



Plymouth LINK Support Team  
Unit 15  
HQ Building  
237 Union Street  
Plymouth  
PL1 3HQ  
Tel. 01752 202407  
Email: [info@plymouth-link.co.uk](mailto:info@plymouth-link.co.uk)

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## **Plymouth LINK's response to proposals contained in the Consultation** ***Liberating the NHS: Developing the Healthcare Workforce***

This response is based on feedback themes received by the Plymouth LINK and two individuals' responses (the latter are shown in yellow and blue boxes) from our Stewardship Group.

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

The objectives stated are certainly important. Feedback to Plymouth LINK highlights a need for a workforce that has flexibility to not only meet the clinical needs of patients, but also an awareness and ability to respond to patients' individual needs. This comes not only from training but recruiting staff with positive values and ethos that will respond to diversity in a positive way. Under widening participation Plymouth LINK would recommend that this also relates to involvement in services of patients from all sections of the community through building a workforce that can understand and meet their needs.

Feedback recently has also highlighted the difficulties where health professionals have left and subsequent issues of patient care being picked up in a timely manner before deterioration of their illness. Within the security of supply, this should extend to ensuring consistent, seamless services to patients, despite workforce changes in all areas of services (Plymouth LINK are particularly aware of issues within mental health services).

Yes, with the proviso that the Security of Supply objective includes an acknowledgment that the term 'appropriately skilled' means there will be a nationally approved core basic standard for all the front line roles

Agreed: however with what appears 'choice' the danger is that high skill staff will migrate to those centres leaving a void?

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

Yes, however there is no reference to the principles of a basic core training for the workforce, which would be supported and monitored to ensure consistency in approach. This core training should be in appropriate areas (those identified as important through feedback to Plymouth LINK, for example, would be equality and diversity, partnership working and patient involvement).

The bullet point about sustainable and transparent investment in education, and ensuring that funding allocated is spent only on those initiatives, must apply to all budget heads. There could also be an additional design principle about engagement with existing post holders, at all levels, to help shape the future.

Again above; but also who dictates local training needs; budget holders-GP consortia funding their priorities? There has to be joined up dedicated consultation that is transparent to needs and not specialities; even acknowledging gaps in specialist/non specialist local need. Choice is dependent on being able to afford travel/child care costs/lost wages etc. allocated funding must not be dedicated to GPs but to patient need.

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

It is important to continue to implement skill mix changes, which will be more responsive to patients, also accountability to overarching bodies that can maintain a picture of training pathways, considering demands for professional skills, etc., continuing (and building on) the patient focus.

The existing local knowledge and continuity.

LINks; communities are expected to drive forward change.

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

- Involving patients more in the training of the workforce, reinforcing patient focus and experience of services so that the emerging workforce considers this a priority alongside clinical outcomes.
- A wider view of training and development that builds on formal courses to enable skills development through mentoring and experiencing service provision first hand.
- Workforce planning should be done in partnership with the workforce to ensure ownership, success and relevance.
- Working in partnership with groups such as LINk and HealthWatch will support services to focus training where it is needed. For example, as part of work with NHS Plymouth on improving access to primary care services, Plymouth LINK has raised the challenges of people with a visual impairment. This will go on to form part of training for GP staff next year.

a) Reducing health inequalities, b) Enhanced engagement with patients, carers and voluntary sector. c) Development of meaningful measures and methods of communicating same, internally and externally.

**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?**

Yes, it is absolutely vital that local people are involved in developing the workforce. Local people can help services identify issues and gaps in skills of service providers based on real experiences, which will have an impact on the health, treatment and recovery of future patients. Public consultation has often been seen as a tick box exercise, so providers need to show that this has happened in the widest sense (for example, with their own patients and the wider public) and are monitored on their involvement and the outcomes (how involvement has shaped workforce development).

Yes - and effectiveness of communication should be a performance measure.

Of course agree but return to representation within consortia;

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

Yes, it is a provider's responsibility to know the makeup of their workforce in order to ensure they have trained staff that are legally compliant and can deliver services. This information should be shared to create a local and national picture. This should form part of achieving the monitoring of a contract to provide services.

Yes - BUT against what national basic skills criteria will this be compared? Also who is this information to be provided to and how, as this will establish how much this will cost?

