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).
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Royal College of Physicians supplementary
Greater Manchester Directors of Public Health
Professor Alan Maynard
Faculty of Sexual and Reproductive Healthcare
Written evidence

Written evidence from NHS Employers in the East Midlands (ETWP 05)

SUMMARY
— Employers in the NHS should take ownership of the Education, Training and Workforce agenda.
— This would be best achieved by establishing employer owned networks.
— Such a network would provide accountability and transparency in the management of this vital agenda, within a framework developed by the proposed Health Education England and an agreed running costs envelope.
— East Midlands NHS employers are prepared to pilot such an approach since we see the development of our workforce as essential to our delivery of the challenges we face.

INTRODUCTION
1. We welcome the Health Select Committee (HSC) Inquiry on Education, Training, and Workforce Planning. We have been working together over the last year to plan for the reforms that will arise when Strategic Health Authorities (SHAs) cease to exist in March 2013.

BACKGROUND
2. The East Midlands SHA, now part of the “Midlands and East Cluster”, includes the health services in Derbyshire, Nottinghamshire, Northamptonshire, Leicestershire with Rutland, and Lincolnshire. Twenty-six NHS Trusts and 630 general practices serve a population of 4.4 million; 8.5% of England. Together we employ 92,200 staff (78,900 FTEs) of whom 46,600 (40,900 FTEs), are professionally qualified clinical staffs.

3. The education and training needs of the East Midlands are met locally by contractual relationships with 11 higher education institutions, with 75 contracts supporting 12,500 students and trainees.

4. The services we deliver reflect the characteristics of our distinctive population and so should our local education and training.

THE WORKFORCE CHALLENGE
5. The workforce being trained today will deliver services to patients and the public for many years to come. Healthcare changes very quickly and our workforce system must be responsive. Some examples follow.

HOSPITALS AT NIGHT
6. Delivery of care in hospitals overnight has been transformed in response to the need to improve safety of care and regulatory requirements limiting time spent on call. The best hospitals have embraced these changes and developed a wide range of extended roles for nurses and other staff.

7. Consequentially there are development needs for many staff, including communication skills, team working and leadership as well as new clinical skills. Much of the learning is inter-professional often in simulated environments. Senior professional attitudes and reactions to these initiatives, which challenge traditional ways of working, have been mixed, which creates additional demands.

THE HEART ATTACK VICTIM
8. Care for patients diagnosed with this condition has been revolutionised, leading to dramatic improvements in survival. Formerly, such a patient would be given pain relief and diagnosed, admitted and cared for by monitoring and bed rest under a generalist, with a length of stay up to two weeks. This approach has been supplanted by a time critical, intervention driven pattern of care, involving potent medication and primary angioplasty for many eligible candidates.

9. These changes have affected the learning needs of many people: ambulance staff, primary care colleagues, A&E, specialist cardiology staff, junior doctors and nurses, healthcare scientists are all affected. Critical to the success of the modern system is the response from the first person to whom the patient turns when chest pain arises. Health promotion staff, communication experts who develop public awareness campaigns and staff in general practice receptions and NHS Direct all play a crucial role.

PATIENTS WITH EARLY DEMENTIA
10. The prevalence of dementia and its recognition have increased very substantially. New care pathways have been advocated by organisations such as NICE, to improve the professional response to patients with cognitive impairment and to develop memory assessment services. These will lead to more accurate diagnosis and more tailored management, including access to a range of new interventions.
11. The workforce development consequences of these developments are substantial and wide ranging, being of relevance to a very high proportion of the patient facing workforce of the NHS, especially as so many of these patients have co-morbidity that leads to their care in acute settings.

CANCER

12. For many people with cancer the last decades have seen a transformation in the prospects of survival. Ten fold improvements in the median survival period are seen in lymphoma, colorectal cancer, testicular cancer and others. Meanwhile the prognosis has not improved for other malignancies.

13. Some of the improvements depend on targeted treatment, based on new genetic or scientific diagnostic procedures. Others are driven by early diagnosis. All result in the need for new skills. Thousands of survivors suffer from the late effects of cancer treatment, demanding a new service response.

PRIMARY CARE

14. The role of primary care is becoming even more centrally important with the shift to a focus on long-term conditions. Through increased demand for consultation and longer consultation times the need for GP patient facing time has increased by 55% in a decade. However GP numbers (as FTEs) have been static and currently only 21% of new medical graduates see general practice as their preferred career.

THE SYSTEM FOR EDUCATION, TRAINING AND DEVELOPMENT OF THE WORKFORCE (“THE SYSTEM”)

15. A new system must be established to ensure the sustainable supply of all workforce groups. As employers who are prepared to rise to this challenge we have reached a consensus on the key issues to be tackled:

— The primary drivers for change must be improvements in the quality of healthcare outcomes, improved safety of care and patient experience.
— The system must become more proactive and innovative in relation to changing patterns of care.
— Employers must lead, drive, and own the new system within the context of national regulation and requirements.
— The system must reflect our local circumstances and labour market dynamics.
— High quality services rely on a highly motivated workforce that aspires to excellence. Education, training and development are central to this objective.
— Transparency and equitable access to funding must be achieved to create a fair system.
— Value for money will be a prime consideration.

16. The connections between the plans for service improvement proposed by healthcare commissioners, translated into changed services by providers, and the consequent alterations to the education, training and development opportunities for staff, have been too weak. The quality of workforce planning has been poor because employers have been too remote from the process.

17. The changes proposed following the publication of “Liberating the NHS: Developing the NHS workforce” and the deliberations of the NHS Future Forum, are the once in a lifetime opportunity to address these shortfalls.

AN EMPLOYERS’ NETWORK

18. We advocate the creation by employers of a jointly owned network to be accountable for the development of the responsive, effective system of education, training and workforce development that is required. This network would be the Local Education and Training Board (LETB) envisaged in the Future Forum report and would be directly accountable to and owned by local employers.

19. The LETB would design and deliver a system in response to the commissioning requirements of Clinical Commissioning Groups within the framework of accountability to be developed by Health Education England. It would provide transparent governance of the resources for education and training allocated to it. In return it would expect the freedom to deliver local solutions to local needs.

20. The LETB will work with local stakeholders, including Higher and Further Education providers, CCGs, and partners in local Government. We will engage the voluntary sector, and representatives of patients and carers. We will involve students, the professions, and local private providers of NHS services. This to develop a shared position on the balance between:

— A view of those in training as students who need work experience with their being seen as employees who need development.
— The need for healthcare students to access a liberal education with the need for curricula to prepare them for new and emergent service models and the reality of a career in healthcare.
— Access to the expertise of the educationalist and professional perspective with the avoidance of an education provider driven pattern of training.
— A central role for employers with the need for individual employers to be held to account by their peers if their support for quality education comes under question.
— Greater innovation in healthcare education and development with the need to retain the strengths of the current system.
— A truly multidisciplinary and inter-professional ethos whilst continuing to improve the training of specific disciplines.

FUNCTIONS

21. The LETBs’ functions will be to:
— assure workforce plans and educational commissioning requirements to ensure that sufficient numbers of appropriately skilled staff are available to deliver safe, high quality services;
— support strategic workforce planning;
— commission and contract education which incentivises the delivery of high quality, safe programmes, and promotes the recruitment and retention of staff and students to the East Midlands;
— deliver Deanery functions including management of recruitment, of rotations, of the quality of clinical placements, the assessment of progress and the revalidation of doctors and dentists in training;
— identify and deploy innovative solutions to local workforce issues, reflecting increased local responsibility, greater self sufficiency, informed by our understanding of local demand and labour market dynamics; and
— engage in entrepreneurial activities to create additional revenue streams and to improve the value for money of the workforce development system.

GOVERNANCE

22. The current multi-professional education and training budget for the East Midlands is £374 million. Whilst this is significantly less than would be an equitable allocation (representing 7.7% of the total MPET budget for 8.5% of the population) this large amount of public money needs to be well governed.

23. Whilst awaiting the accreditation criteria, which HEE will develop, we propose to establish a management board with an independent chair and non-executive directors chosen by the network, supported by an executive team, including a CEO, Director of Finance, a Director of Workforce and a Director of Education Quality (which remit would encompass the Deanery functions).

24. A particular emphasis will be to fully engage primary care colleagues in this system. The voice of GPs and their teams has been too indistinctly heard in workforce affairs in the past. They bring three perspectives; as employers; as those involved in the development of the future primary care workforce; and as service commissioners. We are consulting on how to ensure their future central involvement, with current input from LMC identified representatives, and cluster based primary care groups.

25. This management board will be supported by a partnership board, which will be the forum through which the LETB will ensure:
— that all aspects of the work of the LETB is informed by a strong and meaningful voice for patients and the public through lay representatives;
— that clinical commissioning groups can influence the education, training and development agenda appropriately;
— that there is enhanced engagement with local authorities to strengthen the alignment with the social care workforce;
— that the HE and FE sectors can be engaged in the co-creation of educational solutions to workforce challenges and can bring their expertise to the work of the LETB;
— that employers of staff who deliver care funded by the NHS, be they in the independent or the voluntary sector are engaged with the work of the LETB; and
— that students, trainees and staff representatives can contribute to the work of the LETB in a meaningful way.

ORGANISATIONAL FORM

26. A new form of organisation will need to be established to provide these functions. There are the three leading alternatives.

A NEW STATUTORY BODY

27. Typically local statutory bodies in health have been established as Special Health Authorities (SpHAs). The establishment of a series of new SpHAs would not be consistent with Government policy and an SpHA
would not provide the level of employer ownership which we believe to be appropriate for a LETB. They also operate within a financial framework which is too inflexible for the more entrepreneurial approach advocated.

28. HEE is likely to be established initially as an SpHA. It has been suggested that LETBs could operate as local outposts of this body. This might limit running costs but would not, in our view, promote greater employer ownership. Such an arrangement would also not provide the flexibility for a locally responsive service, in our view.

A Hosting Arrangement

29. An alternative would be to establish a hosting arrangement with an existing body, for example a Foundation Trust.

30. The experience of such arrangements for the hosting of other shared services has been mixed. Two variants have been explored. In the first, a host FT might take on the management of education and training funds in exchange for a management fee and the secondment of a group of staff. Full risk and liability would not transfer to the FT, but would be retained by DH, or perhaps by HEE.

