Response to the Department of Health Consultation: “Liberating the NHS: Developing the Healthcare Workforce (England)”
Introduction

With a membership of almost 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes this opportunity to respond to the education and workforce consultation. It welcomes the opportunity of shaping this agenda to enable there to be appropriate staff in appropriate numbers with appropriate training to ensure high quality care for patients as we move forward in these difficult economic times.

Throughout this paper references to nurses and nursing refer to the broadest scope of practice across the family of nursing, midwifery and health visiting.

The RCN used a number of tools to engage with its members and other stakeholders during the consultation period for this paper which can be found in Appendix i.

Executive Summary

The RCN accepts that there is a legitimate role for employers in workforce education and training. However, we believe it is essential that there is national oversight of nursing education and the commissioning of nursing education to protect national standards and ensure that the future workforce is fit for purpose.

An NHS Commissioning Board to provide oversight of the funding plans for training is to be welcomed working in tandem with the new proposed Centre for Workforce Intelligence. However, the RCN has concerns about GP consortia and the local skills networks overseeing training at a local level. There is a lack of detail behind the vision for this area set out in both the White Paper and this consultation and the College would welcome the opportunity to receive more information on the Government’s proposals.

The Prime Minister’s Commission on the future of Nursing and Midwifery in England recommended that urgent steps be taken to strengthen nursing education and research; develop and sustain the educational workforce;

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1 Department of Health (2010) Liberating the NHS: Developing the Healthcare Workforce (England)
facilitate sustainable clinical academic career pathways; and further develop nurses’ and midwives’ research skills.”

Behind these recommendations lay a clear assertion that nurses must be able to lead and apply their expertise in this area. The RCN calls for inclusion of the recommendations of the Prime Minister’s Commission on Nursing and Midwifery in this vision.

Nurse leaders are uniquely placed to play a role in the commissioning of education. Their comprehensive knowledge of educational commissioning systems and understanding of multi-disciplinary care pathways will be essential for future decision-making. There has been an increasing blurring of boundaries across care pathways with teams of staff combining medical and non medical staff. Nurses have shown themselves able to work within these new ways of working and help form a bridge between health and social care systems.

The RCN welcomes the commitment of the Government to involve all health and social care providers in the commissioning process. Since the third sector will increasingly need to expand their healthcare workforce it is appropriate that they should be involved in workforce planning at all levels. However, there is currently no clear mechanism outlined detailing how this involvement would be achieved in practice.

Medical Education England (MEE) has worked effectively because healthcare professionals have been closely involved. Commissioning of nursing and Allied Health Professionals (AHP) training is considerably more complex and involves many more providers. We welcome suggestion of a new body to commission education but ask that clearer guidelines on structure and size be discussed.

The College welcomes the proposal for a Centre for Workforce Intelligence to provide current information and reliable analysis on which to base workforce and training and commissioning decisions but has real concerns that the current stakeholders involved in the work of Centre for Workforce Intelligence appear to be focused on medical practitioners. The RCN developed a very strong and effective relationship with the Workforce Review Team, yet it is concerned that the new organisation proposed may not maintain the same level of investment in the future of the nursing workforce.

The RCN believes there is a need for a comprehensive workforce planning system and strategy, which covers all providers delivering NHS funded services. The RCN recommends that employer organisations should be including non-mandatory training in their training and workforce plans and that training become a protected element in financial plans. Without adequate

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investment in all parts of the nursing workforce, healthcare organisations will continue to struggle with staff shortages, poor skill mix, bed pressures, preventable morbidity and mortality, and poor provision of community health services.

“Liberating the NHS: Developing the Healthcare Workforce” sets out a new system for the planning, commissioning and delivery of healthcare education. To deliver on the aspiration of the first objective in this paper which is “security of supply, having people with the right skills in the right place at the right time” must be applauded. We also welcome the objective that this will be part of a service model that delivers value for money, widens participation, while delivering high quality education and training that supports safe, high quality patient care and which is responsive to patient need.

However, there are a number of issues in this paper which the RCN is concerned about and which we believe need to be explored further before proceeding.

Our overarching concern is that the consultation sets out a series of aspirations – which the RCN share – but that there is not an accompanying clear vision as to how these aspirations can be achieved. We are concerned that there is little evidence shown in the paper on why these changes will be an improvement on the current system.

Whilst the White Paper is explicit about the infrastructures it seeks to remove, the alternative put forward comprises a series of discrete elements without sufficient consideration about how these new bodies relate to one another and no evidence that they can be made to work. Too frequently the consultation asks ‘how’ different objectives could be achieved rather than putting forward a carefully considered plan and seeking views on it.

**Multidisciplinary and service led approach**

We agree with the principle of multi-disciplinary working and welcome the fact that the proposals potentially allow workforce decisions to be taken closer to service delivery and the population’s health needs.

**Local Skills Networks**

We see the potential for local skills networks to deliver a more comprehensive review of local requirements for healthcare education. However, we are concerned that this objective may not be universally achieved through the proposals as they stand. We believe that further guidance regarding the establishment of these networks should be provided.

