a more streamlined system that contributes more to delivering better productivity and improved healthcare outcomes.

Chapter 4 – Developing a new system

12. This chapter sets out the core functions of workforce planning and development. It introduces the proposed roles and responsibilities that different organisations will undertake.

Chapter 5 – Increased autonomy & accountability for healthcare providers

13. This chapter makes clear that the responsibilities of planning and developing the workforce will apply to all providers of NHS-funded care, including providers in the independent and voluntary sectors. The consultation asks for views about duties that might be placed on providers, including a duty to consult on workforce plans and a duty to provide data about their future workforce needs. This information would be used to shape decisions about investment in education and training.

14. More than half the NHS's central funding for education and training goes directly to healthcare providers to support clinical placements. This chapter argues these placements are best managed multi-professionally across a network of healthcare providers. It asks for views on whether the providers should have a duty to consult widely and cooperate on education and training.

15. The chapter also asks for views on the workforce planning and management functions that would be undertaken by the local provider networks, including holding and allocating funding for education and training and taking on the deanery functions. The skills networks would include GPs in their role as providers of healthcare, and work in partnership with representatives of local authorities as providers of social care and commissioners of public health, and education providers.

Chapter 6 – Sector-wide oversight and support

16. This chapter explains why the Government intends to create an autonomous statutory board to support healthcare providers in their workforce planning, education and training. Health Education England (HEE) will be a lean and expert organisation, free from day-to-day political interference. It will focus on workforce issues that need to be managed nationally. It will bring together the interests of healthcare providers, the professions, patients and staff. HEE will take on the advisory role of Medical Education England and the professional advisory boards for education and training. Its functions will include championing the greater involvement of patients and local communities in planning and developing the workforce.

17. The chapter discusses how to get the right balance between strategic national oversight and greater freedom for local education commissioning. It looks at the analytical capability that will be needed for longer-term workforce planning in health and asks how the Centre for Workforce Intelligence can develop to make the most effective contribution. The role of the NHS Commissioning Board and healthcare regulators is also considered.

18. The Government intends to reduce significantly the level of central funding for Skills for Health. It supports moves towards a business model in which employers decide how much they need to invest in the services that Skills for Health can provide. The Government supports a much closer working partnership between Skills for Health and Skills for Care.

19. The professions and medical Royal Colleges have an important role to play in devising and delivering education in their specialties. Clinicians should be involved in the skills networks. The new framework provides an opportunity for the Academy of Medical Royal Colleges to give clinical and professional leadership in working across specialty boundaries. Similar support may be forthcoming from the professional bodies and representatives of other healthcare professions and from the education sector.

Chapter 7 – The public health workforce

20. The Government will consult during 2011 on a workforce strategy for public health. This chapter outlines how Public Health England (PHE) will need to work in close partnership with healthcare providers and local authorities. It asks for views about whether PHE and its partners in public health delivery should be represented on the HEE board. Another question is whether local authorities should become members of the NHS healthcare provider skills networks.

Chapter 8 – Funding and incentives

21. This chapter explains why relying solely on market levers to secure sufficient investment in healthcare skills is an unacceptable risk. It would also be unfair if some healthcare providers bore the costs of providing skills to the local labour market while others did not.

22. Current funding of training and development comes from top-slicing the NHS budget. Over time the Government intends to move to a levy on providers to raise the money needed to train the next generation of healthcare professionals. However, it would not be appropriate to apply a national levy to fund local investment to develop the skills of the existing healthcare workforce. HEE will take a strategic overview of the funding priorities and allocate money to different areas as appropriate. It needs an effective strategic relationship with the funding bodies for higher education, taking account of changes to the funding regime following Lord Browne's Review.

23. The chapter discusses how the flow of funding for education and training can be made fairer and more transparent. It notes that the DH has previously negotiated a benchmark price as a national tariff paid to higher education for the tuition costs of most NHS-funded pre-registration education programmes. Tariffs for medical and other clinical placements and tariffs covering other programmes and placements are to be considered as a way to provide a level playing field. Providers should be allowed time to adjust to these arrangements before further changes are made.

24. The Government asks for views on how quickly tariffs and a levy should be introduced and which healthcare providers should pay. Should it apply to healthcare providers who do not treat NHS patients, but do deliver services using staff trained by the public purse?

Chapter 9 – Transitional arrangements

25. There is a challenging timescale to put in place new systems and processes by 2012 to take on functions of Strategic Health Authorities before they are abolished. Providing stability and continuity will be important.

26. SHAs will hold and allocate the Multi-Professional Education and Training Budget for 2011/12. They will work with local health and social care economies to develop coherent plans for the new local framework. Providers are encouraged to take on SHA staff with appropriate knowledge and expertise.

27. Subject to Parliamentary approval, Health Education England will be established in shadow form in 2011 and as a special health authority to go live in April 2012. The chapter discusses how local healthcare provider skills networks will become legally established, and other transitional arrangements.

Chapter 10 – Equality and diversity

28. The DH will conduct an equality impact assessment on these proposals. The initial screening suggests the policy may provide opportunities to make a positive impact on equality and to tackle current inequalities. The consultation seeks to establish if any individuals or groups might be disadvantaged by the proposals.