Defining the role of integrated care systems in workforce development: A consultation from NHS Confederation

Response from the Royal College of Paediatrics and Child Health

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Question 1: Do you agree with the proposed role and responsibilities of local systems for workforce development as set out in this consultation?

Central/local accountability and priorities

No. This plan would create a further layer/barrier between workforce planning and the Department of Health reducing their accountability to provide a Health Service. As a result, central government will be less accountable when things go wrong and there is a risk of local systems being blamed. There is no mention in this paper about inspections, audit or monitoring of workforce provision against national standards.

We are concerned that paediatrics will be overlooked because local priorities tend to focus on social care and adult services. Local systems will be overwhelmed by social care issues leaving no scope to focus on child health.

Different ICS/LWABs will have different priorities and this will result in different levels of service across the country, with the possibility of a "postcode lottery". There will be different levels of development between the ICS/ LWABs. For example, Merseyside has produced 76 paediatric Advanced Care Practitioners (ACPs), whereas no other ICS has. There will be further regional unwarranted variation as different types of service design make it harder for interoperability. If people move jobs, it is harder for employers to understand their level of training and expertise.

Many services cannot and should not be managed locally: networks are needed to create efficiency in child health provision because of the complexity and volume of conditions. For example, in Paediatric Intensive Care Units and Neonatal Intensive Care Units, larger networks and regions are better ways of delivering care. The balance between central and local planning very much depends on numbers and degree of specialisation.

There is no recognition at all in this consultation of the massive movement of doctors that happens at various points during their training but in particular, application to medical school, application to foundation school, application to specialty training school and application to consultant posts.

Administration

Devolving workforce planning to LWAB level will create more bureaucracy as work is unnecessarily repeated at a local level, and unhelpful competition. The model proposed in the paper encourages 'reinvention of the wheel' in each locality that would be very wasteful and inefficient in our overall specialty and many subspecialties.

Training and Education

Not all ICS have the right training environment: they are not all coterminous with educational establishments. That is, universities/colleges may not exist for some ICS or have capacity for type of

training/education needed for the local health workforce. There may also be regional boundary differences: there are 16/17 deaneries in UK and it is not clear how they map on to ICS for training.

"Growing your own" staff requires finding a university, designing the curriculum and securing enough participants to make it viable. Moreover, in the end this may result in a qualification not nationally recognised or transferable.

Different staff groups

It is not clear if this consultation relates to all staff groups. Workforce planning at the LWAB level may be suitable for support workers, porters, domestic staff and cleaners etc., where networks are less important and local training is standardised. But it is not suitable for medicine and nursing. For advance training there is a need to collaborate across boundaries. Paediatrics is a relatively small specialty with many subspecialties that are even smaller. It is not possible to grow expertise in all these important, subspecialty areas in every locality.

Financial/budgetary

We are concerned that workforce planning will continue to be done according to budget alone and that there is not sufficient in-house expertise in the 44 ICS to conduct workforce planning. Central workforce planning has been a failure, partly because HEE does not have the resources. If workforce planning is devolved, more budget will need to be allocated for this work, otherwise it will fail.

The historic focus on short term costs and a lack of strategic planning and investment has left us in the current situation in paediatrics and many other medical specialties where there is an inability to recruit at local level and to fill tier 2 (middle grade) gaps. This has led to high locum rates resulting in a spiral of early retirements, reduction in job satisfaction, issues around work/life balance and greater pressures on permanent staff.

Standards and Regulation

Implementing these plans will make it harder to monitor and impose national standards for staffing without regulation, such as the British Association of Perinatal Medicine's standards[1]; the RCPCH's Facing the Future standards[2] and the Royal College of Nursing's standards[3]. Since there is an international market for highly qualified healthcare professionals ensuring local conditions and support for professional practice is essential for retention of the best staff.

It is important to have clarity about competencies and skills so employers and patients can be assured about the governance and safety of their services.

Role of Integrated Care Systems

However, we do welcome the proposed moving away from individual providers determining local workforce demand, this has been unsuccessful as it is always finance rather than needs driven. Innovative approaches and local solutions should be encouraged so long as they are embedded within national frameworks and core curriculums.

It is important that powers of Integrated Care Systems regarding workforce are not considered in isolation from the role of ICS's more generally in terms of their overall powers, accountability and links with other structures in the NHS. For example if service planning for a subspecialty is undertaken nationally, there will be conflicts if the workforce for that service is planned locally.

Question 2: What further activities or responsibilities, if any, would you recommend an ICS has future control over, specifically in relation to workforce?

ICS need to engage in advocacy to meet and implement standards, such as the RCPCH's Facing the Future standards[2].

ICS should not just commit to working together across boundaries, but also identify where there is common need in collaboration and work together to address those needs. There is need for clarity about what is local what is regional.

ICS need to collaborate with national workforce planning experts to assess system-wide demand. We are concerned not all ICS will assess in same way because of different priorities, therefore we would question whether they can adequately assess demand in their relatively small footprint.

Rather than just committing to understanding their role in local economy, which should be a given, ICS need to set out actions to help the local economy and work with local economy.

"Growing your own" referenced in the paper needs to be clarified: does this apply to medical training schemes for example?

Question 3: Is it fair to place an expectation on ICS leaders to sign up to the commitments listed under any new future operating model?

This question is unclear. If it is optional for ICS to sign up, and there is not 100% commitment, there will be incomplete and patchy planning, making these commitments inoperable.

Question 4: What support would ICS and STP value the most, whether referenced in this document or not?

ICS would most value extra funding. Beyond that, good advice, data, and evidence from workforce planning centre would be good. If all ICS do workforce planning, and we are likely to see development of different workforce planning systems. Best practise should be shared.

Question 5: What is happening locally that should be highlighted as part of a wider good practise toolbox to other areas of England?

Examples:

Connecting Care for Children https://www.cc4c.imperial.nhs.uk/

Healthier Together in Southampton https://what0-18.nhs.uk/

Surrey Heartland – First 100 days https://www.england.nhs.uk/integratedcare/integrated-care-systems/surrey-heartlands-health-and-care-partnership-ics/

Norfolk Healthy Child Programme – Just One Number https://www.justonenorfolk.nhs.uk/our-services/healthy-child-programme-services-5-19

NHS Cheshire and Merseyside Women's and Children's Services Vanguard – Game Changer initiative to tackle obesity http://www.widnesvikings.co.uk/news/article/54001/report-highlights-impact-of-gamechanger

References

1. British Association of Perinatal Medicine, *Service Standards for Hospitals Providing Neonatal Care*. 2010, British Association of Perinatal Medicine: London.
2. Royal College of Paediatrics and Child Health, *Facing the Future: Standards for Acute General Paediatric Services*. 2015.
3. Royal College of Nursing, *Defining staffing levels for children's and young people's services: RCN standards for clinical professionals and service managers*. 2013, RCN: London.