Without such guidance both the size and membership of these groups may vary considerably and this could impede their ability to properly plan the workforce. If they are too small they may create multiple layers of bureaucracy
with education providers having to contract with several networks. In a similar way particularly large networks may become unwieldy and difficult to manage.

**We believe there should be some guidance regarding the composition of skills networks to ensure key providers are represented.** For example, if local authorities are not present on this group then who will deal with education overlapping into social care and who, for example, would be responsible for commissioning health visitors or school nurse training which will fall under the public health remit.

We believe that there is real scope for joined-up working within these networks but only if the universities and other education providers are directly involved.

We also have anxieties about all staff being treated equitably in this proposal. Many stakeholders will be vying for places on this group and we are anxious about the representation for lower levels of staff e.g. Band 1-4 and also for small providers such as independent nursing homes.

**The RCN has some concerns about employers being solely responsible for decisions on ongoing workforce education and training.** Experience has shown, time and again, when there is pressure on finances, that training is the first budget to be cut. For example, Trust deficits had a marked impact on the amount of continuous professional development nurses received - the average number of days per year fell from 10.6 in 2005 to 7.3 in 2007. The proportion of nurses not receiving any continuing professional development (CPD) rose from 1% in 2005 to 12% in 2007. The 2009 surveys indicated that the levels of CPD did not recover from these cuts, even when the immediate pressure of deficits had passed. The average across all (including those who had not done any) was 6.1 days in 2009, the same as in 2007. ³

CPD for all levels of staff needs to be an absolute priority for high quality patient care to be delivered and this must not be lost, even as a short term measure.

**The RCN therefore asks that all education budgets be ring-fenced for that use only.**

**The RCN also seeks clarity on the funding for these networks in the medium term** – will money move from the SHA/PCT workforce to the skill networks? How is the transition period to be managed?

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³ Royal College of Nursing (2009) *Past Imperfect, Future Tense: Nurses Employment and Morale*
We believe that there is a danger that education plans may fail to align with the strategic plans for patient care being established by the GP consortia and would seek clarification on how that relationship will develop.

The RCN is unclear as to the accountability of these networks and how they link to the GP consortia in a meaningful way.

Higher Education England (HEE)

The RCN believes that HEE could be a mechanism for truly developing interdisciplinary education. However, there is a requirement for the membership of this group to be appropriate and representative. It cannot be a group that is dominated by the medical deaneries if equity of education is to be achieved. The Professional Advisory Bodies (PABs) for nursing and midwifery and the professions allied to health must be strengthened to ensure the voice of the specialists and small professions is heard. We also believe that the voice of our Band 1–4 colleagues needs to be appropriately represented on this group.

We would welcome some further clarity on the accountability of HEE. Are the networks accountable to HEE? Does it have the power to impose sanctions if they fail to meet their responsibilities?

The RCN believes that both the healthcare providers skill networks and Higher Education England need to be chaired by someone outwith any of the professions to assure public confidence and a degree of equity in decision making.

HEE needs to have strong and effective links with the NHS Commissioning Board. Decisions on service commissioning and planning are critical in developing effective workforce plans. HEE and the local Skills Networks also need to attain a dynamic relationship with effective dialogue – it is important that local workforce decisions are assessed in relation to overall national plans and priorities, but those national workforce plans and decisions need to be informed by and recognise and understand local workforce demands.

Pace & Transition

In general, the RCN is extremely concerned about the pace and timescale of these changes. We believe that, in light of all the other NHS reforms and economic pressures affecting the NHS at present, these proposals should be slowed down as far as possible to give time for the new models to be piloted and evaluated. During the transition period the RCN considers that training places should be maintained at their current levels until the new structures are fully operational and able to determine requirements. Any changes need to be publicly monitored.
Specific Questions

Question 1: Are these the right high level objectives? If not, why not?

Overall the RCN believes these are the right high level objectives. Security of supply with the right skills in the right place is clearly an objective that would serve health care well. However, we have a number of concerns.

- One of the remits of Strategic Health Authorities has been to provide a strategic view to workforce development. The paper is very focussed on medical workforce without full recognition of the ‘boom to bust’ cycle in nursing workforce planning identified by workforce experts and described in the health select committee report on workforce planning. One of the conclusions of the health select committee report was to “end the constant reorganisation of workforce planning”.

- It is important that the workforce planning system considers both supply and demand issues and it is for this reason that the RCN is arguing for the workforce planning structures – the Skills Networks and HEE to be integrated with the commissioning structures. This could be either through commissioners having seats on the workforce planning boards or through HEE becoming a subcommittee of the NHS Commissioning Board. There could be a range of options, which the RCN would be happy to explore with DH and other stakeholders. Workforce planning - like service planning -needs to be responsive to patient needs.

- While the RCN supports the objective of ensuring a ‘level playing field’ across providers we would welcome more clarity on what this actually means and whether this is truly workable in a system that encourages greater local freedoms and a more competitive environment.

- The RCN is concerned that a system of workforce planning which is provider-led could very easily be dominated by a small number of large employers, who may have vested interests. This would not be in keeping with the needs of the wider health economy and some of the smaller service providers.

