

DEVELOPING THE HEALTHCARE WORKFORCE

ACADEMY OF MEDICAL ROYAL COLLEGES RESPONSE

The Academy of Medical Royal Colleges welcomes the opportunity to comment on the consultation paper *“Developing the Healthcare Workforce”*.

The Academy’s membership comprises the Medical Royal Colleges and Faculties across the UK. Individual Colleges and Faculties will have submitted their own responses to the consultation paper. These will highlight their own particular concerns or issues.

The primary interests of Colleges and Faculties are postgraduate medical education (PGME) and standards of clinical practice, but they also have a general interest in healthcare policy. The content of this consultation is therefore an issue of core concern to the Academy and its members. Comments focus on the medical workforce and medical education.

Key principles

The Academy believes that the following key principles should underpin any proposed changes and be used to judge the proposals in the consultation paper:

- Without adequate attention and resources being allocated to workforce planning and education and training, the NHS will not be able to provide the workforce required for the future and will fail to meet the needs of patients
- Workforce planning and the commissioning of medical education and training cannot be left to market mechanisms alone and a degree of co-ordination and planning is required to continue to deliver the right quantity and quality of future healthcare staff
- It is essential that clinicians are fully engaged at all levels in discussions and decisions about clinical workforce planning and education commissioning and provide the professional leadership required in the process
- The functions currently carried out by Post-Graduate Medical Deaneries are extremely important. They need to be retained in the new system although there are a variety of ways in which this could be done
- There needs to be transparency about costs of undertaking postgraduate training and education and a proper price must be paid to all those who provide education and training.

Overall comments

- The Academy sees these changes as being required primarily as a consequence of other parts of the Government’s reform programme. The Academy is not convinced there is any case for reorganising the whole structure for workforce planning and the commissioning of training.

- However, accepting that the changes are proposed, the Academy welcomes the clear recognition in the consultation that the planning of future medical workforce and commissioning of medical education cannot be left to the market. The Academy agrees that, as the document states, *“there are in practice no market mechanisms capable of delivering the prospective supply of skills for healthcare* and endorses the statement that without effective planning *“there is an unacceptable risk of undersupply of healthcare professionals which would be unsafe or oversupply which would be wasteful and demoralising”*. (1.4)
- The recognition of the need to fully engage clinicians, and indeed the Medical Royal Colleges, in the process of workforce planning and education commissioning both locally and nationally is welcomed. Our key concern is ensuring that these intentions transfer into reality, both in the practical terms of involvement in Health Education England (HEE) and Local Skills Network and, more broadly, in terms of attitudes, behaviour and culture.
- In broad terms the Academy are content with the proposed establishment of HEE and Local Skills Networks although there is still considerable detail to be resolved. Local Skills Networks should not be responsible for both the management of post-graduate medical education and its operational commissioning and quality assurance. There must be proper College and Clinician input throughout these structures.
- The Academy considers that it is essential that Deanery functions are properly maintained in the new structure. There are a number of ways that this could be achieved. One option would be to retain Deaneries with all their current functions as separate entities.
- An alternative is to split the quality assurance and commissioning functions from those of administering PGME. This would allow Local Skills Networks to manage PGME arrangements with the commissioning and quality assurance processes carried out separately. The Academy considers that this provides a degree of challenge in the system and has merit.
- If this separation of functions is adopted there are different ways this could be put into practice:
 - The majority of Colleges support the model of the operational commissioning and quality assurance functions of Deaneries being carried out by a sub-national tier accountable to HEE
 - Alternatively some of the functions could be undertaken by Colleges using their local schools/regional offices
- The Academy strongly supports the proposed duties on providers in relation to consulting, provision of information and co-operation in workforce planning and providing education and training. Without the participation of all healthcare providers, workforce planning and the provision of education and training will fail. These provisions are therefore essential.
- While the logic of CPD being an employer responsibility is understood, the Academy is most concerned that funding for CPD does not get squeezed locally in the current climate. It should be recognised that medical professionals require participation in regional, national, and sometimes international events to share best practice and improve their knowledge and skills for the benefit of patients.

