31st March 2011

Department of Health consultation – Liberating the NHS: Developing the Healthcare Workforce

1. I write with regard to the Department of Health consultation – Liberating the NHS: Developing the Healthcare Workforce.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College has responded separately to the consultation on the Government’s White Paper – ‘Equity and Excellence: Liberating the NHS’ and to the six further consultation papers relating to this that have been published. This response should be read in the context of our overall views on the proposed reforms to the NHS and the information appended at the end of this document.
General Response

4. The College has many very serious concerns about this paper, and urges the Government to reconsider very carefully before implementing the proposed changes. The purpose of education and training is to provide a healthcare workforce that is competent and safe – safety that must be assured both during and after training. We support the principle of seeking to improve quality and efficiency, but believe that reform should be evidence-based, and tested by rigorous evaluation for unintended consequences. It is our view that many of the proposals in this paper do not meet these standards, are likely to result in negative consequences for the future healthcare workforce, particularly in primary care, and ultimately may lead to poorer outcomes for patients.

5. It is worth noting that many of our members, including senior experts in the field of medical education, have found aspects of this paper unintelligible and sometimes confusing. There is a lack of detail which makes a full appraisal of its pros and cons extremely difficult. If our response appears to have misunderstood any of the proposals, we think this reflects significant flaws in a document with such far-reaching implications.

The Current System

6. Though we do not claim that current systems are perfect, our members strongly support the retention of deaneries, or equivalent regional bodies with strategic oversight, with the range of functions they currently fulfil, as a tried-and-tested approach to medical education, particularly for primary care.

7. We do not believe that a sufficiently strong case is made for the failings of the current system, such that the proposed changes would mark an improvement. There is an assertion that ‘the current system is too top-down’; but our respondents have argued that in many cases a standardised approach is likely to be appropriate to attaining a consistently high standard of output and fulfilling a number of additional but essential functions:

- the setting of standards;
- the implementation and monitoring of placements;
- the coordination of appraisal processes;
• the case management of doctors in difficulty, and;

• the quality assurance of education and training

8. It seems to us that many of these deanery functions are ignored altogether, to the extent that the document portrays a very limited, partial view of the education and training role, one which the medical educators among our respondents would scarcely recognise.

9. In particular, there is no mention of revalidation, a process which will be of enormous significance to the medical workforce and which should be implemented in the very near future. It is critical that the implications for this process be considered before dismantling large parts of the system which would have been expected to implement it.

10. The assertion is made that the costs of running the system are high (paragraph 3.19). We would like to see international comparisons and a breakdown of costs in relation to outputs before accepting this contention. And we need a far clearer explanation of why the proposed system will be more cost-effective – it seems to us that the greater devolution of administrative activities is likely to be more inefficient. Costs may become hidden in local funding, but this complexity is therefore likely overall to be less good value for money, and to have major opportunity costs for personnel involved.

Provider Skills Networks

11. Local schemes within regional frameworks currently allow flexibility and tailoring to populations and context. It is not clear how the proposed new system will accomplish these functions more effectively; It does not seem to us that the proposed system of ‘provider skills networks’ funded by levy will be nearly as effective, fair or efficient, nor that the proposed Health Education England will have sufficient capacity to carry out all these functions effectively nationwide.

12. We are concerned that the ‘provider skills networks’ as proposed will be unwieldy and uncoordinated – representing so many competing concerns that they will find it difficult to make decisions.

13. We are also concerned that, given the many other changes to be implemented in the NHS, there may not be sufficient drivers to compel providers to prioritise education and training. With all the other priorities for service development, it may not be
possible for GP commissioners to isolate educational priorities and ensure that these are consistently implemented. How is it proposed that providers, who will of course have considerable financial pressures and an increasing range of competitors, will be persuaded to plan education for the long rather than the short term?

Education and Training for Primary Care

14. We see a major risk that the large foundation trusts will dominate networks, and through control of education effectively blunt any initiatives that commissioning consortia propose – we assume that this is not the intention, given the Department of Health’s strong support for clinical leadership and the vital need for more treatment to move into primary care settings. It is not helpful that the level of engagement of primary care in the proposed Networks is not considered – is it expected that GPs will be represented at practice level, or by their GP Commissioning Consortium, though these are not strictly providers? What about other primary care providers – dentists, optometrists etc?

