RCOG response to consultation

Chapter 2

Q1. Yes

Q2. Yes. The concept of local skills networks fits well with the RCOG structure of training in programmes. However the risk of loss of quality is high if these networks are not linked to a) regional and b) national standards for our profession both in terms of education and clinical care and if they do not provide a flexible approach that allows trainees to follow patients and access high quality training throughout the curriculum. A myriad of different provider approaches within a 'distant' high level regulatory framework increase the risk of differing levels of quality and losing the impetus for improvement.

Chapter 3

Q 3.

3.1 Workforce planning in medicine is complex and requires sophisticated planning based on accurate data, appropriate engagement with stakeholders planning the future care models and sustained dialogue between all areas of healthcare including clinicians, experts in education and users. The relationships that are developing between the CfWI, employers, the service and the medical Royal Colleges are still relatively new and need reinforcing. The pace of change and the lack of any structure outside a Skills Network puts at risk difficult decision with reference to medium and long term planning from the short term pressures faced by employers and service providers. To keep and develop the key strength of a workforce planning system that reflects short, medium and long term strategies the RCOG would want to see the links maintained between the CfWI and our expert advice on workforce and future professional and clinical developments.

3.2 The RCOG has championed the role of consultants in the front line of service delivery. A new approach must reflect the complex nature of postgraduate medical training; the RCOG represents a wide range of doctors trained to work in all areas of women's health. Our trainees provide a large amount of 'service' and any workforce plans have to reflect the complex interactions necessary to safeguard patient care as the system changes. While the RCOG welcomes an increased role for local providers in planning the future workforce needs of a population the risks of very rapid or poorly planned changes are significant.

3.3 The RCOG strongly supports the emphasis on education and training as vital to the future improvement of patient care. However the daily pressures at local provider level can be counterproductive to this aim. The RCOG is aware of the importance of local providers and employers valuing consultant time in education, training and

research in an equitable manner and protecting this part of the service during this challenging financial period.

3.4 The reference to 'deanery functions' needing to be transferred is of concern to the RCOG. The role of the Deanery Schools of O&G has enhanced the quality of education and training and transferring these functions to a Skills Network risks destroying the effectiveness, economies of scale and concentration of expertise that have developed over the last 5 years. It is not clear in the consultation how the quality management framework would reflect both the requirements of the regulator or improve the quality of training if the Skills Networks were to be the single organisational level reporting to HEE. The expertise both professional and managerial within the postgraduate deaneries and the RCOG is maximised through the Schools and has led, for example, to a most successful national recruitment programme maximising efficiency, minimising resources including consultant time to recruit but involving all areas through local consultant input.

Q4.

4.1 The emphasis in the consultation on workforce planning is understandable however postgraduate medical training differs from that of other healthcare professions as the primary links are between the service, where training takes place, the Royal Colleges who set the standards and the programmes and the postgraduate deaneries that manage the delivery of the programmes in their totality. The role of the GMC as regulator and its predecessor the PMETB have lead to significant improvements in the quality assurance processes. There is an opportunity for Royal Colleges to enhance their role in terms of raising the quality of education and training and hence the standards of patient care. The RCOG would want to keep the present School (regional) structure and would want to agree national quality metrics and key performance indicators for each School. Local Skills Networks would then be able to quality control their individual training posts/programmes against clear standards and commissioning of training would be against a nationally agreed, professionally set benchmark.

The benefits of postgraduate medical education and training in the UK are widely respected not least because the input of the service is beyond that of a University. The links between different aspects of care and trainees exposure to different service models encourages innovation and develops high levels of competence throughout a training programme not just at its completion. The RCOG strongly supports the delivery of care through consultants in 'front line' service but recognises the transition to this model is not immediate and that the model needs developing to reflect local variations in service need.

The RCOG curriculum is designed to provide the flexibility demanded by the service within the final two years of our seven year programme. Linking the local and

regional workforce plans more effectively into educational planning would allow focussed development of doctors with the skills necessary for a local provider. There is however no evidence that local providers will be willing or able to perform this function of *'commissioning the education and training that will achieve the right workforce'.* The RCOG would welcome close collaboration with regional and local workforce plans and has detailed, annually collected workforce data available to inform planning.