- The Academy has considerable concerns over the transition to and establishment of Local Skills Networks. This poses very significant risks in the short term. The Academy believes that there should be some form of readiness assessment before individual Networks become operational.
- The Department of Health paper is focused on secondary care whereas more and more care is to be delivered in primary care. The Academy wishes to see greater detail of how workforce planning and training issues for primary care, specifically GPs and practice based staff, will operate.

Responses to the consultation questions

Chapter 2

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

Yes

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

Yes

Chapter 3

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

The planning of the future medical workforce is by definition complex and generally without a single or simple “correct” answer. The requirement is to get it the least “wrong” possible. This will only happen through real engagement and dialogue between those with clinical, educational and service expertise. That has happened with varying degrees of success over the years but there is now clear understanding that this has to be the basis of successful planning. This must not be lost and it must be ensured that planning is genuinely based on “needs” and not just “wants”.

The creation of MEE has provided an opportunity for medical professional input at a national level which we do not want to see diluted in HEE. Medical training is different not only in terms of complexity but also because trainees provide a large amount of service over many years of training. Nevertheless, closer working with the nursing and other professions and the continued opportunity to learn from training in other related professions is welcomed.

In terms of education and training, the Academy believes that Post Graduate Medical Deaneries play a crucial role. The Deanery functions are key to the quality of medical training and the support of trainees although there is room for improvement and efficiency gains. Those functions and specifically the medical expertise which underpins their work must not be lost.

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

While there may be a new approach, or at least new structures, it is important to recognise that the tasks remain the same:

- To plan the future workforce with as much accuracy as possible to avoid any significant over or undersupply

- To commission and manage high quality education and training that meets the evolving needs of the service and clinicians.

The opportunity must be to do this as well as is possible. This requires active involvement of individual clinicians at a local level and Colleges nationally.

Opportunities also exist to give HEE a coordinating role across medical education including in undergraduate medical education specifically ensuring that medical student numbers are included as part of overall manpower planning. Close collaboration is also required about the knowledge, skills and attributes required in medical graduates.

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?

Yes, absolutely. The Academy believes that the duties on providers in relation to consultation, provision of information and co-operation are essential. The participation of all providers in workforce planning and the provision of education and training is crucial. Without full participation, information will be incomplete and the processes will fail. It is therefore important that these duties exist to ensure participation and the effective operation of the system. It is important that there is a clear process if a provider fails in any of these duties (Q19).

Specifically on the issue of consultation, as stated earlier, it is essential that clinicians are fully engaged in the development of local workforce plans. Without this involvement it is almost inevitable that plans will be flawed from the outset.

Engagement with the groups identified will need to take place at differing levels of detail. Clinicians and staff who will be responsible for managing and providing services will need to be centrally involved from the outset in the development of workforce plans, and should be driving the proposals. Patients and community representatives will have an interest in the overall workforce plans but some may wish to be involved in the detail of proposals at individual service, specialty or department level or in the detail of training arrangements.

The Academy proposes that all healthcare providers should develop clear processes setting out how they will consult with their clinicians, staff and patients and be able to show how they have engaged, and with what result, when they submit workforce plans to their Local Skills Network.

It is, of course, essential that trainees themselves have the opportunity to comment on issues relating to education and training.

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

Yes, this duty is vitally important. Accurate data is the foundation of effective workforce planning and education commissioning. It is essential that there is transparency over data.

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

See Q6 above. Data about future needs must be derived through involvement of clinicians.

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

See Q5 above. It is crucial that all healthcare providers cooperate in planning the healthcare workforce and in planning and providing professional education and training. As the consultation acknowledges, these are not tasks that can be undertaken by individual organisations on a stand-alone basis. It is an essential part of a national health system. Without full engagement the system will be fatally flawed and there needs to be a requirement for individual providers to cooperate.

It is crucial that there is a clear process if a provider fails in any of these duties (Q19).

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

These are the key areas for cooperation. It is important to stress that providers need to work together on the provision and delivery of education and training as well as commissioning. The required range of medical learning experiences cannot usually be provided within a single organisation and exposure to only one provider is limiting and undesirable. This applies to CPD as well as post-graduate medical training.