15. Furthermore, with the likely greater specialisation of some providers (where specific treatment types may be carried out more efficiently), and the non-requirement for all providers to provide educational opportunities, we are concerned that the overall quality of postgraduate generalist medical education may be negatively impacted by exposure to a reduced range of environments and treatment types.

16. We foresee something like an ‘inverse care law’ in medical education and training – with quality variable from area to area (or network to network) and conceivably lowest in areas where other demands on resources are highest. This may result in differential opportunities for trainees, differential success in exams and, ultimately, differential outcomes for patients.

17. Difficulties will be magnified when considering workforce development and transfer between the four nations of the UK, and consideration should be given to implications for trainees from Scotland, Wales and Northern Ireland. We are a four-country College, committed to the maintenance of standards across the UK and concerned for any imbalance that may occur between these.

18. One solution that has been suggested would be to have separate primary and secondary care provider skills networks, and to give primary care directors full control of the budgets for primary care training (where currently they only have control of that part of training which takes places in primary care settings).
19. Within this kind of solution, there are obviously opportunities for primary care to improve the quality of education and develop the primary care team as a whole, for example through investment in post-CCT education.

Pace of change

20. We have particular concern with the pace of the proposed changes, which we feel will make them less likely to be effective. It appears to us that the pace is dictated by other aspects of the NHS reforms (such as the abolition of Strategic Health Authorities in 2012) – but we do not believe that the proposed ‘provider skills networks’ will be sufficiently organised in time to fulfil their functions, nor that Health Education England will be securely enough established to provide the intended support. These changes are not intrinsic to the other reforms of Liberating the NHS, and if they are to be implemented this should not be done at the same time as those reforms.

21. In summary, the proposals mark an unjustified revolution in medical education. We are seriously concerned that there could be profoundly harmful implications for education and training in primary care, and we would urge very careful and detailed reconsideration before turning inside-out a system that currently functions broadly well. Greater improvements would be achieved, with greater cost-effectiveness, by a more nuanced approach that tackles specific difficulties in the present system.

Response to Specific Questions

22. The consultation on ‘Developing the Healthcare Workforce’ contains 46 questions, to which we have provided answers below:

Consultation Questions – Chapter 2

Q1: Are these the right high-level objectives? If not, why not?
The high-level objectives as stated are appropriate – though essentially very similar to the objectives of the current system. However, there are several further objectives that ought to be considered:

- To retain and improve the high quality outputs of supply, and encourage recruitment into the NHS at all levels. We need to retain the best candidates for the NHS, not merely a secure supply of staff.
- To ensure professional leadership and evidence-based planning of education and training – aligning with the intention expressed throughout Liberating the NHS to have clinical leadership in all aspects of healthcare.
To expect that all healthcare services that are publicly funded contribute to the education and training of staff in pursuit of better healthcare outcomes for future patients. There should be a commitment to education as being an integral part of the running of a healthcare service.

Q2: Are these the right design principles? If not, why not?
There are numerous difficulties and omissions with these design principles:

- Fundamentally, the education of a high quality, professional workforce is a professional, not a bureaucratic endeavour. Professional engagement is mentioned only in relation to safety and quality, but it should be integral to curriculum design and all other aspects of education and training.
- It is unclear why it is a necessary design principle, as opposed to a political choice, that education, training and workforce planning must be aligned with healthcare commissioning and carried out at the most local level possible. In the case of formal speciality and postgraduate training this does not seem necessary or appropriate, disregarding as it does the regional (English) and national (including the devolved nations of the UK) levels at which this workforce should be considered. Local variation may impede planning flexibility at these levels.
- The emphasis on a multi-professional approach to planning, while at times appropriate, should not be over-emphasised. There are many occasions within the training of most professions when a uni-professional approach is more appropriate.
- As stated, investment needs to be sustainable and transparent – but it should also be adequate to develop excellence, and protected from other demands. It is a concern throughout these proposals that education budgets will be exposed to competing priorities.
- Fairness and transparency are mentioned – within these, patient voice and trainee voice should be explicitly mentioned as central to the design of education and training.

Consultation Questions – Chapter 3
Q3: In developing the new system, what are the key strengths of the existing arrangements that we need to build on?
There are many strengths in the current arrangements, such that we would encourage a more evolutionary, as opposed to revolutionary, approach to reforming it:

- The current model of professional curriculum development, implemented by deaneries embedded at the regional level and liaising closely with universities
and Royal Colleges, encourages an integrated approach to under- and postgraduate curricula, and ensures attention is not solely focused on immediate priorities – such as academic posts, where there may not be a clearly identified local need but which still perform a vital function.

