Royal College of Psychiatrists
Consultation Response

DATE: October 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Liberating the NHS: Developing the healthcare workforce

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by the Professional Standards Department at the College.

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<u>Response to the consultation on Liberating the NHS: Developing the healthcare workforce</u>

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We welcome the opportunity to respond to this consultation, which raises matters that are of major concern to the College. Our comments will focus mainly on issues to do with workforce and education as they apply to psychiatry and to mental health services.

<u>General points</u>

We welcome the move to improve workforce planning. A great amount of resource is used in teaching, training and research and it is vital that it is used efficiently and effectively. It is wasteful to train specialists in skills that are not needed in the workforce.

We believe that there must be alignment around the whole "life-time" trajectory of the workforce and thus in medicine, workforce planning needs to tie together entry to medical school through to foundation programmes, academic clinical fellowships and lectureships, specialty training and consultant and staff grade numbers. While it is acknowledged that the top down method has had some drawbacks, it is by no means clear that local planning will be any better while there is lack of consensus about the structure of services.

We support steps to improve transparency and equity, but we do not want this to be at the expense of excellence.

We are concerned, however, that the proposed local structures may not support robust and fair methods of quality assurance. In medical education,

these are currently well provided by the regulator, supported by the Medical Royal Colleges and Universities. We believe that such methods of quality assurance are essential to maintain and improve the highest standards of education, training and research. We would welcome the opportunity for the profession, including trainees (clinical and academic), to be fully involved in quality assuring as well as commissioning education and training. It should be noted that the Royal College of Psychiatrists, along with the other Medical Royal Colleges, and the postgraduate medical deaneries, has considerable expertise in standard setting and quality assurance of postgraduate medical education. This expertise must be fully included in new structures and processes.

As psychiatrists we especially wish to see safeguards to ensure that local provider networks meet the needs of the most vulnerable members of society who are often the least vocal of service users. So the workforce needs of mental health services must not be drowned by the clamour from acute trusts.

Consultation questions

Chapter 2

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

With qualification. Education is not complete without research, and improving clinical research and linking this to clinical aspirations needs to be built into the main objectives.

Empowering healthcare providers to plan and develop their own workforce is likely to undermine long-term thought-through national strategic planning. The latter is very important and we believe has benefits. It takes out the problem of conflicts of interest and short-term planning and influence of competitiveness between localities which could be quite divisive, lead to poor

plans and inefficiency costing more in the long term. These potential problems meed to be factored in to any new developments.

Security of supply is fine, but not necessarily secured by the proposals for involving different professions in planning for each other. To achieve this aim requires excellent coordination. Removal of national planning removes an essential coordination role in successful planning.

Greater flexibility may be an aspiration, but this can be at the expense of successful coordination.There needs to be a sensible balance that will work rather than an idealistically driven motive for change.

Q2 Are these the right design principles? If not, why not?
With qualification.

We welcome the principle of the professions taking “a leading role on safety and quality issues”. We believe that this principle should be extended so that the voices of trainees, which are already incorporated in the Medical Royal Colleges, are also heard on these issues.

A number of design principles, such as ensuring strong partnerships with universities, inherently requires strong cross-boundary strategic planning in partnership with Research Councils. The central role of training clinical academics within the framework and necessary collaboration with universities needs to be embedded here.

Initiatives such as the Psychiatry Summer Schools project exemplifies the crucial role of effective collaboration between the Royal College of Psychiatrists and University Departments of Psychiatry. These initiatives have direct impact on national workforce planning, and such planning would not necessarily work at local level.

To achieve an effective leading role in safety and quality, relies upon ability to influence budgets strategically.

Chapter 3

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

The postgraduate medical deaneries currently provide a number of administrative and quality assurance functions relating to postgraduate medical education. Many of these tasks are highly specialised (such as dealing with trainees with differing needs) and depend upon expertise that has been developed over a long period of time. Through postgraduate schools, deaneries also provide forums for education and service providers to meet and share information and in some deaneries these forums are addressing medical workforce planning. As indicated above, the Medical Royal Colleges and Universities have a great deal of expertise in areas of standard setting and quality assurance. We would be concerned not to lose these strengths in planning.

Academic Clincal Fellowships and Walport Lectureships are a start in developing careers in research but this needs building into longterm planning. Employers will not be primarily moved to do this without some statutary requirement and national strategy to involve Universities, Royal Colleges and Research Councils in planning.

Much has been done recently to address areas of concern around the quality of medical training and providing adequate supervision and assessment of medical trainees. There is a danger too much control and 'spoon feeding' will stifle this progress.

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

The key opportunity is to involve clinicians and clinical academics at all levels from local to national in the commissioning and management of excellent education, training and research.

Chapter 5

Q5 Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how the plan to develop the healthcare workforce?

Yes. Steps should be taken to ensure that the academic community is involved in the new approach as well.

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

It will be impossible to plan effectively if this is not the case. This is particularly so for more specialised areas of workforce.

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

Yes, as above. This is particularly the case for more specialised areas of workforce. Data and needs must be fully informed by clinical input and research.

