Liberating the NHS: Implications for Oxford PGMDE

1. These notes provide a synthesis of the White Paper, Equity and Excellence: Liberating the NHS; the Health Command Paper, Liberating the NHS: Legislative framework and next steps; the White Paper, Healthy lives, healthy people: our strategy for Public Health in England; the consultation paper, Liberating the NHS: Developing the Healthcare Workforce; the Operating Framework for the NHS in England 2011/12; and the NHS Outcomes Framework 2011/12.

2. Before examining the implications Postgraduate Medical and Dental Education (PGMDE), the paper reviews the vision, the perceived issues with the current systems for healthcare and healthcare education commissioning and delivery, and the proposed system architecture.

Vision

3. The white papers set out a vision for patients and public at the heart of everything the NHS does; health outcomes amongst the best in the world; and increased autonomy and clear accountability at every level with healthcare professionals empowered to deliver results.

4. The NHS Outcomes Framework envisages that from 2012, the new NHS Commissioning Board will monitor NHS performance across five domains using quality standards developed by NICE:
   a. Preventing people from dying prematurely;
   b. Enhancing quality of life for people with long-term conditions;
   c. Helping people to recover from episodes of ill health or following injury;
   d. Ensuring that people have a positive experience of care; and
   e. Treating and caring for people in a safe environment and protecting them from avoidable harm.

5. Decision about the commissioning of most clinical services will be taken at a local level by GP consortia. Similarly, education and training commissioning will be taken at a local level with healthcare providers, working through networks, taking a lead role.

6. A new national body, Health Education England (HEE), will be responsible for allocating and accounting for NHS education and training resources with education and training typically commissioned through networks. The key objectives for workforce development are:
   a. Security of supply
   b. Responsiveness to patient needs and changing service models
   c. High quality
   d. Value for money
   e. Widening participation

Issues with the current system

7. **Too top down** - The current systems for education commissioning and delivery are perceived to be too top-down and unable to respond to bottom-up changes and locally needed patterns of services. It is argued that service development planning is not integrated with financial and workforce planning.

8. **Professional silos** – planning around single professional silos is not integrated with planning and commissioning of other healthcare professionals e.g. relying on doctors in training for service delivery has limited medium to long-term workforce planning.

9. **Continued Professional Development (CPD)** - the system is too focused on new recruits to the detriment of skills for those already employed in delivering services. This is hampered due to lack of clarity about the responsibility for CPD.

10. **Cost** - There has been over-reliance on agency staff and there is significant variation in costs of workforce planning and development across Strategic Health Authorities (SHAs).
Proposals for the new system architecture
11. Figure 1 shows the proposed architecture for health and social care in England. SHAs will cease to exist by April 2012. It is expected that clusters of Primary Care Trusts (PCTs) will be formed by June 2011 and the total number of PCTs reduced by 2012 ahead of their abolition in 2013. These clusters must reduce operating costs, oversee current service delivery and the close down of the system, and provide support to the emerging GP consortia.
12. The NHS Commissioning Board, the Care Quality Commission, Monitor, Public Health England, and the professional regulators will provide oversight.

Figure 1: New NHS architecture

13. The new system for developing the workforce will be provider-led (Figure 2). This is grounded in the NHS Constitution commitment that all NHS funded providers must ensure a high quality working environment for their staff including personal development, appropriate training for their jobs with line-management support. To enable providers to meet the current and future needs of their local communities, they will need to form local healthcare provider networks.
14. Local healthcare provider skills networks - will take on current SHA functions to ensure effective local workforce planning and development and include all NHS-funded healthcare providers and GPs. The exact footprint is yet to be determined and networks may need to work together to:
   a. Contract, manage and quality assure high quality clinical placements including demonstrating value for money;
   b. Manage and improve the quality of workforce data and plans;
   c. Develop a local skills development strategy in consultation with partners;
   d. Take on deanship functions and be responsible to GMC and GDC for quality management of placements and programmes and ensure appropriate supervision and assessment;
   e. Work in partnership with Universities and other education providers;
   f. Work with local authorities;
   g. Ensure continuous quality improvements and assurance of standards; and
   h. Contribute to the development of national policies and issues.
15. Health Education England - will be accountable to the Secretary of State and be responsible for:
   a. Providing national leadership on planning and developing the healthcare workforce;
   b. Ensuring the development of healthcare provider skills networks;
   c. Promoting high quality education that is responsive to the changing needs of patients and local communities; and
   d. Allocating and accounting for NHS education and training resources.
Implications for PGMDE

16. With the abolition of SHA’s, it will be necessary to find a new home for deanery functions. It is suggested that deanery functions will transfer to local healthcare provider skills networks.

17. Leadership and timing - SHAs will be accountable to the Department of Health in 2011/12 for leading the transition across their regions ahead of their abolition in April 2012.

18. Shape of networks - Further details about provider skills networks are likely to be provided after the consultation closes at the end of March 2011. However, the networks will need to be multi-professional, capable of providing data, responsive to local needs and capable of taking over the core deanery function of quality management of PGMDE. This will include commissioning and coordinating services from across the network or in partnership with other networks. The consultation indicates that there will be local flexibility to determine the most appropriate footprint for the new legal entities.

19. Funding – it is proposed that healthcare providers should be responsible for funding the CPD of existing staff and that the Multi-Professional Education and Training levy (MPET) will only be used to fund education and training for the next generation. From 2012, HEE will allocate funding to networks. In the future funding will be linked to quality metrics through tariffs which are net of any service contribution and it is suggested that these may be drawn from a levy on all NHS funded providers.

20. Consultation - The consultation paper, Liberating the NHS: Developing the Healthcare Workforce is currently out for consultation with a closing date of 31 March 2011.

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