- The current arrangements consistently ensure the quality of medical education and allow an independent view of the quality of training, distance enabling deaneries to resist potential pressures from large providers to accept lower standards. Deaneries are engaged with medical Royal Colleges and others in a variety of programmes to improve education (and thus workforce) quality both for the next generation of professionals and for the present workforce – will provider skills networks have the same regard to long-term quality improvement rather than short-term service requirements?

- GP recruitment coordinated at regional level helps ensure consistency of supply – a more localised approach would mean that global view and flexibility will be lost and inequalities of supply are likely to increase.

- The clear ring-fencing of the MPET budget means this cannot be diverted from education and training use. We support the assertion in this document (paragraphs 3.10-3.11) that it is vital for the Department of Health to continue to ensure investment in education and training, so that the UK can develop its own workforce and not be dependent on staff from outside the country.

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

In theory there are opportunities in the new approach for greater innovation, for local accountability, and for developing local hubs of excellence. There are also, notwithstanding the comments above, opportunities from greater multi-professional education and training that could be beneficial if realised. We are concerned that, if there is not adequate funding, committed coordination or evidence-based planning these opportunities will not be realised, and instead there will be greater fragmentation and disparity of standards.

**Consultation Questions – 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?**

As mentioned already, we welcome opportunities for patient, community and staff engagement. We are wary of the notion of a ‘duty to consult’ if in practice this results in a form-filling and box-ticking exercise without meaningful outcomes. For smaller providers
this could be a considerable bureaucratic burden with unproven benefit. What will be the driver to compel providers to respond to the results of consultations?

Q6: Should healthcare providers have a duty to provide data about their current workforce?
Yes, we are clear that they should have this duty, so long as the Centre for Workforce Intelligence is clear about the data required and does not make the process unnecessarily bureaucratic – however this will be a new requirement with cost implications which must not be disregarded.

Q7: Should healthcare providers have a duty to provide data on their future workforce needs?
Yes, they should have this duty – the collection of this kind of data would make sense whether workforce planning was to be carried out at a national, regional or local level. Again, only necessary data should be collected and the system should be kept as non-burdensome as possible.

Q8: Should healthcare providers have a duty to co-operate on planning the healthcare workforce and planning and providing professional education and training?
Yes – there should be an absolute responsibility for all healthcare providers to co-operate in this way. This is desirable in any case but clearly essential in the context of the proposed reforms. GP training in particular is absolutely dependent on this form of co-operation, which is crucial to the development of generalist expertise.

As the College and others have argued previously, to develop the range of expertise and proficiencies expected of GPs and allow experience and reflection on the variety of clinical settings, GP training should be extended from the current three years, which is lower than for specialist training and lower than in other European countries.

Q9: Are there other or different functions that healthcare providers working together would need to provide?
The functions suggested are reasonable – but it must be made clear that, in the fulfilment of these functions, providers will be expected to set aside time, backfill and

sustainable leadership for the provision of educational supervision and mentoring. Efficiencies may be desirable, but providers must not be permitted to do education and training ‘on the cheap.’ In addition, providers would need to:-

- provide a minimum number of relevant placements across their health community;
- accept the need for training the trainers and quality assurance of the educational experience in their area;
- commit to support for national workforce supply as required;
- commit to provide for excellence in the provision of postgraduate education and training and adhere to defined outcome measures – recognising that many of the general practice and specialist trainees passing through the local training system and thus supervised by the provider skills networks will not go on to work in the local area;
- be obliged to work with medical Royal Colleges and specialty schools with regards to postgraduate education;
- and submit to a monitoring process to ensure that they meet all these obligations.

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

Yes, this should be an obligation, particularly important given the greater diversity of providers anticipated under Liberating the NHS. The UK’s system of workplace learning is a great strength and must be supported. If fewer providers were to participate this would have a very harmful effect with long term consequences particularly for the skills and experience of the generalist workforce, to the detriment of patient safety and outcomes. Despite the emphasis here on multi-professional working, there are clearly differing requirements in many areas for different specialties. By not giving any direct consideration to these differences it is inevitable that the document will leave many clinicians suspicious of the potential consequences for them and their specialty.