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

Yes there is a clear need for providers to cooperate in planning and providing education and training.
As the White Paper states elsewhere (paragraph 1.4), these are not matters that can be left to the market to regulate. Additionally there will be a need for some training to occur across a number of Providers in order to achieve all required learning outcomes.

The Royal College is aware of a number of independent sector providers that have started to offer training placements in particular areas of practice, for example highly specialised forensic psychiatry services. This is a welcome development because NHS providers are not commissioned to provide a number of these services, so the independent sector may be the only place where the necessary learning opportunities are available.

There must therefore be processes in place to ensure that providers who may be in competition with each other, fulfill their duties to cooperate. In our view, it is difficult to see how this can be achieved without a form of central regulation.

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

Successful postgraduate medical training usually relies upon a number of different providers to work together to deliver coordinated programmes. At the moment many of the coordinating functions, such as selection for training programmes, post allocation and monitoring of trainees' progress in psychiatry is conducted by providers working together through the deanery postgraduate school of psychiatry in collaboration with university departments of psychiatry.

In addition, as mentioned in our response to question 3, postgraduate medical deaneries and universities currently provide a number of specialised functions, such as dealing with trainees who have differing needs which can better be provided by a group of healthcare providers rather than a single one.

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

Yes. But this will need to be coordinated by national strategy through a robust system of coordination.

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 but there will need to be controls in place to ensure short-term planning does not override long-term objectives that is informed by research. Here, links with universities are vital.

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?

There needs to be a link between financial incentives and approporiate consultation. This will be facilitated if the outcomes are closely linked to those that are clinically meaningful and informed by research.

Chapter 6

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

Yes. The work of the HEEB must be informed by the Medical Royal Colleges and the universities.

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

The overwhelming need is for clarity in the detail concerning roles and responsibilities. It is essential that all parties know who has responsibility for setting standards, how the standards will be monitored and what will be the incentives for meeting standards.

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

There needs to be a balance of power in the relationship between a provider and its provider skills network.

It is difficult to see how the organisations making up provider skills networks will be able to align clinical services and training and to resolve conflicts that arise between these interests. One solution is for HEE in consultation with the GMC, Universities and Medical Royal Colleges to establish explicit training standards and outcomes that providers will be judged by. These outcomes should be placed alongside the clinical ones in CQC reports. Research also needs to be included.

The framework must provide incentives for equity. Allowing long-term workforce planning might lead to some provider skills networks deciding, for

financial reasons, to allow other regions to train parts of the medical workforce and then benefit from this by merely recruiting the workforce to their region. Incentives for training need to be appealing and penalties for not training might also be considered.

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?

In order to fully command confidence, HEE will need to be independent of interference by the Department of Health and service providers.

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?

CfWI will need accurate and timely information from providers. There also needs to be input from the universities and research communities, so their workforce needs are included in planning.

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

Devolution to local providers will make this extremely difficult to ensure – particularly in highly specialised areas of need. Clear and explicit outcomes for training need to be established against which organisations are assessed. Training of doctors is not an add on but a central role of the organisation and reflects good patient care and research outputs. There is a risk that education and training will be required to respond to commissioned needs that may be short-term and financially driven, rather than driven by curriculum.

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 an absolutely crucial area and it is vital that there is clarity about processes. The College believes that it is essential that there is professional involvement in this. Mention is made in the White Paper of CQC and Monitor, but no mention of the GMC and equivalent regulatory bodies for other professions. Historically, at least in psychiatry postgraduate education, the Royal College of Psychiatrists played a key part in this area. Since the establishment of the PMETB and the Postgraduate Board of the GMC, these bodies have taken on the task of quality assurance through postgraduate deanery structures. We have welcomed the ways that these structures are beginning to seek expertise from professional bodies and we believe it is essential that this involvement is extended.

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

No comment.

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

No comment

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

Reaffirming that the professions are central to education and training future arrangements is welcome. At the local level this will need significant improvements in linking the medical profession further with service

restructuring and making training a key activity represented at Board level. Employers must allow clinicans time and support to participate in these activities.

Nationally, as indicated in our response to Q19, the Medical Royal Colleges and universities already have considerable expertise in this field and we believe it is essential that this expertise is taken into new structures.

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?

We welcome the prominence given to the development of leadership and management skills. We believe that a coordinated approach must be taken to leadership and management training for clinicians, which is why the Royal College of Psychiatrists has fully supported the integration of the Medical Leadership Curriculum into postgraduate training in psychiatry. We also believe that for leaders and managers to develop appropriate behaviours, these skills must be developed and exercised in their workplaces. We are therefore piloting the use of tools to support learning and assessment of these skills in the workplace. For this to be successful, providers must fully support this aspect of training and should themselves model appropriate leadership behaviours.

Q24 Should HEE have responsibilities for developing clinicians and managers in an integrated way both across health and social and across undergraduate and postgraduate programmes?