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We consider a key objective is to develop a system that enables strategic forward-looking workforce development (for example to support the policy of increased community based care). Our concern is that the proposed system places too much reliance on determining tomorrow’s workforce needs on the basis of current and past patterns of provision.

**Question 2: Are these the right design principles? If not, why not?**

We fully support the principle of planning the workforce for current and future use. However, we do not see much evidence of “how” the future demand for care and nature of services will be anticipated, either locally, regionally or nationally.

While we welcome the links with Public Health and social care, neither the principles nor the objectives truly recognise the need to ensure effective workforce planning across the entire health economy (including all providers and not just those delivering NHS funded care)

We would welcome reassurances that the workforce planning system will represent the entire workforce and that Bands 1-4 (and their equivalent) across the entire health economy will have a voice in this process.

We would very much welcome a system that offers transparent, simple and cost effective methods of funding and also welcome the commitment to ensuring strong partnerships with the education providers, but we are concerned that MPET monies will no longer include post registration funding.

Generally within the objectives and principles the ‘professional’ and academic voice is missing, the focus appears to be on the process of the workforce planning. There is no mention of working with the Nursing and Midwifery Council (NMC) or Health Professions Council (HPC). The RCN sees these regulatory bodies as being important stakeholders in workforce planning.

**Question 3: In developing the new system what are the key strengths of the existing arrangements that we need to build on?**

There are a number of strengths in the current system including:

- Partnerships that are already in existence e.g Higher Education Institutions and SHAs where it works well.
- Electronic Staff Records and the Information Centre.
- A national job evaluation system which is used by all NHS employers to evaluate and band jobs and is responsive to changing roles and job responsibilities.
- The Knowledge and Skills Framework (KSF) system which encourages staff to develop portfolios and which can be carried from one employer to another.
- Professional and trade union involvement in workforce planning.
- Regional level overview through Strategic Health Authorities. Although these have worked differently in different parts of the country they have provided a framework to allow a translation between “bottom up” local needs and regional “top down” perspectives. The system also allows for commissioning and provider dialogue on workforce planning.

**Question 4: What are the key opportunities in developing a new approach?**

We would welcome the opportunity to plan a workforce that relates to services and skills and teams required to deliver them and that creates an opportunity for commissioning to support integrated care.

We believe that in developing a new approach we have the opportunity to widen academic and health science culture to demonstrate not only how research informs teaching but how it can improve patient care, thus improving the delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme.

We would also welcome some consideration of finally resolving the issues surrounding nurses developing an academic career path to facilitate this agenda i.e the challenge of recruiting nurses to academia and the issues of pension transference etc.

However, while longer term strategic service commissioning is indeed essential we believe that for it to work effectively we need to see clear evidence of how long term mapping of need by service commissioners will be translated into service plans and how this is related to ‘bottom-up’ workforce plans by service providers. We will also need to ensure that small professions (such as speech and language therapy) are involved.

This is an opportunity to increase the number of clinical placement learning experiences for nursing and midwifery students within the independent and primary care sectors. It may also be a key opportunity to involve school education and teachers who are actively involved in public health and healthy child agenda.

It could represent an opportunity to create equity in learning and development for the entire workforce. At present, we recognise that medical staff generally get their Continuing Professional Development (CPD) paid for while nursing and Band 1-4 staff report that 43% do not get any study requests fulfilled or have to complete it in their own time and at their own expense.

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7 Royal College of Nursing (2010) *Nursing Survey: Continuing Professional Development*  
RCN London
The RCN has already raised concerns about the potential for CPD to be cut and therefore we argue that all skills networks need to ensure that CPD monies are ring-fenced and that individual providers include data on the allocation of CPD monies and protected learning time across staffing groups and grades.

We would be anxious about an on-going increase in on-line learning as a cheaper option for employers as staff on lower bands are less likely to be able to access adequate computer support either at work or at home. We would welcome a closer examination of this.

There are weaknesses and a lack of clarity in the current system, concerning the link between workforce planning, which includes education and training planning and education and training commissioning and its performance management and quality assurance (fitness for purpose).

**Question 5: 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?**

We believe that the way in which services are staffed (and future plans) should be transparent and publicly available so that the public, service commissioners and regulator can see how services are staffed and how staffing at one place compares to another.

We believe providers have a duty to consult front-line staff about decisions affecting education and training, CPD, and configuration of workforce.

The RCN is unequivocal that providers (and perhaps equally importantly service commissioners) should take into account patient preference. However we do not consider this can be / should be mandated or that providers can be bound by it. For example, patients may indicate that they prefer to have all services delivered by the GP rather than a member of nursing staff (or vice versa) – but there will be clinical and economic considerations to consider. Hence our view is that providers seek patient views and take them into consideration, along with clinical/professional judgement, and evidence of best practice regarding workforce configurations.