The concept of the “lead employer” in terms of the employment of post-graduate trainees has proved successful in the North East and North West. The practice has benefited both employers and trainees. This would be an area where providers could work productively together.

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

Yes. This is very important. The Academy believes that one of the responsibilities of the local networks should be to ensure that all healthcare providers meet the duties.

It is important that the Networks have the right relationship with Commissioning Consortia. While it should be providers who determine what their workforce requirements are in order to deliver specified services, there also needs to be informed discussion with commissioners.

It is unclear who will provide input to Local Skills Networks on the workforce requirements for GPs and other practice-based staff. It is of course essential that these requirements are factored into local workforce plans. The obvious source would be the GP consortia but this would be a provider rather than a commissioning responsibility.

The Academy does not believe that “Local Skills Network” is a particularly helpful name. “Local” must incorporate a sizeable population base and number of providers to allow training over a wide range of specialties.

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. The Academy supports the idea that providers take this greater level of ownership. Too often in the past clinicians and managers in local organisations have felt distanced from the workforce planning process and disempowered. The consequence has been that the quality of input has not been as strong as it could have been. Greater ownership should lead to greater responsibility and higher standards.

However, as stated earlier, this cannot be accomplished in one provider organisation alone. The duties support this cooperation but should not undermine providers taking greater ownership and responsibility. The right balance has been struck.

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?

It is essential to ensure that the financial system supports this cooperative approach and does not act as a perverse incentive to encourage individualist and separatist behaviour. There have to be rewards not penalties, direct or indirect, for working together.

There will be HR/workforce flexibilities, such as portability of CRB checks, which would enable the lead employer concept to work more easily to the benefit of employers and trainees.

However, it is the right cultural and behavioural attitude that will achieve cooperation and cohesion as much as anything.

Consultation Questions – Chapter 6

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

Yes. The functions set out in 6.6 to cover the required areas.

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

Any framework must be developed through joint discussion between HEE and the Networks. What is important is having joint acceptance of the principles underpinning the relationship and the respective roles of both parties.

The Academy welcomes the recognition that there may be “occasions when HEE would want to commission more or fewer education and training posts than the aggregate of local plans”.

The development of this framework cannot wait until HEE and local networks are formally established but should begin as soon as possible once/if the proposals are agreed.

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

It is important that there is a clear understanding of the roles and responsibilities of all parties. HEE has the responsibility of “holding healthcare provider skills networks to account for effective commissioning and delivery of education and training”. The manner in which this is done will be crucial to the success of the system as a whole.

Ensuring the correct checks and balances between a local network and its members will also be crucial and potentially difficult. It is unclear how a network will be able to handle a recalcitrant provider member particularly if that happens to be a major institution. Ensuring

a balance within local networks which allows all voices to be heard and avoids dominance from one or two providers will be crucial. This will require the right governance arrangements from the outset and good management of the networks.

The Academy believes that the balance in the system will be improved if there is a separation of the operational commissioning and quality assurance roles from the management and delivery of education and training. There are various possible models to achieve this, the Academy has suggested an intermediate tier of HEE and a role for Colleges.

This structure provides a separation of commissioning and delivery and removes from Local Skills Networks the potentially difficult and conflicted role of quality assuring the services delivered by their own members. It provides an opportunity for a degree of challenge in the system which local networks may find difficult at times to deliver.

Whoever undertakes these roles must, of course, work closely with, and be responsive to, the needs of local networks and providers which will need to shape education commissioning proposals.

It would also be sensible if the Local Skills Networks were large enough so that relatively few are in each sub-national HEE area and that their boundaries were such that each Skills Network fell within a single intermediate area. It is expected that these HEE intermediate bodies might cover larger geographic areas than existing English Deaneries to produce efficiencies.

With these bodies concentrating on commissioning and quality assurance, responsibility for managing and administering PGME should transfer to Local Skills Networks.