31. In a second variant of “full hosting” the full levy budget and associated risks would become the responsibility of the FT and would form part of Monitor’s consideration of the risk rating of the organisation, with the resources consolidated into the FT accounts.

32. These options would avoid the establishment of a new organisation, and the financial regime of FTs has greater flexibility than that of SpHAs. However, there is an inevitable risk that those employers that are not the host will question the level of influence that they would have, especially in challenging circumstances. The scale of the MPET budget would be a significant part of the turnover of any local FT.

A Social Business

33. In this option (proposed in the initial consultation document) the employers of the East Midlands would establish a not-for-profit social business as a joint venture vehicle, specifically created to plan and manage the development of their collective workforce. The employers would be owners of the business and would agree through the articles of association the approach to collective decision making, and would appoint Directors to run the business.

34. The business could take one of a number of specific organisational forms. In all of these the legal entity could enter contractual relationships with educational providers and suppliers. In other areas of healthcare, staff transferring to such an organisation have retained their employment rights. Such an arrangement would need to meet the criteria to be established by HEE for LETBs and would need to operate within the running costs envelope agreed as part of the accreditation process.

35. Employers as owners would take full responsibility for this agenda. We believe this approach to have great merit, it is our preferred option, and we would be prepared to pilot such an approach.

Conclusion

36. The staff of the NHS are its greatest asset but employers have had constrained influence in the education, training and development of their workforce. We want to take the lead in creating a system that is accountable, responsive and transparent, which will deliver excellence in outcomes and in patient experience.

37. We are dealing with the challenging circumstances facing the NHS over the foreseeable future. The education, training and development of our workforce is fundamental to our meeting these challenges. A year on from the publication of “Liberating the NHS; developing the healthcare workforce”, and as we approach the last year of the stewardship of SHAs we need to be enabled to take the lead in this agenda as soon as possible.

December 2011

Written evidence from Professor David Black, Sir David Melville and Mr Duncan Selbie (ETWP 04)

EXPERIENCE OF A SUCCESSFUL INNOVATIVE MODEL OF POSTGRADUATE MEDICAL EDUCATION DELIVERY

1. Summary

1.1 This paper sets out a straightforward and cost effective model that has been developed in the south east coast for the organisation of postgraduate medical education.

1.2 It argues that a postgraduate deanery is a comprehensive provider of postgraduate medical education in the same way that an undergraduate medical school does the same job for undergraduate medicine.

1.3 Medicine should be nationally commissioned with opportunities to develop important inter-professional training issues at a regional level.
1.4 It is possible to put in place a nearly virtual board to oversee the education functions and as a model suggest that Local Education and Training Boards should be nearly virtual in operation.

1.5 It demonstrates that it is possible to have a hosting arrangement which allows the deanery to continue working equitably across the whole geographical patch.

1.6 The Postgraduate Deans in England should be primarily managerially accountable to the Director of Medical Education (England).

2. How is medical education structured?

2.1 The Royal Colleges write the curriculum for each medical specialty. The curriculum contains the syllabus (what has to be learnt), the way the syllabus will be taught and how it will be assessed. The writing of a curriculum is a slow and complex process which involves taking many factors into account obviously including the predicted future needs of the service.

2.2 The GMC is now the competent authority for medicine and must approve all curricula. The GMC is also the body for both undergraduate and postgraduate medicine that quality assures that the curricula are being delivered to a national standard.

2.3 Deaneries are charged at a “regional level” with ensuring that the curricula are actually delivered. Postgraduate medicine is largely learnt by experiential learning in the workplace. For every specialty and level of training the deanery has to ensure that appropriate doctors have been recruited; that they rotate through planned posts in hospital and the community where they will gather appropriate experience mapped to the curriculum; that the doctors who are training them are properly trained; that every doctor in every specialty is assessed as to whether they are making adequate progress every year; that all aspects of the curriculum have been covered (including issues such as clinical leadership); that doctors who are struggling are properly identified and managed and, important issues such as maternity leave and part-time training are planned for and accommodated. The average deanery is probably managing around 3,000 doctors at various stages of training at any one time.

3. How is a Deanery structured?

3.1 The simplest way to consider a deanery is as a postgraduate medical school (see Table A).

3.2 A deanery is composed of a number of specialty schools (eg Paediatrics, GP) that are led by a clinician in that specialty and the school takes responsibility for all trainees within that specialty. The Head of School (HoS) is normally appointed by the deanery and the Royal College jointly, but is managerially responsible to the deanery for local delivery. The HoS also have a significant role within their own Royal Colleges in ensuring standards and helping plan curricula for the future based on local experience of delivery.

3.3 The deanery integrates all of the schools into a single business unit. The deanery ensures single systems for managing the Annual Review of Competency Progression (ARCP), single systems for managing trainees in difficulty, single systems for training the trainers, single systems for developments that cross specialty such as clinical leadership and simulation. The heads of school also develop cross specialty programmes together such as Acute Care Common Stem which is a generic core training that allows people to enter Anaesthesia, Acute Medicine or Emergency Medicine.

3.4 The deanery coordinates all the posts and placements and the recruitment activities across all the schools taking into the account the progression and educational needs of all the trainees currently in each specialty programme.

3.5 A fundamental role of the deanery is its quality management activities. There are an integrated series of activities to ensure that trainees are receiving proper education to allow them to progress and ensuring that the needs of the service while being met are not preventing adequate educational progress. This is a continual iterative “total quality management” type activity to maintain standards, to improve standards and to fire fight crises. The service is constantly changing in activity and structure so the placements and education opportunities must continually be reviewed as education can only occur on the basis of current service.

The GMC quality assures postgraduate medical education and oversees the work of quality management activities of the deanery to ensure that they meet national standards.

Medical education is a national (England and the devolved nations) activity.

4. Commissioning and provision in Postgraduate Medical Education

4.1 There has been a considerable misunderstanding about the role of commissioning and provision in postgraduate medical education.

4.2 The discussion in section 3 make a clear case to consider a deanery and its activities in exactly the same light as an undergraduate medical school, as a comprehensive provider unit of medical education. The main difference being the largely virtual nature of the postgraduate campus and the far greater focus on service
rather than research. It is also crucially important to understand that most of MADEL is used for salary support for trainees (see Enclosure 1).

4.3 Most aspects of postgraduate medical education are nationally determined, this includes the number of posts that can be recruited to in each specialty in each year in each locality, the curriculum are national and the regulator is national. The allocation (MADEL) was originally based on the number of training posts but this has now become a historical anachronism and there appears to be no direct relationship between MADEL and the size of the population or the number of training posts.

4.4 There is a considerable variation of funding for higher specialty training historically by SHA (see Enclosure 2). There is also huge variation in the number of training posts that are entirely funded by local trusts again based on historic differences (see Enclosure 3).

4.5 The funding issue has also been complicated in that MADEL comes down as part of a bundle of funds to the SHAs, which then individually decided how much can be used for medical education and how much should be diverted to other activities. The old South East Coast SHA has been one of a small number of SHAs that have continued to pass all MADEL through for postgraduate medical education because of the relative local underfunding.

While postgraduate medical education in the community in General Practice has always been seen and funded as a “supernumerary” experience, in secondary care postgraduate education is completed integrated into the service. It is extremely difficult to move posts and finance around the system which has driven the intensive work on deanship quality management.

4.6 The arguments over the last three years about commissioning and provision have been complex and often unhelpful. The funding and numbers are nationally determined so presumably this is national commissioning. The amount of money that each SHA will allow to go into medical education is then decided at SHA level so this is presumably regional commissioning. The deaneries allocate funding for salary support and educational infrastructure support to trusts so this is presumably deanship commissioning, however the system as described above is much more complex and interdependent. Certainly whatever model is implemented in the future must surely increase transparency, increase equality of funding and rewarding excellence for meeting educational standards, yet not destabilise service in a time of great strain.

5. The South East Coast model

5.1 In 2010, the South East Coast SHA came to the conclusion that the postgraduate deanship was a comprehensive provider of postgraduate medical education for the South East Coast SHA and it wished to separate the provider function of the deanship from what was seen as the commissioning function of the SHA.

5.2 The deanship, through a tendering process, was put out for hosting by any NHS organisation within the South East Coast. A critical part was for the hosting organisation to propose mechanisms that would allow the deanship to thrive in its mission of ensuring the highest quality of postgraduate medical education across the South East Coast.

5.3 Following five expressions of interest and two formal bids, Brighton and Sussex University Hospitals made a successful bid to host the deanship. The crucial part of this bid was that it was very clear that hosting was about supporting the generic functions of the deanship (Finance, HR, IT) for which a fee would be paid. But the work of the deanship would be overseen and supported by a Deanery Board that was completely independent of the host organisation with an independent chair.

5.4 From April 2011, the KSS Deanery has been hosted by Brighton and Sussex University Hospitals and the Deanery Board has been set up and implemented. The SHA and Brighton and Sussex University Hospitals appointed in open competition an independent chair (Sir David Melville) and the independent board was appointed to forthwith. This has representation from acute and mental health providers across KSS, PCTs, HEIs, the medical school and the SHA. The terms of reference and membership of the Deanery Board are set out as Enclosures 4 and 5.

5.5 Brighton and Sussex University Hospitals have a three year contract to host the deanship and the deanship has key performance indicators that it must be meet for the SHA on top of the requirement to meet the standards of all the national regulators. There are quarterly contract review meetings between the SHA and the deanship when all the key performance indicators and the financial performance of the deanship is reviewed.

6. What has been achieved?

6.1 The full support and buy-in of the only university hospital in KSS as well as much closer collaboration with the medical school.

6.2 Far greater involvement of Chief Executives from local education providers in postgraduate medical education. Significant competition for membership of the Deanery Board.

6.3 Much better understanding of the roles of HEIs in the work of the deanship. The potential to get HEIs to work together with the deanship schools across the whole of the geography of KSS.
6.4 Greater clarity of funding and its usage.
6.5 Genuine discussion with the service when educational changes need to be made.
6.6 Genuine involvement of local education providers in strategic planning by the deanery.

7. Risks and opportunities in the future DH model

7.1 The current model allows the Government to state that a certain amount of money is being dedicated for postgraduate medical education by allowing the intermediate tier to completely ignore its allocations. This is confusing for both the service and the public. The Department of Health should determine the money to be spent on postgraduate medical education as this is a national endeavour and it should pass as directly as possible to the deaneries to use to deliver the national curriculum.