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?

Whilst mostly agreeing with the duties specified, we do not believe they are at all adequate to ensure the quality and excellence of medical education, particularly postgraduate education and training, and secure the national supply of a high quality workforce in the medium to long term. We are particularly concerned that the linkage of
funding, planning and provision will drive down quality – especially without far greater attention being given to the quality management of the arrangements.

**Q12: Are there other incentives and ways in which we could ensure that there is an appropriate degree of co-operation, coherence and consultation in the system?**

There may need to be legal duties and financial penalties to ensure that the specified duties are kept and that quality is maintained – relying on the self-interest of providers to invest in education and training at a time of many other financial pressures will not be sufficient. A commitment to the education and training of the current and future workforce needs to be a key part of providers' mission statements, a key responsibility for Foundation Trust Boards, and subject to monitoring by the CQC.

**Consultation Questions – Chapter 6**

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

On the whole these functions do seem to be appropriate. Our concern would be over whether the HEE will have:-

a) sufficient teeth to ensure provider skills networks live up to their obligations and to adjudicate between the competing demands of short term local workforce needs and long term education planning;

b) sufficient capacity both to supervise activity at the local level and engage in national workforce planning;

c) and whether there is sufficient focus here on specifically medical workforce issues.

Our preference once again would be for centrally funded regional bodies as the appropriate locus for many of these functions – that is, the retention of deaneries or the commissioning of their existing structures and staff as the delivery arm of skills networks is highly desirable.

We would also question the proposal that HEE be responsible for reviewing curricula, quality improvement and assurance – these are regulator roles, belonging to the GMC in the case of medical education.

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

It will be essential to ensure the involvement of professional and educational bodies at the interface between HEE and the skills networks. Organisations such as the GMC and the Medical Royal Colleges who have responsibility for the quality of the future medical
workforce must be consulted at the development stage to ensure that the framework is fit for purpose and limit any unintended consequences.

Q15: How do we ensure the right checks and balances throughout all levels of the system?
Please see our answers to Q13 and Q14 above. We are concerned that the proposed system leaves a gap at the regional level, and offers insufficient control over the activities of skills networks. The engagement of the relevant professions will be essential to address this gap and minimise consequences.

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 line with the Department of Health’s intention to encourage clinical leadership at all levels of the NHS, it is essential to have clinical/professional leadership (including specifically representatives of the medical Royal Colleges) of the HEE, as well as board members elected by stakeholders rather than politically appointed. Within this, it is vital that primary care specifically be represented and continue to be represented.

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?
As already discussed, healthcare providers must be obliged to provide information on their current and anticipated workforce needs. The Centre for Workforce Intelligence:-

• must be funded and staffed appropriately;
• have links with the professional organisations so that it can share in a full understanding of profession-specific and long term educational developments;
• have links with GP commissioning consortia and the proposed local authority Health and Wellbeing Boards to ensure a full appreciation of local workforce needs.
• Look at workforce planning on an international scale to ensure that lessons are learnt from outside the UK as well.

Above all, if it is to optimise its collection, analysis and supply of information, the CWI must not work in isolation from the many bodies that have a stake in education and training.
Q18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?
At the local level, GP consortia should have strong representation within the provider skills networks, to ensure that hospital trusts do not dominate and hinder the implementation of commissioning decisions that are dependent on educational developments. Alternatively, as already suggested, separate primary care skills networks, or full control by medical directors of primary care training budgets may help ensure consortia plans for primary care are supported by education.

At the national level, Health Education England should be represented on the board of the NHS Commissioning Board, to ensure that the integral role of education and training in healthcare planning and commissioning is recognised.

Q19: Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and co-operation in planning the workforce and in the planning and provision of professional education and training?
Our respondents were divided over this question, with some arguing that this was a proper role for the CQC – as education and training ultimately has implications for patient safety and outcomes, both in terms of long-term workforce supply and short terms quality and safety issues; others felt it was a role for Monitor, since it would be crucial under ‘any willing provider’ to ensure that certain providers did not gain unfair commercial advantage through the way they carried out their education and training responsibilities, and that all money allocated for education was spent on education; others felt the responsibility belonged to both CQC and Monitor.

However much responsibility is shared amongst appropriate organisations according to their particular remits, clear lines of accountability should be established in the system.

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 framework?
No comment.
Q22: How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?

