House of Commons
Health Committee

Education, training and workforce planning

First Report of Session 2012–13

Volume II

Oral and written evidence

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/healthcom

Ordered by the House of Commons
to be printed 15 May 2012
The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Membership

Rt Hon Stephen Dorrell MP (Conservative, Charnwood) (Chair)¹
Rosie Cooper MP (Labour, West Lancashire)
Andrew George MP (Liberal Democrat, St Ives)
Barbara Keeley MP (Labour, Worsley and Eccles South)
Grahame M. Morris MP (Labour, Easington)
Dr Daniel Poulter MP (Conservative, Central Suffolk and North Ipswich)
Mr Virendra Sharma MP (Labour, Ealing Southall)
Chris Skidmore MP (Conservative, Kingswood)
David Tredinnick MP (Conservative, Bosworth)
Valerie Vaz MP (Labour, Walsall South)
Dr Sarah Wollaston MP (Conservative, Totnes)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), David Turner (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

Contacts

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
## Witnesses

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Taken before the Health Committee
on Tuesday 15 November 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Dr Daniel Poulter
Chris Skidmore

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Jamie Rentoul, Director of Workforce Development, Department of Health, Dr Patricia Hamilton CBE, Director of Medical Education, Department of Health, Kate Lampard, Chair, Health Education England steering group, and Christine Outram, Senior Responsible Officer for Health Education England and Managing Director, Medical Education England, gave evidence.

Q1 Chair: Good morning. Thank you for coming. I apologise for keeping you waiting. We had a couple of internal issues we were going to resolve. Could I ask you to begin by introducing yourselves and telling us which bits of the Department and the institutions you have come from?

Dr Hamilton: I am Patricia Hamilton. I am a doctor. I am seconded, and now, in fact, full time at the Department of Health as the Director of Medical Education. My particular interests have been, obviously, with medicine but also with the broader aspects of education. I have worked with setting up Medical Education England and continue to work in the Department on policy and education.

Jamie Rentoul: Good morning. I am Jamie Rentoul, Director of Workforce Development. I have the lead on education and training, policy, funding, adult social care workforce, equalities in the NHS and size, shape and capacity of the health workforce.

Chair: What do you do in your spare time?

Kate Lampard: Good morning. I am Kate Lampard. I am, formerly, chairman of the South East Coast SHA. I am now vice-chairman of the cluster of SHAs for the south of England. I have recently taken on the role of chairing the steering committee that is going to oversee the setting up of HEE, Health Education England.

Christine Outram: I am Christine Outram. I am the senior responsible officer for Health Education England, leading on the set-up of it, which I have been doing for six weeks. I am also Managing Director of Medical Education England, which is a non-departmental advisory body advising the Department of Health.

Q2 Chair: Thank you very much. It would be very useful to the Committee this morning if we could begin by asking you to set the scene. There are obviously major changes going on in workforce planning and education of the medical and non-medical workforce going forward. These are to a significant extent, clearly, the consequence of the service changes going through in the Health and Social Care Bill. Do you see that as an opportunity to do something which was necessary anyway, or are these changes in workforce questions simply the consequence of service changes requiring changes in institutional arrangements?

Jamie Rentoul: I will kick off and my colleagues may want to add in. First, before launching into structures and all the rest of it, it is worth restating that this is about better health and health care for people and, as in our consultation document and the Future Forum report, recognition that excellent health and healthcare depend on an excellent health workforce with both the right professional and clinical skills and the right compassion, kindness and respect for people. Although it is a self-evident truth, it is about keeping what we are trying to achieve in our minds.

In terms of the summary line for the set of reforms, it is: developing a system which is more responsive to service and employers while being professionally informed and underpinned by strong academic links. That is the summary line we have of getting the three bits right. Within that, it is: consistent with the wider set of reforms across the NHS landscape in terms of delegation of decision making, strong professional leadership, more transparency and information about quality and performance and a stronger patient-centred view. Therefore, you are taking a more joined-up view to meet the needs of patients. It is not a consequence of those reforms. It was part of the package. But the Secretary of State decided we would consult on it a little later; to have the consultation on the rest of the system reform first and then engage with people about how you get the education and training and workforce planning system to best support and enable the wider system change. The themes of stronger employer engagement, more multi-professional building capacity and focus are also themes you have seen in workforce planning, education and training changes over a number of years. Some of the Darzi reforms were also in that direction. This set of changes moves that on further in terms of what we are trying to achieve.

Q3 Chair: Would anyone else like to comment? The question is: what are the key strengths you are seeking
to preserve and take forward from the old system and what are the weaknesses you are seeking to address in the new system?

**Jamie Rentoul:** In terms of strengths, over the last several years there has been an investment in developing the health professional workforce. Compared to a number of years ago, we are much more self-reliant in terms of doctors, nurses and midwives coming through and having the right training package for that. With the establishment of Medical Education England and with the Professional Advisory Boards for nursing and allied health professionals getting stronger, professional advice into the system and ownership of change has improved. We want to build on that in Health Education England.

The strategic health authorities and the establishment of the Centre for Workforce Intelligence have sought to start to build more capability on workforce planning and horizon scanning—the analytical underpinnings—but we have further to go. The critical change in this is the stronger accountability and responsibility for employers within a national framework and with national leadership. Getting this right will provide a basis for employers being able to set out, much more clearly, the future service need and how the workforce goes with that: the integration of service, financial and workforce planning, at a local level, driving the system more, within a system of checks and balances and with national leadership.

**Q4 Andrew George:** The fact that you are talking about a new system which is more responsive and professionally informed, more transparent and more patient-centred—language you used—is all very welcome. Also, in view of the last answer, where you refer to “locally informed,” how do you gather that intelligence at a local level? When you are making your assessments, are you confident, in looking at the local situation, that the trained staff-to-patient ratio, particularly in the acute sector, is adequate to cope with the front-line challenges which the service faces? If you are, are you confident that you can build up a picture of a safe service where that complement of trained staff at the front line is adequate to provide the service safely?

**Jamie Rentoul:** I will try and answer that in a few chunks. Do you want me to talk about the new system as we will see it working?

**Q5 Andrew George:** Yes. You talked about “local.” At the anecdotal level, people are picking up a picture of staff not being able to cope because of the staff ratios being insufficient. To what extent are you picking that up in the intelligence you are gathering?

**Jamie Rentoul:** Within the system, it is the responsibility of the healthcare employer to make sure they have the right suitability of staff to deliver high quality safe care. The Care Quality Commission, as part of its set of essential standards, has a set of standards about the suitability of staffing. The responsibility is clearly on the employer there. Within the system we are consulting on and seeking to develop, we are proposing that the Local Education and Training Boards—as the Future Forum called them—would bring together the local employers with the education sector to be able to say, “In understanding the service commissioning intentions of the Commissioning Board and clinical commissioning groups, this is the pattern of services we need to develop to respond to that and the workforce we need to provide the high quality care.” That analysis and work will happen at a local level but within a framework of accountability to Health Education England such that Health Education England is going to be able to look at the data coming out of the Local Education and Training Boards. The Centre for Workforce Intelligence will still provide analytical information and, to a degree, challenge in the system as to whether your staffing levels are right, such that HEE can say, “We have concerns about X, Y and Z.”

**Q6 Andrew George:** You have taken it very quickly beyond the level where the intelligence begins, which is the front line of the service itself. You were saying that it is down to the employers and the CQC to make those assessments. To what extent do you interrogate that assessment? Are you satisfied that that assessment of trained staff complement at the front line is adequate to do the job? And you simply stand and accept the information that is provided to you from the CQC and the employers, which I think is what you are saying? Can you confirm that is the case?

**Jamie Rentoul:** As to the current system, certainly the strategic health authorities, with their current duties, very much carry out that challenge function in assuring workforce plans in terms of the safety and clinical quality of care which can be provided where there are workforce changes. Again, our view is that that is an important challenge function to have in the system. You do not simply accept what is coming forward. Also, the service commissioner—clinical commissioning groups, in time—has a due diligence function to ensure that what it is purchasing for its communities meets that quality. Health Education England will have a function of saying, “Are we developing and supporting with a workforce that has the right skills going forward?”

**Q7 Andrew George:** You are content that that arrangement provides the intelligence you need to plan forward for the numbers of trained staff required at the front line of the service. You are not providing what you call a challenge function. That challenge function is provided by others.

**Jamie Rentoul:** Yes.

**Kate Lampard:** Can I leap in? In the new world under Health Education England, a significant part of Health Education England’s work, to begin with, will be setting up an accountability framework. This will be the process under which Local Education and Training Boards will be held to account. They will also have authorisation criteria. Part of that structure, of course, will be focused on ensuring the right decisions are being made locally for numbers and quality of training. As I see it, Health Education England will have close working relationships with other parts of the system—the National Health Service Commissioning Board, Public Health England and local commissioning groups. And there will be a
Andrew George: Sorry, I did not pick up the Chair: “Intention.” “expectation.” That is good. benefits and negatives, one issue, which was raised the setting up of the MTAS system, which perhaps has happily. On the training of junior doctors following We can all accept that, and everyone is nodding quite there are two aspects: the theoretical and the practical.

Q8 Andrew George: The challenge function, it seems to me, is primarily provided by those parts of the service also responsible for managing the resource. Commissioning bodies, the trusts themselves and the managers of the hospitals are dealing with the management of a scarce resource, which is their staff—hopefully not too scarce, but certainly a limited resource. If the challenge function is provided by them as well as rationing that resource, because, clearly, it has to be limited, I am not necessarily satisfied—are you—that there is a challenge function scrutinising whether the staffing levels are adequate at the front line?

Kate Lampard: I think you are assuming that Local Education and Training Boards will only be employers. That may not be the case. There will be other stakeholders involved locally, not least the education service providers and representatives. Presumably—although this is yet to be determined—commissioners themselves will be represented. In addition, there will be this line of accountability to Health Education England which, as it were, being divorced from the service, offers a much clearer line of accountability and challenge.

Dr Hamilton: Deans and deaneries also have an important role to play, certainly for medicine. They have accountability to the General Medical Council and to Health Education England, in future, to ensure that the supply of young doctors is appropriate. They already exist, to ensure trainees have a proper opportunity.

Andrew George: We have gone from “hope” to “intention”.

Q9 Andrew George: It is fine for doctors, but what about nurses and care assistants?

Dr Hamilton: One would hope that the new system provides opportunities for that sort of arrangement to be strengthened.

Q10 Andrew George: You said there was a “hope” there. There is no certainty.

Andrew George: We have gone from “hope” to “expectation.” That is good.

Chair: “Intention.”

Andrew George: Sorry, I did not pick up the “intention”.

Q11 Dr Poulter: In terms of training and education, there are two aspects: the theoretical and the practical. We can all accept that, and everyone is nodding quite happily. On the training of junior doctors following the setting up of the MTAS system, which perhaps has benefits and negatives, one issue, which was raised by Jamie Rentoul in his evidence earlier, was about employers or hospitals—who do a lot of the primary-level training of junior medics, except when GPs become GP registrars—investing in their staff properly. Is it fair to say that, under the current system, there is variability in whether that happens? We often have four-monthly rotations now, as opposed to the previous six-monthly rotations, and we have the European Working Time Directive, which often pushes a lot of hospitals towards service provision rather than training. Is it fair to say that the quality of training, both practical and theoretical, offered in different hospitals can, at best, be described as hugely variable?

Dr Hamilton: Yes. That is one issue the new system is proposed to improve. We recognise variation in training. The latest General Medical Council survey on trainees has recently been produced and while, generally, satisfaction has improved, there remains variation across teaching and training institutions. It is very important that we raise that bar of quality and improve opportunities to train in primary care and community settings. That work has already started, following two reviews: the Temple review, which Medical Education England commissioned, on the quality of training and the Working Time Directive, and the Collins review on the foundation programme. Both raised issues of poor supervision in places and also the importance of giving all trainees opportunities to train in primary care and in community settings. The curriculum is being rewritten to address that. The important point you make about service issues trumping training is one of the things we are trying to fix with the proposed new system. That will not be contemplated or permitted in the extra checks and balances we are putting in to complement the General Medical Council’s assurance framework, which already exists, to ensure trainees have a proper opportunity.

Q12 Dr Poulter: We know, for example, that there is a finite number of doctors on an on-call rota, shall we say, or in a particular department in a hospital. We also know that, for GPs, the time they spend in their specialities in hospital is essential and what they learn there benefits their work in the community, so I accept your point about community-focused training. It is very important the time in hospital is not compromised. I see you are nodding in agreement. But I fail to see, when there is pressure on budgets and you have a finite number of doctors in a department on a particular rota, how this is going to be achieved and how we are going to improve the quality of education. The driver with the European Working Time Directive means that there is very little flexibility for hospitals to build in training time for staff.

Dr Hamilton: As a result of the Temple review, we look at the impact of the Working Time Directive, which showed there is time, within their 48 hours, to train—but not in our current system. I agree with your shaking your head in that the way we currently run the service, with our most junior doctors providing most of the service, means they cannot train in that 48 hours. We are planning to involve consultants
more, and that is already happening. As a response to that report, Health Education England has set up a programme, which Christine Outram might like to talk about, called “Better Training Better Care,” in which, with a more consultant-present service and different ways of working across and within the professions, we can provide safe service for patients without compromising training. But we have to change the system in order to achieve that.

Q13 Chair: Could I bring in Christine Outram but ask you, in this context, to address the question of what you see as the role of the GMC, the regulators and, indeed, the Royal Colleges in providing an independent view of the answer to Dan Poulter’s question? This is in danger of being too much management-led and there needs, surely, to be a strong professional commitment to standards based on regulation as well as management priorities.

Christine Outram: Indeed. Can I start with the question about the “Better Training Better Care” programme which Patricia Hamilton began to describe? Medical Education England, in the current system, commissioned the review of the impact of the Working Time Directive on training. Shortly after we had done that, we also commissioned a review of the foundation programme, which review had been one of the recommendations from Sir John Tooke’s report in 2008. As Patricia has said, both the Temple review and the Collins review highlighted the issue about junior doctors being so heavily required to be on out-of-hours rotas that they were missing out on training opportunities in-hours from which they would undoubtedly benefit. It is the case, however, that some hospitals have managed the changing scenario with working time much better than others. There are hospitals where consultants are present much more. It does not mean that consultants are overworking, but they are working differently. Their hours are structured differently so there is greater availability of senior doctors to oversee the work of juniors and be available when juniors need particular guidance or advice. It goes without saying, of course, that it is also much better for patients that their care should be properly supervised by a senior doctor.

As a result of the recommendations of these two reviews, we have established a programme called “Better Training Better Care” which has two main themes to it. One is to support trusts across the land to increase the time available by consultant staff—the more senior staff—to support the juniors and have better supervision. The other is something we have dubbed “Make Every Moment Count,” where we focus on education in the workplace in order that all opportunities for training are taken. That is a new programme. We are going to be working with trusts across the country to find different ways of improving training. In the new system, Health Education England will pick up on this programme because it is important and is supported by very senior levels across the medical profession. The way the new system will support it is through greater accountability. As well as a supportive approach, which we adopted through “Better Training Better Care,” there will be the opportunity for Health Education England to set some important strategic priorities for the service. One of those, without a doubt, would be the better supervision of junior doctors. It is an issue we are all very concerned to fix.

As far as the regulators, and the GMC, are concerned we have a common interest, obviously, in quality. It is the role of the GMC, for example, to set standards for the education and training of doctors and to ensure they are met. Health Education England will have an interest completely in common with the GMC, but we will have different information we need to share. Health Education England will be allocating the money to the system to be spent on the training of junior doctors and, therefore, will have some levers in that respect. The GMC has different levers. We will need to work together and we are talking to the GMC, at the moment, about how we can use the creation of Health Education England to fix some of these issues and to strengthen the work they are doing.

Q14 Dr Poulter: I hear what you are saying. However, the point the Chairman makes is well made. We have a well-meaning but slightly utopian view being put across at the moment: a management view rather than, necessarily, the view put across, say, by the Royal College of Surgeons. You will be aware of the very real concerns they have about medical training. What the Chairman was asking, and what I was trying to drive at as well, is this: it is very difficult on the ground, in a small district general hospital, to rearrange rotas. There are real practical problems in you saying that, within a 48-hour working week, you can do service provision and training and free up consultants out of their outpatient clinics or their time in theatre to do all this extra training. I think a slightly utopian view is being painted. Certainly there is concern, among the colleges, that what is there at the moment does not work and we need something much better in the future. I am not hearing anything other than “management-speak” coming across about how this is going to change. When the Royal College of Surgeons have been expressing real concerns about the training of surgeons and surgical trainees, what are you doing to make sure those concerns are addressed and that the training of surgeons is improved.

Christine Outram: I am not describing a utopia I have imagined. I am describing practices I have seen in hospitals, which I could take you to, which I have visited.

Q15 Chair: But you have acknowledged—or your colleagues have acknowledged—there is too much variation.

Christine Outram: I do acknowledge there is too much variation. It is hard. We are tackling a system that has grown up over decades in the way we organise the training of junior doctors. It is not easy for hospitals to change. Small hospitals have particular issues, but so do large hospitals.

Q16 Chair: With respect, you are compounding my concerns. You are saying there are some examples of excellence, which we acknowledge, and then you are telling us how difficult it is in smaller hospitals. That is the problem. Where is the cutting edge?
Christine Outram: There are examples of excellence in smaller hospitals, too.

Q17 Chair: I accept that.

Christine Outram: Large and small hospitals have taken different approaches. The approach we are taking, at the moment, is to spread the use of these good practices and encourage hospitals to look at the way they organise themselves to improve what we all acknowledge is an issue. The Royal College of Surgeons are involved in the work that we are doing. Do they have concerns. We have to be particularly careful with the training of surgeons to ensure that people have enough time in operating theatres, for example, and are not spending all their time elsewhere. That takes organisation and focus.

Jamie Rentoul: At the risk of lapsing slightly into management-speak, some of this is about recognising that good education and training cannot be left to an individual provider, small or large, but is a collaborative effort in terms of the right rotations, the right support and so on. Therefore, these Local Education and Training Boards are about employers coming together, working with postgraduate deaneries and increasingly across professional groups to say, “What are the quality standards we are going to make clear everyone has?” They will be held to account by Health Education England with better information, transparency and focus over time. It is not a quick fix—these problems have been around for a long time, haven’t they?—but it is about a system which sees this as critically important to sort out.

Q18 Valerie Vaz: How are you going to encourage them to use the money for training for that purpose? There is already raiding of the budgets going on now, is there not?

Jamie Rentoul: Not to a great extent. In terms of Health Education England allocating money to Local Education and Training Boards, the deal is about specifying the outcomes, quality of training, numbers trained and so on in return for the funding flow being received and, over time, building up a better set of information which gives you the accountability in the system. One of the issues at the moment is that the information about quality and so on is rather weak. We need to build it up so that the Local Education and Training Boards are genuinely held to account for what is being achieved.

Q19 Valerie Vaz: I do not know if we are moving on to architecture, but they are not set up yet.

Jamie Rentoul: Again, as you know, we have not made policy decisions on this yet and the Government have not published details. The size and shape of them are still to be determined. The discussion going on at the moment is that they are of sufficient size to be able to take a broad view of the workforce in an area and have economies of scale, but also to have the clout to take action where there are concerns about quality.

Q22 Valerie Vaz: Will they be outposts of Health Education England?

Jamie Rentoul: As I said, the Government have not published yet. We are waiting for the Future Forum. The Secretary of State will determine that in what we publish shortly.

Chair: We might have some recommendations.

Q23 Dr Wollaston: Concerns have been expressed about the scale and pace of this, another major untested system change. Could you clarify what was so bad about the existing system—that is still not clear to me from your answers—that it could not have been fixed under the existing arrangements? As you have mentioned, we have variability but examples of very good practice. What, in the existing system, would have prevented you addressing that variability adequately to justify this scale and pace? Also, how confident are you that the time scales can be met?

Jamie Rentoul: On the scale and pace, you will know that we consulted in December last year and then the Future Forum did its first round of engagement and produced its report. As a result of the forum’s first report, the date of the abolition of strategic health authorities got pushed back a year. Their strong recommendation, which the Government accepted, was that we needed more time to make sure we were building the right local relationships, thinking about the development of the Local Education and Training Boards and giving people enough time to form new relationships and have clarity of role. That has given us some more time in terms of pace of change, and people are more comfortable with it.

In terms of what needed fixing in an organisational sense, first it is about establishing national leadership and focus with Health Education England; rather than having a set of functions sitting between the Department of Health and strategic health authorities, having Health Education England at arm’s length from the Department providing that national leadership. Secondly, within the Local Education and Training Boards—

Q24 Dr Wollaston: Could you go back? Are you saying Health Education England did provide national leadership?

Jamie Rentoul: It did not exist. Medical Education England was an advisory group to the Department. It provided advice. It did not have executive responsibilities or funding allocated through it. It was medicine, dentistry, pharmacy and scientists, not nursing, midwives and allied health professionals. Health Education England will encompass all the professional groups in its remit. The proposal in the consultation was that the central funding will be
allocated through it. In bringing together the employer view, the professional view, commissioners, regulators and the education sector in the Health Education England decision-making, it has funding flows that go with it and give it, therefore, grit in the system in terms of outcomes achieved.

The second bit is getting more employer engagement and ownership of workforce planning, education and training, which is where the Education and Training Boards come in.

Q25 Chair: Can I explore this question of the relationship between HEE and the regulators a bit further? You were implying that everyone’s interests were the same. I am not quoting you directly, but the sentiment coming out was, “We are all in this together. We are all going to the same destination. There are no choices to be made.” Life is seldom like that in reality. I would like to understand how you think Health Education England will relate, in particular, to the GMC and the medical regulatory bodies.

Christine Outram: The GMC are involved now with Medical Education England and are a key partner for us. They are on our boards. When they do work on particular issues we are invariably involved in some way, and vice versa. I know that that will continue. It is not that we are all in this together, but we are looking at the same hospitals and the same issues.

Q26 Chair: But you might come to different conclusions about a given set of circumstances. That is the key point, is it not?

Christine Outram: We might, initially, in which case a productive relationship with the regulator would be one where we had a dialogue. In Health Education England we brought our information. They have an enormous amount of in-depth information which is extremely useful in dealing with the sorts of questions we have discussed. For example, the survey of junior doctors provides an awful lot of information about their experience—what they are going through. The way I see it, Health Education England will have information that comes through a particular management line and through the perspective of an organisation that holds the funding, sets some national strategy, reports and is accountable to the Secretary of State and is concerned to have the particular priorities the Government wants it to have. The regulator is looking at the standards of education and training, in this case, constantly and consistently with that focus. Both parties have something to bring to the table in terms of information. The GMC, obviously, registers doctors and accredits training courses. HEE will allocate funding for the local partnerships to spend on training. Health Education England and the GMC have different levers to make things happen. For the various scenarios you could picture, there may be some where the GMC’s levers work and some where Health Education England, through strengthening the accountability in this new system, can make things happen that the GMC have not been able to. We have regulators who do a very good job, but the world is not perfect now. There is still work to be done.

Q27 Chair: What concerned me in the way you presented it the first time—and it is slightly different now—was the implication that there was no tension. It seemed to me that, between a commissioner with budget responsibility in the form of HEE and a regulator with professional standards responsibility and, ultimately, no accountability for money, there is inevitably, and should be, tension. I would be more comfortable if I felt that was something being explicitly recognised and welcomed rather than shuffled under the carpet.

Christine Outram: I do acknowledge there is a tension, but tensions, if they are going to be helpful, need to be worked through.

Chair: Of course.

Jamie Rentoul: The GMC or others will make their decisions on whether standards are met and HEE has to live with them. They are statutorily responsible for that decision-making. Sometimes those will be uncomfortable decisions, but then HEE and the employers will have to respond to them and take action. That, again, is part of what you were talking about earlier in terms of another challenge function outside the management line which you need in the system.

Chair: But it is interesting that it is coming into the conversation in response to questions rather than being volunteered. That is the point I am seeking to draw out.

Q28 David Tredinnick: I would like to move on to the multi-professional approach to education and training. Does the Department intend there to be a more multi-professional approach to education and training, breaking out of professional silos? If so, what form will that take in practice?

Dr Hamilton: When deanseries, as we have discussed earlier, move out of the SHA aegis at the end of March 2013 and into the new system architecture, the intention is that this will be the time to make them truly multi-professional. Clearly, there are obvious economies of scale and economies to be made in back-office functions being shared and so on. More importantly, it will bring us multi-professional training. That is not, necessarily, training within the same classroom, but learning with and about each other. Instead of only training expert teams—and we do train expert teams—we train them to work together, not each being an individual team. A lot of work is already being done on training in a multi-professional way. For example, using simulation, the various professions all train together in putting their skills into practice in emergency situations and so on. Working together, the deans can, as we do not do now, learn about innovative ways of education and training from each other, using the spread and adoption of research and education. We need more research in the other professions to encourage research in nursing as we need to foster it in medicine. We can work together to learn from and train each other, and to encourage junior doctors, for example, at times to learn from specialist nurses or others working in the community.
Q29 David Tredinnick: Does anybody else want to come in on that?

Jamie Rentoul: The other thing to add, again thinking back to what you are trying to achieve in this, is that, as you think about changing demography, patterns of service and more people with long-term conditions, it is about getting that bit of the service, financial and workforce planning together and saying, “What is the right skill mix to provide appropriate integrated care for people in later life?” Then you go back to, “Who do we need to be delivering those skills in the provision of care?” rather than saying, “We are starting with an X and we need lots more of these with this set of things.” Again, it is addressing perhaps some of the longer-term challenges about sustainability.

Q30 David Tredinnick: Earlier on, you were talking about patient-centred views. Patient choice is critical in the Bill and this is what we are hoping to achieve. We are also getting better regulation of some therapies which have not been available. For example, herbal medicine is about to be regulated by the Health Professions Council can then think about the right professional body to provide that advice and who is going to oversee it. Thus, care assistants—something being discussed a lot at the moment—getting the right training standards such that the Health Professions Council can then think about that in voluntary registration. There is a degree of wanting to see the bottom-up drive of what services we want to offer, the mix of skills and therapies to do it, and then how we respond to that in terms of the training and education needs. It is a generic response, I appreciate, and maybe there are specifics we will need to pull through that.

Q32 David Tredinnick: I think there is going to be a change in that patients are going to start asking for different services, now they have choice. I would like to move on now, if I may, please. One of the Department’s key objectives is to widen participation in health professions so that all groups of the population are properly represented. What is the scale of that challenge? How do you think the proposed reforms will address it, please?

Dr Hamilton: Certainly from a medical side, it is a real challenge. It is one of our stated objectives for the proposed changes for the new system that we aim to widen and improve participation. We do not underestimate the challenge, perhaps particularly for medicine but for all the healthcare professions. There is good practice going on, and one of the aims we hope to get out of the new system is the swifter spread and adoption of good practice. We know, for example, that King’s College has done a great deal to not only increase participation and the uptake of medical students from a wider section of society but to support them through the first year of training. That is often where they drop out because people think, “Job done. We have recruited them,” when in fact they need further support. Our statistics still show a greater proportion than we would perhaps like to see—no disrespect—of public school people attending. In medicine, it is still very high and we do not have as much participation as we would like. It is, as I have said, a stated objective of the reforms. It is, I imagine, something of a challenge for Health Education England to get better statistics, better availability of information and better spread, and encouragement and expectation that people will adopt the sorts of good practice that we have seen in various locations.

Q33 David Tredinnick: I have raised this before in sessions, but we have a huge expansion in Chinese medicine which is about to be better regulated. I am suggesting to you that you need to factor this in. There is also another group of people who are now regulated by Act of Parliament, the chiropractors and the osteopaths. Have you had any thoughts about how you can make better use of them and take the pressure off orthopaedic surgeons?

Jamie Rentoul: It links back to the point we are making—as employers think about responding to services and services’ commissioning reflects patient or community views—of being in a position where the employers, working together, then think about appropriate training to deliver that care. Some of that will need a national perspective. You may want common training standards, for which you need to consider the right professional body to provide that advice and who is going to oversee it. Thus, care assistants—something being discussed a lot at the moment—getting the right training standards such that the Health Professions Council can then think about
controversial, homoeopathic medicine has been part of the Health Service, pretty much since its inception, through the regulation of doctors through the Faculty of Homoeopathy. When you look at the broadening of scope, do you think you will be considering whether it is necessary to have better assessment of this particular discipline and how you will be able to respond to the increased demand from the general public now that they are being given more choice?

That is my last question, Chair.

Jamie Rentoul: We should probably offer to write to you on that, consulting colleagues in the Department, if that is okay.

David Tredinnick: You would like to think about it. Very well.

Jamie Rentoul: Yes.

Chair: Write to me and I will circulate it. It will be read with particular interest by Mr Tredinnick.

Q34 Andrew George: First of all, my apologies. I have to attend Questions to the Deputy Prime Minister in a moment. Coming back to the theme I was inquiring about earlier on workforce planning, as I understand it, under the new architecture, the Centre for Workforce Intelligence will be retained as such which will obviously provide intelligence on future planning of the workforce. To what extent will it be publishing and informing both the public, but also itself, on what it believes the skill mix and skill needs of the service will be and the extent of that need?

Jamie Rentoul: It is core to its role to get that information published so people can debate it, prod and poke it and say, “You have not thought about X, Y and Z in that bit of modelling.” Again, as successive reports have said, good workforce planning and horizon scanning and so on is very hard to do, but doing it is better than not and you need to get it as good as you can. You have Peter Sharp coming in the next evidence session. That is a critical part of their role.

Q35 Andrew George: Coming back to or, if you like, going further in the direction of the questions I was asking earlier, when you were talking in terms of interrogating the assumptions underlying that data, are you content that there will be sufficient interrogation of the skill mix needed literally at the front line? In other words, will there be any assumptions made at all about trained staff-to-patient ratios at, say, ward level at hospitals depending on the acuity of the patients on that ward? For example, will that be left entirely to the managers of those services?

Jamie Rentoul: We want challenge at a sufficiently granular level that people are able to do something with it. The national average information does not help you a lot of the time in delivering local services. As a way of working, part of the purpose in having the Centre for Workforce Intelligence contracted but out of the system is that they are doing the analysis. It is their analysis for the colleges, professional bodies, patient groups, commissioners and employers to have a go at, to get it as good as it can be, and give that challenge. To choose something topical, to deal with maternity care workforce as a whole you have to do that at unit level in terms of complexity of case mix—age of mothers and so on—for them to be able to aggregate up and say, “What is the future need in terms of training commissions?”

Q36 Andrew George: As to what level of assumptions will be provided, taking the case of midwives, if the intention of Government is to offer choice, including home delivery—in which circumstances, at second stage, you probably need to have two midwives present—that appears to imply a need for more midwives. Will the assumptions underlying the numbers that are provided at the national level provide a commentary which will inform those numbers and advise people as to how you have arrived at them?

Jamie Rentoul: Yes, that is certainly the intention. It comes back to that clear articulation of service commissioning reflecting patient views—mothers’ views in this case. What is the range of services between a midwife and their junior at a home birth and an obstetric unit that is going to be commissioned for a local community? What is the right skill mix and what are the implications for doctors, midwifery, midwives and maternity care practitioners that you need to deliver that with the safety, quality and mother’s experience you want to get to? It has to be quite granular.

Q37 Andrew George: Thank you. That is very helpful. Finally, in relation to overseas and agency locum staff within the service itself, is it the view in the service that the use of agency and locums is, by implication, a failure of workforce planning?

Jamie Rentoul: The view is that the level is too high. Generally, it is useful to have some because it gives you flexibility and so on, but the NHS is spending too much on agency staff at the moment. As I said at the start, we have seen significant growth in terms of the number of people in different professions coming through training such that you would expect us to be making progress in reducing agency usage, though not seeking to eliminate it. I do not think that would be the right goal.

Q38 Dr Poulter: I want to put a question to Kate Lampard. Can you explain your role—as steering group chair of Health Education England?

Kate Lampard: I am going to be leading, or chairing, the steering group. The steering group is designed to ensure that, from the outset and at the early stages where we are designing and setting up Health Education England, we get the involvement and the perspective of a wide group of stakeholders. They will be able to ensure that all those whose interests need to be taken account of in workforce planning and the provision of education and training are heard and ensure that we do not lose what is good and what needs to be preserved about the system as we presently have it. The stakeholder group is going to meet on a regular basis. In practical terms, we will be providing the leadership to ensure that we set up the new system, the new architecture, appropriately, so that it takes account of the views of the stakeholders, and to offer support, encouragement and challenge to

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the staff as they set up Health Education England. In due course, we will hand over, to a formal board, Health Education England.

Q39 Dr Poulter: I put it also to Christine Outram. How will the existing professional programme boards and advisory boards be integrated into Health Education England? Will there be similar structures created for other healthcare professions?

Christine Outram: Medical Education England has four professional boards covering doctors, dentists, pharmacists and scientists. In addition, the Department of Health has established two groups, which Jamie referred to earlier, covering nurses and midwives, on the one hand, and allied health professionals, on the other.

Pretty much across the board, those groups have done some very useful work and have ensured that all aspects of education, training and workforce development being led by the Department of Health and the SHAs have been informed by some coherent professional input and opinion. For those reasons, the White Paper stated, right at the start, that Health Education England’s advisory structure would build on that which had been developed in Medical Education England in the Professional Advisory Boards. As far as I am concerned, we need to ensure a smooth transition of those arrangements. All the groups are doing some very important work, from the sort of work I talked about on medical education to some changes to the undergraduate pharmacy curriculum, which will improve the training of pharmacists. All of them have important work going on. They bring all the stakeholders to the table: sometimes there may be disagreement but there is a place for those disagreements to be worked through, rather than the Department being advised by conflicting parties. We will need to ensure a smooth transition of those arrangements into Health Education England.

In terms of the individual programme boards, that will not be too complicated to achieve and the professionals round those tables expect to come into the future. There are a few professions which are not yet covered within those different boards and we certainly need to make sure that all the health professionals have some means of their interests being represented through the advisory structure. We have not worked out how we are going to do that yet, but we certainly intend to do so.

The missing bit comes back to the discussion we had about the multi-professional debate. At the moment, the main board of Medical Education England brings the four professions within Medical Education England’s remit to the table and has done some useful work on looking at healthcare issues in a cross-professional way. Health Education England will need to ensure some means for it to have strategic multi-professional advice that finds solutions to the workforce problems of the future. Again, that is in discussion. I do not yet know exactly how we will do that, but we certainly will do it in some way.

Q40 Dr Poulter: In terms of the relationships and responsibilities of Health Education England and the need for educational boards or local skills networks, it will be more at a national level than a local level. How do you see that?

Christine Outram: You have to do some things at a national level.

Q41 Dr Poulter: What are they?

Christine Outram: They are national functions. There are very small specialties, for example, where branches of some of the professions need very few people—types of medicine where you might need about 10 people across the country. There is no sense in that kind of workforce planning being done at a local level. HEE will need to make sure there is a national view that keeps an eye on those smaller specialties, for example. Another example, also in relation to medicine, is about the recruitment of junior doctors for the different specialty training paths. At the moment, that is led by a partnership of the strategic health authorities with the Department of Health and Medical Education England. There is an understanding that, to get that planning right, you need to take a national view. Again, HEE will need to make sure that there is a view which is safely transferred from the old system to the new.

Much of the strength of the new system that is being proposed will depend on the involvement of providers, professionals and employers on the ground locally. A large part of their workforce plans will be made up on the basis of what those particular primary care practices and hospitals believe they need for the future. There has to be a balance. I do not believe that HEE will start to specify hundreds of different outcomes to be achieved in a particular year, but it will set some standards and some priorities.

Q42 Dr Poulter: I want to follow up on that, and this is very much what Jamie Rentoul was saying earlier about local service providers and healthcare providers having much more of an interest in the education, development and training and having much more of a voice in that than perhaps they do at the moment. In terms of the training of doctors, a lot of the essential training, historically, that provides the basis and the basic knowledge for community care and general practitioners’ care is provided in the hospital setting, initially, in terms of paediatrics, obstetrics and gynaecology and psychiatry. That used to be six months and is now four months since the European Working Time Directive came in. That is a great amount of clinical exposure, experience and training that has been lost to general practitioners. Do you think there needs to be a review of that in a national setting?

Christine Outram: I will ask Patricia to start off.

Dr Hamilton: The Department has worked before with the Royal College of General Practitioners to look at enhancing and potentially extending the duration of training for general practitioners, which currently stands at three years in total. The case is being re-looked at presently by the Royal College and will be submitted, in the spring, to Medical Education England for consideration. There are two things to be considered. One is the strength of the educational case and the other is the cost-benefit analysis, balancing...
the inevitable costs against the benefits that we have. Those cases will be considered early next year.

**Q43 Dr Poulter:** I have one final question. It is at a slight tangent but it will be of general interest, I am sure, to members of the Committee. There is a growing wish, in particular, for simulators in training and multi-disciplinary working and training in emergency scenarios that go on in hospitals. That is being developed at a local level. I know the Chelsea and Westminster Hospital has this in obstetrics. Is the Department of Health looking at how that education and training could be beneficial to the agenda, for example, that we have in areas like obstetrics and gynaecology or emergency medicine to overseas aid and development; how the Department and our training programmes here can link in better overseas; and how our doctors could benefit and help—a symbiotic relationship to their training and the overseas aid programme—by improving education in that respect?

**Dr Hamilton:** It is an enormously important topic. Technology-enhanced learning generally, a combination of the simulation techniques and E-learning for healthcare, can be—and we anticipated that it must be—an important part of training both here and, as you say, with potential for distance-based learning. The Department is about to publish a strategy and framework for technology-enhanced learning. We also believe that the new system would be an excellent one. This is the sort of innovation and good practice which is potentially expensive and needs to be used wisely, but can be used as part of a network very constructively. I strongly support what you are saying. We are supporting it, too.

**Q44 Dr Poulter:** I have a quick supplementary to that. Concerns are sometimes raised, for example, by doctors who are linked with the armed forces, and also doctors who want to go and spend some of their training overseas. They have difficulty in negotiations with the deanery, even though it would be very beneficial to the countries they are going to, and indeed to the armed forces, as well as beneficial to their training and British medicine when they return. There are difficulties with the deaneries in this respect at the moment. Is that something you will be looking into?

**Dr Hamilton:** We will. We have looked at it with the Ministry of Defence. I know that the Royal College of Surgeons runs a very intensive simulation programme for doctors going overseas into warfare situations. With the armed forces themselves, there is not a problem. Certainly, one thing we want to do in working with the deans and deaneries is to ensure there is consistency generally on the issues of study leave and out-of-programme training and experience.

**Q45 Chair:** Before we leave HEE, can I ask about the intended relationship between HEE and the other home countries and the extent to which this is a UK-wide brief? All the questions we have discussed about the links with the regulators, the development of training and so forth, are clearly UK questions. They are, in particular, in relation to smaller specialties but not only in relation to them. **Christine Outram:** They are indeed, and that is obviously the case now. With Medical Education England, therefore, we have been very conscious that we have to take a UK perspective on anything we do, and work with our colleagues in the devolved Administrations. We are a very small advisory body, but we have established good links with Scotland, Wales and Northern Ireland. HEE will need to continue to do that because you cannot make changes to the training of our major healthcare professionals within an England-only context, particularly, as you say, in some of the smaller ones. We will establish and build on the relationships as we have them now.

**Q46 Chair:** You are seeking to develop a UK view before you move. You said you could not do it without taking the others with you, which was quite a strong statement. **Christine Outram:** Perhaps my language was not tight enough. I do not think HEE has to take a UK view, but it has to bear in mind that the labour force it is working with—the market it is operating in—is UK-wide. For example, if it was to cut the number of healthcare scientists it was training, in my opinion, it should not do that without discussing it with the devolved Administrations. It would be pointless. They are all involved.

**Q47 Chair:** There is a bit of a tradition of Scottish-trained doctors in England. **Christine Outram:** Indeed. **Jamie Rentoul:** Some of the Scottish numbers are now reducing and, therefore, that has a potential impact on England. It is about having the exchange of information so that we each understand what is going on.

**Q48 Dr Wollaston:** If you increase the time of training for GPs to five years, would you only be able to do that if there was a similar change in Scotland? **Dr Hamilton:** We are working with the devolved Administrations on this. When we are discussing this, we are discussing it with them as well.

**Q49 Dr Wollaston:** Would you not go ahead with it unless it was across national boundaries? There is a real concern that we might see inconsistency here. Doctors, of course, are constantly moving across boundaries. **Dr Hamilton:** It would be a real shame if we could not get agreement with the DAs, and we will work very closely to make sure that whatever agreement we reach is compatible across the borders. You are right in that we do not want to disadvantage trainees. Clearly, we each have to recognise each other’s CCTs. It would not de-recognise a training that was of a different length, because we are part of the European Community, but we would prefer to go ahead with agreement from them. Scotland has already piloted a four-year GP programme, so we are hoping that, whatever solution we come to—and we have not yet made that decision as to whether it is four, five or whether we can justify the extension at all—we will
be making it in conjunction with representatives from the DAs.

Q50 Dr Wollaston: Further to that, on the point of GPs, there is a concern that we are not training enough GPs considering that we are moving to a primary-care-led service. Is that something the panel shares a concern about?

Dr Hamilton: We do share that concern. It is one of the issues we think the system is here to be cognisant of and try to fix. We have been aware of a specialist drift and that we are training more specialists than generalists. That includes general practitioners but, also, general surgeons, general paediatricians and general physicians. We now have the accurate numbers. We have made more general practitioner places available in the recruitment rounds over the last two years and have increased and intend to continue increasing that proportion.

Q51 Dr Wollaston: One problem, of course, is that those places are often not filled. How are you going to drive a change so that trainees have realistic expectations? They cannot all become renal specialists. As people go through medical school, they tend to have very much a hospital-based focus, and I wonder what plans you have to change that.

Dr Hamilton: You are absolutely right. Every year we publish the competition ratios. I write an article in the BMJ about careers saying, “Be aware, if you are applying for surgery, these are the competition ratios.” but, still, they apply. We know that we need to address this issue at several levels. There is the expectation when you apply to medical school—the hidden curriculum, the subliminal messages that are given—that, if you are doing well, you ought to be a specialist at medical school. Also, we have been working with the Royal College of General Practitioners on our career websites to give positive podcasts to try to attract young people into general practice.

Finally, we have a big project called “The Shape of Training,” looking at the shape of postgraduate medical training, in which we are trying again to take forward some of John Tooke’s recommendations. We are starting with the option of a more broad-based training, following foundation, which includes paediatrics, general practice, psychiatry and medicine. For those who are undecided, they can get experience and training in those specialties and then can transfer the competencies and skills they have acquired across to their final chosen specialty. They do not have to start again at the bottom of the ladder.

Q52 Dr Wollaston: That is a very important point, yes.

Dr Hamilton: We are hoping that we will attract young people into psychiatry and general practice, which are both under-recruiting at the moment.

Dr Wollaston: Thank you.

Chair: Still we have a discussion about whether there should be competition in medicine.

Q53 Valerie Vaz: I want to turn to the new architecture, where HEE fits into it and how you are going to interact with the different bodies; for example, Public Health England, the commissioning groups and, as Mr Rentoul mentioned, employers. That has come up quite a few times. How would you see it all working in terms of education and training, for example, now that we have Hinchingbrooke Hospital being taken over by Circle? Is that what you meant by employers?

Kate Lampard: As far as the other organisations, and where HEE fits in the new architecture, are concerned, it is important that it acts as an integral part of the system and that it has working relationships with the NHS Commissioning Board, Public Health England and regulators, CQC, Monitor, the professional regulators and the Royal Colleges. Unless one understands the priorities of those organisations, one is not going to make much sense of the workforce planning and be able to address that in delivering the numbers of trainees to fulfil the priorities from those organisations. On a general level, I see this as a two-way communication and involvement. It is not simply about HEE having to be apprised of the priorities of those other organisations. Equally, of course, HEE will have information about how employers and the service generally are fulfilling their responsibilities to train the right staff.

Q54 Valerie Vaz: Are you capturing data in some way? Is there a mechanism for capturing data?

Kate Lampard: As I see it, there will be. If we have an authorisation system and criteria, and if we have an ongoing accountability, we will have to gather the information to assure what they will tell us. I hope we will also gather very soft information, for instance, about students’ or trainees’ experiences. That sort of information should be handed on to the other parts of the system having responsibility for policing the system as much as we do. It is that sort of general view.

Jamie Rentoul: In terms of the employers—healthcare employers generally—you want a system, to take your example on Hinchingbrooke, that should be part of the training and education system. Therefore, you want third-sector providers—Macmillan or whoever—to be involved in your Education and Training Boards if they are providing NHS-funded services. We are thinking about the training needs in the round.

Q55 Valerie Vaz: Do they sit on a board or a local group?

Jamie Rentoul: I was being less specific than that because we have not yet published the Government response. In terms of the Education and Training Board, you would expect that to have healthcare employers represented and the academic health sector and the education sector represented as a detail of that representation. You cannot have them all on it, but you need employers to have confidence that their needs and interests are being taken forward in the work of the board.

Q56 Valerie Vaz: Does anyone have anything to add?

Christine Outram: Perhaps the other relationships to think about, which are particularly important, are...
Dr Hamilton: Most definitely. The dean should be terms of their training. Are they going to be involved up what the students say about a particular hospital in deaneries are quite good—or so they say—at picking up what the students say about a particular hospital in terms of their training. Are they going to be involved in it, too? Do you have a role for the deaneries?

Dr Hamilton: Most definitely. The dean should be part of the board, because it is crucial that they represent the quality of education and training, and also the relationships with, for example, the Academic Health Science Centre, so that the research and innovation sector is also represented.

Q57 Valerie Vaz: You mentioned the students. The deaneries are quite good—or so they say—at picking up what the students say about a particular hospital in terms of their training. Are they going to be involved in it, too? Do you have a role for the deaneries?

Dr Hamilton: Most definitely. The dean should be part of the board, because it is crucial that they represent the quality of education and training, and also the relationships with, for example, the Academic Health Science Centre, so that the research and innovation sector is also represented.

Q58 Valerie Vaz: I will give you a scenario. We have had women dying in hospital while giving birth, and there has been a shortage of midwives. How is that picked up in terms of training more midwives? There is also a Department of Health initiative saying that there must be more health visitors. We are not sure we need health visitors. Whose job is it to say to the Secretary of State that we need more midwives, not health visitors?

Jamie Rentoul: Within the system, the Secretary of State will give a mandate to the NHS Commissioning Board, in terms of service outcomes in return for the money allocated. That will cover maternity care and, indeed, the offer to families and under-fives which health visitors then help deliver. He will also, in a similar way, have a mandate to Health Education England with some resources attached to it which work is going on and will be taken forward after which gives you function and some decisions on form, discussing it. Pending the Government publication, local employers and education institutions, are Edward Glinion, Dr Patricia Hamilton CBE, Kate Lampard and Christine Outram

Q59 Valerie Vaz: That is spoken like a true, good civil servant. I am thinking more along the lines of HEE having a separate responsibility. You know you need more midwives, because that is going to plug the gaps, than you do health visitors. How does that get fed into the system, into the Secretary of State and into that pot of money? You will get the soft and the hard evidence, will you not, that there are not the midwives out there?

Christine Outram: Yes. You would probably do both things. If a Secretary of State—that is all speculative now—had a particular priority because of a national situation, HEE would need to take that on board. It is accountable to the Secretary of State. It will have a mandate—an agreement—with the Department that will be reviewed, over time, to deliver certain things. If Health Education England was aware there was a real shortage of midwives coming up and supposing—I know it seems unlikely—the Department of Health had not realised that, it certainly would be Health Education England’s role to make sure the Department of Health was aware of particular problems brewing and, therefore, the action it would propose taking. The money, of course, goes through Health Education England. It would need to agree how it is going to spend it with the Department of Health, but different priorities can all be met and have particular—

Q60 Valerie Vaz: Do you have the framework for that in terms of passing down the money and the training? Do you have the framework to set up what is needed?

Jamie Rentoul: To a certain extent, it is building on where we are now. The strategic health authorities— and you have Tim Gilpin coming next—will, if you take the maternity example again, think about what is happening with the birth rate, complexity, age profile and so on, in terms of service need. For example, “What do we need to do in terms of doctors, midwives and maternity care practitioners to deliver safe and high quality care? What does that mean for numbers of training commissions when we understand attrition, participation rate, retirement patterns and so on?” That is leading to SHAs, at the moment, commissioning education training places, keeping a tight eye on completion of courses and people getting into jobs after them. Therefore, the new system is building on what we currently have in that respect.

Q61 Chair: Do you know yet how many Local Education and Training Boards there are going to be across England?

Jamie Rentoul: No, not yet. The SHAs, working with local employers and education institutions, are discussing it. Pending the Government publication, which gives you function and some decisions on form, that work is going on and will be taken forward after we publish.

Q62 Chair: I am all in favour of form following function, but you have put the emphasis on “local” and links with employers. How many of these bodies there will be, and what shape they are going to take, is not an unimportant detail, is it?

Jamie Rentoul: The discussions at the moment suggest they are going to be quite big—10 to 15 across England, not 200.

Q63 Chair: That is roughly the same number as there used to be SHAs.
Jamie Rentoul: It is perhaps 10, and deaneries is 12.

Q64 Valerie Vaz: Is that a general figure, or are you suggesting that is what might be the case?

Jamie Rentoul: That is what some of the discussions at the moment say. The Secretary of State has not made a decision yet.

Chair: That is the level of local engagement rather than one training board per acute trust under discussion.

Jamie Rentoul: Yes. The general view in consultation with people is that that sort of level is too local and you do not get the right scale to think about experience, right rotations and so on and so forth, and you have issues in the system about the right running costs.

Chair: I can understand that and have a lot of sympathy with it. The counter argument will be that local engagement, from a commissioner point of view, at a regional level has always been quite difficult to establish.

Christine Outram: The issue is that you would be looking at too small a scale to do it locally. The challenge is going to be getting the employers involved, which perhaps comes back to the balance of power discussion that we had and getting that right.

Chair: We are very short of time now, but there is a question on deaneries, and we should not avoid funding.

Q67 Dr Wollaston: I will ask very quickly about deaneries. The Department has said that the functions of postgraduate deaneries are going to move to the local skills network. Could you explain how that is going to work and what it means for the survival of deaneries themselves? There are many people who feel that deaneries do a very good job and are concerned about them disappearing.

Dr Hamilton: They are very important and their function is essential. We have done a lot to assure their continuation during transition and the intention is that they continue beyond transition with, probably, many of the same staff. We have to talk about functions rather than individuals, but those functions will continue into the new system architecture.

Q68 Dr Wollaston: They will not lose any of their functions but will probably expand their role and become more multi-professional. Is that how you envisage it?

Dr Hamilton: Yes, absolutely.

Dr Wollaston: Thank you for clarifying that.

Q69 Chris Skidmore: Mr Rentoul, in one of your earlier answers, you mentioned there is a fixed pot of money. Obviously, in terms of the funding for the multi-professional education and training levy, at the moment, for 2011–12, that is flat in cash terms, but I imagine a decrease in real terms. Also, there are reports that the levy itself is being cut by 15% over three years, if I am right. I was wondering what the reasoning behind this was. Might you be able to shed some light on it?

Jamie Rentoul: I do not think you are right on the cut point. The multi-professional education and training levy—central funding—is broadly flat cash, a 2% cash increase with dentists’ vocational training going into it. That is the kind of position.

Q70 Chris Skidmore: I will blame Healthcare Finance for the error. It is not my own.

Jamie Rentoul: We had discussions with the strategic health authorities when we did not know what the spending review settlement was.

Q71 Chris Skidmore: None the less, at the same time, there will be an increased burden on the MPET in terms of not only midwives’ but also health visitors’ increased training. Do you not see there is a mismatch? Even a 2% increase in cash terms is not necessarily—

Jamie Rentoul: Certainly, there are pressures on it regarding health visitors. Improving access to psychological therapies is another pressure area. Equally, there has been progress made with some of the lowering of attrition rates from courses. You do not need to train quite as many people if you are managing to hold on to them well. In some SHAs there has been a small drop in nursing commissions in making sure they have the balance right.

Q72 Chris Skidmore: We have had reports of universities that their commissioning is decreasing by 10% to 15%. We can talk about it, but the information we have had is that if there are cuts, they are being front loaded to the first year. In some universities they have seen 50% cuts in midwifery courses. I do not know if you would recognise that at all.

Jamie Rentoul: I would not recognise the midwifery numbers because the commission numbers in midwifery are still at near record levels. Some of the nursing numbers have gone down, a reflection of us having gone from a period of significant overall NHS funding growth to a more constrained position such that it is about getting a balance. You do not want to be producing so many nurses that you are creating unemployed nurses.

Q73 Chris Skidmore: Regardless of this position, we are going to have a significant shift from the MPET towards tariff-based funding. That looks like it is coming on the horizon. Again, what was the rationale for that? Was that a flaw in the MPET system itself?

Jamie Rentoul: Within the multi-professional education and training budget, money goes out to real people in three ways. First, it goes through the NHS bursary, administered by the NHS Business Services Authority. That supports the living costs, essentially, of health students. Secondly, it goes through the benchmark price with universities for non-medical courses—nursing, midwifery and AHP. There is an agreed price, which is, effectively, a tariff such that the competition is on quality of what is being provided. Thirdly, it goes to support clinical placements, either through the service increment for teaching for undergraduates or the medical and dental
education levy, as it is called—I am lapsing into management-speak jargon—for the postgraduate. It is that clinical placement bit that, at the moment, is not a fair tariff across the country. It reflects historical allocations. That is what we are proposing you should have: a fair tariff so that funding follows the student trainee equally and, therefore, the additional costs of providing clinical placements are met.

Q74 Chris Skidmore: How this tariff will operate is still under consideration at the moment. Is that right?
Jamie Rentoul: Yes.

Q75 Chris Skidmore: Are there any particular options that you are still considering and have not made up your mind on?
Jamie Rentoul: In the consultation the Government said it was committed to the principle of tariff but recognised that we should move with care in terms of funding flows. In anything like this, where you are trying to get an equitable tariff from the previous position, you get winners and losers. You need to make sure people have enough planning time and clarity about where they are going to be able to make the adjustment in terms of their overall finances.

Q76 Chris Skidmore: Within the framework of the tariff, there have been two issues that we have certainly been made aware of. One was quite recently on the Health Service Journal website, “Private sector warns of training levy danger,” as to there being a disproportionate levy placed upon the independent sector. Their argument is that the independent sector does provide sufficient training, if not more than is recognised. Obviously, they are worried. They also claim that they have been deliberately excluded from the Future Forum. I do not know if you have any comments on the role of the independent sector and the fact they may be facing a heavier tariff burden.
Jamie Rentoul: Separating out tariff, which is how the money gets allocated to training providers, from levy, which is how the money gets collected in the first place, at the moment, the multi-professional education training funding is a top slice from the overall allocations. What we consulted on was whether—in terms of transparency and people understanding the actual costs of education and training and having all those receiving the benefits of it contributing to the cost—there would be merit in moving to a levy for all healthcare providers such that a percentage of whatever figure you choose on income would be levied from them to contribute to the costs and then be allocated back out through tariff. In the consultation, we said that is quite a big shift. It needs careful thought, modelling and thinking across the NHS, the independent sector, the third sector and the implications on people coming in from the EU and so on. We should take our time to do that. That is the next step on this path, and for the Secretary of State’s confirmation.

Q77 Chris Skidmore: The other issue, very quickly, is that the new levy would not cover post-registration training and continual professional development. Instead, that cost would be met by the employers.
What is the rationale behind that?
Jamie Rentoul: In the current system, the multi-professional education and training funding is very largely for the development of the next generation. SHAs have some flexibility to say that there are particular issues on bands 1 to 4, training or continuing professional development or other aspects of innovation, which they think would be strong value for money to carry out. In the consultation, we said perhaps we should restrict the multi-professional education and training levy and reinforce the employer responsibility for CPD investment, which would give better transparency about what is happening there. That is a key bit of right skills of the workforce. There was a pretty strong view coming back in consultation that the flexibility is valuable. You do not want to get locked into a professional or non-professional line but you do need employers to have the flexibility to think about the right skill mix. Again, we will be reflecting on that in the publication.
Chris Skidmore: I wonder if anyone else on the panel has any comments on the concerns I have raised. I know there were several there.
Chair: That probably concludes this session. We have had witnesses who have been waiting for half an hour now for us to get through what has been a very full session. Thank you very much indeed.
Q78 Chair: Thank you for your patience, and I apologise for keeping you waiting. Could I ask you, briefly, to introduce yourselves and tell us where you come from?

Peter Sharp: Hello. I am Peter Sharp, Chief Executive for the Centre for Workforce Intelligence. By profession, I am a psychologist and was Chief Psychologist in Southampton till 10 years ago when I moved to the private sector. I have worked as Director of the National Healthy Schools Programme before becoming Chief Executive of the Centre for Workforce Intelligence.

Tim Gilpin: Good afternoon. My name is Tim Gilpin. I am Director of Workforce and Education for the northern cluster of strategic health authorities, which was brought together about a month ago. That encompasses Yorkshire and the Humber Strategic Health Authority, the North East and the North West. I have spent most of my career working within the NHS in hospitals, community services, mental health services and, more latterly, at strategic health authorities.

Q79 Chair: Thank you very much. I would like to start by directing some questions at Peter Sharp about the Centre for Workforce Intelligence. This is obviously absolutely central to workforce planning processes. Could you tell the Committee a bit about the work that you do and also cover the slight oddity—possibly—that you are an organisation within the private sector owned by a private sector company?

Peter Sharp: Yes. The centre’s primary purpose, a bit like Jamie said earlier, is to improve people’s lives. What we are about is not only producing intelligence to inform better decision-making. It is decision-making that ultimately improves people’s lives. In essence, it came into being following your last Health Committee report, and I paraphrase, that said there had been catastrophic failures of workforce planning for 15 years. A lot of the system distrusted the advice that it was getting. The centre was created as a contract which was tendered openly and competitively, and both public and private sector bodies tendered for it. It could have gone either way. We were appointed to run the centre and we have been in existence now for 16 months. We opened our doors in July last year. We also TUPE transferred most of the NHS Workforce Review Team into the Centre for Workforce Intelligence. While we are private, we have a number of the workforce planners that were in the NHS Workforce Review team working with us.

Q80 Chair: How many of those are there and where are they?

Peter Sharp: There were 28 who transferred across to us. We have maintained the Winchester office, where their Workforce Review Team sat, rebranded as the Centre for Workforce Intelligence, we have a Westminster office, across the road in Matthew Parker Street, and we have a small office in Leeds near the Department of Health.

Q81 Chair: In terms of how you work, what is the source of the data you are using, who are the customers for the data and how do you relate both to source and customer?

Peter Sharp: There were lots of questions in there. As to sources of data, we analysed, on appointment, nearly 100 sources of data that were available to us. We looked at what the previous Workforce Review Team had used, which was a smaller number of data sets than we currently access. We are not a data warehouse. Our job is not to house data. It is to use data and turn it into intelligence. Primary sources include the NHS Information Centre data they furnish and ESR, the employment records. We work with the GMC. We work with the Royal Colleges. We have an expansive stakeholder map of people who hold that data. We have tried to do the equivalent of “Trip Advisor” on it as to its relevance, value and whether or not you would want to use it and so on. We are in the process of categorising data, which we think has great merit.

I should say that the centre is responsible for health and social care, so it looks at integrated healthcare, not just at health. We also access the national minimum data set for social care, which has the virtue of being a genuine national minimum data set, although only about 50% of employers currently complete their returns on that. There are issues about data that have always plagued the veracity and accuracy of workforce planning. There are two aspects to that. One is about completeness. The second is about quality. We have been working closely with the Information Centre and the GMC to look at how both of those might be improved. We are not only a customer of those organisations, in terms of using data they supply, but an influencer in the fields in which data is collected. As the centre evolves, it would be our hope to see the construction of a core national minimum data set for health and social care. Going back to earlier discussions, there needs to be collection of local data. We already take that currently, from SHAs, PCTs and, indeed, foundation hospitals. We have all those sources of data in health. Within social care, there are 44,000 employers and we have started to negotiate points of entry for collecting data even from the private sector employers within that. We talk to the private sector employers in health as well.

Q82 Chair: Are you developing your information based on the data you collect in response to questions asked of you by key customers, or are you sending information at large and hoping somebody uses it?

Peter Sharp: I do not think we send information at large and hope that people will use it. Our intent is to look at how the quality of the intelligence that we furnish impacts behaviour. I can say—and I know you are aware of this—that there were three or four years of data each year saying where there were shortages in particular specialties of doctors. There was oversupply of some specialties, and the numbers were not regarded. When we produced our first set of data,
in August last year, we looked at which of the strategic health authorities implemented the advice and guidance—and that is the status of what we produce—and implemented it. In nine out of 10 cases, it was to the number. We worked closely with the tenth case to tell them that, the following year, the numbers they had not regarded would go into the numbers for 2012. So they would compound the problem by choosing not to follow or have due regard to the advice. We are more interested in impact of reporting and we certainly are not simply publishing and then travelling in hope, as it were. Our ambition is to work closely with the stakeholders to make sure the advice and guidance we produce is tailored to their needs. To that end, we are working more closely with the employers than was the case, for example, in the Workforce Review Team.

Q83 Chair: Presumably, you have quite an important customer sat on your left.
Peter Sharp: I do indeed, yes.

Q84 Chair: How would you characterise the value the centre has added to your work?
Tim Gilpin: For us, it is fair to say that it is early days with the centre. As Peter has said, it was established a little over 15 months ago. A lot of the work has been nationally specific, particularly around medical staff, for the reasons that Peter has said. But we welcome the arrival of the centre, particularly for those national and, indeed, international issues they can bring to our attention that help inform local workforce planning. We welcome their arrival and employers, in general, do as well.

Q85 Chair: Can you put your finger on instances where you are making decisions now on the basis of better information than you used to? You have been in this field for some time.
Tim Gilpin: Yes, I think there is a lot more rigour around the medical workforce planning model. Peter liaises very closely with the Royal Colleges and other national colleagues to understand both the supply of doctors into the system and what is coming through our plans, but also alongside the Royal Colleges. The quality of that information and the first report that was produced, which went into all the different medical specialties, was a lot better informed than we have had in the past.
Peter Sharp: We published, again in August this year, for the 2012 numbers and, on the back of that, each of the 62 medical specialties had individual liaison with us. We are much closer to the mark now in understanding what the view and perspective is. Where, for example, a college disagrees with us, we put that in the report and say why they disagree. Then, if we are maintaining a recommendation which is in disagreement, we say why. In the past, what tended to happen was that there was more horse trading and a number went in. What we try to do now is say what the evidence base is that leads us to the recommendation or the conclusion that we have. That is a significant shift in the way it is done.

Q86 Chair: To understand one of the implications of the earlier discussion, are you making recommendations about numbers of different types of skilled person independent of the training budget?
Peter Sharp: Yes. Let us take the three broad areas that the centre works on: leadership, intelligence and planning. Until now we have concentrated on intelligence, which is very specific, at the end of the day: how many people should there be, what should they be doing at what level and where should they be doing it. In addition, we do thought-leadership pieces where we look at it, for example, from the patient service user or citizen perspective—patient for health, service user for social care and citizen for public health. We try to look through the lens of what they are in receipt of, work backwards to who might provide the service, and then travel forwards. Our ambition is to work closely with the stakeholders to make sure the advice and guidance we produce is tailored to their needs. To that end, we are working more closely with the employers than was the case, for example, in the Workforce Review Team.

Q87 Valerie Vaz: Mr Gilpin, how do you plan for the NHS workforce in the north of England and how far ahead are you looking?
Tim Gilpin: In terms of the way that we plan, we have had quite a good discussion this morning about how medical workforce planning is co-ordinated nationally. From the bottom up, the way that we work, first of all, is to start with the provider workforce plan. The provider workforce plan will have workforce finance and activity as part of that plan, but it is the workforce element, obviously, that we are interested in. We take a five-year outlook for non-medical staff. There are all sorts of pitfalls in all of this, which we may come on to. Nevertheless, that is our starting point. We take that into a dialogue with commissioners, in particular, so that while the provider plan should reflect commissioner intentions, we think it is very important—indeed, local health communities do—that they work on these things together.

As we look at the QIPP challenge and things like that, we are seeking reconfiguration of services, more integrated care and planning much more along a pathway rather than within an institution. We think it is very important that commissioners are involved in shaping that plan. We also take the national priorities, the things that we talked about earlier, in terms of health visiting and access to psychological therapies—any of the national drivers that we have in the system and which, in future, may come through HEE. We are...
taking care of that as well. Basically, we then prepare a regional development plan that aggregates those things. It also takes into account any regional initiatives. For example, under the Darzi review of two or three years ago, every SHA published a strategy. That was along certain themes. It may have been around trauma or end-of-life care, but things that, as an individual provider, it is not possible to plan for. Those are things that we need to take care of regionally. That is how we do it, basically. We base our commissions with universities on that as well, and the CPD elements that Jamie Rentoul talked about earlier. The one thing I would emphasise about this is that it is all about dialogue, relationships and talking through the issues the particular providers and health communities are facing. There is no substitute for that. It is okay filling in a plan on a piece of paper with numbers on it, but we think that is a critical role for the SHA in working with employers and local communities to take forward. That is how we do it.

Q88 Valerie Vaz: What if your local plan differs from the national priorities?

Tim Gilpin: It seldom does because the national priorities are fairly limited in terms of what they ask of us. This year, the only national “must do” issue relates to health visitor numbers and that is what we are working on anyway. The other thing that seems to happen is that themes develop, both sequentially and in parallel, in terms of what clinical issues are facing the country. Often, the bottom-up plans are what people would have expected to see anyway in terms of some of the clinical developments that are occurring in hospitals and community services.

Q89 Valerie Vaz: How do you see that fitting into the new system?

Tim Gilpin: The way I see it, and, certainly in the north of England, the way that we are talking about setting up the local skills networks, which you have heard about, is that they will be coterminous with the current workforce directorates that work very closely with the providers and commissioners along the lines I have said. To some extent, this is as complex as people want to make it. If we have good relationships now, if the strength of our plan is tested by, “Do we have big surpluses or big shortages of staff?” and the answer to that is, “We do not. We think we are getting it roughly right,” it should be a relatively straightforward transition into the new. The relationship with the centre, I would hope, will be much as it is at the moment with the Department. One has to accept that there will be—and quite rightly—a dialogue and an overview from HEE in terms of quality, national standards, national career frameworks and things that, realistically, can only be done nationally.

Q90 Valerie Vaz: As to the good relationships that you have, who are you having them with now and are they going to be different people under the new architecture?

Tim Gilpin: I do not think they are.

Q91 Valerie Vaz: Are they all still there?

Tim Gilpin: Yes. They are largely with employers and now, as we have reformed the system, it is with PCT clusters as commissioners. Looking forward, they will become the embryonic parts of the NHS Commissioning Board. Personally, I do not see a massive change in that. But, of course, the governance arrangements will change depending on the guidance that is issued on the skills networks and how they would work.

Q92 Chair: There is an issue, is there not, over the rate of change? You describe a system where everyone knows roughly where they are going. But if the Nicholson challenge is going to be met, one of the things increasingly talked about is the need to change the way care is actually delivered, which will have implications for the skills network. Is keeping the workforce aligned with a faster rate of change more problematic than perhaps you are suggesting?

Tim Gilpin: I do not think it is problematic if employers get engaged to the extent that the reforms would see them getting involved. For me, the people that have to be on their feet, agile and understand what commissioners wish to do have to be the employers that employ the staff that we educate. Yes, you are right. If the system does not change, the speed at which it can respond may not be fast enough to keep up with the challenges you have suggested.

Q93 Chair: Going back to the subject we were exploring earlier, one of the potential breaks in that process is professional conservatism.

Tim Gilpin: Yes. I think that is right.

Q94 Chair: With a small “c”.

Tim Gilpin: I think that is right. As to the way you characterised it earlier, I do not see this as good and bad. It is healthy tension in a system that needs checks and balances within it. Neither part of the system should dominate, in my view. You are right that sometimes people out there—employers—would say, yes, the professions are conservative with a small “c”.

Peter Sharp: Can I add to that? My tutor, when I trained as a psychologist, John Bowlby, said, “There is no progress without conflict.” You alluded, earlier, to tensions between different organisations. There is, of course, constructive discontent and constructive conflict and then there is destructive of both varieties. What I see starting to happen, which I think has come about with the pace of change, is that you can have a conversation and a genuine dialogue. I am not saying, necessarily, people agree. Why would they? But what is happening is that we are talking about things discussed in rooms but not properly aired. We are talking about role extension, role substitution, different ways of working, new categories of workers, different stration of career structures and so on. All of that is now out in the open, which can only be a good thing.

The second point I would add, on the back of what Tim was saying, is that, apart from local workforce plans, what we need to do is have a much longer-term focus on workforce planning. Hitherto, it has tended to be one, two and three years and driven largely by
finance. What it needs to be is 10, 15 and 20 years and, based on what the needs will be over there, work backwards from that. Otherwise, what you tend to be doing is constantly looking at what is happening now, next year and possibly the year after. That is part of what our initiative on horizon scanning is doing. That involves groups of universities and stakeholders from health and social care. We will be publishing a whole series of policy briefs about each of those areas on long-term and long-range planning.

Q95 Valerie Vaz: Do you have much flexibility about length of time—the flexibility to be looking over 10 to 15 years?

Peter Sharp: I am not sure what you mean by, “Do we have the flexibility?”

Q96 Valerie Vaz: I mean the flexibility to know when things are changing.

Peter Sharp: First of all, there are ways to look at what they call “megatrends” and “wild cards”. A megatrend would be obesity or ageing population or things that are known, and we even have a good handle on how much. We know what the demography will look like in 10 and 15 years’ time with a good degree of accuracy. We know, based on the last 20 years of what has been going on with obesity, it is not likely to turn around in the next three to five years. Those things we have some handle on. Christine Outram talked about trying to look ahead because it is 15 years from your A-levels to being a consultant, and that is on a good year—having no absences, electives or whatever. You have to look 15 and 20 years ahead in order to have the right number of consultants because they are in the system now. We have to know what is going to happen in 10 and 15 years.

Q97 Valerie Vaz: I want to go back to my midwife point. It took women dying, and not having enough midwives, for people to realise that you needed more midwives in the training system.

Peter Sharp: I do not want to disagree entirely, but I would say there are midwives often in the wrong place and not prepared to move. There are midwives who have left. When we look at the number that there are—

Q98 Valerie Vaz: But there is a problem there, is there not?

Peter Sharp: There is a problem of getting—

Q99 Chair: Forward planning has to discount for the fact that you are employing human beings.

Peter Sharp: No, on the contrary. I would say that the finer tuning of the workforce planning is getting a handle both on the numbers and then on the regional, sub-regional and locality levels. The number of midwives is at its most difficult in London, but there is a surplus of midwives in Manchester, where there also happens to be a training centre, where very many are trained. It is very hard to get them, for financial reasons, to want to come and work in London. Part of the workforce planning has to be about re-examining where we put the training, not just the global numbers of how many midwives there are.

Going back to an earlier question about Local Education and Training Boards and how many there are, one part of our work in 2012–13 is to get from national down to regional—or whatever word is used instead of “regional”—and then local and hyper-local. We have a project where we will have GPS plotting right down to a hospital level where we will say where there are shortages. We will have a “red, amber, green” of any of the professions, whether doctors, nurses or midwives. We have a plan to put in place a system that can show local issues around workforce planning and highlight it back to the system.

Going back to Christine Outram’s point about very small specialities, for example, some of these things are hyper-local because there are only 15 of those hyper-specialist people in the country and there is no service available in the north of England if that specialist retires.

Tim Gilpin: My comment would be that all of this is an art. It is not an exact science where you are going to get it right all the time. The other thing I would say is that about 60%, to 70% of the staff we have currently will be working in the service in 10 years’ time. We are concentrating an awful lot on commissions from universities or doctors when, in fact, quite a lot of investment has to go on with the current workforce.

There are some things it is very difficult to predict. If we think about cardiac surgery 10 years ago, and about what interventional cardiologists and radiologists can do now, the clinical scene does move. The technology and the pace of change is so fast that we need to look—I know Peter is looking at this nationally with colleagues—at how we build flexibility into systems as well to say, “It is not a linear path that we can see exactly what is going to happen in 15 years. Perhaps, in the way we train doctors, we need to have a position where people can step on and off a training programme if the demand for that speciality at CCT level changes.”

Q100 Chris Skidmore: Mr Gilpin, I am sure you are aware that, since about 2005–06 when the ring-fencing was removed from education and training budgets, strategic health authorities have raided those budgets, in the past, in order to achieve financial balance. I am not saying that happens in your local area, but I wonder if you have had any experience of that and its effects generally?

Tim Gilpin: I have not, and I can say, in the north of England, that has not happened. What does happen, which I think happens around the country, is this. If you think about Yorkshire and the Humber, which is the area I am best acquainted with given that I was doing that job until a few weeks ago, we have an MPET budget of about half a billion—£500 million. It would not be prudent or sensible not to hold back some money for eventualities that will occur during the year.

Q101 Chris Skidmore: What sort of eventualities would those be, generally, within the SHA or particularly regarding education issues?
Tim Gilpin: There could be an issue in terms of a particular demand, say, where you have a shortage of staff or where we want to promote a particular issue. It could relate to a return to practice.

Q102 Chris Skidmore: Would it still be within the workforce?
Tim Gilpin: Yes, definitely. But then what happens, when we create a reserve, is that can be used to offset. It is called control totals in the NHS, but it is a budgetary issue. That helps, but it is never taken out of workforce, certainly not in the north anyway, and spent elsewhere. We get that money back the next year. That goes to the point about the flexibility we need to use that money as we see fit. In the last two years, by carry-over and prudent use of money year on year, we have £15 million. That has been spent in clinical skills development and simulation centres, throughout Yorkshire and the Humber, that are used on a multi-professional basis. Certainly, my experience is that it is not used elsewhere. Yes, reserves do accrue, but that is quite a deliberate thing, from our perspective, in order to help either in things that may come up mid-year, as I have said, or to spend on big capital developments.

Q103 Chris Skidmore: It is tiny—one third of a per cent.
Tim Gilpin: Yes.

Q104 Chris Skidmore: I was interested to read your comments in the Healthcare Finance magazine in March 2011 because I did not realise the difference in the figures. You have mentioned, “At some London teaching hospitals the income per student for a placement per year is between £70,000 and £100,000, whereas in newer medical schools such as the Hull York Medical School it would be around £36,000.”
Tim Gilpin: Yes.

Q105 Chris Skidmore: Obviously, if this proposed tariff came in, you would be a tremendous beneficiary. If you could deliver education costs at almost half of some of the bigger London teaching hospitals and the tariff was as mentioned in this article, about £35,000, you would do the teaching very well. You would have a movement of students to your area, would you not?
Tim Gilpin: Not really. That comment about the country applies within an SHA as well. What we are talking about here is a payment that is essentially made for clinical placement. Traditionally, that has only applied to undergraduate doctors in training. Those costs are so embedded, particularly in large teaching hospitals—that is no one’s fault, it is history—there is no transparency. When you do the sums—if we are talking about Yorkshire and the Humber—in Sheffield teaching hospitals it is about £70,000 per medical student that they would get, in Sheffield Children’s Hospital it is about £120,000 and at Leeds teaching hospitals it is £70,000. But all of the DGHs and other hospitals, apart from the HYMS, which I have quoted in there, are much less. That could be as little as £10,000.

For me, the underpinning processes this new system is trying to put in place are critical to getting employers engaged. There are two aspects to that, which Jamie Rentoul mentioned earlier. One is a fair and transparent tariff that follows the student wherever they go. Therefore, people are rewarded for good education because you could move students around if education was seen not to be at as high a standard as you wanted. The other side of it is—and I understand this is a very complex thing to do—a levy that says, “This is your money that we are going to use in education and training.” For me, those two things would add transparency. They would bring employers to be really interested. Therefore, it is not only about the system, it is about the processes and incentives.

Q106 Chris Skidmore: It is very similar to the Any Qualified Provider model.
Tim Gilpin: There are parallels with Payment by Results, the tariff that works in the general NHS. There are parallels with what is called the best practice tariff, which you may have heard about. We could then incentivise places, say, in primary and community care, where, at the moment, training is largely concentrated in hospitals. Having accepted that that is necessary, if we are going to create an NHS that is more based on community and primary care, it would seem logical to me that the systems we produce to underpin it incentivise education in those environments.

Q107 Chris Skidmore: They seem tremendous advantages. Are there any disadvantages, in your own mind, that arise?
Tim Gilpin: Yes, there are. One of them is—and it is back to the Chairman’s remark—about the pace of change. If we were to reduce the income, which is effectively what we would be doing for the two hospitals in Sheffield and the Leeds Hospital, in Yorkshire and Humber, that could destabilise them. Any proposals would have to be worked through over a long timescale so that they were managed properly. Personally, I do not think everything can be “tariffed” because, particularly in education and training, we need resource for flexibility, whether it is clinical skills facilities that I have mentioned or e-learning or other methods of learning we are just discovering and researching. If everything is tied up in tariff you are not going to have any money to spend on that, so there are disadvantages, but the advantages far outweigh them.