The cultural shift necessary to move the service from dependent on trainees to being delivered by trained doctors is significant and the RCOG has extensive experience of complexities that such a change produces. It is important to recognise that the education and training of doctors must continue through any changes generated and that sustaining present training programmes, educational opportunities and the production of high quality professionals is vital. Doctors presently in training will be the future educators and leaders as well as providers of patient care. The impact of uncertainty and constant change on this generation must not be under-estimated. The Royal Colleges have a significant leadership role and the RCOG would work with our Fellows and Members and through the Academy to provide professional support and advice. The RCOG sees the Postgraduate Deaneries as partners in providing the medical expertise managing training and is concerned that transfer of deanery functions to an unclear organisation is a significant risk. It is unlikely that Skills Networks will provide the economy of scale for efficiency or the overarching quality assurance necessary for high quality education and training.

The establishment of HEE will provide the opportunity to plan the medical workforce in conjunction with other health care professionals and coordinate both workforce numbers and educational opportunities from medical school through to completion of specialist training.

Chapter 5

Q5. The RCOG believes that providers must consult with patients, local communities, staff and commissioners about the development of the health care workforce. It is essential that education and training provision are integral to any plans and the RCOG has patient users and trainees on all education and training committees to ensure that we have wide participation in every aspect of developing high quality training. The policing of such involvement should be by commissioners and must be robust. The model of self policing for Skills Networks with regard to both workforce planning and the quality of education is not aligned with best practice in quality assurance.

Q6. The availability of accurate data that is triangulated from several sources is an absolute requirement for effective workforce planning. Local providers must have a duty to collect accurate data and a standardised data set should be developed. The

risk of individual, small Skills Networks developing is that differing nomenclatures, different data sets and drivers for change will appear making rational large scale, regional or national planning impossible. The quality control of data needs to be agreed and the role of the Royal College census information should be to provide longitudinal information mapped to national trends supported by the CfWI analysis.

Q7. Individual providers must be required to cooperate on planning the healthcare workforce and planning and providing professional education and training. The availability and transparency of data used to inform workforce decisions should not only be with providers but also with the CfWI and Royal Colleges.

Q8. Cooperation and collaboration between all providers of in workforce planning and the delivery of education and training is vital. The National Health Service requires more than a simple local focus if high quality care is to be enhanced through innovation and education. The risks of a single provider not acting in a cooperative manner are to patient safety and the sustainability of the service. The process by which cooperation is assured needs to be clarified.

Q9. Providers need to collaborate to deliver the complex, integrated education and training for postgraduate doctors. The RCOG curriculum requires exposure to the totality of Obstetrics and Gynaecology and an individual unit may only provide a segment of learning. Commissioners need to have the knowledge and expertise of each curriculum and the standards required in order for education and training to be delivered at high quality across a matrix of providers. The size and content of Skills Networks are not defined and the models proposed need to ensure that they can reflect the complexity and richness of postgraduate medical training. The efficiencies required mean that providers must work together to reduce both costs and administrative impact on the service. The deaneries have developed good working practices in collaboration with the Royal Colleges through the Academy to reduce duplication, maximise efficiency through electronic processes and reduce individual consultant time spent not in service or training pursuits. Any changes to the system must plan for transition so that trainee doctors are not compromised and the service maintained.

Q10. The RCOG supports the view that all healthcare providers should work within a network and that the responsibilities of a network are clearly defined with respect to the quality of education and training and the future workforce of the NHS. The structures around and within a local Skills Network are difficult to define given the complexities of commissioning and providing within the same framework. However with HEE in a commissioning role it would seem to be necessary to have a level

'above' a Skills Network to reflect regional and local commissioning and quality assurance. There have been a multiplicity of new terms suggested in recent years and very clear definition of both form and function is needed of duplication is not to result from poorly managed transition.

Q11. The RCOG is supportive of local providers taking greater ownership for planning and developing the healthcare workforce. The RCOG is aware that the quality of data provided by local providers is much improved if there is a sense of shared responsibility and shared outcomes. The RCOG offers both clinical and educational standards that can inform both providers and commissioners however the effectiveness of high quality planning is likely to be much greater in partnership than in single providers.

Q12. Incentivising high quality is likely to be more effective than introducing penalties however the RCOG would want to see organisations that value education and training and perform at high quality levels benefit. Consultant-delivered care will change the ratio of trainees to trained doctors in the workplace and some units will no longer provide training. Developing quality metrics and an ethos of education for the future care of patients will enable training to be placed with providers of the highest standard.

Chapter 6

Q13. The RCOG supports the functions for HEE as described but the needs of the medical profession in terms of education and workforce planning are significantly different and more complex than those of other healthcare professions.