This must be part of an overall healthcare performance strategy; Social service PCC consortia; that empowers the holistic to be studied against 'best performance, and against national targets; only then can improvements be targeted inclusive training and retention needs. Cost should be built into QIPPs budget, locally and nationally.

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

Yes, forward planning of workforce needs will allow providers to respond to increases in use of services or emerging unmet needs. Data will allow for targeting of training and recruitment to meet developments and changes in service provision. Data can help to provide a national picture to influence skills development, resources and commitment. The need to provide such data will force providers to proactively consider the future and should be based on a range of different information (including local feedback and priorities gained through HealthWatch). Providers should have to evidence the consultation and how their future workforce needs respond to and meet the needs of local people, the issues they face, their experiences of services and improvements for the future.

Again who is the intended audience for this information and is this the sort of priority the Public would want. After all when a member of the public wants a plumber in the middle of the night, the priorities are availability, cost and competence, not whether the parent company has an all singing, all dancing future needs skills profile

Yes they do . . . the public is the community; the information provided will be an instrument of accountability; it then becomes possible to 'choose' best practice rather than 1<sup>st</sup> entry in yellow pages.

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

Yes, the breadth of professional education and training will help to ensure that the workforce has a broad view of healthcare, a greater awareness of partners/services and understanding of a patient's pathway. Feedback to Plymouth LINK shows that local people often experience a narrow focus on their health, which doesn't take wider issues into account or work with wider services to deliver a comprehensive package of care.

Professional training should span acute, secondary care, adult social care and the third sector (where possible and realistic) to ensure that health professionals have a better understanding of the context in which they provide a service. Workforce experience in other settings may not necessary be relevant to a specialism but will help staff understand treatment and follow up after a referral, for example, or how health and social care services work together. Providers' duty in relation to this should extend to involving patients, HealthWatch and others to plan and be involved in training. Patients who have experienced a service are best placed to educate staff on delivering a service to meet patients' needs.

This is a double edged sword because if localism is the desire then central government must be prepared to accept that some health care provision will come from small business's and the voluntary sector who do not have budgets for training opportunities to the same extent that large businesses do.

NGOs have taken a severe cut in finances and are severely concerned regarding future cuts; training resources (MIND for example-mental health (hate that word)); the 3<sup>rd</sup> sector cannot afford the future perceived training requirements and less fashionable concerns & specialist NGOs will lack an up-to date trained workforce and volunteer base.

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

As well as the functions listed, a skills network needs to evaluate the training and education of the workforce – is it meeting the needs of providers and patients? Is it effective? The function of ensuring continuous improvement should apply not only to postgraduate education but all training and development programmes.

No response

above representation of Healthwatch in the process to highlight community concerns and gaps in provision

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

Where Plymouth LINK hears increasing experiences of services not working effectively together to provide healthcare to people (its core business) there is natural suspicion that it will be difficult to set up a skills network that providers have to work within. LINK members' concerns about smaller providers and capacity for involvement are important. Also, in a climate where there are a number of strong networks already in existence and a growing number of groups and bodies (Health and Wellbeing Boards, HealthWatch, consortia), the need for another organisation to encompass providers will be challenging.

Providers will need to register with the CQC, talk to HealthWatch, be accountable to the commissioning consortia (or Commissioning Board), be regulated by Monitor, work in a more competitive way to achieve in a climate of 'any willing provider' and also actively work within a providers' skills network.

This will present a challenge for providers and use of existing networks could help to minimise the need for additional responsibilities which small providers in particular will find challenging.

This also raises the questions – who will the skills network be accountable to? Who will lead it? There may be an argument for a function within the Health & Wellbeing Boards to oversee the workforce development strategy as part of commissioning for local people.

Plymouth LINK support the need for involvement and accountability of providers, but recommends that implementation is carried out where possible through other existing/planned channels.

Again what about small businesses and the voluntary sector.

Yes but there are ownership issues in NGOs which become protectionism; only support in accepting roles in the holistic that can again only be viable through representation

**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?**

The relationships between healthcare providers and education providers are important; however the relationship between healthcare providers and HealthWatch is as important. Plymouth LINK receives much feedback relating to services not understanding patients' individual needs. Patient views and experiences are essential to the planning and development of the healthcare workforce and should be reflected within the duties and accountability of skills networks.