Q108 Chris Skidmore: On that point about workforce planning, Mr Sharp, I have read your memorandum and it certainly sounds like, in the past two years, there has been a great deal of work on the supply side of the workforce. Do you feel that the pace of change with this tariff might disrupt some of the good work that has already gone in intelligently planning for the future workforce?
Peter Sharp: I do not think it will disrupt the work. There has to be more work done about doing the full triangle of workforce planning. You talked about supply and demand. Most of the workforce planning in the last 15 years has been stock and flow and supply-led. What does that mean? It means that people say, “How many have we got? How many do we need
whenever—next year, three years?” Demand-led modelling, looking at future demand and what people need, and particularly if you introduce the element of choice and you introduce the possibility of them having different ways of having their needs met, will shift the need for that supply.

As to the third leg of workforce planning—supply, demand and then cost, cost effectiveness and affordability—the centre concerns itself with cost and cost-effectiveness and leaves affordability to—

Q109 Chris Skidmore: If you have a flat tariff, does that negate any understanding of where the demand might be?

Peter Sharp: Not necessarily. I will give you a worked example. We have been asked to look at a business case for NHS Global: the possibility of UK plc using some of its spare capacity for teaching others in healthcare and social care. There are clients—other countries—waiting for that. It is not that their workers would replace ours. It is that they want them for their own country. There is a shortage of doctors across Europe of nearly 1 million. We have worked with the WHO, OECD and the European Commission and represent the UK at what is a three-year joint action programme on workforce planning. That takes us into an area that says if there were distortions, because of a local way of transacting business, it is possible, with longer term planning, to mop up, for example, spare capacity if one area of the country suddenly found itself deluged with applicants.

Q110 Chris Skidmore: You were both here for the earlier sessions. Do you have any comments to make on what the Department said about funding and possible funding cuts to the MPETs? Did you have any understanding of what might be happening in the next couple of years, whether it was flat cash or a 2% rise in cash?

Tim Gilpin: The answer you got was the right one; we did get flat cash this year. There was an increase in the dental vocational training budget, but, to be fair, that was offset by the pressures around things like access to psychological therapies and health visitor number increases. The net result was that we got flat cash and that is what we have been asked to plan for next year.

Peter Sharp: The only comment I would make is that we have been asked to and have produced for the Department a report called “Workforce risks and opportunities.” For example, we have identified risks as to midwife and GP shortages. We would look, in the coming year, at any impact, according to financial settlements, of 0.5% flat cash versus whatever inflation is currently—4.2%. There has to be consideration given to what is the net effect of that over a period of time, with it being unlikely that inflation is going to drop.

Q111 Dr Poulter: Mr Gilpin, you made the point about having a demand-met service. There has historically been a tension between that and what have sometimes been shorter-term political priorities, shall we say, and specifically perhaps the trend to training for acute medicine, whereas we see the medical admissions ward or the surgical admissions ward are often an A&E bypass rather than necessarily being a service that exists for its own sake in some hospitals. What I am driving at is this. Have you had concerns in the past—when we look at the bigger demographic challenges that we face in obesity and the ageing population—that short-term political initiatives have interfered with the longer-term workforce planning?

Tim Gilpin: I have not detected that, I have to say. The big tension we have talked about a little is the balance between the long-term interests of workforce planning, in terms of the supply of the regulated workforce, and short-term necessities from providers who are just managing workload and peaks in demand, in particular. If you want to, give me some examples of where you may have seen that.

Q112 Dr Poulter: I did give you one with acute medicine. Previously, you would have had an A&E department that would have dealt with the majority of admissions. Then, because of the waiting targets, a lot of hospitals set up almost an A&E bypass with a medical and surgical admissions unit. There was a drive for the acute position, if you like, which would have been a job covered by the A&E doctor historically.

Tim Gilpin: I see. I do not have any insight on it. All I would say is probably organisations would say that they were streaming the patients more appropriately and so say, “If you have arrived and you have a surgical issue, then you can be seen in surgery and medicine according to your need.” I do not think it has been a major issue in workforce planning terms. You are back to that flexibility and where people can be deployed.

Chair: Not only have you got past the GP, you have also got past A&E and straight on to the ward.

Q113 Dr Poulter: Exactly, and without being treated as well, very sadly, in some cases. There is another issue about how we plan for workforces. It is almost a slightly different point rather than on the target-driven distortion of how workforce planning can occur; and we do see that in hospitals. As we see medical care improving, we also see, for example, that we have fewer generalists. For example, we know that angioplasty is the gold-standard treatment for someone having a myocardial infarction, a heart attack, so what we do is set up a cardiology rota. Previously, however, some of those cardiologists may have done general medicine in a hospital as well, so while the specialist rota is a great benefit, you lose their generalist expertise. The earlier witnesses commented about the need to have more generalists, be it in hospital or in general practice. Is there a concern that we are creating more and more specialists, and that we should take into account the need to maintain general medical skills and generalism in workforce planning?

Tim Gilpin: It is two sides of the same coin. I think you are right. There is no doubt that increased specialisation has led to those pressures in hospitals in terms of rotas. It is an issue of training curricula and other means of educating doctors in specialist areas to take account of the needs of the
generalist as well as the specialist. As you say, that would then impact on longer-term workforce planning, in particular for medicine. I do not know whether Peter would like to add anything.

Peter Sharp: We have held workshops where we have looked at the shape of the medical workforce. Some of the things suggested that would, at least, begin to answer some of the issues you have described are: better triage and a consultant-present service so that the first diagnosis is more accurate. The more junior the doctor in making the first decision, the more likely they are, allegedly, to get it wrong. That is what clogs things up and sends people in the wrong direction, and so on.

Part of what we have put in the report that will be published in December is talking about what are the benefits, first of all, for patients and then, potentially, cost benefits. Although it is more expensive to deliver a consultant-present service, it is argued that you get it back by not sending them to the wrong place or giving treatments they did not need. That is certainly part of what that document is trying to do, to get that debate to the surface. We have looked both at emergency medicine and at the acute sector and discussed, with the colleges, about how getting the first diagnosis right matters most for them.

Q114 Dr Poulter: This would be about the consultant on call perhaps taking the referrals rather than one of the junior doctors.

Peter Sharp: One thing that clinicians have said to me is that they should not be on call. They should be there.

Chair: We will not start that debate at one minute past one. They should be there.

David Tredinnick: Chairman, I always apologetic for starting a line of questioning after one o’clock and I know my friend over here has sent me some fairly powerful signals about not speaking for too long. I would like to ask a couple of questions about the scope of your intelligence and data collection. I am thinking about the supply of services, which services you are monitoring. I will start by saying you have mentioned integrated healthcare twice and that your second goal is planning for the whole health and social care workforce. Integrated healthcare may mean one thing to you but, for me, as the chair of the parliamentary group for integrated healthcare, it means something else: integrating what we used to call complementary and alternative medicine into mainstream healthcare—Chinese medicine, acupuncture, herbal medicine and homoeopathy—which has been part of the Health Service almost since it began with the Faculty of Homoeopathy regulating homoeopathic doctors. We now have other groups that are performing services. I will quote one. At George Eliot Hospital, in my constituency, we have aromatherapists who, at the request of the doctors who are delivering babies, have helped with pre and post natal care and made it easier for them to focus on their core work. I am suggesting to you that you should have a register of what these services are, be aware of them and try and have some intelligence about the scope of their use. In particular—this is my last point and I am not going to ask lots of subsequent questions—now that one of the core objectives of this health Bill and the Health Service is patient choice, a lot of patients are going to demand these services. I would like to throw that to you as the last ball of the day.

Valerie Vaz: Yes or no. [Laughter.] Peter Sharp: I will answer very quickly by saying that the Centre for Workforce Intelligence is agnostic as to which services it considers. It wants to look at it through the lens of the patient or the service user. If we find evidence that patients and service users are expressing a preference for a particular service, we would feed that into a report that says that. We would be honour bound to look at the efficacy and the evidence base for the outcomes of those treatments and to look at the literature, particularly high quality double-blind literature, to say whether it was a treatment that workforce funding and training should be shifted into. We have to be evidence based. Although my colleague said we were an art—and some say a dark art, workforce planning—we also like to see parts of it as properly scientific. We would want to be sure that we had an evidence base for whatever we were recommending.

David Tredinnick: I have a tiny supplementary. Doctors for years have also used observation as a method of assessing whether a treatment is effective. I hope you are not going to exclude that.

Chair: That was a very skilful answer. Thank you very much for your evidence. It has been a useful experience of the real world. Thank you very much.
Tuesday 29 November 2011

Members present:

Mr Stephen Dorrell (Chair)
Dr Daniel Poulter
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Professor Sir Christopher Edwards, Chairman, Medical Education England, Professor Sir Peter Rubin, Chair, General Medical Council, Professor David Sowden, Chair, Conference of Postgraduate Medical Deans of the United Kingdom, and Sir Alan Langlands, Chief Executive, Higher Education Funding Council for England, gave evidence.

Q116 Chair: Thank you very much for coming, and for coming in earlier than originally planned this morning to accommodate the Chancellor of the Exchequer. Could I ask you to begin by introducing yourselves, the organisations you come from and the role you play in this area of byzantine complexity?

Professor Sir Peter Rubin: Thank you very much, Stephen. Good morning to you all. I am Peter Rubin, Chairman of the General Medical Council. The GMC is the independent regulator of medical education and training in the UK. We determine the content and outcomes of undergraduate medicine and of all the postgraduate medical specialties, we determine the fitness for purpose of the exams that are taken by students and postgraduate doctors and we quality-assure medical education and training. We do all those things throughout the UK.

Professor Sir Christopher Edwards: Good morning. My name is Sir Christopher Edwards. I am the Chairman of Medical Education England. As you know, this was set up following the MTAS disaster and on the recommendation of the Tooke report. Tooke suggested that this should be a medical body and should hold the budget. What happened was that the Government eventually accepted the recommendation but set up a body which represented not only medicine but medicine, dentistry, pharmacy and healthcare sciences. We have now been going for three years. We do not hold a budget but we have been successful in producing a series of reports, which you might want to come to later on. In addition, I am the Chairman at Chelsea and Westminster Foundation Trust and Chairman of the Council of the British Heart Foundation.

Sir Alan Langlands: I am Alan Langlands, Chief Executive of HEFCE, the Higher Education Funding Council for England. We fund higher education and research in universities in England. Included in that is a wide range of health-related education and training. In 2009–2010 we spent £360 million on medical and dental education and training. I think there has been a failure to focus on excellence—there has been more of a inflexible system. If we can make some of these changes, then we can move things forward.

Professor Sowden: Yes.

Professor Sir Christopher Edwards: There is a risk. At the same time, I would like to think there are enormous possibilities to implement significant change. When I take a few steps back and say, “What are the problems?” first of all, we have a system where, perhaps, we have not had transparency of funding—where a very large budget is not being used in a transparent way and, often, is not being used for the purpose for which it was allocated. If we look across the fence at the establishment of NIHR, that has produced very considerable transparency in relationship to research and development, and I would hope this new structure could do the same thing for education and training. I think there has been a failure to focus on excellence—there has been more of a competence culture—and that we have a very inflexible system. If we can make some of these changes, then we can move things forward.

Q117 Chair: Thank you very much. I already used the word “byzantine” for this system. Do you agree with this proposition: one of the problems in this area is that, every time there is a problem, we invent a new organisation to deal with it without properly working through how the new organisation will relate to all the existing organisations, and we are at risk of doing the same thing again?

Professor Sowden: Yes.
very difficult to change that system because, at the moment, if you make any changes it is immediately thought to produce changes in service. With the 72% increase in consultants in the last 10 years, and with our particular review of how this could be done, we can actually change that for the first time. There is a whole series of very positive things that could be achieved.

Q118 Chair: I hear that as being a description of the role of HEE as the national commissioner of education, at least in England, for all the health education professions. Is that what you are describing?

Professor Sir Christopher Edwards: Yes. It is a partnership. It is between HEE, as a co-ordinating central body, and the local organisations. There has been relatively little criticism of the concept of HEE. There has been much greater concern about what might be the local structure. I am sure we will come on to debate that.

Q119 Chair: We will come to the local structure later. If HEE is to be seen as the national commissioner of healthcare education, the first question—with the national organisations represented here—is how that relates to the activity of the GMC as a regulator, engaged from that perspective, and, indeed, how it relates to HEFCE, a position, Sir Alan described, that they currently fulfil. How do those three functions relate to each other?

Professor Sir Christopher Edwards: I am sure we all have views on it. If we look at the GMC, for example, of the four specific tasks required of it by the Medical Act, two are entirely distinct from any role of HEE—the whole question of registration and fitness to practise. Those are quite distinct. But there is the potential for overlap in relation to the quality of education and training and the quality, in fact, of the workforce.

Q120 Chair: There is an overlap on initial registration as well, is there not? In order to qualify, you have to pass through a commissioned training programme.

Professor Sir Christopher Edwards: Hopefully, there is a partnership. I will give you a simple example. We are extremely anxious that we should have a mandatory period of shadowing. In other words, when a house officer is going to start on 1 August, they would have a period, in the week before starting work, in which they are shadowing their predecessor. There is a lot of evidence which shows that this makes things much safer for the patient and reduces stress as far as the doctor is concerned. To do that, there has to be GMC registration at an earlier stage. In the three pilots done on this, the GMC have done exactly that. They have registered these people at an earlier stage. So there is a partnership between the two.

Professor Sir Peter Rubin: We have some years’ experience of working through a body such as HEE because we have worked closely with NHS Education for Scotland for some years. At the GMC, we determine the content and outcomes of all medical education and training, and ensure the assessments are fit for purpose. Therefore, we ensure that the training that Dr Poulter is getting in obstetrics is the same wherever he trains; whether it is in Aberdeen or Exeter, the content and the outcomes will be the same. What NHS Education for Scotland does in Scotland, and what MEE or HEE will do in England, is to fund the education to make sure the education can happen and ensure that the quality of education, at a local level, is at a standard that would be expected. We would anticipate that HEE, through Local Education and Training Boards and postgraduate deans, would troubleshoot and ensure that the quality of medical education locally is of the required standard. If it is not, we are there at a national level. We have extensive statutory powers to move in, if necessary, and ensure, in extreme examples, that trainees are removed from an environment where training is not appropriate and so on and so forth. So we are there at a UK-wide level determining content and outcomes. What HEE do, and what NES do in Scotland, is fund the medical education and training.

Q122 Chair: There are two problems I have with that. The first is that the people controlling the funds, as Sir Christopher explained it, also have a responsibility for quality. Take the example of the two hospitals which were delivering two different standards of training. Who owns the problem of addressing the difference of standard of training received in two different locations in the same city?

Professor Sir Peter Rubin: Can I answer that from a GMC perspective and then Chris could answer it from an HEE perspective? Assuming the new world happens as anticipated, we, the GMC, would expect that HEE, through the Local Education and Training Boards, would have identified that Hospital A has a problem with its training; put it on notice that the funding for trainees will be withdrawn from that hospital and moved to where the training is good; that they have six or 12 months, or whatever, to sort out the problem; and, if the problem is not sorted, the funding and the trainees get moved. We would expect them to be doing that. If, for whatever reason, that does not happen, we are there, as the nuclear option, to say that, as a national regulator, we are going to remove approval for these posts at Hospital A and they need to be moved to Hospital B.

Professor Sowden: Can I follow up on that? I have experienced covering this pre-GMC, and now this present situation. The situation that Peter is referring to does work extremely well—much better than it once did. We now have an opportunity for dialogue with the regulator about problems with the delivery and standards of delivery of postgraduate medical education. I can tell you that that is a very potent lever to get the attention of trusts. If, at the same time, HEE is established and makes very clear the standards to
which it wishes to see the money put, there will also be another lever which can operate there. The only important thing is to ensure the people quality-managing delivery of postgraduate medical education, or, indeed, other aspects of healthcare professional education, have sufficient independence because a lot of pressure can be put on you by local education providers and trusts. When you take the money away you take the doctors away, and that has a big impact on service. Their claim is, “However bad we are, we will be worse if we do not have the junior doctors.”

Q123 Chair: Sir Alan, you have experienced this argument from many different perspectives.

Sir Alan Langlands: I have, of course, from the perspective of the NHS in England and, indeed, running a university in Scotland, where the NES model is interesting. I want to take a step back to your question and suggest that what we are trying to do is not terribly complicated. What we are trying to do is achieve excellence in education and training and, as a result, better patient care. It seems to me that some of the tensions between different bits of the structure creep in when people start taking a transactional view of this rather than working in partnership, as I think they have to. The other thing we have an opportunity to do here, which is rarely discussed, is give some coherence to the continuum of education, from undergraduate and basic training right through to postgraduate and post-basic—continuous professional development. We have a very fragmented system in this country still—a very British solution—and the opportunity here is to do something about that to give it more coherence.

I am for a model in which form follows function, that there is an opportunity here to get things right that imply that HEE are going to be doing some of this monitoring and then you come in later? Are you doing some of this monitoring now and will you be doing that? It seems to me there is a duplication of work.

Q124 Chair: There are two points, one made by Sir Alan and one by Professor Sowden, which I would like to pick up. First—Sir Alan’s point—your fear that the higher education world is being squeezed out of the process. Could I ask you to enlarge on that? Then I would like Professor Sowden to enlarge on the point about where the pinch points are now and the extent to which we are at risk of creating new ones in the new world.

Sir Alan Langlands: Most higher education institutions formed good relationships with their SHAs, in particular. Following some teething difficulties with the previous structural change, we are on a reasonably even path that allows universities and, hopefully, the health bodies and health providers, to take a medium and long-term view of the development of education and training on their patch. In the scramble for what I think of as the pre-LETB period, where people are positioning and where there is organisational turmoil, there are early signs that some of the NHS operators are thinking of this as a contractual transaction rather than a productive partnership with universities, misunderstanding the importance of the medium and longer-term thinking and the links with research, which are hugely important. We are dealing here with the knowledge system at the interface between universities and health bodies—knowledge creation, knowledge dissemination and knowledge application. That requires everyone, with all their different sorts of expertise, round the table thinking and working it through, not being excluded on the basis that there is some perception of conflict of interest. NHS providers have conflicts of interest in relation to this because of their responsibilities for postgraduate education. My simple plea is that everyone is at the table and works in partnership and that we do not get caught up, especially at a time of financial squeeze, in being obsessed with numbers and transactions. These are means, not ends.

Professor Sir Christopher Edwards: To underline Sir Alan’s point, he talks about potentially going down a road to disaster if universities are squeezed out. We have been down that road before and I am sure you will all remember the very large amount of money which was spent on the establishment of the NHSU. It would be an absolute catastrophe if we shut out the universities. We are already, probably, the only country in the world in which the universities do not play a dominant role in postgraduate medical education. If this was an opportunity to further shut them out of that, it would be an absolute disaster.

Chair: There are some quite strong words being thrown around—“catastrophe” and “being shut out.”

There are clearly some concerns below the modulated tones that you are using in evidence to the Committee.

Q125 Valerie Vaz: I am struck by some of the things that have been said. I would like to hear, from all of you, how you see this new body working nationally and locally. Professor Rubin, you mentioned something about you being “the nuclear option.” Does that imply that HEE are going to be doing some of this monitoring and then you come in later? Are you doing some of this monitoring now and will you be doing that? It seems to me there is a duplication of work.
I am here as the ordinary voice of the patient, not a doctor; clearly, I see it from a slightly different angle. The accountability point is quite important. How is this new body going to be working nationally with everyone on board—this is your chance to tell us and set it out—and how do we do it locally? Also, there is this point about Scotland. There are doctors being trained and moving from different parts of England. How do we keep tabs on all that and make sure we get that quality coming through?

**Professor Sir Peter Rubin:** I will start at the UK-wide level and then move in a leftwards direction, maybe. We are the UK-wide regulator. We have very extensive statutory powers in the Medical Act. We do not need new powers in order to hold to account HEE, when it exists, or the Local Education and Training Boards. Those powers exist already because of the way in which the legislation is worded. We have the power to inspect and hold to account an amazingly wide range of organisations. It would be inappropriate for the UK-wide regulator to be trying to ensure, in every hospital and every general practice in every part of the UK, that everything was going perfectly. We need to hold to account others who are nearer the front line.

The key thing is holding somebody, not a nebulous committee but a named person—naming a named person—to account for the quality of postgraduate medical education in their area. That needs to be the postgraduate dean. The postgraduate dean needs to have the levers necessary to produce change when change is needed and those levers will usually be financial levers. Money talks, and the money will flow from HEE.

It is entirely appropriate to have a national body like HEE because they have the national overview—and our experience of working with NES in Scotland is very positive—and they hand the money down to a more local level. It is when we get to the local level that people have the granular information to say, as Christopher was saying earlier, “Hospital B is doing a really good job. Hospital A is not. We are going to sort this.” We are there at a national level with extensive powers to use if we need to use them. We will use them—be in no doubt that we will use them if we need to—but if HEE and the LETBs work well, we will not need to use those powers. They would have done it already.

**Professor Sir Christopher Edwards:** Picking that up, first of all, how will HEE work? It will be a partnership with a series of bodies. The GMC will be a key partner. The Royal Colleges—and we will probably come back to those—are another part of the partnership. There would be an absolute need to have shared data and databases. That is going to be extremely important in terms of people and functions. That is a key point.

We have talked about the question of the need for a UK-wide perspective. This is absolutely vital. To give you a practical example, the figures that have come out of Scotland are quite worrying. There are about 8,000 consultants and GPs in Scotland. There are 6,000 people in training, a ratio of 1.3:1. You would normally expect a ratio of 3:1. Why is that? It is partly because there has been a 54% increase in the number of consultant jobs in Scotland but very particularly because 74% of their SpRs have gone to England, so you start to see a tremendous interdependence. As soon as the tap is turned off—and, of course, the tap is turned off now because of finance—there is not going to be that growth. It is extremely important that we have a balanced approach across the UK and that we understand each other’s problems.

**Sir Alan Langlands:** On the UK point, it is terribly important to recognise that we are now running four separate health systems and four separate higher education systems, at least to the extent that the fee models and the teaching funding models are different across the four countries. There is one huge galvanising force at work in the UK, which is research funding and the way in which research is orchestrated on a UK-wide basis, and I do not think there is any great appetite to move away from that. That binds, certainly, the university and strong parts of the health community together through these changes.

The only other point I would make is to draw a distinction between—and I am told I am going to be one—the role of a national regulator and the important work that needs to be done closer to the coal face, I would argue, in the LETBs, or whatever emerges in that area; the important work that needs to be done in tracking quality, effectiveness and safety going forward. That, to me, is the dialogue which needs to take place to inform the development of ideas around workforce and future education and training practice.

**Professor Sowden:** I have to go back a little—where we started—to one of the problems we are trying to solve. One of the problems is to get the full engagement and responsibility of employers for the future workforce. Whatever has been done over the last 12 years—and I have seen most of them at first hand—nothing has really worked. Whatever changes have happened have made the employers feel they are simply being supplied whatever it is, doctors or nurses, and they have to lump it. I am paraphrasing slightly, and I am sure they could speak more eloquently for themselves, but that is very much the situation. They do not feel they have very much influence.

One of the things which has to be sorted out in the LETBs is getting the employers fully engaged: working out what the services are going to look like in the future, how they might be delivered in terms of skill mix and what that means for education and training. But that has to be subject to checking. You can have people going off on extreme divergent patterns which are either not in their interests or those of the population they serve or which destabilise the wider economy across the whole of the health system in England. That is where HEE has an absolutely critical role.

Also, I think HEE will build on what MEE has achieved, which is considerable. The only other thing I would say is that HEE will have to have a very close relationship with the Commissioning Board. We are already seeing examples of the commissioning of services destabilising the provision of postgraduate education systems, at least to the extent that the fee models and the teaching funding models are different across the four countries. There is one huge galvanising force at work in the UK, which is research funding and the way in which research is orchestrated on a UK-wide basis, and I do not think there is any great appetite to move away from that. That binds, certainly, the university and strong parts of the health community together through these changes.

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medical education to the point where it might not be deliverable in certain areas because of the way in which commissioners are acting. A very important link needs to be made there and I do not see it referred to nearly enough in some of the paperwork coming out at the moment.

Q126 Valerie Vaz: Could you give an example of that?

Professor Sowden: Yes, I can give an example of it. In our area, one of the commissioning groups has changed the requirements for people to have reduced visual acuity for second cataracts. The consequence is that we do not have enough simple cataracts for our ophthalmalnis trainees to learn the basic techniques. We are having to go into negotiations to see if that can be reversed. The troubling thing was that the commission was changed without thinking about the consequences it might have more widely. I can understand why the decision was made. Equally, I can see why it should not have been made.

Professor Sir Peter Rubin: May I also return to one aspect of your question? All we are saying is predicated on the assumption that the money voted for medical education and training will be used for medical education and training. There are concerns—and I think it is important to state these concerns here this morning—that the LETBs may not, and I emphasise “may not,” have the independence needed to ensure that the money voted for medical education and training is used for that purpose. That is, potentially, one way in which we, as the independent regulator of medical education and training, will have a very powerful role.

Q127 Dr Poulter: Picking up on a common theme which has come across, there has been a concern expressed by all of you about the lack of investment by some trusts in their trainees. Professor Sir Christopher Edwards made the point, at the beginning, about the variability between two trusts that were highlighted in the London deanery area.

As you say, the employer has requirements for service provision and those requirements and rotas are much more stretched with the European Working Time Directive coming in. There is also reliance on the willingness of the staff within a particular hospital to train their juniors. When there is that great pressure, how are we going to encourage hospitals to invest across the board in the staff they have to train, particularly when we are dealing with the potential deskilling of registrars in certain hospital specialties?

Professor Sowden: Can I follow up on the point you have made? There is no very close correlation, for example, between the amount of money an institution receives, and, therefore, the support it gets for postgraduate medical education, and its quality. What I have noticed most in my career is that, where there is good quality care, there is usually good quality education, and vice versa. Again, there is not a terribly close correlation there with the amount of money some institutions receive.

While I take your point that there are some resource issues, you often see very high quality postgraduate medical education—and for other professional groups—delivered in organisations which are struggling, in financial terms, but still manage to provide very good care and training. However, the situation is made worse—you referred to rotas—by the extraordinary inequitability, historically, of the distribution of the money that supports postgraduate medical education and training. It goes very disproportionately to certain areas, and it does not bear any relationship to future workforce supply.

Q128 Dr Poulter: Are we talking about big teaching hospitals?

Professor Sowden: We are talking about big teaching hospitals and big geographies. East Midlands receives 13.5% less funding than capitation equity would suggest. That is 500 to 600 junior doctors. Spread across our trusts, that would get rid of all of our EWTR problems at a stroke.

Q129 Chair: When you say “capitation funding would suggest,” you are taking a norm based on capitation. What is the capitation? Is it capitation of trainees, capitation of patients—

Professor Sowden: Population.

Q130 Chair: That implies that the training should reflect population. Is that right?

Professor Sowden: Increasingly, there is a lot of evidence that it should. When I was training, doctors were very mobile. Doctors are very, very much less mobile than they were. We have a lot of people now who train in the medical school, train in the local hospitals and end up practising there. Certainly, in terms of specialty training, 70% of people train within 60 miles of where they end up working. That suggests you have a very local system. In general practice, it is 20 to 25 miles.

Professor Sir Peter Rubin: There is a slightly different angle you can take on this as well, and I think it is the direction from which the GMC will be coming. Reducing it to its simplest, where do you want medical education and training to happen? You want it to happen at the place where the patient numbers are right, the patient mix is right, the doctors have the time to learn and the trainers have the time to train. It is as simple as that.

If those four boxes are not ticked, we will expect—initially at a local level, the postgraduate deanery analysis—to say, “Those boxes are not being ticked. What are you going to do about ticking them?” If it is not possible to tick those boxes, then we will say, and we will do this if it is not happening locally, “I am afraid that the doctors in training in this environment need to move to where those boxes can be ticked.”

Professor Sir Christopher Edwards: Danny, you asked, particularly, what we are doing and how we are going to solve the problem. When Christine Outram gave evidence to the Committee she talked about MEE’s “Better Training Better Care” programme. We are taking the recommendations in the Temple Report on the impact of the European Working Time Directive on the quality of training and taking the
recommendations of the Collins Report on the first two foundation years—and, literally, going out to a series of hospitals to look at it in a practical way. We are saying, “Can we look at best practice, how to do this?” “How is it that some hospitals manage to do it and others do not?” “Is it, in fact, purely to do with staffing, or is it that there is a different attitude in terms of how they cover the 24 hours?” We are trying to say that it is a soluble problem. Certainly, Sir John Temple thought it was a soluble problem as far as the impact of the European Working Time Directive was concerned, but, obviously, there are certain places where they do not have an optimal structure, for a variety of reasons, and where we have to try and influence those people. There is, through that programme, which Sir Jonathan Michael has kindly agreed to Chair, an opportunity to look at this in a very practical way.

Q131 David Tredinnick: May I take you, Sir Christopher, back to what you were saying about the importance of universities and ask if you think that, at a strategic level, medical education should in fact be university-centred?

Professor Sir Christopher Edwards: I have a very strong belief that the partnership between the NHS and universities is absolutely key. That partnership is a very clear one as far as undergraduate medical education is concerned. It then goes to the first foundation year and, gradually, becomes less clear as you proceed.

Q132 David Tredinnick: Would “disassociation” be a better word to use than “less clear”? Is there a complete split? I got the impression there was a division: we have all these people in the universities doing one thing and everybody else doing something else after that.

Professor Sir Christopher Edwards: Certainly, if you went to America, you would find that your postgraduate training was absolutely the province of the university. That is not the case here.

Professor Sowden: It would be too much to describe it as a disassociation. It is patchy, as well. For example, if you look at Scotland—this is not necessarily the consideration here—the relationships are very strong, partly because of the way that NES has been set up. I would say that some of the disassociations or difficulties we experience in England have been because of the way the Strategic Health Authorities dealt with their business on some of the postgraduate medical education. But that is not to say, for example, that COPMeD is not now working very closely with the Medical Schools Council. We are meeting again tomorrow to discuss how we can work more co-operatively and collaboratively. Certainly, as to the way that the F1 year is delivered—the first year of postgraduate training—and the last year of medical school, we are working very closely on that because of work done by the GMC. You do not have to create an institutional solution to this because I think people genuinely do want to work together in partnership.

Q133 Chair: Do you agree with that from a university perspective?

Sir Alan Langlands: I do agree with that. In the academic health science centres or health systems, we have a model that would be conducive to that. It would bind the thinking and effort on research, education and patient care in strong and creative ways. I know that all these reforms are obsessed with the notion of commissioning, but we should not lose the opportunity of the academic health science centres—which I think will grow in number and, therefore, we could conceivably have a reasonable spread across the country—to think of them as a focal point for achieving the coherence we do not always achieve at the moment. That is certainly worth thinking about. That argument will be reinforced if there is an Executive, in moving forward his work on innovation, begins to draw on the expertise in these centres as hubs for that process. That is something the university community generally could be excited about.

Q134 David Tredinnick: I have one other question. You talked about sharing information. Do your computer systems talk to each other? Can you practically share information from one machine to another, and are you satisfied that the IT systems being used at the moment are satisfactory, please?

Professor Sir Christopher Edwards: The answer is that, at the moment, we are very much based, as a very small organisation—MEE has five staff—within the NHS body, so to speak. Clearly, when one is looking at a new body like HEE and that body is to have a rather distinct profile—if it is set up, in fact, as a special health authority—it is going to have to make those sorts of decisions. My own feeling is this—and it was asked as a simple question: If, for example, you look at one aspect of IT, namely, the question of your website, “Should HEE have the same approach as NIHR, that is, “hee.ac.uk?” which I perceive very much to be an academic, educational and training institute, it seems to me that is a key thing, whether or not you see it as part of education or very much part of the NHS. At the moment, we have to recognise that, on the educational side, there is a long history of sharing IT systems. The health side has had a considerable series of problems on the IT side. That is quite an interesting divide.

Professor Sowden: We clearly do not have common systems, but a lot of the data we hold in deaneries should not be available to the GMC and so on because it is private data about individual trainees. I would emphasise that we have recently worked very closely with the GMC, and increasingly so, with the full knowledge of MEE, around data collection, management and analysis about postgraduate medical education. That is beginning to identify areas where attention needs to be paid but also giving us information about what is working. That is working extremely well. The plans are for that to be a much more intensive programme of work over the next year or two. The fact we do not have common systems does not prevent us working together effectively around common data sets.
Q135 Dr Wollaston: Going back to what you mentioned, Sir Alan, that Medical Education England had five members of staff, how big will Health Education England be and how happy are you with the lines of accountability between that and Local Education and Training Boards?

Sir Alan Langlands: That is probably a question to Chris. It is not for me to comment, although I would love to do so and I could give you a very good answer.

Professor Sir Christopher Edwards: You might be interested that, relatively recently, we had an extremely helpful seminar to which we invited a series of bodies that had gone through a similar process. We had HEFCE, Monitor, FE people and NIHR people all come to talk to us. One of the things we agreed at that meeting, learning from their experience, is that there is great advantage to having relatively small bodies and that a body of about 100 was probably appropriate. The budget, as you know, is likely to be somewhere in the region of £5 billion. We looked very much at the advantages that HEFCE has had of being small in terms of excellent interpersonal relationships within that body, and a whole variety of things that stem from that. Personally, I would not want to be in a body, as is proposed for the National Commissioning Board, of 3,500 people. That could be a rather difficult organisation.

Professor Sowden: The relationship with LETB, I think, is going to be critical. There is a fundamental impediment to that starting off well by virtue of the fact the LETBs are supposed to be in shadow format by April with HEE, the body to which they are accountable and which is supposed to be signing them off, coming into a shadow format in October. Forgive me, but it is like having the cart before the horse.

Q136 Chair: Does that not rather beg a question: are the LETBs locally accountable or accountable to HEE?

Professor Sowden: They have to be accountable to HEE for the expenditure of the money that HEE passes down to them. Obviously, that will be done through some contractual mechanism, presumably a service-level agreement, which will specify the activity and the standards to which it will be done. It does seem rather odd that you are setting people off down a track and they are going to make some assumptions about how they will work. HEE may not have those same assumptions. It is going to be very difficult to pull this back and then have a genuinely co-ordinated system that works across the whole of England to common standards.

Q137 Chair: Let us explore this a bit further. Would it be fair to say that the relationship between HEE and the LETB is similar to the envisaged relationship between the Commissioning Board and clinical commissioning groups? In other words, you have to authorise them and be satisfied that they are capable of doing their job before they can go ahead and do it.

Professor Sir Christopher Edwards: Yes. What is proposed is an authorisation process. Looking at things that this Select Committee could do, it would be immensely valuable to say, “Could we try and fill this vacuum rapidly?” Unfortunately, the problem we have is that, if we wait until next October to set up HEE in shadow form, and then start to work in April 2013, there will be chaos. What is going to happen—and this is happening at the moment—is that all sorts of organisations, who are setting up, will be saying, “This is what we think a LETB should be.” Not surprisingly, we will find that may be very different to the model which is eventually being proposed. What will happen next is that people will say, “No, we cannot change our model because it will produce chaos in terms of staff and training and everything else”. As soon as possible, we need to have a blueprint of what this might be.

The model which I find very attractive is one which David Fish has. David Fish, of course, is on the Future Forum. The UCL Partners model is a very interesting model. If you asked David Fish, “Who pays you? Are you paid by UCL?”, the answer would be “No.” As to, “Where does your pension come from?”, it is none of those places. It is independent. They have set up an independent group which closely relates to all these organisations but can make independent decisions. It is going to be extremely important to have that sort of structure so that HEE can then negotiate a contract which can be seen to be fair. Otherwise, there will be some very powerful people sitting round the table who, clearly, will not want to make any changes in training or in their staff.

Sir Alan Langlands: Could I make a point very briefly? It is the shifting sands on SHAs moving to clusters, and the early moves at a local level to set up these bodies in advance of there being clear national leadership, that is creating dissonance and causing concern in universities. When I used the term “shut out,” some of these local models that are developing are excluding the higher education institutions that provide training, apparently. We have to deal with that quickly. As I see it, if the HEE has clear authorisation responsibilities, clear responsibilities for allocating and accounting for resources, and indeed the outcomes achieved, there must then be a sense of the LETBs being set up in a way—independent, quasi-independent or otherwise—where they can account to HEE for delivering their part of the deal. I would strongly argue that part of that has to be the clear involvement of universities from the outset.

Q138 David Tredinnick: What you are saying is that the Government needs to review immediately the priorities in the change process. Is that correct?

Sir Alan Langlands: Absolutely.

Professor Sowden: To some extent, the pause we have had has been too long. It is an understandable pause, but the Future Forum came out with a very clear direction of travel for healthcare professional education and training. I am not quite sure what can be added to that, but we have not had the Department of Health’s policy statement on what is to follow. It was due out in the autumn. I will ask you whether this is autumn now because it is getting a bit difficult to believe that. That policy gap prevents anybody, so you get this turmoil, turbulence and dissonance within the system.
Q139 David Tredinnick: You have good people out there trying to make the new system work, but there is lack of direction. Is that it?

Professor Sir Christopher Edwards: We are trying to anticipate how it might work, yes.

Q140 Valerie Vaz: Following up your independent little group, we are talking about public money, so who would they be accountable to? You can have lots of independent groups, but where do you get the national standards from?

Professor Sir Christopher Edwards: David Fish would be most upset if he thought that was the case. What one is saying is that there may be, for example, that type of group within an academic health science centre or partnership, and one can see very much how that would be relevant. But I can see a similar thing being relevant outside the AHSC. For example, supposing you had 15 LETBs, you could have that core at the centre of the LETB and then, in fact, have a whole variety of people who then come round and are clearly round the table. However, when it comes to the allocation of resources and the accountability, there is a very clearly and legally defined core. If you want everyone to be legally defined, the Health Service is going to spend a vast amount of money on all trusts saying, “What is my legal liability of going to the allocation of resources and the accountability, that would be relevant. But I can see a similar thing being relevant outside the AHSC. For example, supposing you had 15 LETBs, you could have that core at the centre of the LETB and then, in fact, have a whole variety of people who then come round and are clearly round the table. However, when it comes to the allocation of resources and the accountability, there is a very clearly and legally defined core. If you want everyone to be legally defined, the Health Service is going to spend a vast amount of money on all trusts saying, “What is my legal liability of going into this enterprise?” I am not sure you want to do that.

Q141 Valerie Vaz: Some of the independent groups can exclude universities.

Professor Sir Christopher Edwards: No.

Q142 Valerie Vaz: You have to have something that says that certain people have to be round the table.

Professor Sir Christopher Edwards: Yes, and that is what in fact UCL Partners has. You have the Health Service, universities and other key players who are round that core table.

Professor Sowden: That can be done by HEE specifying the kinds of things that must be included within these local arrangements.

Q143 Dr Wollaston: Can I turn, next, to the situation with the deaneries? The Department of Health has said that postgraduate deaneries will continue, but under the umbrella of LETBs, and that they will become truly multi-professional. How confident are you that will take place and that the deanery structure and the best of the deaneries will be preserved?

Professor Sowden: There is a little bit of me which says they have to be because they fulfil such an essential function at the moment. If they were not there, you would only have to reinvent them. Some countries around the world are in the process of inventing postgraduate deaneries by another name because they have had problems with systems that do not have postgraduate deaneries in them. The issue about multi-professional deaneries is interesting. I used to run one, but not any longer. Some of my colleagues run multi-professional deaneries. The multi-professional bit is not difficult. It requires a different mindset and approach, but it is perfectly possible to achieve. We need to ensure that we secure the expertise we have within the system at the moment. Within a multi-professional deanery setting, that will be the existing postgraduate deanery staff together with those people in strategic health authorities who run education commissioning—so they are commissioning for the other healthcare professional groups—and workforce planning and development.

Without those two bits together, you cannot create a multi-professional deanery. Part of the problem, at the moment, is this huge gap with people thinking, “What are we going to do?” These people are a scarce resource. Other people want them. Some of them are going off into the private sector and elsewhere. It will be almost impossible to get their like again for several years because we have struggled with that skill set over the last decade or two.

Q144 Dr Wollaston: Again, another big problem with having an overly long pause.

Professor Sowden: Indeed, yes.

Professor Sir Christopher Edwards: To pick it up a little more, first of all, David is absolutely right. Obviously, you have to have such a structure. I would hope, however, that we do not create a parallel universe again to the universities. A number of these things can, in fact, be shared with the universities in terms of the infrastructure and it would be sad if we spent a lot of public money on recreating an entirely separate group. We have talked a lot about the link with universities. I ask a simple question: who appraises the postgraduate dean? In some places, you will find it is a joint appraisal between the university and the SHA. In some places you will find it is only the SHA; there are no links with the universities at all. That brings out the problem, as far as I am concerned. We have to provide that link. I have talked about the model where we had a core. I would want the postgraduate dean to be part of that core in the LETB.

Q145 Chair: Can we follow the money for a second? This is not only an enormously complicated set of structures. It is also the conflicting funds flows. Earlier in the conversation, Sir Peter talked about the risk of funds that are voted for training finding their way into other activities, Professor Sowden talked about a mismatch, as he saw it, between funds available in one part of the country and another and there is also a question of whether funds should be related to the delivery of high quality as opposed to being distributed by formula. What confidence do you have that the mechanisms are going to change in a way that creates sufficient flexibility in the system to allow those different challenges to be met?

Professor Sir Christopher Edwards: I hope we would have the kind of courage that the NIHR had in changing the system. What happened, as you probably will know, with the Culyer funding—the research funding for R and D—was that that was totally opaque. No one really knew where it was going or how it was being used. What they did on day one was to take the money away. They took it away, gave it...
back for a three-year period and then produced a very clear plan. It is going to take quite a long time to work it out. If you take Scotland, NES—NHS Education for Scotland, a similar body—were given responsibility for the additional cost-of-teaching (ACT) money. That is equivalent to the service increment for teaching (SIFT) money here, a very large pot of money. They took four years to have a dialogue with people locally as to how the money was being used and how it could better be used, and so on. They have now come up with a really sensible way in which that money is being properly allocated. You cannot change things overnight. You will destabilise not only teaching and training but also the delivery of healthcare. We have to be very careful, but it is possible to do it if you have that sort of approach.

Sir Alan Langlands: It is terrible, but I know these two examples well. In fact, I have lived through the second of them and the first of the NIHR story. It is hugely important to recognise that these good changes were made at a time of growth. This change is going to be made at a time of financial retrenchment. We have already had quite significant reductions in HEE/HEFCE funding in relation to healthcare disciplines.

We know, from our relationships with SHAs for nursing, midwifery and allied health professions, that over the next three years we are going to see a cut of 14%.

Some of the tensions between different players in the system will be heightened by the fact that resources are reducing and that, on both sides of the equation of health and higher education, some quite difficult decisions are being made. One imagines that that is only the beginning of a longer process of change. I do not think we should underestimate the difficulties in putting more sense into this, but I agree that Chris’s examples are very strong.

Q146 Chair: Wearing both a university and a former NHS hat, do you think that the structures envisaged will have sufficient authority to be able to change, in a consultative way, the funds flows? These are multiple systems driven by different drivers, traditionally. I question, in what we have seen so far, whether there is going to be sufficient flexibility to do all the things that you have talked about this morning.

Sir Alan Langlands: If we get the relationships right from the outset, there are strong possibilities—maybe even a high probability—of getting some of this right. Widening Chris’s point about NIHR, the research example, for the first time in my lifetime the funding councils, the research councils, NIHR and the Department of Health, universities and, indeed, some industry funders are working together in a coherent way to achieve real progress in biomedical research. We could replicate that for education. But it demands that there are knowledgeable people of goodwill who can sit down and thrash this out and that there is an even-handed relationship between the NHS and higher education with cross-representation on the key groups. We have been working at that on the education front, but this set of changes has rather thrown all that up in the air. We have to be very determined to get that right for the future.

Professor Sowden: There is a genuine view in the system—certainly with the discussions that have happened since the consultation came out from the Government—of a wish to see greater transparency. At the moment, this is opaque and through a glass darkly for almost everyone in the system. You cannot properly explain to anybody exactly how money flows right to the end point, which is the delivery of education and training for the student or trainee. That is not an acceptable position. The aspiration to have a tariff-based system is absolutely right and proper. I agree it will take some time to achieve, but it will be worth the effort.

Q147 Chair: What is a key step? You have given evidence about the relationship between HEE and the LETBs and the need to get that clear. Does that address these funding issues as well or are there other specifics that are urgently required to get that process moving more smoothly?

Professor Sir Christopher Edwards: No. I think it does address the present.

Chair: Good. Are there any other questions?

Q148 Valerie Vaz: Can I ask about continuing professional development? That seems to be quite a key thing. How do you enthuse that in the new system? Is that something that will come from you from the centre?

Professor Sir Christopher Edwards: To a certain extent it is part of what has been said. There is an opportunity to do something which produces an educational continuum. That is what I think we should have. We cannot simply say, “You have qualified as a consultant. I touch you on the shoulder and you are now God. You are perfect. Nothing needs to be done.”

Q149 Valerie Vaz: They do not do that for lawyers, either.

Professor Sir Christopher Edwards: Everyone needs to have continuing education. It should be part and parcel of the process. If you go to Scotland, NES has a responsibility for CPD. We have to look at this as something which is a challenge across the board.

Q150 Valerie Vaz: My point was that the GMC, obviously, have revalidation, and that is all going to be part of that. But what about the nurses? You will be responsible for everyone after that, will you not?

Professor Sir Christopher Edwards: Absolutely. The same thing applies. We have not talked about SAS doctors. They have to have access to training and continuing education, etcetera. No part of the Health Service should feel that it is isolated from continuing professional development.

Professor Sowden: Following up on that point, everybody talks about the feed-in of newly-trained doctors and nurses, but it is a drip into a swimming pool. The bottom line is that the swimming pool is the established staff. If you do not continuously focus on their continuous professional development—and it needs to be continuous inter-professional
Q152 Valerie Vaz: Do you think that will solve the problem of agency staff?

**Professor Sir Christopher Edwards:** Agency staff is a complicated issue. We have to be extremely careful. Wearing my Chelsea and Westminster hat, a couple of years ago we had problems in midwifery. We looked at it very carefully and found that, over the weekends, we were getting up to 45% agency staff. That was behind the problem. Since then, we have put in a radical change and approach. People often do not realise it can be much more expensive to employ agency staff, because of the rates of pay, and, of course, they do not have the same allegiance, attitudes and local knowledge. One has to be extraordinarily careful about the percentage. You are going to need some, but sometimes it gets too high.

**Professor Sowden:** It is obviously a more complex issue on the locum front than that, and there is probably an issue to do with the fact that sometimes, and certainly in my experience, trusts tended to be quite prepared to pay agency locums a lot more than they would be prepared to pay in-house cover. That is a generic problem. But that is not for now and not for discussion today, perhaps. A desire has been expressed by Medical Education England for better training and a better care plan, to bring back more consultant-present services to deal with EWTD issues and to make training needs less subservient to service needs. I touched on that earlier, but how feasible is that?

Q154 Dr Poulter: Certainly the traditional model has been that the registrar is the workhorse of the team, as it were and, obviously, we want to have competent registrars. I have two questions on this. First, if we focus purely on consultant-delivered care, are we going, per se, to run the risk of deskilling our registrars and taking away a lot of decision making which has historically, particularly by more senior registrars, been made very well? Are we risking deskilling that group?
Professor Sowden: Could I follow that up? A common view—forgive me—that I hear from junior doctors says, “I am not independent enough. I am not allowed to go off and make decisions, so I cannot learn.” First of all, I am not sure that patients would be terribly happy at the concept of an inexperienced doctor making decisions. What I was going to say was that good supervision does not mean the consultant doing the job. It means the consultant is there to make sure they pick up a situation which is getting out of hand. With consultants present, you can often stretch juniors far more and far more safely than you can in a system where they are not present.

Q155 Dr Poulter: It is absolutely right that there is always consultant advice and supervision available, be it at the end of a phone, as it may be, or on site, but often the service provision of consultants can be in the form of clinics or in the operating theatre. What I am trying to drive at is whether we need to make sure we have a system—because we obviously have a system that is more stretched with EWTD—that is not deskillling the registrar from being able to step up to become a consultant at the end of their training?

Professor Sowden: No, absolutely. I do not know what Peter would feel about this, but we are aiming to produce people who have completed the curriculum in its entirety. That is part of the responsibility of the education system. Part of that is moving to a point where the person is capable of entering the specialist register and to become a consultant. I do not think we are producing doctors who are as experienced as they were 20 or 30 years ago. That is because they are much younger at the point at which they become consultants than they were then. Is that a bad thing? I do not think it is a bad thing, but it means that you have to understand these people will also need some level of support when they go into consultant posts. At the moment, the system is not terribly good at that.

Q156 Dr Poulter: No. Is it the fact that you perhaps do need a senior registrar level or another grade in there that reflects this to some level?

Professor Sir Peter Rubin: I wonder if I should try and answer that, Dr Poulter, because I think there may be a bit of cross-purposes here. It goes back to the four boxes that I said needed to be ticked—that the trainees have time to learn and the trainers have time to train. You can have a consultant-delivered service while the trainees have time to train and the trainers and the consultants have time to do the training. Over the many years that I have been involved in education in this country, there has been a significant misunderstanding about the difference between experience and training. The two are completely different. Experience is making the same mistakes but with greater confidence. That is not what this is all about. The key, as Chris has said on a number of occasions, is changing attitudes, culture and organisational structures to ensure that the consultants are there but with the capacity to enable the registrars to grow in their confidence as each year of training goes by.

Remember that in North America—where, in my view, there are some examples of world-class postgraduate medical education and training—they often produce specialists in four years. That is because there are enough trainers to train. There is enough space in the system for the trainees to learn. We need to aspire to that here. It will come down to ensuring that the environment is right and the four boxes, to which I referred earlier on, are all capable of being ticked. That will not be true everywhere.

Q157 Dr Poulter: The second part of what I was coming on to, the issue we touched on earlier, was the investment of the employer in the employee but also the trainee. Is there a key point in this process that, as doctors move up the training scale, it is becoming an increasingly big jump, as has been said by Professor Sowden, from registrar to consultant but also a big jump and step up from, say, foundation doctors to trainee and, particularly, from more junior trainee to what would be a registrar level trainee?

Is there a case, perhaps, for longer-term placements of some trainees at hospitals to engender that sense of thinking, “At the end of your ST2 year,” or whatever it may be, “we want to have an ST3 we can use at this hospital, who would be useful on our rota”? Often, at the moment, there is not necessarily that investment. The trainee may have ticked their competency boxes, but are they going to be able to cope at that more senior level?

Professor Sir Peter Rubin: Could I have a go at that one? This is the kind of thing that postgraduate deans and LETBs, if they are working well, could be very influential in achieving. What you have alluded to is something which I personally feel very strongly about. It is one thing to produce a doctor who has shown that they have achieved a certain competence; it is quite another to produce a doctor who is capable of doing what the public expects doctors to do, which is synthesising conflicting and incomplete information to reach a diagnosis, dealing with uncertainty and managing risk—all the things that doctors do day in, day out. We have to have training programmes which enable doctors to learn these core skills that go to the heart of being a doctor. That is so much more than ticking a competency box.

Professor Sowden: May I follow that? You make a very valid point. We are expecting an enormous amount from these young people. They are training, and it is very challenging, they are usually going through major life events, at the same time, and they are being employed in a system that many would describe as quite hostile. That is quite a triumvirate. There is an argument for saying exactly what you are saying, but it would require curricula to be more modularised and also require credentialing—in other words, saying you have reached a certain level which allows you to do a certain range of activities within the system. But this idea of stepping on and off an education and training escalator has a lot to be said for it. I agree with Peter. If the LETBs operate well and work well with HEE, there is a real opportunity to deliver that kind of flexibility. Going back to a point
Sir Christopher made right at the beginning, we do have a relatively inflexible system at the moment.

Q158 Chair: I am conscious we are on borrowed time. Sir Alan wants to make a point.

Sir Alan Langlands: Yes, very briefly. I sense we are going to move away from the workforce issue but, before we do, I wanted to run up a flag for the clinical academic workforce. Hugely significant progress has been made in recent years to rebuild the clinical academic workforce—not only in medicine, but increasingly in other areas. In these more difficult times, we have to keep a focus on that as a mainstay—a foundation stone—for some of the other things we have been talking about.

Chair: Thank you.

Q159 David Tredinnick: I want to ask one or two questions about wider participation in the medical profession and multi-professional education. As a preamble, I would like to ask you about strategy. I was at the launch of the chiropractors’ prospectus for the next two years, what they are hoping to set out. Your predecessor—I think he was your predecessor, Sir Peter—Sir Graeme Catto was there, making a presentation. It was a very interesting presentation, too. My point is that he has now gone off to be the Chair or President at the new College of Medicine. Do you agree with or have views on their strategy, because it seems that this could be the way forward? This College brings doctors and other health professionals together, renewing traditional values, creating a more holistic patient-centred and preventative approach to healthcare. There needs to be better communication between all those who contribute to good medicine. It is essential, they say. Is that a model that you would subscribe to? Do you see that as a way forward, please?

Professor Sir Peter Rubin: Yes.

Q160 David Tredinnick: That is a major break with tradition, is it not? It means it is more patient-centred and more holistic, so it will be looking, presumably, at going back to some of the older traditions in medicine.

Professor Sowden: For example?

Q161 David Tredinnick: For example, the Health Professions Council is now regulating herbal medicine and traditional Chinese medicine. There are these shops popping up in every high street, and I absolutely welcome this regulation. I am sure you are all in favour of better regulation. I am wondering, looking into the crystal ball before I get on to the core questions, whether you subscribe to this view, as I think Sir Peter says he does.

Professor Sowden: There absolutely has to be an understanding of the wider spectrum of the provision of healthcare for the benefit of patients. There is a limit, though, to the extent to which you wish to go down this path. As somebody who would wish to see the doctors I train practising evidence-based medicine, I would be concerned if they were practising medicine or seeking to practise medicine in areas where there is little or no supporting evidence. With that proviso, then, fine. I think you will find that most general practitioners, for example, have good working relationships with osteopaths and chiropractors, but often with a very narrow window of interface. I am much more concerned about some of the extreme aspects of practice.

Q162 David Tredinnick: I sat on both those Bill Committees in 1989 and 1992. I think, from memory, and statutory regulation has brought those professionals from being alternative right into the mainstream, where they are now taking the pressure off orthopaedic surgeons. Do you agree that, if that is a model, there are others that can come in and help? We must move on to other things, but do you agree with that?

Professor Sowden: You have to be cautious in the sense that you can stoke demand to the detriment of the care of those who have other illnesses.

Q163 David Tredinnick: Fine. I am probably testing the Chair’s patience. The Gateways to the Professions report showed the need to make medicine a more socially diverse profession. What effect do you expect the new student fees regime to have on this problem, please?

Sir Alan Langlands: I was the author of that report and I also have the job of introducing the new fees system for higher education, so you can imagine I have wrestled with this issue a little. The honest answer to your question is that we do not know. We have seen a slight drop in the UCAS October figures of applications to medical programmes, but, given the huge demand, maybe that is not a big issue. The question is: is that drop reflecting a particular part of the population or not? It will be some time—probably December 2012 when we understand what the 2012 intake is actually like—before we know the honest answer to your question, or at least begin to get an answer to your question.

That said, there has been tremendous follow-up on this issue. My work was followed up very strongly by the work that Alan Milburn did. There are some spectacular examples—my favourite is King’s—of university initiatives in outreach for medicine, but that is replicated around the country. People in medical schools, in particular, but in other health professions too, are working hard on trying to raise aspirations in schools, in trying to give better information, advice and guidance to young people wanting to enter other health professions and in trying to assure best practice in admissions. I would argue that progress has been made, although there is probably a long way to go.

What effect will fees have? I do not know. Generally, for the last five years, we have seen a 32% increase in young people, 18 or 19 year-olds, from disadvantaged communities coming into universities. Will the fee issue put that into reverse? I do not know. I do not think the Government intend that. They have put in place very generous support packages for students and a national scholarship programme that is supposed to mitigate that effect, but we will be watching it very carefully indeed, for no other reason than it is
important that the professions reflect the communities they serve.

Professor Sir Christopher Edwards: To pick that up, I am very supportive of the point Alan is making. There was an article in the BMJ by Kieran Seyan, a fifth year medical student. He produced what he called “a standardised admissions ratio” to medicine and the figures were quite alarming. If you think that I was what you would expect, an Asian in social class I was 6, and an Afro-Caribbean in social class IV was 0.07. No pupils in social class V from an Afro-Caribbean background came into medicine over a 5 year period. We have to recognise that there are some quite serious issues. My concern is that some of those groups are very adversely affected by money. One cannot be surprised. If you are an Afro-Caribbean person and you want to do medicine—it is pretty difficult anyway—is this going to make it more difficult? We have to recognise some of these problems.

Q164 David Tredinnick: Yes, indeed. What are the consequences of strategic health authorities “raiding” education and training budgets in the past to get financial balance within their health economies?

Professor Sowden: It has reduced the investment in the education and training infrastructure for all professional groups. In some areas of the country, that has been much more of a problem than others. It has continued in the last couple of years, in some areas, to the detriment of the system. Those systems are likely to have to pay a price for it in due course.

David Tredinnick: Thank you very much. On that note, we need to move on. Thank you very much for your evidence. You have given us plenty of food for thought. Thank you very much.
on a whole workforce basis of 2.1 million. Within that, a lot of our focus has been on the bands 1 to 4 workforce because that is where we feel the greatest need is in terms of investment. Our functional roles are things like developing national occupational standards and apprenticeship frameworks. We run academies across England as well.

**Q166 Chair:** Do we have any increase on 2.1 million?

**Professor Ebdon:** I am Les Ebdon, Chair of million+, which is a university think-tank that has 28 subscribing universities, all of whom happen to be post-1992 universities. The name of the organisation reflects the large numbers of students studying in those universities. Most of the universities who subscribe to million+ have significant partnerships with the NHS in terms of training nurses, midwives and other professions allied to health. My day job is as Vice Chancellor to the University of Bedfordshire.

**Q167 Chair:** Thank you. I would like to start on an area of this subject that we did not cover with the previous panel, but is relevant to both panels—the question of the changing skill mix in healthcare. I would be interested in your perception of the effectiveness of the old arrangements, and whether that will change in the new arrangements, of ensuring that the training that we provide reflects, accurately and in an up-to-date timely way, the changing needs of healthcare providers in order to ensure that skills are kept up to date.

**Dr van der Gaag:** Are you specifically interested in the change from the current system to HEE and LETB, or are you interested more generally?

**Q168 Chair:** The answer to that is both. We are clearly going to be reporting, in particular, on changing institutional arrangements but there is no point in only focusing on those. What we are interested in is solving the problem, not just commenting on the structures.

**Dr van der Gaag:** From the perspective of the professions we regulate, clearly we are constantly observing and, in a sense, assimilating changes that are required by patients and service users. That is what we should be as a regulator. We need to be responsive to the changes that are going on in health and social care. We do that through a consultative approach. We regularly have to look at changes in curriculum and provision in higher education and then need to, in a sense, make changes that reflect what is going on in the workforce. That is something happening currently.

It is important that, under the new regime, there is a truly multi-professional input in terms of decision making, be it at the HEE level or the level of LETBs. There is some concern that, when we talk about partnerships, we need to make sure those partnerships include all the professions. That can be very challenging because there are so many of them.

**Q169 Chair:** Partnership does not mean only between the doctors and the universities.

**Dr van der Gaag:** Indeed.

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**Professor Hazell:** “Partnerships” is a word that has cropped up on many occasions this morning. That is certainly something we believe is absolutely essential. But, of course, it needs to be more than a word; it has to work in practice. We are conscious that, increasingly, care is delivered, certainly in hospital settings, within multi-disciplinary teams and that the skill mix within those teams is constantly changing. Therefore, we very much welcome anything which increases the partnership between a national perspective of that skill mix and what is locally happening currently, with a local understanding of how it might be tweaked to reflect particular needs. We certainly believe that it will be very important for there to be a real working partnership between HEE and the LETBs and we would want to be very significantly involved in that at a very early stage.

One of our concerns is that some of the proposals put forward tend to put the regulators a little further down the line. As you heard this morning, from our colleagues from the GMC, we do have a statutory responsibility for setting standards for education and training and, of course, for assuring the quality of those. I would like to think that the partnership will be meaningful, with everybody working very much together.

**John Rogers:** I would like to widen the definition of skill mix, in that 60% of our workforce is professionally qualified. We have 40% who are not. If we are going to achieve the £20 billion productivity challenge, we need to better use the whole of our workforce. Within that, currently, we spend about 3% of our training budget on 40% of the workforce. There is a question mark in terms on how you upskill that 40% to improve that skill mix to improve productivity and quality.

**Q170 Chair:** Could you give us one or two examples to dramatise what that means in practice, where there are opportunities to spend money to improve care for patients that you do not think are being followed up at the moment?

**John Rogers:** There are examples that we have on our website, and I can give you loads of written evidence following the oral evidence. Essentially, you can have examples of healthcare assistants who have been trained up in assistant practitioner roles. Within breast-screening services, that has been rolled out over the last four years and has been very successful. We have other examples there whereby it has been successful in Trust X but has not been adopted across the country. Within that, the issue is about how we get that widespread adoption, but underpinning it all is how we get the investment in those skills.

**Q171 Chair:** Your core message, if I am not putting words into your mouth, is that you can deliver care for patients by other means than regulated professions in some circumstances.

**John Rogers:** Yes. A lot of the discussion I have heard this morning, and in previous weeks, centres on the professions around medicine. That is absolutely right and proper and I do not think anybody would have any kind of challenge to that. Therefore, this is
Dr van der Gaag: kinds of CPD programmes are absolutely vital. Increased need to control hospital infections. Those when many nurses originally trained—and also the have existed or been present in the United Kingdom patients with HIV/AIDS—a disease which may not have been run in recent years about care for all professionals, for example, taking the programmes development in the NHS. In particular, issues arise for the importance of continuing professional development. That would be a serious mistake because we heard, in the earlier evidence, a more graduate-based profession. We can see that around the country. I sound one note of concern about continuing professional development and the proposition that, in the future, the MPET budget should not fund continuing professional development. That would be a serious mistake because we heard, in the earlier evidence, the importance of continuing professional development in the NHS. In particular, issues arise for all professionals, for example, taking the programmes which have been run in recent years about care for patients with HIV/AIDS—a disease which may not have existed or been present in the United Kingdom when many nurses originally trained—and also the increased need to control hospital infections. Those kinds of CPD programmes are absolutely vital.

Dr van der Gaag: If I may reinforce that point, one of the hopes for the new infrastructure is that there will be more proportionate funding, particularly for post-registration—CPD for professions across the board—and, taking John’s point, the support workers also need investment in training. As the needs of the population change, there is much more investment needed in working with people with long-term conditions. The workforce needs to adapt and be funded in order to achieve that.

Q172 Valerie Vaz: I want to turn to the Local Education and Training Boards and your role in them. You are UK-wide organisations, are you not? How do you see where your members fit into this new structure, and in terms of the lines of accountability?

Professor Hazell: We are very fortunate in the education of nurses and midwives in that the involvement of local health providers has been developed extensively over recent years. As Les said, it is a genuine partnership, 50:50, and we take that very seriously. When you look at a local situation of education and training for nurses, you are already going to have, in most instances, a very strong involvement both of the higher education section—it tends to be predominantly HEIs that provide these programmes—and the actual care providers, local trusts and so on.

We would expect and anticipate those true partnerships to be reflected in the LETBs because it would be such a shame if so many of the benefits that we have developed in the current system were lost in the new system. The first question that was posed this morning to the other panel was, “Do we need a new system?” The answer that they gave would be very much the same as I would give. There is a lot of good in what we have been doing so far, but we need to make it better. Let us not throw out the good, but let us ensure that that is integrated effectively and adequately into these new structures.

Professor Ebdon: While we are emphasising the importance of partnerships between various parts of the NHS and universities in encouraging excellence and relevance of training and education, nurses, for example, spend 2,300 practice hours with the NHS. Therefore, universities have to be well schooled in what the needs of the service are. Indeed, universities are responding rapidly to the desire to make nursing, for example, a more graduate-based profession. We can see that around the country.

I sound one note of concern about continuing professional development and the proposition that, in the future, the MPET budget should not fund continuing professional development. That would be a serious mistake because we heard, in the earlier evidence, the importance of continuing professional development in the NHS. In particular, issues arise for all professionals, for example, taking the programmes which have been run in recent years about care for patients with HIV/AIDS—a disease which may not have existed or been present in the United Kingdom when many nurses originally trained—and also the increased need to control hospital infections. Those kinds of CPD programmes are absolutely vital.

Dr van der Gaag: If I may reinforce that point, one of the hopes for the new infrastructure is that there will be more proportionate funding, particularly for post-registration—CPD for professions across the board—and, taking John’s point, the support workers also need investment in training. As the needs of the population change, there is much more investment needed in working with people with long-term conditions. The workforce needs to adapt and be funded in order to achieve that.

Q173 David Tredinnick: Is not the move to a degree-based nursing profession very discriminatory in terms of socioeconomic classes? Will it not exclude a lot of wonderful people who love and care for people, just because they have not got a degree?

Professor Hazell: Clearly, I must respond to that. The simple answer is no, I do not believe that, but you would expect me to give some justification for it. We need to remember that we have had degree-based education and training for nurses since the 1970s. There have been a lot of provider programmes that are already offered at degree level.

In Wales, for example, since 2004, all the programmes have been degree-based. We heard earlier, from the previous panel, about the expectations that are now put on doctors to have skills and competencies that perhaps go beyond some of their initial training. I would suggest that, increasingly, that is the case with nurses. Degree-based approaches to education and training for nurses does not in any way imply that those individuals do not have the same commitments to providing compassionate, fundamental care based on dignity and respect. Increasingly, they are expected to provide higher levels of skill, analysis and leadership.

We believe that the programme being rolled out now in England, to come in line with the rest of the UK, will enhance the quality of that fundamental care. Wales has done some very, very interesting monitoring over the six or seven years that they have had this. They are now producing some very useful evidence to say that there is nothing to support the idea that these people are in any way less caring.
Q174 Dr Wollaston: Can I follow that up with a question? So much fundamental nursing care is now being provided by healthcare assistants and many of those that I speak to tell me they want to have access to improved training and to become assistant practitioners. As Mr Rogers touched on, if we want to have better training for the 40%, we are going to need a bigger share of the 3% of funding. But then you are up against the issue that the medical profession is very powerful. How confident are you, within these new organisations, that you will be able to wrest a fairer share of that postgraduate or, if you like, continuing professional development cake?

John Rogers: To be absolutely honest, which I am in this Committee, I am not very confident at all. I have been in this arena for about 25 years. Every time you get a downturn, the actual constriction of investment hits the 1 to 4 bands more than it does anywhere else. We have done brilliant work with the 1 to 4 bands over recent years. We had a £100 million joint investment fund between the Learning and Skills Council and the SHAs. Also, the Department put about £10 million into apprenticeships last year and there were 5,000 new apprenticeships. The problem with that, for bands 1 to 4, is that it is all initiative driven. It is a pot of money here and a pot of money there. There is no continuity in terms of people being able to plan. That affects the relationships between trusts and further education, and it affects training departments within trusts. It is all stop-start. Within that, the bottom line, if history repeats itself, is no, I am not that confident.

Q175 Dr Wollaston: What powers would you need to make it better? The public are very concerned, are they not, about improving the standards and the access to training, particularly for healthcare assistants, as they are themselves?

John Rogers: Within that, a lot of the focus for me will be around the LETBs—the Local Education Training Boards. If they are truly employer-driven, the employers see the agenda in terms of the challenge with the productivity agenda, then they recognise that they need to invest in that level of workforce. The LETBs need the flexibility from the new NMET and, through HEE, the LETBs, it is a question of maintaining the argument within that budget, is it the right level? Discuss.

Professor Hazell: Can I add a comment? All of us are committed to improving patient care, patient safety, and so on. That is the object of any enhanced training. We also need to ask ourselves whether there are other things we can do to contribute to that. Certainly, we believe there are. From the NMC’s perspective, we are currently doing some very important work on improving the guidance we offer to nurses and midwives regarding the delegation of tasks to healthcare support workers. We recognise that those support workers play a vital part in the overall provision of care, but, most of the time, they are going to be given tasks that have been delegated by nurses and midwives. We do not feel that our current guidance on that reflects current practice and situations. We have begun—and we are almost at the end of it—a piece of work that will improve the guidance and the support for nurses and midwives so that, when they delegate tasks to other people, they are confident those people are competent to undertake those tasks. That is something we can do in addition to—and I totally agree with John here—further investment. I travel up and down the country and have come across some absolutely first-class examples of local training initiatives for healthcare support workers, often done collaboratively across a number of education providers. I would cite the north-west as a very good example of that. It is not all bad. There are some very good practices out there.

Q176 Dr Wollaston: Is that because they receive better funding in that part of the world or is it that they are performing within the system of funding?

Professor Hazell: It is probably a combination of both. Clearly, the funding available does influence it. A lot of this is about a genuine belief and a commitment of people that they can work together, improve things and be innovative. Again, sometimes we do not talk enough about the innovative approaches to education and training that take place across the UK. We should celebrate those far more than we do.

Professor Ebdon: One practical proposal to safeguard education and training is to ring-fence the education and training budget. It has been, in recent years, a soft target for savings and we have seen damage, particularly at the healthcare assistant, nursing and midwifery end of the spectrum.

Q177 Dr Wollaston: Would you ring-fence it so there is more of a bias towards healthcare assistant continuing professional development and you do not have powerful interest groups taking a disproportionate amount?

Professor Ebdon: Absolutely, is the answer.

Chair: We have a budget and then we are ring-fencing 3% of it.

Dr Wollaston: No. I am wondering how feasible it is to wrest a greater proportion of it.

Q178 Chair: Is it not about the balance? If there is a training budget which is to be the responsibility of HEE and, through HEE, the LETBs, it is a question of maintaining the argument within that budget, is it not? If you start with 3%, who knows whether 3% is the right level? Discuss.

John Rogers: The important part with that is consistency. If it is 3%, or whatever it is, and people know that that investment is going to be made and that can be done in partnership with the trusts, with the colleges, and so on, then it is about the ability to plan. Yes, we would like more as well, but I realise that there are financial constraints with all of this. Tony was saying the north-west is an absolutely fantastic example. That is where our major academy presence is and we have worked with all 38 trusts, with the 15 colleges in the area and very much with the backing of the SHA who have invested in this area. The results there have been brilliant.
Q179 Valerie Vaz: Following up on that point, where is this good practice going? Is it going to some person in the Department of Health and why is that not being rolled out across the whole country? Could you do that under the new system?

**John Rogers:** As a Sector Skills Council, one of our funders is BIS, as with all of the Sector Skills Councils. We have recently put in and won a bid to BIS for the years 2012 through to 2014 to set up networks for spreading good practice. That is one of the things we are concentrating on in terms of getting networks of employers together and spreading that good practice.

Q180 Valerie Vaz: Did you feed your good practice in the north-west back up?

**John Rogers:** Yes. On our board, apart from the chief executives from the trusts, there are the four Department of Health representatives as well. They are fully engaged in terms of what we are doing and are very supportive about that.

**Dr van der Gaag:** I want to add two quick things in terms of looking for examples of good practice. There was an interesting mention of NES this morning. For all of us, there is a sense that NES in Scotland has done a huge amount because it is very much taking a multi-disciplinary approach. In England, the multi-professional deaneries are also a good example of where there is more integration and more shared understanding of what the workforce as a whole needs in terms of education and training and continuing development. Those are few and far between, at the moment, in England, but it seems to me they are very good models that the new system could build on.

Q181 Chair: Dan Poulter wants to come in, but I observe that the Chairman of the Deaneries, who was here earlier on, was one who used to run a multi-disciplinary deanship and moved away from it. Does anybody have any comment on that?

**Professor Hazell:** I have no idea why that might have been. Perhaps I can give you another example of where it works very well and apologise, in a sense, for using a Welsh example. A week or so ago, I was present at the opening of a brand new building on the University of Wales hospital site, the Cochrane building, which is a tripartite partnership between the School of Medicine, the School of Nursing and Midwifery and the School of Health Sciences—various health professionals. That is going to be a truly multi-professional activity. It seems to me not a very good idea to separate out the areas we are talking about. Others are not so broad-minded. People from the private sector in the settings that you are talking about, others are not so broad-minded. It seems to me not a very good idea to separate out your staff from this. If we want the same standards, let us have the same CPD activity and let us train and educate these people together.

Q182 Dr Poulter: Indeed. What I am trying to drive at is how we make sure that those people who are performing healthcare work—and they may have previously worked for the NHS but are now, perhaps, working in the social care sector—have continuing professional development and that their training and skills are of the standard we would expect in the NHS but putting that across to adult social care. That is what I am driving at.

**John Rogers:** Basically, we work with our sister body Skills for Care, which is the Sector Skills Council for Care. The national occupational standards, which the care assistants’ qualifications are based on, are the same standard for both social care and health. They are the same standard within the qualifications. In terms of work that we have recently been asked to do by the Department of Health on code of practice and training curricula, that is a joint piece of work between ourselves and Skills for Care to cover the health and care sectors. That partly answers your questions. It is fine in terms of how far it goes. The question in terms of extended roles within that area is much more trickier to answer.

**Professor Ebdon:** Can I make a practical suggestion to this problem? Some NHS trusts are broad-minded enough to let their professionals study continuing professional development programmes alongside people from the private sector in the settings that you were talking about. Others are not so broad-minded. It seems to me not a very good idea to separate out your staff from this. If we want the same standards, let us have the same CPD activity and let us train and educate these people together.

**Dr van der Gaag:** Can I give you an example? I can only speak for the professions that we regulate, but we do not have any real hard data as to how many of these people have the same qualifications as for the people working in the NHS. We have to work closely—and we do—with the systems regulators, which, of course, is a devolved responsibility. We have four systems regulators. Of course, you have mentioned the social care sector, but it is health and social care. The further you go out into the community and the independent sector, the greater the blurring becomes, as I am sure you are aware. We have to work with systems regulators in the current situation and try to get them to share that responsibility. It is not going to be an easy task. We do not have any real hard data as to how many of these people the NES are actually discussing. It is very difficult to know whether we are adequately controlling them. We saw, only a few days ago, reports in the social care sector of providing care in people’s homes. How do you monitor that? That is a difficult challenge, I think.

Q183 Dr Poulter: In terms of looking for examples of good practice. There has been a lot of mention of NES this morning. For all of us, there is a sense that NES in Scotland has done a huge amount because it is very much taking a multi-disciplinary approach. In England, the multi-professional deaneries are also a good example of where there is more integration and more shared understanding of what the workforce as a whole needs in terms of education and training and continuing development. Those are few and far between, at the moment, in England, but it seems to me they are very good models that the new system could build on.
have had in place, since 2006, mandatory standards on continuing professional development. We audit, on a random basis, those on our register against those standards. Wherever they work—whether they work in people’s homes or in independent care homes or in the NHS—they will all be subject to those same standards on continuing professional development and will be selected for audit regardless.

That is a very important baseline, in a sense, on which we work with the professions to ensure that they continue to keep up to date and are fit to practise. That is for the professions we are currently regulating. Obviously, when social workers come into the Health Professions Council, they will be subject to the same mandatory standards on continuing professional development.

Professor Hazell: Can I add that perhaps a number of our healthcare support worker colleagues, whether in health or social care, might be a little surprised at us focusing on CPD. Many of them would be only too pleased to have some initial training. On that basis, we very much welcome the new initiative that Skills for Health and Skills for Care will be undertaking to introduce basic common training for these people. That is where we need to start. We welcome that initiative and look forward to contributing to that work in a constructive and positive way.

Q184 Dr Poulter: A lot of the issues are concerned with who is responsible for adult social care at the moment. Obviously local authorities have, presumably, a great deal of responsibility for that. What role would you say they should have in helping to co-ordinate or develop training at a local level? It is all very well to have a national initiative, but, in my view—and I do not know whether you share this—it is important that the people who are implementing that are able to and are doing it. What role do you see for local authorities in helping to support this? We have the NHS that does it in the hospitals, we have the local authorities more than ours do.

Professor Hazell: I am sorry to introduce the word “partnership” again, but it is vital that we acknowledge there are some very good examples of local authorities and health organisations working together, particularly in areas such as public health where the responsibility is very much a shared one. It is essential that local authorities do contribute, particularly on the social care side but, equally, on the healthcare side. We have to try to identify where there are some good examples and roll those out, talk about them and try to encourage. I am more optimistic than I would have been perhaps 10 or 15 years ago about the collaboration that exists between local authorities and health authorities. Anna’s professions cover the local authorities more than ours do.