**Question 6: Should all healthcare providers have a duty to provide data about their current workforce?**

Yes - we absolutely consider that they should provide data about their workforce.
The RCN has called for providers to produce ‘top level’ nursing workforce indicators including:

- nursing staff in post as a percentage of establishment,
- proportion of nursing staff that are registered nurses
- nursing number relative to population served (or bed in hospitals)
- deployed patient:nurse ratio

However, while much information is available through Electronic Staff Records (ESR) not all NHS providers (Foundation Trusts) utilise ESR and it is not available to Independent Sector providers. The challenge for workforce data supply in relation to nursing is that current workforce data is not sensitive to the range of different roles nurses perform within and across different specialty areas. The ESR currently provides broad general figures on the nursing workforce, which does have limited value.

The Skills Networks and CfWI will need to prioritise the development of core data requirements across the range of different providers. There may be issues about consistency and standardisation to allow meaningful comparison to be made by regulators, commissioners, public etc.

We would suggest that for nursing and midwifery the Nursing and Midwifery Council have comprehensive data that could and should be accessed.

**Question 7: Should all healthcare providers have a duty to provide data on their future workforce needs?**

Yes, we believe they should provide data or intelligence in relation to short-term plans and proposed workforce changes.

However, in order to inform their decisions on future workforce needs, providers need to be in a position to understand future service planning – this can only be achieved if there is an effective relationship with service commissioners.

The RCN has concerns that employers do not have adequate or complete data on all staff and their continuing development. The same issues about consistency and standardisation of data may apply across all providers making it difficult to accurately assess workforce needs.

We believe that this will require consultation with staff and professional bodies and trade unions. We believe the results of this consultation should be shared to allow commissioners to plan accordingly.

**Question 8: Should all healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?**

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Royal College of Nursing (2010) *RCN policy position: evidence based nurse staffing levels.*

RCN London
The success of the Skills Networks and workforce planning system, as described, relies on all healthcare providers cooperating on planning healthcare and education and training and delivering CPD. We consider that there should be a duty to cooperate and that there should be a requirement for skills networks to ensure that all provider voices are accommodated within workforce plans and education commissions. Skills Networks should have a duty to describe how this will occur.

In relation to practice placements - for all disciplines to achieve the quality and range of experience required will require significant cooperation, not just locally but also nationally, to effectively manage the smaller professions who may struggle to find placements within one provider.

We have some concerns about how this will be managed although we accept that HEE will have responsibility to oversee the national issues.

The proposal suggests that this will be managed multi-professionally across a network of healthcare providers but we are concerned at the lack of clarity on how this will function.

We would like to see more detail as to how the duty for providers to cooperate will be applied. What are the levers and sanctions to ensure participation – and who will monitor the level of participation and success of the networking arrangements put in place?

**Question 9: Are there other or different functions that healthcare providers working together would need to provide?**

We believe that there needs to be more emphasis on how the local skills networks will work alongside commissioners to ensure linkage of their plans to that of local services.

**Question 10: Should all healthcare providers be expected to work within a local networking arrangement?**

Yes, but we have concerns about how can this be ensured in a context which creates greater provider freedoms and less regional/centralised control.

We have significant concerns about the lack of clarity regarding the composition, size and exact remit of skills networks. The current proposals provide no mandate or guidance as to how (or which) providers will work together. There is a danger therefore that with the potential of too many small groups there is an increased level of bureaucracy and duplication of effort. We will also need to ensure that large organisations do not dominate the networks, and that smaller services or staff groups are not lost or forgotten.
GP consortia and other commissioners of services need to be actively involved in discussions on workforce planning as there needs to be a link between commissioning strategy with workforce development.

Placement coordination and management by skills networks, rather than individual providers could be helpful and free up capacity in non traditional placements especially if money follows the student.

The RCN understands that there are already some areas where skills networks are being developed. We believe that there would be an appropriate role for the Department of Health workforce team to highlight areas of best practice and provide guidance to skills networks on the engagement of providers.

**Question 11. Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?**

Given the complexities of planning a multidisciplinary healthcare workforce and enabling integrated provision that is responsive to service needs, the RCN is concerned about the lack of clear guidance on planning, or legislation in shaping, these new bodies. The RCN believes that given the critical importance of robust workforce planning systems there needs to be clearer direction to skills networks on core activity, processes and the scope of clinical engagement in decision making. Partnership working with professional bodies and trade unions is essential.

Reference is made in this part of consultation to “health and social education” but we note that there very little throughout the document about planning social care workforce.

Whilst we very much welcome the emphasis on a multi-professional approach we remain concerned that without an independent chair for both skills networks and HEE that a medical influence will dominate.

For nursing and midwifery education the links to local education providers are vital, particularly within continuing professional development (CPD), and at present we believe these links are not clear enough.

Para 5.30 states “We will review the extent to which these powers are sufficient in relation to workforce planning, education and training and how to extend them, if necessary”. The RCN would want more clarity on the potential for a review, and we would want to participate in that review as a key stakeholder.
Question 12: 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?

We are unclear as to what incentives are proposed to ensure cooperation, coherence and consultation.

We believe that additional monies and resources will be required to support the setting up and development of the networks.

Current workforce planning knowledge and expertise within local providers is limited and we would be keen to see HEE and Skills Networks developing strategies for building functions and roles within provider units. We also believe that there should be an available central resource, which can be called upon to support those developments.