Despite the claim in this section that the new framework ‘reaffirms the central role of professionals’, we do not find much in the proposals that actually achieves this. Professional leadership in medical education, based on co-operation between the medical Royal Colleges and deaneries, is currently very strong – devolving responsibilities to networks of providers would appear to threaten to weaken this. There must be a requirement within the framework – either on the skills networks or HEE – to fund and support academic professional leadership.

Furthermore, the vital role of professional bodies in the provision of educational inputs – as opposed to the oversight role – is neglected throughout the document.

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?

HEE must have a strong responsibility, as well as ring-fenced funding to support the development of leadership and management skills – given the emphasis throughout Liberating the NHS on clinical leadership it is vital the resources are in place to provide this.

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

Yes, it should. We note that managers are the only significant group with the NHS that are not regulated with a code of conduct. Respondents suggest that this might be well worth developing.

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?

Medical Royal Colleges are currently giving considerable attention, particularly in the light of Liberating the NHS, to programmes for the development of leadership and management skills. In the case of the RCGP, we have in recent months launched a Centre for Commissioning in conjunction with the NHS Institute for Innovation and Improvement, which aims to equip GPs with the necessary skills to commission healthcare for better patient outcomes. Even before this:-
In 2007 we introduced the first UK-wide curriculum for GP training to ensure every trainee receives the same quality of training.

We incorporated the Medical Leadership Competency Framework (MLCF) into our curriculum to demonstrate our commitment to GP leadership.

We issued a leadership strategy\(^2\) in 2009 encouraging GPs to consider leadership roles.

We are developing a leadership programme specifically for GPs in the first five years of their careers.

We run a fifteen month Leadership Programme in conjunction with the University of Exeter.

Many of our faculties run local leadership events.

We have dedicated a section of our website\(^3\) to leadership - providing a comprehensive overview of how members can develop their leadership skills, as well as links to external publications and resources to assist professional development.

It is clear that the RCGP and other medical Royal Colleges will remain committed to the design and implementation of innovative leadership training opportunities. Where there are opportunities for integrated and multi-professional education and training we will pursue these.

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?

Though reserving the bulk of our comments with regards to Public Health matters for our response to Healthy Lives, Healthy People, it is clear that, given the shared responsibility of all healthcare professionals for public/population health issues, it is desirable to have as close co-operation as possible on workforce planning. It does therefore make sense for Public Health England to have a role within HEE, and similarly for local authorities, presumably through local Directors of Public Health, to have a role in local provider skills networks.


\(^3\) [http://www.rcgp.org.uk/professional_development/leadership_and_the_rcgp.aspx](http://www.rcgp.org.uk/professional_development/leadership_and_the_rcgp.aspx)
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?

As argued above, local authorities should become members or at least be expected to work with the networks - as for funding, this could be centrally provided or levied, though this may depend on the scale of ring-fenced public health budgets.

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?

We have concerns that developing a system that is provider-led and multi-professional may be at odds in places with the commitment to excellence, equity and value for money. Our chief worry is that provider skills networks, members of which may be on five year contracts, may find it difficult to commission for the long term or for roles that do not have a specifically local emphasis. Therefore a fair degree of central funding and 'ring-fencing' of funding is essential. Furthermore, for the sake of a diverse and fully-equipped workforce, the obligation on providers to participate in education and training must be enforced, and the levy on those who do not participate should be sufficiently heavy to act as a disincentive.

Similarly, whilst there will undoubtedly be opportunities for multi-professional training, there are also a great many specialist training requirements, and funding for these must be ensured.

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

Some degree of central investment should be maintained, in order to ensure continuing support for academic and extremely specialist posts. Medical education and training is a social good that supports better healthcare outcomes for patients, and society must be prepared to support this. It is our view that the current investment through MPET provides good value for money – far more evidence should be presented before any proposal to remove this.

Q30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?
It is not clear from the context why this is felt to be a risk. Nonetheless, if innovative approaches are planned by skills networks, based on evidence from the CWI and in congruence with the commissioning plans of local consortia, local authorities and the NHS Commissioning Board, funding streams should be flexible enough to adapt.

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 support the transition to tariffs, as we do not believe there is evidence that it will improve on the current system and may have significant negative consequences. In particular medical education is dependent on trainees receiving a broad range of experiences, and it would be regrettable in the extreme if a tariff system were to hamper this by disincentivising participation by some providers. We would require greater clarity regarding the proposed approach before we could be confident that this would be avoided.