Dr van der Gaag: Yes, you are absolutely right to foreground partnership working as being essential. You are also absolutely correct to say that there is a level of concern about the amount of supervision, the supervisory structures that are in place and the amount of read-across that is there at the moment. The development towards national standards with much more of a focus on investment in training for those at support worker level is to be welcomed by all of us.

Q185 Chair: Can I turn to the question of the range of social backgrounds for people joining healthcare education—in particular medical education, but not exclusively that? Professor Ebdon, the view was attributed to you—you may think inaccurately—that schools should be willing to be flexible on their entry standards in order to encourage students from low income, disadvantaged backgrounds. Do you think that is right?

Professor Ebdon: There are things other than A-level grades which suggest somebody will become a good doctor. I would hope that medical schools would look at the range of capabilities of individuals and not only their academic achievements. We also have to recognise that, now, the academic achievement levels set for entrance to medical schools is so high that it favours a certain type of school, those which are particularly academically focused, but, in particular, as we can see from the statistics, fee-paying schools as opposed to state schools. It is quite clear that we would want a range of people from different social classes, and indeed different ethnic groups, to go to medical school. The evidence that Sir Christopher gave was quite challenging, was it not, in the previous session? I very strongly believe that universities should be looking for potential in candidates as opposed to only past achievement. The potential demonstrated by getting good grades in a school where that is unusual is indicative of somebody with potential as opposed to perhaps getting very good grades in a school where everyone gets very good grades.

Professor Hazell: I said earlier that most of the programmes for pre-registration nursing education take place in the higher education sector. But many of those higher education institutions have very good partnerships with a range of FE colleges which are providing—and have done for a number of years—with what we could loosely call access programmes, increasingly foundation degrees and so on, and a whole range of innovative approaches. The relationship they build with their higher education provider enables people to have greater access.

I would say that higher education has a good track record in working across the higher and further education sectors in encouraging people from non-traditional backgrounds to come into those professions. That is certainly what we see in nursing. It is not only people from different socioeconomic backgrounds, but people at different age levels and from different walks of life. We should be encouraged by the relationships that already exist and build further on them.

Q186 Chair: That is taking the view of engaging with the place where the student does the A-level, or whatever pre-qualification it is, rather than simply trying to guess from an A-level score.

Professor Hazell: Absolutely.

Q187 Chair: Is that what you meant?
**Professor Ebdon:** I do not think those universities that use what is known as contextual data are guessing. There is a good deal of research evidence behind that now.

Q188 **Chair:** I acknowledge the mistake.

**Professor Ebdon:** It is a clear issue about medical education, as we heard from the last speaker, and it is something we have been able to solve in nursing and midwifery. Engagement with schools, colleges and communities is, of course, an excellent way of ensuring a good supply of a diverse population into professions allied to health. Hopefully, the medical profession will learn from it.

**John Rogers:** Within that, particularly within nursing, there has been a good tradition, as Tony says, in terms of vocational pathways with people coming through NVQ routes—as was—into nursing. Certainly, everybody would encourage that in terms of how you get the vocational pathways into higher education as well.

**Dr van der Gaag:** I want to add that we have done quite a lot of work in the area of understanding the needs of people with disabilities who might want to become a physiotherapist or an occupational therapist and so on. We produce guidance on this now, which is another way in which we can, in a sense, target particular individuals who might feel that they were excluded.

In fact, we are saying that we very much welcome applications from people with disabilities. Going back to our earlier conversation about the changing needs of the population—more and more people with long-term conditions requiring services—having people who have a personal experience of disability working as professionals with those individuals, improving their quality of life and so on, is very important. That is another important group that needs to be foregrounded in this. We want more people with disabilities in the professions.

Q189 **Dr Wollaston:** Can I ask a follow-up question of Professor Ebdon? Where universities have a good track record of recruiting students from disadvantaged backgrounds, such as King’s that was quoted earlier, do they find when they look at the data in terms of pass rates at the end of the course, that these students are as likely to pass as those from more advantaged backgrounds? It is quite a long time to commit to a course like medicine. I wonder what the data is on that.

**Professor Ebdon:** I believe that is so, that the application of contextual data is based on actual cases of student achievement at universities reflecting on their A-level grades coming in. The King’s example is an excellent example of reach-out to local communities as well as a sensible use of entry routes into the profession. It used to be generally true that research suggested students who joined university through an access route achieved significantly better than those who did not. Part of that is because of the greater pressure on such students to achieve and the fact they have overcome major hurdles. They have sorted themselves out on their access programme and, by the time they arrive for the university course, they have learnt a wide range of study skills which, maybe, some of our 18 year-olds have not yet acquired.

Q190 **Dr Poulter:** I have a quick question for Professor Ebdon. The Department of Health states that the number of midwives entering training is at record levels. Yet the Royal College of Midwives recently had a survey which showed a third of students are leaving their courses due to fears and concerns about debt and a lack of jobs, even though we know, perhaps, there are the jobs available and there is a need for more midwives. Why do you think this is happening?

**Professor Ebdon:** There is a desperate need for stability in training the workforce. A few years ago, we had a situation where there were deficits in local trusts in the regions that we serve. Drastic measures were taken to balance those budgets in one year and, as a consequence, no new midwives were taken on. You had a situation where people who had been successful nurses had decided to study midwifery and, because of the accident of the year they made that decision—the year they came out as fully trained midwives—there were virtually no jobs locally. That has a knock-on effect years down the line with people considering training for midwifery. We need to make sure that any reforms to education and training in the NHS do promote stability. The idea that you can take these education and training programmes and treat us like the people who supply the roller towels is ridiculous. For example, at my own university, the University of Bedfordshire, we have invested in a new campus in Aylesbury because we have the contract to train the nurses and midwives for Buckinghamshire. We have spent about £2 million in a simulation and skills centre at one of our campuses in Luton because we think it is increasingly important to use simulation, where we can, because of issues about hospital-borne infection. These are big investments. If, suddenly, somebody says, “We can get this done cheaper down the road,” that would be a severe discouragement to universities to make those kinds of investments in excellence in education and training.

Q191 **Dr Poulter:** You seem to be saying that the hospital trusts need to take a more long-term view of service provision in midwifery and nursing—in this case, midwifery. You say that, in order to meet short-term financial squeezes in the past, there has often been a freeze on recruitment in midwifery and that lies at the core of the problem. The decisions at those trusts were not being made in a co-ordinated manner looking at the long-term need for midwives and not co-ordinating with yourselves.

**Professor Ebdon:** Short-termism is a real enemy of stability and not co-ordinating with yourselves. For example, to meet nursing shortages, has, on occasion, denuded other countries of their nurses and brought large cohorts of them into our hospitals. We need long-term planning for the health workforce in this country.

Q192 **Dr Poulter:** The key issue here also is the tie-in with the local employer, is it not? If trusts are
making those short-term financial decisions to freeze the number of posts when we know there is a need for more midwives, there is a disconnect between the long-term workforce planning, what you are doing in terms of training midwives and nurses and the decisions being made by chief executives and boards of local trusts.

**Professor Ebdon:** Many nurses and midwives train and work locally. In fact, midwives, traditionally, are more mature in years than nurses and will very often have their own families. Having a family can make them think, yes, midwifery is a valuable profession that they would like to enter. But people’s mobility is very much reduced because of all kinds of social phenomena, such as housing, schools for children and so on, and we understand the importance of stability in the education of our children. So they are very on, and we understand the importance of stability phenomena, such as housing, schools for children and so on, and we understand the importance of stability in the education of our children. So they are very so on, and we understand the importance of stability in the education of our children. So they are very

**Dr van der Gaag:** Does anyone want to add to that?

**Dr van der Gaag:** I have a quick point. It seems to me that, in terms of workforce planning, we tend to rely on descriptive data rather than analysing the social dynamics that are at play. There needs to be far more of that kind of investigation and understanding of the reasons why people leave, why they feel they are not supported sufficiently in their own training and development. Thinking about the future, that investigation seems to me to be something that we could do much more of to the greater good than we have done in the past.

**Q194 Valerie Vaz:** Who has the grip, nationally, of those figures? Who is going to have the accountability to look at the UK and England strategically?

**Professor Ebdon:** Higher Education England is going to be supported by a workforce planning unit. We have to acknowledge that, as a nation, we have not had a great track record in workforce planning. We also have to take on board the fact that this is very much a localised issue. For example, we find it is very much more difficult to recruit to our programmes in Buckinghamshire than our programmes in Bedfordshire, which suggests that there are many other work opportunities for people in Buckinghamshire compared to Bedfordshire. If you go further north still, then you will find that recruitment gets easier.

**Q195 Valerie Vaz:** Who do you think should be responsible for that? You can have lots of nurses in Buckinghamshire, but you do not need them there.

**Professor Ebdon:** I assume the idea of having Local Education and Training Boards is to get that local dimension—

**Q196 Valerie Vaz:** I am trying to tease out of you a possible pathway up to the Secretary of State.
Dr van der Gaag: Absolutely. I would fully support it. As I said, from 2009 the Health Professions Council has fully supported the recommendation and we will work with the Department to that end.

Q200 David Tredinnick: I have one further short question. The Lords also recommended that statutory regulation may also be appropriate eventually for the non-medical homoeopaths. Do you see a role for yourselves there in the future, possibly?

Dr van der Gaag: It is for the Government to make that decision. We are aware of our colleagues in the Council which currently holds a voluntary register for a number of the alternative and complementary therapies. There was talk about homoeopaths coming under that umbrella some years ago. We are very much waiting for the Government to give us direction on this.

Q201 David Tredinnick: Are you not in danger of becoming completely overwhelmed by your workload? The Health Bill has given you a whole new mandate. We have various appendices here listing them. Are you not up against it?

Dr van der Gaag: I do not believe so. We have a strong and good track record in delivering cost-effective and efficient regulation for the 15 professions that we currently regulate. Also, we have very good systems in place which ensure that the professions themselves are involved in decision-making where they are required to be and that lay people are involved in decision-making where they are required to be.

Due to the fact that we are truly multi-professional and our standards apply across all 15 professions, there is scope for extending that to other professions who are very keen to come into a statutory regulatory regime. Multi-professional regulation, as delivered by the Health Professions Council, works and can work for additional professions should the Government choose to direct us down that road.

Chair: I gave us the objective of concluding at 12 o’clock at the beginning of this session and it is 11.59. Thank you very much for your evidence. We will reflect on it in the course of our deliberations.
Tuesday 24 January 2012

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Dame Julie Moore DBE, Chair, NHS Future Forum Education and Training group, Professor Sir John Tooke, Head, School of Life and Medical Sciences, University College London, and Dr Peter Nightingale, President, Royal College of Anaesthetists, gave evidence.

Q202 Chair: Good morning and thank you for coming to see us. Could I ask you to begin briefly by introducing yourselves and telling us where exactly you come from in the system and your “stake”—which I think is the modern word—in the subjects we are discussing this morning?

Dame Julie Moore: I am Julie Moore. I have come from Birmingham this morning where I am Chief Executive of University Hospitals Birmingham. My stake in this is as an employer, but I was asked to chair the Future Forum Education and Training work group.

Professor Sir John Tooke: I am John Tooke. I am a physician, a diabetologist by background. I am Vice Provost of Health at University College London and I am the academic director for our academic health science centre, UCL Partners. I have been part of the education and training workstream of the Future Forum.

Dr Nightingale: Good morning. I am Peter Nightingale. I must apologise for my very bad upper respiratory tract infection, but I am suitably armed.

Chair: You got it from me.

Dr Nightingale: I am a consultant anaesthetist and intensive care doctor. I am President of the Royal College of Anaesthetists. I was invited on to the Future Forum because I have an interest in education, training and workforce.

Q203 Chair: I thank you for that and begin, if I may, with quite a general question, which is to ask you to reflect on where you think this process has now reached. The original scale of the changes implied by the wider changes in the health service for the education and training system caused some disquiet, both for the scale and lack of clarity of the direction. Do you feel that those have now been addressed and that we have the clarity we need or are there still some anxiety about the number of players or has it been addressed?

Dame Julie Moore: The first Future Forum report addressed that. One of the things we asked for was some speed in putting into place the arrangements, like the establishment of Health Education England. That indeed is progressing. In the second Future Forum, we would have liked it to have been a bit quicker, because they have a pivotal role to play in setting this up. That said, there are people in post now, and they are getting to grips with some of the problems. I found on the second listening exercise that people were getting some clarity and were a bit more reassured about the direction in which things were going. I cannot say to you that we went out and found unanimous consensus about everything because we did not. There was a range of views about everything and we have tried to map a course through that in our report. Things are more settled this time, although there is still some anxiety about the way things are going to end up in any change process that happens.

Professor Sir John Tooke: I would echo those comments. I was personally pleased that education and training was integral to the initial discussions. Clearly you cannot effect the necessary transformation of the NHS without attending to the workforce, new roles and, in particular, having a very clear future focus on what the learning and skills needs are going to be. This has been a solid attempt to address that. There is always vulnerability with transition, but the pace that has been injected now is appropriate. I am confident that the structural proposals can be made to work.

Dr Nightingale: I would echo that as well. There were some concerns about the exact nature that LETBs were going to take. There are still concerns about exactly how they will function, but, generally, the feeling is that, having got this far quite quickly over the last few months, people now can see the end in sight and can start looking at the important things about funding, time for training and assessment.

Q204 Chair: When we talk about an “end in sight”, we are talking about clarity and permanence—in so far as these things are ever permanent—from 1 April next year and a clear map, from your perspective, to get there.

Dr Nightingale: There is now a time line, posts are being populated and documents are being produced. Some of them are still very developmental and there is still quite a bit of work to do, but we feel now that we are on the final road to getting the LETBs and the education systems sorted.

Q205 Chair: There was reference in the Future Forum report to the number of players in the system. There is nothing new in this. The education training system has always had so many players and letters that it is unclear who does what. Do you feel that there is still a concern about the number of players or has that been addressed?

Dame Julie Moore: No, it has not been addressed. I must say that you grow up used to these structures...
and systems so you do not realise quite how many there are until you make a comparison, but, if you think about other professions such as law, you have universities, the Law Society and the places where people practise. In medicine, there are far more and some of those roles needed clarification. It was quite interesting that at least four or five bodies thought they were responsible for quality of education, and they all had a role to play in that. One of the biggest roles in maintaining quality should be the employers, and in the past they had probably not played as full a role as they could have done. There are still a lot of players there and some clarity is needed because these are organisations that are here to stay. We need to be clear and also make sure that the burden of regulation on both education and health providers does not grow as a result of any of this, which is why one of the things we recommended was some kind of accord between the regulators to make sure that there was not duplication. I can tell you that, at times, we do feel very regulated.

Q206 Chair: Presumably, the problem arises when you have multiple regulators with incompatible regulation.
Dame Julie Moore: It can apply and it does.
Professor Sir John Tooke: If I could add a point, we need to avoid creating greater complexity with the new structures. One of the things that concerned us is this. The academic health science networks have been variously projected to promote the innovation agenda, potentially act as a host community for LETBs and are essential for innovation and for the diffusion of best evidence-based practice and so on. It is very important that we do not set up two or three identical structures and there is one coterminous structure to deliver those activities.

Q207 Chair: One of the things that the Committee was puzzling over before you came in was academic health science networks, academic health science centres and academic health science clusters.
Dame Julie Moore: The clusters probably do not exist. That was transition terminology, if you like.
Professor Sir John Tooke: I see it quite simply. There are academic health science centres. There are five that are designated as such, which are major centres of biomedical science expertise and have a diffusion mechanism to translate research into practice. The networks are taking that latter important role, which I would argue needs to be present throughout the country, to ensure that innovation is driven forward. Of course, some of those regional networks will be doing substantive amounts of biomedical research and they may qualify for academic health science centre status in the future. I can see a model of a relatively small number of globally competitive AHSCs and then a regional panoply of networks that is a diffusion vehicle for the NHS.

Q208 Chair: But definitely more networks than centres.
Professor Sir John Tooke: Absolutely.
Dame Julie Moore: Yes. One of the problems we had was that Sir Ian Carruthers’s review—he was leading this work for Sir David Nicholson—was at exactly the same time as we were doing this work. As John has said, we were keen that we did not have one structure that was this boundary and then one that was that, and so I would end up going to this meeting with 10 people and then again with a slightly different few people. Education and academic research are intimately bound together anyway and it makes sense for these to be coterminous, for there to be the one organisation dealing with that.

Q209 Dr Wollaston: Could you make clear to us whether or not you think these changes are going to change education and training for the better? You have talked about it perhaps being more complex in some ways rather than simpler. Is it going to be clear to people who are in the system, or working with newly-qualified doctors and nurses, that they will be trained better?
Dr Nightingale: I think, overall, yes. The current system is pretty good and it is producing well-trained doctors for the future. But there is no doubt that there are concerns about variability. There is variability in performance of deaneries, for instance, in education providers and there is variability in who is doing the quality management and quality control. The new structure, because it is line-managed down from HEE to the LETBs and then out to the education providers—hopefully with the money following the trainee—then with the education outcomes framework, will have a more open ability to check that the education is being delivered appropriately. What needs to be sorted out is the slight confusion and variability regarding assessment. Is it the GMC that is working with the new LETBs or is it going to be the colleges working as agents of the GMC? There still needs to be some clarity about that. Personally, there will be a clearer structure and accountability right down, as Julie said earlier on, to the education providers, the foundation trusts, etc., themselves.
Dame Julie Moore: In theory, a mechanism existed to deal with poor placements at hospitals but it was very rarely applied. Often there seemed to be, for non-medical education, little scrutiny of the quality of the courses going on and we had reported to us concerns over poor education. There has been a lot said nationally about that, with employers feeling they had little influence sometimes over their local education provider, whereas this does provide a mechanism for it.
Professor Sir John Tooke: I would argue that the new structures permit a system which is more service-sensitive—the LETBs’ provider presence ensures this—but yet academically and professionally informed. The “academically informed” is incredibly important because what we have seen in medicine, of course, is the post-graduate deanship function divorced from higher education. We are the only system in the developed world that has done that and, I would suggest, at a cost, so that we are not linking in educational expertise with the training of that important professional group. These changes, in joining providers with an HEI presence in the LETBs, create a real opportunity to redress that and drive up standards.
Q210 Valerie Vaz: Could that not have been done with the structure that you have at present? It seems to me that MEE is now becoming HEE, but there are LETBs. The governance around LETBs—who sits on them and what they do—is still very unclear. Is that not something that could have developed? What I am getting at is that there is no point having change for change's sake because it costs a lot of money. Is that not something that you could have looked at?
Dame Julie Moore: Except the SHAs have disappeared where they sat, so—

Q211 Valerie Vaz: They are disappearing because of this, are they not, because the new structure is in place?
Dame Julie Moore: The problem the first Future Forum addressed was that the strategic health authorities were disappearing, so where is the dean going to go? Is the dean going to stay? Who is going to look after education? Who is going to be the responsible officer? The status quo could not exist because it has gone already.

Q212 Valerie Vaz: I suppose that is what I am asking you. What was wrong with the system before that made you want to put it right? It seems there is a whole series of acronyms that have come up which—
Professor Sir John Tooke: In my view, the SHAs were divorced from the service front line, so that information was not being fed in first hand. The deanery was over there in the SHA and was not connected, in most cases, with the higher education institutions. That was wrong and this is a better interpretation. Also, by connecting the LETBs very clearly with HEE, central health policy, for example, moves towards more community care, can be fed through to the LETBs. That national perspective can be co-ordinated and fed through and yet the system remains locally responsive in precisely how it interprets those policy directives.

Q213 Valerie Vaz: Where does that information go from the LETBs? It is going to HEE, is it?
Professor Sir John Tooke: I am sorry, where does—

Q214 Valerie Vaz: The locally-cleared information.
Professor Sir John Tooke: As to the local sensitivity information, there has to be a requirement on providers and the LETB to feed back through the Centre for Workforce Intelligence and HEE so that there is some understanding of what the local need is. It needs to be nuanced by what the political direction of the Health Service is—and how it is going to deal with taking that national responsibility for issues that need to be addressed at scale.

Q215 Valerie Vaz: Does this organisation have the scope to say to the Secretary of State, for example, whatever it is, that they want more health visitors and you say, “We do not need health visitors. What we need are more doctors”? Does this new structure have the ability to do that?
Dame Julie Moore: It has the ability to do it.
Dr Nightingale: At the LETB level, working through the employers, they will have a better ability to influence what kind of workforce is going to be trained. There is a limited amount of money for training. If they wish to move into one kind of practitioner rather than another, then they have an ability to influence that upwards, to get HEE, with CfWI, to make the changes.

One of the advantages I would see with the new system is that there would be more conformity. LETBs will be able to innovate and to have freedoms, but the postgraduate dean function in a LETB will be more circumscribed; there would be less variability across the country. What we need to see is more standardisation of the deanery functions. Also at the higher end, the colleges, working through HEE, need to be very clear about what they want from the QA process.

Q216 Rosie Cooper: It is going from a “could have/should have” to what actually is going to happen. Who is going to produce the workforce information that says how many doctors, nurses, or whatever, you need? Currently it is very difficult to get that information. I understand some PCTs, for example, find it difficult to extract that. Is it not mandatory that foundation hospitals have to pass that on. Do you think that should be a mandated part of the contract? I suppose I am trying to think it on, but, if the other part of it is that workforce planning is going to be in the clinical commissioning groups, will that cost envelope be enough to do it in a meaningful way? This is a huge jigsaw and I can hear people talking about the bid at the top, but, as a former chair of a hospital, there was, “We have too many doctors,” “We don’t have enough doctors,” “We have too many nurses.” We were for ever on that roundabout. The theory is that the clinical commissioning groups will do it. The truth is there are not good information flows.
Dame Julie Moore: The clinical commissioning groups will not do it. They will have some input to it. Currently there exists the Centre for Workforce Intelligence, which is feeding it. At the moment hospitals do feed in workforce information. It is collated by the strategic health authorities and goes up to the Centre for Workforce Intelligence. The Centre for Workforce Intelligence will continue and that will feed information to Health Education England.

Q217 Rosie Cooper: You said it goes to strategic health authorities, not necessarily to PCTs. Will they necessarily give it to the clinical commissioning groups in the world as you see it?
Dame Julie Moore: It is shared where I am now, so yes.

Q218 Rosie Cooper: But not everywhere.
Dame Julie Moore: It might not be everywhere, but the proposal now is that it will be incumbent on every organisation to share their workforce planning. That will be fed through the Local Education and Training Board up to the Centre for Workforce Intelligence, which informs HEE’s decision making. The problem with workforce planning is I can say next year that I need more ENT surgeons, but it takes 10 or 12 years to make one and by the time you make one somebody
might have invented a cure. There has always been that tension in the system and we have never ever been very good at workforce planning. One of the ways to get round that is that we believe there should be more flexibility in training so that, if somebody did invent a cure that meant you did not need a certain specialist, or you needed far fewer, then it would not take forever to retrain somebody. There has to be more flexibility in the way we train our workforce at the moment.

Q219 Rosie Cooper: You said “incumbent.” Is there any mandatory bit? Is there a way that people could duck that?

Dame Julie Moore: That would be at their peril, and they would suffer. The way the funding is going to flow down from HEE at the moment, whoever has the money has the power. If the money is coming from HEE and they are not getting the information from a trust, I doubt that they would sit in the sunshine, shall we say, on that one.

Dr Nightingale: It is absolutely essential that all users of medical and nursing staff feed in workforce data. The National Board will have a function that would be linked across to HEE. As part of the service contracts and the outcomes framework, I am sure there will be some requirement, if you are doing NHS work, to feed in workforce data. It is essential because the electronic staff record is flawed in this way, and it is also not universal. We need to have mandated data flowing up to the Centre for Workforce Intelligence.

Professor Sir John Tooke: May I make one point? It is very important that we have a central view and central intelligence as well to integrate policy changes in the NHS and interpret that through the type of workforce that we commission but also to ensure that, for certain specialties, a national UK-wide provision is protected. That clearly will not happen if all you rely on is local recognition of need. There will be some subspecialties which perhaps few LETBs would want to take on, but which are needed for national provision. That central oversight is crucial.

Q220 David Tredinnick: I want to explore accountability of the Local Education and Training Boards, if I may. The Government have agreed to the Future Forum’s recommendation that Local Education and Training Boards will be subject to an authorisation and accountability framework set by Health Education England. Can you explain the reasoning behind this and how it might work in practice, please?

Dame Julie Moore: One of the problems frequently raised with us was a lack of transparency and accountability for both the money and how it was spent. Health Education England will have the money devolved and will devolve it out to Local Education and Training Boards. They have to be held accountable for how they spend that money. Most of us have dual accountability in our professional lives. The Local Education and Training Board will be accountable to its provider organisations, the members of the board, but also there will be professional accountability for the professional people on that board and also for the spend of money up to Health Education England, which was why it was essential that that was up and running and could start coming up with the authorisation criteria. There will be differences. Some parts of the country are already getting ahead and have established shadow Local Education and Training Boards, but, as Peter has already said, we wanted some consistency and felt that Health Education England needed to start providing a steer to people so that, for example, it would not be acceptable not to have some clinical advice to a Local Education and Training Board—that kind of thing.

Dr Nightingale: Certainly the governance and financial scrutiny needs to be there. HEE will have set standards for authorising LETBs when they can show they can fulfil those.

Q221 David Tredinnick: To what extent will these training boards be autonomous?

Dame Julie Moore: That is where there will be a tension. As John has already outlined, if we needed to train a very small specialty and there are very few places in the country that could do that, that Local Education and Training Board might be asked to train five of a rare specialty, whereas there is no requirement for them in that Local Education and Training Board. That has to be a discussion with HEE. But, on the whole, for the vast majority of people we are talking about, Local Education and Training Boards will be planning for their own workforce for the future but may well be asked, in certain circumstances, to do something for the country.

Dr Nightingale: They will be large, so they should be able to take a population view.

Q222 David Tredinnick: The autonomous aspect is not entirely clear. There are still some questions there.

Dame Julie Moore: It is clear on the finance, but, if as a nation, we need more, then we might be asked to do so.

Q223 David Tredinnick: Another area that is a bit hazy is the legal status. Would you agree that the legal status of the Local Education and Training Boards is not clearly defined?

Dr Nightingale: As an outpost of HEE, I see them being held to account through that mechanism.

Professor Sir John Tooke: Right. That is how I see it.

Dame Julie Moore: Yes.

Q224 David Tredinnick: Finally, the Department stipulates that these boards must have a director of education and quality who “may also be the Postgraduate Medical Dean.” How satisfactory do you think this arrangement would be in terms of transferring deanery functions to the new boards?

Dame Julie Moore: We recognise the importance of not losing expertise and experience. If the director is not the postgraduate dean, then there must be the medical representation on that board. There are different patterns of deaneries currently round the country. Some are purely medical and some are multi-speciality deaneries, but we would see that being a central function that would transfer over and the director of
education and quality must have advice from the deans. In some places, it is more than one providing that advice there because that is essential.

Chair: Andrew, you want to move on to workforce planning.

Q225 Andrew George: We have partly covered it, with the remarks by Professor Tooke earlier. It is clearly a desire to integrate policy changes into workforce intelligence.

Professor Sir John Tooke: Yes.

Q226 Andrew George: Taking that as a theme, could I take, for example, a recent pronouncement earlier this month, in this case by the Prime Minister, about taking the initiative with regard to improving the standards of nursing and the announcement of the creation of an independent nursing and care quality forum? One of the initiatives that will be encouraging or seeking to encourage is hourly ward rounds by nurses. The Prime Minister might be trying to break in while I am asking the question, but I did ask the Prime Minister what the consequences of this might be in terms of future workforce planning, such as how many additional nurses, if any, might be required to fulfil the requirements of additional ward rounds. I was told by the Under-Secretary of State in the Department of Health instead that the independent nursing and care quality forum will be tasked with ensuring that the best nursing practice, including hourly nursing rounds, is spread throughout the NHS and social care. So the intention is to do that.

To what extent—if you were trying to integrate policy with workforce planning—is that actually happening? Has there been any attempt to assess what the workforce implications are in terms of demand of those types of initiative and whether they are fed into the workforce planning process?

Dame Julie Moore: That one in particular has not because it has come after the work was done, but we did come across some examples where it certainly has not happened. As for moving care to the community, as part of talking to people involved in training of nurses for the community, there are very few placements to train people there at all. That might be one of the ways that workforce intelligence could feed in. Politicians might well say, “We will have more of this,” but we have a very long way to go before we have enough people to do some of that.

Q227 Andrew George: Does that apply across all nursing? Are you, in effect, saying, and of course the mantra is, “We want more primary as well as acute and social care in the community and to reduce the size of hospitals”? In order to achieve that, is that a different skill set from the ones—

Dame Julie Moore: Yes.

Professor Sir John Tooke: There is a distinction to be drawn between a practical solution—the hourly ward rounds you referred to—and establishing some principles about the direction of the Health Service. There is a real danger, I would suggest, that you stifle innovation and local communities finding the solution to this problem of how you lift the quality of nursing care if you prescribe that too much from the centre. The Centre for Workforce Intelligence should be scoping the future, taking account of financial, political and technological developments that are going to impact on the workforce—the skill mix required—and deducing from that the likely pattern of staffing that is needed to broadly inform what the commissions need to look like. You must retain a local sensitivity and an ownership of the NHS values, the qualities and the aptitudes we wish to see in our trainees at a local level.

Q228 Andrew George: Do you all believe that the Centre for Workforce Intelligence, given the fact that this is as much an art as it is a science and that you cannot be precise about the future, is doing a reasonable job?

Professor Sir John Tooke: It is early days. It is an inexact science and the only question you have to ask is would you rather have no workforce planning at all or try and make an honest attempt at scoping what the requirement is? I have confidence in that process being able to operate because, up until the late 1990s, there was the Medical Workforce Standing Advisory Committee, which did quite well in terms of projecting student numbers. You could argue that the current uplift we have seen followed from the dissolution of that standing advisory committee. There was a move around the turn of the century, not based on data, when another thousand medical students, for example, were added. It is very important that we ground our projections in data.

Q229 Andrew George: An example recently of what is clearly, one presumes, a failure to anticipate a need is the shortage of emergency practitioners working in emergency centres, or A and Es. Dr Nightingale, since it flows into your specialty, do you think that is an issue that could have been anticipated?

Dr Nightingale: Many things can be anticipated. It is a case of whether they are deliverable. There is no doubt that the Centre for Workforce Intelligence has had a fairly sticky start inasmuch as it did not have good quality data on which to begin making its projections. It is improving, but it can only do a very good job if it gets very good data. That is the essential part of it. One of the advantages of the LETBs will be that the education and the service providers will be able to look at their workforce and see how it could change in the future and feed that wish list up to the Centre for Workforce Intelligence, which then can help make projections about how future multi-professional and inter-professional training should take place. We know that in certain specialties there is a shortage of consultants, and emergency medicine is one of those. In fact there is a disastrous shortage of consultants, considering how much the emergency medicine workload is increasing. As one of the halfway houses to try to get a consultant-led and delivered service in emergency medicine, practitioners have been promoted. The need is there. It is a case of whether you can find the funding and get the curricula written and the higher education institutions to deliver it forthwith.

Dame Julie Moore: It is also about how attractive these jobs are to people. One of the things that we
have talked about is being flexible, but also we talked about long, whole-career job planning, if you like, because these are very intense, very acute jobs. We have to think about whether you can continue doing the same kind of job all the way through your life, because they are so intense—middle of the night and things like that—and, partly, why do we not attract people into some of these jobs?

Q230 Andrew George: Coming back to the issue of nursing, there is evidence—certainly given to us by the RCN and others—about an unsustainable staff-to-patient ratio on a large number of hospital wards at the moment. Do you think that is a question of financial pressures or the result of a shortage of nurses, or do you deny the fact that that is the case?

Dr Nightingale: From a clinician’s point of view, many of us feel that the nurse-to-patient ratios on the ward are not appropriate. Many of the disasters or failures of care and compassion that we hear about are due to wards not having enough nurses on them, especially at night. I personally would throw my weight behind any way that we could put the ward sister back in charge of the ward and increase the numbers of people caring for patients on the wards. They may not all be nurses, because many nurses, although they are caring individuals, have other jobs to do. But I do think there is a role for people that will care for the patients as well as nursing them.

Q231 Andrew George: Dame Julie, in part of the answer of the Under-Secretary, to which I was referring earlier, she mentioned the rolling out of the NHS Institute for Innovation and Improvement’s Productive Series “Releasing time to care” initiative, which is a bit of a mouthful. Are you aware of that?

Dame Julie Moore: Yes. It does have a shorter common title.

Q232 Andrew George: Will that help in terms of addressing issues of the effective use of staff?

Dame Julie Moore: To answer several of your questions in one point, introducing the hourly care observations, writing things that relatives have said back down. A lot of the so-called bureaucracy is helpful in identifying where there are wasteful tasks and steps being taken. Over the years nursing did build up a lot in its documentation that can be stripped right back down. A lot of the so-called bureaucracy is stuff that we have to do. It is recording patient observations, writing things that relatives have said and so on. It is very important to do that. Education has a key part to play in that, but so do employers in getting this right and getting quality of care right.

Q233 Andrew George: If they are properly staffed—

Dame Julie Moore: We do it and have been doing it before the announcement. If you have a ward that is understaffed, it will have an impact. Both of those things are right. "The Productive Ward" is very helpful in identifying where there are wasteful tasks and steps being taken. Over the years nursing did build up a lot in its documentation that can be stripped right back down. A lot of the so-called bureaucracy is stuff that we have to do. It is recording patient observations, writing things that relatives have said and so on. It is very important to do that. Education has a key part to play in that, but so do employers in getting this right and getting quality of care right.

Q234 Andrew George: Finally, as to dependence on overseas locum and agency staff, are we in a happy place now? If we are too dependent on external resources, particularly expensive agency and locum staff, how do we address that particular issue?

Professor Sir John Tooke: If I could start, we would be less dependent if we had the most accurate workforce planning that we could. Accepting that we are not always going to get it right, I would argue—for medicine here—that it would be far more preferable to find a way of increasing the number of overseas medical students that we could accommodate, who would go back to their own country once they were trained. They would be a very significant export for us, would be good for global health, good for future relationships between our country and theirs and yet provide a reservoir of talent we are to get the numbers wrong and under-pitch in our own estimates. That is far more ethical than under-providing and then taking away people from whence they have been trained.

Andrew George: That is very helpful.

Q235 Dr Wollaston: Can I turn to the outstanding recommendations in your report, Professor Tooke, about expanding generalism and flexible career pathways? Can you explain these issues and say how satisfied you are with the Government’s response to those outstanding issues, particularly how we are going to foster generalism and help flexibility in career pathways?

Professor Sir John Tooke: Thank you, yes. The Future Forum report acknowledged that many of the principles that were espoused in “Aspiring to Excellence” are still sound ones. A deeper understanding, for example, of the role of the doctor—what the contribution is—is a starting point. Dame Julie’s point about enabling flexibility through a grounding in generalism is absolutely critical so that you do not have to go all the way up the speciality ladder—one of the myriad specialities—and then find out that you are redundant in that role and have to go back down, snakes and ladders, to the beginning again to retrain as something else. Recognising that, as the population ages, co-morbidity is an increasing feature so that everybody needs to know about more things than they did perhaps a few decades ago, then that generalist grounding is critical. I do not think it has been adequately dealt with to date. We proposed in “Aspiring to Excellence” some ways of converting foundation year 2 and the early part of core training into, say, four broad-based generalist starts to specialist training. That has not been uniformly adopted and needs to be revisited.

Q236 Dr Wollaston: How confident are you that we will be able to introduce five-year training for generalists?

Professor Sir John Tooke: Do you mean for general practitioners?

Dr Wollaston: Yes.

Professor Sir John Tooke: Again, we regarded that as absolutely central if we were going to meet the policy requirements of more care in the community. More importantly, if you are going to meet the expectations of an increasingly sophisticated public, if you move care to the community and people have been used to highly sophisticated care in a hospital...
sector, they are not going to accept some lesser version of that in a community setting.

Q237 Dr Wollaston: When do you think that will be introduced? Accepting the principle that that is necessary, do you think that—

Professor Sir John Tooke: As I understand it, the Department and the Royal College of General Practitioners are working on reviewing the length of training for general practice. Again, we are fairly unique in Europe in assuming we can train a generalist—a general practitioner—in three years. We know, for example, that only half of GPs will have had relevant paediatric experience and probably the same proportion of relevant psychiatric experience. Yet those two disciplines account for a huge amount of the workload in the primary care setting. If we are going to have a top class NHS, it is one of the first things that need to be addressed.

Dame Julie Moore: We were persuaded strongly by the arguments that GP training needed to be longer and we recommended that. There had been an issue about affordability, which I think is why it had not been there, why the Royal College of General Practitioners had come up with some quite imaginative, in our view, ways of keeping the cost down and why we recommended that the Department and the Royal College work together to find a way of achieving it. But, in our view, it is essential that training is more comprehensive than it is at the moment.

Dr Nightingale: It is probably worth pointing out that, relative to many of the western nations, this country is still relatively under-doctored. One of the things that a move to more generalism will produce in the secondary sector, of course, is a reduction in the availability of specialist consultants’ advice. The only way to get round that is either to expand that section of the medical workforce or to reorganise services. That nettle has not been grasped fully yet. There is a need to put more of the specialised services in fewer numbers of larger hospitals if we are not going to expand the consultant workforce to work in more hospitals. There are a number of other areas which flow from that, one of which is to try and bring back a more team-based approach for education and training. There is no doubt that quite a lot of the service and training tension that is in there, where trainees are not adequately supervised, is due to there being too many hospitals trying to teach those specialty areas.

Dame Julie Moore: One of the other points about generalism is that generalists are often seen as, or felt to be of, a lower status than the specialist. We felt that that was wrong and needed reversing. In actual fact, you need a wider range of skills to be a generalist, and in the States they probably call them diagnosticians or something. The doctor in “House”—if you have seen the television programme—has a very high status with the television programme—has a very high status with the public perception, the consensus was that doctors did have a role to play in partnership with policy makers and the public in determining where resources went. It has been accepted, and there is indeed an acknowledgment in the new blueprint for undergraduate medical education that doctors have a role. I see the opportunity in the new postgraduate medical, education and training area—and indeed it could extend to other professions as well—to enhance education through providing, on a modular basis, education regarding service improvement, which would take into account intelligent commissioning, research, education and diffusion of evidence-based practice. Those are the things that are going to drive service improvement. I would accept that they have not had the due recognition they deserve in curricula to date, but I am confident we can redress that because UCL Partners, which is already in effect acting as a LETB, is beginning to build in that type of postgraduate provision as part of its reinterpretation of training curricula.

Dr Nightingale: It has certainly started to appear in curricula much more frequently now.

Q238 Dr Wollaston: Thank you for clarifying that. Following on from that, one of the big issues for GPs in the future is going to be their role in commissioning. Of course, currently in medical schools or in a GP’s training there is no teaching about commissioning. Do you see that as something that we are going to have as a specialist teaching aspect?

Professor Sir John Tooke: Yes. Going back to my point about the role of doctors, when we held the consensus conference following “Aspiring to Excellence”, the whole issue of the doctor’s role in advising on the allocation of resources came up. In line with the public perception, the consensus was that doctors did have a role to play in partnership with policy makers and the public in determining where resources went. It has been accepted, and there is indeed an acknowledgment in the new blueprint for undergraduate medical education that doctors have a role. I see the opportunity in the new postgraduate medical, education and training area—and indeed it could extend to other professions as well—to enhance education through providing, on a modular basis, education regarding service improvement, which would take into account intelligent commissioning, research, education and diffusion of evidence-based practice. Those are the things that are going to drive service improvement. I would accept that they have not had the due recognition they deserve in curricula to date, but I am confident we can redress that because UCL Partners, which is already in effect acting as a LETB, is beginning to build in that type of postgraduate provision as part of its reinterpretation of training curricula.

Dr Nightingale: The “Better Training Better Care” plan was intended to bring about more “consultant-present” services, taking into account the European Working Time Directive, and to make the training needs less subservient to service needs. How feasible do you think “consultant-present” services are?

Dame Julie Moore: Peter will start, but one of the things I will say is that, in talking to people—juniors and trainees—not everybody wants to be a consultant. We had recommended that there should be more stop-off points, if you like, in a career for somebody who does not want to undertake the full range of consultant responsibilities. Peter has been very involved in “Better Care”.

Dr Nightingale: The “Better Training Better Care” initiative is trying to get rid of the service training tension where trainees are often asked to do too much service in their early years and are not getting direct supervision and training on the job, as it were. As part of their training, of course, they should be developing the ability to take independent decisions, but in the very early years we know from feedback from the GMC survey that many trainees do not get adequate supervision. It varies very markedly between specialties. In my specialty, for instance, anaesthesia,
a core training year 1 new starter cannot work independently for at least three to four months generally, whereas in other specialties they are expected to crack on and do whatever with more distant supervision. Trying to introduce more consultant supervision and more consultant-led training early on is very important. It has an affordability factor, of course, and again brings me back to reorganisation and that perhaps not every hospital should be having trainees.

Q240 Rosie Cooper: Not every hospital should be having trainees.

Dame Julie Moore: Indeed, “Not every department within a hospital” is one of the other things we said. Within a hospital, a good department for education might be next door to one that is not so good for education. Whereas there is an expectation that everybody who receives NHS funding should train, not everybody will be deemed competent enough to train. It is part of the role of the Local Education and Training Board to say so.

Dr Nightingale: As consultant numbers go up and we get closer to the perceived balance point, the numbers of trainees that will need to come through the system will start to fall. At the moment we are starting to move into an overproduction of trainees to develop service, unless we start re-expanding the consultant or other grade.

Q241 Rosie Cooper: When do you see that balance point arriving?

Dr Nightingale: It has just arrived in my specialty. The year 2012, if you look at the graphs, is where we probably have reached the level of consultants that we set out to have. I personally do not think we have enough yet, so the bar might need to go up. But the numbers of trainees that we are producing is starting to become in excess of the consultant jobs being advertised.

Q242 Rosie Cooper: I am beginning to think I have been too long in the job as I have heard this conversation several times in my little career.

Dr Nightingale: The consultant expansion has pretty much stopped in many specialties now.

Q243 Rosie Cooper: Perhaps we will move on. The Government have accepted the Future Forum’s recommendation that the Nursing and Midwifery Council should lead on developing a properly structured post-qualification career pathway for nurses and midwives. How do you see the professional body achieving it? How do you think it will affect the current NHS career structure that we are operating in and midwives. How do you see the professional body structured post-qualification career pathway for nurses and midwives. How do you think it will affect the current NHS career structure that we are operating in?
behind, five years after the stents, we need the surgeons back again. We are always going to have a problem with workforce planning and the way the cardiac surgery nurses then went to learn new skills to look after patients who had had a different procedure. We have to keep people up to date with skills. We want to be very clear that we separate out mandatory training. People are going through their fire training and things like that, but that is not professional development. How to look after patients does change. I could not easily go back and work as a registered nurse on a ward now. I would need to do a very big course because it has changed so much. Some of the things are still the same. We want to try and get back to the fact that you need skills and knowledge to do these jobs, but you also need the right attitude and aptitudes as well. That is why we want to have more involvement from people who are clinically involved in the selection of people to undertake all clinical careers, but certainly including nursing.

Q246 Rosie Cooper: The Future Forum welcomed the Government’s announcement of a voluntary code of conduct for foundation trusts and standards for healthcare support workers, such as healthcare assistants. You also recognised “the need for further checks and balances.” I know there is a big debate on whether it should be statutory or voluntary, but why did you not recommend the statutory approach?

Dame Julie Moore: It was because, as a listening exercise, we heard such a wide variety of views and there was not a strong clear view coming through. We were persuaded of it where you had two pathways to one career in public health; so you have the medically qualified who are registered and recommended that. There was such a huge variety of views and there was strength on both sides of the argument.

Dr Nightingale: For information, I was very pro regulation. The bit I wanted to have in the report was watered down, to my mind. The reason Julie is such a good Chair is that she can take both views and come up with a consensus. I personally feel that those professions that wish to be regulated should be regulated.

Dame Julie Moore: There is ongoing work on this in the Department at the moment. We are not the Department. We can make recommendations. There was such strength of feeling on both sides of it, and of our group we were persuaded—

Q247 Rosie Cooper: Where everything is voluntary, it is all very wishy-washy. For example, here the voluntary approach may be seen to be inappropriate when NHS care will be provided by foundation trusts that are independent, legal organisations. Why would you not want to statutorily require it?

Dame Julie Moore: The views expressed to us were that it is going drive out flexibility. You will register somebody within that package of jobs. Too often, when we have put a safety net in, it has acted like a net that holds people down in the NHS and people were frightened of that. There should be minimum standards below which you do not fall. Quite often we put that safety net over the top and do not let people rise above it. There was a strong view that bringing in more and more regulation and rigidity would drive out innovation.

Q248 Rosie Cooper: Do you all agree with that?

Dame Julie Moore: The Future Forum rarely agreed on an awful lot. We are all independent people coming together in that way.

Rosie Cooper: What about the panel?

Q249 David Tredinnick: Dr Nightingale, you said that those who want to should be statutorily regulated. I would like to put it to you that, now that NICE guidelines are recommending acupuncture for lower back pain, we should listen to the acupuncturists who were here in force yesterday—both the western ones and the Chinese, because it was the Chinese new year—expressing a view that they need that statutory regulation, which apparently the Government are not in favour of. Would you support that?

Dr Nightingale: I can remember the debates that went on in the council of my college when the previous senior vice-president was the dean of the faculty of pain medicine. They submitted a very strong response to the consultation on alternative practitioners and the management of back pain, and they were completely ignored. Although the NICE guidance is out there, it does not necessarily have the full weight of the profession behind it. When we debated in the academy as to supporting complementary and alternative therapies being regulated, the general view was no, because we would prefer to throw our weight behind something that was evidence-based. We could not find the evidence for complementary medicine.

Professor Sir John Tooke: This is the problem if you sweep up all complementary and alternative medicines as an entirety.

Q250 David Tredinnick: I was not doing that. I was talking about acupuncture.

Professor Sir John Tooke: I know you are not, but, as to Peter’s point on the evidence-based approaches, I would argue that the NHS should not be adopting anything that does not have an evidence base to it. If it is proven that acupuncture may contribute and it will have a risk/benefit ratio like any treatment. If the risks are deemed to be significant, then it should be regulated.

Dr Nightingale: When I said, “Those people that wish to be regulated should be regulated,” I was not including things like homoeopathy. I was including practitioners that give anaesthetics or fix broken bones in the emergency department.

Q251 David Tredinnick: I wanted to ask you about acupuncture because it is now recommended by NICE. The acupuncturists themselves have made it quite clear that they feel it would be in their patients’ interests and their interests to have statutory regulation.

Dr Nightingale: That is outwith—

Chair: We have probably covered that.

Q252 Barbara Keeley: The Future Forum report raises the issue of education and training budgets being “raided” for other purposes. How effectively do
you think the new system puts an end to that raiding that is happening at the moment and what risks are there in respect of the transitional year 2012–13?

**Dame Julie Moore:** We heard a lot about how education and training had been used for other purposes in the past. We wanted it to be very transparent so that people knew where the money was going. I would like to believe that our recommendation would lead to that not happening, but I do not think I could guarantee that. Once HEE gets the money, it will go down because it has nothing else to spend it on. We were concerned that HEE was given the full sum that was available this year, which is why we made that recommendation. I was quite heartened by the discussions with HEE—or the one person that is HEE at the moment—about keeping their costs down and making sure all that money did go out to education.

**Q253 Barbara Keeley:** The Government plan further work and consultation on how the NHS education and training levy should be constructed. What do you think the key features should be? Can you also give your view on the levy to which private providers might be subject to ensure that they pay toward the costs of NHS education and training, bearing in mind that what we might see in future is an absolute explosion in terms of percentage of provision in hospitals that is private patients, private beds and private operations?

**Dame Julie Moore:** That is a very attractive proposition when you first hear it. When it was raised in the first Future Forum, the charities and social enterprises raised the issue that that would apply to them, and, if that happened, they would not be working in health at all. At the time, we were trying and still are trying to encourage social enterprise, which is why we recommended that it is very carefully modelled through to look at the numbers involved, where they might go and how it might differentially apply. You would not want to try and apply the same to a non-profit-making organisation as you would to a big multinational that has lots of—

**Q254 Barbara Keeley:** You would differentiate between a social enterprise and a very large private provider.

**Dame Julie Moore:** Yes. That is what we had recommended should happen.

**Q255 Chair:** If a social enterprise is employing people who have been through a training process, what would be the argument against them contributing, and being funded by the commissioner to contribute, to the training process?

**Dame Julie Moore:** They should, and that would be entirely right. The points are as follows. Do those organisations have a responsibility to train? We have said that anyone who has an NHS involvement should do so. Secondly, they have to be assessed. If they were doing that, are they contributing in that way? That is why that modelling had not brought the two together. The third point is if people are paying a levy. Pharmacists are a very good example. A lot of pharmacists go and work in the private sector afterwards. How would they contribute? It needed far more detailed modelling so that people could see the impact of that coming through. But some of the charities, particularly those concerned with palliative care, were very concerned about this as a charitable organisation. In fact, one of them said to us, “I will bring in all the nurses from abroad.”

**Q256 Barbara Keeley:** The focus of my question was not about charities or even pharmacists, to a certain extent. The big change, if it happens, is the move in of the private providers to utilise the resources of NHS hospitals and the time of NHS consultants and other doctors. That is the key. It seems ridiculous that we are still at a point where this is so vague. The building trade has a levy system that seems to work. Other sectors seem to be able to pull together a levy. Why can’t our system pull together a levy system that would work?

**Dame Julie Moore:** I am sure it can, but it needs to get on and do it.

**Dr Nightingale:** Of course many doctors and nurses who work in the private sector also work in the National Health Service. They may work in both institutions. The training is not wasted. I fully support your proposal that, if somebody takes away full time, almost, a doctor or a nurse who has been trained by the public purse, there should be some recompense.

**Q257 Barbara Keeley:** It is not going to be “if,” is it? If foundation trusts are allowed to use 49% of their resources for private patients, there is no “if” about it, is there? That is a very significant proportion. It would have to be reflected in a very significant proportion of the levy, I presume.

**Dr Nightingale:** That money comes into the trust.

**Dame Julie Moore:** Yes.

**Q258 Barbara Keeley:** It seems to make sense, because we have been in a situation where private medicine or private patients have been at the fringes, at the margins, and this proportion is not at the margins. It is almost, is it not? It is an issue that cannot be ducked.

The Future Forum also advocates the development of a “quality premium,” which would be paid where “quality outcomes in learning” are demonstrated. How do you see that working?

**Dame Julie Moore:** In much the same way that the quality premiums are introduced for clinical care, so people who achieve high quality standards get a premium to allow them to continue to develop their educational services. The quality premium you get now for clinical care is a bit of the budget that is held back. If you achieve it, you are given that extra and it is a low percentage, 1% rising to 2%. It could be done similarly to recognise high quality education. Of course very low quality education would be recognised by it being removed.

**Dr Nightingale:** The problem is finding the metric which tells you that you are developing high quality education and training, and that is the educational outcomes framework ongoing process.

**Professor Sir John Tooke:** It would have to start with process measures and stakeholder feedback. For
example, in relationship to medicine, it would be preparedness for practice. Ultimately, of course, what you want to see is a lift in patient care quality. I think we would all accept that that is a long-term outcome.

Q259 Barbara Keeley: It is difficult to measure. Dame Julie Moore: We did recommend that in the first report, and we are very pleased that the Department has cracked on with that.

Dr Nightingale: Of course there is nobody else in the world attempting this very difficult job, so we are leading there.

Q260 Andrew George: With such a future diversity of providers, to what extent are you confident that everyone will be making a contribution? I am still not clear that you have stated your own views on that. Related to that, do you think that those who have been trained at public expense—just as they do in a number of developing countries—are obliged to commit to public service to certain areas for a certain duration after their publicly-funded training has been completed?

Dr Nightingale: It is very much like joining the Army, by the sounds of it.

Q261 Andrew George: It is not unusual in many national systems for this to be the case. For example, in Sri Lanka they even insist that you will go and work in rural areas where they cannot recruit. So it could go further than that. Do you think there is merit in that suggestion?

Dr Nightingale: I would have sympathy with it.

Dame Julie Moore: I would.

Professor Sir John Tooke: I think it does have merit. For example, bursaries could be used to meet some less popular requirements. The fact is that, once people have worked and trained in these environments, they often find them to be very fulfilling roles. It is the unfamiliarity, as much as anything else, that is the challenge.

Q262 Chair: If we had a universal system whereby private and voluntary sector providers were contributing to a training process, that would undermine the argument for those people committing to a particular form of employment at the end of training, would it not?

Dame Julie Moore: That is why it would need quite sophisticated modelling. If you contribute to the education, do you pay a proportion or do you pay none of the levy? That needs some financial modelling to be done, and we are not—

Q263 Chair: You are not financial modellers.

Dame Julie Moore: No, we are not the modellers.

Q264 Dr Wollaston: Would quality outcomes in learning also apply to medical schools, for example? It is very difficult, is it not, to set quality outcomes, particularly if you do not have a national assessment? You hear some comments that there is variability between the standards achieved at various medical schools and also some reports from students themselves that their feedback is not being listened to.

Do you think there is a role for a quality premium in addressing those issues?

Professor Sir John Tooke: Can I perhaps correct some misconceptions? The first is that all medical schools are already reviewed on a very regular basis by the GMC. There is a quality standard that is applied. That does not mean all medical schools produce identical people. The professional range that their graduates tend to go into will differ. All medical schools in this country already have access to, and use a common assessment question bank. Within the final exams there are embedded questions from a pool which have all been validated to try and ensure consistency across the piece. It is thus a misconception that we do not have some form of national comparison. In terms of the outcomes, there is ongoing work, for example, on preparedness for practice of new graduates. Those things are largely in hand.

Q265 Chair: I have one brief supplementary on that. It is striking that this is the first mention of the GMC in this evidence session, in this highly populated group of bodies. How important is the role of the GMC in the future world as a participating body in making decisions about the education and training of doctors?

Dr Nightingale: For doctors, of course, it is the regulator and monitors the standards that colleges have set in their curricula. It is essential that it continues to do that. What I would like to see, personally, is further involvement of the colleges with质量 control as opposed to the GMC working with the old deanery function to quality manage what is going on. There is no doubt that, again, it varies between specialties. The surgeons will tell you that they need to have more quality control of what is going on at the coal face in surgical training, whereas others can take a more relaxed view.

Q266 Chair: But when we have Health Education England, the local boards, the GMC and the Royal Colleges securing it, it is back to multiple regulators and potentially incompatible regulators, is it not?

Dr Nightingale: They need to be working much closer together.

Professor Sir John Tooke: The GMC role is key. One of the proposals that was rapidly adopted, of course, from “Aspiring to Excellence” was the fact that the regulation of undergraduate and postgraduate education was combined under the GMC. As you all know, formerly postgraduate education was regulated by the Postgraduate Medical Education and Training Board. Although at the time, because of the personalities involved, the principles which underpinned their processes were close, there was a very considerable risk that you could embark on undergraduate training to one set of GMC policies and then enter your postgraduate training with a different set of policies. We now have a continuum from undergraduate, postgraduate and CPD. To provide the flexibility, you need that continuum to inculcate, as much as anything, the concept that medicine and other healthcare professions are professions engaged in life-long
learning and the same standards and regulatory processes need to prevail throughout.

Q267 Valerie Vaz: I have a couple of quick questions for Professor Tooke. Your report “Aspiring to Excellence” came about as a result of the debacle around the medical training application system. Are you content that that kind of debacle will not happen again under the new system?

Professor Sir John Tooke: We have heard this morning how complex the system is. An absolute guarantee would be difficult to give. Am I more confident with this system than the previous or current evolving arrangements? Yes, I am. I think the NHS academic alliance is going to be central to that. Ensuring that the postgraduate deansery function is informed by educational expertise that resides within our universities is a way of assuring that, and being very clear about the central oversight of HEE and the local sensitivity of Local Education Training Boards provides the right balance. None of those features was really as well developed in the previous system at the time of the debacle you refer to.

Dr Nightingale: One of the reasons HEE will probably work well is that it is taking the MEE model of having boards underneath it. The medical programme board took control, with the DH, of recruitment. One of the success stories over the last three or four years has been how we have built incrementally a UK offers system now that is not quite universal, but it is getting there. It has been done by very slow, incremental “hearts and minds” tactics. My specialty is now about to go into the UK offers system for entry into core anaesthesia. If that goes well, I would expect other specialties to do that also. So by 2013—or certainly 2014—we will have essentially what was the MTAS system, but it has been built from the ground up.

Q268 Valerie Vaz: With your university hat on, we have the new training regime going on, evolving, as you say, and the higher education fees.

Dr Nightingale: Yes.

Q269 Valerie Vaz: Do you see any adverse consequences for universities?

Professor Sir John Tooke: Yes. Everybody is aware that potentially the fee level impact on medicine could be quite profound. The total debt burden for a medical student could be north of £70,000. Whereas the rise to fees of £3,000 pa—the evidence suggests—did not have a negative impact on social mobility, I believe that the relationship with fee level will not be a linear one. There will come a tipping point when families who are debt-averse will simply not contemplate that level of debt even though there are mechanisms to support them. It is just that the concept will be very challenging. That needs to be watched extremely closely, because we are committed to try and have a clinical workforce that represents the society it serves so that it has that deep understanding of societal need. It needs to be watched extremely carefully and efforts made to offset any negative impact.

Q270 Valerie Vaz: Do you see a change in this year’s applications?

Professor Sir John Tooke: Do you mean in terms of the social class data?

Valerie Vaz: Yes.

Professor Sir John Tooke: We cannot assess that until after entry, so it would be difficult at this point to say whether that is the case.

Chair: We have come to the end of our allotted time. Thank you very much indeed for answering a wide range of questions.

Examination of Witnesses

Witnesses: Professor David Peters, Professor of Integrated Healthcare, University of Westminster, Professor Ieuan Ellis, Chair, Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, Professor Rajan Madhok, Chair, Greater Manchester Health Innovation and Education Cluster, and Dr Mike Farrell, Head of Educational Development, Skills Academy for Health North West, gave evidence.

Q271 Chair: Thank you very much for joining us this morning. Could I ask you to begin the session by introducing yourselves, please?

Professor Peters: I am Professor David Peters, a GP by training and an osteopath as well. I am Professor of Integrated Healthcare at the University of Westminster with an interest in innovation, self-care, complementary medicine and inter-professional education.

Professor Ellis: Good afternoon. I am Professor Ieuan Ellis. I am Dean of the Faculty of Health and Social Sciences at Leeds Metropolitan University. I am a physiotherapist by profession. I am Chair of the Council of Deans of Health that represents the 85 UK universities that provide nursing, midwifery and allied health professions. I am also Co-chair of the National Allied Health Professions Advisory Board.

Professor Madhok: Good afternoon. I am Rajan Madhok. I work as the Director of Special Projects at NHS Manchester. I am a public health doctor by training. I also serve on the Council of the General Medical Council.

Dr Farrell: Good afternoon. My name is Mike Farrell. I am Head of Educational Development at the Skills Academy for Health North West, which is part of Skills for Health the Sector Skills Council for the health sector.

Q272 Chair: Thank you very much. Can I begin by asking you the same general question that I began the previous session with, and that is to ask whether you feel that there is now a sense of emerging clarity about how professional education structures are intended to work from 2013 onwards, whether you share the sense
that was expressed to us by the previous panel of
optimism—I think it is fair to say, in general terms at
least—that the new structures are emerging and are fit
for purpose?

Professor Peters: I think so, broadly speaking. The
previous witnesses gave a marvellous account of their
views of how the structures are developing. The
uncertainty is as to how the NHS is going to cope with
the financing problems, deficit reduction and what the
consequences are going to be of a very much slimmer
NHS. It is hard, as yet, to see how we are going to
bring down the costs of the NHS unless we do things
very differently. I do not yet see the policies emerging
that will help to create a greater degree of self-care
and resilience. Michael Marmot’s review—where he
talked about the overarching concerns for social
justice, health and sustainability—may have not yet
fully emerged as shaping policies in the NHS. For
some of us who are looking toward how we might
educate doctors and others to have a greater sense of
how they can encourage resilience and self-care, to
anticipate and prevent better and how there could be
more generalists. I am not absolutely sure that we
understand how things are going to develop well
enough to plan adequately for, say, the 10-year
horizon.

Professor Ellis: I certainly think that, following recent
publications, there is greater clarity as to some of the
proposed architecture. As recently as yesterday, I
know that the steering group for Health Education
England met and I know that LETBs are starting to
take form in shadow form, but we are now moving
into a more detailed level of discussion. Where clarity
still needs to emerge is in the way in which these
changes will be transformational. There is an
emerging understanding of the transactional
relationship between different groups, but questions
will remain for the moment over the transformational
benefits of the new system as compared to the
previous system.

Professor Madhok: If I may make a distinction
between the “what” and “how”, we are quite clear on
what needs to happen and what the significant pieces
of the jigsaws will be. What is, however, unclear at the
moment is how they will all fit together and
whether that will work. So I sit on the fence in terms
of the answer to your question.

Dr Farrell: There are two perspectives from Skills
for Health Academy working with the new structures.
There is certainly further detail about how those
would fit, but we are certainly accepting the drive of
providers and employers in driving education needs.
It is to be warmly welcomed. There is evidence from
the participation that some of the shadow boards are
already reflecting enthusiasm by employers for that
role and responsibility. Of course, transition means
disturbance and disturbance to current arrangements,
which, in some cases, are beginning to have an impact
in terms of productivity, skills development and
flexibility. But there is a point about how we should
disturbance and disruption of current arrangements,
which, in some cases, are beginning to have an impact
in terms of productivity, skills development and
flexibility. But there is a point about how we should
not lose that momentum as we make this transition.

Q273 Chair: Can I turn particularly to Professor
Madhok and ask you, in a sense, the same question I
asked one of the previous witnesses as to the
relationship between the academic health science
networks, the clusters and a third one—and I cannot
remember what it is—that uses the same phrase? You
sit in one of those in the north-west. How confident
are you that that provides a basis for connecting the
training for the future with current academic ideas
and opportunities?

Professor Madhok: I chair the Greater Manchester
HIEC. In Greater Manchester we have all of these
initiatives in place. We have the Manchester
Academic Health Science Centre, we have the
CLAHR and we have the CLRN—the
Comprehensive Local Research Network. When the
HIEC came along, it was quite challenging to try and
find our own niche. We did so. We managed to find a
niche in terms of developing the existing workforce,
so that is what we have concentrated on. Obviously,
since they were set up, further changes have come
along. I suppose behind your question is whether we
are confident that it will all come together for us. The
reason I get confidence is that at least we are talking,
even though there is a lot more clarity still to come,
and hopefully the next six months will be very helpful
in that regard. We have continued dialogue, and
certainly, as far as the HIEC is concerned, the support
that we have received from the strategic health
authority has been invaluable. They have made sure
that we do fit in with the emerging LETBs. In our
case, there is still work to be done in terms of the
relationship between the academic health science
networks that are proposed and the existing academic
health science centres.

Q274 Chair: Do you think with the emerging LETBs
it is a genuine dialogue or is there more of a “tell”
relationship one way or the other?

Professor Madhok: LETBs are not there yet in the
north-west and there is still some debate to be had in
terms of the relationship between the arrangements
that need to be put across the whole of the north-west,
which was the previous footprint for the strategic
health authority, and the three so-called natural health
communities within the north-west—the three natural
health communities being Greater Manchester,
Cheshire and Merseyside and Cumbria and
Lancashire. So there is still discussion to be had and
meetings are taking place about what would be, first,
the geographical coverage of those arrangements and
also the function that they will be discharging.

Q275 Chair: NHS North West says in evidence to
us: “It will be for the new provider led networks/
LETBs to find funding to support HIECs”—the Health
Innovation and Education Clusters—“if it is
considered that they have been effective.” How
confident does that leave you?

Professor Madhok: I hope that they will feel we have
been effective, certainly in terms of helping—

Q276 Chair: Have you had dialogue with them about
effectiveness and therefore future funds flow?

Professor Madhok: Can I separate the two? In terms
of the dialogue itself, yes, and that goes back to what
I said a few minutes ago about the SHA being the
broker. In fact, as far as the Greater Manchester
proposed LETB is concerned, they have recognised that they need to do something about the HIEC. Next month, which is only the second or third meeting that the new LETB will be having, they have asked us to present the work of the HIEC. In that sense, I am fairly comfortable that communication is ongoing.
In terms of the funding, I suppose we are all waiting to hear what is going to happen, but hopefully they will be able to see the work that has been done. When all is said and done, what people will realise is that, at the end of the day—forget HIEC as an organisation as such—the function is absolutely crucial. If I may link it back to the debate that took place with the previous panel, where there was a lot of discussion about the Centre for Workforce Intelligence and the numbers, what we need to understand is that planning is an inexact science. That is the term that was used.
You need something like HIEC that can help speed up the changes that you need, which is basically modernising the existing workforce. When all is said and done, people will realise that, if we did not have them, we will probably end up creating something like the HIEC because of all the pressures that have already been articulated.
Professor Ellis: I want to add, with both the HIECs and the academic health science centres, that they have illustrated this mutual interdependency of academia in driving clinical excellence and also innovation. Innovation is an important part of workforce planning. They have also demonstrated multi-professional, multi-disciplinary and inter-sectoral research. The five academic health science centres were described earlier, which tend to be biomedically focused, and that is not a criticism; it is just an observation. In moving to the networks, it is important that we do not lose the inter-sectoral, multi-professional research and indeed the research from nurses and allied health professions that we heard about in the previous session, and the importance of developing those clinical academic careers in order that all of those professions are able to contribute to innovation and transform the NHS.
Q278 Rosie Cooper: You feel that there will be impact on doctors in training now and those about to join, if you like.
Professor Peters: I cannot see how it can be otherwise. There will be less money to go round.
Chair: All our witnesses want to come in on this one.
Professor Madhok: To add to what has been said, it is not only more with less but it is more with less and faster. That is the demand being placed on the system at the moment. There is no doubt that there will be major implications because of what is happening right now. The question, however, is not about the implications. The question is how we are managing that risk. Although we think we will be able to answer your question in about six months to a year’s time. That would be my guess.
Q279 Rosie Cooper: The Secretary of State does not think there is a problem with anything, so I have serious worries about whether you are going to get that answer. In the meantime, there is a risk to training and a risk, for me, to the system and to patients.
Dr Farrell: May I make a couple of comments on that? The tone and the language will be really important over the transitional phase, such as what is the common endeavour being focused on that and the different parts of the system, understanding the value that they can bring to the new arrangements. Taking our successful work, particularly say, on the north-west footprint regarding workforce development, it has been about very strong partnership relationships, many of which will survive these arrangements, and need to if we are to sustain the momentum that we have in place. Our contribution at that particular point is also recognised. As the LETBs pick up this leadership change, one of the first changes that will be to set the tone for the conditions where this will continue to flourish, and needs to flourish well.
Professor Ellis: There are two ways to answer. One is: am I reassured that under the future system we will be able to deliver value for money? The signs are that, yes, that will be there. My principal concern at the moment is the transition. Many, I know, have referred to the time delay in terms of getting HEE, in particular, established. In terms of looking at some of the threats to the current workforce, you have received written evidence on some of the cuts in commissions that have been happening in nursing, in allied health professions, where there is limited oversight of that. While there are rationales as to why those are needed in the short term, currently there is not oversight of that to give satisfaction on medium and long-term planning.
There are changes happening as we speak. A 26% reduction in nursing commissions in London was
announced last week, whereas in medicine there was a more sensible approach, a “no surprises” approach. There is a group chaired jointly through HEFCE and the NHS that is looking at a “no surprises” model. There are real risks that are seen in terms of some of the professions that are currently being commissioned through the transition.

Q280 Rosie Cooper: Thank you. I wanted to pick up on that because I think there is potential for a huge impact. It may be that people are happy with the future model, but it is the detail and how you get there.

I would like to address some comments to Dr Farrell about the Skills Academy for Health and how it operates in the north-west. Also we have been told about the apprenticeship scheme. Could you tell us how that operates and how successful it has been?

Dr Farrell: The Skills Academy for Health thrives on partnerships in supporting the development of the future and current workforce. Through those arrangements we support a number of activities. In terms of apprenticeships, there are two arms to that. One is into employment, a cadet scheme, something that has been evident in the north-west for many years going back to the last couple of restructurings, which was primarily set up to help widen participation, particularly given some of the demographics that we face in the north-west and the need to support opportunity. Typically through that route, we will see about 400 young people between the ages of 16 to 19 coming into a cadet programme. One of the things that we have moved to, given the skills drive around the apprenticeship agenda, is setting up and piloting of an apprenticeship training association whereby, on this first cohort, 130 participants will be directly contracted under the training programme on an apprenticeship scheme and gaining work placements through organisations. As to the other arm, which has been a significant bulk of work as well, NHS North West, as the strategic health authority, has been very committed to the drive of apprenticeships and has made substantial funding available to engineer that.

Through the Skills for Health Academy and our engagement with trusts, we have been able to manage on behalf of NHS North West the use of that funding in order to generate the number of apprenticeship starts that we have to date. Last year, it was just under 1,300 apprenticeship starts, and this year we are anticipating 1,400 apprenticeship starts being supported.

Q281 Rosie Cooper: That sounds fantastic. Could you quickly describe the cadet scheme?

Dr Farrell: The cadet schemes are set up on either a one or two-year programme, with a qualification base such as a BTEC qualification or Level 2. We support the work-based element of those cadet programmes with our local employers, whereas the actual teaching and delivery is through our partnership relationships with our local further education providers.

Q282 Rosie Cooper: You are characterised as an employer-led body.

Dr Farrell: Yes.
because their popularity has diminished such that there is not sufficient demand. It is not a decision based on any other reasons than demand. I would add that the standards are set in the ways that we work with other professional bodies and other regulators. In devising the curricula, we work closely with the relevant professional statutory bodies to ensure that curricula are developed in that way, subject to the quality assurance mechanisms both of higher education, if it is based on higher education, which mine is, and those professions.

Professor Peters: I have a curiously similar story. Having had a wider range—quite a big portfolio—of complementary medicine BScs, we are running most of them out. We still have BScs in acupuncture and herbal medicine, which are still recruiting, but there is less demand than ever. We do not know if those will survive.

Q287 David Tredinnick: Can you explain why you think there is less demand, please?
Professor Peters: For us there are a number of reasons. A very high proportion of our students have first degrees and are mature career changers. The new funding arrangements mean that it is not possible to get these loans on a second degree, and that was 25% of our people previously. Also, as our entry requirements go up, that has squeezed our territory. It could be entirely financial. In times of uncertainty people are not choosing a career as unpredictable as being a practitioner of complementary medicine, especially against a background of having at one time felt the NHS would be bringing in more complementary medicine and we now see it very much in decline.

Q288 David Tredinnick: What actions do you think should be taken to stop that decline?
Professor Peters: I keep hearing about the bits of the jigsaw when we debate workforce planning. I am curious about the big picture. What is the picture on the box? I hear about biomedical centres of excellence in education. I do not hear much about biopsychosocial excellence. I do not hear how this seamlessness between medical, nursing and social care comes about—what the models are. We know it can be done because we have done it in our own practice in Marylebone, so there are ways of not being biomedically focused in primary care. That is the way we need to go.

In terms of the models of complementary medicine, what they have in their favour is that they are based on patient experience and driven by patient choice. They address some of the problems that people find in the biomedical system to do with engagement and health promotion. It is a resilience-based self-care model, and people come to it on the basis of self-care. It ought to have something to offer, but the system—the NHS—will have to move in a more resilient, sustainable and biopsychosocial direction in order to make space for complementary medicine. I hope it will and that, when it does, there will be room for CAM in the mainstream.

Professor Ellis: Clearly one of the facts that may be contributing is the debate on the scientific basis, which Sir John alluded to earlier. There will be views on that on both sides of this table. That spills over into how prospective entrants to that profession will view it and also the opportunities for employment. The complementary therapies, like many others that contribute to healthcare, are funded in different ways. Within my own faculty I have, for instance, osteopathy, which is high interest, with people still applying; even though it is not funded by the NHS. I have dietetics, which is funded by the NHS, but alongside that public health nutrition, which is not, and yet there are public health nutritionists being employed in the NHS. I also have mental health nurses who are employed and their training funded by the NHS, but I have art psychotherapists and counsellors where their training is not funded by NHS. It is part of a broader debate as to why people are applying. Clearly there is more that some of these professions need to do to market themselves so that people will apply, but also there are anomalies as to the way in which different professions who are all currently providing services as part of the NHS are funded in some cases through the NHS and in others are not.

Q289 David Tredinnick: I will ask you about that in a moment. Can I suggest to you that there are huge potential cost savings for the NHS in complementary and alternative medicine? Obviously, I have a vested interest in putting this forward because I have been Chair of the parliamentary group for a long time, and freely admit that, but this is my observation. From a personal point of view, Chair, last year I did not visit my general practitioner at all, but I had a number of minor ailments to do with eyes, stomach upsets, colds and flu and things like that, which I treated myself using a simple homoeopathic medicine box, which cost not very many pounds. I have learned a little bit about it. I think, particularly with homoeopathy we are completely out of line with Europe now where you can get these products in almost any chemist. I wonder why we are lagging behind and why it is that we are not encouraging people to try and treat themselves for minor ailments before they burden general practitioners, like my hon. Friend on my left.

Professor Peters: The system is trying to encourage more self-care. There are campaigns about it and we know that self-care could unburden the NHS of a vast amount of minor illness. We know that. The problem is that there are not the good cost-effectiveness studies around complementary medicine. We have run pilots lately looking at acupuncture and osteopathy for back pain. The results are good. It is not clear about cost-effectiveness, but patient satisfaction is high. It is a complex research issue. If we are going to wait for cost-effectiveness studies, the problem is that, if we do not have services in the NHS to study, we cannot create the evidence to bring the services in. It is a problem.

Q290 Chair: If the services exist, it must be possible to produce the necessary records of the evidence of outcomes.

Professor Peters: There are a few services. There are some acupuncture and some osteopathy services, and
they are doing the outcomes, but we are not at the level of having randomised control trial evidence, which is what is demanded increasingly, of course, by EBM.

Professor Ellis: In such research, one also has to differentiate between the profession and the intervention. For instance, there will be physiotherapists who will be using acupuncture as one of the tools that they use—one of their therapeutic interventions. You could evaluate the efficacy of that as distinct from evaluating complementary therapy or an acupuncturist. Part of the complexity is teasing out the intervention from the particular profession that is providing it.

Q291 David Tredinnick: Do you think that this emphasis on double-blind trials is something that has been taken to an extreme? In the past, doctors used to operate on the basis of observation. If you take acupuncture, for example, there are approximately 50,000 hospitals in the People’s Republic of China using acupuncture and it has been around for 3,000 years. Should we not take greater note of observation and give greater credibility to it?

Professor Peters: That is not the way the system is going, but evidence-based medicine was supposed to include observation, clinical experience and patient preference. That is the nature of EBM. We are focused very much on randomised control trials. In an industrialising system where you want to be able to offer equitably an intervention across the board for millions of people, you probably need that kind of statistically valid information. The problem for complementary medicine trials is that often in the placebo arm you have very high rates of response. The problem is, apparently, that false acupuncture—sham acupuncture—seems to work extremely well. We can only attribute that to some kind of human interaction and context effect. It still means it is highly effective, but it does not mean to say that it is efficacious in the sense that a drug would be in an RCT. It is a complex argument, but at the moment the RCT rules and we have to adapt to that, I think.

Professor Ellis: Your point is well made, and I would argue that it applies equally to many of the other professions that are carrying out health interventions which cannot necessarily be measured in a clinical trial, double-blind kind of way. If we are looking at the impact on public health of interventions from often more than one professional working with a client, then it is about looking at the ways in which we evaluate effectiveness of outcomes.

Q292 David Tredinnick: When the Committee went to Torbay, because of the new regime with personal health budgets and the expectations therein, it found that various patients, or people the Committee spoke to, were looking for acupuncture. Does that not reinforce the case that we need statutory regulation? If we are going to have a health service that embraces a wider range of remedies, surely this is a very high priority.

Professor Peters: I would agree with you if we are looking at more patient choice. We can see that, when people have the money, they will often choose acupuncture and osteopathy for back pain, but still only some 2% of the population have access to acupuncture and there are only 13,000 acupuncturists in the country, half of them physiotherapists and allied professionals. If there were a high demand at the moment, we could not meet it. I also question what was said before by the previous panel of witnesses about there being a lack of an evidence base for acupuncture in chronic back pain. The evidence base is rather good, but the NICE guideline does not push PCTs to provide it because back pain is not a high priority. If people with back pain are using the private sector, that, in a sense, unburdens the public sector to some extent but results in an equity problem. People who cannot afford acupuncture are potentially being deprived of an effective treatment for low back pain, which is an enormously costly problem.

Chair: We probably need to move on.

Q293 David Tredinnick: I have one last question on this. Do you think the Health Service should provide greater financial support for these services, given the personal health budgets and the reorganisation that we have now?