We would also suggest that there may be a wider role for CQC in assessing whether providers are meeting their standard to ensure that staffing levels are adequate, thus creating a feedback loop into future workforce plans.

Contracts for education and placement provision need to be of a reasonable length, perhaps 5 years and roll on unless there is a quality issue. Anything less is inefficient and destabilises and distresses both providers.

Incentives for placement contracts should be based on quality and responsiveness and not simply on student numbers.

Question 13: Are these the right functions that should be assigned to Health Education England Board?

HEE looks similar in structure to NHS Education for Scotland - however the numbers of staff and providers in England ensures that this is a much more complex organisation.

We are concerned that given one of HEE’s focuses is on workforce issues that need to be managed nationally, that it might focus primarily on medical and specialist workforce and that the remainder of the workforce (80%) is ignored and only discussed locally.

In line with several other organisations we would welcome the requirement for an independent Chair for HEE to avoid the situation where HEE becomes a new MEE with all other professions sidelined.

Question 14: How should the accountability framework between healthcare provider skills networks and HEE be developed?
We are disappointed and concerned that the consultation does not put forward a proposal for addressing the key issues of accountability and the relationship between HEE.

As presented, it seems that HEE will only oversee national issues but in carrying out this role, they will need to work with skills networks, ensuring national and local plans complement each other.

There are potential tensions between the potentially short/medium term view of skills networks in response to provider demands and the medium/long terms views of HEE for overall workforce needs.

**Question 15. How do we ensure the right checks and balances throughout the system?**

The RCN is particularly concerned that the proposed system offers little in the way of checks and balances – which we consider to be vital. We would welcome much greater detail about the mechanisms and processes that could enable us to determine in the future whether workforce development and planning is happening effectively throughout the country, and whether the objectives set are being met.

We believe that one way to achieve transparency throught the system is to have clear national guidance on minimum standards for all so that the work of the skills networks are consistent and relevant across and within health economies.

There will be the risk of pressure from providers to dilute the skill mix while the emphasis on training will be for training professional groups rather than support staff.

As already discussed, the RCN believes there needs to be stronger links between the new workforce planning structures and the commissioning functions at local and national levels.

**Question 16. 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?**

We consider that the governance structures of HEE need to be particularly robust to enable this body to be truly interprofessional, enable it to deliver a workforce that is fit for purpose and to have credence around the various organisations. We would certainly suggest that an independent Chair is needed to demonstrate that decisions are fair and transparent.

Professional Body and Trade Union engagement should also be incorporated within the governance structure.
Given the role in ensuring quality and professional standards there will also need to be involvement from the professional regulators.

**Question 17: 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 RCN has concerns about ability of CfWI to deliver an effective evidence base on nursing, The CfWI role would be enhanced if it supported skills networks and providers in developing standard data sets, which were more sensitive to the range of different roles within the nursing workforce.

Experience from Scotland, in establishing government/staff side partnership working some years ago and indeed from South Central SHA more recently is that the information that is held locally is not much more than the basic Electronic Staff Record. Information on levels of qualification or training delivered, achieved and in some cases revalidated or reviewed is not so readily available. We believe there will be a significant piece of work to do to create these standard sets and without that we cannot guarantee equitable education provision.

We also consider that more data (and interpretation of it) is required about workforce in non-NHS sector (some of whom will nonetheless be providing NHS services). A better understanding of the independent sector labour market and workforce is needed to inform NHS workforce plans.

The CfWI needs to deliver effective risk assessments in terms of workforce, which can inform decisions by HEE, skills networks and local providers.

We would also see a role for CfWI in looking at the wider UK and EU picture in respect to mobility of the professions.

**Question 18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning board?**

We are concerned that there is a real danger that the workforce plans generated by providers through the skills networks will be disconnected from commissioning strategies – both locally and nationally. We are unclear as to what systems will be in place to affect the ‘responsiveness’ sought or how its achievement will be monitored. Ensuring sector-wide education and training plans are responsive to strategic commissioning intentions will be challenging for pre-registration education, but potentially harder still for post-registration workforce development plans.

One way of resolving this issue might be for HEE to become a formal sub-committee within the NHS Commissioning Board, so formally accountable to
the Commissioning Board for its work. Failing this, there may be value in the Commissioning Board having a seat on the HEE board.

In respect to para 6.12 is not clear to the RCN who has responsibility for assessing the population’s health needs. Overall we would like to see much clearer guidelines on how information will be shared and how we ensure that the system and processes adopted will be transparent.

**Question 19: 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?**

Whilst CQC already regulate providers to ensure that they take measures to determine that their current staffing is adequate, we do not believe they would be in a position to go beyond this role.

The Skills Networks may have a role in ensuring and supporting providers in consulting on workforce plans. Provision of workforce information and cooperation in workforce planning and education and training could be enforced through the service contract – each provider delivering NHS funded services is required to enter into a contract with the appropriate commissioner. The contract allows for compliance with a range of activities and standards – one of these could be workforce planning.

**Question 20: What support should Skills for Health offer healthcare providers during transition?**

We believe that Skills Passports should be made available for all staff so that providers are assured of competencies at least at the point of achieving them. However this raises a number of questions about who will maintain and quality assure them.