7.2 Having an intermediate tier of Local Education and Training Boards has the potential to interfere with those funding flows. The role of the Local Education and Training Board should be to work on the crucial areas of inter-professional learning (for example, communication, team working and leadership) but it should not be able to alter medical education funding without formal HEE approval.

7.3 The current model demonstrates that the important driver of getting service involvement in postgraduate medical education can be achieved at low cost in what is nearly a virtual organisational role. The only cost to the Deanery Board is three days a month of the chairman’s time. We suggest this is good practice that should underpin the formation of Local Education and Training Boards which in large part should be virtual organisations with the absolute minimum of appointed staff.

7.4 A major focus of Health Education England must be to ensure not only that medical education funding is spent on medical education but that it becomes more equitably distributed around the country wherever it can be demonstrated that national standards are being met. Much less of the curriculum now needs to be delivered in University hospitals compared with 10 or 15 years ago.

7.5 Medical education is a UK wide endeavour and as such the postgraduate deans of England should be managerial accountable to the Director of Medical Education for England.

7.6 It is crucial that educational bodies are hosted but not managerial integrated into employing organisations to ensure and be able to demonstrate a clear operational independence.

7.7 Although we have not presented the evidence here other specialties such as Pharmacy and Dentistry that are largely a postgraduate education based in clinical placement work extremely well within a Deanery model. In KSS these specialties are fully part of the same quality management and trainee in difficulty process as medicine.

Enclosure 1: Overview of use of MADEL in KSS.
Enclosure 2: Funded NTNs per 100,000 population by SHA.
Enclosure 3: Trust funded specialty training posts as a proportion of total specialty post numbers by SHA.
Enclosure 4: KSS Deanery Board—Membership and Terms of Reference.
Enclosure 5: KSS Deanery Board Membership.

November 2011

Table A

<table>
<thead>
<tr>
<th></th>
<th>Undergraduate</th>
<th>Postgraduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recruitment</td>
<td>Selects school leavers to start undergraduate education in medicine.</td>
<td>The deanery runs selection processes at various levels of training: undergraduate to foundation training, foundation to core training, core training into specialty training, foundation training into GP specialty training. Many of these local processes are part of national coordinated recruitment.</td>
</tr>
<tr>
<td>2. Recruitment buy in</td>
<td>Each medical school has its own culture and selects students with the best fit.</td>
<td>Clinicians who will work with, and train doctors, in postgraduate education are fully involved in selection to their own programmes. Almost entirely experiential undertaking clinical work supervised by consultants or GPs. Some taught programmes and a large amount of self-directed learning.</td>
</tr>
<tr>
<td>3. Delivery of the curriculum</td>
<td>Significant taught programme including lectures and laboratory work with increasing experiential learning in the workplace throughout training.</td>
<td></td>
</tr>
<tr>
<td>Health Committee: Evidence</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Undergraduate</th>
<th>Postgraduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Clinical placements</td>
<td>Medical school arranges clinical placements in the local trusts, surrounding hospitals and community. SIFT funding is used to pay for this.</td>
</tr>
<tr>
<td>5. Educational environment and infrastructure</td>
<td>Medical school infrastructure and some support for trusts providing undergraduate medical education funded through SIFT.</td>
</tr>
<tr>
<td>6. Assessment of progression</td>
<td>Multiple examinations and assessment throughout undergraduate training.</td>
</tr>
<tr>
<td>7. Quality assurance and management activities</td>
<td>The GMC quality assures undergraduate activities and medical schools undertake activities to assess placement quality.</td>
</tr>
<tr>
<td>8. Failure to progress</td>
<td>Medical schools provide remedial support wherever possible.</td>
</tr>
<tr>
<td>9. Training the trainers</td>
<td>Locally based systems.</td>
</tr>
<tr>
<td>10. Research</td>
<td>A major focus of undergraduate teachers and medical school function.</td>
</tr>
</tbody>
</table>
Enclosure 1

Finance

Review of Trainee Numbers

The table below gives details of the number of trainees by grade across KSS in 2010/11 and also provides a forecast of the following year's anticipated activity.

<table>
<thead>
<tr>
<th>Training guide</th>
<th>Actual numbers as at March 2011</th>
<th>Forecast numbers for March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>488</td>
<td>481</td>
</tr>
<tr>
<td>F2</td>
<td>488</td>
<td>481</td>
</tr>
<tr>
<td>Core Training Years</td>
<td>598</td>
<td>598</td>
</tr>
<tr>
<td>Higher Speciality (SpR)</td>
<td>105</td>
<td>10-20% increase</td>
</tr>
<tr>
<td>GP run-through years 1 and 2 (based in hospitals)</td>
<td>560</td>
<td>560</td>
</tr>
<tr>
<td>GP run-through year 3 (GpR)</td>
<td>280</td>
<td>280</td>
</tr>
</tbody>
</table>

Payment to NHS: 87.5%
Educational costs: 5.0%
Foundation School: 0.5%
Speciality Schools: 0.3%
Staff Grade CPD: 0.5%
GP CPD: 0.2%
Non consultant career grade development: 0.2%
Trainee recruitment and assessment: 2.5%
Other: 3.3%

Enclosure 2

Funded NTNs per 100,000 of population

Number of NTNs

Data Sources:

* Populations extracted from the ADS2004 and reconciled to ONS mid 2003 estimates for PCOs
* Funded posts from DH data 2008/09

South East Coast SHA: 50
East of England SHA: 45
South West SHA: 40
West Midlands SHA: 35
East Midlands SHA: 30
North West SHA: 25
South Central SHA: 20
Yorkshire & Humberside SHA: 15
North East SHA: 10
London SHA: 5
Ev w10  Health Committee: Evidence

Enclosure 3

Data relates to 2009-10 Postgraduate Medical Training Posts - taken from Deanery Deep Dive returns as part of the RPMET Review.

Enclosure 4

DEANERY BOARD
MEMBERSHIP AND TERMS OF REFERENCE

The Deanery Board will:

(i) promote excellence and innovation in postgraduate education and encourage and develop educational research including development and evaluation of assessment and learning;

(ii) oversee the business planning process for the Deanery as a provider within the context of SHA commissioning of postgraduate medical and dental education, undergraduate and post graduate pharmacy education and possible future national commissioning;

(iii) add value to and promote the success of the Deanery as an organisation both nationally and regionally;

(iv) assure all stakeholders that work with the Deanery on a regional basis that the work of the Deanery is equitable, in particular, in its allocation of finances, quality management processes and operational contracting with Local Education Providers;

(v) assist the Dean Director in setting strategic direction and effective educational management capacity and capability;

(vi) oversee the Deanery communication strategy in order to ensure engagement of all stakeholders;

(vii) take a lead role in the appointment of the senior staff; and

(viii) review the overall performance element of the evidence required by the commissioner to meet national regulatory standards and local key performance indicators.

Its principal functions are to:

(i) receive reports from the Dean Director and other Deans;

(ii) consider and approve the Deanery strategic direction and business plan;

(iii) approve and review the Deanery financial plan;

(iv) receive and comment on the national workforce plans;

(v) receive and approve the Deanery quality management reports;

(vi) receive and comment on GMC and other national reports;

(vii) appoint Appeals Committees as required; and

(viii) receive and comment on the risk register and escalate any risks to the Brighton and Sussex University Hospitals (BSUH) Board of Directors.
The Chair will be responsible for the operation of the Deanery Board, ensuring that it makes an effective contribution to the governance of the Deanery and its pursuit of quality and excellence. The Chair will work closely with the Dean Director and the Secretary of the Deanery Board and will ensure that key and appropriate issues are discussed by the Deanery Board in a timely manner and that relevant information and advice is made available to the Deanery Board to inform the debate and decision-making process.

**Membership of the Deanery Board**

The membership of the Deanery Board will comprise:

- From the Deanery: the Dean Director, the GP Dean and the Chief Operating Officer.
- From the Brighton and Sussex Medical School: the Dean or designated representative.
- From the SHA: the director responsible for commissioning postgraduate medical, dental and pharmacy education.
- From a Higher Education Institute: two representatives elected from the HEI college arrangement with a minimum of one place to be reserved for either the University of Kent or the University of Surrey.
- From local acute Education Providers: three representatives elected through the LEP college arrangement based on the three counties of Kent, Surrey and Sussex.
- From the three county based Mental Health Trusts: one representative.
- From the three new county based PCT clusters: one representative.
- An independent Educationalist.

The Deanery Board will meet monthly in the first instance.

The Membership of the Deanery Board will be based on the principle of no substitutes.

**Enclosure 5**

**KSS DEANERY BOARD**

**Board Membership**

*Sir David Melville*
Independent Chair

*Professor David Black*
Dean Director, KSS Deanery

*Professor Abdol Tavabie*
GP Dean and Deputy Dean Director, KSS Deanery

*Mr Chris Bird*
Chief Operating Officer, KSS Deanery

*Professor Zoe Playdon*
Head of Education, KSS Deanery

*Professor Jon Cohen*
Dean, Brighton and Sussex Medical School

*Dr Judy Curson*
Clinical Lead for Medical Education Commissioning, NHS South of England (East)

*Professor Shirley Price*
Associate Dean of Learning and Teaching Division of Biochemical Sciences, Faculty of Health and Medical Sciences, University of Surrey

*Professor Julian Crampton*
Vice Chancellor, University of Brighton

*Mrs Susan Acott*
Chief Executive, Dartford and Gravesham NHS Trust (Kent)

*Mr Andrew Liles*
Chief Executive, Ashford & St Peter’s Hospitals NHS Trust (Surrey)

*Mr Phil Barnes*
Medical Director, Western Sussex Hospitals NHS Trust (Sussex)

*Dr Rachel Hennessy*
Medical Director, Surrey and Borders Partnership NHS Foundation Trust
Dr Robert Stewart  
Medical Director and Director of Clinical Commissioning, NHS Eastern and Coastal Kent

Written evidence from the Medical Protection Society (ETWP 06)

Summary
— Poor communication is one of the most common reasons for a patient to make a complaint.
— The Medical Protection Society (MPS) is wholly committed to promoting openness between clinicians and their patients. We consistently advise members to be open with their patients when things go wrong.
— This area of medical practice is not well understood by practitioners who often think that being open is an admission of legal liability.
— We believe a root cause for this misunderstanding is a lack of training, and that where training and education is provided, they form only a small part of the curricula or programme.
— Doctors often take a very strategic approach to the way in which they engage with education and training.
— The skills gap identified here could be addressed by placing a greater emphasis on the importance of developing these skills, and by more rigorous assessment of their understanding.
— The GMC could take responsibility for this by better incentivising doctors to engage in these areas.