Professor Ellis: Possibly I pre-empted that question with my earlier answer. Patients need to have access to interventions that are effective, evidence-based and provide value for money. The current historical way in which funding from the NHS supports training is very varied for acupuncture. Working in a finite resource, there are reductions in the funding to many of the other professions that are currently funded by the NHS; so, in adding more to that, something has to give in the system.

David Tredinnick: Thank you very much.

Q294 Rosie Cooper: The Council of Deans in its written evidence to us has suggested that Health Education England must have “a power of direction” over LETBs to ensure longer-term workforce planning. How satisfied are you that such a power will exist under the plans as they currently stand? Do you support that?

Professor Ellis: To a degree. The relationship between HEE and LETBs and the governance arrangements are clearly quite crucial. That has been rehearsed in the previous session. My understanding is that the initial status of Health Education England and its relationship to LETBs is as a special health authority and they will in effect act as sub-committees of that. There is a question mark as to where that authority lies in terms of both the authorisation criteria but also the way in which the outcomes framework is used. “The power of direction” comment is more specifically about the fact that, as they move to becoming a different kind of legal entity, as a non-departmental public body, there needs to be quite clear specification as to that relationship and the control. The example—and you may have raised this—was the question of national versus local. To take the health visitor, as a current example, if LETBs, in their totality of the 12 of them, commission based on their need and that falls well short of a national target, who wins the argument, putting it bluntly? Do HEE say, "In the interests of the national numbers that
I have an observation on that. That about ensuring that there is joining up in that system. If the health visitors are needed. It is also nursing would seem to suggest you are cutting off the flow of the health visitors that are needed. It is also about ensuring that there is joining up in that system. Dr Farrell: I have an observation on that. That relationship clearly has to be established, but one of the things which has been hard won over time is the practice of being responsive at a local level. There is a range of tools, a range of approaches, that can be used with effect to meet a local solution. One of the things in the “power of the direction” of the relationship between the HEE and LETB is not to constrain what might need to happen at a local level. There needs to be some flexibility for that to be responsive.

Q295 Rosie Cooper: Do you think it will be there? I suppose that is the real question. How confident are you—this is bits flying everywhere—in the safety net? Are you going to be able to hold it together? Professor Ellis: My belief is that there is likely to be a focus on short to medium-term workforce planning at a LETB level. The responsibility of HEE is to make sure there is a medium to long-term focus. Where that clarity of relationship exists, it is to ensure that there is that medium to long-term focus on workforce planning. The question, if you like, to be asked of the LETB is: how does that workforce plan meet the 10, 15 and 20-year workforce projection rather than the one, three and five-year projection?

Q296 Rosie Cooper: Who is going to deal with the one, three and five-year projection? Professor Ellis: The one, three and five-year projection needs to be addressed, but we have referred to the Centre for Workforce Intelligence. We will be looking at their longer-term projections as to what the workforce is going to be looking like as well as asking the local employers, “How many of those do you need in three to five years’ time?”, which is, in effect, the current system. Rosie Cooper: We could not get it right under the old system, so I am perplexed as to how the increasing complexity at this time of great uncertainty is going to get better, but there you go.

Q297 Chair: We are reaching the natural end. We had some discussion earlier on about the role of regulation of healthcare assistants and the changing demands, in particular, for generalised care provision by people who traditionally would have been called nurses and now, in some cases, are called healthcare assistants. Do you have views on the debate on regulation of those healthcare assistants? I suspect Professor Ellis may have. That is why I asked the question.

Professor Ellis: I do. I do not see statutory regulation as necessarily the way forward. There has to be proportionality of regulation. Support workers should be working under the supervision of a registered practitioner. It is ensuring the appropriate supervisory arrangements and also ensuring that there is the appropriate education and training. That in itself does not mean that they need to be statutorily regulated. As a further comment, many of the concerns that have surfaced to do with care and nursing are care more generally. With that, I am not saying that nurses are not in all cases not to blame; there may be some fault there, but it is more generally a system failure. In some of those instances—and I know the Nursing and Midwifery Council have commented on this—when reported, it was not about a nurse but a support worker. The education, training and supervisory arrangements for support workers are crucial, but that in itself does not lead me to conclude that there needs to be statutory regulation.

Q298 Dr Wollaston: That was the question I wanted to draw on. Do you think that turning nursing to being all degree training has left us with too much of a gap between them and healthcare assistants? Should we be training healthcare assistants up further so that we lose that gap? Professor Ellis: No, I do not. Clearly there is a kind of “too posh to wash” myth that is frequently perpetuated.

Q299 Dr Wollaston: That is a myth, do you think? Professor Ellis: There are misconceptions about graduate nursing. At the heart of those is a misunderstanding of the way in which entry to programmes is operated currently. There have been comments recently made such as, “It takes more than a few GCSEs to become a nurse.” I agree. That is why all university providers are assessing potential entrants not just on academic qualifications. It is a requirement under the NMC that there is consideration of those non-academic requirements to make sure that entrants have the caring, empathetic skills. They are not mutually exclusive. It is a mystery to me why people feel that to be academic means to be uncaring. I do not hear that rehearsed elsewhere.

Q300 Dr Wollaston: The concern is often expressed that some people who are extremely caring, who perhaps are not academic, are feeling excluded from nursing. Whereas previously they could perhaps have become a state enrolled nurse, there is a sense that a whole group of people who would be valuable to the NHS are being excluded. Professor Ellis: I hear that argument and this is where I would turn to Mike and say that a number of the pre-registration programmes for nursing articulate with access pathways—there are progression opportunities—universities working with NHS Employers and NHS Careers. They are raising awareness and aspiration to a wide variety of individuals about a range of different entry points so that people can progress through, perhaps, a support worker programme and then be able to progress into
a pre-registration nursing programme. The fact is that there is a balance between their academic entry requirements and a lot of good examples of non-standard entry requirements in order to enter such programmes, but I have to say that probably the sector needs to do more to explain that because there is this myth that it is about the academic qualification.

Q301 Dr Wollaston: Can I clarify that? You are saying that, in future, it will be possible for people who are not getting into the graduate entry level to progress on and become registered nurses without having then switched and done a degree programme, or would they have the opportunity to do a degree programme like a diploma in-house?

Professor Ellis: There are already opportunities for progression and have been for a number of years.

Q302 Dr Wollaston: But would that be closed off to them in future once it becomes an all-graduate—

Professor Ellis: No, not at all. In fact, in Leeds we have students who are following support worker programmes, who are working with the employers, and in institutions some of those study alongside nursing students. Students are able to progress in and recognise that there are a number of ways in which one can demonstrate one’s academic potential for a career alongside having the necessary personal attributes.

Q303 Rosie Cooper: But what you are saying is that they still need to do the degree programme.

Professor Ellis: They would need to enter the degree programme, but there is the concept of stepping in and stepping out, which was talked about in postgraduate medicine. There would be a stepping-in point, which would be a matter of looking at each individual programme—because programmes will differ as to what people have done before—to decide whether they come in, as it were, at the beginning of the three-year programme or one could give recognition to skills and experience that they already have to come in at a more accelerated point of that programme.

Dr Farrell: The biggest risk can be characterised in two ways. Certainly through our widened participation, we have seen people who have not been working for five or 10 years come into it at an entry role and, with planned progression, then feeling confident to be able to flourish and go on to widening participation programmes, and in some cases eventually leading to registration as a nurse and indeed other healthcare professional roles. We have to value that widening participation route because of the very strong values that those individuals come with.

We need to look at those because the move to degree at the minute could mean that some of these potential widening participation learners get lost. The big thing that is needed, though, if we really want people to feel confident about going forward is effective information, advice and guidance. The current arrangements, both in the wider UK and the reforms surrounding IAG services, put that at risk. Although there is some clarity about what will happen with the health specific IAG services going into HEE, what it feels like for the individual and how they would access that is going to be the big question area. If participants do not get that IAG at the appropriate time in the appropriate way, they will not feel confident or supported to move on.

Professor Madhok: I want to make two general points, picking up on what has been said. The first is that we need to turn this debate upside down. All the debate is about the number of healthcare assistants, nurses, whether they are degree-trained or not. We need to turn it upside down and ask what the patient needs. The whole thrust of this reform was, “No decision about me without me”, and we need to bring that debate back somehow and then build our system upwards from that fundamental premise. That is where the ultimate solution has to be some kind of a loose-tight arrangement. It has to be loose enough within a national framework for people to work up these pathways. What we are talking about is creating a fundamental reform in how our Health Service works at the moment. It has to be loose enough for people to experiment and create more pathway-centric competencies and make sure that there are an adequate number of well-trained people along the pathway who are available. Yet it also needs to be tight enough because we cannot leave it too loose. It needs to be tightened up because we are talking about scarce resources. We need to have a very tight framework from the centre that focuses on delivery but, most importantly, reinforces some of the behaviours that will be crucial in terms of delivering this vision. Those behaviours are all about inter-agency and inter-professional learning. That is the crucial bit.

I will finish off by picking up on, I suspect, a theme that has come through your questions, which is that you are seeking assurance. I do not think assurance is possible at the moment. Equally, we will not have any assurance unless we get past this structural debate. This structural debate is getting in the way now and people, at the end of the day, will rise to the challenge. That is where the comfort comes. There are enough people talking and there is enough leadership in the system to make these structures work. People are waiting for that to settle down.

Rosie Cooper: Can I commend our Select Committee Report, issued today, on that very subject?

Chair: That is probably a fitting note, perhaps on today of all days—unless, Sarah, you want to pursue it further—on which to draw matters to a close. Thank you very much for coming to join us today.
Tuesday 21 February 2012

Members present:

Rosie Cooper
Dr Daniel Poulter
Mr Virendra Sharma
David Tredinnick

In the absence of the Chair, Rosie Cooper was called to the Chair

Examination of Witnesses

Witneses: Dean Royles, Chartered FCIPD, Director, NHS Employers, David Worskett, Director, NHS Partners Network, and Sally Taber, Director, Independent Healthcare Advisory Services, gave evidence.

Q304 Chair: Good morning. Thank you very much for joining us. My apologies from the Chairman, who is attending a funeral in his constituency. I am a pale reflection of him for today. Your presence is very much appreciated. Can you begin by telling us your organisations and who you represent, please?

Dean Royles: My name is Dean Royles. I am Director of the NHS Employers organisation. We represent employers in the NHS across the plethora of workforce issues, things like pay, pensions, employment practices and education and training.

David Worskett: I am David Worskett. I am the Director of the NHS Partners Network, which is the association of independent sector providers of healthcare working with and in the NHS.

Sally Taber: I am Sally Taber. I am Director of Independent Healthcare Advisory Services, the trade body for acute independent healthcare providers; I also look after the cosmetic surgery providers; I run the Independent Sector Complaints Adjudication Service as no private sector patient has access to the Health Ombudsman; and I am doing some work with the Government on introducing a self-regulation scheme for Botox, dermal fillers and lasers used for aesthetic purposes.

Q305 Chair: Thank you very much. Can you summarise how each of your organisations views the Government’s reform plans set out in “Developing the Healthcare Workforce”, and in the recent update, “From Design to Delivery”?

Dean Royles: As the employers’ organisation, we broadly welcome the direction of travel. In particular, we welcome the idea that employers and providers are more directly involved in the planning of education and training. We like the idea of a national body responsible for overseeing multiple professional Development Confederations. We achieved local involvement there including the involvement of the independent sector providers, and sharing of training programmes and so on. The LEBs could be like that. It is great that we can really get back to local involvement. How you get the private sector—deliver better care for patients?

David Worskett: From an independent sector perspective, the first thing to say is that this discussion has moved on slightly since we embarked on it, in that the Government have now published a strategy. Broadly, that is pretty satisfactory from our point of view. We think it has come out in very much the right sort of place. It is important to say that most independent sector providers—certainly all those of repute—place quite a high importance on staff training, although it is sometimes a different sort of training to that done elsewhere. I do not know of any of my major members, certainly, who do not regard training and development of their staff as a very high priority, which, in a sense, is what you would expect in organisations that need to train people and look after patients properly in order to survive.

If we have some concerns—and they have been partly alleviated by the latest Government paper—it is more in the area of people not understanding the training our members do, and how intensive that is and how committed they are to it, and not fully appreciating the value of it. The world has moved on quite a long way since the first independent sector treatment centres from undertaking training. That prohibition was removed quite quickly, and we now have a very much healthier situation in regard to participation in training and people moving between organisations—public and private sector—for training purposes.

Sally Taber: I go back as far as the Workforce Development Confederations. We achieved local involvement there including the involvement of the independent sector providers, and sharing of training programmes and so on. The LEBs could be like that. It is great that we can really get back to local involvement. How you get the private sector representative on there needs to be discussed. My organisation has now been contacted by UCL Partners running the central London ones. We have also been invited to do a pilot with NHS Midlands and East. We
are already part of that. A few years ago, when there were Workforce Development Confederations, I co-ordinated the independent sector representation throughout the 28 of them, and we achieved a lot then.

Q306 David Tredinnick: I would like to start with looking at the new organisational structures, and I raise this with Mr Royles to start with. The NHS Employers has said in its evidence to us that Health Education England must be employer-led. On that basis, what specific form do you think it should take and which employers should be involved in leading it, please?

Dean Royles: When you look at education and training, employers are very well placed to understand the needs of patients. They deal with patients on a day-to-day basis. They see the needs of patients; they see training and services; they have active engagement with their patients, with their local population and the boards that they have in place; and they also speak very freely to their clinicians about how services are developing. From our point of view, we welcome the idea that, if you put new architecture in place, you do not just get a lift and shift of the old system into a new system and say, “We have a change in NHS architecture, let us make sure we get education and training that works in there.” This is an opportunity to get a fundamental rethink about how we look at what are the needs of patients and how we plan our workforce into the future. To enable that, you need Local Education and Training Boards that have good employer representation on them and feel as if they have autonomy and authority to make decisions based upon the evidence they would use to come to that. The Government have put forward that that would be overseen by Health Education England. There was a variety of different models they could have gone for but they chose that particular model, and I understand why they have done that. In so doing, there could be a tendency towards centralisation. The natural order of these things is if you set up a central body it looks to centralise and make decisions on a central basis.

Given that we need to get that sort of authority for Local Education and Training Boards in there, and to make sure that happens, we need employer representation and it will be provided by Health Education England so that if there are disputes, conflicts or issues people have trust in that system. That might be about bringing people into Health Education England who have particular expertise in this area and who also happen to be employers and, maybe, medical directors, nursing directors, HR directors and chief executives. We think we have a role as an employers’ organisation. We are active on the ground in looking at what good practice is; the things that people are doing; innovation; sharing what works with people; and lessons learned, so we have a role to play in that as well. That employer role in there is important.

Also with Health Education England we have a tendency to think of things like Medical Education England as a committee. This should be an organisation that has engagement at its heart—not a series of meetings that makes decisions—that is seeking information and evidence in order to run its business and affairs. It has something like £3 billion worth of education and training funding to deploy and we should be able to make sure we can use that efficiently and effectively if we get all the right voices in the right place.

Q307 David Tredinnick: Thank you very much for that. In the new system, as it is planned, the Local Education and Training Boards will be employer-led. What capacity and capability will employers need to assume this role and how ready are they to assume it?

Dean Royles: Employers have been engaged in education, training and workforce planning for a number of years. Many of the NHS organisations are large organisations in their own right, with 5,000, 6,000, 7,000 and 12,000 people in some cases, with a board of directors of workforce people involved in there looking at what patients need and bringing in clinician expertise in terms of planning those services. So people have been engaged in that workforce planning.

There is something of a paradigm that has developed that suggests employers are not really that interested in education and training and it is best left to the professions who understand. My understanding is that employers are very passionate about wanting to provide the best quality staff they can for the patients they serve. In terms of a willingness to do it, they actively want to get engaged. We want them to get engaged in those Local Education and Training Boards where they feel as though they have authority and decision-making powers to be able to do that. If we can deliver that for them, then it will not be a capacity issue because there will be the will there. They will want to bring in the use of expertise from things like the Centre for Workforce Intelligence, they will want to bring in information about what is happening on the ground and they will want to share ideas of good practice. But the capacity and the will is there if we can construct a system that shows them they can be approved to make appropriate decisions for their patients in their constituencies.

Q308 David Tredinnick: So the will is there. That is very reassuring. Can I ask David Worסקett and Sally Taber to come in at this point? How satisfied are you that independent sector representation will be provided in Health Education England?

Sally Taber: What we need to create in the independent sector, first of all, is very much an awareness of the LETBs. There is not total awareness yet. I hope it is not going to be like the last Workforce Development Confederations where there were some excellent examples but, also, those that perhaps did not engage the independent sector. There must be, almost, a mandate for all the LETBs to have an independent sector representative on them. As I say, we have a pilot about to start with NHS Midlands and East in which we want to involve the private providers—obviously those that do NHS funded care. The management of that LETB is going through Skills for Care to involve the social care side. There is a huge workforce out there that is not involved. We have started collecting workforce data, which we did until 2006 and then stopped. I have a sample with
me of the aggregated data. We have made sure that the organisations that have given us data have given it from individual organisations. It can then be split up for NHS Midlands and East LETB, for instance, because they are not going to want to know the whole of the workforce. They are going to want to know what is in their area from the independent sector. We have also done quite a bit of work on what training opportunities there are as in the booklet we did last year “Careers in Healthcare” from the independent sector. The Guardian picked up on one example of how the independent sector contributed to education. I will leave you an example of that. We have recently completed a review of critical care nurse education and supported the publication to make sure that all the acute healthcare staff are aware of their responsibilities.

I am not confident that all independent sector organisations are aware of LETBs yet, but we have a joint conference with the NHS Partners and Skills for Health on 18 April and we have the LTB agenda on it.

David Worskett: The short answer is that there is no guarantee. There is nothing in the structures that guarantees there will be proper engagement with the independent sector, with the LETBs. It would be a great pity if we replicated what has tended to happen in the past, where the level of involvement between the sector and the deaneries has been patchy. In some parts of the country it has been excellent and in other parts of the country it has been very weak. We need to avoid replicating that patchiness.

Q309 David Tredinnick: How are you going to do that?

David Worskett: It is partly incumbent on us. There is no point in always blaming somebody else. We have to get out there and talk about what we have to offer and why it is worthwhile involving us. We need to take that very seriously, which is one of the reasons we have this joint conference running. I also think it is important for those on the other side of the fence, as it were, to think carefully about the merits of involving the independent sector in some types of training. There are two very obvious examples. If you want to look at some of the finest standards of end-of-life care, you would want to involve, say, a great hospice in your discussions about training. It is almost what I might call a “no-brainer” that you would want to go there for training support for that type of care. If you were looking at innovative care in the home, very often, some of the more innovative clinical services in the home are provided by independent sector providers. The whole issue of how you train for delivering those types of care is quite a big one because it is a new model. Exactly how you train for them needs to be thought through, but not to involve a company which is doing very well for health authority—non-departmental—a public body, and the Local Education and Training Boards will be part of that. The staff would be employed by that special health authority.

Q310 David Tredinnick: We have a lot to get through this morning, so I will try and speed up a bit. What about the legal status of the local boards? What do you feel about that?

Dean Royles: The Government have said that these should be part of Health Education England, so Health Education England will be set up as a special health authority—non-departmental—a public body, and the Local Education and Training Boards will be part of that. The staff would be employed by that special health authority.

Q311 David Tredinnick: Are you happy with that?

Dean Royles: It is the same point that I was making earlier. We understand that as a direction of travel. As we put the architecture in place, it is very important that we get the responsibility and accountability right. As there is one body, there will be a tendency to centralisation. We do not just want to “lift and shift”. We want to fundamentally change the way we engage employers in that, so we have to put the right accountability and governance arrangements in place. That is do-able because you have the right people involved asking, “How can you make sure that they exercise that in an appropriate way?”, and they feel that they are taking local information from organisations, from their patients and their clinicians, and saying, “This is where we think the direction of travel is. We have the evidence to support it. Therefore, we want to move forward on that basis.”

Q312 David Tredinnick: We were told, certainly, that workforce planning has to be done at a national level. If that is the case, local boards cannot be wholly autonomous from Health Education England. How do you think they are going to function?

Dean Royles: There is workforce planning that needs to happen at national level, at Local Education and Training Board level and at individual organisational level. All those labour markets are very different. At the Local Education and Training Board level, there is a regional labour pool where people are recruiting newly-qualified nurses from a range of different higher education institutions in their patch. They will want to ensure that there is an appropriate supply of those. That is better done in a region like the north-west, South Yorkshire or the north-east where people have those relationships with the higher education institutions.

Q313 David Tredinnick: You talk about “sub-LETBs” in the Health Service Journal on 26 January this year. That is something you are very much in favour of, unless you have changed your mind.

Dean Royles: The appropriate thing is that, if you set up Local Education and Training Boards, they are given the authority to say how best they can configure themselves to deliver for their local organisations and the patients in those areas. With the idea of a labour market in somewhere like South Yorkshire, for example, or places in the north-west around Greater Manchester, where they share a variety of different higher education institutions, it makes perfect sense
that that is where that relationship is carried out. Then
the governance is in place that means they have done
time also, and they are allowed to make
decisions on what they feel is an appropriate amount
of new training commission or continuous
professional development that should be done in that
area.

Q314 David Tredinnick: I have one more question.
As employers, do you think there is a danger that the
local boards will be dominated by employers who lack
academic involvement?
Dean Royles: The criteria, in terms of getting them
established, is that they should have active
engagement with their higher education institutions
and that those are explicit in the way that they work,
that higher education institutions are engaged.

Q315 David Tredinnick: Should there be an
obligation there? You are wishing it and you say it
would be a great idea, but should we go further and
say there must be some obligation—a requirement?
Dean Royles: The obligation is there through the
accreditation process.
David Tredinnick: I will leave it there. Thank you.

Q316 Valerie Vaz: I want to quickly follow up on
something that you said earlier, and I am happy to
hear comments from other people. You said the right
people should be on the board. Who do you think are
the right people? Perhaps that would help.
Dean Royles: Employers are best placed to
understand what their patients want, how services are
changing and how they can better provide those.
There are two ways you can approach those changes.
One is to try and understand the different ways in
which patients want treatment, how medical advances
are changing and where people want services
delivered—closer to home, more in the community
or in a specialist hospital environment—and to ask
professions about how they might want to adapt to
that different area. Then you bring those together
saying, “When we look at our planning, what are the
sorts of skills we need in the future to be able to
deliver those?” That may be something new or
different. It may be about training existing staff rather
than trying to recruit new staff.

Q317 Valerie Vaz: I was talking more about specific
personnel. When you said “bring people on board”,
could you be a bit more specific? Would you have
patients, doctors or nurses? Would you have other
members of the workforce?
Dean Royles: From an employer’s perspective, it
would be people like chief executives, medical
directors, nursing directors and some of the allied
health professions leads that have an employer view,
but those are supported in terms of an understanding
of what a broad range of employers want. They have
access to information. So it is personal expertise and
a range of information that supports that.
Sally Taber: It is very important that whoever is the
independent sector person on the LETB has the
opportunity to get the rest of the people round the
table to understand the independent sector. So many
times, when I go to working groups, people do not
understand. With medical revalidation we had a model
that would fit the NHS. Suddenly, we find the smaller
organisations that have resident medical officers that
have come in from overseas or whatever, and we have
to rethink the agenda now. Before we start, we can
work with the Centre for Workforce Intelligence to
make sure there is a real knowledge of the
independent sector.

Q318 Valerie Vaz: Thank you. Mr Worskett, who
would you have?
David Worskett: I agree with that. It is quite difficult
to prescribe the exact balance of skills on these
boards. To some extent, it may also depend upon the
availability of people in a particular area. But, clearly,
you need a balance. You need people from an
employment perspective, academics and clinicians of
a variety of kinds. As it will differ slightly according
to the needs of the area, trying to prescribe it
absolutely from the top down seems to me to be
quite difficult.
Chair: We turn to general workforce planning.
Virendra?

Q319 Mr Sharma: The Government plan to require
providers to consult, provide data and co-operate for
the purposes of workforce planning. How do you
respond to concerns that foundation trusts and private
providers could duck those duties in pursuit of
commercial interests?
David Worskett: I cannot answer for foundation trusts,
but those of us who are currently deeply embroiled in
the proposed licensing conditions being developed by
Monitor are aware that there are going to be some
very tight licence conditions about provision of
information and data. We have said we understand
that, we think it is right and we need to try to get the
level right so that it is not disproportionate,
particularly for small organisations and third sector
providers. From the point of view of those
independent sector providers who are working for and
in the NHS, we absolutely accept the obligations that
will be within those licence conditions to provide the
data that is required on the same basis as the rest of
the NHS. Therefore, it is a common cause, with NHS
providers, to try to get that information properly set
out and the balance right.
Sally Taber: I feel very strongly about this. We
provide data for the Scottish Government and Welsh
Assembly Government. We check the data they want
and we give it to them each year. They have Scottish
independent sector credentials and Welsh independent
sector credentials. What we need here is a mechanism
for exactly what data is needed. The data I have here
this morning is head counts of nurses, physiotherapists,
occupational therapists, radiographers, ODPs, how many doctors who are
employed and those who have practising privileges,
and the number of healthcare support workers. This is
not the entire sector at the moment, but there are for
example 19,800 with practising privileges. So there is
a fair amount of workforce there. What we need is a
questionnaire that suits the LETBs, with exactly what
Sally Taber: I think I have told you that we have it data that would be required for this purpose? independent sector organisations gather the types of the independent sector database. To what extent do question partly, I still want to go further and ask about patient care. provided, it is going to be used for the good of wherewithal and the assurance that, when it is providing data per se. It is giving them the to support you as an organisation in the delivery of serious amounts of money in education and training are providing data to look at how we can invest spent for the best impact on patients?” That is the development. Where do you think it would be best spend some of that on continuous professional data because we have £500 million to spend in our happen to it. People will be more than willing to bureaucratic form when they do not know what requirement for you to provide some information.” I do not think that employers per se have any problem with providing data. This is a good example of where to avoid the lift and shift. Employers have a problem with providing data in a bureaucratic form when they do not know what happens to it. People will be more than willing to provide that information if you say to them, “We want data because we have £500 million to spend in our Local Education and Training Board and we want to spend some of that on continuous professional development. Where do you think it would be best spent for the best impact on patients?” That is the advantage of getting employers engaged locally; “You are providing data to look at how we can invest serious amounts of money in education and training to support you as an organisation in the delivery of care to your patients.” It is not a problem with providing data per se. It is giving them the wherewithal and the assurance that, when it is provided, it is going to be used for the good of patient care.

Q320 Mr Sharma: Although you have answered the question partly, I still want to go further and ask about the independent sector database. To what extent do independent sector organisations gather the types of data that would be required for this purpose?

Sally Taber: I think I have told you that we have it here from the main independent sector organisations and the individual ones.

Q321 Mr Sharma: Can you expand on that?

Sally Taber: Where you have a problem with the independent sector is that there are so many tiny organisations. For instance, with medical revalidation we found that 287 in central London did not answer the letter from NHS London. They are tiny, with perhaps three or five people. That is where we need some more communication to them to say, “We have to know who you are.” The main providers do not have a problem in providing data, providing, as Dean says, they know where it has gone, what it is for and we are collecting it in the right format. The LETBs need to dictate to us exactly in what format the data is required and then it will be provided.

Q322 Chair: We should have a conference to decide what kind of data. It is difficult in the sense that, if every request for information has to be justified at the level you are suggesting, different people will have different views on that and we will go round and round. Somebody at some point has to say, “This is the information we want; everybody has to do it.”

Sally Taber: Yes. That is the role of the Local Education and Training Board at the moment. That is done through a learning and development agreement. In many organisations a learning and development agreement goes to organisations that says: “To access this training and development money, there is a requirement for you to provide some information.” You get better quality data if people feel they are providing data that is making a real difference to how they use it on the ground. That is the advantage we have in a system that more actively engages employers and providers.

Q323 Mr Sharma: Thank you. The Government want to reduce the NHS’ dependence on agency and locum staff. How necessary is that, and how easily achievable is it?

Dean Royles: First of all, it is important to say that agency and locum staff play an important part in having a flexible workforce. Therefore, occasionally, we need to bring in staff temporarily for short-term increases in activity or to cover unexpected or more long-term sickness absence. All those things are a legitimate use of agency and locum spend. What you want to try and establish from an organisation is whether they are doing that in the most strategically appropriate way. Are you doing it as a short-stop measure because you have an initial problem? The Government are trying to say, “In terms of looking at that going forward, is there a more planned way that you could have a more efficient temporary workforce to supply those needs, using staff more associated with the organisation so that they provide better patient care?” I do not think it is about eradicating it completely. It is trying to use it in the most strategically efficient way that you can.

Sally Taber: We have worked, from the acute independent sector, with the Migration Advisory Committee who had cut out theatre staff from the shortage list. The independent sector needs a fair amount of theatre staff and they had said that they should not be on the list any more. We managed to get them to change their minds, giving the sector an opportunity to grow its own theatre staff. Skills for Health have done a lot of work with how we grow our own theatre staff. We realised that we were using a lot of agency theatre staff but we persuaded the Migration Advisory Committee to change its mind. There are other ways of doing it: to think a bit more laterally than simply saying, “No more agencies”, and asking, “Why have you got agencies?” That is what we did with theatre staff. We have got agencies because the Migration Advisory Committee said they could not come in any more, that they were not on the shortage list, but they have changed their mind on that until the sector can start growing its own.

Q324 Dr Wollaston: Could I ask the panel to comment, particularly Mr Royles, on whether you feel there is a shortage of generalists within the NHS? There has been a concern expressed that if we have a provider-dominated service we might see that organisation naturally tending to want to increase the supply of specialists within the hospital sector rather than develop generalist skills. What are your views on that?

Dean Royles: It comes back to the understanding of how care is changing, what patients want and how we can deliver that more effectively. We then start to ask questions as to what sort of skills we need to be able to deliver that, rather than how we adjust and have more or less of a particular variety that we have at the moment—
The idea in a number of reports now, for example, has been about having a more consultant-present system, seven days a week or 12, 15 or 24 hours a day. Looking at that, you get to the view that you need more generalist skills to support it and specialist skills alongside. I think you would also come to the view that, if you want to treat people closer to home, it would make sense to have more nurse training, for example, carried out in the community where there is a general range of skills, and specialist training back in the hospital. As I say, that is the advantage of looking at a system. Starting with, “How do we deliver care? What is it that patients want?” and then asking ourselves questions as to how we best provide that has to be a good way of looking at how we do our workforce planning in the future. That would take you down the route of more generalist skills for people who are working longer hours in an acute or hospital setting, and people who are working in community settings, supporting people in their homes—or closer to home than a district general hospital or a teaching hospital, for example.

**Q325 Dr Wollaston:** You do not think there is going to be an issue with not training enough or encouraging more medical graduates to go into, say, general practice training rather than encouraging them to come into fields for which there may not be a consultant post at the end of it.

**Dean Royles:** There is a challenge there with communication. The work we are doing, for example, with the NHS Careers service is starting to explore that with people in primary and secondary school now so that they are changing their career expectations about what might be available in the future and how that may be carried out, rather than having someone going into medical school determined to be a surgeon—and that is going to be a lifelong ambition for them—when that will not necessarily be available to them when they come through 10 or 15 years of training. There is an opportunity to engage local communities about how professions are changing, how care is changing and the different roles that are needed rather than repeating what has always gone on before. It is the old story that if we keep on investing the same amounts of money on the same amount of professions we will keep on getting broadly what we have. Some years we will have too many and some too few. If we start looking, fundamentally, at how we do it differently then we get into a cycle of breaking that and understanding the different roles and occupations that might be available for people now thinking about that at primary or secondary school.

**Q326 Mr Sharma:** The Government also wish to reduce dependence on overseas-educated staff. How necessary, and achievable, is that?

**Sally Taber:** That is what I described about the Migration Advisory Committee. IHAS are on their advisory group and we share all the information with the independent sector. It is very important to work with them because we know that we should not be taking staff from South Africa or from the African countries. The majority of the acute independent sector has probably moved to recruiting from the European countries, but there you have the language problems and we are pleased that that issue is being addressed. There are other ways of doing it and, as I said to you, of thinking a bit laterally on, perhaps, working with the Migration Advisory Committee, saying, for instance, “Why are we short of cardiac nurses? What can we do about that?” Certainly, having been a director of nursing in the independent sector, I worked together with the local trust. We did a critical care course half in the independent sector hospital that I ran and half in the NHS, and the same with renal care. There are lots of ways of working together and, hopefully, the LETBs will encourage this. As David said, where there is best practice, let us share it and try to address some of these problems together.

**Dean Royles:** It is worth saying that overseas staff have made a fantastic contribution to the NHS, from those who came over in 1948 on MV Empire Windrush and started working in our hospitals to those who are coming from Europe now, or doctors who have come over and transformed things like general practice or care of the elderly, for example. There has been a fantastic contribution from trained overseas staff. Increasingly, in a number of roles, we are an international labour market, where people want to move around in their careers. We have physiotherapists that may want to go and work in Australia when they come out of university and maybe, at some point, come back. We have to have a look at it and manage migration. We have an ability to bring appropriately trained staff in from overseas, particularly when they can come and get learning, education and training and, in that global labour market, take something back to their countries. It is both recognising that the world is much smaller now in terms of people wanting to do that, and making sure that we have a good supply through our own institutions, and that they are providing a sustainable workforce for the future.

**Q327 Dr Poulter:** On that issue of overseas workers—before I come to my questioning—it is absolutely right to say that the NHS would not function without the many doctors, nurses and other healthcare practitioners who come and work from overseas. We would not have a functional service. However, because of the European Working Time Directive, there are specific problems sometimes with locum provision and the need to employ more locum doctors at some trusts. We all accept that anyone who works at a hospital should have a basic standard of English, but do you have concerns over the fact that a number of doctors who are on the books of locum agencies, for example, are not necessarily familiar with the British medical system and how things operate in this country?

**Dean Royles:** Absolutely. We have been talking with the GMC about how we might, together, do some form of international induction for doctors on how the system works here and the different cultural norms that may exist, as well as English language testing for people who come from overseas countries to make sure they are competent in the language in which they are going to be prescribing and speaking to other.
professionals, I would agree with all of those, while acknowledging, as I say, the contribution that people from other countries have made to the Health Service, the way that we run it now and what some people are able to take back to the benefit of their own country as well in terms of education and training.

Q328 Dr Poulter: For example, would you agree that sitting, say, in medical terms, the PLAB—the conversion—exam in itself is not necessarily good enough to show that somebody is able to work as a competent doctor in the British medical system?

Dean Royles: The difficulty with the plans that people want to put in place is how can you do appropriate English language testing within the rules that does not look as though you are re-checking whether people are educationally qualified? There are a variety of different sorts of pilots and tests being done about how you can get the best sort of model of that that gives people who are coming in assurance. The vast majority of our staff sit through some form of interview and have to go through a range of questions and an application form and accept it. I agree with you that, on locums, there is a different process coming in. But we can develop appropriate practice that says, “How can you be assured, at the time you get a locum in, that there has been appropriate language testing?”

Q329 Dr Poulter: That is right. Particularly with the European Working Time Directive coming in, there has been a problem in a number of specialties—for example, obstetrics and gynaecology, which is my own specialty—where there has been an increasing reliance in the hospital sector and in GP out-of-hours service, as has been well documented, on getting people from within and outside Europe coming to work. They may be perfectly competent doctors in their own country, but their understanding and communicating with them about how things work in this country is a problem. There have been well-documented cases where that has had tragic consequences. Simply being able to pass a PLAB or a competency exam, for those people who are non-European doctors, or being able to pass an exam in their own country, does not necessarily mean they are able to be an active, effective or even necessarily safe member of the workforce. It is that which I am driving at on locums because of the EWTD. What do you think needs to be put in place to improve and deal with those issues?

Dean Royles: I do not know that it is all necessarily driven by the Working Time Directive in some of this. Some of the contractual arrangements—

Q330 Dr Poulter: We will come on to that in a moment.

Dean Royles: It is another discussion, maybe. The problem has been acknowledged. Now the issue is how we put a system in place that people understand—a system that is transparent and not overly bureaucratic—so that we can bring workers in at relatively short notice knowing that they are appropriately trained and have the right educational standard and appropriate level of English to be able to do their job effectively, and we avoid exactly those tragic consequences you were talking about.

Q331 Dr Poulter: Yes. But what I am trying to get at is how can we deal with locums? It is very easy for a hospital employer to deal with. If we went over the river to St Thomas’ they would be able to make sure that those staff who come and work for them are inducted. Responsible employers will induct those staff. Where they have concerns, they will also make sure that those staff can shadow existing doctors within the organisation. There has undoubtedly been an increasing reliance on locums to run services because of the EWTD, and the fact that people have not been able to work the hours they were able to work. Maybe one of your colleagues could shed more light on it.

Chair: Both would like to.

Dr Poulter: Both would like to, because this is probably quite a real concern, not only to the people in this room but to the public as well, in terms of safety.

David Worskett: I want to pick up, in particular, the out-of-hours problem where there have been one or two terrible and tragic cases. What is noteworthy about most of those is that they were what I would call quite localised, home-grown arrangements. Interestingly, as time has passed, more of these out-of-hours arrangements have been grouped together in the hands of rather bigger providers who have the clinical governance arrangements and the support structures in place to make sure that things are going to be all right, not only in terms of language but training and how to deal with what is often quite a complex system. What I see is a move towards using the better equipped, more quality assured—as it were, properly governed—indeed independent sector providers to manage these processes rather than well-intentioned, but ultimately terribly risky, home-grown ventures where not all of this support and validation is available. It is very important that we use the right sort of quality providers to manage these processes.

Sally Taber: I think medical revalidation is going to sort this out. There are pilots going on with local agencies at the moment. Some of the local agencies out there are not going to survive because they will not have the structures in place. Every independent sector hospital has to have a resident medical officer 24 hours a day and we use agencies—they are supply agencies—to get those doctors. They all used to come from South Africa, but now they are coming from Europe. As to how that is going to be managed, three organisations at the moment are being worked up as designated bodies to have a responsible officer to check that those junior doctors coming in have the right governance structure to work within, are appropriately qualified and have the language skills. It is happening as we are talking and, as you know, medical revalidation is planned to start at the end of this year.

Q332 Dr Poulter: It will be happening, yes, but at the end of the year. At the end of the revalidation process, which will take a few years, you are hopeful of that. In the meantime, bad things can still happen. We will leave that there.
Sally Taber: We are working hard.

Q333 Dr Poulter: Going back to the workforce issues, there has been—and it was touched upon earlier—the issue about the drive for consultant-led care on the ward, in the emergency department and elsewhere. That is something everyone would like, I am sure—to see a consultant first off. What are the benefits and risks of that in terms of the training of the workforce? Indeed, what about the ability of the registrar—historically, they have been the workhorse of the team—to then step up and become a consultant if their level of responsibility, when they have been working in this way, is having less patient contact and being much more intensively supervised? How do you see the benefits and risks of consultant-led care in terms of, effectively, training the next generation?

Dean Royles: It is going to be a fundamental shift for us, I think. There are elements about how we see and perceive the entire medical workforce. We tend to think of junior doctors as untrained doctors and consultants as trained doctors, but we also have a whole range of staff and associate specialists who make a fantastic contribution in the workplace. This idea of an appropriately qualified doctor seeing people over a range of specialisms and different times is appropriate, but it is about how we look at that entire workforce—not only from junior doctor to consultant but also things like staff and associate specialist doctors—how we deliver care and the extent to which we mean that to happen, in terms of elective care over a longer period of time or emergency care where we have more doctors, consultants and qualified doctors on site. There is a fundamental review about how we look at the medical workforce to deliver that.

It is a point I was making earlier about how we can sometimes look at education and training in isolation from things like employment practice and contractual arrangements. All these things go hand in hand in terms of how we deliver them. It is not just about training more to fill the holes created by new service development but how we deploy those and use the other non-medical members of the workforce, nurses and allied health professionals in different roles. As I said right at the top, it is also about how we use staff in support roles, those in bands 1 to 4, who have a huge amount of patient contact. They are hugely important to the patient experience and yet they are often forgotten when we look at education and training needs.

David Worskett: Might I take the opportunity to make a directly related point about how different conditions are in the different sectors, because the question that was asked is absolutely relevant to the mainstream NHS? In the independent sector, of course, it is interesting that when people are trying to look at what we do and do not do, they sometimes forget that we do not run A and E departments. We have big hospital groups who run them in other countries in the world, but we do not run them here. In a sense, the issue does not arise there. We cannot train in that sort of work because we do not do it. Only consultants can carry out surgery in independent sector hospitals. Therefore, in a sense, it is already fully consultant-supervised because only they can do it and there is not the opportunity to teach junior doctors on the job. This is not a complaint, but the question prompted me to make the point that the conditions are very different in terms of what one is able to train in, not because of what we do or do not want to do but because of what we are and are not allowed to do. That changes the dynamics of what you can do in terms of training and education.

Q334 Dr Poulter: Specifically on that point, the healthcare reforms are going through and there is going to be an increased ability—it will not necessarily happen but it is likely—for private sector providers who are currently in your sector to come forward and provide services. As you say, at the moment in private sector providers, it is only consultants who provide the service and there may be some voluntary sector involvement as well in providing some services, perhaps in palliative care, with bereavement, for example. How does that impact on training?

David Worskett: I am not sure that it is going to make any significant impact in the acute sector. In a sense, the position will remain unchanged there in terms of surgery, in particular, only being carried out by consultants on the register. The interesting area, and it is an unknown area, is what happens with some of the new community services—I have members like Healthcare at Home who provide care at home—and to what extent we are going to be able to meet the training needs and participate in training for services of that kind. That is an unknown factor. I very much hope that we will be able to participate much more in training in those things. But in the area you are talking about, the acute sector and the hospital sector, I am not sure I see this making a huge amount of difference.

Q335 Dr Poulter: I am sure that private sector providers will be bidding for contracts—as long as that is done in an integrated way and meets all the right criteria—and you have acknowledged that is the case. If the private sector meets all those criteria—integration and everything else—there is then going to be an issue that private sector companies may be awarded that NHS contract. If, as at the moment, your services are consultant-led and they are not engaged in training, there may be a legitimate concern that the training in certain areas—where private sector companies then come in to provide NHS services—may potentially suffer.

David Worskett: Effectively, we already have what is an “any qualified provider” regime for elective care. Looking only at the hospital sector, that is why I am not predicting a huge amount of change. The regime which the Bill proposes across a wider range of services, to all intents and purposes, already exists for elective care. You are absolutely right in terms of the wider range of services as private sector companies bid for that work. I think the issues you raise are entirely valid.

Sally Taber: There are models out there that we could look at as best practice examples, particularly in the
independent mental health sector. St Andrew’s, for instance, does a lot of training between the NHS and the independent sector. There is a model that we put together—and people might not want to hear about this at the moment—on cosmetic surgery training because there is none in the NHS. Patients were told that it was going to be a registrar coming across with the consultant and the fees would be adjusted accordingly. So there are models that could be taken on board. I talked to the president of the Royal College of Physicians about this model and he was quite impressed. Obviously, the whole situation has changed at the moment in view of PIP implants, but I think we could look at that.

Q336 Dr Wollaston: I would like to move on to nurse education and training. There is a view that clinical placements for student nurses are too often of low quality, that mentors may be overstretched with students not having enough supervision and taking on tasks which they are not confident to carry out. How fair do you think that assessment is?

Dean Royles: It is going to be varied. Something like 18,000 nurses, or thereabouts, get trained each year. They spend about 50% of their time in academia and 50% of their time in a clinical placement. In some places—and probably the vast majority—that is going to be a great experience in both academia and in the clinical placement. When we get into whether there has been poor-quality training, trying to define if that took place within the academic setting or the ward environment is one issue that needs to be resolved. Part of the evidence that we put forward, for example, is what we mean by high-quality training and how we can measure it at the end. It is not only about educational attainment but also about the values that people express and how they go about them. That relationship, as I think we touched on earlier, between the higher education institution and the employer—the local hospital, for example—is very important.

Q337 Dr Wollaston: I am referring specifically to the fear that, when they are doing their clinical placements, staffing levels are overstretched and students are not having adequate supervision and training in the clinical aspect of their work.

Dean Royles: I am sure in some places that will be the experience for some students going through. Whether that is a regular occurrence every time they go on to a placement, I do not know. There are also arrangements in place where people can raise those concerns and say “This was not quite the clinical placement I got.” There are ways to intervene for the local employer, in the current system, through the strategic health authority, about looking at the quality of the clinical placement and where it went wrong, how to correct it and what sort of thing needs to be done to put that right in different places.

Q338 Dr Wollaston: How widespread do you think that is?

Dean Royles: I have no evidence available that says “in X percentage of cases”, but my understanding—from talking to employers and higher education institutions and the work that we have done—is that in the vast majority of cases people are getting a high quality educational input and a good quality clinical placement. That will not be perfect for all the staff all of the time, but it is largely being delivered. There are processes in place to check it out, all the sorts of tests that are in place. I do not have any evidence that says it is wrong in X percentage of cases. I can try and find if any exists, but other people may know.

Sally Taber: Certainly, there is plenty of evidence that with clinical placements in the independent sector the staff do well because we have a different staffing structure and a different layout of the hospitals. We will put in written evidence—and I apologise that we did not—but we have quoted the London Clinic, who have been identified as a good practice example from the Nursing and Midwifery Council. They did 92 student nurse placements last year in oncology and critical care and all were very well evaluated. With the LETBs the opportunity is there to use local independent sector providers for placements, which will be an excellent thing. In the past, when I first started in the independent sector, we identified a model, backed by Lord Hunt, where we paid half for a clinical placement adviser and the Department of Health paid the other half and we then co-ordinated all the clinical placements around England. That worked very well. The opportunities are there because there is plenty of space in the independent sector and good examples of working practice.
Q341 Dr Wollaston: Has there been any independent evaluation of the sort of feedback that you received from nurses having their placements within the private sector compared with their placements within the NHS?

Sally Taber: There has been quite a lot written in the nursing press, the Nursing Standard and the Nursing Times. If you want evidence of that, we could get some evidence.

Q342 Dr Wollaston: Thank you. Turning to voluntary codes of conduct for training standards for healthcare support workers, it is widely argued that statutory regulation is essential to protect patients. What is your view?

Dean Royles: I do not think the case has been well made that regulation is the right answer in terms of healthcare support staff. From my point of view, there is a variety of other things that you can do in terms of standards, right from how we recruit people, the values they have, the training they are given, the qualifications they have, the supervision they receive on the ground and the ongoing training and development. They are all crucial to the way that they deliver high-quality care. If we only looked at regulation as a solution to some of the problems that have come up, we would miss a trick. Making sure we have those right, and appropriate standards, is a good way forward to have a look at that huge workforce that operates in a variety of different settings. One of the other things I would be anxious about in terms of regulation is that it would reduce flexibility. You would have different kinds of healthcare professionals that could do different pieces of work when you want them to be appropriately trained and supervised to be able to do a range of work that exists in the variety of different settings they find themselves in. Often it gets portrayed in the press as an “untrained workforce”. That is offensive for them. They are very well trained. They get access to training, education and qualifications—NVQs, apprenticeships and all those things that go with them. We should not look at the fact that they are not regulated as saying they are not appropriately trained. We can do more in terms of looking at the processes for recruitment, supervision and oversight, and so on.

Q343 Dr Wollaston: How would you recommend we reassure the public that people are competent to carry out the tasks that they are carrying out? Who is ultimately taking responsibility and accountability if they are not properly trained?

Dean Royles: First of all, it would be to say to the public that being regulated does not mean people do not occasionally get it wrong and find themselves on the wrong side of that regulation regime. Regulation is not a solution in itself to stopping poor practice. What we can do is make sure that, with great recruitment and selection in place, we are recruiting the right people, they are appropriately trained when they come in, they are supervised and there is good ward leadership. A culture or an environment where people can raise appropriate concerns will deliver high-quality patient care. Having staff engaged and feeling valued in the work that they do is, to me, more akin to delivering high-quality care than saying, “If we regulate them, it will solve all of those problems.”

Q344 Dr Wollaston: Should those standards be set nationally by Health Education England or should we leave it to LETBs to decide?

Dean Royles: I think, in the current system, we should be getting someone like Skills for Health to have a look at what an appropriate standard may be and how that might work in practice so that people can understand it. Having something national in terms of a standard makes sense, rather than having it locally. That will enable a member of staff to have some sort of transferrable piece of paper to show that they are trained to an appropriate standard and that they have access to the right information when they go into different organisations. Going back to the point about investing in that particular group, making sure they have access to training and development is, of course, key to that.

David Worskett: Can I add to that? It is quite interesting that the public is particularly concerned about some of the failures in compassion and basic care rather than what you might call the higher level of clinical standards. I would very much hope that the LETBs, as they get into their stride, will look at some of the independent sector facilities, because if you look at the Care Quality Commission’s published data, on all of its core measurables—which are a lot to do with dignity, compassion and attention to the patient—the independent sector facilities score very highly. I do not want to get into the field of invidious comparisons—it is in the evidence we gave you anyway—but that is, as Sally Taber was saying earlier, partly because of the different management structures and partly because of the greater time provided to training staff in how to look after patients at that level. There is quite a lot that we have to offer there and which the LETBs should try to take advantage of. The evidence of that training, those management structures and that time paying back in terms of the quality is there in the independent CQC data.

Sally Taber: May I say that IHAS is in four countries, so we work in Scotland and Wales. Both now have employer-led and employee-led standards. One of the major independent hospitals in Scotland piloted them. Ministers in both Scotland and Wales, when they launched the employer-led and the employee-led standards, included the independent sector, as we wanted to mandate ourselves. The standards that are there are excellent. I know Wales took Scotland’s, so I cannot understand why we cannot take them. Until we can get regulations, please let us introduce these. Health Education England could do it straight away. I feel strongly, having been a director of nursing, that any regulation is not going to substitute for somebody like me, the ward manager, going round saying, “You do not feed somebody over the cot sides. This is how you do it.” That is all in these standards. I urge people to take this on board fairly quickly.

Q345 Valerie Vaz: I am going to turn now to the thorny issue of money and how we fund future doctors, nurses and health professionals. I was quite
interested in your views, to start with, on education and training funding and whether it should be ring-fenced. Mr Royles, you specifically said that there should be ring-fencing but certain services or parts of the workforce should not be ring-fenced. Could you explain that in your answer, and then could I hear from the other two, please?

**Dean Royles:** I apologise if I get into lots of acronyms now because this is an area that is full of them. We believe that having the £4.9 billion to £5 billion of education and training money ring-fenced at the national level seems to be an appropriate thing to do to make sure that we invest in that existing workforce in terms of continuous professional development and the future workforce that we are trying to recruit. The idea of having access to some national money, enabling employers to do that, is appropriate. What I do not think is appropriate is the way you start ring-fencing parts of that money to certain professional groups. As someone said in reports in the past, once you do that you get into the situation of those that are training-rich becoming richer and those that are training-poor never getting access to it. The idea of using that money more efficiently and effectively across the whole workforce is appropriate.

When you look at the funding breakdown, something like £2,000 million of that is for medical education, £1,500 million is for nurse and allied health professional education and about £500 million is for bursaries. There are huge amounts of money that are spent each year in those areas. But the way that we treat patients has moved on. If we always start by putting it in the pockets of those professional groups, then we do a disservice to the patient—we let the patient down—in that we do not adapt the way we train people to those changing needs. Once you say that all together. Work that some regions have done, from the support staff. It is very important that we do sure they adapt to that? How can we help staff in more training requirements for the existing staff to make that is appropriate.

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**Dean Royles:** I understand that there is a large amount spent on medical education and training because of the amount of time to get trained and how salaries are paid in terms of junior doctors. I understand there is a big call upon that money, but I do not think we should say that we must always spend exactly the same, year on year, on one particular professional group. It might take a long time to bring people to a qualified point, but most of our staff need training from day one to retirement. They want access to that sort of training. It is a 40-year career for people and we want to give them access to appropriate training so that they can do their job better each day.

**Q347 Valerie Vaz:** Can I hear from the other two about a ring-fenced budget?

**David Worskett:** I have nothing to add to what Dean Royles has said. I am sure that is right.

**Sally Taber:** From the independent sector point of view, we are pleased that the levy seems to be requiring more work on it. We can provide training opportunities, or placement opportunities, in different areas, particularly, as David mentioned, Healthcare at Home. Bupa Home Healthcare do a lot of work in the community. If we could work with the LETBs to make sure there are training opportunities—so that we pay our way that way—that will be much better.

**Q348 Valerie Vaz:** I was going to come on to ask you about what your view was on the levy.

**Sally Taber:** It needs a lot more work on it. Levies take a while to work out. The independent sector pays a levy at the moment for the National Joint Registry and that is all worked out—everybody pays. But there are only certain providers that do joints, so it is easier to work out.

**Q349 Valerie Vaz:** How would you see it in the future? You have a chance now to say how you see it. 

**Sally Taber:** I do not, actually. I see us being almost mandated or encouraged to provide training opportunities so that we contribute financially that way, in that we provide training in the areas the independent sector works in.

**Q350 Valerie Vaz:** You do not want a levy then.

**Sally Taber:** I do not know how it is going to be administered. No, not particularly. I do not.

**David Worskett:** I have not yet addressed the levy because I suspected there might be a separate question on this. Let me now try and deal with it. From the point of view of the independent sector NHS providers, of course we understand the high-level thinking which drives the idea of a levy. Indeed, on the face of it, one can see why someone might come up with that idea. It does seem to us that in order to make it work effectively and to avoid it producing another set of distortions of its own, and there are a lot of distortions in the current system—the issue, if you get a levy system, do you finish up with simply a different set of distortions? I think you probably would—for a start, you would need to have a full understanding of who did what training anyway and what the value was. As I have been trying to explain at various points, there is an awful lot of training that
goes on already which is not valued and costed, and you would need to get to the bottom of all that before you could decide exactly how to structure a levy. Our feeling is that you would probably finish up by creating another more complex scheme which would have as many snags in it as the current one. The current one is not working that badly. If I might be forgiven for saying so, we have seen some examples of inventing new approaches which add additional complexity even when they were not meant to. So there is a danger there.

We rather like, as a better approach, what has emerged from the Government when it published its strategy, which is the very sound principle that anybody who is appropriate to do training should be allowed and used to do it, that the money should follow the trainee and that you run a system which works that way. I am sure the people who belong to the Partners Network would want to participate very fully in that and bear their full burden of the training responsibility.

Q351 Chair: Do you think that would address the widely-held view that the independent sector does not pay its way—that the taxpayer pays for the training of the doctors and health professionals you utilise in your companies and you then make a profit? You are not paying your way or contributing to the training costs of those doctors or health professionals. You are simply utilising their skills, at the end of the day. Do you think that what you have said so far would give reassurance to those people who believe that?

David Worskett: It should give a lot of reassurance, yes, but I also think it is important to look at the way the whole of the health system in this country has been structured for a long time, which has always had health professionals of all categories moving between proportions of work done in their own right. It does not matter whether you are a one-person consultant business who goes and makes money in your own right or whether you go and work for a large hospital group. This is a pluralist system in which people work sometimes as their own business and sometimes for the NHS. Trying to unscramble all of that is a huge challenge.

Q352 Chair: But, overall, the taxpayer and the patient will be getting the benefit of that, not the private company. You are not unscrambling that for me.

David Worskett: I am not quite sure I understand the question.

Q353 Valerie Vaz: Can I put it? You are benefiting from a very long training of professionals. Do you not feel that you should pay something back towards that, given you have the benefit of that expertise?

David Worskett: Ideally, it would be through doing more of the training ourselves and putting the training in.

Q354 Valerie Vaz: But nothing else—no levy back to the public sector.

Sally Taber: Having worked in the independent sector on the shop floor as a director of nursing for 10 years, I only stayed there because I wanted to dispel the myth that we do not do any education. I have raised it with the Chief Nurse and this is why we did the booklet called “Dispelling the Myth”. I think that what you have said is wrong. We do contribute. I have an example of the London Clinic and what they contribute. They do not ask to be paid for that at the moment because that is not the structure. But, as David said, we could let the money follow where the trainee goes, providing the independent sector is prepared to train. There are so many opportunities there. I had somebody purses the whole time that I was director of nursing for 10 years and made sure that they received good training. We evaluated what we were doing. I think you are living with a myth that is not true.

Q355 Valerie Vaz: Okay. Let me put a scenario to you. I have spoken to a doctor, a radiologist, who says she is penalised because she is doing 25 scans as opposed to someone else who is doing 30 scans, and that is how they are measured. But, she says, “I take trainees.” How do you build that into the system? How do you build someone who is prepared to train the next generation and they do not quite come up with the tick box of having done enough scans?

Sally Taber: The independent sector has always taken trainee radiographers as well. I think it is a myth that needs to be dispelled. Perhaps it is our fault that we have not raised our profile enough to say exactly what we do. I am going to leave you this. Please look through it and we will put in evidence as to how much training the organisations actually do.

David Worskett: Specifically on the radiographer point, both the major independent sector diagnostics companies who belong to the Partners Network have very substantive training programmes for radiographers and put a lot of time and money into it. The other point we need to remember is that if you try, in a sense, to almost unravel this complex plural structure you have to look at other costs. As we can only use a consultant in an independent sector hospital to carry out surgery and we cannot use a registrar or an even more junior doctor, that in itself—a training opportunity which we are not allowed to engage in—also means we have a higher cost because a significant proportion of operations in the major NHS—

Q356 Valerie Vaz: You can charge more.

David Worskett: This is when we are doing NHS work. We do not charge more when we are doing NHS work. We do it at NHS tariff. That is quite important. But the cost to us of doing that, given that we can only use a consultant, is, by definition, going to be higher. If we are going to try and even this out—and I absolutely understand where the question comes from—we will get into a terrible morass of interlinked issues, and the system does not work that badly at the moment.

Q357 Valerie Vaz: We are here to find out your views. That is why we are here. Turning, slightly differently, to what is happening to the budget now in terms of education and training, how do you stop that from being raided by the SHAs before 2013?
Dean Royles: You occasionally come across this, that the education and training budget is being raided in some way. I will often say to people, “Just make sure you provide the evidence locally because it would be a scandal if that was the case.” What some people mean is that money that they think was ring-fenced to one particular profession is not spent in that profession but is spent somewhere else. With the cycles of the way that the money is spent, an academic year tends to work September to September and the financial year tends to work April to April; therefore, sometimes, at the end of the financial year, you have not spent all the money that you would have spent in an academic year. I do not think there is any attempt to try and raid the education and training money. On the levy and the funding issue, the principle of the idea that you have money following the training makes sense if you can develop something that is transparent to people and they understand how that makes sense if you can develop something that is an academic year. I do not think there is any attempt to try and raid the education and training money.

On the levy and the funding issue, the principle of the idea that you have money following the training makes sense if you can develop something that is transparent to people and they understand how that works and it is not too bureaucratic. Then you have to look at what the transition period might be because this needs money moving around the system. It is important that we do not destabilise organisations in terms of making rapid changes with regard to what can be large amounts of money.

Q358 Valerie Vaz: Could I, finally, hear your views about what the Future Forum have proposed in terms of a quality premium?

Sally Taber: It is a good idea. We have asked the CQC to consider it for those independent sector organisations that use a quality management system, to note that as a premium. I am not saying to reduce their fees but for it to be noted. I think a quality premium is an excellent way forward.

David Worskett: I agree with that. I would like to see part of it targeted at some of those things that are not looked at as much as they should be, such as the more basic evidence of patient care, compassion and dignity, because we need to build that in a rather harder-edged way.

Dean Royles: Again, I agree in principle. The idea of rewarding high-quality training, given in both an academic and clinical setting, makes sense if we can get a good definition, working with different partners, about what we mean by “quality”—that there is an agreed measurement for that—and then understanding how that might apply in practice and what is the impact on organisations. In principle, it seems to be a very good idea.

Q359 Dr Wollaston: Can I return to an earlier point? Sally has made a good case for the contribution that the private sector can bring to nurse training. However, I am a little concerned. If the contribution to training surgeons is that you offer a discount to less wealthy cosmetic surgery patients in order to have their surgery carried out by registrars, it is rather worrying. Is there a case for saying, in the case of surgeons, that there should be a levy that goes towards providing further training? I realise, to some extent, that your hands are tied.

Sally Taber: Perhaps you did not understand the model. It is a discount to patients, because they are having a senior registrar come across to be taught and because you cannot charge the full rate. It was really very much a model to contribute to training because there is not cosmetic surgery training in the NHS.

Q360 Dr Wollaston: I am sorry, did you say there is not cosmetic surgery training in the NHS for surgeons?

Sally Taber: No. This has been part of the problem—that surgery has been self-taught. Each of the faculties have been asked to look at how they build a cosmetic element into their training. Certainly Dr Andrew Vallance-Owen, who is the chair of our cosmetic surgery group, has written to BAAPS to say, “You have to get on with this.” So, as such, if a patient requires a mastectomy and breast implants, that is built into training, but there is not a proper training model that is out in the public domain. One of the things we have written to say is, “Please, let us work together to get on with it.” I think you are all aware of the conflict that is happening now between the independent sector and the plastic surgeons. It has to stop because we can only tackle this problem if we work together and make sure that people are adequately trained. I feel very strongly about it.

Q361 Dr Wollaston: Or maybe we should reduce the perverse incentives that exist for people to have cosmetic surgery in the first place. I will not get into that.

Sally Taber: The good providers are not—

Q362 David Tredinnick: I had better not run with that one. I could easily come up with 10 questions on that subject, based on our inquiry on breast implant removal last week, but I will not be drawn, Chair. I think, Mr Worskett, you said that often, or sometimes, as private providers you are making a contribution over and above the basic NHS costs in terms of training. I think you said, for example, that a consultant might be used for training. That is an example, is it not, of where you are offering something as private suppliers which benefits the NHS?

David Worskett: Yes, absolutely. We were talking in the last few minutes about the consultants and the doctors, but that proposition is true in spades of other types of training of nurses and others.

Q363 David Tredinnick: This is significantly underestimated and under-publicised.

David Worskett: Yes, it is.

Sally Taber: Our problem is that we under-publicise.

Q364 David Tredinnick: Perhaps we will give you a chance to publicise and finish by asking you to tell us what the London Clinic does do. You have a paper there that you almost talked about.

Sally Taber: Yes. The London Clinic has a clinical development nurse managing student nurses—a contract with City University. They offer placements for physiotherapy, radiology and radiotherapy students. As I said, last year they had 92 student nurses for clinical placements. They have done 30 so far this year. They have an award in critical care and oncology from what they have done with City
University and they have a key mentor forum which looks at good practice and consistency. This has been recognised by the Nursing and Midwifery Council. That is just central London—

Q365 David Tredinnick: How much of that is a free service in terms of the Health Service there?
Sally Taber: It is free to the NHS.

Q366 David Tredinnick: The NHS is getting this from the private sector for nothing, so that we are absolutely clear.
Sally Taber: Yes.

Examination of Witnesses

Witnesses: Dr Tom Dolphin, Chair, Junior Doctors Committee, British Medical Association, Sara Gorton, Senior National Officer, Health Service Group, UNISON, Dr Peter Carter, OBE, General Secretary, Royal College of Nursing, and Obi Amadi, Lead Professional Officer, Unite/Community Practitioners’ and Health Visitors’ Association, gave evidence.

Q367 Chair: Good morning to our second panel. If I might briefly explain, the Chairman is away at a funeral in his constituency. He sends his apologies and the pale reflection will continue to chair the meeting.
As I said to the initial panel, could you briefly tell us about your organisation and also how you would summarise your organisation’s view of the Government’s reform plans in “Developing the Healthcare Workforce” and the update, “From Design to Delivery”? We can wrap those two up into one question because we have a lot of questions to ask you. Thank you. Can we start with Tom?

Dr Dolphin: Good afternoon. I am Tom Dolphin, Chair of the Junior Doctors Committee at the BMA. The BMA, as I am sure you know, is the professional association that represents doctors in the United Kingdom.
In terms of our response to the “From Design to Delivery” report, we are broadly quite happy with the detail in that paper and we are pleased to see, particularly, that the postgraduate deans will continue to have a role in the new system and the deaneey functions will carry on within the LETBs—the Local Education and Training Boards. We are glad that those boards will also have an independent chair. That is quite important and we are very glad to see it.
In terms of remaining concerns, we are concerned a little about the proposal to extend the use of the existing training funds to cover more things, the education for bands 1 to 4 in Agenda for Change and continuing professional development, spreading it to cover those as well. We have concerns about the linked “Shape of Training and Shape of the Workforce” project that is going on at the moment as to training pathways in the future.
Lastly, we want to see more detail about how the LETBs’ duties will be delegated to them. There seemed to be a lot of scope for flexibility as to how they run their governance structures and we would like to see more detail on that.

Sara Gorton: I am Sara Gorton, a Senior National Officer at UNISON. We are the trade union that represents about 450,000 members working in the National Health Service. Broadly, 60% of our membership is from the nursing family but we have also been responding on the education and training issues, particularly from the perspective of our staff working in support services—therapy support, support to nursing, ambulance support workers and technicians. From the start, we have been concerned about the oversight and governance of the proposed system and potential conflicts of interest that could arise. We have been raising issues about the inclusion of the wider workforce and the responsibility of recognising the important role of training the bands 1 to 4 staff. We were pleased to see that that has been recognised to some extent in the “From Design to Delivery” document but we still have concerns about the lack of detail as to structures and accountability, particularly with the LETBs and their function. There need to be firmer duties covering the wider workforce. There is a range of issues about how you achieve buy-in and participation from all of the future providers within a post-Bill system into the education and training plans but also how that translates into active workforce planning and reshaping at the moment. Running through all of them is a general concern about the pace of the changes and the risk this has of creating instability.

Dr Carter: I am Peter Carter from the Royal College of Nursing. The RCN has over 420,000 members. We represent registered nurses, student nurses, healthcare assistants—increasingly so—and a range of other roles such as nursing cadets.
It is worth mentioning that although we have a membership of 420,000, 100,000 of our members do not work in the NHS. Nearly 25% of our members are working elsewhere, in the independent sector, the voluntary sector and so on.
We welcome the Government’s aspirations and, broadly speaking, this is a good way forward. However, similar to what Tom and Sara have said, we have huge concerns about the governance and accountability arrangements. The phrase I would use is that there is a lack of what I would call the hard-wiring. We are not quite sure where the levers are or
My name is Obi Amadi. I am the Lead Professional Officer for Unite the Union working in the health sector. In the health sector, Unite the Union represents 100,000 health sector workers, including a large number of community nurses, health visitors, school nurses and mental health nurses as well as other professions, such as pharmacy.

We are very concerned about the Health and Social Care Bill. Potentially, it could be a disaster in terms of education and training for the workforce because of the fragmentation it would cause, the increased cost and the risk of privatisation of the service. We recognise that the current system is not ideal but we are concerned about the new system being put in place and its ability to function effectively for the workforce.

As to the amendments of the House of Lords, yes, we acknowledge that. But we are still concerned that they do not go far enough in terms of where we feel we need to be to guarantee long-term workforce planning and education for that future workforce.

With regard to HEE and LETBs, it needs a lot more definition. We are concerned about governance, the lack of detail and clarity and also the timing in terms of moving those forward.

Chair: Thank you. I will bring David in on new organisational structures.

Q368 David Tredinnick: It seems as yet unclear what legal status Local Education and Training Boards will have, and it is a point you touched on. Where would you think it should be and how far should the local boards be autonomous from Health Education England? Who would like to take that? We have quite an agenda to get through—a whole range of things—but we are going to stay on organisational structures for a moment before going to general workforce and planning issues. Perhaps we should go down the line, Chair, with your permission.

Dr Dolphin: The BMA is quite supportive of the LETBs having delegated authority from Health Education England. Rather than necessarily being fully independent and autonomous bodies, they should have their authority delegated to them from HEE. That would ensure that they can continue to be held to account for the quality of the training they provide, commissioning, and workforce planning and that sort of thing.

Sara Gorton: We have a concern about the vagueness of the legal status that LETBs seem to have and we would like to see some tightening on that. In particular, we would like to support the idea that Dean Royles was promoting about strong employer involvement. Maybe looking at hosting the LETBs within existing NHS structures could be a way of doing that. We would also like to see a duty on LETBs to promote collaboration from among provider organisations within a local health economy so that you can get the best possible chance of achieving a kind of whole sector buy-in from across quite a wide range of providers.

Dr Carter: We believe that LETBs should be legally established as NHS organisations. Again, there should be clear accountability. We also believe that it would enable more existing NHS staff to be able to go and work in LETBs if they are part of the NHS for their terms and their conditions, otherwise you could end up losing expertise.

Obi Amadi: We are of the opinion that, in terms of the LETBs, there is still some clarity that we need to have, but accountability for them needs to be very strong. There needs to be robust governance. We think that it should remain within the NHS but, also, there are issues to address in terms of conflict of interest.

Q369 David Tredinnick: May I ask Sara Gorton why UNISON is worried about the possibility of a social enterprise model for the local boards in some areas?

Sara Gorton: It is not so much the social enterprise model per se. It is the distancing of the role that the LETBs will have from provider organisations. Maintaining that function, as other people have contributed, will mean, if those people are all part of the NHS, that you do not see a sudden leaching of skills outside the statutory sector. It will also make collaboration across different parts of health provision much easier. One of the panellists earlier talked about end-of-life care. If you are looking at workforce planning for an area like that, which touches on a range of different types of providers, it is much easier to do if it is within part of an existing NHS organisation having a statutory role.

Q370 David Tredinnick: Dr Dolphin, the BMA memo suggests that a wide range of stakeholders should be represented on the local boards. How do you respond to the argument that this could make them cumbersome and effectively stop them from being employer-led?

Dr Dolphin: In the past, as we heard from Dean Royles and others before, there have been problems with employers not having enough voice and input into workforce planning. There certainly needs to be more opportunity for employers to be involved. One of the concerns we had originally was that the LETBs looked like they were going to be too employer-dominated—too heavy on the employer side. The proposition that is currently on the table is a lot better in the balance that it achieves. We are concerned that we have to have all the relevant stakeholders on board, yes. If that includes the private sector providers providing training, they need to be there as well. You have to have the full range there to make sure that you get a valid workforce plan out of the LETB.
Q371 David Tredinnick: You have also suggested that postgraduate deans could be employed by Health Education England and seconded to the local boards. Why do you think that is a good idea?

Dr Dolphin: That would be better in terms of allowing the deans to remain independent with regard to enforcing the quality of training. They would be able to act without fear or favour when they go to the different employers, without having to worry that their employment status might affect their judgment. It also means that, if they are coming from HEE and being sent out to the different LETBs, there will be consistency in how their role is applied across the different LETBs across the country. So you have consistency of standards across the UK.

Q372 Chair: Thank you. I would like to ask a couple of questions to Sara, Peter and Obi. The Chancellor has asked the NHS Pay Review Body to report in July this year on regional and local pay. Could you say what you think the implications are for national workforce planning? Sara, do you want to start?

Sara Gorton: We have huge concerns about the impact of the introduction of a regional pay model, particularly in winding back the clock to reverse the work that has been done and the investment that has been made in the Agenda for Change pay system. In particular, in relation to the education and training issues, we would see the introduction of regional pay militating against a whole joined-up system—the opportunity to share that approach with each type of provider and the different ways that we can respond to patient need and train people for different parts of the care pathways so that we can achieve best system efficiencies. The whole of the workforce in the way that it should. If this goes ahead, we see huge problems emerging in different LETBs across the country. So you have consistency of standards across the UK.

Obi Amadi: I agree with my two colleagues in terms of that change. It is something that we think should definitely be avoided. The work that was done on Agenda for Change and the principle of it is something that we still value and still has currency today. We are already hearing examples of tensions that exist where some organisations have merged, finding that staff with the same or similar roles are being remunerated differently. The organisation’s way forward is immediately to put all staff on reduced pay, rather than evaluating what their job roles are and paying them according to that. If this is something that is introduced and there is local pay, we can very clearly see that there will be tensions in the cost of living in different parts of the country. Sweden is a very good example because it is often held up as an economy that is stable and is, relatively speaking, a wealthy country. But there are significant differences in the cost of living in different parts of Sweden. They tried this and after about eight years, I think it was, it had resulted in such chaos that they basically dispensed with it and went back to the arrangements broadly similar to what we have in the UK. Our advice would be “Do not go there.” It is not worth the candle, so to speak.

Q373 Dr Poulter: I have two practical points on this. First of all, accepting what you have said, we know that there are some hospitals, even within relatively affluent parts of the country, and hospitals in Wales as well, for example—and I know we are dealing with a different healthcare system in Wales, but nevertheless—that have difficulty recruiting. Would you say, notwithstanding you are saying there should be a national pay level, that it is a good idea for some hospitals to financially incentivise people to relocate, to go and work at those hospitals? From a doctor’s point of view, it is difficult for some trusts to recruit junior doctors and consultants, but also—another view—
some nursing and specialist posts are going unfilled. When we talk about workforce redesign, it is difficult to redesign a workforce if people are not going to move to work in a certain location. Would incentivisations to get people to move to those places where there is a problem with recruitment be something you would accept as a good idea potentially?

**Sara Gorton:** Within the Agenda for Change potentially?

**Q374 Dr Poulter:** That is a point of opinion, not a point of fact. I can see that you have accepted what I have just said. It is a political point, not a point of fact. I am sure you would like to get it on the record as a point of fact, but it is not. My experience as a doctor, when I was training in London on rotation, was that some of the hospitals I went round had very good go-slow. Diaries were better before the Nicholson challenge or any of the current healthcare reforms—records of staff recruitment and retention premiums have been applied to attract staff to specific types of environment, forensic and mental health environments, for example. We would say the system already does have the flexibility. What is militating against applying that flexibility at the moment is the efficiency savings.

**Q375 Dr Poulter:** I have one more question before I come on to questions for Dr Dolphin, if that is all right. Earlier on, Dr Carter and Obi Amadi raised the issue that there is a concern with the current healthcare reforms about the potential fragmentation of training. Those are my words, not yours. At the moment, in terms of the nursing workforce and healthcare assistants, a lot of those people are employed not in the NHS, not in the hospital like the one over the river, but in care homes and the care sector as well. A very real problem we currently have—and it has been flagged up in previous evidence—is that we already have a system that is fragmented and does not deal with the training needs of those people who do not work directly for an NHS employer. This is quite a long-standing problem. I was wondering about what you may flag up as solutions, as to how we can address that.

**Dr Carter:** Can I take the liberty of contributing to your previous question before that is lost? You mentioned the issue to do with differentials in terms of some employers being able to recruit staff and some not. I do not want to sound glib, but I do not think regional pay will solve that. What you have to do is look at why it is that hospital X retains their staff and can recruit staff and hospital Y cannot. I visit hospitals and healthcare facilities all over the country and you will often find staff who will drive past a hospital for, maybe, several miles, because they are working for an employer who makes them feel very valued and that sort of thing.

In relation to the recruitment and retention premiums—and, again, I completely agree with Sara—if Agenda for Change is properly implemented, there is sufficient facility in there. However, what I would encourage you, at some stage, to give further thought to is the whole issue to do with key-worker housing. Different Governments in different eras have looked at this. There is an issue to do with—and I will use this as an example, as you would expect me to—newly-qualified nurses earning £23,000. Many of them train in London and want to stay there, but it is totally unrealistic. They often move off to other areas, giving up jobs that they really enjoy, because they simply cannot afford to get on the housing market. Some more imaginative thinking on that would be a sensible way forward.

**Q376 Dr Poulter:** Can we get back to my other question? I do not want to be too time-indulgent. I want to get back into the question about fragmented training because that is quite an important issue. A number of the medical workforce nurses and care assistants are in the care sector and that has been a long-standing issue. I hear the concerns you are raising with the healthcare reform, but this is a very long-standing issue. How can we go forward in a better way to make sure that that workforce—the workforce that is not directly employed by an NHS hospital—receives the training and support that they need to do their job and to adapt their working practices to modern challenges, such as the increasing numbers of people with dementia?
**Dr Carter:** I agree with you. Again, this is something that has been a long-standing problem that has gone on for decades. This is not a new phenomenon, which is why, with the reservations that I expressed, we broadly welcomed this latest initiative. There have been long-standing problems with workforce planning, which I am sure we will get on to later, and—again, I am sure we will come on to it later—variances in the standards and quality of education and training. That is why, broadly, the idea of having a refreshed approach to this seems to us to be the right direction of travel.

**Obi Amadi:** In terms of being able to reduce this fragmentation and the variation that we have, some work needs to be done to understand very clearly the roles that are required—the competencies and the standards of practice that that workforce have to adhere to. If bringing that under the remit of LETB s and others is the way forward, then that is what we need to look at to bring that into better perspective.

**Q377 Dr Poulter:** Dr Dolphin, we heard earlier from the private sector providers that they were quite hopeful that this new initiative would enable them to do a good job already and can do a good job in terms of workforce training. What is the experience of BMA members—I speak as one, but I am obviously asking you—of the involvement of the private sector in training junior doctors? Is there any?