No response

NO planning and control do not exist; funding does not permit individual provision within the 3<sup>rd</sup> sector

**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?**

Plymouth LINK recommends that consultation with patients and local people should be ensured and that this can be achieved through a strong voice and representation in the structures influencing workforce development (within the skills network).

No response

representation

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

Yes, point 3 – promoting high quality education and training that is responsive to the changing needs of patients and local communities. This function needs to ensure, as part of continuous improvement, that patients are able to support the evidence that education and training is delivering patient-focussed services. In order to make the board effective in delivering these functions, it should be able to enforce change.

What 'teeth' will HEE Board have if their recommendations / guidance are ignored?

See 6

**Question 14: How should the accountability framework between healthcare provider skills networks and HEE be developed?**

Within the framework, there needs to be clear accountability to patients and service users and carers through a strong representation at HEE and skills network levels.

HEE could establish core standards. Skills networks would then have the right to meet those standards in whatever way they feel best suits local needs / conditions. But there needs to be penalties for those skills networks not meeting the standards.

Only Payment by performance is being advocated; needs must be to address those who cannot reach basic standards. Enforcing two tier provision and increasing NHS post code lottery

**Question 15: How do we ensure the right checks and balances throughout all levels of the system?**

A set of standards that covers responsibilities and accountabilities at all levels. A strong patient voice and contractual responsibilities for providers, including responsiveness to patient feedback.

A combination of audits and inspections, supported by feedback from groups like local HealthWatches

No response

**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?**

Governance should be developed, influenced by, and involve service users and carers through groups such as HealthWatch. Ownership and involvement of frontline workforce will also support confidence. The HEE Board should include representation from NHS commissioning Board, CQC and HealthWatch England.

By ensuring a wide and diverse range of stakeholders are engaged, including rank and file health employees.

No response

**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 description of the expertise of the Centre for Workforce Intelligence relates to labour markers and risk management. There is no mention (although this may well feature) of patient experience data contributing to the expertise. Plymouth LINK throughout the consultations have promoted the importance of patient experience and feedback (such as that received by Plymouth LINK) in modelling services for the future. Such feedback should support the picture developed by the Centre for Workforce Intelligence.

Establish clear measures including such factors as % staff turnover; % long term vacancies; % employees from minority groups etc.

HealthWatch representation and plain English reporting

**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?**

Unless there is a strong partnership, training plans will not dovetail with commissioning intentions. These two areas form two different parts of an overarching strategy to improve health and social care, i.e. should go hand in hand. Once commissioning intentions are agreed, the HEE board needs to respond to these. Communication of training plans need to reference their links to commissioning and how they will support delivery of services.

An alternative way forward is to incorporate NHS Commissioning Board Strategic Initiatives, directly into Training Plans

Would think that was already identified!

**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?**

Accountability at local level should be with the skills network, feeding to the HEE Board, which should have representation from HealthWatch, regulators and commissioners. Enforcing providers' responsibility can then be done through contract management of commissioners, regulation and local HealthWatch.

A conglomerate board / Committee comprising members from CQC, Monitor and HealthWatch England

Through representation

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

No Comment

Details of contacts and liaisons that currently exist at both national and local level

And Financial to change publicity/policies and training needs to keep up

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

If employers can decide whether to invest in advice and support from Skills For Health in the new system, there may be employers who prioritise spending in other areas, despite needing to invest in support. In view of the move towards integrating health and social care more closely, Plymouth LINK would like to see Skills For Health and Skills For Care merged to cover wider health and social care. Delivery of health and social care services may not be so clear cut in the future, therefore a Skills Council should consider a wide view of training and development for a workforce delivering services across the spectrum to ensure smooth care pathways, seamless services and partnership working that begins with training of staff.

As a sub committee / working group of the Centre for Workplace Intelligence

Not a sub-committee but an integral part of the system; any staff/NGO member should be able to locate and identify training requirements and suggest/report to a training needs advisor who the reports directly to budget holders and other appropriate persons. Training is ongoing non training produces vacuums in care

**Question 22: *How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?***

Regulatory bodies named in the consultation will play a role in ensuring training and education meet professional standards and need to be involved as stakeholders as part of HEE. National buy-in will help agreed standards to filter through via local skills networks and also via the regulatory bodies as part of a consistent approach. Ensuring clinical leadership locally needs ownership from providers through a continuation of involvement in the process as a stakeholder in the skills network and accountability to clinical leadership through regulation and monitoring.