Introduction
1. MPS is the leading provider of comprehensive professional indemnity and expert advice to more than 270,000 doctors, dentists and other health professionals around the world. We have nearly 120 years experience and operate in more than 40 countries. In the United Kingdom approximately 180,000 doctors, dentists and other healthcare professionals are members representing around 50% of all doctors and 70% of all dentists.

2. As a mutual, not-for-profit organisation we offer members professional support and expert advice, on a discretionary basis, with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, disciplinary and professional regulatory investigations, inquests, complaints and general ethical and professional advice.

3. We advocate a culture of openness and provide training in open disclosure and high quality communication for health professionals. In our publications we promote a learning culture, making use of our claims experience to highlight common mistakes and spread awareness of specific risks.

Background

4. In this submission we wish to concentrate on the importance of promoting openness and strengthening communication skills within the education and training curricula, as MPS experience suggests that poor communication is one of the most common reasons for a patient to make a complaint.

5. MPS is wholly committed to promoting openness between healthcare providers and their patients and we consistently advise our members to be open with their patients when something has gone wrong. However, this area of medical practice is not well understood by practitioners, who often express concern that by being open and honest they are admitting legal liability and potentially exposing themselves to litigation.

6. MPS believes the root cause for these misunderstandings arises from a lack of training and development in the advanced communications skills necessary to do this effectively. Furthermore, where education and training in these areas is provided, it is quite often the case that these subjects form only a very small part of the curricula—particularly the undergraduate curricula, and even less for the foundation and specialist training curricula.

7. We believe this could be addressed by placing a much greater emphasis on the importance of developing these skills within the education and training programmes, and by more rigorous assessment of medical students and doctors in training on how they have developed these skills. Our view is that doctors often take a very strategic approach to the way in which they engage with education and training. There is such a lot of material to absorb and unless they perceive a strategic benefit from concentrating on a particular area—they will be assessed on it and need to pass that assessment in order to progress to the next level—we believe it is unlikely that they will focus greatly on it.

8. MPS strongly believes the culture of training in relation to these areas need to change and we would recommend the GMC could take a more active role in incentivising doctors to engage in these areas.

December 2011
Written evidence from Ed Macalister-Smith (ETWP 07)

1. I am writing in a personal capacity.

2. I am the Interim Independent Chair of the shadow LETB—Leadership, Education and Training Board—for NHS South Central (South of England). NHS South of England has written to you separately and I support that submission. However, there are some additional comments that I can make more easily in a personal capacity.

3. The LETB for NHS South Central has the resources of a workforce team, the two Deaneries in Oxford and Wessex, an annual budget of c £320 million, and around 22,000 trainees and learners every year.

4. Following early guidance, and enthusiasm from key players in the region, a shadow LETB was established and has met four times.

**Summary of my Comments**

5. The opportunity afforded by the proposed changes to the education and training system should be used to:
   (a) Enable the education and training systems nationally to be a foundation stone for safe and respectful care and treatment, alongside provider’s own induction and staff development resources.
   (b) Enable the education and training system locally to provide a key part of the leadership development role for the service, alongside the proposed national leadership academy.
   (c) Enable the education and training system locally to connect with other NHS innovation and quality improvement work, and be seen as a key component of organisation or system turnaround in the case of system failure.
   (d) Enable the local health economies both to support national requirements for workforce numbers, but also to resist nationally imposed directives which may not be required locally.
   (e) There is an urgent need to resolve the future organisational ownership of staff.

**Safe and Respectful Care**

6. Our view locally is that the education and training function should not simply be seen as a mechanistic vehicle for working out the future workforce requirements in a coming period, and then commissioning that volume of training places. Ensuring that staff have clear preparation for their work in the NHS, instilling key values for the service in relation to respect and dignity for patients, and instilling mutual respect between professions in multi-professional training environments are all important contributions to service excellence. This is not to deny the vital role of employer’s own induction, training and CPD responsibilities—rather it is about ensuring a systematic baseline on which employers can build. HEIs must allow these issues to be a part of the training programmes, even though HEIs may perceive that they are training staff for careers other than in the NHS—the NHS is paying for most of it, and local NHS providers arrange most of the work placements.

**Leadership**

7. Our local translation of the LETB acronym deliberately starts with the word “Leadership” (rather than the usual designation of “Local”). It is our view that leadership development should be, indeed must be, an essential component of the role of local systems. NHS South Central through the Medical Director Peter Lees has developed an exemplary programme of leadership training and development which operates in a multi-disciplinary way, and which reaches future leaders early in their careers. It adjusts flexibly to local needs (eg most recently to CCG leader development). This position is not to deny the importance of a national leadership academy as proposed for the NHS Commissioning Board, but rather is complementary to that. There will simply not be enough capacity at a national level, and it will be unable to be locally flexible to meet the needs of the service, unless there is a local component to leadership development.

**De-cluttering and Partnerships**

8. There is an excellent opportunity to build on the proposals from the NHS last week (INNOVATION) to mandate a national roll-out of Academic Health Science Networks (maybe 14–18 systems nationally). This to be accompanied by a de-cluttering of related and overlapping organisational structures, in a process that needs to be led preferably at CEO (or Executive Director) level in every provider organisation. The geographic footprints of LETBs could usefully be co-terminous with AHSNs, and could incorporate HIECs and CLAHRCs. Provided that these systems are multi-professional, and fully representative of (and owned by) all local organisations, they could be powerful, mutually supportive forces for service change and improvement. However, there are risks to manage in reaching for this opportunity:
   (a) Avoiding the loss of current local excellent initiatives, while gaining the benefits of reduced bureaucracy and merged overheads.
   (b) Take-over by single sectoral interests (eg a University, Foundation Trust, or individual profession)—in this context I disagree with the position put to Secretary of State by COPMED and AMRC two
weeks ago that might tend to isolate medical education from the need to work with local provider organisations and with other professions.

(c) On the other hand, adopting a single national operating model and “requiring” innovation might tend to unhelpfully bureaucratise the process and neutralise the world class excellence of e.g. doctor training at Oxford University, which is a great asset locally.

**LOCAL AUTONOMY**

9. There is no point in having local structures unless they have a clearly defined and significant degree of local autonomy (otherwise it would be cheaper and quicker to operate by centralised directive). Two examples may help to define what I would regard as local decisions, but which currently are largely centrally mandated.

(a) At a national level, there is a need to train more GPs. GPs often enter practice close to where they have trained. Parts of the affluent south east of England have significantly more GPs than their “fair share” of NHS funding would suggest is affordable. These areas should not be required to train more GPs if they do not see the need, and if they wish to invest instead in expanding other community services.

(b) Some areas are well-supplied with health visitors. National initiatives to increase numbers everywhere will distort local priorities.

**URGENCY TO RESOLVE ORGANISATIONAL OWNERSHIP**

10. Changes to education and training arrangements were announced many months ago. Future arrangements remain unclear, especially for the organisational ownership of staff associated with this work whether workforce teams or deaneries. This matter does require rapid resolution, as continued delay is highly de-stabilising for staff who have been very committed to running a high quality system.

I do hope that these comments are helpful.

*December 2011*

**Written evidence from Bayer (ETWP 08)**

1. **EXECUTIVE SUMMARY**

1.1 Bayer is the leading pharmaceutical company with a focus on contraception. We believe that ensuring that women of all ages have information on and access to the full range of contraceptives is critical to reducing unintended pregnancy, and to improving women’s health, well-being and life-chances. To ensure women have access to the full range of contraceptives a highly trained NHS and public health workforce is crucial for ensuring high standards of care and in providing choice for users of such services.

1.2 Bayer has welcomed the Department of Health’s commitment towards “maintaining a well-trained, highly motivated public health workforce”, as set out in the Public Health White Paper. Such a commitment is vital to address and avoid unnecessary variations in access to contraceptive services.

2. **ENSURING THE RIGHT NUMBERS OF APPROPRIATELY QUALIFIED AND TRAINED HEALTHCARE STAFF**

2.1 In order for the Department of Health to deliver on its commitment for a well-trained public health workforce, it will be critical for Public Health England and local commissioners to have a clear idea of the number of qualified health professionals required to meet the needs of local people.

2.2 Long-acting reversible contraceptive methods (LARC) are birth control methods that provide effective contraception for an extended period of time. Contraceptive options that are LARC methods are: the intrauterine system (IUS); intraterine device (IUD); contraceptive injection; and sub-dermal implant (SDI). The IUS, IUD and SDI methods need to be fitted and removed by a trained and qualified healthcare professional, and not every general practitioner or practice nurse, for example, may be trained and able to provide these options to women who wish to choose them (although they should be able to refer women to another clinic where they could access them).

2.3 Currently there is no audit or register of the number of health professionals who are qualified to fit and remove each type of long-acting reversible contraception (LARC). It is essential that existing and emerging commissioners, as well as local health and wellbeing boards, have this type of information available when developing commissioning plans. This will mean that they can make an accurate assessment of whether they have a sufficient workforce in place to meet existing and future local health needs, or if they need to train more healthcare professionals to provide fit these methods.

2.4 The Committee should consider recommending to the Department of Health that health professionals’ regulatory bodies should collect details on the number of healthcare professionals trained to fit and remove

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different types of LARC. This information should be made publicly available to identify variations and ensure there is sufficient provision of trained LARC fitters in all parts of the country to meet existing and future need.

3. Delivering High and Consistent Standards of Education and Training

3.1 Bayer is concerned that an unintended consequence of the Department of Health’s proposals to transfer responsibility for training provision to providers could exacerbate the existing shortage of healthcare professionals who are trained to provide, fit and remove all forms of contraception.

3.2 Bayer is further concerned that a lack of set training requirements for healthcare professionals could lead to unacceptable variations in the standards of education and training, thereby impacting on the quality of interventions.

3.3 The Committee should consider recommending that the NHS Commissioning Board and Public Health England are required to set training requirements for healthcare professionals delivering interventions such as sexual health and contraceptive services.

3.4 The Committee should consider recommending that Directors of Public Health are encouraged to highlight examples of good practice in training and development which can be shared with other commissioners at a local, regional and national level.