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?
Perhaps – but we feel that any introduction must be phased in very carefully to minimise instability.

Q33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?
Some of our respondents suggest that a weighted capitation approach, with local variation to meet local priorities and e.g. allow for historical levels of investment, would be more appropriate. This is a complex area, and beyond the scope of this response to consider fully – for example there has historically been proportionate over-funding of training posts in London – but should be open to further discussion.

Q34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?
For fairness and transparency, we would expect a costing exercise to be necessary – this would need to be carried out nationally and be sensitive to regional variations.

Q35: What is the appropriate pace to progress a levy?
Any change to a levy must be implemented very carefully and with a phased approach, especially given all the other changes to the financial set-up of the NHS. The risk is that
for small providers, including GP practices, this could be an additional burden and result in an exodus of senior staff.

**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?**

On principle this is clearly fair. However, it risks destabilising those providers who have not previously had to pay for training, making a phased approach as mentioned above all the more essential.

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

It is not clear how the levy itself is intended to incentivise investment in education – unless it is differentially implemented on those who provide greater or less support for training. We would like to see far more detail and clarity in the proposals here, including a comprehensive comparison with the current funding streams so that the benefits and consequences would be clearer.

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

The requirement on providers to report on training activities and future plans – to the CWI but also to commissioning bodies would encourage transparency.

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

In the short term, making use of existing administrative systems as established by the deaneries will be vital to keep transaction costs down and minimise disruption. In the longer term, we do not see how the new system, which effectively moves responsibility for education and training to smaller units of organisation, can fail to increase transaction costs, even if these will be borne by providers rather than a central budget.

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

Our respondents made a number of suggestions in this area:-

- Some worried about the principle of using metrics, especially if these were to be linked to incentives – pointing out the potential for ‘gaming’ and resulting unintended consequences in many areas.
- Some felt the best use of metrics was as a tool to help providers improve performance.
• Any use of metrics must be piloted extensively and subject to academic evaluation before rolling out nationally.
• If the principle of using metrics is accepted, the chief requirement would be to define fitness for purpose for each profession or specialty (which of course is a changing and not a fixed point), and then evaluate whether training programmes deliver a workforce that is fit for purpose and fit for local needs – outcomes, in other words.
• Other metrics might include retention rates, trainee satisfaction and assessment of quality processes which are not heavily reliant on self-reporting.

Consultation Questions – Chapter 9
Q41: What are the challenges of transition?
Our overriding concern is with the pace of the proposed transition, coming as it does concurrently with many other revolutionary changes within the NHS. We do not believe that this pace of change is necessary, and we definitely do not think it is done with the best interests of medical education (and by extension medical care and patient outcomes) in mind. The notion that the whole architecture of provider skills networks and Health Education England will be in place and equipped to perform their roles, whether or not current deanery staff have been retained, in almost exactly one year from the closure of this consultation, without significant disruption to education and training in the interim and for the foreseeable future, is frankly unbelievable. The workload expected of SHA and deanery staff in preparing for the changes, at a point when their own jobs are uncertain and morale is likely to be low, is also unrealistic.

Moreover, as we don’t believe that the proposals in this document acknowledge the full range of functions that deaneries, in conjunction with professional bodies such as Royal Colleges, perform in support of education and training, an additional risk of transition is that these functions, which include supervision of the appraisal system and the training of trainers, will be neglected and need to be recreated from scratch.

Q42: What impact will the proposals have on staff who work in the current system?
There is a high likelihood that highly skilled and specialised staff will be lost during transition, to the long-term detriment of medical education and the healthcare workforce. Those who remain will need to be convinced, rapidly, that the new system is able to deliver and will offer them personal and professional opportunities.
**Q43: What support systems might they need?**
They will need secure employment with permanent posts, clarity of roles and lines of accountability, transparency and fairness from regulators, and adequate funding through the transition process and beyond.

**Q44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?**
The CWI will need to shape up rapidly and develop the tools outlined earlier in the consultation, in order to be in a position to identify shortfalls and problems in the system and support the other bodies involved.

**Consultation Questions – Chapter 10**

**Q45: Will these proposals meet these aims and enable the development of a more diverse workforce?**
The NHS already has a highly diverse workforce, and we see nothing in these proposals that will increase that diversity. It appears to us, however, that the greater fragmentation of workforce planning and education proposed, moving away from nationally coordinated recruitment, is likely to result in a more diverse *experience* of education and less fair systems.