We also believe that there may be a role for Skills for Health in training healthcare providers in developing skills and functions to support workforce planning.

**Question 21: What is the role for a sector skills council in the new framework?**

We believe that they could support the education and training of unregistered staff with national frameworks. Working more closely in conjunction with Skills for Health and the standards they have developed we believe that a sector skills council could be the voice of the Band 1-4 staff which is often missing.

**Question 22: How can the healthcare provider skills network and HEE best secure clinical leadership locally and nationally?**
We believe there should be significant further investment in Clinical - Academic careers in nursing which would potentially ensure leaders had both knowledge and practice. Healthcare providers should be encouraged to integrate leadership development across each sector rather than in silos.

**Question 23: 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?**

This paper sets out the goals for professional involvement, which are welcome, but does not put forward mechanisms for achieving these goals.

At a certain level and in some contexts, generic management and generic management training would seem to make good sense. However, the RCN – in conjunction with Dept of Health- have highlighted the vital role that clinical leaders such as ward sisters play, but highlight the paucity of management training or support generally on offer.⁹ Taking this as an example of identified need, we would like to see how this might be addressed through the new system and involvement of HEE.

We believe there needs to be integration across the sector including involvement of royal colleges in professional or clinical development.

**Question 24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?**

We question why there should be a national body responsible for the development of managers when the development of all other types of staff is being managed locally. However we believe this may be a useful approach. We would need to see detailed proposals of how this would work in practice before offering further comment.

**Question 25: What are the key opportunities for developing clinicians and managers in an integrated way both across health and social care and across undergraduate and post-graduate programmes?**

We welcome the fact that all nursing curriculum now includes leadership skills development and consider that moving away form "silo" working would help to integrate staff.

While there is clearly a need to educate and train individuals to meet the requirements of their roles (and professional regulation), we do believe that there are always opportunities to have integrated training as this will help build more effective team working.

⁹ Royal College of Nursing *Breaking down barriers, driving up standards: The role of the ward sister and charge nurse.* RCN London
This approach would allow the service to tap into the resources and expertise of all the Royal Colleges for their clinical and/or professional development. There could also be better use of Management Schools throughout the education sector.

However, once again whilst in principle we can see a number of benefits we would need to see provisional plans in order to evaluate them. We would want to learn from successes and challenges of the past in terms of mechanisms for delivering leadership and management education and training in the NHS.

**Question 26: How should Public Health England (PHE) and its partners in public health delivery be integrated within the new framework for planning and developing the healthcare workforce?**

Planning must integrate and align the commissioning of public health nursing education and patient services; covering all settings and sectors. Capacity for further growth and development of a sustainable public health workforce must be supported at all levels irrespective of where staff are employed.

The delivery of this vision will depend not only on the training and development of public health specialists and practitioners, but also on the professional and regulatory standards to which they adhere.

We believe that it is important that the nursing profession, along with other public health colleagues, discusses the development of a public health nursing workforce supported by comprehensive workforce planning linked to service planning, which has the support and input of commissioners, providers and professional groups.

To achieve these objectives will indeed require PHE and its partners to be integrated into the new framework – and we look forward to learning how this is envisaged so that we can offer our perspectives on the proposed mechanisms, in order to assess whether we consider them to be effective.

**Question 27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities: and what funding should be employed with regard to the public health workforce?**

We agree that we need to be able to make connections between health and social care in terms of developing workforce. Linking Local Authorities into health skills networks covers their role as care providers but what about their strategic commissioning intentions – in terms of workforce planning. How will their commissioning intentions feed into the proposed system?
Certainly Local Authority membership on skills networks may go some way to help address the issues raised in Question 26 but without clear guidance as to the composition of the skills networks, how can participation of Local Authorities (or any other providers) be consistently assured?

**Question 28: 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 RCN firmly believes that the emphasis should be on service-led not provider-led education to facilitate the highest quality patient care. Providers may want to provide the same service as last year, but commissioners, local population, or policy, may mean that the service provided (and staffing associated) needs to change e.g. moving into more community based care.

Previous experience suggests that when finances are under pressure that education and training budgets are raided. This is particularly true for continuing professional development and even more so for lower levels of staff. The RCN believes that training budgets should be ring-fenced and providers should provide data to the Skills Networks on how those budgets are accessed by staffing groups and grades.

Equity in training cannot be achieved while some disciplines get their post-registration education funded and others don’t. Steps need to be taken to address this as nurses too have to take part in CPD to maintain their professional registration. However, much of this happens in their own time and is funded by the staff themselves.

Annual contracts do not facilitate long term or medium planning so we suggest that contract periods be extended – up to 5 years and rolling for pre-registration courses and consideration given to length of other contracts e.g. mandatory training could be considered under 3 year contracts.

We cannot assume that the proposed approach actually can ‘drive excellence, equity and value for money’. Introducing change is generally costly, if it is to be done well and properly implemented and bedded in (as we saw with AfC). The RCN suggests that the introduction of skills networks are phased in supported by a process of shared learning.

We believe that ongoing evaluation and review is an essential part of the system, involving all stakeholders and including service users.