The Academy believes an additional advantage of the proposals is that the intermediate structures of HEE could provide stability and continuity during the transition. It might be sensible that they maintain the administration and management of PGME (which are together in current Deaneries) until each Local Skills Network is ready to take on the role, and only transfers those responsibilities at that time. This transfer of responsibilities would therefore take place at different times according to the readiness of the Local Skills Network and ensure that the operation of the training and appointment system for junior doctors is not disrupted.

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?

The Academy supports the concept that HEE will bring together the interests of healthcare providers, the professions, patients and staff. While its output must meet the requirements of the service, its work at every stage must be informed by professional clinical expertise.

As HEE is to be a statutory Board, the Academy's assumption is that it will comprise a mixture of non-executive (in the majority) and executive directors. While the non-executives must perform the usual governance role the Academy considers that it is important that between them they have an understanding of healthcare workforce and education and training issues.

The Academy believes that it is crucial that HEE has a suitably qualified Medical Director/Director of Medical Education as one of its Board Executive Directors.

The document recognises that HEE will have to “combine profession-specific insights with an over-arching multi-professional approach” (Para. 6.5). To achieve this profession-specific insight HEE must establish effective mechanisms and structures below Board level to gather that professional insight. The Academy believes it is essential that there is some form of Medical Programme Board or Committee to consider the detail of medical numbers and training. Such a group must have strong representation of the medical profession through Royal Colleges. Similar arrangements will be required for other professional groups.

Consideration needs to be given as to how the output from separate Programme Boards/Advisory Groups is brought together. It is likely there needs to be a cross-professional Forum (or committee) between the Programme Boards and the HEE Board. This Forum should comprise at least the professional chairs of the Programme Boards with additional employer, lay and professional input while keeping the total membership less than 20. The chairman of the Forum should be on the Board to provide effective two way communication.

Consideration needs to be given to the relative merits of appointing Programme Board chairs or allowing the Boards to elect their chairs. The former may provide improved functionality, the latter has the advantage of obtaining professional buy in.

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?

The Academy believes it is important that Centre for Workforce Intelligence (CfWI) is clearly accountable to HEE and it is understood that its role is restricted to data and information analysis and not policy recommendations.

If the CfWI is to have the confidence of professional and service stakeholders there has to be transparency in its working, operation and methodologies. This is not currently the case and professional confidence in it is extremely low.

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

It is essential that the HEE’s work be aligned to the intentions of the Commissioning Board. There are a variety of ways in which this can happen and representation of the Commissioning Board on the HEE Board, and vice-versa, may be appropriate. However it is important that HEE is seen to be and operates as an autonomous organisation. HEE is not managed by the Commissioning Board and must be seen to be free from political interference.

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?

This is a crucial issue. The Academy endorses the statement in the paper that “*there is a need for robust processes so that if education and training does not meet designated standards then action is taken.*” The Academy believes that adherence to these duties is essential to the success of the whole system.

The Academy would hope that providers themselves will see the benefits of consulting, providing information and cooperation and willingly undertake these duties. We are confident that for most providers this will be the case.

However, where there are problems with an individual provider the first responsibility must lie with the Local Skills Network. The Academy would expect the peer pressure of other providers in the Network to encourage engagement and compliance. As set out in Q15 the Academy recognises that this may not always be easy for networks. If a powerful local provider or providers are not cooperating it may be difficult for a network to influence their behaviour. This will be a key issue for networks and how effectively this issue is handled will to a large extent determine how successful the network is.

If networks are unable to ensure the cooperation of providers or networks themselves are ineffective, there has to be a clear process for further action. The Academy believes that the paper correctly identifies the professional regulators, the Care Quality Commission (CQC) and Monitor as the key organisations who can take action. It is crucial to ensure that there is clarity in responsibility between these organisations and a clear process, accepted by all parties, for taking action. In terms of education and training one of the sanctions must remain the withdrawal of training facilities.

HEE itself also has responsibility for holding Networks to account and this must encompass whether or not providers are meeting the required duties. The intermediate commissioning tier accountable to HEE which the Academy has proposed can also challenge Networks.

Consideration also needs to be given as to how information about deficiencies in education and training is obtained. The Academy believes that Colleges and professional organisations can play an important role in early identification of problems. There needs to be clarity about what is done with that information and who has responsibility for taking action with it.