**Dr Dolphin:** There has been some in the past. It is quite limited. Within the independent sector, there have been centre contracts that were mentioned before, some of those centres were set up to receive trainees for very short, focused periods of time and there was some training that took place in them, but it was quite limited in scope for the reasons they have said. The concern that we have with it is this. First of all, if you try and draw them into the training economy, as it were, they may be less willing to provide training because it requires quite a lot of investment of infrastructure and so on in order to set those things up. Medical training, in particular, requires quite a lot of infrastructure, set-up and time for teaching and training and so on. Although it may not be the case in the past, it has certainly been the case in the past that the independent sector has treated training as an externality that they can rely on others providing for them. That may be becoming less so, but it was the case in the past.

The other thing is this. When you have these independent sector providers providing training, because of the way the health economy works, they tend to take cases that are going to be simpler and with a high turnover. That is fine for going there and doing short bursts of getting lots of experience and cases under your belt, but it does not give you exposure to the full breadth of clinical practice and you have quite a limited scope within those training posts. It is quite good for topping up your training but not very good for making sure you have the full coverage of everything you need to be fully accredited for the Royal College.

**Q378 Dr Poulter:** That is very useful. There is a general discussion about the need for consultant-led care or the drive for that. Some of it may be dictated by good practice and some of it by the fact that consultants need to be bodies on the ground with the EWTD. What is your view? Is it a good thing to have 24-hour consultant-led care, or the drive towards that, or is it a bad thing? What impact will it have upon training?

**Dr Dolphin:** The model we are proposing is not so much consultant-present as trained-doctor service. A trained doctor, of course, can include not just consultants, GPs and clinical academics but also staff and associate specialist doctors who are trained for the role that they are performing. Although it is limited in scope, they are trained for that and often have many years of experience and provide excellence in that area.

While training occurs through exposure to patients and delivering patient care, our view is that junior doctors ought to be viewed as being employed primarily to train. There will be service provision arising from that, but their primary focus should be training. It is the current arrangement they have for GP trainees and we think that ought to be the same in hospitals. Having a training service or a consultant-present service—however you want to describe it—would allow that to be achieved.

You mentioned earlier that you were concerned people might be over-supervised. I would disagree with you there and say that, if you are better supervised, you are going to get better training because you have somebody there explaining what it is that you are seeing and correcting mistakes or misapprehensions you may have and so on. You and I have both experienced the stress of being under-supervised at work and not feeling that you are being supported. I think the days of “do not hesitate to cope” have to come to an end.

**Q379 Dr Poulter:** The Future Forum has pressed for the Government to support Sir John Tooke’s recommendations on longer GP training, more flexible career pathways and encouraging greater generalisation in training in primary and secondary care. What is the BMA Junior Doctors Committee’s view on that? Does training of junior doctors need to be longer? Do you need there to be more generalism and, specifically, does GP training need to be bit longer than it is at the moment?

**Dr Dolphin:** The stated rationale for the need for increased GP training is that the long-anticipated—in fact, forever-anticipated—shift to community care means that GPs will need to have a broader range of exposure, and so on. There needs to be a good educational case made for it. They have almost made it, but not quite yet. The Department of Health are very keen to see that whatever extension there is has to be affordable and sustainable. It is quite right that it does have to be—and it should not only be—about providing more service while you are in your training years, which is a concern that we might have, partly because it will involve increasing the number of hospital posts that those GPs rotate through. Not all GP training happens in general practice; a lot of it happens in hospitals as well. They go through exposure to the different specialties they will be
looking after in the community. We are concerned that we do not want to impact too much on the hospital by taking training places away from the specialty training.

If I could mention at this point the “Shape of Training and Shape of the Workforce” work stream, something that the Department of Health are doing at the moment and is related to your question, it is looking at the training pathways and how long the training should be, how it should be structured and where people take breaks in that. We are quite concerned at some of the work that is being done at the moment—some of the suggestions that are coming out—that would introduce more break points in training where people leave training in order to consolidate their experience, i.e. by providing service at a junior level. While that is an interesting career path, we are concerned that there will be paths out of training but not clear paths back into training and we will end up with people being stuck on the outside of training, partly trained and unable to get back in to continue.

We saw a similar thing in the mid-2000s with SHOs being stuck, unable to get on to the next stage of the ladder. There was a growing cohort every year. More people would come in at the back end trying to get on and nobody was getting on to the next stage. That became a very serious situation and we had large numbers of people that were only dealt with through the MMC issues that arose. We are very keen not to see that happen again and we are worried that what is being proposed at the moment might result in that.

Q380 Dr Poulter: Can I clarify specifically the issues about the current training and GP training system, accepting the previous problems? There is now a progression in training in different specialties. The EWTD has come and reduced exposure and time on the wards and service provision, and has compromised training—we have heard in previous evidence—in some hospitals. Do you feel, in view of that, that junior doctors need to train for longer in general practice—have more general training—before they specialise perhaps?

Dr Dolphin: There are several questions within that. We need to distinguish between having more people who are training and having more generalism within hospital specialties, which are two things that get a little confused with some of the questions and in other things—documents—outside. In terms of whether people should be training longer, there is a lot of wasted opportunity for training in hospitals.

We accept that the European Working Time Directive has had a negative impact, particularly on the craft specialties—the surgical specialties. Despite that, we think it is possible to train in a 48-hour week. It can be done, but there has to be more focus on training. At the moment, the service still depends on junior doctors for delivery of care. That has to come first, obviously, but that does not leave much time in a 48-hour week for providing training. If we shifted, as I say, to a trained-doctor service, where the service is not reliant on the junior doctors, they would have a lot more opportunity to get the training they need and to get all the things they need covered within the 48-hour week. In some cases, it may be that the curriculum needs to be extended to cover an extra year, but it is for each individual specialty to make that decision.

Q381 Dr Wollaston: I want to move on to non-medical education. Can I ask Peter Carter a question, please? You have been quoted as saying that some nursing degrees are too geared to classroom learning rather than hands-on training. How much do you feel the blame for poor-quality courses lies with the universities, and how much do you feel it lies with the Nursing and Midwifery Council?

Dr Carter: Thank you for the question. Can I answer that by saying, at the outset, that although I have been quoted in various newspapers as saying things, I want to set the record straight? The vast majority of Britain’s universities that train nurses train them well—or educate them, I should say. I want to be crystal clear about that. Overall, Britain’s training and education of its nurses is something to be very proud of.

However, I have been concerned—albeit with a small number of universities—that we have come across some significant problems. It is a shared problem between the universities and what I would call the service, rather than just the hospital. As you know, nurses are educated and trained in a variety of settings. We have been concerned that, at times, there is a lack of congruence between what the universities and the service are expecting. There has been more joint working. I do not want to trade off where it is working well, and I have already made that point. I have to be concerned with where there are problems. Can I also take the opportunity to dispel what I consider to be one of these myths? It has nothing to do with nurses being educated at degree level. People currently are saying, “The problem with nursing is they all have these degrees.” In actual fact, that is statistically not true. Most nurses currently do not have degrees, so if you are attributing any current perceived difficulties to them being degree-educated, it is not true. All-graduate education comes in next year. Over the course of time, that will be the case, but nursing degrees have been around since 1926.

If I could go on, you get some of the problems and I was sitting in on the previous session—when the placement might be satisfactory but, often, there are too many student nurses in the setting. I will give you a brief example. Back in the autumn I was visiting a very good hospital in the south-east and I was on the paediatric unit. It was everything you could have wished for. I spoke to parents and it was great. I spoke to the ward sister and said, “It all feels too perfect. There must be something that concerns you,” and she said, “Yes, it is the student nurses.” When I asked what the problem was, she said, “The problem is that at any given time I can have up to 12 student nurses, and I do not have the capacity to be able to give them the education and the training that they need to help them with this placement.” That would be an example, we would say, where there is a disconnect between the university and the service. We know that all placements are subject to an annual audit. That is an example where, for whatever reason, it has broken
down. That is no good for the individual nurse and, ultimately, no good for the service. What we say is that, in these small numbers of universities where it is clearly not working, you have to have your act together for all the reasons that we would understand. Does that help to clarify it?

Dr Carter: Often organisations, Governments and employers look to systems to solve problems. In my experience, irrespective of the architecture, it is how well you implement it. If you take the example that I gave of what was clearly a very good hospital—and I also said, “You have to get together and sort this out.” I rarely think that reorganising will solve a problem if the problem is poor implementation of the existing arrangements.

Sara Gorton: In terms of the causes, when Agenda for Change was put in, there was an assumption that the NHS workforce, as a whole, had a properly embedded culture of appraisal and development. We found, to our cost, in many places that was not the case, particularly for those groups of staff who did not have a framework for continuing professional development set as a result of post-registration training and development. There was no reference for those groups of staff, particularly in bands 1 to 4, who are often providing front-line care and have quite a lot of face-to-face time with patients. Suddenly they were presented with what, in the hands of some organisations, became seen as an overly bureaucratic process.

We have now reached a stage where, in 2010, the staff survey found that 77% of staff have had an appraisal. That sounds very good, but when you dig underneath a little, only 34% of those people found that it was meaningful. That means there is still some way to go in order to correct those issues. Lots of work has been done over the last year to make the KSF—the Knowledge and Skills Framework—a lot more pragmatic, and it has increased take-up. We look forward to the staff survey figures in a month’s time to show whether the proof of the pudding follows through into the eating.

In terms of the consequences of lack of appraisal and lack of buy-in, I would return to the issues about the future shape of the workforce. People in the previous session—Dean in particular—were talking about the way of not simply replicating old systems but responding to changing boundaries for provision, and new ways of providing care, particularly as we look to move more care outside of hospitals and into people’s homes. We would miss the opportunity to tap that resource, to buy people into that system and, also, to grow our own. One of the risks that we would see from a more fragmented type of provision—plus moving to an all-graduate nursing profession eventually—is that we would have to put more checks and balances in place to make sure that the workforce still reflects the local community that it serves as well, and that people who start working within the nursing workforce at bands 3 and 4 still have the opportunity to progress through that system via the Skills Escalator.

Dr Carter: We fundamentally disagree. The situation that we find ourselves in right across the UK is that, over the last two decades, the number of healthcare assistants and support workers has grown incrementally year on year. The current situation is this. Within the NHS you now have 300,000 healthcare assistants and you have the same number, broadly speaking, in the non-National Health sector, in care homes and residential homes. I do not want to give you a mixed message, but healthcare assistants are an absolutely integral part of the workforce. We want them, they are valuable and we need them. The issue for us is that, while some employers at one end of the spectrum educate and train them to a very high degree and some do it okay, there are copious examples of employers giving them next to nothing. What basically happens in some of our healthcare settings is that people are employed, they are given a tunic—they look like a nurse—they are put into wards and other healthcare settings and they have to pick it
up as they go along. That is wholly unacceptable. You would not do it in any other walk of life and I am not sure why we think it is acceptable in healthcare. It is particularly so with the elderly. Most of the care in elderly care settings nowadays is provided by healthcare assistants, often under the supervision of a ward which has one registered nurse on it at any given time. Many of these individuals, well motivated as they are, are literally picking it up as they go along. We would say you need mandatory regulation and training. If I may, Chair, I will give you one brief analogy—and I know you are pushed for time—which I have used in another setting. John Lewis, by way of example, is often held up as an exemplar of a very good employer. Yesterday was Monday. Could you imagine John Lewis taking on a shop assistant, giving him a John Lewis tunic and sending him on to the shop floor and saying, “You basically pick it up as you go along”? Of course they do not. What do they do? They take these people in, put them through a proper training course and bring them up to speed so that when people hit the shop floor they know what they are doing. We do not do that with our healthcare assistants. Frankly, it is one of the reasons—only one of the reasons—why the reputation of healthcare in this country is being besmirched. Far too often you have people, however well-intentioned, doing things that they have not had the proper education and training to do. 

Sara Gorton: I very much support that view, that we need mandatory regulation. It is all very well having a code of practice and standards for training and service delivery, but unless that regulation is mandatory it will not be enforceable, it will not have any teeth and the current postcode lottery will continue. I would also add that it needs to happen in a way that is responsive to the different types of environments they are looking at. Maybe the HPC, as a regulator, which currently works well with regulating groups of staff like occupational therapists who work across different types of provision, both in health and social care, could be a good model to look at. 

Obi Amadi: In terms of the whole debate, we need to remember that there is a definition of a profession and regulation regarding that profession that we need to be very clear of when we are looking at healthcare support workers. It is a two-stage thing. There are issues about competencies and standards in education and training as well as regulation. We need to explore regulation as a first stage voluntary registration but also be very clear of when we are looking at healthcare regulation regarding that profession that we need to consider what statutory regulation could do. Before we get there, we need to be very clear about looking at the competencies and standards. 

David Tredinnick: I want to take Dr Carter to task here. I am having problems with this comparison with John Lewis and being on the shop floor. I have been a salesman in my life and been thrown out, told to “Go and sell”, and I have got on with it. I do not think it is a fair comparison to say that on a Monday morning in John Lewis everybody has some training. They may do, but selling on a shop floor is a totally different job from providing medical care. Medical care of all kinds is likely to be more complicated. Or have I completely missed the point? 

Chair: My life might depend on it. 

David Tredinnick: Did I completely miss the point? 

Dr Carter: I think you have completely missed the point. 

Q386 David Tredinnick: In which case, I apologise. Maybe I was distracted. 

Dr Carter: Let me be clear that that is the very point I am making. John Lewis would not dream of doing it but, in many of our healthcare settings, that is what we do. We take people on and put them into wards and other departments. We do not give them any training and, as I said, they pick it up as they go along. That is wholly unacceptable. It is predominantly with elderly care. There is this kind of myth around that, somehow, when you are nursing the elderly, all you need is a bit of common sense. That is not all you need. Again, through the Chair—if you could indulge me for a moment—if you look at the clinical presentation of an infant who is ill and the clinical presentation of an elderly person who is ill, they are, by and large, very much the same. They are often highly dependent and usually unable to communicate their problems. However, you will find on most paediatric units that the ratio of nurses to children is 1:4. On most elderly care units, the ratio of registered nurses to patients is 1:10. There is a huge differential, yet the needs are broadly similar. Elderly people are highly dependent and quite often incapable of helping themselves. We say that to nurse and care for the elderly you need a workforce that has had proper education and training in order for them to carry out a complex range of tasks that are required in terms of wound care, skin care, nutrition, hygiene and catheterising people. I could go on. 

David Tredinnick: So could I, but I had better not. Thank you. 

Q387 Valerie Vaz: I am conscious that everybody is hungry—and that is not just me. I want to turn to money and repeat the questions I asked earlier. Where do you see this budget for education and training? Do you see it ring-fenced? Where do you see it and in which structure would you like to see it? We will go down the line because I have a series of questions. 

Dr Carter: Definitely ring-fenced. I have a lot of time for Dean, whom we heard before, but, despite what people say, the sad fact is that when the health economy is in trouble it is the education and training budgets that are one of the first to be raided. We know, because they tell us, that our members cannot get study leave and the whole continuing professional development is compromised. Why we want the governance and the accountability structures and these organisations set up as legal entities is so that the money is ring-fenced, they produce budgets and we know that the money ends up where it is intended—that is, to develop and educate the workforce. 

Dr Dolphin: I entirely agree. I would also add that, certainly on the medical side, there is very little fat in the budget to trim. I do not know about nursing, but I am sure it is the same there. There is very little fat
that can be trimmed from the budget, so if you start trying to make that money do other things, you end up cutting into quality and training placements.

**Sara Gorton:** We have not seen the impact of the cut in commissioned nursing places this year. There has been a cut of 20% in nursing places from the commissions, but that will not read through until 2014, I think, when those people are trained. It is important that the money is ring-fenced, particularly while the planning stage goes ahead. In terms of contributions that you had before, we would also flag up the need for all parts of the system to be bought in to the same provision so that we are not needlessly replicating within different parts of the future NHS different types of training models but that everybody can, through the LETBs, participate in both the funding arrangements and also the provision of good quality clinical placements and CPD.

I would flag up one more concern around the “any qualified provider model” and how important it is that some sort of mechanism is found for people who are working for any qualified providers. AQP providers have to operate with surplus capacity and we think that this cutting into some of the roles, we think, some types of specialist nursing, for example—they will do so by retaining existing NHS staff or trained staff on zero-hours contracts. Under that model, how do they provide good CPD to people? How do they make sure that those people have access and, also, how do they contribute to providing it? If all of the niche provision for a certain type of cancer care, nursing, for example, in one health economy is provided through AQP, where do people get the experience, where do nurses go to train and how do they provide clinical placements? It is that buy-in of participation that is of concern.

**Q388 Valerie Vaz:** Do you agree?

**Obi Amadi:** I say absolutely yes, in terms of ring-fenced budgets. Currently, in terms of the way that money is allocated to training and education, there are professional groups who either manage to have access or do not. You often hear stories about “There is not any money for training” and we would not want this to become more of an issue. Clearly, in terms of the new NHS architecture, there are going to be many more organisations involved in providing and employing staff. We need to ensure that staff very clearly have access, and that the employers—any qualified providers particularly being an area of concern—ensure that staff do have access to the training and education that they need.

In terms of the AQPs, there will be, potentially, short-term contracts. With that, what is the thing that you can let slip? What is the thing that you do not invest in? It is your workforce. We need that more than ever because there is a corporate responsibility here to provide care for the populations that they are going to serve. That may well be the thing that gets trimmed off.

**Dr Dolphin:** Dean Royles talked earlier about the importance of allowing flexibility within the MPET budget that is there for training of medical and allied health professions. One of the things that worries us slightly about the plans as they are on the table at the moment is that, with this fixed budget that we have—the £5 billion or so—the money would stay the same but it would have to cover a lot more things. As I have said, there is not much fat in the budgets for any of these sectors, so if you are trying to make it do more, you are going to end up with lower quality in what you are doing already.

**Q389 Valerie Vaz:** I want to follow up on that. Where you have a pressure now on more health visitors, how does that fit in? Where is the tension between a broadly flat cash MPET budget and adding more health visitors, the request for which has come from above?

**Obi Amadi:** In terms of the target of increasing the number of health visitors, that needs to be accommodated within the budget. We have looked at workforce over the last 10 or 15 years and it very clearly showed that there was a certain level of investment and increase in other areas of the workforce while this workforce was reduced and constricted. There is now an evidence base that shows very clearly that that needs to be turned around in terms of the effectiveness of that professional group. It should not be done at the expense of the other professions. Very clearly a way needs to be worked through and priorities need to be adjusted and accounted for in terms of the longer-term planning. It is not a short-term fix and it should not have been put in the situation of being a short-term fix.

**Dr Carter:** This is a concern of ours because, again, we welcome the Government’s initiative to recruit 4,500 additional health visitors, which are badly needed, but it is no good if you are not going to fund it. We have been assured that it will be new money coming into the system and that is good news. If you simply raid another pot for it, health visiting will do well but it will be at the expense of something else, which is in no one’s interests.

**Q390 Valerie Vaz:** The Government are consulting on education and training and a levy for that. How would you see that constructed?

**Dr Dolphin:** As was discussed before, it ought to be a levy that is imposed on all the secondary and tertiary care providers, all the ones who use the staff that are trained using this money. They ought to be contributing to it. Obviously, some of them will then get their money back in the form of the trainee coming to them with the funding, but it ought to be centrally done and then managed by Health Education England within its MPET budget.

**Q391 Valerie Vaz:** All the providers should be levied.

**Dr Dolphin:** Yes, because they are using the staff so it is right that they should contribute.

**Dr Carter:** I agree with that, but it is complex. I listened very carefully to what Sally Taber said and I completely agree with her. The thing is, though, that not every establishment has trainees. The baseline should be that everyone should pay a levy and then there should be a mechanism for recouping or reimbursing as appropriate. There are also problems with economies of scale. If you get, say, an owner of
a small residential home with 10 places who might not carry out any training but have two or three nurses that were trained at the NHS, you might disproportionately penalise them. You would have to get proportionality into it, but I think it is right that anyone who owns or is running a private establishment should make a contribution to the fact that many of the staff trained at the public’s expense.

Q392 Valerie Vaz: If the Government move to a tariff-based system, what are the key features that would make that system work?

Dr Dolphin: We should learn from the tariff for service and make sure that we do not end up with a tariff that simply rewards activity. There has to be an element of that it is linked to the quality. Although it is quite difficult to measure that quality in health training, it can be done. There is work going on to find out how best to measure it and it ought be linked to that. The quality premium is a good move towards that.

Dr Carter: The principle is fine. Again, converting that and operationalising it is where it needs far more work. The tariff, as we see in the NHS at the moment, has really struggled. It is not comprehensive and it has been subject to huge criticism. Again, the principle is right. But let us make sure that we get the operation right.

Q393 Valerie Vaz: What do you see as the key features that could make it work?

Dr Carter: One of the issues is that what you have to get is—a bit like I was saying about the nurse education—the component parts of the service talking to each other to be clear about what is the cost, who should be paying for what and drill down and get into the detail. I think, hitherto, that has been a problem.

Sara Gorton: As to the content, people have articulated the complexity in setting that up in terms of relating it to the needs of the workforce, to the quality outcomes framework that has been produced over the last few years and the relationship between the levy and the tariff. It is a very complex set of relationships. I would flag the pace issue and the fact that the tariffs for some of the care pathways within existing elective care have taken a long time to get right and have that right balance. A similar approach needs to be taken here. Doing it without due care and at a dangerously fast pace, as we would see it, is destabilising.

Dr Dolphin: What we have seen from medical student training is that the SIFT funding—Service Increment for Teaching for medical student—comes in two components. There is the placement rate, where the money follows the student from hospital to hospital, and there is also investment in facilities, where the hospital is given money to invest in education centres, simulation suites, seminar rooms and that kind of thing. There needs to be some element of predictability so that hospitals know they can make an investment in those facilities that will be made use of and that they are not wasting their money building an education centre and then all the trainees move to another hospital. That would be a disincentive to being involved in the system.

Q394 Valerie Vaz: I have a few more questions. Did you want to comment on that?

Obi Amadi: I agree particularly with what Sara has said in terms of the complexity of setting out the tariff. As to some of the work that has been done in the past, there was almost a tendency to look at what was the lowest, cheapest common denominator and charge for that. It is much more complex if you want to have quality in that service.

Q395 Valerie Vaz: Could I stay with you for a minute, Obi? You mentioned in your memorandum that there is an impact on public health. Could you explain that a little?

Obi Amadi: In terms of moving things forward, there is a lack of clarity in some areas regarding different public health services and public health practitioners. More work needs to be done in terms of clarifying that role, where people sit and consider the future role of Public Health England, which has not been, we think, fully explored and clarified.

Q396 Valerie Vaz: Should they be part of the LETBs?

Obi Amadi: Yes, they should.

Q397 Valerie Vaz: I will let you go shortly, but I have a final question to Dr Dolphin. The new higher education funding regime may have an impact on future medical students. Professor Les Ebdon says that some of the doctors coming through do not want to go and work in working-class communities. How do you see the new higher education funding affecting our future doctors?

Dr Dolphin: When the tuition fees were put up from £3,000 to £9,000 there was not much consideration given to how that would affect students on the longer courses, like medicine and dentistry and so on. It was also done before they had had time to assess how the £3,000 tuition fees had affected things because the people had not yet worked their way through the system. So we still do not know what impact it is going to have.

There is no doubt that these huge debts put people off from applying to medical school, particularly people in lower socio-economic groups. The debt aversion there is a big deterrent. The Department of Health did a study three years ago that found—and this is the quote—that there was “consensus in research that debt aversion for non-traditional students is a factor that deters entry into higher education.” There is no doubt about it. Obviously, if you have a course like medicine or dentistry where you end up with huge debts— and we are projecting £70,000 for people with the £9,000 fees—they are going to be more averse to entering those courses than they are to the shorter courses. We have seen that already. When you look at the socio-economic groups of the people applying through UCAS, the university system, 14% of them applying for medicine are from the lower socio-economic groups. When you look at all the courses as a whole it is more like 29% or 30%, so almost half the number of people in the lower socio-economic groups are applying for medicine. There is a clear difference there.
Q398 Chair: We are due to finish at 1.00. Thank you, Valerie. I wonder if I can seek the indulgence of my colleagues very quickly, and could wrap up by asking two very short questions, one of Obi? Unite raises questions about the impact on long-term workforce planning of “any qualified provider” and, of course, the diversity that is envisaged. Could you quickly explain what your concerns are and what evidence there is? Also, very quickly, the first panel talked about the private sector scoring very highly in terms of quality and staffing ratios and that their training is something the NHS could well copy. What is your view and are there lessons to be learned from that? 

Obi Amadi: In terms of the “any qualified provider” there need to be some very clear legal duties that they have in order to participate fully in terms of the education and training of the workforce. In terms of the AQP's bidding and getting contracts, they are likely to be undercutting others. One of the things that will have an impact and allow them to be able to do that is reducing the money and the commitment for training for the workforce. We have already had some examples come to us of our members working in Social Enterprise where there is training that is available and freely given—freely at the point of contact—for NHS staff. Staff that are working in Social Enterprise now want to access that, but, because they are no longer officially part of the NHS, the requirement from their employers is to buy that service, and they are refusing to. So, already, we are getting indications of where staff will be disadvantaged in not having access to the training that they need, which is a core part of the role that they play and the service that they give.

Q399 Chair: What about the question of quality staffing ratios, and training in the private sector?

Dr Carter: As in any aspect of life, it is rarely uniformly good or bad. There are some terrific examples of high quality, excellent care in the private sector but I also think it is the same in the NHS. Equally, from time to time, we come across things in the private sector that are as shameful as what we have found sometimes in the NHS. The most notorious in recent times has been the private hospital, Winterbourne View, which is hardly an example of best practice. While, as I say, there is a lot that is very good, there are also concerns. I always fall back on the statistic that 92% of patients who currently use the NHS express high degrees of satisfaction. That is a noteworthy statistic.

Q400 Chair: Thank you. Are there any further points?

Sara Gorton: The amount of provision that is in the private sector at the moment and the lack of variety in terms of the whole workforce means that it is very difficult to compare the two. Rather than get distracted by what works within a particular pocket of provision—because we do not have private sector organisations training paramedics, specialist therapists or nurses in the same way as we do across the healthcare system—the best use of the resources that we have are going to come from the LETBs and HEE working with what we know works and the systems that have already drawn success, rather than looking to replicate models that work in completely different environments.

Dr Dolphin: If patients are going to be moving in increasing numbers to the independent sector, you are going to have to move the people who are going to learn from them, to follow them into the private sector—hospitals as well. But if that happens, we are going to have to make sure those hospitals are regulated to the high standards that we have come to expect from the NHS, which is an obvious point.

Chair: Thank you. Can I thank the panel for your answers and my colleagues for their patience?
Tuesday 6 March 2012

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Dr Daniel Poulter
Mr Virendra Sharma

Dr Patricia Hamilton CBE
Mr Burns:

Mr Burns: The overarching one is to make the workforce more accountable and more relevant to the changes within the treatment patterns and the innovation within the NHS. That is the overarching thing. Where there are specific crucial areas, there does need to be far greater accountability—and I assume this will arise in future questioning—through the LETBs. There is greater ownership of education and training where local employers, the local health economy, universities and local authorities can all come together to identify and plan the workforce they need, ensuring that they get the training that is required for them to be a highly qualified, first-rate workforce. If you take the funding arrangements—again, an area you may wish, during the course of today, to come back to—there needs to be far greater transparency. At the moment, we are basing the funding on historic criteria and we need it to be more flexible and more adaptable to local conditions and local LETB areas. That is a significant change.

Examination of Witnesses

Witnesses: Rt Hon Simon Burns MP, Minister of State for Health, Jamie Rentoul, Director of Workforce Development, Department of Health, and Dr Patricia Hamilton CBE, Director of Medical Education, Department of Health, gave evidence.

Q401 Chair: Thank you very much for coming to join us, Minister. Could I ask you, first, briefly to introduce your two colleagues so that we know the area of expertise that is there for you and for the Committee?
Mr Burns: Thank you very much, Chair. It is a pleasure to be here this morning. On my right is Jamie Rentoul, one of the officials who is an expert in workforce issues within the NHS. On my left is Dr Patricia Hamilton, who is an expert in education and training.

Q402 Chair: Thank you. I would like to begin at a very general level, if I may. There is a lot of institutional change going on in the whole healthcare system and, of particular concern to us in this inquiry, on education and training. Focusing on education and training, it would help the Committee to understand what the problem is that we are trying to solve. Why is there this desire to change all these arrangements?
Mr Burns: To start with, I should explain that the reform is necessary because they are helping—aiding and abetting—to achieve the Government’s vision as outlined in the Equity and Excellence paper back in late 2010–2011. Services need to become more responsive to the needs of patients and local communities, and the NHS workforce are obviously central to achieving that. We believe that education and training is integral in shaping the values and calibre of the staff and needs to keep pace with technological innovation, developments and opportunities for further improvement of the nation’s health outcomes. We also think it is crucial that accountability and decision making need to sit with employers, who have told us, time and again, that they want greater autonomy and accountability for planning and developing the workforce. Primarily, those are the overriding reasons for the concept of the whole modernisation programme, as has been outlined in the White Paper.

Q403 Chair: If you are looking at the difference between the performance of the system when all these arrangements are in place and the performance of the system prior to 2010, what are the changes that you are looking for? What is the improvement of performance of the management of the education and training system that is the justification for the case? What is the case for change measured against the criteria you have described?

Mr Burns: The case for change measured against the training system that is the justification for the case? Performance of the management of the education and training is integral in shaping the values and training needs to keep pace with technological innovation, developments and opportunities for further improvement of the nation’s health outcomes. We also think it is crucial that accountability and decision making need to sit with employers, who have told us, time and again, that they want greater autonomy and accountability for planning and developing the workforce. Primarily, those are the overriding reasons for the concept of the whole modernisation programme, as has been outlined in the White Paper.
For that to continue to be developed, we will have to see changes in the workforce because there will need to be a more highly skilled, trained workforce working in the community setting rather than in an acute hospital setting, even though there will still be a very important role for acute hospitals. That is where the LETs will have a particularly crucial role because, being locally based and locally focused, they will be able to take decisions on planning and the prerequisite training to ensure that need is properly met.

Jamie Rentoul: If I could add a little to the Minister’s comments, the other point is as to the relationships between Health Education England nationally and the Local Education and Training Boards more locally with the commissioning system. This will mean the National Health Service Commissioning Board being able to set out the strategic service commissioning intentions for the system and having that relationship between it and Health Education England in setting an overall framework for workforce planning, education and training. Similarly, at a local level it will mean having the Local Education and Training Boards talking to and consulting with the clinical commissioning groups such that workforce planning intentions—the education and training plans—reflect those commissioning intentions in terms of the sorts of service changes you are talking about.

Q405 Chair: There is a tension, is there not, between a clear national view, in the form of the NHS Commissioning Board, transmitted to Health Education England, and the bottom-up approach which may not get or attach the same priority to that service change agenda?

Jamie Rentoul: Yes. Again, part of the change is to strengthen that bottom-up view in the system so it will be a less top-down system than the one that currently exists. Inevitably in this system, as in any other, there is that national-local tension about a small number of national priorities that people need to pay attention to.

Q406 Chair: It is an interesting question as to whether the bottom-up approach is more or less—small “c”—conservative than the top-down approach. In other words, which is the most effective way of driving change through the system?

Mr Burns: There is a combination, but what is crucial about the local approach through the LETs is that these are local businesses—local NHS and universities—and because they are in a far better position to be able to identify local need, they will be the driving force. That will be the stimulus within local communities for meeting workforce numbers and requirements for the provision of healthcare there.

Q407 Chair: We need to move on, but at the heart of these questions, it seems to me, is whether you achieve the change through a planned approach or whether you do it through the accumulation of small local decisions.

Mr Burns: Yes, but it is a combination of both. Health Education England has an overall view and responsibility to improve, enhance and secure the proper workforce and the quality education which will then—through the stream-down to its committee on the ground, the LETs—be delivered in each local community, fitting local requirements. It is a two-pronged attack—or approach, rather than attack.

Chair: Our plan has lasted 10 minutes and is in ruins already. We will have questions from Sarah, Valerie and then move on to David.

Q408 Dr Wollaston: How local will they be? How many LETBs are we going to have?

Jamie Rentoul: I will start on that one. Having published the guidance document on 10 January, we are now in the process of working with the strategic health authorities and the local employers on their plans for what we have described as shadow Local Education and Training Boards to start from this April. They will have a year in shadow running before going into full operation in April 2013.

Q409 Dr Wollaston: How many will there be?

Jamie Rentoul: We have not yet signed off the proposal. They have not yet formally submitted proposals for the exact geography.

Q410 Dr Wollaston: But it is crucial, is it not? If we are talking about it being local and there only end up being, say, four LETBs, that is not going to be local by most people’s definition. How many would you anticipate?

Jamie Rentoul: When I came to this Committee in October I said something like 10 to 15 as a kind of estimate.

Q411 Dr Wollaston: Is that still your view?

Mr Burns: The estimate is 12 to 16.

Jamie Rentoul: There is quite a lot of active discussion locally on what they see as the right footprint, relationships, scale and leadership capability for them, and so on.

Q412 Dr Wollaston: We are quite far down the line now, are we not, not to know what the structures are? It is very difficult to discuss how local this kind of thing can be if you do not know what size they are going to be.

Jamie Rentoul: A number of places have been operating with committees pulled together—the members of a LETB—already. They are well advanced but there are still some discussions about “Do we want one covering this area or two?”, that sort of thing, and “Does this bit of service want to associate with this area or another?” So they are well advanced but not yet finalised.

Q413 Valerie Vaz: Minister, thank you very much for coming. This is a joke; I flag this up because you do not always laugh at my jokes. You called these LETBs “LEPs” and I am wondering if that is going to be your new Ministry—if there is a Freudian slip there—but they are LETBs, are they not, Local Education and Training Boards?

Mr Burns: Yes, they are Local Education and Training Boards.

Q414 Valerie Vaz: You were calling them “LEPs”, were you not?
Mr Burns: Listen: the initials are so odd that I thought long and hard before coming to you to work out what it was. I thought the easiest thing was to call them what tripped off the tongue easiest because you, being intelligent people, would all know what I was talking about.

Valerie Vaz: Thank you.

Mr Burns: But it is an odd one.

Q415 Valerie Vaz: This whole process is odd. There are so many acronyms that I have had to do a flow chart about everything, the funding—

Mr Burns: From the day I walked into the Department of Health, in May 2010, I found that and I thought, “Why can’t people just talk in plain English rather than acronyms that are meaningless to new people?” But that is not really the question, is it?

Valerie Vaz: So it is not your new Ministry.

Chair: It is beyond the power of this Select Committee to achieve that.

Q416 Valerie Vaz: Can I confirm this, because we have a lot of different intelligence coming out? Do the LETBs exist now? Could you confirm how many exist?

Jamie Rentoul: They do not exist now. There are SHAs establishing essentially, sub-committees of the strategic health authorities—sorry I lapsed into another acronym—at the moment to bring the right people together to form the Local Education and Training Board. What we have said is that from April this year they should have shadow arrangements in place, which will still be sub-committees of the strategic health authority, because the strategic health authority will still have the statutory duties and responsibilities up till the end of March 2013. Then, during the year, as Health Education England gets up and running, it will run an authorisation process with the shadow LETBs to ensure that they are fit for purpose to go in April 2013.

Mr Burns: Would it be helpful on that—

Q417 Valerie Vaz: What will be the governance of these LETBs and would they be on a statutory footing?

Jamie Rentoul: The Local Education and Training Boards will be committees of Health Education England. Health Education England, subject to parliamentary approval, will be set up as a special health authority. The Local Education and Training Boards will be sub-committees of that special health authority with formal schemes of delegation for what they are being asked to do.

Q418 Valerie Vaz: But Health Education England does not exist at present, does it?

Jamie Rentoul: No.

Mr Burns: No.

Q419 Valerie Vaz: You have the LETBs forming and then you are going to get Health Education England coming on afterwards. Is that right? Is that a good way round, do you think?

Jamie Rentoul: Again, we have a transition team for Health Education England at the moment working within the Department of Health and a senior responsible officer for Health Education England transition who was involved in the process of talking to the strategic health authorities and the employers about the shape of Local Education and Training Boards. Then we will have the formal authorisation process once Health Education England is established.

Q420 Valerie Vaz: What if Health Education England does not like what is happening on the ground—they do not like the LETBs? What happens then?

Jamie Rentoul: In terms of the authorisation process, you will have a degree of delegation agreed through that according to the demonstrated capability of the shadow LETB. So if the Local Education and Training Board is not demonstrating it has the right governance, financial controls or partnership arrangements, then it may be that it does not have as much delegated authority as somewhere that is able to demonstrate that.

Q421 Valerie Vaz: Who do you see as members of these LETBs? Do you have a list?

Mr Burns: Yes. What they are going to have, first, is an independent chair. They will derive their board membership from a range of healthcare and public health providers, so that all types of healthcare are included and their views can be considered. What the board will also have is representation from local education providers who will agree in the developing of local public health workforce and research, as well as local government—the new academic health service networks. They will set up advisory arrangements to reflect the breadth of local interest and ensure that the decisions that are taken are reflective of the needs of local communities.

Q422 Valerie Vaz: What about more specifically?

Mr Burns: More specifically?

Jamie Rentoul: What do you mean by “more specifically”?

Q423 Valerie Vaz: Who is actually going to be on them?

Mr Burns: Representatives of the groups I have just told you about.

Q424 Valerie Vaz: Will it be academics? Can you not give me names? You must know if they exist already.

Mr Burns: If you are asking can we give you names of individuals—

Q425 Valerie Vaz: What about groups of organisations, roughly?

Mr Burns: I thought I had done so, with respect. There will be representatives from local education providers.

Q426 Valerie Vaz: Such as?

Jamie Rentoul: Universities.

Mr Burns: Universities and colleges in the area. They will be from local health providers, public health,
we cannot give you individual names at this stage because that is too premature.

Q427 Chair: How many members do you think there will be on a LETB?

Jamie Rentoul: We have not said “You must have X number.”

Q428 Chair: Are we talking about 10 people, a committee or a parliament?

Jamie Rentoul: We are talking about a board that is able to make decisions, therefore not a very large number. A number of them—again, in their current development stage—have a board, which may be 12 to 15, but also a wider partnership council that involves the wider range of stakeholders, to make sure the range of interests is represented.

Q429 Valerie Vaz: Where do you see the deaneries fitting in?

Jamie Rentoul: We see them fitting in as part of the Local Education and Training Board and their operational team.

Q430 Valerie Vaz: Do you consider the system that you are setting up in the future to be sufficiently flexible? For example, if there is a need for midwives in a certain area and someone at the Department of Health—or even the Prime Minister—makes a reference to, “We are going to have 4,000 health visitors”, what happens in terms of accountability when someone in a LETB is crying out saying, “We need many more midwives but you are talking about health visitors”?

Mr Burns: They will have the flexibility to identify how many midwives they need for the area that they cover. When you talk about a political figure—you used the Prime Minister—as saying—

Q431 Valerie Vaz: He has made an announcement, has he not?

Mr Burns: Yes, but he did not pluck a figure out of the air.

Q432 Valerie Vaz: Really.

Mr Burns: Yes, really.

Q433 Valerie Vaz: That becomes committed spending.

Mr Burns: I know it will come as a surprise to you, but no, he did not.

Q434 Valerie Vaz: It becomes committed spending. Maybe you do not understand that. The Treasury will see that as 4,000 health visitors. That is committed.

Mr Burns: Yes.

Q435 Valerie Vaz: Right. So it is committed spending and you do not need it.

Mr Burns: Yes, but he will not have plucked the figure—

Q436 Valerie Vaz: You do not need health visitors. You need midwives.

Mr Burns: No. If we are going to be historic for a minute—if you will allow me—the Prime Minister identified two areas, when we were in opposition, where he strongly believed that there needed to be more staff within the NHS to deliver the services. That is why he gave that commitment.

Q437 Valerie Vaz: “Staff” is different from “health visitors”. That is specific.

Mr Burns: It is playing around with words.

Q438 Valerie Vaz: I am trying to work out the accountability line. Minister. People on the ground—like, for instance, a radiologist—will tell me that we need more consultants and other people will say we have too many consultants. But, clearly, there is a move to consultant presence, so maybe we do need more consultants. I am saying that people on the ground sometimes know differently from us at the top. That goes for me too. I am trying to find out how flexible this new system that you are going to have is.

Mr Burns: The LETBs will be identifying the needs for the local community. Also, an overarching monitoring of the workforce requirements of the NHS will be done partly through the work and advice of the Centre for Workforce Intelligence, which was set up at the back end of 2010. It is there to look at, in so far as one is able, the anticipated workforce requirements of the NHS over the coming decade.

Q439 Valerie Vaz: Can I quickly turn to the Workforce Directorate—this is my last question—and then I promise I will shut up? I want to ask what is happening to the Workforce Directorate. I understand it is going to be disbanded.

Jamie Rentoul: Do you mean the Workforce Directorate in the Department of Health?

Valerie Vaz: Yes.

Jamie Rentoul: In changing its structure, the Department of Health is setting up a new directorate called the Directorate of External Relations, which will include those functions currently in the Workforce Directorate that continue in the Department. There will continue to be a Department policy remit and sponsorship of Health Education England, for example, within the Department, but a decent chunk of what is currently in the Department, in terms of education and training policy, would move across as a function to Health Education England.

Q440 Valerie Vaz: Are the staff still there, have they left or are they going to move across?

Jamie Rentoul: We have not carried out the moves yet. There is a process of Health Education England setting out its structure—the policy for transition of people—such that we then take that forward in terms of the moves of individuals.

Q441 David Tredinnick: Minister, I am not as brave as Valerie to try and make a joke out of acronyms but I thought it was very commendable to do that. I also think that choosing “LETs” was a pretty fair way to determine your thought process on this knotty subject.

Mr Burns: It seemed easier to trip off the tongue.
Q442 David Tredinnick: It seemed to be reasonable. I would like to ask you a few questions on the organisational structures, some of which have already been touched on. The first one is that the Secretary of State—I think clarification would be helpful, continuing the theme we have had—has advocated that “form follows function”. Could you elaborate on that, please?

Jamie Rentoul: In terms of the rationale for the reforms and setting up Health Education England as a dedicated body, it is to give focus and national leadership for workforce planning, education and training, running through into the system. That then gives, at a local level, the employers, local professionals and education providers coming together—again, in a board—a focus on this area. You give it the attention and specialised expertise it needs as a system, if that is what you are getting at.

Q443 David Tredinnick: Health Education England must be “employer-led”. How far is that part of the Government’s plan? I will expand a little on that. The NHS Employers have said in evidence to us that Health Education England must be “employer-led”. How far is that part of the Government’s plan?

Mr Burns: I am not altogether sure that I have the question right. The focus of Health Education England is to provide national leadership and oversight on strategic planning and development of the health and public health workforce. It will allocate the education and training resources to meet those ends. Therefore, to my mind, what is driving Health Education England is that overarching responsibility to ensure that it succeeds in its aim. It will have a number of functions, which I am sure you are familiar with, but to my mind, that is the driving force of HEE. If you could elaborate a bit more on what you mean by workforce-driven—

Q444 David Tredinnick: This came up in evidence that we have been given and I wanted to have your comments on it.

Jamie Rentoul: In terms of documents that the Department has published, we have said that Health Education England needs to carry the confidence of employers, the education sector, professionals, patients, the commissioning system and, indeed, regulators. In terms of setting it up, it needs to be established in a way to do that. This is about bringing together a range of different perspectives and making the system work effectively.

Q445 David Tredinnick: Health Education England is going to be set up as a non-departmental public body. Why is that, please?

Mr Burns: First of all—if it would be helpful to give the time line—it is going to be at arm’s length from Government is that we believe that is the most effective and efficient way to deliver, particularly within the general philosophy of an NHS that is not micromanaged and politically controlled from the top.

Q446 Chair: Can I ask a question about the relationship between HEE and LETBs? There was a discussion document that the Department published last autumn, Education and Training Reform, and there was a stakeholder event on 19 September 2011, which talked about the relationship between HEE and LETBs as being a contractual relationship so that the performance of LETBs would be defined in contracts, with penalties to flow if the LETBs did not perform to contract. Is that still the model that the Department is expecting to implement?

Jamie Rentoul: Not quite. That reflected the original consultation document of December 2010 when we were consulting on the Local Education and Training Boards being autonomous bodies, whether statutory or hosted by another NHS body. Following the consultation and Future Forum exercise, the policy, as set out in the January 2012 document, is that the Local Education and Training Boards will be hosted by Health Education England, as I talked about earlier. In employment terms, you would expect people to be employed by Health Education England, so a contractual relationship is not the right relationship. It will be more of a service level agreement and a formal scheme of delegation.

Q447 Chair: It will not, in truth, be as independent as is implied by a contractual relationship. It will be a subset of HEE, basically—a subsidiary of HEE.

Jamie Rentoul: It will be formal sub-committees of HEE with the level of delegation reflecting the authorisation process, again, with the intention of more delegated, devolved decision making.

Q448 Chair: If the starting point was a contractual relationship, you could argue that the model, as it has emerged, is less delegated, could you not?

Jamie Rentoul: In practice, you are going to be holding the LETBs to account from HEE centre, whether they are hosted by it or they are contractual bodies.

Q449 Chair: Do you envisage a single formula for the relationship between the HEE and the LETBs or is that, in reality, going to be a service level agreement negotiated one by one between the centre and the locality?

Jamie Rentoul: If I have followed your question, there will be some common elements to the agreement between HEE and the Local Education and Training Boards in terms of the outcomes expected for the funding flow that will go to them. The detail will obviously reflect what the local education and training requirements are.

Q450 Chair: Will those be public, transparent documents?
Jamie Rentoul: Yes.

Q451 Chair: But potentially, at least, every one of them different.
Jamie Rentoul: They will have a common framework.
Chair: With a common core—
Jamie Rentoul: A common core.
Chair:—but, potentially, reflecting different—
Mr Burns: In parts, yes.

Q452 Dr Poulter: I want to pick up on a couple of points that have been made. Obviously there is a desire that there will be “any willing provider” in the workplace. If it is the case that contractual arrangements between providers will be over a five-year period or a 10-year period—whatever it may be—and different providers could be coming in to perform different parts of what is currently perhaps one hospital specialty at the moment, how would you envisage that impacting upon the workforce training?

Jamie Rentoul: I will start off on that. In the passage of the current Bill through the Lords, there is an amendment, which the Government accepted, of having a duty on all providers to co-operate in the planning and provision of education and training. That will also be a standard term in the NHS contract. In terms of the Local Education and Training Board having oversight and leverage to make sure that training placements are where they need to be across the providers of healthcare services, you have the mechanisms to make that happen. Clearly, if you have a high volume procedure, such as cataracts, which goes off to a particular provider, you need people to have the experience of providing that service. Therefore you need arrangements to make sure that they get that experience as well as other bits of their wider experience.

Q453 Dr Poulter: Where other providers of services at the moment are being used or have been used by the NHS to reduce waiting times and the like, how would you describe the training arrangements that have been set up, or that have previously been in place, with those providers? Has there been any training taking place alongside the provision of, say, cataract operations provided by another provider to reduce waiting times or, for example, heart bypass operations?

Jamie Rentoul: Are you talking about the current position?

Q454 Dr Poulter: Yes. Historically, the previous Government introduced private sector providers to reduce waiting lists. Was training any part of using those providers? Was that an inherent part of their use?

Jamie Rentoul: I am sure Patricia will add more detail. If you talk to people around the service, it has been pretty patchy. There are some good practice examples and there are some other areas where it has not been properly addressed in the contracting arrangements.

Dr Hamilton: We have good examples where people have taken trainees into the private providers to gain training and experience, but it has been an issue, particularly with these high volume, low risk procedures, that our trainees do not always get enough experience. That is going to be an advantage of having the deans and deanery part of the planning of deployment of the workforce. They can plan the training alongside the planning that is going ahead for the service so that we can make sure the training is spread properly throughout the service provision.

Q455 Dr Poulter: We have heard, as a Committee, that in a number of hospitals—partially due to the EWTD and for other reasons—service provision sometimes has gone ahead of training. If you have the functions of a particular department being performed over multiple sites, inherently that would make service provision more challenging, but it could also make training, in particular, more difficult as well.

Dr Hamilton: That is why it is very important to preserve the function of the deans. We would expect the LETBs to be able to demonstrate that the dean can act independently of the conflicts of interest that may arise, particularly with service and training, in making sure the quality of training is preserved and not sacrificed to service and yet not compromising service either so we get that balance right.

Q456 Dr Poulter: Would you accept that one of the weaknesses of the current system is that, very often, the arrangement between the current deaneries and local hospitals can mean, in some cases, you have a very good accommodation of training but, in other places, service provision is prioritised at the great expense of training? Is that a fair comment?

Dr Hamilton: It is a fair comment and it is one of the things that we are trying to address, to reduce that variability to make sure that we do have high standards of quality.

Q457 Dr Poulter: Where contracts for providers come in—perhaps that are not private sector providers, but otherwise are coming in—are you looking at making sure that, inherently, as part of that contract, trainees are specifically addressed in a holistic way?

Dr Hamilton: Yes. We are building checks and balances into that system so that providers will have to demonstrate they are meeting the educational outcomes framework being drawn up at the present time. Not only do they have to meet the process requirements of the GMC, as before, but there are also metrics and indicators being drawn up whereby they have to demonstrate that they are meeting those provisions. With the increasing transparency of the funding flows, it gives Health Education England and the Local Education and Training Board itself the power of holding the money.

Q458 Dr Poulter: You are confident that making sure training is inherently written in as a part of the new contracts by the providers is a way that could potentially enhance the quality of training available, which was not done in the past, I believe.

Dr Hamilton: Yes. That will be part of the duty to co-operate.
Q459 Dr Wollaston: Can I follow that up with a supplementary to Dr Hamilton? It is not only an issue with postgraduate training but, I understand, for undergraduate training as well. Where certain services have been, if you like, sent out entirely to the private sector in some areas—for example, provision of services for drugs and alcohol—medical students are being denied access to those sites where they are in the private sector. Is that something that you are concerned about and have plans to address?
Dr Hamilton: We would want to address that. We are increasingly trying to make undergraduate and postgraduate training much more of a seamless process. We are looking at, particularly, the final undergraduate year at the moment to make sure that they do get the breadth and depth of experience, not only in content but in context, as you are implying—that they experience different contexts of training as well.

Q460 Dr Wollaston: Do you envisage for the private sector—not just the private sector but perhaps social enterprises—that it would be a duty for them to have to accommodate medical students if that was not available in the usual university and NHS setting?
Dr Hamilton: It would be up to some local determination as to what is suitable. They still have to meet the curricular requirements of the GMC, so I am not sure that the duty to co-operate would absolutely specify exactly what each place has to do. However, if the deans, in conjunction with the higher education institutions, feel it is beneficial to the student or the trainee’s education, then that should be worked through.

Q461 Dr Wollaston: Is it something that you recognise, at the moment, as a potential problem, that students are sometimes being denied access to experience in areas like, for example, drug and alcohol? Do you recognise that as an issue?
Dr Hamilton: I think it is an issue. There are still many things we could improve in education and training, and that is part of the purpose of this work. It is something that we need to look at. They certainly need to be aware of drug and alcohol problems and we do need to be able to give them that experience. It is always difficult getting everything into the curriculum, but having broader representation across a LETB and bringing those people to the table may help to increase the experience that is available to the trainees.

Q462 Chair: Am I right in thinking that one of the amendments in the House of Lords to the Bill is to require a provider of care, in response to an NHS commission, to participate in the training system?
Jamie Rentoul: Yes.
Mr Burns: Yes.

Q463 Chair: There is a gap between legislative commitment and reality, of course, but the requirement is there in any commissioned service to the NHS.
Mr Burns: Yes.

Q464 Rosie Cooper: My comment was going to be in that direction, in essence. I heard from your previous answers that it would be in the contracting process. I was wondering whether foundation trusts may consider some of that information to be commercially sensitive and, therefore, not want to share it. Is there any possibility that that would happen?
Jamie Rentoul: Again, there is a requirement in the current Bill about the provision of information which covers that. There will need to be processes within the Local Education and Training Board that it is able to take in some commercially sensitive information and handle it in terms of the workforce plans. But the requirement on all the providers to provide the information will be there.

Q465 Rosie Cooper: The Centre for Workforce Intelligence suggests that there is a risk of having too many hospital consultants, given the number we have in the pipeline. How do the Government intend to address that?
Mr Burns: There will be changes. As you are aware, in recent years there has been a 60% increase in consultants in the NHS. As we see more treatments and care being carried out in the community rather than in an acute setting, there may well have to be adjustments to the workforce to cater for that, where relevant, and at other levels as well possibly. That is something that would have to be identified locally within the local providers to make sure that there was the right level of staffing for the treatment of patients in whatever setting it is.

Q466 Rosie Cooper: Minister, I understand the Department is already looking at how to handle consultant numbers and redundancies or whatever. Could you be a bit more open about where you are?
Dr Hamilton: I could help to build on that. We have asked the Centre for Workforce Intelligence to look at this because we are predicting a continued increase in the number of consultants. Obviously there are the dangers of oversupply and issues around affordability and so on. Therefore, the centre is looking at planning the whole workforce and at scenarios to cope with that.

Q467 Rosie Cooper: Thank you. You are looking at the provision as of now. The Bill will drive more services into the community. Mike Farrar, for example, is very clear about, and a number of people have talked about, the number of hospitals that will close. Therefore, there will be much less need for consultants. Are you already looking at areas where you think there will be over-provision, where hospitals may close and that kind of thing?
Mr Burns: Can I say—and I will get my colleague to elaborate further on your question—
Rosie Cooper: Well rescued.
Mr Burns:—that part of your question had a statement as if it was fact about hospital closures. It
is local decisions that determine the provision of the local health economy. I am not convinced that we get very far forward with somewhat vague suggestions of hospital closures, with all the associated emotive language.

**Q468 Rosie Cooper:** Where is the massive over-provision of consultants going to come from?

**Mr Burns:** There will be changes in provision. If, as I said earlier, one is going to see more care being appropriately provided in the community, then, yes, local areas will have to look at the layout of the way in which they are providing care at the moment. But that has to be driven at a local level.

**Q469 Rosie Cooper:** In short, hospitals will close. The premise is the same. I understand that if you are driving more services into the community there will be gaps. This morning I have been to an all-party group on health and they were talking about CCGs becoming system managers. If you are going to provide more in one part of the system, there will be less in another. That is likely to be the acute sector. We can already see closing of centres of consultants, but if units close then that will become more acute quite quickly. Where are your plans currently, at the Department of Health, to manage that?

**Mr Burns:** First of all, we are not—to use your words—driving care into the community. What is driving the configuration of the provision of care is: What is the most appropriate care for the patient? It is not a question of driving it, like herding cattle. Secondly, the NHS, as you well know, is constantly evolving. We have seen throughout the history of the NHS, with changing medical practice and changes in medical procedures, wards closing and other wards opening to reflect those changes, that evolution and local needs. That will continue. But it will be—as I get back to my basic point—down to the local health community to determine the best configuration of services to meet the needs of the local community.

**Q470 Rosie Cooper:** That may be that, in your view, the hospital will close.

**Mr Burns:** I am sorry, but I am not going to fall into the trap that you keep pushing me towards. I will not go over the edge.

**Rosie Cooper:** I am quite happy. My point is made. I was not going to go on very much longer.

**Q471 Mr Sharma:** I want to ask that if we are—not driving, but certainly whatever phrase you would like—

**Mr Burns:** The most appropriate care setting for the patient.

**Q472 Mr Sharma:** Will those community-based services be provided by the third sector or do you think there should be a new sector created to provide the services?

**Mr Burns:** They will be provided by a variety of different providers, as they are now. The NHS will provide some of it, as may the voluntary and charitable sector.

**Q473 Mr Sharma:** Is it “may” or “will”?

**Mr Burns:** “May”. I cannot anticipate, in a local community, who is going to be the provider of certain types of care because that is up to the commissioners and the local communities. As you know, now there are a variety of different providers of NHS care within a community as well as within a hospital setting. You will be familiar with the fact that the last Government dramatically increased the input into NHS care by the private sector. We have seen myriad different types of care provided for NHS patients based on the core principle that it is free at the point of use for the patient.

**Q474 Mr Sharma:** Do you not agree that that will lead to closure of some hospitals in some areas?

**Mr Burns:** No. I will get back to my original point because I can see where you are hoping I am going to go and I am determined not to. The fact is—

**Mr Sharma:** But you will see the—

**Mr Burns:** Let me finish. The fact is that the provision of services in a local community—the configuration and the reconfiguration of services in a community—must be driven by the local health economy and the commissioners. That is what has happened in the recent past. That is what will happen in the future. It is local decision making to make sure that the services provided are those that are relevant and needed for the local communities.

**Q475 Rosie Cooper:** What potential do you see to make use of non-career grades—specialty doctor and associate specialist grades? I always had problems with this when I was at the Women’s Hospital. They were much admired by the general staff, but consultants maybe did not rate their colleagues too highly.

**Dr Hamilton:** We recognise that we have not valued this cadre of doctors as we should have done. Increasingly—they have already had their terms and conditions changed—we are looking, for example, at some of the work that we are involved with in emergency medicine, where we know that we need more staff to look after the emergency departments, and we have not been using and valuing them enough. We have been using them but not in a way that values them. As part of the whole new system, locally and nationally, we need to increase their value, job satisfaction, career progression and continuing professional development. There are many ways in which we can use their skills, particularly when we will need to reduce the numbers of trainees. We can very much weave in the skills of the associate and specialty doctors.

**Q476 Rosie Cooper:** When you talked about reducing the number of trainees, how do you see that spanning out over the next 10 years? How many do we have in training now? How many do you see in five, 10 or 15 years?

**Dr Hamilton:** We are working, as I said, with the Centre for Workforce Intelligence on three areas, starting with undergraduates but also with the specialty trainees. The centre produces an annual report that shows that each year we have reduced...
slightly. We have come down from an intake of 7,000 per year to about 6,500. We are not planning to reduce dramatically more but we are trying to direct more trainees into general practice. We have, at the moment, a slight excess of specialists and not enough people in generalist training or in generalist specialities.

Q477 Rosie Cooper: Thank you. I was about to ask you about Sir John Tooke’s recommendations and whether the message to send out is that the career structure within medicine is changing and changing quite dramatically.

Dr Hamilton: Yes, indeed. We are taking forward Sir John’s recommendations, and we have been doing that piecemeal. We have been looking at some of the things that he suggested in terms of having broader-based training and being able to be more flexible about changing from one training programme to another. We are about to start a big review on the shape of postgraduate training in which we are looking at changing the career path to make it more responsive to the needs of the service and patients, but also to the needs of trainees. We have, in fact, developed a broad-based programme which includes paediatrics, psychiatry and general practice so that the trainees in that programme get an experience of those specialties. They can then go into the specialty of their choice without having to go—snakes and ladders—right to the beginning of training, but can carry some competencies with them as they move from one to the other.

Q478 Rosie Cooper: This is my final question. Should all hospitals be involved in training and, if not, how does that impact on the plans you have? How does the jigsaw all start to fit?

Dr Hamilton: I think all hospitals should be involved in training, but that does not mean the traditional “SHO, middle grade, nearly consultant” rota we have had in the past. We know that we are going to have to reduce the numbers of trainees and we know about the European Working Time Directive, but also, to the needs of trainees. We have, in fact, developed a broad-based programme which includes paediatrics, psychiatry and general practice so that the trainees in that programme get an experience of those specialties. They can then go into the specialty of their choice without having to go—snakes and ladders—right to the beginning of training, but can carry some competencies with them as they move from one to the other.

Q479 Rosie Cooper: I am not talking about overall, but in that case would you not need a slightly raised number of consultants available in order for them to be there almost round the clock?

Dr Hamilton: Absolutely.

Q480 Rosie Cooper: How difficult is that?

Dr Hamilton: That is what we are working on at the moment—having a greater consultant presence. Someone already referred to the “consultant present” service. We think it is better for patients to have the consultants nearer the front line and earlier in the patient pathway, but it is also good for training.

Q481 Rosie Cooper: When I was chair of the Liverpool Women’s Hospital, we had a huge consultant presence in the hospital, but that was so difficult to achieve. In the wider sphere, I am sure, and in the different specialties, that will be incredibly difficult.

Dr Hamilton: It will, but we have the—

Rosie Cooper: We should do it.

Dr Hamilton: We have large numbers of trained doctors coming through so we will be able to expand the trained-doctor workforce.

Q482 Rosie Cooper: Will you be able to afford it?

Dr Hamilton: That is what we are looking at. Of course, at the moment, a lot of them are paid to work extremely long hours and you can have more doctors working slightly shorter hours. There are ways you can look at this. You can look at the career structure through a consultant career pathway, which will, of course, be much longer because they get to consultancy earlier and are going to carry on working later. That is what we are asking the centre to model at the moment. As well as a consultant presence for greater periods during the day, we are looking at developing the seven-day week hospital. We will need more consultants to staff that as well. That does cost, but it will mean that patients get some of the routine care on Saturdays and Sundays that they expect during the week.

Q483 Rosie Cooper: That would be easier to provide, more cover in a smaller number of units, would it not?

Dr Hamilton: It would.

Rosie Cooper: I look forward to following that. Thank you.

Q484 Chair: Is there not a tension emerging from the questions of the last quarter of an hour between the following two views? One view, articulated by Sir John Tooke’s report, is that we need more generalist, community-based care provision, training, manpower and workforce planning to reflect that changing model of care. The other view is that articulated by the Minister in response to Rosie Cooper, that this is all about local decision making and there is no national view about how the care model is going to change. I wonder whether there is a clearer national view and if there might be some value in articulating what that view is about the shape of what future care needs to look like. It would enhance both patient and public understanding and professional understanding about what the new service needs to look like five or 10 years hence.

Mr Burns: On the narrow point of the questions from Rosie Cooper on reconfigurations, the thinking behind that question was a little wider than the tensions you highlight in your question. One got the impression that she was desperately tempting me to say something on reconfigurations and hospitals that was—

Rosie Cooper: I was genuinely trying to understand the global view on consultants and where that excess
was coming from. I would not dream of tempting you into telling the truth.

Mr Burns: I think I am a bit older than to be reassured totally by—

Chair: We seek cross-party truth on this Committee—

Mr Burns: Indeed you do, but I am not going to be tempted down any cul-de-sac—

Chair:—in a political minefield—

Mr Burns:—that will come to haunt me.

Chair: Could I tempt you to answer my question?

Mr Burns: Yes, absolutely, on the tension one.

Mr Sharma: Truthfully.

Mr Burns: They always are, sir.

Dr Hamilton: I hope it is a creative tension; all these tensions are. There is a difference between strategy and strategic leadership. Health Education England is set up to provide some of that leadership in developing innovation or encouraging innovation from local LETBs. The way in which that strategy is interpreted and implemented locally is up to the LETBs.

Q485 Chair: I understand that, but is it not part of national leadership to create the space, and indeed the leadership, to encourage local roll-out of that vision at a faster pace than might occur if it was left to local initiative?

Dr Hamilton: I am sure it is, and I would hope that Health Education England would demonstrate its leadership in that way. As you know, we are trying to develop leaders through the Leadership Council to encourage and foster innovation. I would have hoped that one of the purposes of the system is to get that flowing, perhaps both ways, more easily with a shorter distance than it has hitherto.

Chair: Thank you.

Q486 Dr Wollaston: I have a follow-up question to Dr Hamilton. Where should training to be a commissioner come into this? Should that happen at all levels of medical education and postgraduate education or do you envisage it coming in at a particular part of training?

Dr Hamilton: Some understanding of the business of commissioning should come at all levels of training, and I think it should start in undergraduate years. My remit is slightly more for postgraduate and we have put in that all colleges have to include in their curricula some competencies that we have developed with the National Institute for Innovation on leadership and management. That included some understanding about the commissioning process. That is in the core generic curriculum so that everyone has to have a basic understanding of how that process works.

Q487 David Tredinnick: How will the voices of the smaller non-medical professions and the smaller sectors and employers be heard in the new system, please?

Mr Burns: Can I ask what your definition of smaller is?

David Tredinnick: Not as large as the others.

Chair: He is there before you, David.

Q488 David Tredinnick: I am thinking about my long interest in complementary and alternative medicine, in particular. I would like to suggest to you that at a time when we are trying to increase choice in the health service, there is, broadly speaking, an inconsistency in the provision of other services which are outside the mainstream health service that we have been talking about this morning but, nevertheless, assist doctors and provide alternatives for patients who may want to take a different route from the conventional biomedical route.

Mr Burns: Thank you for that. I thought that was what you meant but wanted to clarify so that we were talking from the same hymn sheet. The fact is that, as you know, the Department of Health does not maintain a position on any complementary or alternative treatments. However, decisions on whether to commission and fund complementary and alternative medicine treatments are made when they have satisfied themselves as to safety requirements and clinical cost-effectiveness, as well as the availability of suitably qualified and regulated practitioners. It is a matter decided on a local basis within that framework.

Q489 David Tredinnick: We had Professor Ellis in front of us, the Dean of the Faculty of Health and Social Sciences at Leeds and Chair of the Council of Deans of Health. I recall him saying that one of the problems at the moment is that demand for courses at universities is high, for example, for osteopathy, which is not currently funded. However, there are other disciplines such as dietetics “which is funded by the NHS, but alongside that public health nutrition, which is not, and yet there are public health nutritionists being employed in the NHS. I also have mental health nurses who are employed by the NHS, but I have art psychotherapists and counsellors who are not.” He was suggesting that we have a lot of anomalies here. Would it not be possible for the Department to look at ways of having a more consistent arrangement?

Mr Burns: Do you mean for the provision of courses in our universities?

Q490 David Tredinnick: For the provision. Another point related to this is acupuncture, which is now recommended by NICE guidelines for lower back pain. In another answer we heard that only 2% of the population have access to acupuncture and there are only 13,000 acupuncturists across the country. Now that the Health Professions Council is to regulate herbal practitioners and now that we have a regulation that is related, through Chinese medicine, to acupuncture, would it not be possible to have a policy of the Department to provide a wider scope for these treatments on the National Health Service? There could be significant cost savings there.

Mr Burns: If I can deal with the first point, then I will ask my colleague to come in on your second point. The first point was about the provision of courses at universities. I know from past evidence given to this Committee and your questioning that you were concerned about what has been happening at Westminster university.
David Tredinnick: That is right—Professor Peters. Mr Burns: The straightforward answer is that it has to be up to the academic institutions to determine what courses they are going to put on for students to attend rather than any direct involvement by the NHS. On your second point about this whole area of medicine and the NHS, I will ask Patricia to give you detail.

Dr Hamilton: Certainly as far as training and regulation is concerned, herbal medicine has gone on to a statutory register because of a European law which means that they cannot practise without being part of a register. As to training, our curricula are being increasingly driven by service need and employers. We have not included these alternative and complementary medicines in the curricula at the moment because there has not been the drive for that. They work on a slightly different framework than the more scientific, evidence-based framework from which we compose the rest of the curriculum.

David Tredinnick: Thank you very much. I would like to return later to one of the elements to do with the funding of students, which we will cover in another section.

Q491 Chair: Can I pick up the slightly broader question of the smaller non-medical professions? It is not just about alternative and complementary medicine. It is also about the broader range of non-medical specialisms in healthcare. There is a concern in some of those areas about the degree to which their voices will be heard in a training system that appears to be, to some extent, the son or daughter of MEE. Therefore, there is a danger that it is medically led without adequate voice for the non-medical clinical professions.

Jamie Rentoul: We have been pretty clear in the documents we have produced that this is about a whole workforce view and it is not a medically-led system. It is a multi-professional system we want. If you look at some of the non-medical numbers on nursing and allied health professions, they are very big numbers. The issue, then, is that you have some smaller groups within that and are they going to get enough attention at Local Education and Training Board level? Again, we have said we will be looking to Health Education England to have particular regard to smaller professional groups. In terms of some of those, you will need more of a national view of the numbers. You will not be able to do your workforce planning at a Local Education and Training Board level, but you may have a Local Education and Training Board looking at it on behalf of all the others. That is a clear part of the brief to Health Education England.

Q492 Chair: That is a specific option that will be developed, is it? One LETB would be the lead commissioner, for example, for physiotherapy training.

Jamie Rentoul: That is the one. Whether physiotherapy, where there are still quite significant numbers—

Q493 Chair: Let us say occupational therapy training then.

Jamie Rentoul: They are smaller numbers there. Yes.

Chair: Thank you.

Q494 Dr Poulter: I come back to the current quality of training available to doctors, nurses and other healthcare professions. If you expand the number of training places, there is obviously a finite number of existing professionals who can train them, or if you expand the number of medical schools and the number of medical students, for example, there are only a finite number of hospitals they can do their clinical placements at. Do you have a concern that the quality of the clinical experience in clinical training available to medical students, nursing students and midwives is reduced by these factors, that there is an increasing number of students but the structures have not expanded adequately to train them?

Dr Hamilton: There is concern at the moment that we have too many students and trainees in the system. We are looking, with the other devolved Administrations and with the Higher Education Funding Council for England, at medical student numbers at the moment with a view to thinking that we might need to reduce them. Clearly, we are thinking very carefully before we do that. Certainly, we are very careful to try to match the number of good training places to the numbers of trainees coming through the system. Again, one of the aims of this whole plan is to make sure that we do get the deans and deaneries involved in planning the workforce, the placements and the programmes within and across the LETBs to ensure that everyone who is in the system gets a good quality of training and a good experience of different content and contexts of training.

Q495 Dr Poulter: Turning away from medical training directly, we know there has been, as the Minister said earlier—a political message, and on the ground that is borne out by what the Royal College of Midwives would say—a shortage, for example, of midwives in some units. Yet we know that there are increasing numbers of midwives being trained, for example. We also know that there are increasing numbers of midwives who want to go back to work. There seems to be a disconnect here between the employer and the workforce planning that is going on; if you like, the acknowledgment by Government and by workforce training that there is a service provision gap but, at the coal face, these people are not necessarily being employed once they have been trained. Why do you think that is happening and how can that be addressed?

Mr Burns: Can I start? You have identified one area where there is a need for more staff. The NHS has worked hard in the last year or two to try and reduce the disconnect and increase the numbers to meet the needs. You rightly identify that, for the last two years, there have been significant numbers of people in training. In the current year there is a record number. I think it is 2,507, off the top of my head, or 2,573—one of the two figures. Also, since May 2010, there has been an increase in the total number of midwives of 869. That is a step in the right direction, but there...
is far more that needs to be done to identify the problems that you have highlighted. More has to be done on retention but also on encouraging those who have taken a break—for a variety of reasons—to re-enter the workforce and the profession, to help with building up the numbers to fill any pinch points there might be throughout the NHS. To get some greater detail, I will ask Jamie if he can elaborate on that.

**Jamie Rentoul:** We have also done a bit of work with the strategic health authorities on the future plans that show further growth both in the midwife workforce and the broader maternity team workforce. As the Minister said, near record levels of training numbers are continuing. That is a problem that is well recognised and is being addressed. Indeed, in the new system, we are getting employers closer to this, a closer alignment of the responsibility for then employing the people coming out of it.

**Q496 Dr Poulter:** The thing I am driving at is this. Clearly there has been a commitment to the training, but is there an issue that local employers—local hospital trusts—have to make that commitment to employ those trainees to fill these workforce gaps and make the financial commitment at a local level? Do you feel that is happening as much as you would like it to happen?

**Jamie Rentoul:** Again, as the Minister said, we have had a growth of nearly 900 in the midwifery workforce since the coalition Government came in. Within the processes—at the risk of lapsing into jargon—the integrated planning process that the SHAs currently lead is about drawing together both your view of future demand and activity and the workforce planning, education and training such that you get that commitment to the jobs for people coming out of training places.

**Q497 Dr Poulter:** Is there a place in this to ensure that employers employ those people who are being trained to meet that demand, and that there should be, shall we say, mandatory staffing ratios or levels? Is there a case that that may encourage employers towards doing that, or good practice in what staffing ratios ought to be, both to encourage adequate training of healthcare professionals but also to meet that service provision and make sure that people who have trained because there is a demand actually have somewhere to go and work and meet the demand they trained to meet?

**Jamie Rentoul:** Yes. We would be supportive of your latter position about good practice and people making the right local decisions, professionally informed, rather than setting staff-to-patient or mother ratios that do not take account of different case mixes, how care is provided and the overall shape of the maternity workforce team. It is about people making the right decisions, professionally led, and about the staff they need to deliver good quality outcomes of care.

**Q498 Dr Poulter:** Having some knowledge of maternity, generically it is fair to say that you would expect a labour ward, be it in Bradford, London or in rural Suffolk, which I represent, to have the same standards of patient care. We ought to be saying, and I believe the view at the Department is, that every woman should have a dedicated midwife throughout to delivery. But is it a case of making sure, where we know that is what the policy objective is, and we are training and getting more midwives in place, that those trusts at a local level ensure those things happen? That is where the disconnect appears to be.

**Mr Burns:** Yes.

**Rosie Cooper:** It costs a lot of money as well.

**Q499 Dr Poulter:** It is also a question of local spending priorities and how we make sure that the trusts, the managers and the boards put that workforce to the use they have been trained for and meet those national policy objectives of good care. That is what I am driving it.

**Jamie Rentoul:** Yes. That links into the other bit of the system around CQC as well. As professional regulators have CQC as a regulator saying what the essential standards are as to suitability of staffing, that you have the right numbers of properly trained staff to provide the care. That, again, needs to reflect the good practice that is required.

**Chair:** Hopefully, the commissioner might take an interest in that one day.

**Q500 Rosie Cooper:** Listening to Radio 4, I heard nursing leaders insist that nurses needed degree level training because they had so much patient contact. Yet most people would say that the group that has the most contact with a patient would be healthcare assistants. The Government do not even wish to regulate that group of employees in spite of a strong body of view in favour of it. Can you explain the reasoning behind the fact that you do not want to regulate healthcare assistants?

**Mr Burns:** Yes. We have said that our response should be proportionate. As you are aware, we are setting up a register. We think, at this stage, that is a proportionate response. We will obviously look at it when it has been in place and we have an opportunity to analyse the impact it has had and whether it has been effective or not. Depending on what comes out of that, we will be able to consider the way forward. It may well be that a register is the appropriate way forward rather than the regulation that you are talking about. If that is the case, it is the preferable alternative.

**Q501 Rosie Cooper:** How are you regulating standards of healthcare assistants now and how do you think that a voluntary register, almost, will bring a solution?

**Mr Burns:** At the moment, as you know, both health and social care sectors are subject to numerous tiers of regulation which are there to safeguard the health, safety and welfare of patients and service users. As Jamie said in answer to Dan Poulter’s question, there are also the requirements under CQC. Ultimately, if employers think it is appropriate, they have the use of existing systems, such as referrals to the Independent Safeguarding Authority, if there are problems with individual people.
Q502 Rosie Cooper: But it does not drive up the standard, does it?
Mr Burns: No.

Jamie Rentoul: I have a bit to add to the Minister’s comments. We have commissioned the relevant sector skills council, Skills for Health and Skills for Care, to do a joint piece of work on both code of conduct and minimum training standards for support workers. As part of that, we will need to think about the transparency and information provided on those training standards being met and, therefore, the obligations on employers and Local Education and Training Boards.

Q503 Rosie Cooper: For the person who has the most contact with the patient on a day-to-day level, all we are doing there is minimum standards.
Mr Burns: I would not quite go along with that rather loaded question.

Q504 Rosie Cooper: That would be as I take it. You are setting minimum standards, but that is it. It is not about driving quality. It is not about raising it up. It is not about giving it any value or making it the important role that it really has to be because it has the most contact with the patient during the day.
Mr Burns: Yes, it is an important role and no one is downgrading that role or suggesting otherwise. The question of driving up standards will come, in addition to what Jamie and I have just said, from the whole working ethic of the hospital—the standards and quality that are provided there.

Q505 Rosie Cooper: Mid Staffordshire?
Mr Burns: You are picking an exception—a sad exception—and it is being looked at now, awaiting the publication of the second Francis report and the recommendations he comes out with. But for every Mid Staffordshire—fortunately there are very, very few of them in the NHS—there are also dozens and dozens of hospitals around the country where a dedicated staff, day in and day out, are providing absolutely A1 healthcare for patients. What I am saying is that it is the responsibility of the hospital to be there to drive up standards within that hospital environment. I do not see how, per se, simply throwing regulations at an issue is going to make any difference. Rather than rush in with the full panoply of regulation and all that that entails, we should see what the impact is going to be with a register.

Chair: Could we have one more on this, Rosie, and what the impact is going to be with a register.

Q507 Mr Sharma: Very briefly, if I take it that this is a pilot, how long will you give it to?
Mr Burns: I think it is a year.

Chair: One more, Rosie, because this is on education and training and not regulation of health assistants. Then we will move on to Valerie.

Q508 Rosie Cooper: What is your current view of the professional development, appraisal and training of staff in bands 1 to 4 and what is being done to improve it? Overall, my involvement in the health service has meant that I am very into the boom and bust—too many of them, not enough of them, too many.
Mr Burns: The what? Did you say boom and bust?
Rosie Cooper: Would I say such a thing?
Mr Burns: I thought I heard it.