Q14. The integration of the medical specialties while maintaining the very separate needs of each risks being subsumed within HEE. MEE has provided the focus and concentration necessary to debate major challenges, deliver both workforce and educational transformations by having a Medical Programme Board. The RCOG would support the cooperative, focussed work of the MPB and the Task & Finish groups reporting to the board. Without a clear structure supporting HEE the ability to deal with large scale risk or to provide leadership will be fragmented.

The RCOG supports HEE being the responsible body for all supply issues concerning workforce. Delivering workforce changes, particularly if this requires reduction in training numbers, has proved to be difficult when translated into the local environment and a clear mandate for HEE to take this responsibility would be welcomed. The maintenance and development of the workforce needs constant vigilance and the funding for this should be controlled by HEE. If funding for education and training is diverted into the service it risks being diverted to manage short term service crises.

The accountability between local Skills Networks and HEE is difficult to define exactly until the constitution of a Local Skills Network is agreed. The RCOG has expertise in setting the standards for education and training and workforce requirements and would want to contribute through our local representatives to Skills Networks recognising the need for a national overview. There are functions currently provided by the Deaneries that are national and could not sit within local Skills Networks. Similarly the local and regional commissioning developed by Deaneries with SHAs needs to be reflected in any governance and accountability structure and does not appear in the HEE – Skills Network proposal. The success of the professionally lead Schools in O&G has been because of their accountability to the 'region' with representation from each local provider, experts in education, trainees and lay representatives. The reflection of national policy is therefore through the regional and local structures and should be preserved.

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

Local Skills Networks must be large enough to be able to provide education and training for the generality of patient care. It needs to be clear how a network will function if one provider declines to, for example, follow agreed workforce proposals. The relative 'power' of individual providers may lead to inequitable distribution of resources both human and financial. One of the major benefits of the Calman reforms to postgraduate medical education in the 1990s was the 'spread' of trainees rather than the single hospital focus previously. Good management of the networks needs to encourage 'learning from others' and the best use of such expertise offered by, for example, Royal Colleges.

The commissioning element of education and workforce numbers should be a separate function from those if a Skills network. The RCOG supports the view that there are economies of scale and efficiency if there are regional level structures working with a number of local Skills Networks. Present deanery functions cannot be transferred to Skills networks as this would increase the bureaucracy and reduce the efficiency within the system allowing the disruption previously seen. The risk to the present well respected recruitment of trainee doctors should not be underestimated both in terms of potential disruption to the service but also with respect to 'buy in' to the wider opportunities offered in the proposed structure. Even if regional commissioning structures were transitional the reduction in anxiety about the pace of change and the opportunity to develop Skills networks across all healthcare professions would provide significant impetus for the new system. Many deaneries have moved towards a commissioning model with first line local providers beginning to make impacts on the quality of training. Protecting and enhancing this function regionally will allow the checks and balances within the HEE to local Skills networks be developed.

Liberating the NHS: Developing The Healthcare Workforce - RCOG response

Q16. *How should governance of HEE be established so that it has the confidence of the public, professions, healthcare providers, commissioners of services and higher education institutions?*

The RCOG would support the role of Medical Director or Director of Medical Education England as Board member of HEE. This individual should chair the equivalent of the present Medical Programme Board and offer leadership to the community of those responsible for all aspects of medical education. Each of the healthcare professions will be represented on HEE but the increased input of medical professions to a MPB through the Royal Colleges would strengthen the decisions about the details of medical training numbers and training.

The relationship between HEE and the GMC as the medical regulator need to be defined. If innovation and new ways of training the medical workforce are to emerge then a clear definition of both HEE and the GMC's responsibilities is imperative. The role of the CQC and Monitor as professional regulators is indentified but the complexity of the inter-relationships between all the regulating bodies puts stress within the system with the potential for poor management of problems within a network because of misunderstanding. The role for regional commissioners (the present deaneries) in holding networks to account within the regulatory framework and being accountable to HEE provides a mechanism for quality assurance and challenge.

Q17*. How do we ensure that the Centre of Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?*

The CfWI needs to work more closely with the Royal Colleges. The RCOG is responsible for training in Obstetrics & Gynaecology and all the sub-specialties. We work closely with the Specialist Societies who have the expert, detailed knowledge of medical advances, the standards of care and the requirements for a trained workforce in their area of interest. Involvement at all stages of the CfWI work would be valuable and is not secure at present. The models developed to date by the CfWI are not as forward looking as the RCOG would wish and do not reflect the intelligence provide by our membership working within the service. Influencing the culture of medicine is an important component of the leadership offered by Royal Colleges and would enhance the effectiveness and implementation of workforce plans developed nationally.