A clear synergy between providers, educators and funders is required. There needs to be equal representation of the health professions for these areas and shared responsibility for the overall education programmes.

There is a need to ensure consideration of 4 country and possibly EU issues.
Question 29: What should be the scope for central investment through the Multi-Professional Education and Training budget (MPET)?

We welcome the continuation of the MPET funding for pre-registration training but question where the money for CPD is to come from? Central investment would need to continue to fund those smaller professions eg speech and language therapists, optometrists etc whose training will not be facilitated through a local skills network. It will also be required for some specialist training both in medicine and nursing.

Question 30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?

Funding streams for education and training need to be linked to service commissioning strategies and QIPP initiatives. The RCN believes that openness, fairness, equity and publishing regular audit updates is the absolute minimum.

Question 31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risk to providers?

We believe that this raises questions of timescales and the speed with which all of these changes have to be implemented and we suggest that it is almost certainly going to cause instability and carry some risk with it in the short term.

To ameliorate this we would suggest that early consultation takes place and that a degree of transparency and openness is incorporated into that consultation. We would also suggest that longer contracts, where appropriate, should be implemented.

The tariff for clinical education has to be in line with the recent Browne review. There is a concern that clinical education will be too cheap for the universities to sustain and that this needs to be costed appropriately. There are risks to the universities within this process too, so a transition framework needs to be established to oversee all training/education of providers and encourage synergy with all partners at a senior level.

Question 32: 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?

We would require more detail on both to answer this comprehensively but we believe that tariffs need to be determined independently and transparency re data used - including variation in costs-relative to variation in success, outputs, and attrition rates etc.
Question 33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?

This may well seem to be the fairest but we could not accept a national average cost as the basis without knowing more about how actual costs vary e.g. smaller branches of nursing e.g Learning Disability cost more than larger ones. We would also wish to know whether the variation is due to unavoidable variation in costs, or associated with benefits in proportion to additional cost.

Question 34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

We believe that there is a need to establish training needs of all staff from Level 1 i.e. a “baseline” in order to assess cost. We would also require proper assessment related to associated benefits, exploring regional variation etc.

Question 35: What is the appropriate pace to progress a levy?

We think this should commence slowly to allow for learning from engineering, law etc which already use this system.

Question 36: 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?

Yes, we believe that all organisations should be covered by the levy, not just those delivering NHS funded services. However any model that achieves this will be complex and will require adequate time and early consultation to establish.

Question 37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?

This could be a consideration in designing the levy, but as already discussed, any model will be complex and will require engagement of all stakeholders.

Question 38: How can we introduce greater transparency in the short to medium term?

We believe that this will only happen if systems are open and transparent in relation to decision making, involving stakeholders in the decision making and ensuring information is publically available.
Question 39: How can transaction costs of the new system be minimised?

It should be and needs to be recognised that change costs. There will need to be additional up front investment required to get new systems and mechanisms off the ground and then to allow for proper development and ensure that the correct checks and balances are in place to monitor the whole process.

Question 40: What are the key quality metrics for education and training?

The first are quantitative metrics under 4 themes with examples on these can be measured:

- Financial – value for money, waste, money generating,
- Research performance, research grants, papers published, doctoral students etc
- Operational - number of mentors on placements, number of lecturers per student, student survey
- Learning and growth – Student pass rates, progression, attrition

Qualitative indicators would explore the learning growth and student experience in more depth.

Question 41: What are the challenges of transition?

We believe the biggest challenge for transition is the proposed timescale and the relentless drive for change, happening at a time when the NHS is under intense financial pressure. The danger is that in the interim, before a new system has been fully established, changes to the number of commissioned places may be made on the basis of cost savings that have long term consequences.

For example, the steady reduction in investment in the number of health visitors and district nurses trained over the last decade has had a knock on effect on the educational infrastructure for these groups. This is difficult and slow to reverse. Hence the enormity of the challenges we face in meeting the Health Visiting targets set for 2015.  

More recently, in relation to midwifery numbers, the ability of the government to implement its policy on maternity care was threatened by proposed cuts in the number of midwifery training places.  

DH London
11 Nursing Standard (March 16-22, Vol 25, no28) Research spurs U-turn on midwifery training
We are extremely anxious that security of supply as outlined in the objectives of this paper is put at risk unless extremely robust transition arrangements are put into place. We see little evidence of this in the suggested process.

The RCN proposes that during the transitional period, training places are maintained at their current levels until the new structures are fully operational and bedded in. Any changes to the number of places commissioned should be subject to public scrutiny to ensure they do not undermine future service delivery.

**Question 42: What impact will the proposals have on staff who work in the current system?**

The RCN would hope that successful implementation of these plans would have a positive impact on nursing and midwifery staff at all levels in that there will be appropriate and adequate training for all staff. However, we would require assurances that, given current experience where medical education takes priority within budgets, that there would be fair and equitable distribution of education and training budgets, which includes Health Care Assistant staff. We would also be seeking assurances, in the interest of high quality patient care, that healthcare providers are held to account for the education and training they provide for staff.