Q509 Rosie Cooper: We have too many gynaecologists, then not enough, and all that kind of thing. There are two questions there. What are we doing about bands 1 to 4 and the overarching view of how you stop?
Mr Burns:—boom and bust. On the last point—and I will ask Jamie to come in on your first point—the measures that are being taken, first of all, the creation of the Centre for Workforce Intelligence and the work that it does is crucial. The work of HEE—when it is established—through its committees will also help to minimise that. You are never going to eliminate the problem 100% because of the ever-changing needs of the NHS, some of them very rapid, given the time scales for training some of the staff. But with careful, strategic and intelligent over-viewing planning you can help to minimise the problem. Through HEE and the LETBs you can also have a positive impact on seeking to minimise the problem, though you will not be able to eliminate it altogether, for the reasons I have given.

Jamie Rentoul: On bands 1 to 4 we have been clear, again in the remit to Health Education England, reflecting what people told us in consultation, that it should have a whole workforce perspective and not only be about the registered professions. Clearly, quite a lot of the central funding support is about registered professions but, again in response to the consultation, we have said that there will be the ability for the Local Education and Training Boards to use some of that money to support innovation and pump priming of
development for bands 1 to 4 and care practitioners and that sort of thing. It is not going to be something where you say “There is a big new pot of central money that is going to support it”, because it is primarily an employer responsibility, but there is that leadership role for HEE and the Local Education and Training Boards and some flexibility in terms of the resources available to them to support innovation.

Q510 Rosie Cooper: So we will not expect to see too much too soon.

Mr Burns: As you are aware, the current budget for this year is £4.9 billion. It is not ring-fenced. We are working at the moment on the new budget for the next financial year under the changes and, at this stage, I cannot tell you what the figure will be because it is too early vis-à-vis the consultations we are given. What I can tell you in one way—hopefully this is a reassurance—is that we want a far more transparent system so that people can see what the money is delivering. Also, there has been a problem with the existing formula for setting the finances because it is historic, outdated and inflexible. It cannot move properly to meet adapting changes. One is hoping to build into the new system and the new way of calculating and handing over the money a system that has more flexibility to take those factors into account, and certainly more transparency. It will not be ring-fenced, but what will be crucial is that, of course, the education outcomes framework will be published. That will basically be a statement, among other things, of how we expect the money to deliver the training and the education, which one can look at. That will be the pressure point for delivery of what is expected for the money.

Q511 Valerie Vaz: Minister, could I ask what reassurances you can give to people, particularly in the transition period, about the education and training budget, whether it would be protected—ring-fenced—and if perhaps certain specialties could be ring-fenced as well?

Mr Burns: As you are aware, the current budget for this year is £4.9 billion. It is not ring-fenced. We are working at the moment on the new budget for the next financial year under the changes and, at this stage, I cannot tell you what the figure will be because it is too early vis-à-vis the consultations we are given. What I can tell you in one way—hopefully this is a reassurance—is that we want a far more transparent system so that people can see what the money is delivering. Also, there has been a problem with the existing formula for setting the finances because it is historic, outdated and inflexible. It cannot move properly to meet adapting changes. One is hoping to build into the new system and the new way of calculating and handing over the money a system that has more flexibility to take those factors into account, and certainly more transparency. It will not be ring-fenced, but what will be crucial is that, of course, the education outcomes framework will be published. That will basically be a statement, among other things, of how we expect the money to deliver the training and the education, which one can look at. That will be the pressure point for delivery of what is expected for the money.

Q512 Valerie Vaz: As a follow-up, how do you protect the education and training budget from being raided by the SHAs currently while we are going through this transition? That is usually the first one to go, is it not?

Mr Burns: Yes, but it has not been, thank God. To me it is always a false economy that you raid education and training, not only in the NHS but across the world. When it comes to a time of economic hardship, or whatever, to cut back on the investment for the future is a false economy.

Q513 Valerie Vaz: Perhaps Dr Hamilton could help us as to how you protect it in the transition.

Dr Hamilton: In the future, Health Education England will be holding the LETBs to account for the use of the money to make sure that it is being used for the purpose for which it is intended. In terms of transition, Jamie might be better than me to answer.

Jamie Rentoul: At the moment, we have a service level agreement with each of the SHAs for their MPET money with some key performance indicators and what they have to deliver for it. We monitor and track progress. For the 2012–13 financial year, we will continue to do that to protect the money. As the Minister said, the allocations for 2013–14 are currently being worked on and that reflects the evidence base about the pressures that we need to meet.

Q514 Chair: The SHAs have form, do they not, for raiding this budget?

Jamie Rentoul: People talk about that a lot. When you push for the evidence, it—

Q515 Chair: I thought there was some evidence from the predecessor Committee in—I think I am right in saying—2005, which was acknowledged by the Government at the time.

Jamie Rentoul: Yes, but I am saying in recent years there has been less of it.

Mr Burns: Life has moved on.

Q516 Valerie Vaz: Can I confirm what plans you have for getting rid of MPET, SIFT and MADEL and all those horrible acronyms that we cannot get used to?

Mr Burns: We struggle with them.

Jamie Rentoul: Yes, there are lots of acronyms. As to the multi-professional education and training moneys, essentially there are three ways we are using it. One is on support to nurses, midwives and allied health professionals for their tuition costs at universities. That is a benchmark price and, again, is set as a tariff, essentially. Another is through the NHS bursary support, which is for living cost support for healthcare students. The other bit is the clinical placement support, particularly service increment for teaching and the medical and dental education levy. It is that third bit for which we are saying we are going to develop a tariff such that it is fair across the country and, in due course, funding fairly follows the trainee student in their clinical placement. The current system was built up over time and there are different amounts of money depending on where you are in the country, which is not equitable. We recognise that there is a complex transition in moving from where we are now to where we want to get to. It is going to take some time and we are working with the strategic health authorities over the next few months to develop transition plans for moving to a fair tariff for that bit of the multi-professional education and training moneys.

Q517 Valerie Vaz: MPET, as we know it, will not exist any more.

Jamie Rentoul: Once you have an acronym, it is quite hard to get rid of, isn’t it? There will be tariff support to clinical placements. Whether Health Education
England chooses to call it something different, because it is different, I do not know. That might be quite a good idea, but the service tends to keep acronyms.

Q518 Chair: Do the Government intend to accept the recommendation of the Future Forum that there should be a quality premium built into that tariff system?

Jamie Rentoul: Yes. We are supportive of that.

Q519 Chair: Have you worked out how it can be done?

Jamie Rentoul: It is work in progress.

Mr Burns: It is still being worked on.

Jamie Rentoul: Again, it links to the education outcomes framework the Minister talked about, of having a better set of metrics and indicators that support being able to benchmark performance. In this area we are behind. I think, service quality in terms of the indicators that support a view of quality of education outcomes. You do that—and there have been various bits of work in the last few years on commissioning for education quality and metrics—to try to be able to say, for some of those, “Actually, you will have something which is a little bit like commissioning for quality improvement”—if that is what CQUIN stands for—on the education side, but you have a premium for higher quality delivery.

Q520 Chair: Do you intend to involve the GMC and other professional regulators in that process? They have a statutory responsibility in this field that is always notable by its absence in these conversations.

Jamie Rentoul: We have talked a bit about the GMC today.

Q521 Chair: I think it has been mentioned once so far.

Jamie Rentoul: We are talking to all the professional regulators, and indeed to the higher education stakeholders as well, about information flows in the system. There is a big review going on in higher education about health information because there are quite a lot of information requirements on universities. It is about getting a good set of information. The regulators have quite a lot of it and some of that could be used—GMC trainee doctor survey outcomes, for example—as part of what you are looking to reward.

Q522 Chair: It is particularly relevant, is it not, if you are looking into assessment of quality? Presumably that is exactly what the GMC is interested in when it approves training schemes.

Jamie Rentoul: Yes, absolutely.

Q523 Dr Wollaston: I want to go back to a point we touched on earlier, the role of the independent sector. Where are you with the possibility of the independent sector contributing to the new levies, and what options are under consideration in that regard?

Mr Burns: There is not a lot I can tell you at the moment, for reasons that will become apparent. There is consideration of a possible levy, but no decisions have been taken. We are still looking at it prior to evaluating the pros and cons.

Q524 Dr Wollaston: Are you able to elaborate on the options you are considering?

Jamie Rentoul: There is not a great deal to add to what the Minister has said. We have a lot of work to do with stakeholders.

Mr Burns: In the broadest concept, what has been thought of is a levy of a type. There is a considerable amount of work that needs to be done before working out whether that is the best way forward and, if it is the best way forward, how it can be fine-tuned if need be. It is too soon to be able to give you anything meaningful that would move the thing forward.

Q525 Dr Wollaston: Are you at least able to say whether there will be some kind of levy on the private sector?

Mr Burns: No. Part of the consideration is whether a levy is the best way forward or not.

Q526 Dr Wollaston: You are considering the difference between, say, a levy and mandating that they have to take a formal role in training in the areas we touched on, particularly where there is no possibility of receiving—

Mr Burns: Yes. Regardless, there will be requirements through the contracts to take part in it. As to whether there will be an actual levy decided upon at the end of the day, it is too soon to reach a decision because of the ongoing work that is being carried out.

Q527 Dr Wollaston: It is very important because it matters to people outside this place. I understand the most recent figures are that 66% of NHS consultants undertake some work in the private sector, and I would be grateful for your thoughts about whether that is the most up-to-date figure, but there is a sense, if they do, as to whether we are providing a subsidy to the private sector and there should be a formal recognition of the role that the NHS has had in training those consultants.

Dr Hamilton: During consultation there was a lot of support for that concept. However, it was also pointed out in the consultation that an unintended consequence might be that it would be detrimental to the voluntary or third sector, such as Macmillan nurses, who also provide services. If the levy were to apply to them, that would seem to be unfortunate. That is one of the reasons why it has gone back to be thought about in more detail.

Q528 Dr Wollaston: Is there not any mechanism for distinguishing between the voluntary and private sectors?

Dr Hamilton: That is one of the issues being looked at.

Mr Burns: That is one of the things we are looking at.

Q529 Dr Wollaston: Incidentally, are you able to say whether 66% is the most up-to-date figure of NHS consultants undertaking some private work?
Dr Hamilton: I am not able to say. I do not know is the answer to that.

Mr Burns: We do not know.

Q530 Chair: In terms of when that decision will be made, can you give us any idea about time scale, and also who makes it? Is it a matter for HEE or for the Government?

Jamie Rentoul: We have said we would need to consult formally, if we were going to move to a levy, because of the effect on businesses and so on. We think it is for the Government to develop the policy.

Q531 Chair: It would be a decision that the Department would reserve to Ministers rather than delegate to HEE.

Jamie Rentoul: Yes.

Mr Burns: Yes.

Q532 Rosie Cooper: Minister, the Deputy Chief Nursing Officer for England recently acknowledged that despite Government rhetoric about the need to transfer care from acute settings to community settings, the number of district nurses has dropped below 10,000. He admitted that it was a weakness and could not explain why it had such a priority focus, other than that the Prime Minister had pledged to recruit 4,200 health visitors. I understand the Prime Minister’s wish to have more health visitors, but could you explain what the policy is behind the situation we find ourselves in, how we have arrived here and what you intend to do to resolve the issue around the reducing number of district nurses, which will be fundamental to the future as you see it?

Mr Burns: Did you say district nurses or health visitors?

Q533 Rosie Cooper: You have reduced the number of district nurses while the Prime Minister wishes to increase the number of health visitors.

Mr Burns: Yes. The ambition is for 4,200 more health visitors over the lifetime of this Parliament.

Q534 Rosie Cooper: While district nurses are being reduced as we go. Would you like to tell us, as you see it, the difference between a district nurse and a health visitor?

Mr Burns: I do not actually have the—

Q535 Rosie Cooper: Perhaps we will start at the bottom and work up.

Mr Burns: I do not have the figures in front of me on the number of district nurses.

Q536 Rosie Cooper: The Nursing Times.

Mr Burns: Ah, that important source of information. Rosie Cooper: It does not really matter. The facts are—

Mr Burns: It would be quite nice to ascertain whether it is factually correct. I am not disputing the Nursing Times, but as I do not have the figures in front of me of the number of district nurses, and I would be very grateful if any of my colleagues do—

Q537 Chair: Would you like to write to the Committee with those?

Mr Burns: Thank you, Chair. That is very helpful. I can tell you what we are doing about health visitors, but on the specific point of the numbers of district nurses I will come clean.

Q538 Rosie Cooper: Yes, the Prime Minister has said he is having 4,200 more but the rest can go hang.

Mr Burns: I do not think the Prime Minister said that, certainly. It is not his style.

Rosie Cooper: No. It is mine, though.

Q539 Chair: There is a serious question that is raised in the Nursing Times—the suggestion that there has been a depletion in the number of community district nurses and that that is attributable, at least in part, to increasing the numbers of health visitors. It would be interesting to the Committee to know whether the Department accepts that is true and, if it is true, whether it is desirable and whether something needs to be done about it.

Mr Burns: I am grateful. I can give a guarantee to the Committee that we will write to you, Chairman, and to all your colleagues.

Chair: Thank you very much.

Q540 Rosie Cooper: Could I almost go back to basics? Last week’s Delivering Dignity report said “Student nurses, medical students and other trainee health professionals need to have dignity instilled into the way they think and act from their first day”. Why is that not happening in every case, every day now and how will these reforms fix that problem? If you are out there talking to members of the public, or reading any newspaper, this is core to how you will be treated if you are in hospital. We have to get that right.

Mr Burns: I could not agree with you more. It is crucial. There has to be kindness, compassion, care and making the right amount of time available to deal with the individual to help them at what is an extremely vulnerable and difficult time in their life. Everyone in this room would share that and is saddened, and in some instances appalled, at the experiences of what has been going on in some of our hospitals—too many of our hospitals—in recent years. That is why there is a huge challenge for the Commission on improving dignity in care.

Q541 Rosie Cooper: Minister, the question is how will your reforms fix it?

Mr Burns: There is a two-pronged approach. First of all, if I could carry on about the Commission doing that sort of work, that is one way of moving forward: getting back to basics with nursing and making sure nurses have the time to be able to interact with patients—that the glass of water or the food is near to them, that the patient is able to eat—and provide all that sort of care. That is why we are waiting to see how the Commission will translate into action what needs to be done from their point of view. Secondly, many of the solutions lie within the NHS, the local NHS, itself. Sharing best practice, bringing people together and putting in place the right systems will help to minimise the problem that you highlight.
As to the point on the other side of your question—“How will the reforms make a difference?”—you may not agree, but my view is this. One of the core purposes of the reforms is to put the patient at the centre of care and because GPs—who have the best knowledge and understanding of their patients—will be commissioning the vast majority of the care, they will be concerned that their patients are getting the right quality of care from the providers they are commissioning. They will be active watchdogs on behalf of their patients to make sure that what they are commissioning is the appropriate care but also of the highest quality. Those things, together, a more focused approach in making sure that it is the patients’ needs and the outcomes of treatments for patients that are at the core, will help.

**Jamie Rentoul:** Can I add something on the education and training changes giving employers clearer responsibility and ownership? A lot of this—certainly in terms of who you are recruiting, getting the right training placement support and getting the right first-year experience—is about the partnership between the employer and the university. There are lots of really good examples where that works well now, but it is not working well everywhere. Through this, it is getting those relationships stronger and holding people to account.

**Q542 Rosie Cooper:** Thank you. I do agree with that, but the question is how it translates to the front line. I absolutely agree with the Minister that the patient is at the core of everything we deliver. If we did not have the patient and their best interests at heart, what is the point of doing anything else?

You made comments about making time available for the patient—making sure all the communications are right and all those associated things—and I totally agree with that. But I wonder whether you see a basic contradiction between asking for a lot more value added, a lot more input from nurses and nursing, while, at the same time, as a consequence of the reforms—even before we have reached 2013 and really implementing them—we are already down-banding nurses and reducing the number of nurses. Do you not think that those kinds of things will make it even more difficult to achieve the quality you are talking about?

**Mr Burns:** No. If one takes the issue of down-banding, which I know is a subject that is very close to your heart, it is not a down-banding of the individual nurse. It is a down-banding of the position that an individual nurse may hold. There is an inevitability in an evolutionary health service that where you are seeing changes in the way in which care is provided, one of the offsets is that you will see changes in the nursing requirements, in particular, where you have to make changes. In one area you may change and down-band—to use your phrase—the position that the nurse holds because of the changes in the provision of care. But, of course, the nurse herself may wish to then move to another job within the nursing role of the provider that is in a position that is not being down-banded for the reasons I have given.

**Rosie Cooper:** Minister, perhaps it would be useful to look at the number of roles—and they are senior roles—that are down-banded and how they affect different hospitals. The reality of what is happening is that most hospitals are reducing some of the banding of senior nurses, and, where they may have two or three band 7s, or whatever, they are reducing them to one. That means the morale drops, their pay drops and the nurse is expected to do more for less. The nurse will care about the patient but the truth is that the morale and how the individual feels will be affected by this. Then we are saying to them, “We need to make sure that everything you do”—which, absolutely, it has to be—“is top quality, but we expect more of you.” There is a contradiction there and I will not go any further with that. But we need to care about how these kinds of decisions impact on the very people we depend on.

**Chair:** That is a statement rather than a question.

**Rosie Cooper:** Yes.

**Mr Burns:** I took that as a statement.

**Q543 David Tredinnick:** We are nearing the end, but I have a few questions on inter-professional issues, higher education issues and, finally, the Department’s attitude to self-care. The Government wants a more multi-professional approach to healthcare education and training. We accept that. Can you describe what this will look like in practice, please? What will a more multi-professional approach to healthcare and education and training look like?

**Jamie Rentoul:** I will start on that. It is about taking a whole workforce view when you are thinking about workforce planning so it is not all done in little silos of different professional groups but you look across the whole and the right skill mix. Also, it is about—I think this might be borrowing one of Patricia’s phrases—building expert teams, not teams of experts, so that people in different professional roles understand what the other professions bring to it and they work well together, effectively. It is not about everyone being trained all the time together—because you need your deep professional training—but it is about making the linkages between the professional groups where it is sensible to do so. Do you want to add anything, Patricia?

**Dr Hamilton:** No. I hope we have already started that, but we have been very clear throughout the document that one of the aims of the new system is to get people out of silos and working much more inter-professionally.

**Q544 David Tredinnick:** Following on from that, within this new system postgraduate deaneries will become “truly multi professional”. That is from one of your documents. How will that happen, please?

**Dr Hamilton:** The function of the postgraduate deanship has to be retained. As to the role of the postgraduate medical dean, we absolutely need to keep those. Up to now they have been working only in medicine. Bringing them into the LETB gives the opportunity to broaden and to share some functions. For example, there will be opportunities to share back-office and other functions that they have in common and also, when planning the team, to share...
the competencies that can be shared. It does not necessarily mean that nurses and doctors will train together, but they will put into practice what they have learned in a much more constructive way than we have done previously. That will be overseen by the leaders of education and quality within the LETB.

Q545 David Tredinnick: Fair enough. Perhaps we will go on to the higher education issues. What effect will the new university fees cap have on the NHS training budget, given that the NHS pays tuition fees for non-medical students and contributes towards those paid by medical and dental undergraduates?

Jamie Rentoul: I will start. For non-medical students, as you say, the NHS pays the tuition fees. We have a benchmark price, which has been agreed in negotiation with the higher education sector, and that continues going forward. That is the intention. For the support we give in the latter years of medical and dental training, we have made some arrangements for the 2012–13 entry year that we have agreed with the Department for Business, Innovation and Skills and we are in discussion with them, having made it clear that was an arrangement for that year. As to what the future settlement will be, we have not yet made decisions.

Q546 David Tredinnick: What impact will this regime have on prospects for widening participation in the medical and dental professions?

Dr Hamilton: That is an issue that concerns us. One of the major educational outcomes areas that we are setting is to widen participation. We still have not managed to achieve wider access into medical school. While we hope that what we have put in place will help participation, there is a wider issue of selecting it right back into medical school, which almost means influencing at school, for expectations of people—that they could apply to medical school—to be raised. We know, obviously, that the coalition Government are very interested in this; I represented medicine at a seminar held by the Deputy Prime Minister. Quite a few professionals are balking at the same issue. This is a bigger issue, a much wider issue, than just fees, but clearly that is an important part of it and we still need to do further work on it.

Q547 David Tredinnick: I will finish off by looking at self-care. Part of it is to go back to the earlier theme that I had on complementary and alternative medicine and refer to the point you made about the university of Westminster. Given that universities such as Westminster have already reduced the number of complementary and alternative medicine courses they offer, which they have had to do—this is principally due to the difficulty students are facing with funding, not because of lack of demand—do you think that the university fees regime, which requires up to £9,000 a year in fees, will affect this sector? What impact has it had, and so on?

Mr Burns: The straight answer is that this is a matter more for BIS than the Department of Health. But if one is looking at it logically, off the top of one’s head, then courses, regardless of the cost, will attract students who are particularly interested in benefiting from increasing their education and getting a qualification in whatever the subject is. They will take into account, however much the level of the tuition fee, whether it is going to be value for money for them and their future career prospects in whatever career they decide to take.

Q548 David Tredinnick: A lot of these people, if they graduate in the CAM field, will be looking to teach people how to look after themselves. Can you tell me what the Department’s attitude is to self-care generally?

Mr Burns: There are still areas where there is not enough proven evidence of the outcomes in this field, but I would hate to tread on anyone’s toes in an area which is beyond the NHS, strictly speaking.

Chair: It is a broader interpretation of education and training to take on education and training for self-care.

Q549 David Tredinnick: It is, but this is—

Mr Burns: There are two types of self-care, and I know where you are going.

David Tredinnick: I have not got there yet.

Mr Burns: No, but I know where you are going. Because there is another area of self-care which, of course, is to do with people looking after themselves when they have a cold or whatever. We are all in favour of people self-prescribing over the counter medicines to seek to minimise the health impacts of those sorts of medical complaints.

Q550 David Tredinnick: Thank you. You have walked straight into the space I set you.

Mr Burns: Yes, because I know where you are coming from. But the trouble with the area of self-care that you are raising is that there is not enough evidence, to my mind, with suitable outcomes. That is why that whole area has been at arm’s length from the NHS, by and large.

Q551 David Tredinnick: That is a very important area, that there is not enough research. With the emphasis on double-blind, placebo-controlled trials, rather than observation, which used to be the case, we need more evidence. On the self-care issue, Professor Peters, who came before us, said “self-care could unburden the NHS of a vast amount of minor illnesses”. You raised the matter of colds, I had a chest infection two weeks ago. I have a small box of homeopathic remedies—I have used the system for 20 years—and I successfully treated this complaint using a couple of remedies. I stayed off antibiotics, avoided going to the doctor and saved the NHS money. It is this kind of self-care, of people taking responsibility for themselves, that is fundamentally important if we are going to reduce the costs on the health service at a time when there are increasing demands. I would like to suggest to you, Minister of State, that this is an area that you should address. What we need, even if the NHS is not providing the service, is a proper availability of practitioners in these fields so that people who opt to go to them should be able to get those treatments and reduce the burden on hard-pressed doctors.
Mr Burns: You raise a very interesting point. I am neither medically nor ministerially qualified to the depth that you are, but I do have, if it helps the Committee to make progress, what I hope will be a positive suggestion. As my colleague Anne Milton has responsibilities and greater knowledge in this area, it might be sensible if you engaged with her on the whole area that you are raising at this Committee hearing this morning.

Q552 David Tredinnick: That is a very helpful suggestion, but perhaps you would use your officials to send her a briefing on what we have said so that she could write to me and respond on that issue when she is at liberty to do so.

Mr Burns: I will certainly arrange for that to happen, though it may be a few weeks before she replies, due to her own personal circumstances.

David Tredinnick: We understand exactly what is going on. Thank you so much.

Q553 Dr Wollaston: Can I return to the fees cap and raise the issue that there is a discrepancy of funding between the newer medical schools and some of the older medical schools whose funding has been based on historic levels? Do you see that the introduction of a fees cap may even out some of the funding discrepancies?

Jamie Rentoul: Can I clarify that you are talking about funding from the Higher Education Funding Council for undergraduates?

Q554 Dr Wollaston: Yes, medical school for undergraduates, or do you think there is already good parity between the funding level for undergraduates between the various institutions? Do you think having tuition fees is likely to even that out or not have any effect because so much extra funding comes from the Department?

Jamie Rentoul: The Higher Education Funding Council are also consulting on their funding at the moment. I do not want to add to the list of things to come back to you on, but I do not want to talk on their behalf because they are the funders for undergraduate medical schools.

Q555 Chair: It is outside the remit, I think. Are there any other questions? Thank you very much, Minister, and your two supporters.

Mr Burns: Thank you.

Chair: Thank you for coming. We will reflect on what you have said and other evidence that we have gathered. Thank you.

Written evidence from the Department of Health (ETWP 01)

I am writing to share with you a copy of Liberating the NHS: Developing the Healthcare Workforce—From Design to Delivery which was published yesterday and placed in the Library.1 This forms the core of the Department of Health’s evidence to the Health Select Committee inquiry.

This publication sets out our plans for putting in place a new education and training system for the healthcare and public health workforce. This builds on the consultation Liberating the NHS: Developing the Healthcare Workforce and the work led by the NHS Future Forum.

The new system is designed to be more responsive to the evolution of services and the changing needs of patients. It puts employers and the health professions in the driving seat, and is underpinned by strong links with the education and academic sectors. The Education Outcomes Framework will directly link education and with the funding bodies for higher education to ensure the health workforce has the right quality of education and training. HEE will take a strategic overview of funding priorities and together the interests of healthcare providers, the professions, patients and staff to improve the quality of education and training.

There are two central planks to the new system:

— Health Education England (HEE) will provide national leadership and oversight, bringing together the interests of healthcare providers, the professions, patients and staff to improve the quality of education and training. HEE will take a strategic overview of funding priorities and work with the funding bodies for higher education to ensure the health workforce has the right skills, behaviours and training, available in the right numbers, to support the delivery of excellent healthcare and health improvement.

— Local Education and Training Boards (LETBs) will lead local planning and education commissioning, and be the vehicle for healthcare providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of the service, patients and the public. As supported by the NHS Future Forum, the LETBs will be established through a hosting arrangement through HEE, providing stability for the system and a secure NHS base for the people within it.

LETBs will work closely with the new Academic Health Science Networks, integrating clinical, research and educational functions to realise the ambition set out in Innovation, Health and Wealth for an NHS defined by its commitment to innovation and the rapid diffusion of transformative ideas and practice.

We have heard broad support for the direction we are setting out for education and training. The NHS Future Forum’s first report welcomed our reforms and recommended that more time was spent to develop detailed proposals. *Liberating the NHS: Developing the Healthcare Workforce—From Design to Delivery* describes the new system and how it supports the new duty on the Secretary of State to secure an effective system for education and training, which we introduced as an amendment to the Health and Social Care Bill last year. It fulfils our commitment to publish further guidance and planning for a safe transition.

In their second phase of work, the NHS Future Forum concentrated on the impact education and training can have on service delivery, in particular, the quality of education and training. Their further advice and recommendations published yesterday, are reflected in *Liberating the NHS: Developing the Healthcare Workforce—From Design to Delivery*.

Extensive consultation and engagement has ensured the concerns and needs of key stakeholders and senior leaders across health and education sectors are addressed. The new system is intended to streamline current processes and not increase costs. A full economic impact assessment is being developed.

Annex A and Annex B provide additional evidence submitted by the professional advisory boards for nursing and midwifery, and the allied health professions. These professional advisory boards bring together representatives from across the health and education sectors to provide independent advice to the Department. You have already heard separately from the Chair of Medical Education England, Sir Christopher Edwards, in the oral evidence session that took place on 29 November.

The Rt Hon Simon Burns MP and Anne Milton MP are due to give evidence to your inquiry shortly and will be available to discuss all of this in more depth and address any questions you have.

Andrew Lansley CBE
January 2012

**Annex A**

**NURSING AND MIDWIFERY PROFESSIONAL ADVISORY BOARD EVIDENCE**

The national Nursing and Midwifery Professional Advisory Board (PAB), is a board of clinical professionals who provide expert advice on nursing and midwifery workforce planning to the Department of Health’s Chief Nursing Officer.

The purpose of the Board is to

— Provide professional oversight, assurance and expertise to the Chief Nursing Officer’s Directorate.

— Influence decisions concerning workforce planning and development for the nursing and midwifery professions and their support staff at a national level.

— Develop policy and other proposals to inform and deliver changes needed to improve nursing and midwifery education identified in national policy documents.

— Consider transformational developments in service provision and delivery, and the impact upon the nursing and midwifery workforce and their education needs.

Over the last year the PAB has recognised the challenges faced by the nursing and midwifery professions and the services they provide. It has particular concerns about two fields of the profession: health visiting and learning disability nursing. It has also commissioned reports on ways education and training are funded. One report on multi-professional education and training (MPET) funding is available, and a further report on funding continuing professional development has just been commissioned and will be available later in 2012.

**Health Visiting**

The Government is committed to growing the number of health visitors and aims to deliver an extra 4,200 (FTE) health visitors in post by April 2015 (compared with a baseline in May 2010 of 8,092). This is an increase in excess of 50% and will achieve a total of 12,292 FTE health visitors in post.

The purpose of this is to introduce a new service vision and family offer, which improves services and health outcomes in the early years for children, families and local communities. This new model will be delivered through effective partnerships with Sure Start Children’s Centres, GPs and other key early years services and by strengthening community capacity.

The PAB are supportive of the Government’s intention of improving the service offered to families but are concerned that potential health visitors can only be recruited from the current pool of registered nurses or registered midwives. This is also at a time when the commissioned numbers of students are also going down compounding this further particularly on adult nursing. There is no direct entry programme into health visiting so the inevitable consequence of this recruitment drive is a depletion in the numbers of registered nurses (potentially school nurses in particular) and registered midwives.
The Health Visiting Programme Board are also very conscious of this and we are in close contact with them over the numbers of registered nurses, particularly school nurses, and registered midwives who might choose to retrain as health visitors.

We are also concerned that there should be an adequate supply of jobs for newly qualified health visitors to go into. Our concerns are based on previous experience when extra midwives were trained, but the jobs for them to go into were not available in the same numbers. We would not wish this to be replicated in health visiting and accept that this is being monitored very closely by the Health Visiting Programme Board who are working with SHAs to ensure that new posts are being developed and filled.

**Learning Disability Nursing**

The PAB are concerned that there are diminishing numbers of learning disability nurses in England and there are difficulties in reliably identifying the national supply and demand for learning disability nurses.

People with learning disabilities have a disproportionate health burden compared with the general population. They also often need a package of health and social care to support them and specialist learning disability nurses could be used more effectively to help address this.

Given this situation the PAB commissioned an expert task and finish group chaired by Professor Bob Gates, academic and professional lead for learning disability at the University of Hertfordshire, to examine a range of issues and possible solutions relating to the diminishing numbers of learning disability nurses.


**Genetics Report**

In addition to the concerns about health visiting and learning disability nursing, the PAB were also stimulated to consider the impact of significant advances in genomics, which bring unprecedented opportunities for a greater understanding of disease mechanism, and the impact on nursing and midwifery.

The PAB commissioned an expert task and finish group to examine genetics in nursing and midwifery. This was chaired by Professor Maggie Kirk Head of Research/Leader Genomics Policy Unit, University of Glamorgan.

Nurses and midwives represent the largest sector of the NHS professional workforce and are best placed to use the potential contributions of genomics for improving health. However, the challenges facing the professions are:

- The scale and pace of scientific advances is complex and uncertain, but accelerating.
- The needs of patients and families affected by genetics/genomics are not being met.
- Nurses and midwives have limited competence and confidence in genetics/genomics.
- Despite the size of the workforce, there is limited capacity to develop new roles that integrate genomic healthcare in different areas of practice.
- Education provision is inconsistent and education providers may have limited awareness of the relevance of genomic healthcare to professional practice.
- Genomic healthcare and the application of genomic technologies lead to further, and more complex, ethical challenges.
- Confidence and competence in healthcare ethics related to genetics/genomics is low.
- There is a very limited evidence base for the translation of genomics advances into nursing and midwifery practice, and clinical outcomes for practice have not been established.

The task and finish group believes that all nurses and midwives at all levels of practice must be competent to deliver genomic healthcare and that the professions’ leaders should be informing and shaping developments to incorporate genomic healthcare. Action needs to be taken so that nurses and midwives can deliver the current and potential benefits of genomic health care for patients, families, communities and public health.


**Multi-Professional Education and Training (MPET) Funding**

The PAB was concerned that the workforce commissioning teams across the strategic health authorities (SHAs) were reducing the numbers of student nurse commissions funded by MPET. This was in the context of the demands on MPET funding increasing, but employers needing to secure a supply of newly qualified nurses and midwives to meet the demands of their workforce plans and deliver services.

The PAB commissioned an expert Multi-Professional Education and Training (MPET) task and finish group, chaired by Joe McArdle, Assistant Director of Education and Commissioning, North West SHA to consider:

- the key risk and potential solutions concerning the implications of any MPET reductions to future nursing and midwifery workforce supply and productivity;
— appropriate actions that should be taken by the PAB and/or any alignment with existing work programmes such as Action on Health Visiting; and
— advising the PAB of any challenges that arise from the implementation of the national MPET review.

The summary of its recommendations is that:
— Health Education England should ensure that in its process of assuring the supply of nurses and midwives that the Professional Advisory Board or its successor body has timely receipt of the anticipated quarterly performance reports received from the networks.
— Health Education England should drive greater alignment between service delivery and care models and workforce supply through strengthened relationships with economic and quality regulators.
— Health Education England considers building upon the development of Education Commissioning Quality Assurance Framework to promote wider publication of results and findings on the key domains of transparency and consultation.
— The Centre for Workforce Intelligence continue to provide an annual analysis of workforce supply trends but that this is contextualised within the domain of health and social care workforce demand including employment rates.
— The future Local Education and Training Boards should continue to strengthen transparency of consultation and ownership of future planning of the whole workforce taking account of interdependencies across workforce teams and health sectors.
— The future Local Education and Training Boards should continue to benchmark local decisions taking account context of the national supply pool.
— Higher Education Providers continue to develop creative programme resourcing approaches to minimise viability risk to smaller provision.
— Higher Education Providers look to work with the Professional Advisory Board or successor body to smooth the recruitment profiles to all programmes limiting risk of under/oversupply.
— NHS Employers continue to work with NHS careers to proactively signpost prospective nurses to appropriate career opportunities.

The full report and its recommendations can be found at: http://www.dh.gov.uk/en/Aboutus/HowDHworks/BoardsandCommittees/DH_128049

Annex B

NATIONAL ALLIED HEALTH PROFESSIONAL ADVISORY BOARD EVIDENCE

Allied health professionals (AHPs)² make a significant contribution to delivering high quality services for patients and public. They are a diverse group of clinicians who deliver high quality care across a wide range of care pathways and in a variety of settings. As of September 2010, 85,115 AHPs worked in the NHS in England. Significant and increasing numbers also work in other public services, including social care and education, and in the private and charitable sectors.

AHPs are graduates. From the point of registration they are, in the main autonomous practitioners with common attributes; they are, predominantly, first contact practitioners, they work across a wide range of locations within acute, primary and secondary care and perform functions of assessment, diagnosis, treatment and discharge, from primary prevention through to specialist disease management, rehabilitation and reablement.

NATIONAL ALLIED HEALTH PROFESSIONAL ADVISORY BOARD (AHP-PAB)

The AHP-PAB provides professional oversight and expertise to the Department of Health on all aspects of workforce planning, education and training for the 12 allied health professions, both individually and collectively.

The Board comprises representatives of the professions, patients, educators, workforce planners, education and service commissioners, strategic leads, employers, unions and the professional regulator.

The purpose of the Board is to:
— Make recommendations, via the Chief Health Professions Officer, to DH’s Workforce Leadership Group concerning all aspects of AHP workforce planning and development.
— To provide collective expertise and advice on strategic workforce planning and development across the allied health professions.
— To comment on workforce and education commissioning plans.

² The Allied Health Professions are art therapists, chiropodists/podiatrists, dieticians, drama therapists, music therapists, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists & orthotists, radiographers (diagnostic & therapeutic) and speech & language therapists
— To articulate the benefits of a modernised AHP workforce to inform workforce planning and development.

**NATIONAL ALLIED HEALTH PROFESSIONAL PATIENTS’ FORUM (AHP-PF)**

The AHP-PF is a sub-group of the AHP-PAB, Chaired by Roswyn Hakesley-Brown, Chair of The Patients Association. The core function of the AHP-PF is to provide the patient perspective to both inform and influence decisions made by the AHP-PAB concerning workforce planning and development for the allied health professions collectively and individually at a national level.

As part of our work to preserve the functions and values of the AHP-PAB and AHP-PF during transition, the process of procuring a formal evaluation of the AHP-PF has commenced. This will enable the emerging Health Education England (HEE) to build on the best of what the AHP-PF has contributed to date in terms of outcomes and ways of working. The following slide was prepared by the AHP-PF to highlight their activity in the first six months of 2011.

**AHP-PF HELPED & CONTRIBUTED TOWARDS?**

- Consultation Responses
  - White Paper
  - Individual and Stakeholders
  - AHP Patients Forum
  - NICE
  - Others
- Membership
  - shared learning and signposting
  - shared experiences
  - shared best practices, evidence and any impact
- Wider Collaboration
  - NHS London
  - Provider Policy
  - AHP Feedback and Reporting
  - Education Commissioners
  - CIN
  - Academia
  - LSBU Feedback
  - LSBU Collaboration on other projects
- Patients Concerns
  - Shortages of P&Os
  - National Workshop
  - Technicians
  - Cancer
  - Pain
  - Patient Stories
  - Direct Feedback to AHP-PAB
- Profile of AHP Patients Forum
  - Raising awareness of the value of AHP-PF & AHPs’ through
  - engaging with political representatives of all parties
  - House of Lords
  - All-Party Groups
  - Stakeholders
  - Newsletters
  - National & International

**MAXIMISING THE CONTRIBUTION OF ALLIED HEALTH PROFESSIONALS**

The AHP-PAB believes that there is greater scope for the NHS workforce to achieve improved productivity gains by giving increased consideration to the effective utilisation of the AHP workforce and the contribution it can make to changing service models, eg while there is ample evidence from Scotland and DH of the value for money of self-referral to physiotherapists, this has not been fully implemented.

AHPs routinely work across pathways and in a variety of different settings and as such may be working in, or directly employed by, social care, eg speech and language therapists working in schools. AHPs are also an important part of the public health workforce where, eg dieticians advise on school food policy. A particular feature of AHPs is that they practice at the interfaces between pathways and sectors, eg an occupational therapist will support an individual with complex needs out of hospital and into reablement services. The AHP-PAB is concerned that the AHP contribution to public health and social care agendas is often not recognised and this may be perpetuated unless there is effective planning across sectors, eg through collaboration between HEE and Public Health England.

The AHP-PAB has partly funded the production of an AHP QIPP Toolkit that will encompass, in the first instance, five best practice illustrative pathways that show the clinical and economic benefits of using AHPs in a transformative manner. A study that explored the relationship between occupational therapist provision of equipment and residential care, found over an eight-week period cost savings of over £60,000. These pathways will be available for use as best practice reference points for commissioners and clinicians, highlighting
exemplars of AHPs working at advanced practice levels across a range of clinical pathways. The pathways for; musculoskeletal, stroke, cancer, oral nutritional support, diabetes and major trauma will be available in Spring 2012 on the NHS London website.

The Centre for Workforce Intelligence AHP Learning Circle is considering the workforce implications of these pathways and will publish its report in Spring 2012. The AHP-PAB will make recommendations informed by both of these publications.

Ensuring Access to Continuing Professional Development (CPD) Funding for Allied Health Professionals

CPD for AHPs is of critical importance to meet the future workforce needs for delivering improved outcomes for health, social care and public health. The AHP-PAB is concerned by the proposal that employers are solely responsible for funding the CPD of existing staff and believe that funding support for CPD should continue through the central education and training budget. We also believe that HEE should be tasked with the role of monitoring and reviewing CPD support as part of its multi-professional remit.

The AHP-PAB recognises that CPD commences earlier in their career for AHPs than for doctors, forming a core element of revalidation at the end of their undergraduate programme. It was also noted that whilst MPET funding supports pre-registration education for most of the AHPs (although not the three arts therapies), CPD funding, including that for postgraduate education, is decided locally and, as such, is variable.

The AHP-PAB believes that CPD should reflect the need to develop rounded clinical leaders with research and academic interests. It is possible for non-medical consultants to undertake these roles but unusual for managers or leaders to carry a clinical caseload outside of medicine. A number of barriers to developing AHPs through the pathway from frontline clinical roles, to clinical team leader, clinical services leaders, general manager and then director exist, including organisational hierarchy, band compression and service cuts without service redesign.

The AHP-PAB has outlined its thoughts on the responsibilities of individuals, employers and Health Education England:

- **Individual:** fitness to practice through HPC revalidation which in turn maintains fitness for purpose through maintaining up to date professional behaviours, knowledge, skills and competences to undertake their current role.
- **Employers:** mandatory CPD, developing individuals to be fit for purpose for service need and service change and clinical leadership and management development.
- **Health Education England:** strategic oversight of training to meet national clinical priorities both uniprofessional and multiprofessionally, development of the existing workforce to meet service needs for small professions and specialities, strategic oversight of CPD to meet deficits.

A position paper on CPD for AHPs is currently in production. Additionally, the AHP-PAB is working with the Nursing and Midwifery PAB on a joint report on CPD funding that will be available in 2012.

Sustaining the Allied Health Professional Academic Workforce

The AHP-PAB has identified a critical risk to the sustainability of the AHP academic workforce caused by a retirement bulge in the current workforce and an inadequate pool of current AHP clinical researchers.

The AHP-PAB welcomes the robust commitment from the DH to continue to fund the Clinical Academic Training Pathway for Nurses, Midwives and AHPs. However, the AHP-PAB recognises that this programme alone will not be enough to develop a robust research culture for allied health professionals.

The AHP-PAB commissioned research on how this might be achieved. The evidence suggested the DH policy, together with the contribution of the professional bodies and individual AHPs, was working well in developing a strong and effective research culture. There was clear progress and enthusiasm for continuing along the path of success. However, the researchers recognised the pressures on funding will continue to grow for the foreseeable future and developing a research culture in such an environment may be much more challenging. In some areas, limited resources may lead to a greater demand for innovation and so for research; in others, the system may “play safe” and stick to existing approaches, and also cut costs by limiting perceived “nice to haves” such as research.

Security of Supply—Concern Over Pre-Registration Commissioning Cuts in Transition

Significant reductions in education commissioning for pre-registration AHP student numbers are taking place led by the SHA/SHA clusters. These reductions are set in the context of increasing demand on MPET and are being implemented without taking account of the advice of the AHP-PAB. The AHP-PAB has expressed concern about these reductions, and wants to see HEE take action if there is a risk to the sustainability of the medium to long term supply. SHA commissioning plans show commissioning cuts in 2011–12 of 6.4% for AHP pre-registration courses. While there has been a national initiative via HENSE (HEFCE and DH) to
consider medical and dental numbers going forward, the AHP-PAB currently has limited influence in providing national oversight of local (SHA) decisions on commissioning reductions.

The multi professional approach of the new HEE must deliver on the commitment to security of supply by establishing a process of education commissioning over a three to five year cycle working closely with and informed by the Independent Centre for Workforce Intelligence (CfWI).

**Securing the Future Supply of the Smaller Allied Health Professions**

A number of the allied health professions are small and consequently workforce planning and the associated commissioning of education and training requires national rather than local coordination. The select committee has already heard evidence of concerns related to ensuring security of supply of specialist medical consultants, such as paediatric transplant surgeons, and the need for these to be coordinated nationally. The AHP-PAB has produced a paper on the challenges and opportunities for commissioning the smaller AHP professions and the PAB is currently working with CfWI to enhance workforce planning for these professions, eg the AHP-PAB are working with the professions and industry to identify how services could be redesigned to make better use of skill mix.

**Supporting a Whole Workforce Approach by CfWI**

The AHP-PAB supports the need for an independent CfWI to develop robust evidence to underpin decisions on future education commissioning, taking a whole workforce approach. The experience of the AHP-PAB has been that the early work of the CfWI was almost entirely medical in focus. The AHP-PAB has been working closely with CfWI, particularly in the last 12 months to support the development of non-medical and "pathway" plans.

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**Supplementary written evidence from the Department of Health (ETWP 01A)**

**Homeopathic Medicine**

Following last Tuesday’s first oral evidence session on education, training and workforce planning I said I would write to you when I had considered more fully the committee’s question on homeopathic medicine. Specifically, whether greater assessment of this discipline is required and how we intend to respond if there is an increased demand for this service from the general public.

Although the Department of Health provides strategic leadership to the NHS and social care organisations in England, it is for local NHS organisations to plan, develop and improve services for local people. These bodies are, therefore, best placed to respond to patients’ concerns and needs.

The provision of any healthcare treatments on the NHS, be it complementary or orthodox, is the responsibility of frontline NHS organisations and those who commission services from them. The Government expects decisions on local services to be made by these commissioners as they have in depth local knowledge and experience of local health issues and are therefore best placed to make decisions on what treatments are appropriate for patients, including complementary or alternative treatments such as homeopathy.

The safety, clinical and cost-effectiveness and availability of suitably qualified/regulated practitioners are all issues that have to be taken into account when deciding what treatment to provide. These issues also have to be balanced with any locally developed policies on commissioning and funding priorities. If service commissioners decide, in the future, that they want to commission these types of services for their local population then Health Education England would have to consider the most appropriate way of funding the education and training requirements.

The Government currently has no plans to extend statutory regulation to any other complementary medicine profession such as homoeopaths. However in February 2011, the Government announced its intention to ask the Health Professions Council (HPC) to establish a statutory register for practitioners supplying unlicensed herbal medicines. All practitioners wishing to use unlicensed herbal medicines would need to be registered with the HPC.

So this is an issue that we would expect Health Education England to pick up as appropriate in the light of decisions made on the services being commissioned.

I hope this is helpful.

*Jamie Rentoul*

Director for Workforce Development

*23 November 2011*
Written evidence from the Centre for Workforce Intelligence (ETWP 02)

1. What is CfWI and what does it do?

The Centre for Workforce Intelligence (CfWI) is the national authority on workforce planning and development and the primary source of workforce intelligence for health and social care. All our work is driven by the needs of patients, service users, and citizens.

The CfWI provides:
- easily accessible tools and resources for workforce planners in health and social care;
- long-term strategic scenario planning for workforce, based on research and evidence with careful analysis and measured comment;
- some of the best tools and models for workforce planning; and
- applies this thinking to real life situations.

CfWI have two main goals:
- to provide an easily accessible route for health and social care planners, clinicians and commissioners seeking workforce planning and development intelligence, in order to improve health and social care services; and
- to support long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis, in order to build strong leadership and capability in workforce planning.

What is workforce planning?

Workforce Planning is the process of ensuring that a business or organisation has the right number of employees; with the right knowledge, skills and behaviours in the right place, at the right time.

CfWI Areas of Development

Intelligence  Leadership  Planning

IRS Employment Review 790

2. What is the significance of CfWI being private rather than Public?

CfWI was procured through competitive tender in 2010–11 with contract award in March 2010 and the CfWI opened in July 2010. A large part of the NHS Workforce Review Team was TUPE transferred into CfWI alongside private providers and partners. The CfWI was created as a commercial contract in order to establish its independence and to become the national authority on workforce planning and development.

CfWI adopts a “best in class” approach to getting the right people involved in producing intelligence for the NHS and social care system. Our partners, who we commission according to their subject matter expertise, include:
- Manchester University
- Kings College London
- Institute of Public Care (Oxford Brookes University)
- Durham University
- Skills for Care
- Skills for Health
- Solutions for Public Health
In addition we have paid professional advisors for specific projects and subject areas eg Professor James Buchan (Queen Margaret University), Dr Louis Merton (Consultant Clinical Neurophysiologist) et al.

3. HOW IS INTELLIGENCE PRODUCED?

**Raw data into plans for workforce**

![Workforce Planning Framework](image)

**Workforce Planning Approach**

4. DATA SOURCES

The CfWI collects data and assumptions from a wide range of sources. It is useful to divide them into sources that inform supply or demand, and then further into those which a health or social care enterprise has little control (external factors) or strong control (internal factors).

**Supply (external)**
- Training (pipeline of trainees to qualification)
- Demographics (where trainees are)
- Competition (jobs outside of health & social care)
- Potential and actual labour market

**Supply (internal)**
- Workforce characteristics (age, gender, location, current job, skills & qualifications, full/part-time working)
- Workforce trends (vacancies, overtime, recruitment, promotion, leavers, retirements)

**Demand (external)**
- Technological, Environmental, Economic, Political, Social and Ethical determinants of demand

**Demand (internal)**
- How the workforce is structure and organised
- Training and retention
- Policies, plans, budgets, targets and constraints

Accurate supply-side data is critical to workforce planning, and much of this comes from the NHS Information Centre, the Royal Colleges, and the National Minimum Data Set for Health and Social Care (NMDS-SC).

The demand side has greater uncertainties; a technology breakthrough could lead to disruptive change and a shift in demand. A key source here is the Office for National Statistics.

For social care the size and complexity of the workforce, much of which is in the private and voluntary sectors and is not regulated, means that accurate data is not readily available.

<table>
<thead>
<tr>
<th>Data source and purpose</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office for National Statistics, for example population estimates and forecasts</td>
<td>Comprehensive and well-evidenced data but does not cover all factors that influence demand</td>
</tr>
<tr>
<td>NHS Information Centre for Health and Social Care (NHS IC). Used to give the size of the current workforce, and the baseline for supply forecasts and retirement calculations</td>
<td>As with most large data collections, there are discrepancies in data recording and issues with quality. Definitions vary across the system making consistency of data a problem</td>
</tr>
</tbody>
</table>
### Data source and purpose

<table>
<thead>
<tr>
<th>Source</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS IC Deanery monitoring, used for the numbers of doctors in training</td>
<td>Inconsistencies in 2010 data so 2009 data were used for CIWI Shape of the Workforce report. Known issues where trainees for one region are trained in another region, and who manages them (can over or under-state the numbers)</td>
</tr>
<tr>
<td>NHS iView, for example used for consultant salary calculations</td>
<td>As above. iView is designed specifically to allow rapid access by people managing the NHS to figures which support their decision making, not the same as fully quality checked and formally released statistics</td>
</tr>
<tr>
<td>Royal Colleges, attrition, return and delay rates for training</td>
<td>Quality of information varies by profession and college</td>
</tr>
<tr>
<td>National Minimum Data Set for Health and Social Care, primary source of data for social care</td>
<td>Covers public and private sectors but voluntary not so complete. Now includes workforce data returns for local authorities. Data being collected is changing</td>
</tr>
<tr>
<td>General Social Care Council (GSCC) for social worker numbers and those in training</td>
<td>GSCC functions are transferring to the Health Professions Council but as regulator they will not be holding information about students in training, which will otherwise be lost</td>
</tr>
</tbody>
</table>

### 5. Looking into the Future

#### Data from range of providers

The new education, training and planning system means that security of workforce data is critical. The table above details the information that needs to be collected to ensure effective knowledge of supply and demand. The comments against the existing data sources highlight some of the current issues. Clearly, where a system is changing and new providers are being introduced, there is a risk that information is lost due to lack of coordination or legislative requirements, or there are quality issues due to inconsistencies in data standards and collection.

However, the new system could provide an opportunity to clarify data flows, improve planning at a local level, and provide the necessary information for medium and long-term workforce planning, critical to maintain the highest standards of health and social care.

The CIWI strongly recommend that a National Minimum Data Set is introduced covering both health and social care to address these issues. Integration between health and social care data is critical to workforce planning around the shift to community care, and the increasingly complex needs of an ageing population which will require coordination between a wide range of organisations in both the public and private sectors.

### 6. Local Skills Network to Collect Data

CIWI recommends that local skills networks, local education and training boards, and clinical commissioning groups all collect local workforce planning data and needs analysis and share this with CIWI who can then analyse the national picture.

### 7. UK Dimension for Workforce Planning

#### The four countries—key messages

- Significant consultation in England around Shape of the Medical Workforce—Scotland, Wales and Northern Ireland involved in similar exercises, partly linked to QIPP and financial issues.
- Medical issues cited by country—some overlaps in small specialties which are viewed on a UK basis, and some commonality regarding shortage professions (eg psychiatry).
- Employment of medics not currently a big issue as early still in the financial cycle.
- Mobility will potentially grow as an issue in relation to this.

#### 7.1 England

- Significant structural change, new players hence new planning processes emerging.
- Impact of the White Paper still being worked through following Lords approval. Workforce is a high profile issue within the overall package and being given significant attention. Elements of new structures starting to emerge through eg SHA and PCT clusters.
- Key factors—QIPP, and Shape of the Medical workforce.
- The impact of the recommendations in the Medical Numbers report, in the medium term, if implemented will be:
— an overall increase of 283 entry-level specialty training posts in Allergy, Cardiothoracic Surgery, Community Sexual and Reproductive Health, Dermatology, Geriatric Medicine and Interventional Radiology;
— an overall decrease of 167 entry-level training posts for hospital-based specialties in Anaesthetics, General Surgery, Obstetrics and Gynaecology; Trauma and Orthopaedic Surgery, Otorhinolaryngology (ENT) and Renal Medicine; and
— an increase in General Practice (GP) training posts of 450 to reach a stable number of 3,250 by 2014.

Overall, by 2014 we estimate that the average number of entry-level posts for specialty training will be around 6,511.

Key document—Draft CfWI Leadership report on shape of the medical workforce to be published in December 2011.

7.2 Scotland

— Workforce planning is a statutory requirement and was established in NHS Scotland (NHSS) in 2005 with the inception of HDL (2005) 52 “National Workforce Planning Framework 2005 Guidance”, which provided Boards with a base for establishing workforce planning as a key element of the wider planning systems within NHSS.
— Forecasts signed off at high level, high investment in Workforce Planning paying off in engagement, 25% reduction in Management.
— NHS Scotland will make reductions in education commissioning numbers across all staff groups for the next two years. Savings are being transferred to support post graduate training within organisations.
— Workforce planning has become a key element of strategic planning at national, regional and board levels within the NHS in Scotland. Managing the changes taking place within the workforce, and the wider population of Scotland, now and in the future has been recognised by NHS Scotland as key if it is to secure the workforce it requires to deliver services to the population of Scotland.

NHS Board Projected Staff in Post Changes in 2011–12

— All NHS Boards were asked to provide workforce projections for 2011–12 to enable the Scottish Government and NHS Boards to assess the current workforce and skills mix to ensure this is appropriate to meet current and future needs. NHSS projected staff in post changes for 2011–12 were published on 30 August on the Scottish Government website. These show a projected overall decrease of 2,390.5 wte (−1.8%). If these projections are realised, the largest percentage reduction will be in Administrative Services (projected to fall by 4.3%) of which management posts are projected to fall by 9.5%. Workforce projections are part of the normal planning process undertaken by all NHS Boards to ensure that changes to the NHS workforce are driven by and reflect service redesign in order to maintain and enhance the quality of care while increasing efficiency. All projections have been developed in liaison with local staff side representatives in each NHS Board.

7.3 Wales

The National Leadership and Innovation Agency for Healthcare (NLIAH) is part of NHS Wales and works with Trusts and Health Boards to deliver better quality and safer patient services. NLIAH employs 100 staff, based in Llanharan, Cardiff and Wrexham. The work of NLIAH operates across five main areas: Workforce Development, Leadership & Organisational Development, Partnership Development, Service Improvement and QuIP (Quality Improvement Plan) Delivery Support. Each area runs a number of themed programmes as agreed through formal agreement with the Welsh Government.
NLIAH supports NHS Wales in working towards the provision of a world class health service. NLIAH has set up strong UK and international links with leaders in these fields and places a strong emphasis on collaborative working and shared learning.

A new workforce strategy for NHS Wales is under development, which will need to take into account cuts in service provision.

Delegation guidelines issued, range of studies to check effectiveness of earlier initiatives (eg prescribing). Workforce planning simulation exercises. Taking on iView 5% reduction in budget Welsh Government recently issued its Programme for Government which is a translation of the Government’s manifesto into a delivery plan for the NHS in Wales. NLIAH is undergoing a review which will be completed by 31 March 2012.

7.4 Northern Ireland

— The Department recognises the importance of workforce planning in identifying appropriate staffing levels and structures. Local staffing arrangements are the responsibility of individual HPSS employers, taking into account factors such as service needs and available resources. The Department has a role in ensuring that sufficient suitably qualified staff are available to meet the needs of the service overall.

— Workforce Planning Unit has in place a programme of comprehensive workforce planning reviews carried out at regional level across the main professions and a number of supporting groups in the HPSS. The main aims of the reviews are to establish information on the supply/demand dynamics relevant to the workforce group, thereby informing the Department’s decision-making on the number of training places to be commissioned and to develop understanding of the issues impacting on recruitment and retention and career progression of those employed.

— The workforce planning cycle comprises a major review of each group every three years, supported by annual update reviews. The purpose of the annual update reviews is to maintain current workforce information and identify any new issues impacting on the workforce group thereby enabling any necessary action to be taken at an early stage.

8. Mobility UK

CfWI are working with colleagues from the four countries to look at both mobility and training issues in relation to workforce planning.

Health Education National Strategic Exchange (HENSE): Review of medical and dental school intake in. HENSE has commissioned CfWI to undertake a review of medical and dental school intakes in England:

— Recommendations will be made to enable decisions to be taken by the Department of Health and the Department of Business Innovation and Skills on future medical and dental student numbers in England from 2013–14 to 2030.

— The principal purpose of this ten month project is to produce a review that will:

— support the provision of an adequate supply of trained doctors and dentists;
— inform investment decisions on medical and dental school training; and
— advise on constraints to medical and dental students from overseas.

— The CfWI will do this by working collaboratively with wide ranging interested parties including the devolved administrations—Scotland, Wales and Northern Ireland.

9. International Dimension

Joint Action on Health Workforce Forecasting and Planning (EU Commission: 34 countries)

Key Facts

— The Joint Action proposal does not bind any country to EU decision making—its key purpose is to promote understanding and collaboration around capacity building activities for Member States’ national workforce planning.

— A primary product from the Joint Action will be a European Workforce Manual with templates, tools, definition and analysis that can be used by Member States’ however they choose to do their workforce planning.

— The Joint Action will have due regard to the WHO Code of Practice on ethical international recruitment of health workers.

— The Joint Action proposal fully acknowledges that Members States’ must be able to continue to develop their own workforce planning and assessment capability.

— UK seen as a leading edge Member State on workforce planning as a result of the investment over the next five years in CfWI.
Objectives of the Joint Action proposal

— Provide a platform for cooperation between Member States on forecasting health workforce needs and health workforce planning.
— Cooperate closely in the platform with Eurostat, OECD and WHO.

Scope of Joint Action

The scope of the Joint Action is divided into seven work packages below:

1. Coordination of the Joint Action.
2. Dissemination of the Joint Action.
4. Data for health workforce planning.
5. Exchange of good practice with planning methodology.
6. Forecasting future health workforce needs.
7. Sustainability of the result of the Joint Action and framework of impacting on policy.

Peter Sharp
Chief Executive
November 2011

Written evidence from the General Medical Council (ETWP 03)

1. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

2. We welcome the opportunity to give evidence to the Health Select Committee as part of the inquiry into education, training and workforce planning.

3. In this written submission we have included a copy of our response to the Government’s consultation Liberating the NHS: Developing the Healthcare Workforce. Many of the points that we raised in this document, which was submitted in March 2011, remain relevant to the Committee’s inquiry.

Summary of Key Points

— The GMC’s UK wide remit requires it to take an overarching view of medical education and training across all four countries.
— Statutory responsibility for standards, curricula and education systems rests with the GMC.
— The GMC works closely with other key interests to ensure that doctors’ education and training equips them to meet the needs of patients and the service.
— The functions performed by the postgraduate deaneries are crucial to the delivery and quality assurance of training.
— The deaneries must remain accountable to the GMC for managing the quality of education and training in their area and able to act as credible education champions within the new structure of Local Education and Training Boards. This is especially important in the current climate when inevitably the pressure on education and training is considerable with both financial and human resources under strain and service needs likely to be given first priority.
— The GMC is taking forward an ambitious programme of reform in its education work to reflect the changing needs of patients and the service.

Our role as the regulator in medical education and training

4. Professional regulation makes a crucial contribution in ensuring high and consistent standards of education and training. However, this role was not reflected in the government’s proposals set out in Developing the Healthcare Workforce. We highlighted this in our formal response to the consultation.

3 Not printed
5. In 2010, following the abolition of the Postgraduate Medical Education and Training Board (PMETB) and the transfer of its functions to the GMC we became the single regulator for all stages of medical education, training and professional development across all four UK countries.

6. We have a long history of leadership and innovation in the undergraduate arena. We are now extending that to postgraduate education and training.

7. We have a UK wide remit. This requires us to take an overarching view of medical education and training across all four parts of the UK and between the different medical specialties. We make sure the outcomes, competencies and standards for medical students and trainees are consistent and that they demonstrate students and trainees are able to work safely at each point in their training.

8. Our statutory powers are extensive. For example, our inspection powers in postgraduate education (S34M Medical Act 1983) apply to “any body or other person by whom, or under whose direction or management, any postgraduate medical education or training is, or is proposed to be, given”. Thus, they will not need to be amended when bodies such as Health Education England (HEE) or the new Local Education and Training Education Boards (LETBs) are established.

9. The breadth of our regulatory remit in shaping the future of medical education and training is reflected in our Education Strategy 2011–13. As the following paragraphs demonstrate, the ambitious programme of work which flows from that strategy is well underway.

10. However, our ambition is tempered by the need for regulation to add value and to reduce costs wherever possible, consistent with maintaining high standards. For example, we recently concluded that we should not register medical students because the regulatory burden involved would have outweighed the benefits. Since taking on responsibility for postgraduate education last year, we have also substantially reduced the fees charged to doctors new to the medical register, and to doctors entering the Specialist or GP registers, and we are determined to deliver value-for-money in all that we do.

Education standards linked to curricula

11. It is critical that education and training standards, reflected in curricula for medical students and trainees, embed the principles and values set out in our core guidance to all doctors. Good Medical Practice reflects extensive engagement and consultation with patients and the public, the profession and a wide range of other key interests about the attributes of a good doctor. These principles form the basis of good and safe practice by doctors.

12. We check that the standards we set are being met by the medical schools, postgraduate deaneries and local educational providers (hospitals, GP surgeries and other healthcare organisations). This includes inspections, surveys of trainees and trainers as well as various annual reports and data provided by organisations such as medical schools, deaneries, medical Royal Colleges and local organisations which deliver training. Indeed, our annual trainee survey, the only one of its kind that we know of, provides a comprehensive picture of the views, experience and perceptions of more than 46,000 doctors working across the UK, providing care and treatment for millions of patients. We also respond to any concerns or issues that may impact on the quality of medical education and training or on patient safety. We publish reports of our inspections and other quality assurance activities on our website.

13. Despite reducing fees (paragraph 10) since we took on postgraduate education, we have allocated additional staff to monitoring the quality of education and training and we will be increasing resources again in 2012. We are also establishing a new team of doctors whom we can send to organisations where we believe there is a serious education or training concern. The team will provide an immediate assessment and provide advice on next steps, which can range from monitoring the position to withdrawal of trainees, where it is judged that patient or trainee safety is at risk.

14. Our standards and outcomes are set out in two key documents. First, in Tomorrow’s Doctors, we set the standards and outcomes for undergraduate medical education, which medical schools must follow. Second, in The Trainee Doctor, we set out the standards and requirements for the Foundation Programme (the first two years after graduation) and for specialty (including GP) training.

15. Although statutory responsibility rests with the GMC, we rely on considerable input from a range of organisations, including universities, Royal Colleges, deaneries, Medical Education England and NHS Education Scotland and the NHS itself. These organisations help to ensure doctors in training are equipped to meet the needs of patients and the public. In future, in England HEE will be one of those key organisations, although as yet its role has not been fully developed. Until that happens there remains a risk of confusion about both roles and responsibilities. We believe we can work well and effectively with the new body and look forward to developing a memorandum of understanding with HEE aimed at clarifying and facilitating our respective roles.

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5 http://www.gmc-uk.org/Education_strategy.pdf_39254208.pdf

6 We are currently reviewing this guidance and consulting on a revised edition of Good Medical Practice http://www.gmc-uk.org/guidance/9738.asp

8 The reports of the National Training Survey are available on our website: http://www.gmc-uk.org/education/surveys.asp
Quality Improvement Framework (QIF) and the postgraduate deaneries

16. The Committee wishes to consider the future of postgraduate deaneries.

17. The way in which we assure the quality of medical education and training relies on a three tier model. The GMC itself undertakes quality assurance, medical schools and deaneries quality manage the system, and local education providers (LEPs)—the frontline services are expected to provide quality control. In practice this means that the GMC sets the standards, requirements and outcomes for medical education and training. The medical schools and deaneries provide evidence that the standards are being met by the LEPs. The medical schools and LEPs ensure that students and trainees receive the education and training which meet the required standards.

18. As our response to the Developing the Healthcare Workforce consultation made clear, the role of the deaneries in this model is vital. They perform a critical role in making sure that at local level trainees receive high quality training; and to this end we work closely both with individual deaneries and their umbrella body, the Conference of Postgraduate Medical Deans (CoPMED).

19. It is essential that there continues to be an effective means at local level of ensuring quality under the new arrangements. In particular, we believe the postgraduate deans and LETBs should continue to be accountable to the GMC for managing and delivering high quality medical education in their area. This requires a continuing and direct relationship between the deaneries and the GMC. It also requires that postgraduate deans should have a measure of independence locally to challenge when education is being undermined and for them to be credible education “champions”. We are concerned about potential conflicts of interest within LETBs that could inhibit the ability of the Dean to protect training in a Trust which was itself part of the LETB.

20. We therefore believe that the appointment of postgraduate deans needs to balance national and local involvement, with appointments made, or overseen, by HEE and taking account of advice from the GMC on the attributes and qualities required for these key roles.

Standards and quality assurance

21. Our National Training Survey (2011) found the majority of trainees reported that they experience high quality training. But there are some serious concerns, particularly in relation to supervision of some trainees, the lack of feedback in some instances, the impact of the European Working Time Directive in some specialties and the lack of professional support for trainees during periods of career transition.

22. In 2012 we will begin a fundamental review of the way in which we check the quality of medical education and training. Among other issues, the review will look at how we make sure we are consistent in our judgements, whether we should regulate the educational environment, as well as how we measure and report educational outcomes. The review will also examine how we respond to concerns about poor training, how we work with others to share evidence and intelligence, and how we report findings. We also expect the review to take account of the learning from the Mid-Staffordshire NHS Foundation Trust Inquiry.

23. This drive to improve standards will be complemented by our plans for approving medical trainers. We see this as an important step towards improving the quality of training in both undergraduate and postgraduate education. The approach taken will be similar to that which already exists for trainers in general practice. The aim is to enhance the value and visibility of training and the importance of trainers as role models.

Equitable access

24. We strongly support the Health Committee’s intention to consider how to develop open and accessible careers in healthcare for all sections of society.

25. We continue to build up our advice and support for access to the medical profession. We have published advice, Gateways to the professions: Advising medical schools: encouraging disabled students, to help support students with disabilities at medical school. We are now reviewing this advice and considering whether we should extend it to take account of issues in specialty training. We also think it desirable that the profile of the profession should reflect the diversity of UK society but that individual selection decisions must be made strictly on the basis of an individual applicant’s potential to become a good doctor.

26. There is, and should be, no role for the GMC in individual selection decisions. It is apparent there is a wide range of approaches to selection by the UK’s medical schools, and, consistent with our standards, it is appropriate for us to work with the Medical Schools Council (MSC) to review the robustness of the evidence-base for the various selection tools that are in use with a view to sharing good practice with medical schools.

http://www.gmc-uk.org/education/surveys.asp
Reviewing the shape of postgraduate training to meet the changing nature of healthcare delivery

27. The Committee wishes to ensure that training curricula reflect the changing nature of healthcare delivery.

28. Our report, *The State of Medical Education and Practice in the UK* (2011), emphasises the changing nature of the healthcare workforce, healthcare delivery and public expectations, and the need to reflect these changes in our work.

29. In *The State of Medical Education and Practice in the UK* we suggest that there should be a fundamental review of the shape of postgraduate training across the UK. Discussions have taken place with the four health departments, the Academy of Medical Royal Colleges (AoMRC) and the Medical Schools Council about taking forward this review in 2012, and a process for appointing an independent chair is now in train. We regard this as a fundamental and critical piece of work which is likely to have a profound impact on the future of the medical profession over the next 20 years.

30. The review will need to consider the changes in medical practice and the delivery of care that must take place to meet future needs of patients and how these changes will affect medical education and training. The issues include the balance between specialties as shifts occur in the prevalence of disease, the right balance between specialists and generalists to support more community based care and the need for the curricula which the GMC approves to change in order to address these issues.

31. In the meantime, evidence from recent reviews into medical education and training have identified benefits for adopting generic outcomes for specialty training across all curricula. These outcomes would focus on the knowledge, skills and behaviours we would expect from all specialist doctors working in the UK. They would emphasise our core principles and values, set out in *Good Medical Practice*, and make sure all specialists and GPs are trained to a required level in areas such as communication, clinical management and leadership. The GMC, working with others, is leading a programme to take this forward.

Developing the existing workforce

32. We are pleased to see that the Committee’s remit includes reference to developing the existing workforce.

33. We also welcome the support given in the Government’s proposals for the continuing professional development (CPD) of healthcare staff and the emphasis on multi-professional leadership and accountability.

34. With the implementation of revalidation for all doctors planned to begin at the end of 2012, we have recently launched a consultation on the regulation of doctors’ Continuous Professional Development (which will be a key input to revalidation). It focuses on three areas:

   — Revised CPD guidance which provides a set of principles to support doctors undertaking CPD that reflects their needs, the needs of their patients and the needs of the service in which they work.
   
   — How the guidance should be incorporated into local processes (such as appraisal and personal development plans), and how organisations are responsible for making appropriate CPD provision for all doctors, regardless of their grade.
   
   — How we will continue to identify and disseminate information about key trends and developments relevant to doctors’ future CPD needs. For example our research on issues such prescribing errors and the difficulties faced by doctors at stages of career transition will help doctors reflect and act on their CPD needs.

Conclusion

35. Pressure on health service resources is greater now than for a generation. The temptation will be for education and training to be sacrificed to the immediate needs of the service. That would be a mistake and would not serve the interests of patients either now or in the future.

36. Working alongside others, the GMC has a key role in supporting high standards of training and medical practice and shining a spotlight on those places where they are failing to enable corrective action. The programme of work set out in our strategy describes how we are doing this.

November 2011

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8 The Future Doctors review by the Postgraduate Medical and Training Board, 2009;
Written evidence from The Royal College of Anaesthetists (ETWP 15)

EXECUTIVE SUMMARY

— Importance of and need for support to trainers to deliver training and conduct roles outside their parent Trusts to the benefit of the wider NHS.
— Increased conflict between the delivery of service and the delivery of training and the requirement for this to be addressed.
— Importance of Quality Assurance, the role of the Colleges and accountability of Deaneries.
— The requirement for coherent workforce planning linked to a consultant delivered service with full stakeholder engagement.

INTRODUCTION

1. Anaesthesia is the largest single hospital specialty in the NHS. The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty of anaesthesia throughout the UK, and ensures the quality of patient care through the maintenance of standards in anaesthesia, critical care and pain medicine.

2. The RCoA is responsible for the Anaesthetic Curriculum and in fulfilling its role in maintaining standards in anaesthetic, pain and critical care training through working closely with the Deaneries and the General Medical Council (GMC) in accordance with the Quality Improvement Framework (QIF)10 and the Standards for Training as stated in The Trainee Doctor.11 The RCoA is also responsible for the delivery of the Fellowship Examinations of the Royal College of Anaesthetists (FRCA) which are a mandatory part of the anaesthetic training programme. Details of the FRCA examinations can be found on our website.12

TRAINING

1. The Training Programme. The Anaesthetic Training Programme is a seven year training programme divided into Basic (two years), Intermediate (two years), Higher (two years) and Advanced (one year) levels of training. Successful completion results in a Certificate of Completion of Training. The CCT in anaesthetics can be found at the following link13 and a summary of the programme can be found here.14

2. Training Numbers. There are approximately 4,500 anaesthetic trainees in the UK Training Programme which is delivered by Deaneries and Local Education Providers (LEPs).

3. The Curriculum. The 2010 Anaesthetic Training Programme has been approved by the GMC and is delivered by all LEPs. In addition some trainees remain on the 2007 Anaesthetic Training Programme, also approved by the GMC. The training programmes and curricula can be found at the following link.15

TRAINING RELATED

4. Support to Trainers. There is significant pressure from Trust managers on trainers and those who work to provide good quality training and improve training standards Trusts are increasingly reluctant to allow trainers the requisite time in job plans necessary for training delivery and the work required to meet and further improve the standards for training and assessment. These concerns have been raised in the College’s Annual Specialty Report (ASR) to the GMC. A copy of which is available on request. The College continues to canvass the GMC, DH and Trusts to recognise the importance of trainers and assessors and the need for their work to be appropriately recognised however to resolve the issue a more formal process of recognition needs to be agreed.

5. Support to College Representatives. College Representatives such as Regional Advisers, College Tutors and examiners are often unsupported by their Trusts. College activities, including examining and external QA visits to other Deaneries are often undertaken during personal leave time. Regional Advisers, College Tutors and in some cases Educational Supervisors in both anaesthesia and Pain Medicine are having difficulty fulfilling their training and quality commitments as Trusts are restricting professional leave to perform these key tasks. Representatives are regularly expected to pay back clinical time. For example, a leading first wave foundation trust recently unilaterally reduced Supporting Professional Activity (SPA) time in consultant contracts to six hours per week (1.5 SPA) and further specified that none of it would be allowed to be used for national duties which henceforth must come entirely from Annual Leave and Study Leave entitlement. Although CEOs are outwardly supportive of work for the wider NHS this is not reflected in the approach on the shop floor by CDs and MDs, as a result of the increasing pressures on service delivery in the current financial maelstrom. Solutions are required to enable this essential work to continue as doctors will increasingly feel unable to commit to additional work outside of their Trust, resulting in the non-sustainability of externality and other essential training related activities which benefit the future development of NHS workforce.

References:

12 http://www.rcoa.ac.uk/index.asp/PageID=1148
13 http://www.rcoa.ac.uk/index.asp/PageID=1479
14 http://www.rcoa.ac.uk/docs/TrainingProgramme2010.pdf
15 http://www.rcoa.ac.uk/index.asp/PageID=1479
6. Training vs Service. Concerns were identified in the ASR regarding the impact of service on training. Anecdotal evidence from trainers and College Representative supports this:

- Education may become a “Cinderella activity” delivered on a goodwill basis by overly committed trainers in unpaid time.
- As a result of WTR and the consequent gaps in rotas, trainees are undertaking an excess number of on-call commitments, particularly in ICM at the expense of their anaesthesia training. ST trainees are not getting sufficient emergency theatre work.

There is also concern that the planned reduction of training numbers will impact on service and exacerbate the problems listed above, this was expressed during visits to Schools of Anaesthesia and Specialty Training Committees conducted by the College in 2011.

7. Improving Quality. The role of the Colleges in maintaining and improving quality of training is essential and is emphasised in The Trainee Doctor. Formalising the role and involvement of Colleges within the QIF is essential. Deaneries must recognise the importance of informing Colleges of training issues pertinent to the appropriate specialty. This might be best coordinated by Health Education England (HEE) in order to make the procedure and reporting chains more accountable.

WORKFORCE RELATED

8. RCoA 2010–11 Census. The RCoA conducted a census of all departments of anaesthesia, intensive care and pain medicine from October 2010 to April 2011.16 There are 6,849 consultants UK wide (5,639 in England) of which 209 (107) are less than full time, 1,784 (1,553) non-consultant, non-training grades which includes post CCT (fully trained) doctors not yet in a consultant post. There are 244 (197) consultant posts vacant and 281 (236) SAS/SD grades.

9. Recruitment of Newly Qualified Doctors. A total of 522 Anaesthetic training posts were advertised at CT1 for 2011 (entry level for specialist training), this includes two streams which comprise of two or three years of core training, and the fill rate was over 90%. 314 posts were advertised at ST3 (entry into intermediate training) for 2011. This is a year on year cut of 5% from 2010. Trainee numbers broadly match the requirements for new consultant posts but do not take account of the current vacant posts and more detailed modelling is required in conjunction with the Centre for Workforce Intelligence (CWII) to ascertain accurate trainee numbers which will sustain service needs for the future. Anecdotal evidence suggests that the current reduction in training posts is affecting service delivery and putting a greater burden on specialty doctors to provide service. Specialty doctors currently provide approximately 25% of service. Trainees are integral to service and there is considerable reliance on them.