22) - 25) This goes to the very heart of the debate being played out in the media. What for example do members of the public want from local GP. Maximum availability for medical appointments. Or reduced availability because he / she is chairing a meeting of the local GP Consortium? What does the public expect of a Ward Sister or Matron, line management of nursing staff only or a proportion of duty time spent line managing non-medical admin support staff? Does the public care what managerial skills a brain surgeon has or do they want that individual to have the highest clinical skills available. This whole issue needs serious consideration.

22) – 25) Agreed! however it appears from various meetings it's consortia leading and GPs having bigger personal salaries. How can any change on choice be accountable to the 'customer' without representation or real choice; if I do not like the shop I can go elsewhere; when I do not know what is for sell I window shop, based on informed choices I make informed decisions; again representation...

**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?***

Where Plymouth LINK recommends that the healthcare workforce is more focussed on patient experience, pathways and partnership working, this will need support and drive from leaders and managers within professions. Developing leadership/management skills should include responsibility for nurturing, monitoring and ensuring that the workforce has awareness of their local communities (demographically) and the needs of those communities, that they have training and practice patient-led services and are challenged by leaders to continually improve their practice through patient experience. There is also a responsibility to ensure knowledge of and partnership within HealthWatch (locally and nationally). Leaders should also take responsibility for partnerships with

other services within care pathways and foster proactive, positive relationships to tackle issues of transitions between services that Plymouth LINK are aware of.

See above response

See above response

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

Yes – managers and clinicians are part of the same service/profession and should be working together to achieve the same standards.

See response to Q 22

See response to Q 22

***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 postgraduate programmes?***

Plymouth LINK receives feedback that suggests that health and social care services function in isolation, which in turn suggests that the development of clinicians and staff also occurs in isolation.

A skills council, working across health and social care, is an opportunity to develop a workforce that understands a wider health and social care picture (patients' pathways and options across health and social care services). A stronger partnership is needed between health and social care and this can be supported through an integrated training programme which includes experience of other services working with services and engaging with patients (and patient experiences) about their journey through healthcare.

See response to Q 22

See response to Q 22

***Question 26: 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?***

As in question 25, Plymouth LINK recommends that public health be integrated into a wider training/education strategy. With representation on the HEE Board and involvement in local skills network, public health can form part of an integrated healthcare workforce with shared understanding of all services and partnerships. Public health expertise is valuable to managers and clinicians working in health and social care services to help understand local needs (or services and staff training) but also how services have responsibility and play their part in prevention, health promotion and improving the public's health.

Regular meets (quarterly, half yearly) between representatives of CQC, Monitor, Centre for Workforce Intelligence, Healthwatch England, NHS Commissioning Board and HEE

Representation at each group's meeting in non-executive roles - transparency at its most basic

**Question 27: 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 commissioners of social care and public health services, it seems sensible that the local authorities are members of the skills networks.

Regarding funding, the mechanism that should be employed should reflect the same one as used for the health and the social care workforce.

If central government truly wants localism then this issue cannot be mandatory but must be voluntary, in which case a partnership at a national level is to be encouraged.

Yes but as key budget holders to NGOs and involvement it must be mandatory; budget holders have a responsibility of provision this can only through negotiations and acceptance of failure of provision

**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?**

No comment.

No response

transparencies in accountability

**Question 29: What should be the scope for central investment through the Multi-Professional Education and Training budget?**

No comment

No response

acknowledgement of supporting workforce and NGOs

**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?**

In a busy working environment, it is easy not to spend time to source investment in training at the expense of actual service provision. Cumbersome systems to attract funding which require time and investment may act as a disincentive to developing staff skills.

No response

transparencies in accountability

**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 risks to providers?**

No comment

No response

transparencies in accountability

**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?*

No comment

No response

how can you possibly tariff investment in addressing health and social need? Or do we all fight for the scraps

**Question 33:** *Are there alternative ways to determine the education and training tariffs other than based on the average national cost?*

No comment

No response

need

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

No comment

No response

yes - bottom up listening and consultation will lead personnel identifying a targeted planned schedule

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

No comment

No response

no pace is too slow; how can any production of the change be based on levy seeking?