December 2011

Written evidence from The Queen’s Nursing Institute (ETWP 09)

Summary

— Education, training and workforce planning are the most important topics in the health service debate, since plans for commissioning, provision, public health activity, efficiency or service improvement cannot be achieved without the right people with the right skills in the workforce.

— The Queen’s Nursing Institute (QNI) has recently published a report specifically on nursing care in the home which identifies issues of real concern in the quality of care in this hidden environment, due to inadequate attention to education, training and workforce decisions.

— Pre- and post-registration education for all health care professionals must focus on the special skills required to deliver care outside of traditional hospital settings, since policy, economic and demographic drivers all require an acceleration in the movement of care to the home and community settings.

— Continuing professional development for the existing workforce must explicitly re-train practitioners for community-based work.

— Strong national leadership and direction will be needed to ensure that local commissioners hold their diverse providers to the same essential principles in developing their workforces.

— Large-scale retirement of highly skilled and experienced workers in primary care and community services (GPs, nurses and others) is a major risk to the development of community-based services and the movement of significant amounts of work from secondary to primary care.

— Measures to protect the public and ensure high quality care in the community would include:
  — reversing the decline in the number of nurses specifically trained to work in the community;
  — ensuring experienced mentorship and support for practitioners new to community work;
  — supporting the authority and importance of community team leaders alongside ward sisters;
  — regulating health care assistants and standardising their training;
  — strengthening post-registration and CPD opportunities to learn community skills; and
  — monitoring diverse providers’ workforce policies to ensure that they employ sufficiently-skilled and well-supported practitioners.

Submission

1. The Queen’s Nursing Institute is a 125-year old charity which aims to improve the nursing care that people receive in their own homes and communities. We do this by funding innovative, multi-disciplinary improvement projects; by creating Queen’s Nurses to be role models and leaders to others; by running large-scale projects ourselves, such as our Opening Doors project for homeless people; and by campaigning and lobbying to influence the policies that affect the quality of care.

Education and Training

2. Our recent report, Nursing People at Home—the issues, the stories, the actions, heard directly from patients, carers, members of the public and community health professionals about the experience of receiving

2 The Queen’s Nursing Institute (2011) Nursing People at Home—the issues, the stories, the actions. London: QNI
healthcare at home. While 70% of people said their care was excellent or very good, in 30% of cases, care was not up to standard. The key issues were nurses or health care assistants—and 45% of people did not know who had treated them—who either lacked knowledge about the patient’s condition, or did not have the skills required to treat them, or were poor at communicating, or focused only on the task and not the patient, or showed little compassion.

3. Patients and families who responded to the survey showed clearly that they could distinguish the well-trained practitioner from the “task-taught” practitioner; and the inexperienced person from the experienced. The impact of poor care was evident to the patient and their family: they described unnecessary pain, stress and suffering; avoidable pressure sores; avoidable hospital admissions; and even times when poor care was blamed for hastening death.

Patients said:

“My 91 year old mother died at Christmas. Although she was confined to a wheelchair for 12 hours a day she was not regularly assessed re her tissue viability and ended up with a massive pressure sore. Carers were left to deal with the sore and dress it as best they could although they tried to get the district nurse to visit. Eventually I got the out of hours district nurse to come out and she was superb. Sorting out analgesia, pressure relief, appropriate dressings, and daily visits. Unfortunately my mother died 24 hours later and I feel that her last few weeks could have been so different with skilled nursing care.”

“I had excellent help and care from the local district nursing team who helped care for my terminally ill mother... unfortunately this could not be said of the untrained carers who attended one day eg turning up to bath with large rings, long nail … insisted on lying a [short of breath] oxygen-dependent patient flat to change sheets even though with help of me alone could get out of bed. When I stopped them lying her down and explained why she had become agitated and could not breathe, the non-nurse manager still insisted this was the only way to change a bottom sheet ... Fortunately for my mother she no longer required care for the untrained staff as she died later that evening not really recovering from the episode of being laid flat.”

“I have recently had three months district nursing care and valued the skills of the most experienced nurses. The limitations of the less experienced were apparent in that they can do a task to a set written plan but not adapt to changes as they arise or respond to wider needs.”

4. At the beginning of the QNI’s Right Nurse, Right Skills campaign, the national press was reporting the case of Jamie Merritt, a tetraplegic man who lived at home, and who was permanently brain-damaged when a community nurse accidentally turned off his ventilator and did not know how to turn it on again, or to use the resuscitation equipment. Sadly, the incident was recorded because Mr Merritt was so concerned about the lack of skills in the nurses who cared for him that had installed cameras in his room. This case serves to highlight the complexity of care taking place in the community today; and the key role of education and training for the workforce.

5. The nurses who responded to our survey identified three education/workforce factors that are currently threatening the quality of care to vulnerable patients at home:

(a) The reduction in commissions for specialist community courses, such as the district nurse course, leading to more nurses learning “on the job” or in ad hoc courses—the NHS national workforce census for England shows that the number of trained district nurses working in the community has fallen by one third in the last decade, and is now at its lowest ever level.

(b) The loss of experienced nurse leadership in community teams—there were many reports of redundancies as well as retirements amongst more experienced nurses, and the subsequent down-grading of their posts—some community nursing teams are now led by non-nurses, which reduces the advice and mentorship available to less experienced nurses. The district nurse qualification is no longer a pre-requisite for team leaders.

(c) The increasing reliance on health care assistants, who are currently unregulated and unregistered, and do not complete a recognised course of training, to deliver increasingly complex care in the home. The workforce census shows that the number of HCAs in the community has more than doubled in the last decade; and we have had reports of provider organisations aiming for a 60:40 untrained to trained workforce.

Nurses said:

“Nursing skills have been eroded and role which have traditionally involved community nurses have been spread among semi-qualified staff.”

“In essence the patients under these teams may NEVER come into contact with a district nurse and have access to the specialist skills and knowledge. This practice is both dangerous and unfair to patients and their families.”

“As a district nurse, I have seen more and more care given by health care assistants. When I go in, I have to spend a lot of time sorting out problems that have been missed or caused by lack of knowledge. I have come across several cases of wrongly used equipment and poor clinical judgement.”
6. The QNI supports skill mix in community teams, and believes that HCAs have a great deal to offer, particularly in innovative roles spanning health and social care, which help people to manage in their own homes and avoid hospital or residential care. However, we believe that HCAs should be regulated, and that it is unfair to expect them to substitute for trained nurses without adequate preparation, support and supervision. There is a danger that our current approach to HCAs is recreating all the problems and risks of Victorian nurse training, which led to the registration of nursing being set up to protect the public nearly 100 years ago.

**Diversity of Providers**

7. Current Government policy aims explicitly to encourage new providers from the independent and voluntary sectors to tender for contracts to deliver a variety of community services. Indeed, non-NHS organisations already provide much complex care in community settings, including voluntary sector hospices, drug services and terminal care provision; and independent sector mental health, drug and alcohol, and specialist equipment and support services.

8. Since the NHS workforce census does not cover non-NHS organisations, we are already in a position of being blind to the workforce composition, plans and competencies in these services. There is an argument for contracting solely on the basis of outcomes, and leaving the provider to decide who they need in the workforce to deliver those outcomes successfully. However, this builds in a significant risk for the commissioner—and the recipient of services—that could be avoided by more transparency about skills and education of the workforce.

9. Proposals to involve all employers in local networks for workforce planning and education commissioning, and to require them to contribute to the funding of education, go some way to ensure that non-NHS providers are “inside the tent”. But further vigilance may be required to ensure that behaviours already demonstrated within the NHS, to reduce workforce costs by down-grading posts, employing lower-banded staff, reducing education and diluting skill mix, are not replicated unseen by other providers.

**Retirement**

10. Exacerbating the loss of leadership, experience and education in community teams is the demographic profile of this part of the workforce. 72% of the district nursing workforce is over the age of 40, compared to 43% in the hospital sector, according to research carried out in 2008, and therefore eligible to retire within 15 years.

11. In addition to this natural wastage, the QNI has been aware of many community nurses taking early retirement in response to the stresses of recent re-organisation, and the pressure to “do more with less”, the loss of colleagues, down-grading of posts and inability to deliver care of the quality they consider essential for patients.

Some of the comments in our survey were:

"We are not working outside of the hours we signed up for, we have less staff and morale is at its lowest ebb. We are about to lose two highly skilled DNs to early retirement because of these enforced changes and they will not be replaced with the same skill mix and one may not be replaced at all... many believe that the district nursing service is being dismantled to be sold off to the lowest bidder."

"Fewer DNs are coming through training and many are retiring or using their qualification to move their skills to other areas."

"Age profile of district nurses is 50 plus and retirements are leaving vacancies that cannot be filled as staff have not been trained in sufficient numbers to fill the gaps."

12. It is important to stress that experienced, confident practitioners such as these are essential to the development of the future workforce. The increasing numbers of inexperienced, newly-qualified and non-community trained nurses moving into community work will provide very valuable new blood, energy and inspiration, but only providing they are supported, mentored and assisted by people who already have specialist community skills. Every effort should be made to retain experienced community nurses if we are serious about moving the workforce out of hospitals to deliver more care closer to home.

13. The recent reports of poor care on hospital wards have led to a focus on the pivotal role of the ward sister, and the need to restore her authority, status and responsibility. Similar attention and effort should be focused on the “district nursing sister” or community team leader, for the entirely pragmatic reason that we need them to develop the next generation of practitioners and to safeguard the quality of care for patients today and tomorrow.

14. We also need experienced community leaders to ensure that there is not a hidden scandal of poor care and tragic consequences taking place behind the front doors of vulnerable patients at home, right now.

*December 2011*

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Written evidence from The Priory Group (ETWP 10)

EXECUTIVE SUMMARY

— The Priory Group (“The Priory”) as the largest independent sector provider of mental health, specialist care and specialist education services by number of beds, is keen to contribute to the education and training of the NHS workforce where appropriate.

— The Priory is recognised as an “approved practice setting” by the General Medical Council and can offer medical trainees a range of experiences that would be difficult to achieve through receiving training solely within NHS providers.

— As the NHS moves to a more diverse provider market, it will be vital that non-NHS providers are fully engaged in the development of education, training and workforce policy, and that equity between NHS and non-NHS providers is secured.