10. Consultant Delivered Service and Workforce Changes. Time for Training; A Review of the Impact of the European Working Times Directive on the Quality of Training by Professor Sir John Temple advocates a number of key recommendations, principally a consultant delivered service, service delivery implicitly supporting training and focused appropriate training.17 The College fully support the recommendations made in the report. These recommendations still remain an aspiration and it is hoped that further work will be done to implement these. The College has conducted a considerable amount of work on the impact of WTR and this was provided to Professor Temple for the report. Further details on WTR are on the College website.18

11. Feminisation of the Workforce. Feminisation of the workforce will impact on consultant numbers due to the increased requirement for LTFT both in training and at consultant level. Entrants to medical school this year were predominantly female (100% of CT1 anaesthesia trainees in Northern Ireland this year were female) and this trend is likely to increase. Unintended consequences of a move to resident on-call commitments for consultants will have an effect on LTFT doctors and may make anaesthesia a less attractive specialty for women as a result.

12. RCoA Workforce Planning. The College is committed to a coherent and deliverable workforce planning strategy, has engaged with principle stakeholders and is working with them to provide deliverable solutions for anaesthesia, critical care and pain medicine workforce challenges (Appendix A). Anaesthesia numbers are linked to other acute specialties and so any increases in the surgical workforce will require a representative increase in anaesthetists. However, the converse is not true as anaesthetists provide a significant number of other services outside of the provision of anaesthesia to facilitate surgery.

December 2011

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16 http://www.rcoa.ac.uk/docs/2010_CensusSummary.pdf
18 http://www.rcoa.ac.uk/index.asp/PageID=1008
RCOA WORKFORCE PLANNING STRATEGY GROUP—OBJECTIVES AND TASKS

Aim

The RCoA, FCM and FPM are committed to developing a workforce which can deliver the best care to patients to ensure optimal outcomes and facilitate quality improvements.

Principles

- Ensure that decisions are not made in isolation.
- UK wide focus.
- Engagement with FICM and FPM.
- Focus on primary specialty (anaesthesia and ICM) and avoid specialty areas with the exception of pain medicine initially.
- Cooperation with key workforce agencies including Devolved nations, CIWI, GMC, DH (JWG, WAPPiG).
- Involvement and consideration of all grades; consultant, SAS/SD/trust, trainee and non-medical grades.

OBJECTIVES/TASKS

<table>
<thead>
<tr>
<th>Objective/Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep Dive</td>
<td>Work with CIWI and use identified pilot sites to look at anaesthesia, critical care and pain medicine working practices to provide scenarios for further modelling of the workforce.</td>
</tr>
<tr>
<td></td>
<td>- Agree proposed scenarios for pilot.</td>
</tr>
<tr>
<td>Workforce Numbers</td>
<td>Work with DH on anaesthesia workforce numbers to ascertain output and requirement.</td>
</tr>
<tr>
<td>Data Capture and</td>
<td>Agree with CIWI a more pragmatic approach to data capture and analysis to inform decision making.</td>
</tr>
<tr>
<td>Analysis</td>
<td>Workforce Tracking</td>
</tr>
<tr>
<td></td>
<td>Discuss with GMC the availability of ARCP outcome data in order to inform trainee numbers within the specialties and the progress from core to higher specialty training and beyond.</td>
</tr>
<tr>
<td>Workforce Structure</td>
<td>Work with DH, CIWI, GMC to consider workforce structure to include the future of SAS/SD grades and a variety of other grades including trust fellows etc and their role.</td>
</tr>
</tbody>
</table>
Written evidence from Health Professions Council (ETWP 19)

Introduction

1. We welcome the opportunity to give evidence to the Health Select Committee as part of the inquiry into education, training and workforce planning.

2. In this written submission we have included in the annex a copy of our response to the government’s consultation Liberating the NHS: Developing the Healthcare Workforce.19

Background to Health Professions Council

3. The HPC is an independent, self-funded, UK-wide statutory professional regulator for 15 professions working in the health, education and social care sector as well as in independent practice. The HPC currently regulates over 219,000 registrants. Its focus is on the protection of the public and it does this by maintaining a Register of professionals who meet established standards for training, professional skills, behaviour and health. The HPC approves and monitors standards of education and training. It investigates complaints about registrants and takes appropriate action.

4. The Department of Health’s July 2010 White Paper, Equity and Excellence: Liberating the NHS, was followed by the Report of the Arm’s-Length Bodies Review which detailed the intention to move the regulation of social workers in England from the General Social Care Council to the Health Professions Council. Subject to parliamentary approval the transfer will occur in July 2012. The Command paper also sets out the Government’s intentions for HPC to regulate herbal medicine practitioners and traditional Chinese medicine practitioners, and other practitioners who use unlicensed herbs within their practice.

Standards of Education and Training (SETs)

5. HPC uses its statutory powers for approving and monitoring education programmes to ensure that only those who meet its ethical and competence standards graduate with qualifications that allow them to join the Register. These standards are reviewed periodically in order to ensure that they remain up to date with changes in the practice and education environment.

6. We approve programmes which professionals must complete before they register with us. There are currently more than 630 programmes delivered across the UK that have been approved by the HPC (compounded annual growth rate is 6%). The approval process involves a visit and an initial decision about whether a programme meets the standards.20

7. Once approved, there are two monitoring processes in place to ensure that the programme continues to meet the criteria required for approval by the HPC. These two processes are annual monitoring and major change. Annual monitoring requires the provider to submit documentary evidence by which we determine whether a programme continues to meet the standards. Our major change process considers significant changes to the programme notified by the provider. Last year 195 major change submissions were received and 92% of these submissions led to successful re-approval. 8% were re-approved after completing a quality assurance mechanism (a face to face more intensive visit) and were re-approved.21

8. SETs collectively ensure where concerns about a student’s conduct are raised (including whilst on placement) they are effectively managed by the education provider. We would expect the education provider to act appropriately, including considering removing that individual from a specific placement, removing them from the programme, or allowing them to exit with an award that does not confer eligibility to apply for registration with us.

9. By thoroughly assessing education providers and only approving programme providers which are fully compliant with our standards we are able to ensure that students are regulated and work to the highest standards in training and placement. The standards collectively monitor the fitness to practise of students—some particularly relevant standards are outlined below.

10. Standards of education and training: The standards of education and training (“SETs”) ensure students become aware of the standards during their pre-registration education as an integral part of the curriculum. HPC works closely with education providers to ensure that this happens.

11. Admission: The SETs require the education provider to have suitable arrangements in place for admission to the programme including the following: criminal convictions checks; health requirements where appropriate; and appropriate academic and/or professional entry standards.

12. Practice placements: The HPC requires the education provider to take responsibility for monitoring and approval of placement or practice settings. Lack of compliance with these standards can lead to withdrawal of approval of the programme.

19 Not printed
20 See Appendix A
21 HPC Education Annual Report 2010 http://www.hpc-uk.org/publications/index.asp?id=496#publicationSearchResults
HOW PROPOSALS FIT WITH HPC’S EXISTING QUALITY ASSURANCE MECHANISMS

13. We anticipate that the Health Education England (HEE) and the Local Education and Training Boards (LETBs) will see the regulators as complementary to their role in education and training.

14. We also see the complementary nature of our standards with the National Education and Training Outcomes Framework and very much support this outcome focused approach. Consistent with the localism focus of LETBs, the SETs allow for flexibility in programme design and delivery whilst ensuring threshold standards have been met.

15. As the statutory regulator, providers must comply with our standards but we aim to reduce the burden of bureaucracy and work with the provider’s existing quality assurance mechanisms wherever possible. We would welcome the opportunity to explain to HEE and LETBs what we do and how we do it in order to ensure that there is no duplication.

MULTI-PROFESSIONAL PARTNERSHIPS

16. We welcome the development towards a more streamlined, integrated approach to education and training of the workforce. It is essential that the healthcare workforce is managed as a whole rather than in the segmented way that it has been in the past.

17. We think the new proposals can work if the right people are around the table, and the right information is being used to make informed decisions.

18. The challenges will be in ensuring adequate representation of the professions at board level, appropriate workforce numbers and support for the professions once they graduate as well as at the pre-registration stage.

19. It is important that, under the new regime, there is a truly multi-professional input in terms of decision making, be it at the HEE level or the level of LETBs. Partnerships should be multi-professional.

20. The multi-disciplinary deaneries have been a good model, but they were few and far between. They provided a more broad based quality assurance role as well as ensuring that the different professional roles were well understood and included. In Scotland, NES continues to provide a good model for a multi-professional approach.

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

21. Since 2006, the HPC has had mandatory standards in place for CPD that are outcomes based. Registrants who work in all sectors including private practice, local authorities and the NHS are required to undertake and record their CPD, ensure that it contributes to the quality of their practice and service delivery and benefits service users. Random CPD audits check registrant compliance with the CPD standards. These began in May 2008 and are linked with registration renewal.

22. The CPD standards and audit are seen as both quality control and quality improvement mechanisms. The audit is a quality control mechanism in that registrants are sampled to check compliance with the standards. The standards are based on outcomes with a focus on benefits to service users and therefore are a mechanism for quality improvement.

23. The outcome of a failure to meet the standards is administrative removal from the Register. HPC now has over 6,000 CPD profiles and is in the process of undertaking further analysis of the outcomes of the CPD audits to help in the development of risk indicators for the regulated professions.

WORKFORCE ISSUES

24. HPC looks forward to working with the Centre for Workforce Intelligence, the HEE and LETBs in the supply and analysis of workforce data on the 15 professions it currently has responsibility for. Appendix A provides illustrative data on the numbers of registrants from each profession.

25. Workforce planning informs the way in which education and training programmes are structured and funded. We must ensure that education and training programmes and commissioners are equipped with the necessary data to tailor the workforce accordingly.

26. The changing landscape of health needs requires a responsive approach. For example, we know that there has been and will continue to be an increased requirement to provide care outside hospital due to changes in population profiles and a rise in the number of individuals with long term conditions.

27. In relation to these changes there are two key points which need to be considered

   — A recalibration of the proportion of funds available for investment in non-medical workforce, education and training.

   — Increasing investment in the continuing professional development of the existing non medical workforce.
28. During the evidence session on 29 November, the Chair of the Committee asked for specific examples of the ways in which the workforce profile is changing to meet current population needs.

— One example from HPC regulated professions is diabetic foot health care. Current estimates indicate there are 4.5 million people in the UK with diabetes. Of those, 15% are likely to develop foot ulcerations. Foot health care and advice is therefore essential in preventing the development of ulcerations, which can lead to amputations costing on average £48,000 per case. Good practise in the management of diabetic foot health care involves a team of trained technicians who can assess those patients most at risk of developing ulcerations.

— Podiatrists and orthotists provide appropriate appliances, footwear and advice to patients in areas of good practise, this specific foot health regime happens alongside GP and nurse practitioner monitoring of the patient and their overall condition. The team provides a mechanism for minimising risk of foot problems which in turn can lead to mobility restrictions and consequences for maintaining overall health.

Equitable Access

29. We support the Health Committee’s aim to ensure access for all across the healthcare workforce in this inquiry’s terms of reference.\(^2^2\)

30. In 2004, HPC published guidance for people with disabilities considering careers in healthcare.\(^2^3\) In addition, the HPC’s standards for education require all providers to apply selection and entry criteria which include accreditation of prior learning and other inclusion mechanisms.\(^2^4\)

Conclusion

31. There are ever increasing pressures on resources within health and social care. The government should be aware of the continuing necessity for sustained and developed education and training across all professions, both medical and non-medical ensuring equality for doctors, nurses and all other health and care professions.

December 2011

Appendix A

TOTAL NUMBER OF REGISTERED PROFESSIONS NOVEMBER 2011

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number registered October 2011</th>
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<tbody>
<tr>
<td>Arts therapists</td>
<td>3,047</td>
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<tr>
<td>Biomedical scientists</td>
<td>22,765</td>
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<tr>
<td>Chiropodists/podiatrists</td>
<td>13,013</td>
</tr>
<tr>
<td>Clinical scientists</td>
<td>4,524</td>
</tr>
<tr>
<td>Dietitians</td>
<td>7,709</td>
</tr>
<tr>
<td>Hearing aid dispensers</td>
<td>1,667</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>32,802</td>
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<tr>
<td>Operating department practitioners</td>
<td>10,814</td>
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<tr>
<td>Orthoptists</td>
<td>1,279</td>
</tr>
<tr>
<td>Paramedics</td>
<td>17,377</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>46,354</td>
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<tr>
<td>Psychologists</td>
<td>17,172</td>
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<tr>
<td>Prosthetists/orthotists</td>
<td>870</td>
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<tr>
<td>Radiographers</td>
<td>27,651</td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td>12,805</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>219,849</strong></td>
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NUMBER OF NEW REGISTRANTS

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<td>178</td>
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\(^{23}\) [http://www.hpc-uk.org/publications/index.asp?id=82#publicationSearchResults](http://www.hpc-uk.org/publications/index.asp?id=82#publicationSearchResults)

\(^{24}\) [SET 2 http://www.hpc-uk.org/publications/index.asp?id=183#publicationSearchResults](http://www.hpc-uk.org/publications/index.asp?id=183#publicationSearchResults)
### NEW UK APPLICATIONS

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<td></td>
<td>FYE</td>
<td>FYE</td>
<td>FYE</td>
<td>YTD</td>
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<td>234</td>
<td>257</td>
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<tr>
<td>Biomedical scientists</td>
<td>836</td>
<td>831</td>
<td>894</td>
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<tr>
<td>Chiropodists/podiatrists</td>
<td>282</td>
<td>429</td>
<td>427</td>
<td>323</td>
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<tr>
<td>Clinical scientists</td>
<td>469</td>
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<td>Dietitians</td>
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<td>444</td>
<td>453</td>
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<td>1,763</td>
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<td>Physiotherapists</td>
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<tr>
<td>Radiographers</td>
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<td>1,221</td>
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<tr>
<td>Speech and language therapists</td>
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<td>759</td>
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### GENDER OCTOBER 2011

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### AGE RANGE—ALL PROFESSIONS

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<th>Total 2010</th>
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<td>65+</td>
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### APPROVED PROGRAMMES OCTOBER 2011

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<th>October 2011</th>
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<td>Arts therapists</td>
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<tr>
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<td>Clinical scientists</td>
<td>1</td>
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<tr>
<td>Dietitians</td>
<td>33</td>
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BMA memorandum of evidence

1. The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of 147,000 worldwide. We promote the medical allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

2. The BMA believes that the current system of medical education and training broadly works and is not in need of radical reform. Medical education and training in the UK did not develop by planning, rather it evolved progressively over a number of years and incorporated a number of formal, informal, explicit and implicit elements at both local and national levels. The system is complex with interdependent components linked in ways that are not always obvious. It can be easily damaged by ill-thought out changes, however well-intentioned.

3. The BMA believes that a smooth transition into the new system is vital in order to maintain the continuity and quality of the training and education of junior doctors. The BMA is concerned that although there has been no formal detail or guidance published by the Department of Health (DH) about the reforms proposed for education, training and workforce, changes are rapidly underway. The BMA is especially concerned that the final role, function or organisational and legal form of Local Education and Training Boards (LETBs) has not yet been announced; therefore the current efforts to establish Pathfinder LETBs are based only on speculation without clear direction, resulting in very wide variation between the regions in the models used. This poses a significant immediate risk for structures associated with the recruitment, selection and quality assurance for thousands of training posts, and these wide variations will make interaction between national regulators and the sub-national structures much more difficult in future.

4. The BMA welcomed the announcement of the appointment of the Senior Responsible Officer for Health Education England (HEE). However we are concerned that although the NHS Future Forum stressed in their first report (13 June 2011) that the establishment of HEE should be expedited, little progress has been made to date. We would urge that the senior HEE team is promptly appointed in order to avoid significant disruption to the current education and training system.

The future of Postgraduate Deaneries

5. The BMA believes that there should be a national structure of postgraduate medical education and training, and workforce planning with oversight provided by HEE. However, we also believe there is a strong need for sub-national or regional oversight and planning, which postgraduate deaneries have evolved to become highly effective vehicles for delivering. Deaneries are currently responsible for a number of critical functions which they should continue to undertake. Any unnecessary disruption to these critical functions could result in serious implications for doctors in training, for the healthcare workforce in general and for patient care. The current delays to providing guidance from DH on education and training have already necessitated emergency measures, through a specific working group, to ensure stability of business critical functions in postgraduate deaneries and to ensure that trainee doctor recruitment processes in 2011–12 are not significantly disrupted.

6. The current expertise and unique role of deaneries must be maintained in the long term to ensure the quality of training regionally and locally. Deanery functions benefit from being integrated into one deanery
organisation and should continue as such rather than being distributed amongst several provider organisations, and deaneries should therefore be independently housed under the auspices of HEE.

7. Autonomy and independence is necessary for effective oversight and quality assurance, and the valuable autonomy of Postgraduate Deans could be undermined by a close long-term relationship with one employer or provider. Therefore, to maintain this independence, if LETBs are established we believe Deans could be employed by and answerable to HEE and seconded to LETBs to manage the Deanery functions in the LETB’s area. This independence is also imperative to the Deans’ role as Responsible Officers for junior doctor revalidation. We also believe that Deans and Deputy and Associate Deans should have honorary academic contracts with the relevant university.

The future of Health Innovation and Education Clusters

8. The BMA had concerns about the lack of clarity around the overall concept of Health Innovation and Education Clusters (HIECs) when they were first established in 2009, but did welcome their role in promoting research and academic medicine within the NHS.

9. The BMA is concerned about the little impact HIECs have made since their initial establishment, and about their unclear future, as the principle of fostering a positive research culture in the NHS remains important and should continue.

The role of the Secretary of State for Health in the new system

10. The BMA believes that the Secretary of State should have a duty to maintain a system for professional education and training as part of a UK-wide comprehensive health service, and supported the recent Government amendment to the Health and Social Care Bill. The BMA believes that this duty will help ensure more effective national oversight of medical education and training, as well as national workforce planning.

11. The BMA welcomes the new requirement on the Secretary of State “to have regard to the need to promote—(a) research on matters relevant to the health service, and (b) the use in the health service of evidence obtained from research.”, but is concerned that the implementation of any changes to education and training systems (and the wider NHS) must have due regard to this requirement.

The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and Professional Advisory Boards), and its relationship with professional regulators and to the other parts of the new NHS system architecture

12. The BMA believes that HEE should take a national strategic overview and have a clear remit to centrally oversee postgraduate medical education and training. It should generate an ongoing strategy for ensuring that the standards and content of education and training meet the needs of the healthcare system in the long term and the short term. This national oversight will ensure the delivery of consistent standards of education and training, as well as coordinated, equal opportunities for continuing professional, academic and research development. These standards should be compulsory for any provider of education and training and agreed through contractual arrangements. HEE should have sufficient power and resources to mitigate a provider’s failure to meet these.

13. HEE should have an independently appointed Executive Board that sets national principles, guidelines and standards, delegating, as appropriate, to the appropriate professional programme board. The Executive Board should also be required to provide an annual report to Parliament to ensure sufficient accountability. The existing Medical Programme Board (MPB) must continue in its current role of delegated authority to handle operational, policy and technical issues in detail, which the BMA believes it does well at present. Where pan or inter-professional issues need specific discussion, a multi-professional board could sit alongside the other professional programme boards to provide a forum for these issues to be aired and for a consensus to be developed.

14. HEE should be held accountable to ensure that quality assurance processes, as set by the appropriate healthcare regulator, are being undertaken. HEE’s relationship with all the healthcare regulators should be clearly defined, and it should promote information sharing between them. The General Medical Council (GMC), along with the postgraduate deanery, must continue to undertake quality assurance of medical training and should continue to have the authority to remove approval for training altogether from a post or programme.

15. HEE should also be accountable for national healthcare workforce planning. Based on this planning, and an iterative process that includes input from employers, recruitment numbers should be set nationally across the whole workforce, broken down regionally. Medical students and doctors in training should be supplied with information about competition ratios and service needs, so they can make informed career choices.
The proposed role, structure, status, size and composition of local Provider Skills Networks/Local Education and Training Boards, including how plans for their authorisation by Health Education England will address issues relating to governance, accountability and potential or perceived conflicts of interest, and how the Boards will relate to Clinical Commissioning Groups and the Commissioning Board

16. As previously mentioned, the BMA believes there is a strong need for sub-national oversight and planning of postgraduate medical education and training. If this role is to be undertaken by the proposed LETBs, there are certain features which are essential to deliver this effectively and should be included in the required authorisation criteria (appendix one).

17. Stakeholders should be represented on LETBs so that they should have a role in ensuring an appropriate supply of a highly skilled and trained workforce. These stakeholders could include NHS service providers (from all sectors), representatives of trainees and trainers, Higher Education Institutions (HEIs), Medical Schools, HIECs, Academic Health Science Centres, local research networks, local authorities and professional advisory groups.

How the professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

18. Medical Royal Colleges should continue to set their national specialty curricula, in line with the existing guidance produced by the GMC. Employers’ representatives should also be able to input into curriculum development and quality assurance to ensure ongoing relevance to service need. Employers also need to have representative input into quality assurance nationally through close, formal working relationships with the Medical Royal Colleges and the GMC, and through representation on HEE and MPB. Employers and medical Royal Colleges also should be represented on the board of the Centre for Workforce Intelligence (CfWI) and should feed into the Centre’s work.

19. The quality assurance of undergraduate medical education is the function of the GMC, and this must be formally recognised by higher education regulators to avoid duplication of effort and the over-regulation of medicine.

The implications of a more diverse provider market within the NHS

20. The BMA believes it is essential that new providers of NHS secondary care services are required to match, or contribute, on an equitable basis, to the facilities for medical education, training and research available within current providers of NHS services. This is to ensure that, in the event of an increase in the share of services delivered to NHS patients by non-NHS providers, existing opportunities for medical education, training and research are not diminished.

21. Non-NHS providers who also train doctors and students will need regulation in the same way and to the same standard as NHS providers of training and education. NHS providers should continue to provide contractual CPD (continued professional development) for all doctors.

How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

22. The BMA is concerned that non-NHS healthcare providers are less willing and therefore unlikely to provide training posts which will reduce the overall availability of training opportunities, especially if an increasing proportion of patients move into the non-NHS provider for some of their care. Where non-NHS healthcare providers do provide training posts, rather than only resident medical officer posts, the BMA is concerned that they may not be able to provide a broad enough experience to cover the curriculum required for accreditation by the Royal Colleges, because of the more limited (and often simpler) range of cases that are typically undertaken by non-NHS providers at present. All providers and employers of doctors should adhere to the GMC and Royal Colleges’ requirements to complete training, and provide the necessary opportunities.

The role and content of the proposed National Education and Training Outcomes Framework

23. The BMA believes that an Education and Training Outcomes Framework is essential and the proposed framework that has been circulated is broadly acceptable. However, we have concerns that this framework is being developed in a time of change, and its development would need to be handled sensitively during the reforms and in relation to the establishment of HEE and LETBs.

The role of the Centre for Workforce Intelligence

24. The CfWI should provide a whole-system perspective for all healthcare professions and should present the risk analyses and assumptions for all of its projections, estimates and forecasts, without bias. The CfWI should regularly update its projections of workforce supply, with calculations available for review. The role of non-NHS providers of healthcare must be taken into account, as well as changes to the models of delivery of NHS care, such as a shift from secondary to primary care or to the increased use of independent sector providers. The CfWI must forge strong links with HEE, its professional programme boards, the BMA, postgraduate deaneries and individual local training providers in the NHS and education providers, to ensure
that its recommendations are based on the best possible data and agreed strategy, and are implemented nationally and locally.

The role of NHS Employers

25. The BMA believes that NHS Employers should continue their current role of reflecting employers’ views, and acting on their behalf with regard to pay and negotiations and workforce planning nationally. We value the role that NHS Employers has in discharging these functions.

How funding will be protected and distributed in the new system

26. HEE should be held accountable for the Multi-Professional Education and Training (MPET) levy allocations, and decisions regarding this levy should be available on its website. This levy should be protected and only used for the effective delivery of education and training, rather than being top-sliced by employers or used for service delivery. MPB should then take responsibility for the Medical and Dental Education Levy (MADEL) and this funding should then be allocated directly to each postgraduate deanship. MADEL funding should not be used for the continued professional development for other healthcare staff; only posts approved for training by the GMC should receive MADEL funding.

27. Any changes to the Service Increment for Teaching (SIFT) element of MPET should not destabilise the current system and reflect the system locally. We would suggest that funding should be transparent and should pass through the medical schools with funding following the individual medical student. SIFT should cover the cost of facilities in NHS organisations and the time of NHS staff including consultants and junior doctors.

How future healthcare workforce needs are being forecast

28. Healthcare providers should have a duty to provide data on their future workforce needs, and to cooperate with planning the healthcare workforce. Without this, services would not be able to be planned in the medium, short or long term, locally or nationally. They should also be required to make available accurate current workforce census data to inform planning and projections.

29. The projections that CfWI make with regard to the healthcare workforce should be based on a balanced evidence that reflects both employers’ and professionals’ views, with input from lay and patient representatives and from all four nations of the UK, and taking into account the whole workforce of many professions.

The place of overseas educated healthcare staff within the workforce

30. The BMA supports self-sufficiency in medical staffing. The BMA believes more can be done by the NHS to attract UK-resident doctors into posts which historically have been filled by doctors from outside the EEA, but recognises that the rights and interests of doctors from overseas who have committed themselves to working in the NHS must also be protected.

31. The BMA does not support unfettered immigration of overseas doctors but believes that employers must have the capacity to employ staff from overseas, where the staff seek employment in the NHS and where a clear workforce need exists or where an overseas doctor brings specific research skills and experience, or funding. The immigration system must remain flexible enough to employ doctors from outside the UK/EEA where the resident workforce is unable to produce suitable applicants to fill specialist or generalist vacant roles, including locum posts or if an individual has particular skills and knowledge not readily available in the UK.

How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

32. The BMA is concerned that the proposals will result in medical training being inconsistent across the UK. This could lead to recruitment problems in all medical specialities, and especially the small specialities. The BMA believes that there should be medical mobility across the UK to ensure a fair and appropriate distribution of specialists and consistent standards; cross-border movement occurs not just during training but at consultant level too. This mobility should be maintained across the UK, both between the four nations and within each one, to ensure a flexible workforce that works to a consistent standard in all four nations of the UK.

33. HEE and CfWI should formally liaise with each of the devolved administrations to ensure that the UK-wide perspective on workforce planning is not lost. HEE should also be well informed of developments in the rest of the European Union.

How the public health workforce will be affected by the proposals

34. To maintain accountability and line of sight, the delivery and management of public health training should be kept within the NHS family and under the auspices of the Postgraduate Deanelers. To separate this out risks de-professionalisation of the public health workforce, and a decline in the standards of medical public health provision in all three branches of public health practice.

December 2011
Appendix 1

Essential Features for Local Education Training Board Authorisation Criteria

— MPET funding for disbursement should be transparent and received directly by the deanery from HEE, not via an intermediary.

— The host organisation for the deanery (if applicable—some deaneries are presently moving to house themselves within local large NHS Trusts, for example) should have no role in the management or disbursement of the MPET funding. A properly independent quality assurance and management process should be in place to ensure this.

— Funding for staffing, upkeep, etc, for the LETB or deanery should be independent of any host organisation, to ensure full independence of action.

— Standard quality assurance and quality management (QA/QM) processes should apply to all education provider activity by the host organisation as for any other provider (ie no favouritism for the LETB/deanery host organisation if they are also a provider of education).

— Service-level agreements with providers should underpin the QA/QM processes, but should be aligned with the common goals, as set by the GMC, around quality of training and care.

— The LETB should have a separate Board, independent of the host organisation, with input from multiple employers (primary and secondary care, including mental and public health and academic employers), a link to HEE, and trainee and lay representation.

— There must be accountability to HEE for sub-national workforce plans to ensure compatibility with national workforce planning as well as local service demand.

Written evidence from Unite the Union (ETWP 25)

This evidence is submitted by Unite the Union—the country’s largest trade union. The union’s members work in a range of industries including manufacturing, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite represents approximately 100,000 health sector workers. This includes seven professional associations—the Community Practitioners and Health Visitors’ Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA)—and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

Executive Summary

— The Health and Social Care Bill will be a disaster for education, training and workforce planning in the health sector.

— Unite is extremely concerned about how workforce planning, training and education will be provided once large swathes of the NHS are privatised through commissioning to “Any Qualified Providers”. There needs to be clear legal duties on new providers to participate in education training and workforce planning.

— There should be duty of responsibility place on the Secretary of State for Health for education, training and workforce planning.

— HEE, LETBs and the whole education, training and workforce planning system needs to be much better defined, with clearly defined roles, responsibilities and proper resourcing.

Unite Case in Detail

1. Unite is extremely worried about the direction this Government is taking the NHS. The Health and Social Care Bill currently passing through the House of Lords will be a disaster for the health care in England, with knock-on effects across the UK.

2. One of the biggest causes for concern with the Bill is the lack of clear provision for education, training and workforce planning within it. The implications of the Bill of privatisation, outsourcing, fragmentation and increased bureaucracy will seriously undermine any coordination or proactive workforce planning.

3. The Government has still not sufficiently set out a national blueprint for skills or workforce planning. Not only is this key issue absent from the current Bill, but worse still the responsibilities conferred in previous legislation have been diluted (eg the duties on the Secretary of State). Once services begin to be commissioned out, Unite is concerned that training and skills will simply not be taken into account, leading to deficits in appropriate health professionals. Providers will either choose to fill these vacancies by employing already trained staff from the EU or by using lesser skilled and qualified staff in “task” work, who do not have the professional skills to fulfil their role as part of the holistic care of patients. This is already happening in areas
where pathology services are outsourced, and healthcare scientists are being replaced by under-qualified staff who are not able to adequately interpret clinical results.

4. Unite is strongly against the use of non-NHS providers to deliver our health service and thinks that this system will be a disaster for workforce planning issues, staff turnover and ultimately the quality of care the NHS will provide.

5. In particular Unite is concerned about the impact of fragmentation on access to clinical training experience. It is not clear how new trainees will receive this experience and Unite suspects that this will become an additional cost in any contract negotiations. It will be impossible for local providers who may have short term contracts to commit sufficient funds to adequately train the future health professional workforce. Equally, Unite considers that it will not be possible for providers who are in competition for contracts to engage in the necessary cooperation, pooled funding and long term planning to deliver the qualified person to the right job at the right time.

**Balancing Workforce Requirements of NHS and Non-NHS Healthcare**

6. Unite finds it hard to see how the workforce requirements of providers of NHS and non-NHS healthcare will be balanced. The voluntary sector and social enterprises that take on outsourced services will be moving staff out of the NHS training system. This means that they will now have pay for any training they want their staff to get, rather than rely on the tax payer to foot the bill. This has already happened to a Unite health visiting team working for a social enterprise. Unite is worried that many of these organisations may be unable or unwilling to pay for training. Worse still they may attempt to pass training costs onto the workers, especially when professional training is required for them to continue working.

7. In the not for profit sector, when competition was introduced, training was the first thing that disappeared, other than mandatory/statutory training. Unite believes the same thing will happen in the health service. There cannot be an option for the private sector to produce less training than the statutory sector as this will lead to a race to the bottom in training standards that will ultimately hit patients. As a hypothetical example if a non NHS provider such as Turning Point cuts its training for all not for profit work. It wins a contract to run mental health services. It then provides the same level of training to the TUPEd staff as its own workforce therefore bidding for contracts by undercutting other providers.

8. Workforce planning will become harder with the policy of opening services up to “Any Qualified Providers”’ (AQP) The creation of a market suggests the need for over supply of providers and workers, otherwise it will simply be creating a competing layer of legal entities and investors passing staff on between them with every contractual change. With the cuts, this over supply seems unlikely and Unite expects that the real result will be that we enter an era of “famine rather than feast”.

**Breakdown of Agenda for Change**

9. Unite believes that AQP could lead to a breakdown in national bargaining, resulting in health workers being on different salaries in different areas. The Chancellor has already asked the NHS Pay Review Body to consider this option. Any breakdown in national pay bargaining will add considerable costs to employers as they are forced to compete for professional staff across the UK and this will open employers up to challenges through equality legislation.

10. At the moment the health workforce is relatively mobile across the NHS due to defined job profiles under Agenda for Change. Similarly the Agenda for Change agreement created the Knowledge and Skills Framework which provides a requirement on employers and an opportunity for all NHS staff to develop skills and have the chance to progress their career in the NHS. Unite is committed to ensuring that this system is maintained.

**Training Levy**

11. As currently written the Bill places no obligations on providers to play an equal part in workforce development. If there are going to be non-NHS providers, Unite would be supportive of these organisations being forced to contribute to workforce planning. The idea of a specific levy is welcome but does not go far enough. Clinical placements and opportunities for multidisciplinary learning and training must also be included. All practice teachers, mentors, supervisors of clinical training must be trained themselves, and have appropriately adjusted workloads to accommodate supporting students. This should be by law, hard wired into all commissioned contracts along with the NHS constitution. There should be appropriate sanctions for organisations that do not comply.

12. Unite is also concerned about how employers are going to be checked to ensure that they carry out their fundamental responsibility to provide ongoing personal and professional development to the workforce, which may also be part of professional bodies’ requirements to maintain skills for registration. Unite already have encountered problems with this for example where GPs, that employ practice nurses, insist that they do their continuous professional development (nurses have 450 hours each three years) in their own time. There are also already differences in the way employers support the Knowledge and Skills Framework.
13. The fragmented commissioning arrangements in the Health and Social Care Bill are expected to create barriers between different organisations and health staff, and will make it harder for there to be integration of training, particularly across services and providers. It will also make it more difficult to identify suitable and accredited training placements. Private providers, for example, may refuse to provide clinical placements for professionals in training making it harder to train students or newly qualified professionals. These placements should be provided free to students, universities and colleges. There is a lack of clarity as to who will have there responsibility for planning at a national level over a long term scale.

Training Standards

14. In order to counter-act the implications of a more diverse provider market within the NHS, there urgently needs to be a commitment to maintain a set of national occupational training standards, backed up by a statutory commitment by all providers to share workforce data. There needs to be clear proposals as to how this will be monitored, especially the quality of practice placements, given that providers have no reason to stay in contact with colleges and universities.

15. Unite is worried that private sector providers could hide much of this data by using commercial confidentiality rules.

16. Unite also would like to see far more detail about how professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula.

Workforce Planning

17. The sustainability of the Centre for Workforce Intelligence could be key to delivering this. Without good data it will be impossible to understand the required workforce demands for the sector and where recruitment and training are not working. All providers should continue to have obligations to provide workforce data to the CfWI.

18. As it stands, Unite continues to be concerned by the peaks and troughs in vacancy rates and poor workplace planning in many health professions. While the current system is not perfect, these variances are likely to be more marked in the future.

19. Workforce planning should remain a national issue. This is most marked when training specialist health professionals. The NHS needs to steer away from skill mix and people having to work above their professional competencies. This is always a danger when the workforce is cut back and Unite members are already reporting that this is happening due to Government’s austerity drive. Unite members also report the increase in downbanding of roles under the excuse that more automatic procedures are in place. This process leads to a greater turnover.

Duty on the Secretary of State

20. Unite therefore believes that if the Government persists with the privatisation agenda there would need to be a specific duty on the Secretary of State to retain a national system of high-level education and training across all health professions. It is extremely naive to think that this kind of regulation could be anything other than statutory. Unite notes that this issue is still under discussion in Parliament.

21. If there are no national structures in place for skills and training this will mean that skills and training will have to be commissioned at a local level. Unite is not convinced that local authorities will have the information or understanding to plan for long term public health skills needs in their area and this could lead to worsening workforce planning.

22. The Government needs to set up processes for moderating high and consistent standards of education and training across the health service. One concern will be how this is implemented between the various UK countries now they will be organised under such distinct regimes.

23. It is also unclear as to how the existing workforce can be developed and re-skilled for the future (through means including post-registration training and continuing professional development). Unite members report that the Modernising Scientific Careers process has already failed to do this in the last year. Only 16 grown your applicants were successful for the approximately 270 posts that were filled.

Health Education England and the New Structure

24. The structure and role of Health Education England is poorly defined, replacing one layer of bureaucracy with a new one. There is still no clear definition of its powers, responsibilities or how it will be structured and governed. Unite would like to have much more detail about how it will incorporate the roles of Medical Education England and the Professional Advisory Boards. Similarly the relationship to professional regulators and to the other parts of the new NHS system architecture needs clarifying. Lastly Unite would like to know how funding will be protected and distributed in the new system.
25. Unite members want to see much a much greater input from the NHS workforce in Medical Education England so that there is a far greater understanding of the “coal face” training needs. Unite would also like to know what strategies there will be for CPD and PREP.

26. After the criticism that Government plans received from the Future Forum it was promised that there would be clearer guidance on these processes. As yet there has not been.

**LOCAL EDUCATION AND TRAINING BOARDS**

27. In the absence of guidance on how the Local Education and Training Boards should be constituted from the Department of Health many trusts have already started setting them up. The format is varying widely but most are being based on previously existing SHA boundaries. Unite is concerned that these seem to be matching the current Deanery structure. The LETBs need to represent the diversity of the health service workforce including all allied health professionals and non medical staff.

28. Without a clear Government strategy on this there are concerns about the accountability of these new LETBs and the greater risk of conflicts of interests within them. It is not clear how the Boards will relate to Clinical Commissioning Groups and the Commissioning Board or what the role will be for Skills for Health and Skills for Care.

29. Lastly Unite would like to know what the contractual timeframe will be for the LETBs. Will they be on annual or longer term funding? This will have a major influence on their ability to plan for the long term.

**IMPACT ON PUBLIC HEALTH**

30. Public health failure, as defined by the World Health Organisation, is very expensive for the NHS. Therefore Unite thinks that a much greater emphasis must be placed on prevention and early detection of problems. The Coalition Government and previous ones have policies and guidance on this, and in particular the policy to increase the number of health visitors to 4,200.

31. Unite is concerned that there is no additional commitment to increase school nurse numbers from the current extremely low number (1,104 whole time equivalent), with the obvious result that the investment in the health of under five year olds will not be continued as they grow older. The local guidance to the future Health and Well-Being Boards is not clear as to how they must prioritise prevention, and Unite is concerned that illness issues will dominate commissioning priorities. For example, where programmes (such as MEND) are commissioned to treat childhood obesity, or to measure childhood obesity (the National Child Measurement Programme), school nurses are still not trained and employed in sufficient numbers to prevent childhood obesity. We await the final NHS public health outcomes, but are not clear what sanctions are in place for local areas who by commission or omission fail to deliver them.

32. There is no suggestion yet that Public Health England will be well-equipped for workforce development roles, nor how it will relate to HEE. There appears to be a view that workforce development can be managed at local level but a national shortage of public health specialists and consultants will make that impossible.

**R&D**

33. In order for the training curricula to adequately reflect the changing nature of healthcare delivery, there must be a strong commitment to R&D development. This should have national training standards built on the back of these. For example Modernising Scientific Careers (MSC) is a step in the right direction, but it focuses on academia rather than practical skills (creating clinical scientists researching only).

34. Unite notes with dismay the major cuts to HEFCE funding and is concerned that this will have an impact on the future of research and development in the health sector.

**MULTI-PROFESSIONAL AND MULTIDISCIPLINARY LEADERSHIP**

35. The Government has not made any provisions that Unite is aware of for multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels. This issue is extremely important and Unite believes that processes must be brought in to prevent in-house politics from creating barriers to this.

36. While Unite supports the creation of open and equitable access to all careers in healthcare for all sections of society, flexible career paths must not be a skill mix exercise where professional jobs are diluted in order to cut costs. People should be able to progress their careers and this process should be properly funded and trained.

37. Unite members are concerned that there is currently no equitable distribution of resources for different health professions. For example the distribution of MPET funding has already begun with medics dominating, leading to unfair allocation. This issue has been compounded by the evidence that MPET funding has already been slashed (over £50m in London alone).

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25 For example substance misuse, poor nutrition leading to obesity, behaviour that results in injuries and violence and sexual behaviour which causes unintended pregnancy and disease.
38. Unite believes that we need to go back to some of the principles of the Knowledge and Skills Framework, where people should be enabled to develop, and that all organisations are charged with delivering this, or else they lose their contract.

39. As it stands there are currently serious concerns from some Unite members that their qualifications and skills are not properly recognised. For example Unite estates and maintenance workers would argue strongly that their training and development qualifications have not been properly recognised under the current system. These workers undertake a substantial amount of training through the City and Guilds system several years as an apprentice and on the job training followed by specialist equipment training but these skills are still treated as NVQ 2 level. Unite believes that any NHS training and skills structure must work closely with awarding bodies in order to properly value the skills that health sector employees hold.

**Students and Research Funding**

40. Unite is worried about the changes to funding for undergraduate students, as it will be severely impacted by the new university fees regime. Given the high costs now associated with a university degree Unite is worried that this will have a major impact on access to certain professional qualifications creating much great class segmentation in the workforce and undermining equal opportunities for health professions. One major example of this will be in the nursing profession, where those currently doing a diploma would receive a bursary while those doing a degree would need to take out a student loan.

41. In order to have a strong linkage with workforce development and education there needs to be strong systems of career guidance and engagement with schools. In the new structure this will have to come from the LETBs. Unite has not seen any explanation about how this will happen.

42. Unite is similarly concerned about what will happen to post graduate and research funding now that HEFCE has had major cuts to it.

**Impact of Changes to Pay and Terms**

43. The NHS workforce is currently experiencing major upheaval including changes to terms and conditions, pay freezes, job losses and down banding. This is having a massive impact on morale and job satisfaction as well as undermining the professional standards for example in many places school nurses.

44. Unite is also worried about the rapid loss of professional staff and experience from the NHS which is undermining previous workforce plans. The current attacks on the NHS pension scheme will make it far more difficult to keep staff, especially older more experienced staff who may retire early in order to safeguard their pensions.

*December 2011*

**Written evidence from the Royal College of Nursing (ETWP 43)**

**Introduction**

With a membership of more than 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.

1.0 Executive summary

— The RCN continues to call for the Government to further develop its plans for education and training to ensure that their proposals deliver a strong workforce fit for the future. We are concerned that the separate timelines for the Health and Social Care Bill, the outcomes of the NHS White Paper’s supporting consultation Developing the Healthcare Workforce and the continued work of the Future Forum has created confusion, with a risk that different parts of legislation and guidance may not join up.

— The proposals remain too medically focused. We have serious concerns that medical education is likely to dominate Health Education England (HEE). It is therefore essential that the membership is representative and not led by the medical deanseries. We believe that future health care demands will require changes to current roles and responsibilities of health care professionals and there is a real need to traverse the traditional medical and non-medical divide through greater inter-disciplinary education.
— There needs to be greater clarity about the remit of HEE and the proposed skills networks. For example, it remains unclear how the skills networks (or Local Education and Training Boards) will be held accountable for any performance issues and whether HEE will have the authority to do so. We also remain concerned about HEE’s own accountability. We recommend that the skills networks and HEE are chaired by people outside any of the professions, to assure impartiality in the organisation’s decision making.

— The RCN is an active member of the Nursing and Midwifery Professional Advisory Board (PAB), which provides expert advice from stakeholders on workforce planning to the Department of Health and the Chief Nursing Officer. We believe that this group undertakes an important function and would like clarification of how this will be incorporated within the new structures.

— Whilst the Government’s proposals seek to decentralise education and training, we believe that there is still an essential role for the State in delivering these functions. The RCN would like to see the right balance between national, regional and local strategic planning, implementation and oversight.

— Training is often the first budget to be cut when there are financial pressures, such as those that the NHS is currently experiencing. Training should therefore become a protected element in all financial plans and should be underpinned by an assessment of workforce and service needs.

2.0 Will the proposals ensure the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels?

2.1 At present, there is not enough information available on how the proposals will work in practice to be able to say whether they will lead to the right numbers of healthcare staff. With an ageing population as well as an ageing healthcare workforce, the European Commission has predicted a shortfall of 1,000,000 healthcare workers across the EU by 2020.26 In addition, with the move to more integrated care, workforce plans will need to consider what is needed to achieve this across both health and social care systems. A comprehensive workforce planning system, which covers all providers delivering NHS services, will therefore be necessary.

2.2 We have consistently outlined our concerns that if workforce planning is delegated exclusively to local organisations there is a risk that there will not be an appropriately trained nursing and multi-professional workforce able to meet the needs of the population. Local organisations do not have experience of undertaking this role to develop the necessary structures and skills.

2.3 With regards to the nursing workforce, we are concerned that the Government’s proposals are currently too focused on the medical workforce. There needs to be greater recognition of the “boom and bust” cycle in nursing workforce planning, which has been identified by workforce planning experts27 and described by a previous Health Select Committee report on workforce planning.28 The proposals need to ensure that effective engagement with all employers is built into workforce planning systems and that these employers are able to supply robust workforce data and intelligence, which can feed into education commissioning decisions.

2.4 If the new system of workforce planning is provider-led, a key challenge will be to prevent large providers dominating the system. For example, large acute providers may have vested interests and dictate the planning activity to the detriment of smaller, “Cinderella services”, such as learning disabilities services, which predominantly function in social care settings. There may also be difficulty getting “buy in” to the new system from Foundation Trusts and Independent Sector providers.

2.5 The proposals will need to encourage employers to think about workforce planning beyond a twelve month period and to take into account the needs of the wider health economy. Service commissioners will need to be encouraged to engage in the system as getting the numbers right requires constructive input from those who are setting and identifying the demands for the future.

2.6 There is a growing body of evidence which shows that nurse staffing levels make a difference to patient outcomes, experience, quality of care, and the efficiency of care delivery. Highly acclaimed research, carried out by Anne Marie Rafferty, showed that in the UK, patients with the most favourable staffing levels had consistently better outcomes.29

2.7 Over many years, the RCN has made the case for, and carried out research30 into, safe staffing levels, skill mixes and patient ratios as fundamental safeguards to quality patient care. For example, we have advocated the use of a skill mix ratio where 65% of the staff on the acute general and surgical wards should be registered nursing staff, and no more than 35% should be health care support workers.

2.8 We believe that it is vital that the proposals allow stakeholders to work together with the National Commissioning Board to set appropriate and mandated staffing level and ratio standards, and that these are

used to inform workforce planning. We believe that these standards should then be included in Clinical Commissioning Groups’ commissioning arrangements and that system regulators, such as Monitor and the CQC, must then take them forward in their inspection and authorisation protocols.

2.9 In terms of the future public health workforce, there are a number of key challenges. By transferring the public health workforce out of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) into either Public Health England (PHE) or Local Authorities, there will, in future, be a split public health workforce. However, all parts of this workforce will need to work together to deliver the Government’s public health aspirations. It is crucial that there is joined up thinking and scoping of the breadth of the workforce, who will commission it, and how CPD will be maintained.

2.10 Our members who work in public health have serious concerns about any compulsory transfer of the workforce from the NHS to Local Authorities. We expect that trade unions will be fully engaged as stakeholders in this process and will seek to ensure our members retain NHS pay, terms and conditions with access to an NHS pension. In the absence of any formal proposals in relation to the employment of PHE staff and their transfer of employer, the RCN believes that PHE should employ staff on NHS pay, terms and conditions and NHS pension. In the absence of any formal proposals in relation to the employment of PHE staff and their transfer of employer, the RCN believes that PHE should employ staff on NHS pay, terms and conditions and that all staff should continue to have access to the NHS pension scheme.

2.11 In addition, we do not believe that public health specialists (which include nurses) should have a different employer from other public health staff. To introduce any other pay, terms and conditions package would be divisive and create a barrier to future staff retention and employment, as well as potentially leading to equal pay claims.

3.0 Will the proposals ensure that training curricula reflect the changing nature of healthcare delivery, including the medico-legal context?

3.1 Whilst the proposals seek to decentralise education and training, we believe that there is still an essential role for the State in delivering these functions. We would like to see the right balance between national, regional and local strategic planning, implementation and oversight. The RCN accepts that there is a legitimate role for employers in workforce education and training. However, it is essential that there is also national oversight of nursing education and training, and the commissioning of nursing education, to protect national standards and ensure that the future workforce is fit for purpose. National oversight is also necessary in order to meet the standards set for nursing and medical education at EU level.

3.2 We would like assurances that there will be national oversight of training to ensure that it reflects the Government’s aspirations for the future delivery of health and social care and the demands of an ageing population. For example, public health should be a strong theme in all nursing curricula to ensure that prevention and health promotion are embedded in training across the healthcare workforce. Training also needs to reflect the fast moving changes to the use of health related technology, information management and information governance.

3.3 We welcome the proposal that the NHS Commissioning Board will provide oversight for the funding plans for training working in tandem with the Centre for Workforce Intelligence. However, we have concerns about Clinical Commissioning Groups and local skills networks (currently Local Education and Training Boards) overseeing training at a local level.

3.4 Training is often the first budget to be cut when there are financial pressures,31 such as those that the NHS is currently experiencing. However, we recommend that even in the current financial environment, employers should not limit the training undertaken by employees to only what is mandatory. We believe that such a limitation would create a short term gain with a long term loss, as patient care would suffer. Training plans should be underpinned by an assessment of workforce and service needs, which should identify the range of necessary training and workforce development needed. Training should therefore become a protected element in all financial plans.

3.5 We believe that focus needs to be given to the training and development of non registered healthcare staff to maintain and support a competent workforce in all sectors. At present, there is no standardised training programme for health care support workers (HCSWs), who are carrying out more and more of what are seen to be nursing roles. The RCN is currently supporting an amendment to the Health and Social Care Bill, which makes provision for the mandatory regulation and training of HCSWs.

4.0 Will the proposals ensure that all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce?

4.1 Ensuring that all providers and commissioners of healthcare play an appropriate part will be challenging. There needs to be an obligation on providers to engage in the new system, which means supplying workforce information. This obligation could be set through regulation and/or through the contracting process. Without this obligation being put in place, we are concerned that there will be no ownership of the task and that the quality of data provided may not be sufficient.

31 RCN Employment Survey 2011: Views from the Frontline
4.2 With regard to public health, the new Health and Wellbeing Boards, working in collaboration with NHS and Local Authorities, will be where the Local Needs Assessment take place. The RCN would like to see the Government undertake further work to identify if this is where future workforce numbers and training needs will also be debated and managed.

5.0 Will the proposals ensure multi-professional and multi-disciplinary leadership and accountability (encompassing the full range of healthcare professions, specialities and grades) at all levels?

5.1 We believe that the proposed new body Health Education England (HEE) could be a mechanism for developing inter-disciplinary education. However, Medical Education England is by far the largest and best established of the three bodies that will be absorbed into HEE. We are concerned therefore that medical education is likely to dominate the leadership of the new organisation. It is essential that nurse education is treated as equal and the membership of HEE is representative and not led by the medical deaneries. We also want further clarification about how the role of the Nursing and Midwifery Professional Advisory Board will be incorporated in the new structures.

5.2 It remains unclear as to how the skills networks or Local Education and Training Boards (LETBs) (as they are currently known) will be held accountable for any performance issues. More importantly, it is not clear whether HEE will have the authority to do so. In addition, we remain concerned about the HEE’s own accountability, in terms of overseeing the skills networks or LETBs. We recommend that the skill networks or LETBs and HEE are chaired by someone outside of any of the professions, to assure public confidence and impartiality in the organisation’s decision making.

5.3 HEE needs to have strong and effective links with the NHS Commissioning Board, as decisions on service commissioning and planning will be critical to developing effective workforce plans. In our response to the Government’s supporting consultation on Developing the Healthcare Workforce we stated that “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”.32

6.0 Will the proposals ensure consistent standards of education and training?

6.1 In nursing, there has been a problem regarding consistency and standard setting since the demise of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards of Nursing. In addition, the majority of post registration programmes are locally determined, unregulated and variable.

6.2 As mentioned above, we believe that focus needs to be given to the training of non registered healthcare staff to maintain and support a competent workforce in all sectors. At present, there is significant variation across the UK and we do not believe that the Government’s proposed voluntary system with regards to the registration and training of HCSWs will address this.

7.0 Will the proposals ensure that the existing workforce can be developed and reskilled for the future (through means including post-registration training and continuing professional development)?

7.1 At present, the proposals do not make it clear how the Government will ensure that the existing workforce will be reskilled for the future.

7.2 The RCN recommends that CPD is safeguarded against cuts to ensure that nursing staff continue to update their skills and are equipped to tackle the challenges of the future. These challenges include developing better and more effective ways to deliver care for older people and those with long term conditions. We also believe that emphasis for training needs to shift to better represent and include the voice of service users, to help increase understanding of patient experiences.

7.3 The registered nursing workforce expects to participate in CPD, which is reinforced through their regulation. Yet increasingly, the education and training system fails to meet some of the most basic requirements of CPD. For example, equity in training cannot be achieved while some disciplines get their post registration education funded and others do not. The RCN is pressing for CPD to be made mandatory as part of the review of the EU’s legislative framework which sets standards for nurse education and rules for mutual recognition of qualifications across Europe.33

7.4 The RCN believes that CPD and post registration training should be part of the obligation on providers delivering healthcare services, as part of the standard NHS contracting process. For example, the qualification process for providers seeking to deliver NHS funded services should require them to provide evidence of workforce education training plans, with clearly indentified funding streams. It should also require them to provide data to the Local Education and Training Boards and proposed local skills networks on how those budgets are accessed by staffing groups and grades.

5 CPD should be about developing the whole workforce, focusing on role development and expansion. Any system should be cross-sectoral and should move out of professional silos. Funding and resources for CPD should be ring fenced and available to all staff across all grades. We would also like to see providers being able to provide clinical placements and appropriate preceptorships for newly qualified nursing staff.

6 Consideration also needs to be given to CPD, which is designed for the short term (ie to skill the current workforce to deliver care differently in the next two to three years) and CPD, which is based on decisions about training a workforce fit for the future (ie to support more community-based health care in the next 10 to 15 years). There needs to be clearer funding arrangements to support nurses’ post qualification career pathways.

7 There are also significant challenges around the provision of post registration training. For example, there is often significant variation in the standards and course content of comparable programmes at different higher education institutions. The Government’s proposals do not address this as they currently stand.

8 With regard to public health, we believe that it will be important for bodies to undertake scoping exercises locally to establish what they want to deliver and to develop a robust plan of action for the workforce. This plan should include short, medium and long term goals. This should then be used to plan and budget for the commissioning of education and training, which will support the public health workforce.

8.0 Will the proposals ensure open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)?

8.1 There are a number of barriers to flexible career paths. These include: different terms and conditions; different pensions arrangements; and loss of continuity of employment if an individual moves employer.

8.2 The RCN believes that there needs to be some form of equitable access to education and training. There also needs to be a robust Accreditation of Prior Learning (APL) and Accredited Prior Experiential Learning (APEL) approach that will allow practitioners to navigate through the system to the top level.

8.3 We recommend that all education and training for HCSWs should be credit levelled against the Qualifications and Credit Framework and therefore transferrable both across the UK and into higher education settings.

December 2011

Written evidence from UNISON (ETWP 64)

1. INTRODUCTION

1.1 UNISON is the major trade union in the health service and the largest public service union in the UK. We represent more than 450,000 healthcare staff employed in the NHS, and by private contractors, the community/voluntary sector and general practitioners. In addition, UNISON represents over 300,000 members in social care. There is also a wider interest in the NHS among our total membership of more than 1.3 million people who use, or have family members who use, health services.

1.2 This submission offers the union’s views on the questions posed by the NHS Future Forum, as part of its listening events to seek views on education and training of the healthcare workforce.

2. BACKGROUND

2.1 UNISON has proud history of supporting the training and development of its members both as trade union representatives and in their role has healthcare professionals. We have a long standing memorandum of understanding with the Open University and we champion the vital role of lifelong learning. We also support an extensive network of active union learning representatives who assist members to access a wide range of learning opportunities. We seek to enable our members to develop their skills in a range of areas and continue to work with government to drive the widening participation agenda.

3. UNISON’S KEY CONCERNS

3.1 UNISON is worried that too little is known about the role, remit and accountability of Health Education England (HEE). Currently it appears to be solely focussed on pre-registration training and there is little evidence that adequate attention is being paid to the whole workforce. Our fundamental concern relates to the separation of function between pre-registration, post-registration and the development of support roles in Bands 1–4.

3.2 UNISON fully endorses a multi-professional approach to education commissioning. However, it is vital that Health Education England and the local education commissioning groups reflect the diversity of the occupations within the NHS, as well as the diversity of those individuals who access NHS care. HEE will absorb responsibilities previously held by other organisations and UNISON is seeking assurance that this will not result in any single occupation being dominant when it comes to workforce planning, education and training in the NHS. UNISON is also keen to see that staff working at HEE have a proven track record of widening participation. This is particularly important as nursing prepares to move to an “all graduate” profession in 2012.
3.3 UNISON would welcome the opportunity to contribute to discussions regarding the future of education commissioning. Whist we recognise that everything cannot be centralised, we feel strongly that there needs to be adequate strategic oversight to avoid potential shortfalls. For example, nurse places may be commissioned to enable a sustainable workforce, but then the service may train them to become health visitors as soon as they graduate. With the right oversight a balance can be struck which can benefit the whole service, without undermining the original plans.

3.4 Continuous professional development, appraisals linked to the knowledge and skills framework, and personal development plans for all staff must be embedded in day-to-day practice. Despite the best efforts of trade unions and employers, unfortunately there is still a significant proportion of the workforce that does not have an annual appraisal. Many non-registered staff receive little more than basic mandatory training in areas such as fire safety, resuscitation and security.

3.5 NHS employers have a vital role to play in the development of staff. However, we are very concerned that education and training will be compromised as employers are expected to make £20 billion of efficiency savings. In our experience, local training budgets are the first to be hit in times of economic difficulty. Although this isn’t something which employers like to do, it is an increasing reality in many Trusts.

3.6 UNISON would like to see a clear legal duty placed on the Secretary of State for Health to commission education—and also to ensure the continuous professional development of those staff in Bands 1–4. We would also like to see the education and training funds provided to Health Education England and channelled to the Local Education and Training Boards (LETBs) be ring-fenced for this purpose in order to prevent funds being diverted to fill shortfalls elsewhere due to lack of proper funding and the drive for £20 billion efficiency savings and which should include support for the training and development of staff in Bands 1–4.

3.7 UNISON believes that it is of great importance that the NHS education and training budget is managed effectively. UNISON welcomes Recommendation C of the Future Forum Report on Education and Training that: “C. Education is a core element of the NHS High quality education and training are considered to be essential to delivering excellence in healthcare and necessary to underpin any changes to the way healthcare is delivered. It is a core part of NHS business. The NHS Listening Exercise has shown that it is a strongly held view that any successor organisations must remain part of the NHS underpinned by NHS values”.

3.8 We welcome the fact that the government has agreed that education and training is priority and should be included within the Bill (Amendment 44 Earl Howe) However, sadly, the amendment goes nowhere near far enough for the majority of the health workforce as it neglects to include the words “multi-professional” As per Amendment 44 tabled by Baroness Thornton and Lord Hunt of Kings Health—UNISON hopes this will be addressed in the final stages of the Bill’s Parliamentary progress.

3.9 UNISON believes that there needs to be clarity, a clear line of accountability and no potential conflicts of interest over the way funding flows from Health Education England to the Local Education and Training Boards.

3.10 UNISON believes that there is an urgent need to ensure continuity of the Deanery and SHA Workforce Development Planning and Education Commissioning teams to ensure that the necessary skills and experience are not lost to the NHS. UNISON is concerned that the uncertainty over the future LETB structures, staff terms and conditions and number of posts will lead to a loss of skills and experience. UNISON has been concerned to hear that a possible social enterprise model for the LETB has been suggested in one former SHA area, raising serious concerns from staff. We would suggest that the LETBs should be part of Health Education England.

3.11 UNISON has noted a potential conflict of interest if the Higher and Further Education recipients of education and training funds also sit on the Boards of LETBs and take part in decision making that includes the decision to tender and award education contracts.

4. CONCLUSION

4.1 UNISON would welcome further discussion with the NHS Future Forum to enable us to help shape a successful plan for the future of education commissioning. We remain concerned that still too much is unclear about the future process and we would value a meeting to discuss this further.

December 2011
Written evidence from million+ (ETWP 68)

About Million+

1. Million+ is a university think-tank which provides evidence and analysis in respect of the impact of policy and funding regimes on universities, students, graduates and the services that universities and other higher education institutions provide for business, the NHS and the not-for-profit sectors.

The NHS and Social Care Bill and the Abolition of Strategic Health Authorities

2. The abolition of Strategic Health Authorities (SHAs) has significant implications for NHS workforce planning and for the future education, training and professional development of NHS non-medical staff—issues which have been the subject of very little parliamentary scrutiny prior to the Health Select Committee’s Inquiry. Currently, nursing, midwifery and allied health profession education in England is provided via a national standard contract between the SHAs and individual universities which run faculties or departments that specialise in particular NHS professional education and training and have been approved by the relevant professional body. The SHAs are therefore currently the planning and awarding bodies for these education and training contracts in England.34

3. Funding for nursing, midwifery and allied health profession education (NMET) is one component of the “Multi-Professional Education and Training” (MPET) budget which is included in DoH funding of the SHAs. Other components provide funding for postgraduate medical and dental education (MADEL) and support for the practice teaching of medical students (SIFT). The current budget is around £4.5 billion. MPET funding is allocated for NHS workforce education and development for all areas other than for medical training and courses. The Higher Education Funding Council for England (HEFCE) allocates student numbers to universities for medical training and courses as well as for dentistry, pharmacy and healthcare science.

4. At present MPET funding for nursing, midwifery and allied health profession education provides for:
   - pre-registration education;
   - post-registration education; and
   - continuing professional development.

Universities have significant revenue (staff) and capital investments in NMET/MPET contracts and employ academic staff who are experienced practitioners in their field.

5. In addition to nursing and midwifery, MPET funding covers allied health professions such as radiographers, physiotherapists and podiatrists where similar arrangements in respect of registration apply. For example, radiographers must be registered to work in the NHS. For this, they need a degree in radiography from an education centre approved by the Health Professions Council (HPC). All qualifying radiography courses are at degree level, most are three-year courses and students are normally based in a university and in hospital departments for an equal amount of time. Students choose at the outset whether to study for diagnostic or therapeutic radiography degree courses.

Refocusing MPET Commissioning and Budget Reductions

6. The Department of Health (DH) in England signalled that the MPET budget will be cut by up to 15% over three years commencing in 2011/12. Universities in England have confirmed that the number of commissions is likely to decrease by around 10–15%. SHAs have advised that these cuts will be front ended ie with greatest reductions in year one (2011–12).

7. Within this overall reduction, indicative education commissions received by universities from SHAs for 2011–12 demonstrated considerable variation within each SHA region and within individual professions, with some areas (such as physiotherapy) receiving larger reductions over the period. At present, there appears to be a wide level of variation in the number of students being commissioned. For example, in midwifery some universities were initially facing a 50% cut while others were being asked to substantially increase the number of new midwives in training.

8. In the 1980s and 1990s many universities were forced to deal with a “boom and bust” approach to commissioning through large reductions in commissioned numbers for nursing, midwifery and allied health professions followed by large increases in commissions. The NHS experienced staff shortages and the workforce took a number of years to recover and to build back up. This instability resulted in a reduction of professional skills of staff based of higher education and a specialist skill shortage when commissions increased. It would be preferable to avoid this occurring again.

9. There was a very significant concern that DH had used the consultation paper and the NHS reforms to propose that the MPET budget for nursing, midwifery and the allied health professions should no longer fund post-registration and continuous professional development (CPD) provision and be restricted in the future to pre-registration programmes. Funding for post-registration training may understandably not prove to be a high

34 In Scotland, Wales and Northern Ireland, funding is allocated by the individual education funding bodies in the respective nations and devolved administrations for the same areas of professional education and training eg in Scotland MPET student numbers are allocated by the Scottish Funding Council.
priority for Foundation Trusts and GP consortia during a period of radical structural change and when providers will be required to deliver efficiency savings over a four year time-scale on a scale that, as the Health Select Committee have pointed out, has not been achieved in the history of the NHS or by any other healthcare system in the world. However, post-registration training to develop further specialisms is crucial to the effective delivery of improved care in the NHS.

10. MPET funding currently includes NHS professional development and courses for those eg healthcare assistants who wish to enhance their skills. The DH proposal to remove funding for these activities from the future MPET budget and restrict the latter to pre-registration training was seen to be at odds with the life-long learning agenda and the quality agenda to which reference is made in the NHS and Social Care Bill. It is unclear how well the DH’s proposals will serve the future needs of the NHS in terms of continuous professional development and the skills training required to keep pace with developments in care and technology, improve patient care and add value in the drive to improve quality.

11. If the vision for Transforming Community Services is to be achieved, there will be a need for different skill sets to be developed and for more, not fewer, nurses, midwives and allied health professions working in new community services with patients with acute and complex needs. This will require not a reduction in commissioned numbers but a shift in competencies of these staff. People are living longer and staff need to be educated to work with advances in care, treatment and technology. The imperative for needing fewer staff and reducing CPD does not appear to be based on the changing needs of the population or a future vision of health and community services.

Recommendations

12. Consideration should be given to whether pre- and post-registration programmes and CPD funding should be ring-fenced to ensure they are not at risk of being used for deficit reduction in provider organisations that need to make cost savings within the next three years. At the very least there needs to be explicit proposals as to how NHS providers will be incentivised to commission post registration education and training and CPD.

13. Post-registration Education and Training needs to be linked to the DH quality indicator statements. Commissioners of education/senior Trust executives need to understand the role of education in achievements of their quality standards. There do not appear to be any proposed mechanisms for these stakeholders to work together to develop an integrated approach to ensure that education and training is synchronised with service development and quality improvement initiatives.

14. Universities need to be involved in the early stages of the development of NICE quality standards so the planning and commissioning of education provided by universities can be a proactive and an integral process. This would ensure that CPD provision can be developed in a timely manner in pace with the developing needs of services.

15. Robust intelligence needs to be utilised to inform how the reductions in commissioned numbers are to be applied across the individual professions and different regions/localities. Reductions in commissioned numbers need to be sensitive to patient outcomes delivered by each profession/specialists within professions. For example, it would be short-sighted and counterproductive to reduce commissions in areas which are having a positive impact on improved patient outcomes.

Health Education England

16. DH has attempted to address some of the problems associated with the future of workforce planning by the establishment of Health Education England (HEE). Developing the NHS workforce proposed that HEE would provide a multi-professional oversight of the new system. Medical Education England (MEE), which covered medicine, dentistry, pharmacy and healthcare science, will be merged with the allied health professional advisory board and the nursing and midwifery professional advisory board to create HEE.

17. There are risks to this proposal and it will be important for HEE to ensure that the smaller allied health professions are not subsumed to the interests of medical education and the larger non-medical professions such as nursing. The consultation to establish HEE as Special Health Authority was issued on 31 October 2011 with a proposed remit “to support healthcare providers and provide national leadership for workforce planning, education and training”. It is envisaged that HEE will become an Executive Non Departmental Public Body (NDPB), set up by means of primary legislation, in the future.

Local Skills Provider Networks/Local Education Training Boards (LETBs)

18. At present, the SHAs manage MPET budgets according to national, regional and local requirements in terms of workforce planning. Universities are contracted to provide courses and have to meet certain criteria. For their part, universities plan and manage the viability of course programmes and their staffing by appropriately clinically qualified and academic staff and associated clinical placements. They are also required to meet standards and regulations set by the relevant professional health bodies and they have to match these requirements with commissioned numbers. Staff teaching MPET courses are also frequently involved in near-market research with innovative and improved outcomes in terms of products, procedures and organisational efficiency gains in the NHS and health-related markets. The expertise of universities in England in the education
and training of healthcare staff has been an area in which universities have developed international higher education partnerships, training staff in their home countries. This expertise is highly valued and these HE partnerships and contracts contribute to the UK’s foreign exchange earnings.

19. It is questionable whether the local provider skills networks will have the capacity to work in this coordinated way or take a long-term view with student numbers commissioned three years in advance. SHAs also build in additional numbers based on potential attrition and needs of the broader health care economy. The current proposals negate the reality of student social mobility and opportunities to be employed nationally and internationally. It may prove to be difficult to attract high calibre recruits if the market is destabilised in the manner proposed.

20. Originally, DH proposed that Local Provider Skills Networks should be established without specifying the governance arrangements, geographic basis or number of the latter and their relationship with HEE. It was not clear how many of these networks should or would operate in the future. The transfer of the current planning and commissioning function of the ten Strategic Health Authorities to a plethora of local skills networks was a significant cause of concern and further uncertainty in the future planning and commissioning of MPET/ NMET provision.

21. As a legal entity HEE would be able to award contracts. However, if the Local Provider Skills Networks were also expected to commission and award contracts eg for NMET and allied health provision, they would have to be established as legal entities. This would be hugely costly and bureaucratic. In any case, it is difficult to see how this could be achieved prior to the abolition of the Strategic Health Authorities in April 2012.

22. The current arrangement whereby NHS Foundation Trusts operate as independent businesses contracted to provide care is less likely to encourage collaborative working with their competitors. It is difficult to envisage how these Trusts will come together to inform the commissioning of pre and post registration programmes particularly in specialties where student numbers are low and costs high.

23. HEE itself will be established as a Shadow Special Health Authority and will be informed in the long run by the Centre for Workforce Intelligence which is a welcome development. However, the latter will not be functioning in time to inform commissions in 2012/13 and the timescale for its implementation needs to be brought forward. Under DH’s previous proposals, HEE did not appear to have the power of direction over local skills networks to ensure that a more long term approach to workforce planning is able to influence local decisions in the future.

RECOMMENDATIONS

24. Health Education England (HEE) should have an independent Chair and a Board that includes expertise in the commissioning of NMET and all of the allied health professions provision and not just medical education.

25. The establishment of HEE should be underwritten and accompanied by Ministerial commitments that HEE will be provided with an agreed budget which is sufficient to meet operational support and staffing costs.

26. The relationship between HEE, the Centre for Workforce Intelligence and the Local Education Training Boards (LETBs) should be fully clarified.

27. The staffing arrangements, geographic basis, operational costs and the governance arrangements of the LETBs (which are now proposed will provide the functions formerly envisaged for the Local Skills Provider Network) need to be transparent with funding allocated for operational costs and the status of the LETBs as legal entities set-out.

28. Workforce planning at a local and national level must be multi-professional if not interprofessional and avoid professional silos, both in relation to funding and the structures and governance arrangements that underpin workforce planning.

29. There needs to be greater clarity about the responsibilities of providers (GP consortia and Foundation Trusts) to fund training and co-operate with the LETBs and HEE to identify future workforce requirements. Clarity will also be required about the future provision of placements.

30. There should be ring-fenced funding for health education and training among providers of healthcare and there should be an agreement of the continuation of a nationally negotiated benchmark price.

31. There must be clarity about how the new arrangements will provide for the development of non-medical post-registration career pathways, to facilitate a continuous culture of learning and development and to support the delivery of new pathways of care.

32. It is currently suggested that the structure of the LETBs—the main bodies determining local health professional education needs—will only allow for one representative from higher education (not one from each university as is now the case with Local Education Partnerships). In addition this representative will only be in attendance and will not have decision making/voting powers. This is a serious point of contention in the new arrangements. There should be a representative from each university and they should have individual decision making/voting powers.
33. There must be representation of both non-medical and medical education on the boards of the LETBs. To avoid conflicts of interests (which will apply to teaching hospitals as well as universities), commissioning sub committees should be set up to deal with commissioning issues within LETBs.

34. Decisions should not be based on current press reporting eg about nurses receiving “too much” academic content and not enough practical experience during their pre-registration courses but should be based evidence-based. As a statutory requirement all nursing programmes deliver 2,300 practice hours for nursing students (as opposed to 1000 for occupational therapy and radiography and 400 for speech and language therapy students within the same length programme).

35. Education commissioning should be sustainable and informed by evidence, medium to long term workforce planning and include funding and administration for clinical academic and research pathways at a national level. Again there is a lack of transparency as to how this will be delivered within the new arrangements.

36. Further thought need to be given as to how commissions and funding for education and training is aligned with funding for research and knowledge transfer.

37. Consideration needs to be given to how university academic staff and researchers are included within the workforce plan of the NHS rather than being viewed separately. Most university staff working in health are required to have a practitioner background and current registration with a professional body. Arrangements need to include a clear career pathway for practitioners to enter the academic workforce and maintain their professional registration.

**Transparency and Transition**

38. The NHS in England must have an agreed and transparent strategy for the future planning of non-medical workforce education and in particular, a mechanism for the allocation of funds for the education, training and professional development of these staff. It is essential that there is clarity in respect of funding arrangements during the transition period and also the funding arrangements that will be applied in the future.

39. The future award of contracts for the education, training and professional development of non-medical NHS staff are likely to contribute to the drive to achieve efficiencies within the NHS. The risk is that low level commissioning arrangements which lack transparency or robust governance arrangements will not promote effective commissioning in respect of future MPET/NMET education, training and the continuous professional development and innovation which are essential to improved patient care.

40. There is undoubtedly also a risk of instability and short-termism which would make it increasingly difficult for universities to plan strategically and could result in the loss of higher education expertise and expensive capital infrastructure which has been funded from the public purse. This could result in universities having small “branch” cohorts which are uneconomic and could result in students having to travel some distance between placements and the university/academic provider.

**Recommendations**

41. New funding arrangements must provide for an agreement about:
   - the allocation of a tranche of funding for MPET/NMET in advance of the abolition of the SHAs and prior to the introduction of the new NHS organisational and funding framework;
   - the future allocation of MPET/NMET funding bearing in mind the requirements to make effective and efficient use of HE facilities and the need to avoid unnecessary bureaucracy and transaction costs within the NHS and higher education institutions; and
   - allow for pump-priming for innovation.

42. The Select Committee should investigate whether future arrangements are more or less likely to increase administration, bureaucracy and quality assurance requirements in both the NHS and in universities.

**Partnership Approach**

43. There would have been considerable merits in DH adopting the partnership approach currently deployed in the devolved administrations in terms of the planning and allocation of MPET student numbers. This approach already operates in respect of medical training, dentistry and pharmacy in England and will continue under the reforms proposed by the NHS and Social Care Bill. The Scottish Funding Council (SFC) performs a similar role for medical education in Scotland. However, the SFC also manages the allocation of non-medical NHS education and training and associated numbers. These arrangements are proven, known to be workable and are administratively effective. They therefore offer a simpler and less bureaucratic system than currently operates for MPET/NMET funding in England.

44. If a similar approach in respect of the MPET budget was adopted following the transfer of responsibility from the SHAs in England, it would have the advantage of introducing a less bureaucratic system than at present while delivering transparency and an organisational framework for forward planning with HEE taking account of and mediating needs identified on a regional and local basis.
45. It is a missed opportunity that the new arrangements will mean that the education and training of nurses, midwives and allied health professions are still commissioned differently from medical staff, dentists and pharmacists. In addition, unlike funding for medical staff, dentists and pharmacists, funding for nurses, midwives and allied health professional staff will not be ring-fenced. This increases financial risk for universities in what is already a challenging economic climate.

RECOMMENDATION

46. Consideration should be given for England to adopt a similar partnership arrangement to that in the devolved administrations, in liaison with HEE to allow employer needs to be aggregated in the new NHS organisational structure. A partnership approach should be developed between employers and providers with HEFCE taking on similar responsibilities to those already managed by the SFC in Scotland. Such an approach would:

— ensure that a partnership approach was developed between NHS employers and HE providers;
— provide for the professional bodies for MPET education and training to continue their role in maintaining quality and standards;
— ensure that best use was made of expensive university infrastructure; and
— avoid higher transaction costs among providers.

December 2011

Supplementary written evidence from million+ (ETWP 68A)

ABOUT MILLION+

million+ is a university think-tank which provides evidence and analysis on policy and funding regimes that impact on universities, students and the services that universities and other higher education institutions provide for business, the NHS, education and the not-for-profit sectors.

The NHS White Paper “Equity and Excellence: Liberating the NHS” published in July 2010 triggered a number of uncertainties in respect of the future of NHS workforce planning and commissioning in England. Million+ has previously submitted detailed evidence to the Committee’s Inquiry and Professor Les Ebdon, Vice-Chancellor of the University of Bedfordshire appeared as witness to outline specific concerns in respect of the future multi-professional education and training (MPET) budget and the future pre-registration and post-registration training and professional development of nurses, midwives, the allied health professions and healthcare assistants.

As previously outlined the changes in structure and funding which have been proposed (and in some cases implemented) together with reductions in commissioned numbers, have created risks not only in the NHS but also for universities and higher education providers. The latter are currently awarded commissions from the strategic health authorities in respect of the MPET budget and there is an agreed system of consultation to consider local as well as national needs, commissioning and funding. For their part, universities need to manage their own strategic planning and have significant investments in highly qualified professional staff, capital equipment, infrastructure and research related to healthcare at both undergraduate and postgraduate level and in continuing professional development (CPD). This short supplementary evidence is intended to update the Committee in the final stages of its Inquiry.