**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?**
Yes, many of these groups may be disadvantaged – national scrutiny and quality management of education has helped to protect these groups from inequality and discrimination, and the move to far greater localisation is likely to undo much of this work.

23. We gratefully acknowledge the many contributions of College members, in particular members of the College Council, our Patient Partnership Group, Postgraduate Training Board and colleagues from COGPED and Deaneries in formulating this response.

Yours sincerely
Professor Amanda Howe

Honorary Secretary of Council
Appendix: The RCGP and the White Paper – a Framework for our Response

1. Background

The Royal College of General Practitioners exists ‘To encourage, foster and maintain the highest possible standards in general medical practice, and for that purpose to take or join with others in taking any steps consistent with the charitable nature of that object which may assist towards the same’. **OUR VISION is of:**

A world where excellent person centred care in general practice is at the heart of healthcare. Our role is to be the voice for General Practice in order to: promote the unique patient - doctor relationship; shape the public’s health agenda; set standards; promote quality and advance the role of general practice globally.

**OUR PURPOSE is to** improve the quality of healthcare by ensuring the highest standards for general practice, the promotion of the best health outcomes for patients and the public and by promoting GPs as the heart and the hub of health services.

We will do this by:

- ensuring the development of high quality general practitioners in partnership with patients and carers,
- advancing and promoting the academic discipline and science of general practice,
- promoting the unique doctor-patient relationship,
- shaping the public health agenda and addressing health inequalities,
- being the voice of General Practice.

**OUR VALUES**

The RCGP is the heart and voice of General Practice and as such:

- We protect the principle of holistic generalist care which is integrated around the needs of and partnership with patients
- We are committed to equitable access to, and delivery of, high quality and effective primary healthcare for all.

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4 This Framework is based on a paper debated by Council on September 10th. The wording is largely unchanged except for some editing and some additional points of emphasis required by Council, all added by the Honorary Secretary.
• We are committed to the theoretical and practical development of general practice.

The Government published its White Paper on its plans for the NHS, ‘Equity and excellence: Liberating the NHS’ in July. Following on from the publication of this document, four further consultation documents were released. These are:

• Commissioning for patients
• Transparency in outcomes – a framework for the NHS
• Increasing democratic legitimacy in health
• Regulating healthcare providers.

There is an obvious challenge for the RCGP as a UK wide body, as the current White Paper specifically applies to the NHS in England. However, Council on September 10th 2010 agreed that the RCGP should debate the implications, and should respond to the consultation with a constructive critique from all countries and Faculties to reflect members’ concerns to the government, in a way which will maximally influence their eventual policy implementation. Further testing of membership views up till the close of the consultation, will form the basis of our written and verbal efforts over the next period to influence the definitive outputs of this policy challenge.

This Framework is based on an overview of members’ responses, set in the context of the College’s vision, purpose, values and priorities. We have used these to evaluate whether the reforms proposed are likely to enhance or jeopardise our core values, which are that:

• We protect the principle of holistic generalist care which is integrated around the needs of and partnership with patients
• We are committed to equitable access to, and delivery of, high quality and effective primary healthcare for all.
• We are committed to the theoretical and practical development of general practice.

2. Consultation responses

The largest numbers of comments grouped around the following issues.

2.1 Opportunities for:

i. greater influence by GPs on patient care and health services, through direct leadership and greater input to the Department of Health;
ii. overall benefits to patients if instigated effectively;
iii. better use of local knowledge for appropriate resource allocation and strategic planning;
iv. streamlining resource use, less wastage and duplication;
v. a crucial role for the RCGP in setting standards, leading by example, sharing good practice, disseminating information, setting standards for clinical pathways and services (in collaboration with other Royal Colleges) and providing training to skill members up for leadership and commissioning.
Other opportunities flagged by senior officers include the opportunity to work more closely with local government, joining up with social care and public health; delivering even better education and training for nurses and for GPs – including extending the period of GP training to deliver GPs with appropriate knowledge and skills; and potential for better workforce planning. Council emphasised real opportunities to work more closely with patients, and to develop stronger links with colleagues in specialist practice.