**Question 43: What support systems might they need?**

Given the extensive changes within the NHS it is likely that staff will be particularly anxious about their future. Good communication plans about the proposals, about how they can influence what might be happening would be of value.

**Question 44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?**

CFWI needs to provide better quality and more detailed analysis of current nursing and other professions workforce (in health and social care) and projections in relation to supply and demand. There is little evidence that it is prepared for this role or that the healthcare providers indeed have the information to give them. Accordingly, perhaps one of the support roles during the transition period is to examine the requirement for like-for like data sets throughout the system and to establish what these might be and how they may be collected, collated and shared.

It is fundamental to the success of any workforce planning and delivery on education and training that we have the relevant data and intelligence to inform that planning and commissioning
Question 45: Will these proposals meet these aims and enable the development of a more diverse workforce?

It is unclear how these proposals will or will not meet the widening participation agenda or indeed deliver a more diverse workforce.

Question 46: 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?

We were disappointed to note that there appeared to be no equality impact assessment with this consultation.
We know that a disproportionate number of BME staff are employed at the lower levels of healthcare staffing and we would be concerned if they were disadvantaged in this proposal.
Appendix i

Consultation process and participation

The RCN used a number of methods to engage with its members and other stakeholders from a broad coalition of public health bodies on the Education and Workforce consultation.

Information was placed on the RCN website on the Education, Student and Newly Qualified nurses sites for members to engage with the consultation.

Information was also sent out in the Education Forum newsletter.

As part of the consultation with RCN members, a factual briefing of the key themes in the consultation was provided.

A Council of Deans evening event was held to discuss impact of the proposals.

Representatives from the RCN Nursing and Employment Relations Department took part in a House of Lords seminar.

RCN participated in various Department of Health meetings discussing the options.
Appendix ii

Assurances required by the RCN on the NHS White Paper

The RCN believes there are a number of assurances which the Government must provide in order to ensure that the proposed reforms will work in practice to deliver a health service which is sustainable and fit for purpose.

NHS principles
- The proposed reforms must support the founding principles of the NHS, namely that it should be universal, provided free at the point of delivery, based on clinical need and not ability to pay, and financed through taxation.

National pay
- The RCN opposes moves away from national pay arrangements or the undermining of the Agenda for Change package.

Pensions
- NHS pensions must be protected and portable. All staff delivering NHS services must be guaranteed access to the NHS pension scheme.

Nursing leadership
- Existing nursing leadership expertise and skills must be transferred to new health and social care organisations. Capacity for further growth and development must be supported at all levels across the healthcare system.

Education and training
- There must be national oversight of nursing education and mandatory training. Planning must take into account the need to integrate and align the commissioning of nursing education and patient services; covering all settings and sectors and both the medical and non medical workforce.

Commissioning
- Nursing must be represented at a senior level in general practice commissioning consortia and on the NHS Independent Commissioning Board. Nursing expertise must also be recognised and utilised at all levels of the commissioning process.

Public and patient involvement and engagement
- There must be full engagement and consultation with patient and service-user groups, and the wider general public; and the reforms must gain demonstrable support from both before being introduced.
Outcomes framework
- The nursing contribution to the NHS Outcomes Framework must be explicitly recognised.

Workforce planning
- There must be robust mechanisms in place to ensure the nursing workforce is sustainable and fit for purpose. This should include a mechanism for national oversight and integration between medical and non-medical workforce planning.

Pilots and phasing
- Structural reforms should be piloted and publicly evaluated. Reforms should only be phased in if evaluation proves that they are successful.

Political accountability
- There must be clear mechanisms by which the tax payer can hold ministers as well as those responsible for commissioning, delivering and overseeing care, accountable for the NHS funded health and social care services.

Health inequalities
- To prevent the widening of health inequalities, there must be clear mechanisms in place to monitor and address unacceptable variations in service quality/access to services.

Freeing NHS providers
- The Government must set out a blueprint for a system of effective checks and balances designed to provide for a level playing field for providers and commissioners, and prevent the fragmentation of healthcare in England. The system must be developed to work for the whole country, providing guaranteed standards of sustainable, safe, high quality and efficient healthcare for all patients throughout the country.

Co-operation and competition
- The Government must demonstrate how it will ensure that a fragmentation of service provision does not become a barrier to collaboration and the sharing of information, knowledge and best practice.

Social enterprise
- Staff must take a positive decision to work in a social enterprise, following comprehensive engagement and a staff ballot. All staff delivering NHS services must have guaranteed access to the NHS pension scheme.
Regulation
- The Government must demonstrate that there will be adequate regulation to safeguard the quality and safety of patient care. Providers must be able to demonstrate that nurse staffing is sufficient relative to the needs of the patients/clients they serve. There must be a balance between the emphasis on economic regulation of the health and social care service and the quality of care delivered.

Systems management
- The Government must demonstrate how it will manage the risks associated with system reform and ensure that NHS funded health and social care commissioners, provider organisations and regulators work effectively together to maintain the delivery of a sustainable, safe, high quality and efficient service. It must also be clear how the transition costs of reorganisation will be met.

The Health Bill
- The team responsible for the forthcoming Health Bill should include and be supported by advisers from across the nursing profession.