TIMELINE OF NHS AND HEALTH EDUCATION REFORM

Although the NHS White Paper was published in July 2010, consultation on workforce planning only began in 20 December 2010 with a closing date of 31 March 2011. Prior to the end of this consultation period, the Health and Social Care Bill was introduced into Parliament on 19 January 2011. Following the pause in the legislation, the Future Forum included a specific strand of work related to education. However, Liberating the NHS: Developing the Healthcare Workforce from Design to Delivery, the Department of Health’s response to the 2011 workforce planning consultation and the Future Forum work was not published until 10 January 2012.

In the meantime, the NHS Operating Framework was published on 24 November 2011 setting out shorter-term strategic priorities and highlighting the role of non-medical staff in the delivery of services.

In spite of the extended period of time which has elapsed since the original consultation, a number of significant questions remain about the future policy, organisation and funding of NHS workforces planning and education. These centre on:

— The robustness of the future policy framework and planning mechanisms.
— The adequacy of the funding framework.
— Future governance arrangements including the potential for conflicts of interest and the failure to guarantee representation of all HE providers on local education and training boards (LETBs).
— The impact of reductions in commissioned numbers and the new system on the future viability of HE provision.
FUTURE FUNDING FRAMEWORK: KEY QUESTIONS

For the time being MPET expenditure will continue to be top-sliced from the main NHS budget and this has been broadly welcomed by universities. However the top-slice has fallen in percentage and real terms from just over 5% of the budget in 2007–08 to approximately 4.6% of the budget in 2011–12. Moreover, a number of key elements in particular of NMET (Non-Medical Education Training) funding are being transferred to providers while the future of some funding streams is either unknown or uncertain.

Funding streams being transferred/uncertain include the following:

- Non-medical student bursaries (£525 million): the education policy framework is silent on the future of these student bursaries.
- Salary support for staff seconded into education (£230 million): it appears that in future this will be the responsibility of NHS employers.
- CPD and post-registration learning (£101 million): only some will be allocated from central funds in future; if funds are transferred direct to providers who can award contracts to themselves there is the potential for conflict of interest or in the alternative the possibility that less CPD will be undertaken. DH may still wish to seek to impose a levy to fund post-registration training.
- Clinical academic pathways (£20 million): the framework is silent on the future of this funding which provides support to develop academic researchers and educators in healthcare (already acknowledged by DH to be essential to healthcare education and activity in view of the higher age profile of the workforce).

In addition, MADEL (Mental and Dental Education Levy) trainee salary support attracted funding of £59 million while £9 million was provided from the national NMET budget for university management and administration support.

It is not known how the DH budget will be allocated to LETBs while the number of LETBS and the date when they will become legal entities remain undecided. Universities UK has estimated that these proposals have the potential to transfer £1 billion (20%) of the central NHS education budget to LETBs with differential regional risks according to the current distribution of different funding streams to SHAs with consequential uncertainties for university providers in those regions.

GOVERNANCE: KEY QUESTIONS

Health Education England (HEE) has not yet been established via a legislative process. The details as to how higher education will be represented on HEE’s Strategic Advisory Forum (which will include representatives from the NHS Commissioning Board and the Care Quality Commission) are unknown. Nor is it clear whether the Strategic Advisory Forum will have any formal authority or whether its role will be limited to an advisory capacity either before or after key decisions have been made.

LETBs may include a majority—and possibly a monopoly of healthcare providers. The latter tend to be concerned with immediate or short-term workforce requirements rather than achieving sustainability and stability in workforce planning and education.

For example, it is not clear why clinical academic pathways would be funded by these providers/LETBs or to what extent they will in practice be concerned or required to take account of the aging NHS and academic workforce.

There is also the risk that the LETBs will be dominated by the needs of acute providers bearing in mind the different organisational structures that will operate in community-based care. It also appears possible that NHS providers in receipt of CPD funding will be able to award CPD training contracts to themselves.

VIABILITY OF HE PROVISION

How significant amounts of national funding will be divided up between LETBs and/or health providers remains unclear and it is unclear how regional coverage of specialisms will be balanced. Unless this is resolved, question-marks will continue to hang over the extent to which regional education and training provision will be maintained and how the viability of different specialist student cohorts will considered on a regional basis especially bearing in mind that reductions in numbers are already taking place.

For example, NHS London has announced a 20% reduction in nursing places in the capital from 2,000 to 1,580 a year. Other regional reductions over the last three years include a 41% reduction in the number of physiotherapists and a 29% reduction in the number of radiography (therapeutic) students being trained in the former South Central region and an 18% reduction in radiography therapeutic training numbers in Yorkshire and Humber.

QUALITY AND ACCOUNTABILITY

LETBs will have to account for their activities to HEE and to take account of quality when they commission training and education places. The latter will be evaluated by a new Education Outcomes Framework (EOF),
However the EOF is still under development. It is not clear how health and the extensive quality networks already operated by universities will align.

**CONCLUSION**

Concerns about funding, structures and future governance of HEE and in particular the LETBs have to be considered alongside changing service needs, the projected rise in the aging population, innovations in technology and service design and patient expectations. The framework for NHS workforce planning published in January 2012 fails to clarify key questions about future funding, governance and commissioning arrangements and raises serious doubts as to whether the system proposed by Ministers will provide the financial and organisational stability within the required timeframe that both the NHS and universities need to plan, educate, update and develop the NHS workforce of the future.

_March 2012_

**Written evidence from NHS Partners Network (ETWP 69)**

— NHS Partners Network (NHSPN) is pleased to submit this response on education, training and workforce planning to the Health Select Committee.

— NHSPN represents the widest range of independent sector providers of care to NHS patients. Our members deliver care ranging from primary to acute elective provision as well as out of hours and home-based services. NHSPN is one of the networks of the NHS Confederation—the independent membership body for the full range of organisations that make up the modern NHS.

— Many of our members also belong to the broader based Independent Healthcare Advisory Services (IHAS) which also takes an active interest in education and training.

1. **EXECUTIVE SUMMARY**

1.1 Like all good organisations, independent sector providers are keen to provide high quality education and training for their staff. There is clear recognition within the sector that it motivates and develops staff while making a positive contribution to patient care and the wider system. However, the independent sector’s contribution to education and training has historically been overlooked.

1.2 Many independent providers are already heavily engaged in training and educating staff. We know from talking to our members that they all provide some form of training. This includes training for general staff, medical training and learning and development programmes that go beyond organisations’ own employees and extend to a variety of medical, nursing and allied health professional students. Our submission makes reference to some specific examples highlighted by our members.

1.3 While workforce training is extensively provided by the independent sector, medical training varies more widely. This submission covers the factors which prevent organisations from providing more education and training. These factors include:

— the number and range of procedures the sector is permitted to perform;
— contractual restrictions;
— a reluctance by the Deaneries, Royal College and others to engage and permit independent sector training opportunities. This is a historic reluctance which is changing; and
— a requirement by some teaching hospitals to provide “similar” training for all students on large courses. This prevents placements with smaller providers offering high-value, but limited volume, experience.

**Our recommendations**

1.4 The Government’s reforms of the health service aim to create a more diverse and plural system. The intention is for more innovative models of care to be delivered by a wider range of organisations including independent sector providers. Our submission makes several recommendations for the Committee to consider when looking at how healthcare providers can provide good standards of education and training in the new system:

(i) DH decisions to reshape the new system should be based on a clear understanding of education and training already available—we know from our members that the picture is more diverse and complex than is usually assumed. More research is therefore required to quantify this and to understand the reasons that prevent wider engagement.

(ii) Any future arrangements must retain good practice. The complex and varied nature of the education and training the independent sector provides (much of which is based on goodwill and provided at no cost) means there is a risk that an over-simplistic or one-size-fits-all approach could jeopardise education and training currently provided by the sector.

(iii) Any future arrangements should also ensure there is a level playing field for all providers. There should be a presumption that Royal Colleges and Deaneries will cooperate with all types
of provider and remove unnecessary restrictions on the independent sector from offering training. For example, Independent Sector Treatment Centres (ISTCs) provide an ideal learning environment because of their model of high volume focused care that deliver some of the best case-mix adjusted clinical outcomes in the country. More could be made of these opportunities.

(iv) There needs to be a clear unambiguous message at a national and local level that all providers are entitled to, and should be encouraged to, participate in partnership working on education and training. Mechanisms should also be put in place to ensure that providers involved in delivering care through Any Qualified Provider (AQP), and as a result of competitive tendering, are fully engaged with local networks and the wider health economy, to allow them to play a part in education and training.

(v) When assessing the effectiveness of training and education at an organisational level it is more meaningful to have the most important indicators related to the overall quality of care delivered by an organisation to patients, rather than process-oriented measures such as the number of training courses completed.

(vi) Education and training in the new system must be flexible so it can reflect changing models of care. Similarly, approaches to this issue need to be appropriately tailored. The issues around education and training facing independent sector providers vary across different localities and also by the type of care provided. It is therefore important that analyses are sensitive to the varied challenges that face each type of provider, the restrictions that are in place and appropriate solutions. These tailored approaches should cover:

- Independent Sector Treatment Centres—many of which are now beginning to develop innovative partnerships with local NHS trusts having initially been contractually prevented from training as part of the first wave of agreements with the DH.
- Other acute elective care—as the range of medical professionals providing independent sector acute elective care has now broadened beyond consultants, there is significantly more scope to develop more systematic medical training and education opportunities for other staff. We are still at the beginning of this journey, but it offers significant potential.
- Primary and community provision and other models of care—this is a wide and diverse area in which education and training takes place, but subject to significant variation both in traditional NHS settings and in the independent sector.

(vii) There has been some discussion about the pros and cons of a levy to be applied to all healthcare organisations so as to include those that do not provide “mainstream” training. Whilst we understand the concept of a levy in principle, without a significantly more detailed understanding of the full range and depth of existing provision, a levy risks distorting competition and jeopardising existing training provision which is often provided without charge. As well as affecting cooperation within local healthcare economies, this could have a detrimental impact on independent and voluntary sector providers, social enterprises and non-teaching hospitals. Because simplification is rarely achieved through introducing additional measures, it would be better to find ways to enable all providers to participate in education and training.

Further detail

2. THE WORKFORCE THAT DELIVERS INDEPENDENT SECTOR CARE TO NHS PATIENTS

2.1 The independent sector enjoys the support of a large number of healthcare professionals. NHSPN members engage 45,000 clinicians, including surgeons, other medical specialties, nurses and other healthcare professionals, who deliver NHS care from an independent sector platform.35

2.2 A high proportion of these healthcare professionals—over 26,300—are doctors. To put this figure into context, the NHS in England employs 106,720 doctors36 while the GMC has 178,301 doctors registered in England.37

2.3 Independent providers directly employ some healthcare professionals, while others work on the traditional Consultant model. These clinicians wholeheartedly subscribe to the principles of the NHS Constitution but believe in the advantages for patients of a plural provider system with alternative approaches to delivering care. They would firmly support a broad based approach to education and training.

35 Total number of non-locum doctors employed by the NHS (103,504) in June 2011 and locum doctors (2,766) by headcount. Source: NHS Information Centre
36 Total number of non-locum doctors employed by the NHS (103,504) in June 2011 and locum doctors (2,766) by headcount. Source: NHS Information Centre
37 Source: The state of medical education and practice in the UK 2011. The General Medical Council—figure relates to 2010
3. **Independent Sector Training Delivers Excellent Quality and Patient Satisfaction**

3.1 One of the characteristics of the independent sector is the generally very high level of staff satisfaction, which is due in part to the fact that clinical staff tend to have more time to spend caring for their patients. Research has demonstrated that high levels of staff satisfaction are linked to high-quality patient care.\(^{38}\)

3.2 The Care Quality Commission’s (CQC) annual state of healthcare and adult social care in England report 2010–11 listed compliance rates for 11 of its 17 core quality outcomes. Compliance rates for independent hospitals and clinics averaged 91% compared with 72% for NHS hospitals. Independent sector rates exceeded those of the NHS for every single outcome considered by the CQC.\(^{39}\) The independent sector can only provide such consistent high performance across the full suite of care-related outcomes examined by the CQC through highly effective approaches to management backed up by a well-trained and motivated workforce.

4. **A Broad Range of Training and Education Provided by the Independent Sector**

4.1 Like all good organisations, independent sector providers are keen to provide training because it motivates and develops staff while making a positive contribution to patient care and the wider system. A number of independent sector providers have achieved significant improvements in staff engagement and satisfaction, with direct benefits to the quality of patient care. This includes situations where staff have transferred across from the mainstream NHS.\(^{40}\)

4.2 It is also important to remember that many independent providers are already heavily engaged in education and training. Information gathered from NHSPN members tells us that:

- Our members invariably provide some form of training to staff—general staff training is extensive in the independent sector and plays a key role ensuring the high quality outcomes referenced above. Medical training varies in volume, range and depth across the country. This variation is largely the product of factors beyond the control of independent sector providers, and relates to:
  - the number and range of procedures that sector is permitted to perform;
  - contractual restrictions;
  - a reluctance by some organisations, including Royal Colleges and Deaneries to engage and permit independent sector training opportunities—this includes a reluctance to engage directly with the independent sector and also concerns about bringing in expertise from overseas;
  - an historic reluctance, which is now changing, by the NHS to utilise training opportunities in the independent sector; and
  - a requirement by some teaching hospitals to provide “similar” training for all students on large courses—this limits the NHS’ ability to take advantage of valuable training opportunities available from smaller providers offering innovative treatments.

- Many independent sector organisations provide extensive learning and development programmes that go beyond their own employees and extend to a variety of medical, nursing and Allied Health Professionals (AHP) students, both undergraduate and postgraduate, through shared initiatives with university medical departments. For example, Care UK provides no-cost clinical practice placements at most of its 60 healthcare sites throughout the UK; including GP and walk-in services, diagnostics centres, clinical assessment & treatment services, and eight hospital treatment centres that specialise in elective surgery.

- Some independent sector organisations provide training to NHS staff for no cost. Clearly this is unsustainable at scale and providers would inevitably have to review their provision of free training if a levy were introduced that inaccurately reflects current practice.

- Organisations that provide care across the country experience significant variation from region to region in the range of medical education with which they are permitted to engage.

- Many providers make annual investments in staff development which are comparable or exceed NHS expenditure on a per head basis.

- Specialist providers, such as Alliance Medical, have trained graduate radiographers in MRI for many years. There is a six-month probationer programme which trains radiographers to a standard to provide quality MRI working in a small department. In addition, Medical Services Ltd has developed structured training programmes for its patient transport staff and is working on establishing an accreditation programme so that staff will have a nationally recognised qualification.

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\(^{38}\) NHS staff management and health service quality. Department of Health. Gateway reference 16495


\(^{40}\) Engaging and involving employees at Circle. IPA, September 2011
Many Independent Sector Treatment Centres (ISTCs) now offer extensive training working closely with local NHS trusts. These opportunities allow trust and ISTC specialists to gain experience providing care both in high-volume specialist centres and in trauma specialties, bringing advantages of breadth and depth of case-mix. Some major independent hospitals take NHS junior doctors on rotation and there is also significant nurse training. ISTCs make a good training environment precisely because they provide the high volumes of procedures needed for those in training to achieve full competence quickly.

4.3 It is clear that the contribution by the independent sector has historically been understated overlooked. For example, the GMC’s *State of Medical Education and Practice in the UK 2011* made just one fleeting reference in its 108-page report to the independent sector in the context of revalidation.

5. A Possible Levy

5.1 There has been some discussion about the pros and cons of a levy to be applied to all healthcare organisations including those that do not provide “mainstream” training. Starting from first principles, we would question whether a levy is the best approach. If its purpose is to compensate for inconsistencies arising from a complex system, then it is unlikely that the levy, which will in itself create further distortions, could succeed.

5.2 Simplification is rarely achieved through introducing additional measures. It would be far better to remove the barriers to training and education thereby encouraging all providers to participate appropriately.

5.3 That said, if a levy is to have any chance of success, it is critical that a more detailed and accurate picture is first achieved that illustrates the full extent of training and education across all providers. This should include research into how best to resolve those factors that limit provision by the independent sector as well as voluntary providers, social enterprises and non-teaching hospitals.

5.4 Without this information, it will be impossible to create a levy that avoids distorting competition and that risks reducing the valuable training and education already provided by the sector often at no cost. Achieving a more detailed understanding of current provision is especially important given that there are numerous examples of extremely encouraging cooperation to improve training opportunities for NHS and independent sector staff. This research is vital to ensure that any future training and education requirements are structured and funded correctly and that costs are genuinely proportionate, taking existing expenditure properly into account.

5.5 As well as affecting cooperation within local healthcare economies, a poorly constructed levy risks a detrimental impact on independent and voluntary sector providers, social enterprises and non-teaching hospitals. The extent of this should be assessed and should include consideration of the likely impact on current levels of cooperation as well as competition.

6. Flexible and Fit for Purpose

6.1 Education and training in the new systems must be flexible and fit-for-purpose Care models will change as new treatments and models of delivery evolve and models of training and education therefore need to reflect these new care models. It follows that structures need to be sufficiently flexible to respond to emerging care models. It is therefore important that:

- DH decisions to reshape the new education and training system are properly informed by the current range of education and training provided by the full range of organisation types. At the moment, this picture is far from clear. Research is therefore needed to establish, the range, cost and effectiveness of training and education provision across all levels of healthcare professionals.

- There is a level playing field towards all providers—there should be a presumption that Royal Colleges and Deaneries will cooperate with all types of provider, regardless of ownership model, therefore removing unnecessary restrictions from offering training from the independent sector. For example, ISTCs provide an ideal learning environment because of their model of high-volume focused care that deliver some of the best case-mix adjusted clinical outcomes in the country. More could be made of these opportunities.

- Teaching hospitals should be encouraged to allow students to participate in a diverse range of placements. These should go beyond uniform provision to allow students to experience innovative care which, by definition, may include lower-volume provision.

- When assessing the effectiveness of training and education at an organisational level, the most important indicators have to be related to the overall quality of care delivered by an organisation, rather than process-oriented measures such as the number of training courses completed.

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41 The 2011 Hospital Guide published by Dr Foster showed that the top four performers for hip operations and the top seven providers for knee operations are all independent sector hospitals. A significant proportion of this provision occurs in ISTCs.
— As well as being flexible about the type of care relevant for education and training, it is also important that it can be scaled both to handle models of care based on small patient volumes and rolled out to train at a larger scale.

7. Effective Partnership between Health, Education and Research at Local Level

7.1 Any approach to partnership working at a local level must be clear that all providers are entitled and should be encouraged to participate. From the work that NHSPN has done with its clinical forum to establish current levels of provision, we are aware that:
— actual levels of participation very significantly across the country, often for reasons which are beyond the control of independent sector providers; and
— the level of education and training provision in partnership with local NHS trusts is significantly higher in many areas than is generally acknowledged.

7.2 Once those initial barriers to participation have been overcome, it is important that all parties are able to benefit from providing education and training. NHSPN members have illustrated several examples where there have been shared education and training opportunities with local providers. For example, several providers of acute elective care operate placements with local NHS trusts where, for the purposes of training and education, the treatment centres are effectively considered as extensions to the NHS trust orthopaedic departments. As secondary care independent sector provision is currently limited to elective provision, emergency care training would generally be impractical at the moment, although providers have expressed willingness to investigate placements related to neuro-rehabilitation etc.

8. Ensuring Consistency with NHS Values

8.1 In common with clinicians who work exclusively for traditional NHS providers, healthcare professionals engaged by the independent sector provider share the same driving motivation: the wellbeing of patients as encapsulated by the best possible quality of care with ever improving patient experience. Clinicians working for NHSPN members share the values set out in the NHS Constitution and have consistently tried to work in partnership with the other parts of the system, in the interests of patients.

8.2 Models of training and education that focus on the values set out in the NHS Constitution will be the most likely to contribute not only to quality but to putting patients at the heart of the NHS.

December 2011

Written evidence from Council of Deans of Health (ETWP 84)

1. The Council of Deans of Health is the representative voice of UK University health faculties providing education and research for healthcare professionals.

2. The Council plays an influential leadership role in improving health outcomes through its integral role in developing an expert health professional workforce (including nurses, midwives and Allied health professionals) utilising its collective expertise to inform innovative educational practice and translational research.

3. The Council of Deans of Health aims to lead and inform health, higher education and research policies that impact on the development of an expert healthcare professional workforce and improved health outcomes across the UK and internationally. We represent the 85 Universities delivering health professional education in the UK.

4. The Council of Deans of Health welcomes the opportunity to provide written evidence to the committee in relation to these crucial issues. We would be happy to provide further evidence, both in writing or through oral evidence, if this would be helpful to the committee.

5. The Council of Deans notes that organisations have been asked to provide evidence to the committee in advance of the Government “autumn” publication—although we understand that the proposals will not emerge until early in the new year. This will, we understand, set out in more detail the roles and responsibilities of the key players within the new system as well as the system architecture which will take forward education training and workforce. Given this timeframe it would be helpful if the Committee were able to take further evidence from organisations as to their views on the new system. The information set out below is therefore based on issues we are keen to see addressed within the new system rather than our comments on the actual system itself or the roles and responsibilities within it which had not been confirmed at the time of writing.

6. To aid the committee’s deliberations we have identified some key principles that we consider must be part of the new education, training and workforce planning system within England. Our submission explores these issues further as well as addressing some of the key questions that the Committee is exploring in its terms of reference which are not addressed in these key principles.
PARTNERSHIPS

7. The opportunity to change the education and training system offers a once in a generation opportunity to ensure that effective partnership working transcends relationships between the NHS and Universities in the delivery of a world class workforce for patients and service users.

8. In tandem there is a need to ensure that the system architecture is able to support partnerships between Universities and the NHS. A number of individuals who have given oral evidence to your committee have emphasized the importance of University representation on LETBs. We fully support this position. This would encourage proper partnership working in the co-production of the workforce by introducing different operational relationships which focus more on transformational workforce change rather than transactional relationships between commissioner and provider. Therefore we would emphasise the importance of representation of both non medical and medical education on the board of LETBs to ensure effective co-production of the healthcare workforce. To avoid conflicts of interests (which will apply to teaching hospitals as well as Universities), commissioning sub committees should be set up to deal with commissioning issues within LETBs. To support this integration LETBs should have independent Chairs.

9. As well as LETBs involving Universities there is also a need to ensure that all of the system architecture can support and nurture the health professional education and research sector in order to ensure better outcomes for patients, supported by an expert workforce. To ensure that this happens there must be agreement on a statement of effective partnership between the NHS and Universities, advocating the role of university led health professional education in improving patient outcomes through co-production of the workforce. This would be renewed every five years, agreed at national level and would form an integral part of the authorization and monitoring arrangements between HEE and LETBs.

NATIONAL OVERSIGHT OF A MULTI-PROFESSIONAL AND MEDIUM-LONG TERM APPROACH TO EDUCATION TRAINING AND WORKFORCE PLANNING

10. The Health Committee has within its terms of reference a focus on “multi-professional and multidisciplinary leadership and accountability (comprising the full range of healthcare professions, specialties and grades) at all levels”. Whilst a great deal of education commissioning and training has been approached from a multi-disciplinary perspective in recent years, we would suggest that in relation to workforce planning, as well as the commissioning and funding of pre and post registration training, there are still uniprofessional rather than multi-professional approaches.

11. The nature of care is changing, with an increased focus on care being delivered in community settings and in ensuring prevention and improved patients outcomes. With increasing numbers of individuals managing long term conditions and more patients rightly wanting to take an increased role in their own care, it will be vital that the future workforce can mirror the increasing focus on public health. The Council of Deans of Health would emphasise the importance of the new education and training system being multi-professional, both in the systems that are set up and in the structures and governance arrangements that will underpin the system. If decisions on workforce planning and education are made in professional silos, then it will not be possible for the education and training system to be flexible and fit for purpose.

12. At present there is little oversight or debate on the education and training requirements of the whole workforce at a national level in England. For example, the latest publication from the NHS Information Centre in October 2011 (which shows the movement in workforce numbers from September 2009 to July 2011) indicates an increase in the number of doctors by 2% but a fall in the number of nurses by 0.2%. Currently there is no single body which is able to suggest whether this is the right direction of travel for the NHS workforce in the medium to long term or which is responsible for long term planning.

13. Additionally at present there are different approaches to the commissioning of pre registration education and workforce planning within each professional grouping. In relation to nurses, midwives and allied health professional commissioning and workforce planning is carried out by Strategic Health Authorities (SHAs). For the 2011–12 intake, there have been projected cuts in commissioning of 10% for pre registration nursing courses, as well as 6.4% for allied health professionals pre registrations courses. However whilst there has been a national initiative to consider undergraduate medical and dental school numbers going forward, there has been little discussion at a national level in relation to non-medical numbers and specifically the cuts to education commissioning numbers and whether this meets long term workforce needs.

14. The nursing and midwifery and allied health professional advisory boards have only had oversight of commissioning figures once these have been agreed at SHA level, but this has usually been after the figures have been agreed rather than at an early stage.

15. The Council of Deans of Health would emphasise the importance of the new system of education and training moving away from the boom and bust approach to workforce commissioning that has characterised recent times (and which is currently evident with non-medical commissions for 2012–13). If we are to ensure the principle of security of supply which underpins the new system, then commissioning must be conducted over a three- to five- year cycle with proper focus on ensuring an appropriate balance between short term requirements and long term sustainability for the provision of education and training in Universities.
16. Given the lack of clarity around medium-long term commissioning and the uni-professional approach to commissioning, we strongly support the introduction of a multi-professional HEE which has a long term focus on workforce planning and which is supported by clear workforce planning information through an independent Centre for Workforce Intelligence. This will allow, for the first time, a focus and discussion on evidence based, medium-long term workforce planning and the related commissioning of education and training. We would strongly recommend that in order to ensure a change in approaches to commissioning, HEE must be set up in a way which encourages multi-professional approaches and that the authorisation criteria it uses for LETBs should ensure evidence of both partnership working between Universities and the NHS, as well as transparent multi-professional approaches to commissioning by LETBs.

17. The relationship between HEE and LETBs will therefore be crucial. There could be a tension between the short-to-medium term priorities that LETBs would see as their responsibility and the medium-to-longer term perspective that HEE should take. If HEE is to have a medium-to-long term view of workforce planning (which we fully support) then there must be greater clarification over the powers that HEE will have over LETBs. For example, if the 4,200 health visitor target was not being delivered through the LETB commissioning plans, what powers would HEE have to ensure that this was delivered? The Council of Deans of Health would advocate a power of direction for HEE over LETBs to ensure that wider workforce needs can be met and this will need to be considered as part of the functions of HEE within the second session Bill.

Sustainable and Ring-Fenced Education and Training Funding

18. We welcome the commitment to ring-fenced funding of the overall health education and training budget and a continuation of a nationally negotiated benchmark price for health professional education.

19. Since the ring-fence of the MPET budget has been removed, we have been concerned that not all of the central investment on education and training has actually been spent on education and training. The Multi-Professional Education and Training Budget must live up to its name: there should be a principle of equitable funding in relation to future workforce commissioning rather than distinct and separate funding streams within the existing MPET. If there is to be funding for junior doctors’ salaries and postgraduate medical-education placements then, likewise, there should be funding for non-medical education post graduate pathways including preceptorships, career pathways structure and advance learning to deliver equity.

20. The Council of Deans of Health has significant reservations about the proposal to make employers solely responsible for funding the CPD of their existing staff. CPD is a critical element of ensuring that the workforce can continue to develop to meet the health and social care challenges of the future. Higher education institutions already deliver cost-effective CPD, building on their high-quality research. Too often in the past it has been CPD budgets that are cut first and, given the current financial climate, there is a real risk to the development of the existing workforce. We would, therefore, recommend that CPD continues to be funded through the central education and training budget.

21. CPD must not become superficial and of a poor quality in response to wider short-term priorities. Moreover, funding for CPD needs to include the cost of releasing staff for development and training. We note the proposal to put new duties on any provider of NHS care and feel that these should be extended to ensure that there is a duty on providers to deliver CPD to its workforce, as well as on the Secretary of State and the NHS Commissioning Board. It will also be crucial that HEE has a role in monitoring and reviewing the continued professional development of existing staff as part of its remit. This will become increasingly important as revalidation requirements are prescribed by professional regulatory bodies.

Clinical Academic Careers

22. The CFWI report of July 2011 on the nursing and midwifery workforce, “risks and opportunities” noted that the profession consider “that the ageing of the academic nursing workforce, combined with planned cuts to student numbers, will potentially result in a shortage of nurse educators in the future, with the associated loss of teaching skills and evidenced practice and research”. We fully agree. The development, workforce and funding of clinical academic careers gets little attention compared to the actual health professional workforce and yet its own sustainability is crucial for the provision of education, training and research within the health professions. We would urge that HEE and LETBs consider, as a priority, the development of non-medical post-registration career pathways, to facilitate a continuous culture of learning and development and to support the delivery of new pathways of care.

23. We also feel that there is an additional function that HEE could take forward to develop the existing and future clinical academic workforce. The next generation of nurses, midwives and allied health professionals will need the same standard of teaching support, research skills and expertise that the current generation enjoy from their academic support staff. However, the cuts to planned student numbers and the ageing academic workforce could lead to a shortage of teaching skills and evidence practice/research in the future. Universities will need sufficient and stable clinical academic staff to allow them to create a sustainable future workforce. These issues must be addressed in future planning of education, training and workforce issues and form part of the initial agenda for HEE going forward if we are to ensure a sustainable clinical academic workforce and associated career structures and in particular to nurture leaders in the research and development workforce.
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Other Issues

24. As we are bringing to the attention of the committee the key issues highlighted above in relation to education training and workforce planning, the Council of Deans would also take the opportunity to comment on the following aspects of the committee’s terms of reference.

Open and Equitable Access to all Careers in Healthcare for all Sections of Society (by means including Flexible Career Paths)

25. Widening participation is a key issue for University providers and Universities delivering health professional education and training have an excellent record of ensuring open and equitable access to careers through selection. HEIs can help students from low-participation backgrounds to realise their potential. Difference is valued in nursing, midwifery and the allied health professions. Education programmes for nursing, midwifery and the allied health professions are, and should be, inclusive. This is achieved through a variety of initiatives including local nursing image campaigns, liaison with schools, summer schools in skills labs etc. There will also be a need for the new arrangements to clearly set out how bands 1–4 staff are to be supported and developed within the new education and training system. It will be particularly crucial that their development needs are not overlooked in the need to identify cost savings.

December 2011

Supplementary written evidence from the Nursing and Midwifery Council (ETWP 92)

The Nursing and Midwifery Council (NMC)

1. The Nursing and Midwifery Council (NMC) is the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands. We were established by Parliament under the Nursing and Midwifery Order 2001 (the Order).

2. Our core purpose is to safeguard the health and well-being of people using or needing the services of nurses and midwives. We do this by:

   2.1 Registering all nurses and midwives and ensuring that they are properly qualified and competent to work in the UK. There are currently around 660,000 registered nurses and midwives on the register;
   2.2 Setting standards of education, training, conduct and performance for nurses and midwives;
   2.3 Ensuring that nurses and midwives have received sufficient education and training to the correct standard to be fit for registration and practice;
   2.4 Ensuring that nurses and midwives maintain those standards;
   2.5 Ensuring that midwives are safe to practice by setting rules for their practice and supervision; and
   2.6 Maintaining fair processes for investigation of allegations made against registered nurses and midwives.

3. This written submission follows oral evidence to the Committee by Professor Tony Hazell, NMC Chair, on 29 November 2011.

Summary

4. We support the Government’s emphasis on linking the quality of care provided to patients and the public to the education and training environment in which health care professionals learn.

5. We welcome the development of partnerships that respond to local need, a greater role for employers in ownership of professional workforce development and an inter-professional approach to education.

6. Within the current Health Education England (HEE) framework, we believe the consideration of national professional standards should come earlier in the process before local needs are set.

7. Local courses must meet national standards to ensure professionals remain fit to practise and short-term service driven considerations should not overshadow longer term workforce development need.

8. There must be effective working partnerships between HEE and the Local Education and Training Boards (LETBs).

9. There must be a clear distinction between the role of HEE to allocate and account for education and training resources and our role in setting UK wide standards of education and professional training.

10. The new system—which covers England only—must integrate the perspective of Wales, Scotland and Northern Ireland to ensure consistent standards of practice in those seeking admission to our register.
11. In giving employers sole responsibility for continuing professional development (CPD), nurses and midwives must be provided with sufficient time and resources to support their CPD which impacts on their practise.

**Education: The Role of the NMC**

12. We set standards for pre-registration education courses which require curricula in all Approved Education Institutions (AEIs) to contain the core components needed to ensure newly qualified nurses and midwives are fit to practise across the UK. We also approve some post registration programmes, for example those leading to a registered nurse prescriber qualification.

13. We are responsible for the quality assurance of over 1,000 nursing and midwifery education programmes delivered by 82 AEIs across the UK. We also ensure that programmes have the appropriate leadership, expertise and mentorship in place and that learning environments for students provide for effective learning. We quality assure mentorship within learning environments to ensure that there are sufficient resources to enable effective learning to take place before AEIs can run approved courses. We take swift action to request the removal of students from environments which we have assessed as unsafe and/or impede the ability for a student to learn and receive a quality education.

14. Education programmes must prioritise the fundamentals of nursing care including dignity, compassion, attending to personal hygiene and nutrition. We require all newly qualified nurses and midwives to leave their programmes competent, confident and fit to practise to provide high quality care.

15. In September 2010, we introduced new standards of pre-registration nursing and midwifery education. From September 2013, all newly qualified nurses in the UK will undertake degree level education programmes. The NMC will not be approving new programmes which are not degree level from 2013. Scotland, Wales and Northern Ireland have already moved to degree nursing courses, as have many developed countries, including Australia, New Zealand, Scandinavia, and Italy. Degree level learning is not a recent development: nurses have been studying to degree level since the 1970s. In Wales, all student nurses have studied for a degree since 2004.

16. Developed after five years of consultation and close collaboration with the Department of Health and other partners, including patient groups, the standards are designed to produce registered practitioners who are highly knowledgeable, highly skilled, able to work autonomously and able to meet the increasingly complex and demanding expectations of modern healthcare.

17. All students learn about fundamental care. They learn about communication: maintaining dignity, privacy and confidentiality; health and safety, moving and handling; infection control; emotional, physical and personal care and meeting comfort, nutrition and personal hygiene needs. All student nurses continue to spend 50% of the programme learning in practice and 50% learning in the university. Successful completion of the programme and progression to registration requires the student to pass both the theory and practice elements of the programme. There is no evidence that a degree level nursing profession leads to diminished standards of fundamental care.

18. The theory and practice elements of nursing education programmes are not changing: only the academic award given at the end. The benefit to public wellbeing will be newly qualified nurses who will be equipped to provide the fundamentals of nursing care and who will also have the ability to analyse and think critically, acting more autonomously, being more assertive and challenge poor practice, to explore alternative approaches to care delivery and achieve better patient outcomes. This change in education level is designed to reflect the complex and increasing demands of nursing and healthcare practice in the 21st Century.

**Health Education England (HEE)**

19. We believe that there must be effective working partnerships between Health Education England (HEE) which will have a national perspective of the changing skills mix required to deliver care and the Local Education and Training Boards (LETBs) which will have a focus on local understanding of how such a skills mix could be tailored to reflect specific local requirements.

20. We have a unique role in setting standards across the four countries of the UK for nursing and midwifery education and in ensuring that programmes contain the core components needed to ensure newly qualified nurses and midwives are fit to practise. We believe that HEE should consult with us at the very start of any process to establish a framework to determine national leadership for education, training and workforce planning rather than once HEE had commenced working with LETBs.

21. We believe that there must be a clear distinction between the role of HEE (which is limited to England) to allocate and account for NHS education and training resources and our role in setting UK wide standards of nursing and midwifery education.

22. We also believe that there must be sufficient safeguards to ensure employers are held to account if education and training does not meet required standards and to ensure short-term service driven considerations do not overshadow longer term workforce development need.
23. The professional advisory boards are made up of senior members of the health education sector with a vast amount of professional experience. We think it will be vital that key representatives from each of the three boards are integrated within HEE in order to continue to play a central role reflecting professional as well as budgetary requirements relating to the provision of education. This is particularly important at a time when the nursing profession adopts new standards for education of which the non-medical professional advisory board were key partners.

24. Successful integration will be dependent on strong terms of reference that openly recognise the individual importance of education, learning theory and provision as well as commissioning, budget and financial requirements. It will also be dependant on establishing clear accountability within these areas to help facilitate effective decision making and ensuring that all the health professions are appropriately represented within the new structure.

LOCAL EDUCATION AND TRAINING BOARDS (LETBs)

25. We support the role of LETBs in facilitating the integration of employers into education and development, responding to local need. Whilst it remains vital that the courses commissioned continue to meet national quality standards, we will continue to support innovative local solutions to achieve those standards.

26. However, local need should not be to the detriment of national strategic need. HEE should require LETBs to ensure that national considerations are addressed when commissioning education and training. For example, a local commissioning solution developed to address specific local education/workforce needs could lead to fragmentation and possible variations in the quality of education. Such unintended consequences could be anticipated and addressed by ensuring strong lines of accountability are in place and clear national standards are adhered to by LETBs.

27. We believe that local courses must meet national standards to ensure professionals remain fit to practise and short-term service driven considerations should not overshadow longer term workforce development. We would welcome early dialogue and a close long term relationship with LETBs.

MULTI-DISCIPLINARY DEANERIES

28. We welcome the proposal for deaneries to become multi-disciplinary. This is a logical proposal given that healthcare is increasingly delivered by different healthcare professionals working together.

29. However, the composition of deaneries would have to include individuals with a detailed knowledge of the appropriate requirements for nursing, midwifery, medical and allied health professional education and training.

30. There must be clear accountability lines for those making the commissioning decisions to ensure that all professions have equity of funding with due regard to existing and future workforce requirements.

CONTINUED PROFESSIONAL DEVELOPMENT

31. It is the responsibility of the individual practitioner to maintain their knowledge and skills and thereby maintain their registration. This is core to professional self-regulation. A system for post registration education and practice standards (Prep) has been in operation since 2001. Prep sets the requirements for revalidation within the framework provided by the code of conduct by which all nurses and midwives must abide. We are committed to delivering a proportionate, evidence based and affordable system of revalidation for all nurses and midwives which will provide assurance that nurses and midwives have completed sufficient learning and practice experience to retain the knowledge and skills needed to deliver safe care.

32. Demonstrating continued professional development (CPD) will be vital to the system of revalidation we are developing. However, the principles of revalidation, which were agreed by our Council earlier this year, do not focus on prescriptive hours or types of learning. Instead, it promotes a philosophy of life long learning in order to illustrate an ability to deliver safe care.

33. We believe that employers must be made aware of the importance of a healthcare practitioner’s obligation to undertake CPD to prove their continued fitness to practise. Sufficient learning and development time and resources should be put in place. There is always a risk that under-investment in CPD may lead to under development of the workforce.

FUTURE CHANGES IN SKILLS MIX

34. We set the standards of education and training for nursing and midwives to which AEIs, who set the curriculum, must adhere to achieve our programme approval.

35. Our standards emphasise the importance of enabling students to learn the flexibility and leadership skills needed to work across a variety of clinical settings. Education programmes ensure that students spend 50% of their learning in practice environments often with practitioners from other disciplines who have different skills and knowledge.
36. This ensures that nurses and midwives completing an NMC approved course leave with the skills and core abilities needed to work across different clinical settings working alongside practitioners from other disciplines throughout their registration with the NMC.

December 2011

Written evidence from NHS Employers (ETWP 99)

EXECUTIVE SUMMARY

— It is widely acknowledged that the current model for commissioning education and training is unsustainable in the long term. This is because service development planning is often poorly integrated with financial and workforce planning, and medical workforce planning is largely done in isolation from the planning of education for other healthcare professionals. There are well known examples in the English NHS where historic education and training planning and practices have led to a significant mismatch between what patients need now and what is actually being provided, for example, the over-supply of physiotherapy graduates between 2006 and 2008 and the under-supply of midwives leading to the national initiative to increase numbers by 4,000 during the similar time period.

— We believe that the current problems arise partly because employers—ie the people who plan, commission and provide care to meet patients’ needs in their local areas—have not previously been allowed enough of a say in shaping the education and training of their staff. The regular changes to architecture have also made stable, long-term planning harder.

— We need a model that is driven by evidence of what is required to meet patients’ needs. Employers in the NHS strongly believe that all levels of the system, national and local, must be led by employers, in constructive dialogue with the professions. They fully support the plans to place them at the front of decision making in planning and commissioning the education, training and development requirements for the health service workforce. This shift in responsibility and accountability is integral to ensuring employers have the appropriately skilled staff available to meet the changing needs of patients.

— All levels of the education and training system must be joined up and connected to work with the service commissioning system. It is also essential that the new system coordinates education and training for the whole healthcare workforce, not only the traditional professional groups. For example, the work of healthcare assistants and assistant practitioners has a big impact on that of clinical professional colleagues and neither group’s education and training should be considered in isolation.

— The activities of the Local Education and Training Boards (LETBs) and Health Education England (HEE) must mirror the strategic workforce intentions of local employers and reflect evidence of the needs of services. In so doing, they must:

  — Cover the whole healthcare workforce.

  — Take decisions as locally as possible—reflecting the increasingly local commissioning of patient services. If, as some stakeholders have suggested, LETBs are required to adopt structures within HEE, it will be even more crucial that HEE is employer led.

  — Decide locally their own models of operation, based on local agreement, to best fit local circumstances.

— Health Education England (HEE) must be employer led and patient focused. It must operate at a national level, rather than as an administrator of LETBs. Its focus should primarily be setting standards and providing assurance.

— Employers across the country have invested significant time in working together locally to form shadow arrangements to enable them to be in a position to apply for authorisation as LETBs. Given the intention to have the new system in place from April 2013, an early announcement on the range of available structural forms for the LETB will be very important to allow them to be authorised and functional in time.

— Employers value the critical functions provided in deaneries and recognise the need to retain skilled staff to ensure continuity in some core functions particularly for doctors in training. It is critical to ensure roles that are retained from the Deaneries form part of LETBs and are therefore part of the planning for the workforce as a whole.

— The financial and service-delivery implications if staff receive training within different providers in future need to be thought through locally by LETBs. However, these are not insurmountable problems and should not be a reason for stopping moving forwards.

— To ensure decisions about education and training are based on reliable data on future needs, we recommend the Centre for Workforce Intelligence:

  — Ensures the data and intelligence is sufficiently “local” to be meaningful to local employers.

  — Ensures strong partnership working with HEE and LETBs.
— Targets information collection where it identifies information gaps.
— We would support ringfencing of the education and training budget at a national level. But budgets for specific services or parts of the workforce must not be ringfenced as this would stifle change and innovation from the outset.
— The Government’s NHS reforms necessitate some changes to the architecture for commissioning education and training. But, in truth, reform would be needed even without those wider changes. It is therefore essential that we do not merely “lift and shift” the current architecture for commissioning education and training into the reformed NHS structures.
— The reforms to education and training present a unique opportunity to maximise the benefits to patients of the £5 billion annual national investment in education and training, and additional local investment. Everyone involved should focus on making the architecture already set out work as well as possible. The aim must be to change the system from the current focus on creating a supply of professionally trained individuals to one of training to improve the outcomes of patients.

About NHS Employers and our role in the system

1.1 The NHS Employers organisation (NHSE) represents the whole range of views from across employing organisations in the NHS in England on workforce issues, and supports employers to put patients first. NHS Employers is the accountable and representative voice of employers and is part of the NHS Confederation.

1.2 Our role is to help employers understand and contribute to changes in the system to enable them to improve the quality of patient care. This includes providing general advice and guidance on good practice, as well as representing NHS organisations to policy makers. We work with the HR community and the whole range of Board level members to ensure we arrive at a position based on the views of employers. As NHSE we will continue to help shape the design and development of all aspects of the revised system to ensure that we can fully represent the range of employers in this process at national level and support them at local level with good practice, advice, support and information.

1.3 In order for the commissioning of education and training to be a success we must see its function in the broader context of the workforce. Our work spans the whole remit of workforce issues and has both an overview and responsibility for the delivery of a number of workforce functions including pay, reward, employment practice, regulation, workforce planning and education and we have an integral role in the new architecture, supporting employers at a local level and representing them nationally within Health Education England (HEE). We are thus uniquely well placed to contribute to this inquiry.

1.4 Furthermore, because NHSE represents the views of both providers and commissioners and sits within the NHS Confederation, we are well placed to comment on how to support close working relationships between the service and education commissioning functions within the new architecture, so that the workforce is equipped to manage and deliver the services being commissioned for the future.

1.5 We are pleased to have the opportunity to submit evidence to this inquiry and would like to encourage the Committee to be bold in its thinking if we are to make the most of the opportunity this reform presents to deliver better, more sustainable care for patients.

What employers in the NHS want from the education and training system

2.1 Many employers have invested heavily in development programmes for their current staff, from offering apprenticeships, vocational training courses and foundation degrees to staff in support roles and postgraduate training opportunities for staff with previous clinical and non-clinical qualifications. Employers have told us this has helped meet changing age demographics of the local workforce, address local skills gaps and has enabled their staff to be better equipped to meet the needs of patients.

2.2 Back in 2008 NHSE asked employers what they needed from a new modernised medical training and career system. They told us they wanted:
  — A modular approach to postgraduate training which allows people to build up credentials for different skillsets which enable them to have flexible career routes.
  — A multi-disciplinary approach to planning based on the needs of organisations delivering services for patients.
  — A small over-supply to create competition, flexibility and drive up quality.
  — A clear balance between the needs of patient services (of which trainees are often an integral part) and the needs of staff for a supportive learning environment.
  — A managed change in career expectations: in no other profession does each trainee expect to reach the top of the profession and stay there for the remaining duration of their career and in the same professional capacity.

To date, there has been little progress in meeting the requirements outlined above. However, we are pleased that the current reforms now offer the opportunity for these to be taken forward. If we are to enable employers
to make further advances then the outcome must be to create a system where patient need precedes professional development.

The role of Local Education and Training Boards (LETB)

3.1 NHSE supports the creation of LETB to bring together employers, professional advice, education providers and patients to consider the whole workforce requirements of the locality and take responsibility for commissioning the appropriate training and development to meet service and patient needs. They will include skills and expertise from some of the current SHA and medical deanery commissioning functions. Key functions of LETBs should include:

— Considering the training of the whole healthcare workforce including staff in support roles as well as the traditional professional groups.
— Commissioning education and development programmes for current staff and the future workforce based on local need and the ability to deliver quality care.
— Collecting and sharing best practice across the locality and beyond, seeking to ensure that the education and training programmes lead to better patient outcomes.
— Enabling service commissioners to work with providers to map out longer term commissioning plans that will enable workforce plans to become longer term and reflect these service commissioning intentions.

3.2 Employers across the NHS have told us that the system for commissioning education and training must be led and managed from a local level if it is to be effective in meeting the needs of patients. Top down, initiative led, workforce decisions do not have a good record of success. The creation of the physician assistant role is an example often cited as not being as successful as perhaps other supporting roles. Whereas the more generic and evolving assistant practitioner role, created from a service need and then designed, developed and implemented by many employers across the NHS, with significant input from education providers, has been hugely successful in helping employers to work on transforming the shape of the workforce to better and more flexibly meet the needs of patients.

3.3 To create a joined up system with local ownership, accountability and responsibility, the LETB must be a structure that is designed, developed and run by employers and involves their key partners. We recommend each LETB be allowed to decide locally how it wishes to carry out its functions, in a form which reflects local circumstances and meets with local agreement. HEE should award full delegation of powers to a LETB based on an authorisation process which evidences it has the capacity and capability to deliver, rather than seeking to own and mould them into a particular model.

3.4 In order for employers and their partners to truly own and lead their LETB there is strong support from employers for the structure to sit within the locality. Employers across the country have already invested significant time into developing shadow arrangements that will enable them to be in a position to apply for authorisation to exist, employ staff and enter into contracts with educational establishments. Many different forms have been discussed from social enterprise to hosting in a Foundation Trust.

3.5 It has been suggested that one model of LETBs is to adopt a structural form within Health Education England (HEE), however the risk of this approach is that decisions about how to develop the workforce to meet local population need would shift towards the centre, whilst the services that require the staff would be commissioned at a very local level. This would make it harder to align the commissioning of services and education to ensure that local areas have the right workforce for their patient services. If the LETB were to become an “outpost” of HEE the NHS would miss huge opportunities to change the outcomes of education and training commissioning, and to embed an innovation culture within education and training. If this model does go forward, even as a holding measure, it becomes even more important that HEE is constructed to be employer-led.

The role of Health Education England (HEE)

4.1 HEE must be employer led and patient focused. It must start from the premise of focusing on doing what only a national organisation can do if it is to be successful. We need to avoid scenarios that mean HEE is established as an “administrator” of LETB’s. If so, it will not succeed in its strategic objectives.

4.2 Its role should be working with key partners including the NHS Commissioning Board, Public Health England, NHS Employers, CFWI and its partners in the other UK countries and regulators to focus on:

— setting standards;
— quality outcomes;
— assuring that the system is delivering for the medium—long term needs of patients;
— resolving any conflicts in the system; and
— providing assurance that LETBs are properly accountable and well governed, and the education and training commissioning plans align with the services being commissioned and will meet the needs of patients.
The role of the Secretary of State

5.1 The role of the Secretary of State, as defined in the Health and Social Care Bill 2011, shows a clear line of accountability for the system to Government.

5.2 However it is not clear how tensions or disagreements between different parts of the system will be resolved, for example when aspirations from professional groups, politicians or others to increase numbers in a particular profession are not the same as the views of employers. HEE, as an employer led organisation, has a clear role here to ensure there is a mechanism for resolving disputes.

Plans for the transition

6.1 Employers across the country have invested significant time in working together locally to form shadow arrangements within the SHA structure that will enable them to be in a position to apply for authorisation to exist as LETBs, employ staff and enter into contracts with educational establishments.

6.2 There are concerns to ensure that the formation of HEE is not modelled on Medical Education England as this will lead to a missed opportunity to have a truly employer led innovative system that delivers for patients.

6.3 Given the intention to have the new system in place from April 2013, we hope for an early announcement on the range of available structural forms for the LETB as soon as possible to allow employers to ensure they can obtain authorisation and move into the new form in time. This is possible and must happen if we are to maximise the benefits for patients of the new system.

The future of postgraduate deaneries

7.1 Employers value the critical functions provided in deaneries and recognise the need to retain skilled staff throughout the transition and beyond to ensure continuity in some core functions particularly for doctors in training.

7.2 If roles such as the Postgraduate Dean are to remain then it is essential that they form part of the LETB team in which they are located. This is critical to ensure that the planning and training of the medical workforce is properly aligned with that of the rest of the health service workforce.

The implications of a more diverse provider market within the NHS

8.1 There are already a diverse range of providers of healthcare receiving NHS monies to deliver commissioned services (GPs, social enterprise, private providers running NHS services, a whole range and size of independent and voluntary sector organisations as well as the traditional NHS provider organisations). As the landscape potentially becomes more diverse there is a need to look at the provision of training opportunities. In this case it may be more helpful to think about the provision of training and education with those receiving public monies to deliver services and care to patients.

8.2 We recognise that the potential challenges for acute sector organisations in maintaining out of hours medical rotas if trainees begin receiving training in other parts of the system as opposed to an acute hospital. We also recognise the potential financial implications for some providers if a model of funding following the student is used and training moves to a different provider. These implications will all need exploring and thinking through locally as part of the LETB arrangement. However they are not insurmountable problems and should not stop us moving forward with changes that have been developed in order to deliver a workforce that better meets patient needs.

8.3 The NHS Partners Network submission highlights the views of their independent sector members. The independent sector already does a significant amount of training for non-medical professions in relation to softer skills. Many registered clinical staff also move between the independent, private and public sectors sharing knowledge and expertise. Some independent providers will be enthusiastic in future about taking greater responsibility for training, particularly if they provide a greater range of procedures and care.

The Impact on the Public Health Workforce

Clarity is needed in defining the public health workforce if we are able to understand any potential impacts. There are nurses and midwives with specific roles in public health but who are currently not classified as public health workers. This example can be replicated across professional groups and support staff. We recommend that HEE needs to have overall oversight of the health workforce, or arrangements in place to ensure alignment. HEE will need to work closely with Public Health England but it will be for LETBs working with local authority partners to determine the public health requirements locally and what this means for the commissioning of education.

The Role and Content of the Proposed National Education Outcomes Framework

The National Education Outcomes Framework will provide a helpful framework for the Department of Health and HEE to establish their accountability and relationship. The link between education inputs and health
outcomes is to be welcomed. There needs to be some caution in the establishment of indicators for health providers—it should be for LETBs to hold providers to account and not HEE.

11. The Role of the Centre for Workforce Intelligence (CfWI)

Having access to credible data to base decisions upon and continually improving demand-led modelling are both essential to enable any system and ensure value for money and return on investment. The CfWI has a potentially pivotal role in working with local employers, the professions and regulators to collect, analyse and share data to allow evidence based decision making to occur. We recommend the CfWI:

- Ensures the data and intelligence is sufficiently “local” to be meaningful to local employers.
- Ensures strong partnership working with HEE and LETBs.
- Targets information collection where it identifies information gaps.

12. The Role of Skills for Health and Skills for Care

The sector skills councils have an important role in working on the development of educational frameworks in particular for those roles in levels 1 to 4 on the career framework, which are often essential patient facing support roles. NHSE looks forward to working with them in the new system.

Protecting and distributing funding in the new system

13.1 There is an expectation that the budget allocated to HEE will remain ring-fenced for the purpose of delivering education and training for the current and future healthcare workforce. Employers would support ringfencing at this level.

13.2 However, it is important this approach does not also become ringfencing or protection of budgets at the level of specific services or parts of the workforce. The danger of such an approach lies in its inflexibility and inability to allow education and training to adapt to changes in the services and staff skill mix that are needed to enable changes in patient care (such as greater provision of care in community settings). We must not set up a system that stifles innovation from the outset. We would nevertheless expect LETBs to spend money in a transparent way, with appropriate safeguards, and HEE to ensure they meet the appropriate requirements. The allocation of funding must be designed to complement local needs and plans in the short, medium and longer term.

The place of overseas educated staff within the workforce

14.1 Overseas trained staff have a valuable role in the NHS. Individuals contribute greatly to education, training, research and the delivery of high quality care to patients. NHS Employers has worked closely with the UK Border Agency to ensure that the changes needed to the immigration system do not inadvertently have a negative impact on employers’ abilities to recruit highly skilled staff when required.

14.2 Even with these necessary changes to the education system the NHS has a commitment with its global partners to offer training opportunities to individuals from less developed nations and a reputational need to remain competitive in an increasingly global health care labour market. To retain a position of positive international reputation the UK must be able to attract the most innovative and skilled individuals from across the world who will develop and deliver leading edge healthcare for patients.

December 2011

Supplementary written evidence from Professor David Sowden, Postgraduate Dean and Managing Director East Midlands Healthcare Workforce Deanery (ETWP 117)

With the dissolution of the Workforce Development Confederations in 2005, I was formally appointed as Dean Director of the Trent Multi Professional Deenery which operated from 2005 to 2007. In that capacity I had responsibility for the totality of the MPET allocation for Trent, and as the Deenery’s title at the time suggests, we had responsibility for all aspects of medical and none medical commissioning and contracting, together with the continuing responsibilities of a postgraduate medical deenery with respect to the delivery of postgraduate medical education and training, and its interactions with dental training.

In 2007 the Trent Strategic Health Authority and Leicestershire, Northamptonshire and Rutland Strategic Authorities merged, and at that merger I became Dean Director of the East Midlands Healthcare Workforce Deenery which was effectively the same as the Trent Multi Professional Deenery but covering a much wider geographic area. At that time the responsibilities related to approximately £350,000,000.

In 2009 the then Labour Government, through the aegis of PS(L) Lord Darzi, Strategic Health Authorities were asked to implement a commissioner provider separation.

Following lengthy negotiations the East Midlands Strategic Health Authority decided that the best model for the commissioner provider separation would see the commissioning functions for all aspects of multi professional education and training subsumed within the workforce directorate at the Strategic Health Authority.
I think it would be fair to reflect that there was then a period of uncertainty as to whether or not I would move into the Strategic Health Authority as Postgraduate Dean, or whether I would become the Postgraduate Dean for a provider deanery.

The final conclusion was that we would create a provider deanery in the East Midlands, and since the other provision and multi professional education and training is related to higher educational institutions, I was left managing a postgraduate medical deanery as a provider unit, with the Strategic Health Authority carrying out commissioning responsibilities.

This has not, as I anticipated, restricted my involvement with the commissioning and investment planning processes at the Strategic Health Authority and for a variety of reasons (which would not encompass a brief response) I do believe there have been some material benefits in the separation; somewhat to my surprise. Not the least of these has been greater clarity over workforce supply and demand in the medical profession—an issue that until the separation the Strategic Health Authority and the Directorate of Workforce had paid little or no attention to.

January 2012

Supplementary written evidence from the Conference of Postgraduate Medical Deans of the United Kingdom (118 ETWP)

LIBERATING THE NHS. DEVELOPING THE HEALTHCARE WORKFORCE. FROM DESIGN TO DELIVERY

Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD UK) is a UK-wide organisation which represents all the Postgraduate (PG) Deans and Deaneries in the UK including the Dental and GP Deans. COPMeD’s aims include managing the delivery and outcomes of postgraduate medical and dental education (PGMDE) to the highest possible standards, and to ensure that these standards are comparable across the UK. It also provides a UK-wide forum for PG Deans to discuss and share information on important issues in relation to medical training and in particular, postgraduate medical education (PGME) and training.

COPMeD is pleased to be able to provide additional evidence to the Health Select Committee following the recent publication (10 January 2012) of the above document. As the committee will note it incorporates the Government’s response to the Second Future Forum Report on education and training.

COPMeD is pleased to note much of the content of From Design to Delivery, but remains concerned about the considerable delays in its publication and the implications that this has for the work programmes to establish Local Education and Training Boards in shadow format (from 1 April 2012) and the establishment of Health Education England as a special health authority by June 2012.

Whilst the earlier establishment of HEE in shadow form is to be welcomed, because of the need for HEE to set out the accountability framework and approval process for LETBs, COPMeD is concerned as to the availability of resources and manpower to fulfil this very demanding timetable. Verbal evidence to the Committee in November highlighted potential risks with the delays.

In general, COPMeD sees much to commend the policy document, and recognises the importance of increased employer/provider engagement and responsibility with respect to workforce planning, development and the consequent commissioning of education and training. It is clear that previous models for workforce planning and development (educational consortia, workforce development confederations and Strategic Health Authorities) singularly failed to secure an appropriate level of employer engagement and responsibility.

However, whilst the foreword by the Secretary of State makes clear that the model is designed to ensure that “employers supported by clinicians were placed at the heart of the decision making process, with the opportunity to design the shape of their workforce in the way in which they develop the people they employ” COPMeD is concerned that the role of professional groups (with particular respect to PGME) is far from clear at both a national (HEE) and local (LETB) level.

COPMeD would wish to make additional comments with respect to four main areas:

1. **National Standards**

The postgraduate medical education system is a UK-wide system and it is essential that the national standards for PGME, and consequently the training of GPs and specialists, are supported and in no way undermined by local arrangements within LETBs. The current document does not provide sufficient assurance on this topic. There seems to COPMeD to be a genuine risk that local variation could be permitted at a level which might undermine national standards, and it is unclear to COPMeD as to how Colleges and Faculties will input into either national or local arrangements. Similarly, COPMeD remains unclear as to how HEE will interface with the national regulator for medical educational continuum, the GMC. These are potentially serious deficiencies in the present proposals.
2. National Workforce Planning

Whilst it is increasingly apparent that much of healthcare professional workforce demand/supply modelling and planning needs to be conducted at a more local level than currently this certainly does not apply to a large proportion of postgraduate medical specialities. In addition, even where local planning has much to commend it (for example with respect to the general practitioner workforce) it remains essential that a coherent national overview is maintained at the interface between that local workforce modelling and others at a local, supra local and national level.

The current provisions provided in From Design to Delivery do not give COPMeD confidence that appropriate checks and balances will be in place, and that for smaller specialties (of which there are a substantial number) arrangements for national workforce planning at the level of England will remain the preferred option.

3. Funding Arrangements

COPMeD has a number of concerns with respect to the current descriptions of funding arrangements.

First of all, the paper describes a situation where quality assurance functions are protected from the efficiency requirements set out in the Operating Framework NHS in England (2012–13) whereby the expectation is that overall running costs/management costs would be a third lower than 2010–11 by 2014–15. Over the past four to five years there have been numerous attempts to try and create a clear division between those aspects of postgraduate medical education that could be legitimately linked to quality assurance (including educational delivery) versus the actual administration costs. To date these attempts have been unsuccessful because it has proven impossible to get agreement on the parameters which need to be demarcated.

This is, of itself, a significant risk to the delivery and effective quality management of PGME in England to which can be added the very substantial risks of extrapolating the provisions of the Operating Framework (as previously) to even that element of postgraduate medical education which might be legitimately called administration. PG Deaneries have not significantly increased management costs in the past decade, and in many instances the management costs have actually fallen as a percentage of allocations; as a result of mergers or re-organisation. In addition, the administrative burden currently carried by PG Deaneries has increased substantially over the past five to six years linked due, at least in part, to the Modernising Medical Careers reforms, which continue to date. In addition, PG Deaneries will also need to incorporate trainee revalidation from late 2012—a task that is far from resource neutral. PG Deaneries were not the subject of the wider inflation in administrative costs associated with Primary Care Trusts and Strategic Health Authorities. If the provisions of the Operating Framework are, indeed, to extend even to those limited areas of PG Deanery activity which might be called “administration” then there will be an associated loss of functional capability which will directly impact on the successful delivery and outcomes from PGME.

Finally, COPMeD is concerned that the planned “more transparent and equitable funding” of healthcare professional education and training (generally welcomed) described does not explicitly extend to the review of the overall allocation of the MPET monies. Those allocations are largely historic and bear little or no relation to the workforce supply needs of the geographies and populations that will be served by LETBs. If these inequitable allocations are not re-adjusted many health economies will be unsustainable in certain key workforce areas. These changes need to form part of the set up arrangements for HEE, even if the funding changes are introduced over several years.

4. Quality Management and Assurance

COPMeD remains concerned that the proposed arrangements for the establishment of HEE and LETBs do not provide sufficient assurances with respect to the necessary independence of quality management and assurance functions, particularly at the level of the LETBs with regard to PG Deans and Deaneries. As has previously been outlined the development of a provider/employer led LETB means that those organisations will also be largely responsible for the educational environment in which commissioned education and training is undertaken. Unless there are appropriate safe guards put in place there is a real risk that those organisations will not foster an educational environment based on the principles of quality improvement of learning opportunities, and educational outcomes. Rather their focus will be on immediate financial and service concerns, important but they must not dominate thinking and action.

COPMeD would suggest that more work needs to be done on this aspect of the proposed arrangements, ensuring that there is greater independent professional input from both PG Deans and specialties. It will not be credible, professionally, if this quality management activity is not undertaken by an experienced medical educationalist and administrator.

Conclusions

As previously indicated COPMeD largely supports the content of From Design to Delivery but remains concerned that there are significant gaps in the policy content which allows a flexibility of interpretation and implementation which could be to the long term detriment of both workforce planning and the development of
professional education and training for the healthcare workforce in England. This will ultimately impact on the quality of service provision.

COPMeD is concerned that there is increasing evidence that there will not be sufficient room within the next parliamentary session to include additional legislation as it applies to this particular aspect of the Governments reforms, and that as a result careful consideration should be given to amendments to the Health and Social Care Bill to capture some of the most important changes.

For example, COPMeD believes that the role of HEE, to plan and commission healthcare professional education and training, should be contained within the Bill and that HEE should be required to adhere to the following principles:

— The need to ensure that national workforce planning meets the need of the NHS both locally and nationally.
— The need for ring fenced funding, and an assurance that funding is spent according to allocation.
— The establishment of independent quality management and assurance of education and training delivery and outcomes.
— The need for national standards for the delivery and outcomes of medical education in particular.

These four principles—national medical workforce planning, ring fenced funding of healthcare professional education, independent quality management and national standards of education provision and outcomes—should be reflected in the current health legislation to avoid problems during and after transition.

COPMeD also believes that clinical commissioning groups should have a duty to promote the education and training of the current and future healthcare workforce. Similarly the National Commissioning Board should have a similar duty at a national level. In addition, Monitor should ensure that the provision of education and training is a mandatory license condition for Foundation Trusts with certain explicit exceptions.

Finally, integration and collaboration needs to be seen as pre-eminent over competition and competitive activity. This is especially critical if the education and training system is to remain capable of providing coordinated professionally supported training programmes that are able to deliver the nationally approved education and training curricula. This principle could usefully be added to the planned government Bill amendments that highlight Monitor’s role in promoting and ensuring collaboration amongst providers with respect to services for patients.

After all the two overarching responsibilities of the NHS are to ensure the provision of safe, high quality services today whilst ensuring that the NHS is capable of providing improving services tomorrow and in the future.

2 February 2012

Supplementary written evidence from Independent Healthcare Advisory Services (ETWP 119)

1. INTRODUCTION

The IHAS brings together members and specialists across the Independent healthcare industry in all four countries, to share a unique level of knowledge, experience and understanding in order:

— to facilitate effective communication between all its subscribers, the government and external organisations;
— to develop and drive policy advancement through shared subscriber input and consultation; and
— to deliver focused practical information and guidance in all areas of regulation and policy, sharing and distributing knowledge.

The IHAS’s primary focus is in the area of operational policy and the regulation of the independent healthcare sector. As such it seeks:

— to facilitate the development of operational policy, through consultation with its member organisations;
— to provide its members with accurate and timely information regarding regulatory and policy matters;
— to administer an independent complaints process;
— to develop a range of quality initiatives to raise awareness of good practice within independent providers; and
— to represent independent healthcare providers to government, external organisations, and the public, providing a channel for effective communication and dialogue.
2. Development of the workforce

The reforms will increase the involvement of employers at a local level enabling the local population’s needs to be met. There will be a greater emphasis on equipping the workforce to work in multidisciplinary teams and across disciplines. However this will need to include the development of existing staff to work effectively in the healthcare provision of the future.

The independent sector (IS) is fully participating in the development of the Skills Passport for Health and is represented on the Stakeholder Group. IHAS Member Care UK Ltd will be a pilot site alongside the NHS. The IS is also part of the Expert Reference Group for UK Core Skills and Training Framework again working with the NHS to ensure that an appropriate framework is in place which transfers across sectors.

3. Readiness of IS Employers for LETBs

There is a need to create an awareness of the LETBs in the independent sector and IHAS have in partnership with NHS Partners, National Care Forum and Skills for Health, a conference in April where the development of LETBs is on the agenda.

4. Representation of the IS

The outcome from LETBs must be a properly qualified, high quality, sustainable supply of staff and trainees to the health and social care workforce, resilient, flexible, and innovative. IHAS has staked the claim of the independent healthcare providers to be fully incorporated in the work of the LETBs in constructing the new system. This will need partnership between all healthcare employers, NHS and IS, to ensure a multi-professional approach to education commissioning and quality.

The LETBs must meet authorisation criteria—collaborative leadership, proper governance, financial control, engagement with employers, commissioning capacity, effective workforce strategy and planning and clinical focus on safety and quality. As each LETB is set up, IHAS expects employers from the independent sector to participate actively, and it will be a central part of the co-operative IHAS Workforce Advisory Workstream chaired by Catherine Ward, Director of Human Resources, BMI Healthcare (IHAS Member).

To this end the IHAS are working very closely with the NHS Midlands and East to identify a model for the independent sector to work with LETBs and ensure that there are IS representatives on the LETBs. This work we hope will in principle be applied to other LETBs and therefore ensure that there is adequate representation of the IS. This work has already passed the discussion phase, IHAS now being represented at the NHS Midlands and East LETB Challenge Stakeholder Workshop where the makeup of the LETB and Local Education and Training Councils (LETCs) were discussed.

IHAS is also being informed of developments by the North Central and East London LETB in order to ensure involvement of the independent healthcare employers in the locality.

5. IS Data

The Centre for Workforce Intelligence (CfWI) provides oversight of clinical academic workforce levels and set out risk and opportunities for the whole England healthcare sector. It is important that independent sector healthcare employers contribute to and interact with the CfWI to provide data and insight into the future needs of the workforce of the independent sector.

Workforce data is being collected by IHAS retrospectively. Although this data is not complete, it does give an indication of the size of the IS workforce. The data is provided by individual hospitals rather than by national hospital groups, thus enabling data to be provided for the independent hospitals in any local area covered by a Cluster.

The size of the workforce in the acute independent sector for England in aggregated form is given as an example:

- 8,500 nurses;
- 3,000 healthcare professionals (Occupational therapists, physiotherapists, operating department practitioners);
- 300 pharmacists; and
- 2,700 healthcare support workers.

IHAS is in discussions with the CfWI and will be part of the Information Architecture Project.

The IHAS is the secretariat for both the Welsh Independent Healthcare Association (WIHA) and the Scottish Independent Hospitals Associate (SIHA) and produces a yearly Credentials document for each. The workforce data produced forms part of the Welsh Assembly Government’s workforce intelligence and is submitted as part of the Integrated Workforce planning for Wales. Similarly the Scottish Government is provided with the data collected from the independent healthcare providers.
The links to the credential documents are:
WIHA Credentials 2010–11.
SIHA Credentials 2010–11.
SIHA Credentials 2008–09.

6. HOW THE IS IS REDUCING DEPENDENCY ON OVERSEAS STAFF

There is comprehensive staff development and “growing your own” agenda in the independent sector and a number of case studies are described in the “Careers in Healthcare: A guide to working in the Independent Healthcare Sector”.[42] This document was produced in partnership with Skills for Health.

The IHAS has commented and provided evidence to the Migration Advisory Committee on their consultations. For example the evidence submitted helped to ensure that Theatre Practitioners stayed on the Shortage Occupation list allowing time for organisations to develop “home-grown” skilled and competent theatre staff.

If overseas staff is needed as a short-term measure while time is taken to up-skill local staff, Independent providers are concentrating on EU recruitment and not non-EU.

7. MEDICAL EDUCATION

The independent sector has examples of good models for training of medical staff. Mental Health sector is one where a good deal of training is taking place using a partnership model between the NHS and the independent sector. Another example is where the registrars come with the consultant to an independent provider to gain experience as is happening with cosmetic surgery. There is no cosmetic surgery training in the NHS and therefore in order for training to take place it has to be in the independent sector. However, IHAS is very concerned that even though each of the faculties have been asked to look at how they build in a cosmetic element into their training this is taking a long time. Adequate training is essential and in order for this to happen the IS and NHS need to work together.

There are many opportunities where the independent sector can provide training or placements and thereby provide trainees with a broader experience.

8. CLINICAL PLACEMENTS FOR STUDENT NURSES

IS healthcare providers provide clinical placements and have in the past had a MOU with the Department of Health. Individual organisations have now signed agreements with the universities in their area and provide a good number of placements. The organisations are generally rewarded with a number of post registration training days. However, often it is a good will arrangement. This will need to be taken into account when deciding on whether a levy should be applied.

An example is the London Clinic who has a Clinical Development Nurse managing the student nurses’ placement contract with City University. The London Clinic also offers placements for Physiotherapy, Radiology and Radiotherapy students who are managed in the perspective areas.

Last year they had 92 student nurse placements and so far this year they have had 30 students in various stages of their training from first placement to final placement. The Critical Care Unit and Oncology Unit have won City University awards for best and preferred placement. It is the students nominating these areas whilst on placement in the identified areas.

The London Clinic runs a Key Mentor forum which looks at good practice and consistency. This was recognised by the NMC during an inspection as a bench mark of good practice. The Independent Sector is represented by the London Clinic at City University with NHS London commissioning reviews and is part of the curriculum planning committees and involved in fitness to practice hearings for student nurses.

Aspen Healthcare has also been awarded for their excellent training as they won the Laing and Buisson Independent Healthcare award for Excellence in Training.

9. EDUCATION AND TRAINING LEVY

IHAS is pleased that it has been recognised that the levy will require a lot more work as our concern was that it would not provide a level playing field and would be very difficult to administer. As mentioned before, placements and training are on the whole provided free of charge to the NHS and a system of monies following the trainee would need to be developed.

March 2012

SUPPLEMENTARY WRITTEN EVIDENCE BY THE DEPARTMENT OF HEALTH (ETWP 01B)

DISTRICT NURSING

Following last Tuesday’s ministerial oral evidence session on education, training and workforce planning, I said that I would write to you when I had considered more fully the committee’s question on district nursing and health visiting. Specifically, does the Department accept that the depletion of district nurses is a direct result of the Government’s commitment to increase the number Health Visitors by 4,200?

The common thread between District Nurses and Health Visitors is that both are qualified nurses who have undertaken graduate level post registration education to provide services to people within the community.

The two professional groups are educated to deliver very different types of care to very different groups of patients and service users. District nurses focus on treatment and care for adults and older adults with known health problems ranging from recovery from accident, illness or surgery to long-term conditions to end of life care.

Health visitors’ role is in public health working with children under five, their families and communities to improve and protect health through delivering the Healthy Child Programme 0–5, supporting transition to parenthood and providing early intervention should problems arise.

When the Government took office in May 2010, it made sure that the health visiting programme was funded in the current three-year comprehensive spending review to deliver the extra 4,200 health visitors and has reinforced this through the operating framework and performance monitoring framework as well as support to local bodies to deliver the Health Visitor commitment and transform services.

In respect of District Nursing over time, the skill mix of these nursing teams in the community has changed. The Annual Workforce Census published by the NHS Information Centre for health and social care also shows that the full time equivalent number of district nurses has decreased by 33% (4,800) between September of 2000 and 2010. However, during the same period qualified nurses working in community services (which includes district nurses) has increased by over 29% (14,747).

Local healthcare organisations are best placed to plan and deliver the workforce and appropriate skill mix based on the need of local populations. However, the government is committed to improving quality of care for all patients and in particular older patients and has recently established the Nursing and Care Quality Forum. This will be concerned with “quality in care everywhere” and will include expectations around the skilled and safe care people should receive in their own home. Additionally the department is in discussion with the Queens Nursing Institute about a programme of work focused on District Nursing.

The Department has not been presented with any evidence that suggests a causal link between a depletion of district nurse numbers and the Government’s commitment to increase the number Health Visitors by 4,200. Officials work closely with Strategic Health Authorities to assist delivery of the Health Visitor Implementation Plan: A Call to Action—2011–15 (published February 2011), engaging in regular dialogue with clinical, workforce and performance planners based in the regions. Part of this relationship is about managing the impact that the health visitor commitment may have on other parts of the nursing workforce. Commissioners are expected to ensure adequate provision of all community health professionals in their area according to local need.

The Department is seeking to maximise the combined contribution of the nursing disciplines working in the community both in individual care and improving the public’s health for example district nurses are a key group to “make every contact count” in health improvement. The government is also committed to multi disciplinary clinical leadership to ensure that local decisions are based on professional knowledge about the health needs of local people.

I hope this is helpful.

Rt Hon Simon Burns MP
Minister of State for Health
14 March 2012

SUPPLEMENTARY WRITTEN EVIDENCE FROM THE DEPARTMENT OF HEALTH (ETWP 01C)

HOMEOPATHIC MEDICINE

Following the oral evidence session on education, training and workforce planning on 6 March, Simon Burns has asked me to write to you about the points that David Tredinnick raised on homeopathic self-care and the need for research in this area.

I am aware that Jamie Rentoul, Director of Workforce Development wrote to you in December last year and explained that the Department’s role is to provide strategic leadership to the NHS and social care organisations in England and it is for local NHS organisations to plan, develop and improve services for local people.
The provision of healthcare treatments by the NHS, including complementary treatments, is the responsibility of local NHS organisations and those who commission services from them. These bodies are best placed to respond to patients’ needs and concerns. When deciding what treatments to commission and provide, it is important to consider safety and clinical cost-effectiveness, and the availability of suitably qualified and, where relevant, regulated practitioners. Similarly, the provision of university courses is a matter for those who provide and commission such courses locally.

As Simon Burns explained, the challenge for homeopathic self-care is that there is insufficient evidence of proven outcomes. Our position on further research remains as stated in the Government Response to the Science and Technology Committee report “Evidence Check 2: Homeopathy, published in July 2010”:

There are already many trials and meta-analyses on homeopathy and therefore there currently appears to be little advantage in conducting further work of this nature. That said, the National Institute for Health Research and the Medical Research Council do not exclude, *a priori*, any areas from investigation. So further research cannot be categorically ruled out. If proposals were to come forward which could further clarify the impact of homeopathy, they would be considered in the usual way.

I hope that this is helpful.

Anne Milton MP
Parliamentary Under Secretary of State for Public Health
26 March 2012