— The Priory welcomes the Government’s intention to ensure a level playing field in training and education amongst providers, and the Health Select Committee’s investigation of how to ensure that all providers play an appropriate part in developing the future workforce. However there are a number of areas of education and training policy that need to be addressed in order to deliver a truly level playing field:

(a) Equity of access to trainees for all providers.

(b) Clarity around funding flows available for education and training.

(c) Maximising the quality of training offered to medical trainees.

— The Priory reports on its workforce development in its annual Quality Account and believes that all providers should include issues relating to workforce development in their quality account.

ENSURING ALL PROVIDERS PLAY AN APPROPRIATE PART IN DEVELOPING THE FUTURE WORKFORCE: EQUITY OF ACCESS TO TRAINEES

1. In its call for evidence, the Committee has said that it will consider how all providers of healthcare play an appropriate part in developing the future workforce. Existing disparities in equity of access to trainees for non-NHS providers will need to be tackled if this goal is to be realised.

2. Currently there are limited opportunities for independent sector providers to gain access to medical trainees. This is because decisions on placing trainees are currently taken by NHS providers and the situation has deteriorated following the implementation of “host providers” which get first pick of trainees over other providers. There is a perception that educational placements are allocated on the basis of the need to staff NHS organisations, rather than on the quality of educational placements available, or wider workforce planning considerations. This inequality in access needs to be tackled in order to meet the Government’s aim of a level playing field in education and training.

3. Under the Government’s reform proposals, the new body Health Education England will become responsible for providing sector-wide oversight for the planning and commissioning of education and training. One way of addressing the issue of access to trainees would be for the Department of Health when developing further guidance on the remit of Health Education England (HEE) to give HEE an explicit duty to ensure equity of access to trainees between different providers.

HOW FUNDING SHOULD BE PROTECTED AND DISTRIBUTED: CLARITY OF FUNDING FLOWS

4. The Committee is also looking at how funding should be protected and distributed in the new system. There is currently a lack of clarity around funding flows to support education and training, which the Government recognised in the consultation Liberating the NHS: developing the healthcare workforce. The Priory welcomed the Government’s commitment in the consultation to tackle this by introducing “transparent funding flows for education and training”.

5. Currently, funding arrangements are not consistently applied between regions in England, and funding is often not made available to independent sector providers. This means that trainees are missing out both on the range of possible experiences and access to patients with specialist needs that can be gained from working in independent sector providers. Trainees themselves can bring new ideas and play a role in stimulating innovative work practices, and it is important that these ideas are both available to the NHS and the independent sector.

6. The Government’s longer-term reform plans propose that every provider of NHS services may be expected to contribute to a levy for training. Before this is implemented it is vital that clarity and equity of funding flows is established first in order that the levy can deliver maximum benefits.

ENSURING APPROPRIATELY TRAINED HEALTHCARE STAFF: MAXIMISING TRAINING QUALITY

7. Educational placements must be based on workforce planning needs and the learning opportunities available in order to ensure the highest quality training possible and develop a sufficiently experienced healthcare workforce.
8. The Priory provides specialist mental health services and offers care to some of the most severe and complex cases. For example our adolescent mental health, eating disorder and forensic secure services comprise a large proportion of the national bed stock for those treatment areas, and our addiction services have an international reputation. Trainees working solely in the NHS sector cannot benefit from the experience of working with these complex patients because of the rarity of such NHS services. In addition, more than half of all beds for forensic services are in the independent sector and have no trainees attached, and approximately 50% of Child and Adolescent Mental Health Service (CAMHS) and EDU beds are now also in the independent sector.

9. The independent sector could, by being able to take on educational placements where appropriate, contribute significantly to the education of the healthcare workforce. However there are currently limited opportunities for medical trainees to gain experience in these settings due to a lack of access to training budgets for independent sector providers. The Government’s reforms must tackle this issue in order to maximise the quality of training offered to medical trainees in the future.

ENSURING HIGH AND CONSISTENT STANDARDS: REPORTING ON WORKFORCE DEVELOPMENT

10. Ensuring high and consistent standards will require providers to report on their workforce development. The Priory recognises that human resource management is critical to the success of a healthcare organisation. The Priory regularly reports on workforce measures in its annual Quality Account and believes that all providers should include issues relating to workforce development in their quality account.

11. In the Priory’s most recent Quality Account for 2010–11, the Priory reported on the results of a staff opinion survey which revealed improvements in the majority of areas surveyed. The Priory has also reported on completion rates of the programme in its bespoke learning and development programme. This programme has won several awards including the Institute of IT Training “e-learning project of the year” 2007.

ABOUT THE PRIORY

12. Established in 1980, The Priory Group has become the UK’s largest independent sector provider of mental health, learning disability and specialist education services, by number of beds. The Group is also one of the top three independent providers of secure and rehabilitation services by number of beds. Services provided include acute psychiatry, secure and rehabilitation services, complex care, specialist education and elderly care and dementia services. As of 1 December 2011, The Priory Group has 272 facilities and approximately 7,200 available places across the UK.

December 2011

Written evidence from Public Health Manchester (ETWP 11)

MANCHESTER CITY COUNCIL/NHS MANCHESTER

The subject of this memorandum is the problem of the inequitable distribution of GPs in England and the importance of tackling this problem. This is relevant to the following element of the committee’s inquiry:

Whether and how the Government’s plans will ensure the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels.

SUMMARY

(i) This paper describes the current severe inequity in the geographical distribution of GPs in England, and suggests some possible remedies. This inequity is likely to contribute to variation in the quality of primary services and to variation in the effectiveness of Clinical Commissioning Groups (CCGs).

(ii) The relative provision of GPs is calculated in the paper using a standard measure of weighted relevant populations used by the Dept of Health.

(iii) In general, better health areas have a lot more GPs per weighted population than do poorer health areas.

(iv) The range of GP provision at SHA level is from 13% above the England average (London SHA) to 13% below (North West SHA).

(v) The range of GP provision at PCT level is from 53% above the England average (Wandsworth PCT) to 27% below (Nottingham City PCT). Wandsworth thus has more than twice as many GPs per weighted population as Nottingham City.

(vi) The range of inequity at CCG level will be worse than that at PCT level because there is additional geographical variation within PCT areas.

(vii) The extra responsibility of GPs in CCGs for commissioning and budgeting makes it even more crucial for this inequity to be tackled.

(viii) It is important to reduce this inequity as part of the drive to reduce health inequalities.
(ix) The proposed centralisation of the budget for GPs under the NHS Commissioning Board (NCB) provides an opportunity to manage initiatives to reduce the inequity.

(x) Possible initiatives to reduce the inequity include additional central funding for new GPs in under-doctored areas, greater incentives for GPs to work in these areas, and introducing a limit to the weighted list size per full time equivalent GP.

**INTRODUCTION**

“At a minimum the health service should ensure that disadvantaged groups have equal access to NHS services”


1. The geographical distribution of GPs in England has been problematic since the birth of the NHS. Many GPs prefer to live and work in desirable areas. Consequently it has been difficult to reduce the inequity in the distribution of GPs which favours areas of better health. This is despite the past efforts of the Medical Practices Committee, the publicised concern of many past Secretaries of State for Health, the transfer of the primary care financial allocations direct to PCTs and the recent Equitable Access initiative.

2. The Equitable Access initiative demonstrated that new practices can be set up in under-doctored areas provided start-up funding is allocated from central funds. This initiative addressed not only under-provision at overall PCT level but also variation in provision within the PCT area. This is because in general PCTs will have sought to locate the new practices in areas which are most under-doctored within the PCT geography. However the size of Equitable Access was small relative to the problem of the inequity in GP provision. In addition it has been difficult to make it work in some areas because of the time needed to entice patients away from their usual GP practice, despite such practices usually being very over-subscribed.

**GP DISTRIBUTION AT REGIONAL LEVEL**

3. After 63 years of the NHS, the inequity in distribution is still severe; Figure 1 illustrates the latest position by SHA. For example the North West has a shortfall of 13% or 620 full time equivalent (FTE) GPs, while London has an excess of 13% or 570 GPs. The figure also illustrates a strong north/south divide in GP provision—the five southernmost SHAs have 22% more GPs per weighted population on average than the five northernmost SHAs.

4. The calculation of relative GP provision uses the standard Department of Health method of counting Full Time Equivalent (FTE) GPs per needs weighted relevant population, with analysis carried out by Public Health Manchester. GPs are counted at September 2010 as sourced from the NHS Information centre for Health and Social Care, and the population is the 2010 relevant one from the Department of Health exposition book for 2010–11. The needs weighting uses the latest formulae used for primary care allocations to PCTs (2010–11 allocations). The benchmark is taken as the England average and the calculation of the Index of provision (England = 100) and the shortfall and excess of GPs are all relative to this benchmark.
Figure 1

% EXCESS/SHORTFALL GPS FTE BY SHA 2010 DATA

Table 1

GP PROVISION BY SHA

<table>
<thead>
<tr>
<th>Rank</th>
<th>SHA</th>
<th>FTE GPs per 100k wtd pop</th>
<th>Index (England = 100)</th>
<th>GP excess/shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>London</td>
<td>68.3</td>
<td>113.5</td>
<td>+573</td>
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<tr>
<td>2</td>
<td>South West</td>
<td>67.1</td>
<td>111.5</td>
<td>+352</td>
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<td>3</td>
<td>South Central</td>
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<td>110.7</td>
<td>+224</td>
</tr>
<tr>
<td>4</td>
<td>East of England</td>
<td>64.5</td>
<td>107.2</td>
<td>+229</td>
</tr>
<tr>
<td>5</td>
<td>South East Coast</td>
<td>64.0</td>
<td>106.3</td>
<td>+152</td>
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<td>6</td>
<td>West Midlands</td>
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<td>7</td>
<td>Yorkshire &amp; the Humber</td>
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<td>93.4</td>
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</tr>
<tr>
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<td>East Midlands</td>
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<td>89.7</td>
<td>-283</td>
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<td>North West</td>
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<td>87.2</td>
<td>-620</td>
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<tr>
<td></td>
<td>South (four SHAs)</td>
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<td>110.2</td>
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<td></td>
<td>North (five SHAs)</td>
<td>54.5</td>
<td>90.7</td>
<td>-1,530</td>
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</table>

GP DISTRIBUTION AT PCT LEVEL

5. Figure 2 illustrates the situation for PCTs. Very substantial inequity exists with a greater range than at regional level. The range is from 27% under-provided to 53% overprovided compared with the England average and again calculated using weighted relevant populations.
6. Table 2 gives data at either end of Figure 2. The most over-provided PCT has more than twice the provision of the most under-provided PCT. It is clear that it is in general the poorer health PCTs which have the greatest shortfalls in GP provision and vice versa. For example the top ten PCTs all have mortality well below the average and vice versa for the bottom ten. Thus using Standardised Mortality Ratios (SMRs) under 75 years the top ten PCTs population-weighted average is 87.8 ie12.2% better than the England average while the bottom ten average is 128.3 ie 28.3% worse than the England average. The full table of relative GP provision for all 151 PCTs is given in the appendix.