2.2 Concerns

There were many queries about the lack of detail of how the reforms might impact on services and the workload for practices, and a significant numbers of comments on the risks of these reforms to the NHS in England, as follows:

vi. Rather than efficiency savings, both financial and human resources would be diverted away from clinical care and quality improvement into issues around commissioning and resource management. The extent and speed of the reforms risk destabilising both the interpersonal relationships and economic basis of local health economies at primary and secondary care level.

vii. Local diversification will be likely to increase rather than reduce health inequalities.

viii. GPs will be seen as the purse-holders: this could reduce public trust and decrease their ability to advocate for patients, and they will be blamed for failures and cuts in services.

ix. Many GPs currently lack time, skills and capacity for commissioning – this will need addressing urgently.

x. The reforms open a door to increased involvement of the for-profit private sector in the NHS, and tax payers’ money will be diverted into private companies and their shareholders. This could be seen as the break up of the NHS with some private companies ready to take over the provision of services.

xi. The reforms take the health service in England further away from the health services in the other UK countries, although the training for GPs remains the same.

3. RCGP Council Debate

In the light of these findings, and of the content of the proposed reforms, Council had an extensive debate which is reflected in the following statement.

“We are committed to equitable access to, and delivery of, high quality and effective primary healthcare for all: and to protecting the principle of holistic generalist care which is integrated around the needs of and partnership with patients. We are an independent professional body with enormous expertise in patient – centred generalist clinical care. We shall make every effort to influence the outcomes of these reforms in a way that reflects the core principles of excellent general practice, which has already been shown in international research to be highly effective and efficient.

We note the opening paragraphs of ‘Liberating the NHS’:-

- “The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.

- We will increase health spending in real terms in each year of this Parliament.

- Our goal is an NHS which achieves results that are amongst the best in the world.”
In principle, the RCGP welcomes all opportunities which bring the expertise of GPs into effective roles for developing and improving services that meet the needs of our patients. We also welcome initiatives which allow a more effective patient and public voice within the NHS and those which enable people to play a greater part in society; that includes overcoming health inequalities. We believe that GPs can assist in the effective and efficient use of NHS resources, and wish to play an active role in reducing waste and duplicated effort. We accept the need to plan and deliver our services according to evidence based outcomes and public health needs.

GPs already have strong partnerships with other clinical specialities, and the possibilities for more collaborative commissioning and integration of clinical care are welcome. We value the expertise of effective management and want to retain this for the NHS. We also welcome the emphasis on a stronger patient voice, and any ways in which we can improve health outcomes, especially for those disadvantaged by personal and socioeconomic circumstances.

However, some of our members are not convinced that the scale of the changes proposed is justifiable, especially in the context of cost reductions. They are concerned that the proposed scale, pace and cost of change will prove disruptive; and that the proposed reforms may not achieve the stated aims because they will divert effort, costs and human resources into complex commissioning and local decision making. Some members are also concerned that GPs will be held responsible for shortcomings in services, and that this will disrupt public trust in the crucial doctor-patient relationship which underpins effective uptake of services and clinical interventions. Fundamental to those members’ concerns was that the ability of the NHS to provide a high quality service should not be jeopardised by irreversible changes to the infrastructure of the NHS, including imperatives to offer choice and an increased dependency on private providers.

Other members, particularly at the start of their careers, welcomed the opportunities for increased potential to influence services to patients and the wider community.

4. Next Steps

We have consulted with our members on the White Paper and supporting documents and will continue to do so. We shall respond in detail to these by the deadlines, and will include there the many other points already made by members and Faculties, and debated at Council. In particular, we shall highlight the need for the government to provide clearer details on how these reforms will reduce rather than exacerbate health inequalities, as the existing evidence base on commissioning suggest there is little impact on inequalities, and increased local variability can lead to disadvantaged populations being further marginalised. We shall also emphasise our concerns about the diversion of GPs away from clinical work into managerial and leadership roles, and the long-term implications for workforce capacity of these new roles. We expect that we shall be involved in further discussions with government, and that our views and concerns will be taken into account.

Whatever the outcome of the consultation, we shall uphold our values, work closely with patients, other health professionals, and other Colleges to retain and develop excellent primary care for all. We shall offer leadership and guidance to members as they seek to deal
with the consequences of the NHS reforms. We shall also provide guidance, education and training opportunities, and ensure the sharing of good practice to assist our members to develop the necessary skills to lead effective clinical primary care within the context of GP consortia and commissioning groups if these pass into law."