Multidisciplinary team working is essential to modern healthcare. This should be encouraged in training of all disciplines and at all stages. Therefore there should be opportunities for different groups to work together, but this should

be done carefully. We recognise that professional integrity is vital to professional development and that it is unrealistic and undesirable for us to be spead too thinly.

Q25 What are the key opportunities for developing clinicians, managers and other professionals in an integrated way both across health and social care and across undergraduate and postgraduate programmes?

The model of Darzi Fellows that has been developed in London has worked well and identified numerous potential clinician manager/leaders. Similar schemes should be run alongside the generic curriculum for all trainees to develop clinicans who may wish to develop special expertise in another domain, such as education, research or an area of more specialised clinical skill. More thought needs to be given to early identification of such trainees and linking them into clinical academic training programmes, particularly in specialties such as psychiatry with low recruitment. Again, initiatives such as the Psychiatry Summer Schools project also exemplifies the crucial role of effective collaboration between the Royal College of Psychiatrists and University Departments of Psychiatry in this regard. These need to be built into the lifetime trajectory of training programmes from university onwards.

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?

Multidisciplinary and multiagency team working is essential to modern healthcare. This should be encouraged in training of all disciplines and at all stages. The key question relates to which disciplines and agencies. It is important that careful thought is given to this so that the team adds to the desirable outputs for patients rather than teamworking being the only end in

itself.

Q27 Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsiblities; and what funding mechanisms should be employed with regard to the public health workforce?

See answer to Q26.

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 main issues here are to ensure that the system is able to take a long-term view that privileges the overall needs of the NHS to provide for the health of the whole population over the short-term and narrow interests of local providers. As psychiatrists, we are acutely aware that calls for mentally ill people to have excellent services can easily be submerged by louder voices. We foresee a risk that local provider networks will be dominated by acute trusts thus perpetuating the difficulties that mental health providers have experienced in attracting and developing high calibre staff. There must be an overarching framework that ensures equity and promotes excellence through real investment in services rather than ‘re-configuring’ in the shadow of cutbacks.

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

MPET funding will need to be targetted and ringfenced to those specialisms for which local commisioning and provision is not viable.

Q30 How can we ensure funding streams do not act as a dissincentive to innovation and are able to support changes in skill mix?

Through strategic influence of the collaborative network that involves Colleges, Deaneries and Universities.

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?

We do not wish to comment specifically on matters to do with the transition. We do however remember the disruption to services and the damage caused to individuals by the manner in which Modernising Medical Careers was implemented. The College urges that the lessons learned from this debacle, as outlined in the Tooke Report, are applied to the management of this project. In particular, we strongly advise that new systems are introduced only after careful modeling and piloting and following further consultation.

Q32 If tarrifs are introduced, should the determination of the costs and tariffs for education and training as part of the same framework as service tariffs?

Education, training, research need to be seen as essential outputs aligned to clinical outcomes.

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

Yes, based on standards. National average has a levelling down effect.

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

No comment.

Q35 What is the appropriate pace to progress a levy?

No comment.

Q36 Which organisations should be covered by the levy? Should it include helthcare providers that do not provide services to the NHS but deliver services using staff trained by the public purse?

Currently such organisations derive benefit from staff trained by the public purse but do not contribute to their training. While it may be appropriate that not-for-profit or social benefit organisations not to be covered by the levy (although even here does introduce market distortion) but is certainly appropriate for primary commercial organisations to contribute a fair share. Here we need to think imaginatively about how we can collaborate more effectively with industry and the private sector for the common good.

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

Absolutely. See Q32.

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

Local skills networks must publish their figures and justify commissioning decisions and be open to challenge.

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

No comment.

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

The College has a long history of involvement in work to develop and implement quality metrics for postgraduate training in psychiatry and it is essential that we are supported to take this work further. There is a risk that quality assurance will be 'dumbed down' to low order metrics based on attending statutory and mandatory training courses. We wish to see a quality framework that fully evaluates the process and outcome of training including research outputs. The framework should attend to the impact of training on trainee experience and performance, on trainers and on patient outcomes.

Chapter 9

Q41 What are the challenges of transition?

See answer to Q31.

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

It is important to assess impact here because as with any change it can lead to de-moralisation and people choosing alternative careers. It is essential we bear in mind that people have a choice of career and we need to make working in the NHS attractive.

Q43 What support systems might they need?

Sometimes we may need to review those we have and reduce administrative burden on staff rather than introduce more.

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

See response to Q31. In addition, the College would urge that steps are taken to ensure that the considerable expertise located in postgraduate medical deaneries is not lost to the service as a result of these changes.

Chapter 10

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

The College fully supports efforts to develop a more diverse workforce but this should not be at the expence of excellence. The proposals in the White Paper will not in themselves achieve this. There needs to be other changes for the medical workforce in particular to be more representative of the wider community. We need to attract the very best minds into heathcare professions through maintaining rigorous standards and ensuring careers are attractive and competitive.

Q46 Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender identity (including transgender people), religions or belief; pregnant women, people who are married or in a civil partnership 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 adress these difficulties to remove the disadvantages?

See answer to Q45

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