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

The RCOG recognises the need for workforce plans to be aligned with NHS commissioning plans. However the independence of HEE is necessary if the drive for high quality education and training are not to be subservient to short term

workforce 'fixes'. The support of the professions for a national entity will be undermined if it does not function autonomously.

Q19. *Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and cooperation in planning the workforce and in the planning and provision of professional education and training?*

The RCOG supports the need for providers to cooperate with all data necessary to prove quality and support workforce planning. The local Skills Networks will have the duty to produce coherent workforce plans for network that reflect commissioning plans regionally and nationally. The risk of poor compliance from within a network or from a whole network emphasises the need for, at least transitional, arrangements at regional level as commissioners responsive to HEE.

Q 20/21 – not applicable to the RCOG

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

The impact of the proposed changes needs to be communicated widely and effectively to the medical profession. Engagement of both trainees and consultants needs to be timely and iterative. The RCOG has had considerable interest from members providing input to the consultation and can be a vehicle to aid communication if involved at all stages. The RCOG values clinical leadership and has a number of fora where national issues are debated and framed in terms specific to our specialty. The college would support HEE working directly with our college and with the Academy to ensure senior medical leadership input. At local Skills network level the RCOG values the expertise of the Heads of O&G Schools; senior clinicians jointly appointed between the RCOG and the local deanery and with considerable educational and organisational expertise. Local networks should have a link to a School or perhaps to 2 Schools geographically to ensure continuity from the present system and to provide the network with specialty specific expertise.

Q23. *In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?*

The RCOG has significant leadership and management skills training within the approved curriculum. The newly established Faculty of Medical Leadership and Management will provide focus for activities in these important areas and the colleges are closely involved. Integration of both leadership and management skills further would be welcomed and support from both HEE and commissioners will drive this agenda.

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

The RCOG strongly supports the development of exam work both within our curriculum and in all areas of our clinical practice. Team work does not just refer to healthcare professionals but should involve management. If HEE is responsible for both clinicians and managers developing leadership skills then team work and communication at all levels in the NHS will be enhanced.

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?*

Chapter 7

Q26/27. The RCOG would support Public Health having a high profile within HEE and at local level representation through commissioners. Local Skills networks need to be of sufficient size and reflect local public health issues through the relevant local authority.

Chapter 8

Q 28-39 – no comment

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

The RCOG has worked and collaborated with the Academy to develop quality metrics for education and training accepting that more development that is evidence based is necessary. All measures should be based on assessments of trainees, trainers and the training environment. The high stakes measures provided by postgraduate examinations need to be utilised in the context of integrated training programmes and must reflect the application of clinically relevant knowledge. The relationship between HEE and the regulator with reference to the components of quality metrics, their application and the management of the quality reports produced needs to be clarified.

Chapter 9

Q41. *What are the challenges of transition?*

The timescale: The development of Skills Network, HEE and the alterations to the funding structures are proposed within a timescale that seems extremely optimistic. The risks to the quality of training and the accountability of the education that produces the next generation of consultants is significant if transition is not planned, funded and provides the opportunity for reflection and fine-tuning. The focus inevitably will be on the development of primary care commissioning for service and this potentially will conflict with best education practice. There is no clearly described collaborative process for service and education commissioning that will reflect the

complexities of national, regional and local workforce planning. The governance nationally in the form of HEE needs to be in place with a regional support system so that the expertise of the Royal Colleges and the deaneries is not lost as the new structure of Skills Networks emerges. Education and training of doctors cannot simply stop or be pushed into a new system immediately. The NHS relies on doctors in training for the majority of out of hours service work and the length of the training programmes reflects the education and training requirements and the service provision provided.

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

The increasing collaboration between the CfWI and the RCOG is to be welcomed as the College has detailed workforce and activity data as well as being able to 'horizon-scan' for innovative clinical developments that will change service provision in the future. The RCOG sets the Standards of Care in both Obstetrics and Gynaecology for doctors in this specialty and for service providers. The role for the CfWI in interpreting data from the College into the national workforce plan with other health care professionals will continue but the effectiveness of the CfWI will be enhanced by close, detailed work with each specialty and a recognition that each may require different analyses and approaches.