Table 2

<table>
<thead>
<tr>
<th>Rank</th>
<th>PCT</th>
<th>FTE GPs per 100k wtd pop</th>
<th>Index (England = 100)</th>
<th>GP excess/shortfall</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Wandsworth</td>
<td>92.3</td>
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<td>Wiltshire</td>
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<td>Hull</td>
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<td>Sefton</td>
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<td>Blackpool</td>
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<td>Ashton, Leigh &amp; Wigan</td>
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<td>Oldham</td>
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<td>75.8</td>
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<td>149</td>
<td>Wolverhampton City</td>
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<tr>
<td>150</td>
<td>Halton &amp; St. Helens</td>
<td>44.5</td>
<td>73.9</td>
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<td>151</td>
<td>Nottingham City</td>
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<td></td>
<td>England</td>
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<td>100.0</td>
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</table>
7. Figure 3 shows the correlation between relative GP provision and premature mortality (as measured by the under 75 standardised mortality ratio for persons) for all 151 PCTs. The correlation is significant and the slope negative showing that in general premature mortality increases as GP provision decreases. This demonstrates that the inequity of GP distribution is in general strongly to the disadvantage of poor health areas.

**Figure 3**

**RELATIONSHIP BETWEEN GP PROVISION AND PREMATURE MORTALITY (U75 SMR)**

The Effect of GP Distribution on CCGs and the NCB

8. The creation of CCGs brings the problem of GP distribution into sharper focus. Under-doctored CCGs and their patients will be starting at a large disadvantage and they will find it more difficult to absorb the new responsibilities for commissioning and budgeting; they will have little control over the situation because the GP budget will be under the control of the NCB. Consequently under-doctored CCGs are likely to be assertive in their demands for a fair share of GPs to serve the population for which they are responsible. The result is likely to be extensive negotiations between CCGs and the NCB.

9. These likely future problems make it important for the NCB to both review the problem of GP distribution and to develop a plan of action which would ultimately produce a fair distribution related to the needs of the population of each CCG. This action will be important to set a level playing field for NCB’s responsibility to hold CCGs to account for health outcomes.

Ideas to Contribute to a Solution to the Problem of GP Distribution

10. This section discusses possible remedies but is inevitably only introductory in what is a complex issue.

   (i) The most obvious is for the NCB to commission and provide start-up funding for new practices in under-doctored areas. But fundamental problems remain which could hinder this such as a lack of sufficient financial incentives for GPs to work in deprived areas.

   (ii) Gradually introduce a limit in weighted list size per FTE GP in each practice. There is currently no limit to the list size or weighted list size per GP so that there is a financial incentive for practices to maximize list size in under-doctored areas, sometimes rising to 3,000 or even 4,000 patients per GP compared with the England average of about 1,700. This proposal should make it easier for such areas to absorb new practices.

   (iii) Educate patients on the service standards they should expect, and on the weighted list size per GP in their practice. This is designed to encourage patients to move to a better practice if their current one has too many patients and consequently offers a poor service.

   (iv) Give greater financial incentives to attract GPs to poor health areas. The financial incentive in the Global Sum formula of the GP contract (it excludes the health inequalities factor used for PCT allocations), or salaries offered to salaried GPs, may not be high enough to attract GPs into deprived areas or to offset levels of private income in wealthier areas. Some commentators have also blamed
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the MPIG “safety net” payment for helping maintain inequity,6 (though this effect should reduce with time), and some suggest that QOF targets are more difficult to achieve in poor areas.7,8

(v) Investigate the possible relationship between where GPs train in practices and where they gain employment as GPs and if this is positive take steps to increase training places in under-doctored areas.

CONCLUSION

11. The creation of CCGs brings into greater focus the longstanding problem of the severe inequity in the geographical distribution of GPs in England. The chronic shortage of GPs in most poor health areas will serve to further disadvantage deprived communities as their over-stretched GPs are given additional responsibilities for commissioning and budgeting. But the fact that the NHS Commissioning Board will hold the GP budget and contracts centrally presents opportunities for the underlying problem of the geographically unbalanced workforce to be tackled anew.

REFERENCES


December 2011

APPENDIX

Table App 1 GP Provision for PCTs using 2010 data

(GP SHORTFALL/EXCESS NUMBERS ARE “EXCESS” UNLESS NEGATIVE)

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This letter outlines the view of the Academy of Medical Sciences in response to the Committee’s inquiry, “Education, training and workforce planning”, particularly in view of the Government’s current proposals for reform. There is a real opportunity to improve healthcare education and planning as the NHS is reorganised. To realise this, the Government must ensure robust governance arrangements are in place, centred on healthcare leadership at the national level. This will support a smooth transition and the establishment of an effective education and training system.

**Workforce Flexibility**

The Academy welcomes the Government’s ambition to deliver an efficient, responsive healthcare workforce and regards the need for a flexible workforce that can adapt to the ever changing scope of healthcare delivery as essential.

Now is the opportunity to properly address the specific issues regarding training and development, creating a research-aware healthcare workforce equipped to develop and deliver innovative treatments and respond effectively to the needs of patients. However, we wish to highlight that training and development of those already employed within the workforce has not been addressed sufficiently in the education and training proposals to date. We believe there is no end-point to training and that lifelong learning should be the accepted norm.

Local arrangements must encourage flexibility throughout the career pathway to best capitalise on the skills of individuals and to meet the healthcare needs of the population most effectively. The shift to community care has profound implications for how the workforce is structured, educated and deployed. This is an important factor in the changing nature of healthcare delivery.

**Health Education England**

The Academy welcomes the establishment of Health Education England (HEE) and the joining-up of education and training provision across the healthcare sector. In reforming the system, the Government must take the opportunity to establish clear, formal lines of accountability with regard to education and training. HEE is an ideal body to provide oversight and formal leadership during the transition period. For HEE’s leadership to be effective, its establishment must be prioritised.

HEE should lead on drawing together all of the relevant stakeholder organisations to develop medical curricula and to address ongoing concerns around the variation in the quality of healthcare education and training across the UK.

National planning and coordination will continue to play a major role in workforce planning (especially within medicine). Sufficient oversight must exist through HEE to ensure high quality and consistent standards across the UK and that sufficient numbers of trainees exist across all specialties. National priorities and needs must be able to shape local education and training plans. Local Education and Training Boards (LETBs) will need to be responsive to the national priorities set out by HEE, which in turn will be informed by the Centre for Workforce Intelligence and nationally determined healthcare priorities.

More specifically, HEE must be able to manage overall trainee numbers on a UK-wide basis. For example, it should provide indicative numbers for professional training. This is particularly important for medical specialties, where the planning cycle needs to take account of the length of medical training and the need to sustain critical mass in small volume but crucial areas, such as community paediatrics, medical ophthalmology, allergy and public health.
LOCAL EDUCATION AND TRAINING BOARDS

The Government has made strong commitments to encourage and establish partnerships between the NHS and academia. These commitments must be reflected in the education and training of the workforce reforms to ensure their success. LETBs are an ideal place for such NHS/academic partnerships to be fostered at a local level. Amongst advanced nations, the UK is alone in that higher education institutions (HEIs) do not have strong formal links with postgraduate medical education development or provision. We must take the opportunity to redress this issue; a partnership arrangement must lie at the core of LETB governance. This approach would enable curricula to be co-produced by academia and service providers, thus ensuring the workforce is fit for purpose.

LETBs must be structured with clear lines of accountability; conflicts of interest must be minimised. Balanced representation of service and education providers on the LETB board is absolutely essential. The current assumption is that HEIs have a conflict of interest while service providers do not. We simply do not understand how this conclusion could be drawn. Under the current arrangements, service providers will commission themselves to provide postgraduate training. This represents a significant conflict of interest. As neither education nor service providers are free of conflicts of interest, it is essential that they are both represented on LETB boards.

We recommend that LETBs are comprised of an independent Chair and board members drawn from both HEIs and service providers. Academic Health Science Centres provide a good model for a successful partnership between HEIs and HEE and a positive example for LETB governance.

HEE should be established as a sole legal entity with the LETBs under HEE’s control, operating as “sub-HEE boards” rather than separate entities. This will help to address issues of accountability and ensure that HEE provides appropriate oversight. This model should be used by LETBs across the country to ensure consistency whilst retaining the flexibility for LETBs to respond to local needs.

Postgraduate Deaneries perform important functions and their work should be continued under HEE’s guidance with support from LETBs. The work of Postgraduate Deaneries would be enhanced by establishing more consistent links with HEIs. To this aim, the individual responsible for heading up the provider function of postgraduate deaneries should be employed within a university.

RESEARCH

The Government response to the NHS Future Forum’s June 2011 report made strong commitments to research, innovation and the use of evidence. This has been further strengthened by the commitments in the NHS innovation review, Innovation, health and wealth, and the Strategy for UK life sciences. The Academy believes that this commitment must be reflected in workforce education and training. Indeed, it is critical to acknowledge the interdependence of research, education and service—all NHS constitutional requirements.

Establishing close links between academia and the NHS within the reformed system will only serve to strengthen the capacity for research and innovation across sectors.

December 2011

Written evidence from the Centre for the Advancement of Interprofessional Education (ETWP 13)

IN SUPPORT OF INTERPROFESSIONAL EDUCATION IN PRE-REGISTRATION COURSES FOR HEALTH AND SOCIAL CARE

CAIPE is a charity and company limited by guarantee which promotes and develops Interprofessional Education (IPE) with and through its individual and corporate members. It works with like minded organisations in the UK and overseas, to promote the health and wellbeing of individuals, families and communities (www.caipe.org.uk).

SUMMARY

— The case for interprofessional collaborative working is recognised and accepted as essential for effective health and social care delivery by governments across the world. A flexible, collaborative ready workforce is dependent on the way in which professionals are educated.