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

The Academy has no view on this issue. Loss of pre-existing key functions during transition is a major risk but the extent to which additional help is required will depend on the pace of change and how radical it is to be.

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

As the Academy understands it Sector Skills Councils are not involved in medical education or workforce planning issues and therefore has no view on this issue.

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

The Academy believes clinical leadership is essential. This will be obtained by ensuring that clinicians understand the need for change and have confidence that the proposals will work. The former requires more clarity and a strong communications exercise. The latter needs evidence and evolutionary rather than revolutionary change.

Clinicians also have to be given the support, encouragement and time by their employers to participate. Contractually, clinicians are expected to give six weeks' notice to change their clinical commitments. Too often at both local and national level this does not happen. Inadequate notice may be an annoyance and inconvenience for a manager, but can make participation an impossibility for a clinician.

At local and national level, the networks of skilled medical expertise available through Colleges and Faculties should be utilised.

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?

The Academy recognises that it is essential that leadership and management skills are developed in clinicians and it has been driving this agenda. Colleges have already done considerable work to ensure that this is embedded in the curricula for post-graduate medical education for individual specialties. The Academy recently established a Faculty of Medical Leadership and Management which can play an important role in developing and supporting medical management and leadership.

However, it is important that both HEE and local networks play their part in fostering and supporting the development of clinical leadership skills.

The past approach to the development and delivery of clinical leadership skills has been somewhat disparate. While there will rightly remain a variety of training providers there is an opportunity for HEE to develop a coordinated strategy and approach towards clinical leadership.

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

It would seem sensible and would provide a good opportunity to link clinician and managerial leadership development.

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?

With HEE and Skills Networks having multi-professional and under and postgraduate responsibilities there must be opportunities to develop an integrated approach across undergraduate and postgraduate curricula where relevant. Work done by the RCP London and the North West Deanery has shown the gains from joint training of managers and doctors.

Consultation Questions – 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?

Public health workforce planning must be integrated and conducted alongside the rest of the healthcare professions. It is essential that the public health workforce strategy includes an appreciation of the wealth of public health work that is delivered outside of the NHS system.

There should also be mechanisms established to ensure that planning for the public health workforce takes into account the whole public health workforce and not just those that are employed within an NHS setting.

It is essential that Public Health input and understanding is firmly embedded into Health Education England and the Skills Network. It is important that public health requirements

for the workforce planning are undertaken with specialist advice from Public Health England.

Training must continue to be delivered across a range of environments including:

- GP Consortia: whilst these bodies are being established, trainees could be placed there with supervision from local consultants, acting in a pro-active way to support the local commissioning agenda and the QIPP agenda
- Local Authorities: increasing the trainee presence in support of the consultants already engaged in this work.

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?

Yes

Consultation Questions – 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?

The Academy welcomes the statement in paragraph 8.2 that “*relying solely on market mechanisms to secure sufficient planning and investment in essential healthcare skills is an unacceptable risk for healthcare provision in this country*”

The issues that need to be addressed are, in essence, the concerns that resulted in the above statement. All parties involved have to ensure that they are avoiding simply taking a short term approach based on financial pressures. Healthcare workforce planning, education and training are long-term enterprises done for the benefit of future generations of patients. It will not work without organisations taking a long term view and recognition of the overall requirements of the NHS.

The proposals in the paper are based on that premise which is welcome. However, there will be countervailing and very real pressures not to act in this way which may be difficult at times for individual organisations to resist. It is important that the different parts of the system act together to support each other to deliver an approach that provides long term benefits.

This requires the right behaviours and approach from individuals and organisations as well as the right levers and incentives in the system to support not prevent the desired outcomes.

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

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?

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?

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

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

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

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?