**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?*

No comment

No response

any organisation that demonstrates addressing need are budget stressed any increases is another funding reduction; the government must take responsibility for training programmes that identify and improve service provision; anything less is failure to provide

**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?**

No comment

No response

I thought we were discussing how a levy should be raised and where from now how can we migrate our responsibility and make someone else accountable- sorry reviewing this document not the government's future investment in health and social care-kick me kick me!

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

No comment

No response

see all above

**Question 39: How can transaction costs of the new system be minimised?**

No comment

No response

you cannot budget for a change this big with such a statement. Does this mean to minimise impact until levy secured there is only limited training budget?

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

Plymouth LINK has recommended as part of this consultation that training is focussed on areas of patient experiences and includes understanding of local communities, their needs and patient priorities for how services are delivered. Therefore quality metrics should incorporate these areas to help ensure patient-led services for the future, driven by a patient-led workforce.

No response

Improvement in skills and knowledge that provides a holistic health and social care package; held accountable to the community of need.

**Question 41: What are the challenges of transition?**

In order to facilitate change, people must have ownership and be signed up to the change. Communication and consultation is an important part of that. Plymouth LINK has challenged services and trusts to improve the way they communicate and consult with people. Our experience is that communication often involves what they expect people want to hear, rather than what they do want to hear (which is usually how it affects them). We have advised on improving consultation to occur at the earliest convenience (about the change, on what the change should be and how it should be carried out) and consistently throughout the process.

Managing expectation internally and externally and producing timely and understandable communications internally and externally

Maintain service provision to best quality of care

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

It is important that existing staff are not disadvantaged by a new system and have opportunities to benefit from a new education system as much as potential staff who are approaching training. Consultation, communication and opportunity should help to reduce negative impact on staff.

By human nature change is looked on with caution, suspicion and fear by most. And in these financially difficult times amid lurid claims by 'politicians' and the media of huge job losses, it is inevitable the majority will feel threatened by these changes and react accordingly. They will become to a greater or lesser extent destabilised, de-focussed on task, and self-protective, e.g they will do what they know gets measured but will shun activities that may be morally the right thing to do but in the long run do not get audited or counted.

Fear

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

Strong leadership and clear communication. Opportunities to be involved and supported to develop the new system.

Timely and understandable communications and counselling. Time allowed (i.e work time) to absorb information about the changes and to attend official meetings arranged by management and where appropriate the relevant Unions.

CV writing as the workforce becomes more mobile to seek their specialist skills locations

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

No comment

A constant supply of information on how the skills part of job profiles is changing or conversely is not going to change.

Common sense

**Question 45: *Will these proposals meet these aims and enable the development of a more diverse workforce?***

The proposals have good intentions to develop the workforce. Including Plymouth LINK's recommendations on patient focus/experience and dovetailing health and social care training, the proposals could support the aims.

Sadly no. Individual Cultures will always determine what careers and goals are considered worthy and suitable. And these proposals on their own do nothing to alter public perception of the health service and the roles therein.

No response

***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?***

Wider than the workforce itself, if training does not start to address staff understanding of local communities and their needs then there will be patients disadvantaged by these proposals. For example, Plymouth LINK receives feedback from people who have a hearing impairment and who are disadvantaged at doctors' appointments because they can't hear their name being called. Unless staff training addresses this issue (among many others we hear about), these patients will still be disadvantaged. It is essential that these proposals build in a strong patient experience and local knowledge to the new training system.

Paragraph 10.2 states.. *'organisations must create an environment where talent flourishes and where everyone is able to realise their potential'*. This is highly laudable but means, if followed to the letter, that positive discrimination cannot be undertaken, and if the best candidates for a series of posts are all white, middle aged males, or all elderly, BME females, then they must be chosen, and people cannot be recruited to meet any sort of quota.

Agreed strongly but what also has to be taken into account is the financial impact of training that true choice is rewarded not impeded; most lone parents work part time; accountability must be focused to ensure their participation advances equality even if the commitment seems lacking; this in simplistic terms is ALL the workforce and volunteers are recognised as equal