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

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

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

The paper asks series of technical questions (Q29-39) which the Academy does not feel able to address in detail. However, there are some points of principle that must underpin any developments in these areas:

- Education and training must be funded in a fair and transparent manner that accurately reflects the costs involved and rewards good quality training. The current system does not do this
- The move towards a levy is logical and appropriate
- A levy should cover all providers of NHS services but also healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse. This must include primary and secondary care and the commercial sector. It is acknowledged that there be will complex details to resolve and questions to address in terms of those organisations not directly providing healthcare, but who employ clinical staff
- The level playing field required in a healthcare system with increased and regular competition must incorporate the costs of training and education
- The issues identified in Q31 of how to achieve the transition to tariffs and then a levy in a way that provides stability is fair and minimises the risks to providers are fundamental
- There are no benefits in destabilising the system and that this must be the primary consideration in any change process. To this end a slower rather than faster pace may be necessary
- In taking forward these changes it is essential to have professional clinical input at every stage to ensure that revised arrangements work effectively without perverse consequences from a clinical and educational perspective.

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

The Academy and Colleges have been involved in the work to develop quality metrics for education and training and support the approach taken. In essence, the Academy believes that metrics must be based on a full and rounded assessment of performance, the quality and experience of trainees and trainers as well as organisational commissioners and providers.

Consultation Questions – Chapter 9

Q41: What are the challenges of transition?

The challenges are very substantial.

The Academy believes in particular that the establishment of effective Local Skills Networks in the timescale required is going to be very challenging. All the parties involved, whether SHAs, PCTs or providers, have huge additional change agendas to contend with because of structural changes arising from the NHS Bill or meeting the required financial savings.

There is a real likelihood that this will not be at the top of the agenda for organisations with the result that insufficient resources or expertise are devoted to the process.

The establishment of HEE, while complex, is a single task that should be relatively straightforward. The Academy believes that there would be benefit in pushing ahead with this quickly so HEE, or a shadow body, can be properly resourced to play an active role in supporting the development of local networks.

It is essential that there is support to providers for this exercise. Legal entities have to be established with effective governance structures. There will need to be extensive and possibly difficult local discussions between providers before agreement is reached. This is going to be a lengthy, complex and expensive process including potentially large legal costs. While recognising the wish for local flexibility it will be important to give guidance and support to those establishing networks.

The Academy believes that there has to be some formal assessment of readiness before each individual Local Skills Network becomes operational. This would mean that networks may become operational at different dates across the country. However, ensuring that networks will be functional and effective is more important than them all starting on the same day.

While the transition process goes on, which will be disruptive and unsettling for staff, local education provision and commissioning has to continue. Post-graduate Medical Deaneries have a vital role to play in ensuring the smooth operation of the cycle of postgraduate medical education. This is a cycle that does not pay heed to NHS structural reorganisation and has to continue whatever organisational disruption may occur. For this reason the Academy considers that its proposal for some Deanery functions to be retained at regional level by HEE has the further advantage providing a platform for stability by retaining these administrative functions until such time as Local Skill Networks are equipped to take on the role.

As stated in the response to Chapter 8, the Academy is clear that transition to a tariff and levy is hugely complex and will need to be handled very carefully.

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

There will clearly be considerable impact on staff in Deaneries and SHA Workforce Directorates. Such change is always unsettling and upsetting to staff and, inevitably, diverts attention from service delivery. The Academy welcomes the assurance that Deanery functions have to continue and has made proposals about this. How this will happen and what this precisely means for individuals is obviously unclear at present.

Q43: What support systems might they need?

The Academy believes it is important that the medical and other expertise in Deaneries is not lost and the Department of Health and SHAs must put in place all the appropriate mechanisms to ensure that this does not happen and staff are transferred as appropriate.

The Academy would expect that the all the appropriate employment procedures are followed.

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

The Academy is unclear what specific role the CfWI would be expected to play in transition but would expect it to maintain its regular work and contact with providers and national organisations.

Consultation Questions – Chapter 10

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

Structural changes alone will not develop a more diverse workforce. It will be the policies pursued by the new organisations nationally and locally that will determine whether or not there is progress in this area.

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 structural changes proposed should not, per se, advantage or disadvantage any particular groups. It will be the way that new organisations behave that will have an impact in either positive or negative ways. It will be important that HEE and Local Skills Networks are alert to the issues and monitor their activity and impact in this area.

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