— CAIPE holds that well planned, interprofessional, interactive learning promotes flexible, mutually supportive, patient centred and cost effective collaboration, not only in interprofessional teams, but also more widely within a policy-aware understanding of organisational relationships.

— CAIPE makes the case for outcome-led competency-based interprofessional curricula grounded in a coherent, theoretical rationale, while safeguarding the identity of each profession and respecting profession-specific requirements and benchmarking statements.

1. **Interprofessional Education (IPE)**

   1.1 IPE occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care (CAIPE, 2002).

   1.2 Explanations for the growing interest in providing IPE during pre-registration courses include the need:

   — To respond collaboratively to the complexity of problems presented by individuals, families and communities which outrun the capacity of any one profession, putting specialist care and treatment in a holistic context;
   
   — To improve patient safety by improving communication and collaboration between professions variously responsible for the same case;
   
   — To manage relationships between the growing number of professions and their specialties resulting from medical and technological advance;
   
   — To match consumer and media pressure to improve care and services with finite resources in the face of escalating costs; and
   
   — To deploy human resources optimally.

   1.3 A well planned pre-registration professional education proposal will identify how the IPE envisaged will engage with these and other challenges in its objectives, content and learning methods within a coherent rationale.

2. **Cultivating Collaboration**

   2.1 Collaboration is planned and purposeful endeavour within a defined legal and policy context, to ensure comprehensive provision of quality care which transcends demarcations between professions, practice settings and organisations. Teamwork is at its heart.

   2.2 Integrating services is not enough to ensure collaborative practice unless and until the professions are actively, positively and collectively engaged in mediating the application of policies to practice.

   CAIPE recommends that:

   — all pre-registration IPE proposals take collaborative practice as their starting point; interprofessional teamwork is central in students’ learning.

3. **Encouraging Flexible Working Across Professional Boundaries**

   3.1 Effective interprofessional teamwork facilitates flexible working grounded in mutual understanding, respect and trust between members. Members empower each other within the constraints of law, policy and patient safety to respond expeditiously, economically and effectively to needs beyond predetermined professional demarcations. Duplication is reduced.

   CAIPE recommends that:

   — interprofessional learning is designed to encourage flexible working across organisational and professional boundaries.

4. **Improving Care and Services**

   4.1 Critical appraisal of policy and practice from interprofessional perspectives heightens students’ awareness of the need for collaborative practice to improve care and services, as each professional group extends its competence to complement those of the others.

   CAIPE recommends that the interprofessional learning be designed to generate commitment to work individually and collaboratively to improve care and services.

5. **Involving all the Parties**

   5.1 IPE is best planned collaboratively between the participant professions and other stakeholders, including universities, service agencies, students and service users, acknowledging and resolving differences to ensure that proposals are internally consistent and externally credible.

   CAIPE recommends that all the stakeholders are involved in the planning.

6. **Dealing with Difference**

   6.1 Where and how to introduce IPE between two or more professional courses is complex. Courses differ in rationale, length and structure including patterns and timing of practice placements. Teachers differ in their practice backgrounds, their theoretical orientation and their preferred learning methods.
CAIPE recommends: that time and opportunity is provided during the planning process to address and resolve differences between the professional courses and between the teachers.

7. UNDERPINNING WITH THEORY

7.1 IPE built on a theoretical foundation is more coherently planned, consistently delivered, rigorously evaluated and effectively reported (Barr et al., 2005; Colyer et al., 2005; Hean et al., 2009).

CAIPE recommends: that each proposal is underpinned by a theoretical rationale.

8. BUILDING COLLABORATIVE COMPETENCE

8.1 Regulatory bodies promote outcomes which inform collaborative practice (General Medical Council, 2009; Nursing and Midwifery Council, 2010; Health Professions Council, 2009) complemented by formulations of interprofessional competencies (Canadian Interprofessional Health Collaborative, 2010; Interprofessional Education Collaborative Expert Panel, 2011; CUILU, 2006).

CAIPE recommends: that outcomes from students’ interprofessional learning are defined as competencies or capabilities and curricula planned accordingly.

9. PREPARING THE TEACHERS

9.1 Many teachers and practice supervisors are underprepared and feel undervalued in their interprofessional teaching role. Preparation is essential.

9.2 Teachers as “facilitators” enable students from different professions to enrich and enhance each other’s learning; sensitive to the perspectives, perceptions and particular needs of each individual and profession; able to turn conflict into constructive learning (Anderson et al., 2009 & 2011; Freeman et al., 2010; and Howkins & Bray, 2008).

CAIPE recommends: that all teachers and practitioners involved in facilitating IPE receive orientation, preparation and ongoing support.

10. MIXING AND MATCHING THE LEARNING METHODS

10.1 IPE is interactive, calling on a repertoire of methods (Barr, 2002; Freeth et al., 2005). E-learning is widely introduced for self-directed and group-led learning blended with face-to-face learning (Bromage et al., 2010). Interprofessional practice learning permeates professional learning in the classroom and the workplace. Every student needs at least one interprofessional group placement during their course, for example, on an interprofessional training ward (Jakobsen et al., 2009) or in an interprofessional community setting (Lennox & Anderson, 2007).

CAIPE recommends: that a repertoire of learning methods be included.

11. CULTIVATING MUTUAL UNDERSTANDING

11.1 Students create their own opportunities to learn with, from and about each other. Teachers and practice supervisors provide more structured opportunities in the classroom and on placement, where students compare and contrast their professions’ roles and responsibilities, explore relationships within and between groups, building on positive examples, but also taking into account ways in which allegiance to one group can be at the price of invidious, prejudiced or stereotypical perceptions of others. They enable their students to relinquish negative stereotypes as they compare reciprocal perceptions in a positive and supportive climate.

CAIPE recommends: that teachers and practice supervisors optimise interactive opportunities for students’ to learn from and about each other’s professions.

12. INVOLVING THE STUDENTS

12.1 Students differ in their approaches to learning, including interprofessional learning, depending on their prior experience of teaching from schooldays through to their professional education. Some engage more easily with interprofessional learning than do others. All need orienting to its purpose and process to be not only responsible for their own learning, but also their obligations to each other as part of the student group.

CAIPE recommends: that every effort is made to include student groups for professions likely to work in the same settings in their subsequent careers; that students are actively involved individually and collaboratively in steering their interprofessional learning.

13. INVOLVING SERVICE USERS AND CARERS

13.1 Contributions from service users and carers are widely valued in professional and interprofessional education for their unique and firsthand experience (McKeown et al., 2010). They contribute to IPE in curriculum planning and review, teaching, mentoring and student assessment. They need induction, preparation and support, taking care not to compromise their integrity and spontaneity.
CAIPE recommends: that service users and carers are involved as teachers and mentors in IPE after preparation and followed by ongoing support.

14. ASSESSING THE LEARNING

14.1 Assessment should be based on demonstrated competence for collaborative practice. It may be formative, but students and teachers are more likely to value summative assessment counting towards professional qualifications.

CAIPE recommends: that students’ achievement of outcomes from their interprofessional learning are subject to summative assessment.

15. OBSERVING REQUIREMENTS

15.1 Pre-registration IPE is planned within the context of requirements for the validation of the professional courses in which it is implanted. Progress has been made towards harmonising regulations regarding IPE and collaborative practice for allied health, medical, nursing and midwifery and social work courses (Health Professions Council, 2009; General Medical Council, 2009; Nursing & Midwifery Council, 2010; Department of Health, 2002 respectively), complemented by broad-based benchmarking statements from the Quality Assurance Agency (QAA, 2006) summarised by Barr and Norrie (2010).

CAIPE recommends: that each proposal harmonises requirements and benchmarking statements for the professional courses in which it is implanted.

16. LAYING FOUNDATIONS FOR CONTINUING INTERPROFESSIONAL DEVELOPMENT

16.1 Realistically, pre-registration IPE is the first step in a career-long continuum of interprofessional development, as students savour the taste and develop the habit for sustained, systematic and reflective learning during and following their professional courses.

16.2 Continuing interprofessional development complements continuing professional development education in which it is often embedded. It enables practitioners to respond effectively to changing roles and responsibility. It holds in check runaway expectations of outcomes from pre-registration IPE, acknowledging constraints of time in crowded professional curricula and students’ capacity at the outset of their professional journeys.

CAIPE recommends: that objectives, content and learning methods during pre-registration IPE are designed to lay the foundations for continuing interprofessional development.

17. EVALUATING THE INVESTMENT

17.1 The above information will help when formulating criteria with which to evaluate pre-registration proposals which include IPE. The same proposals may also be subject to evaluation as part of internal and external reviews for the professional courses in which it is implanted. Proposals which break new ground, for example, in the problems addressed or the methods employed, may merit systematic and independent research to contribute to the growing evidence base.

In January 2012, CAIPE is publishing a Guide to Commissioning Interprofessional Education within Preregistration Courses for the Health and Social Care Professions. The Guide is addressed to commissioners and regulators as the two groups which, by working in tandem, have the power and authority to ensure that IPE is not only included across professional courses but also accords with best practice grounded in evidence and experience. The case made is pregnant with implications for future policies for education and training for the medicine, health and social care professions. CAIPE is ready and willing to assist.

18. REFERENCES


Ev w32  Health Committee: Evidence


General Medical Council (2009). Tomorrow’s doctors. London: General Medical Council

Jakobsen, I, Fink, A M, Marcussen, V, Larsen, K & Hansen T B (2009). Interprofessional undergraduate clinical learning; Results from a three year project in a Danish interprofessional training unit. Journal of Interprofessional Care 23 (1) 30–40

December 2011

Written evidence from the Family Planning Association (ETWP 14)

1. EXECUTIVE SUMMARY

1.1 FPA is one of the UK’s leading sexual health charities, with over 80 years’ experience of providing the UK public with accurate sexual health information, education and advice services.

1.2 We are a provider of non-clinical sexual health training for a range of healthcare staff and non-clinical professionals. Our training courses cover a range of sexual and reproductive health issues from the basics of contraception to a “first impressions” course for reception and administration staff.

1.3 FPA welcomes the clear statement from the Government in Liberating the NHS: Developing the Healthcare Workforce consultation that, “education and training are integral to ensuring the values and calibre of staff”. We agree that training is vital to the delivery of safe and high quality services. However, we have significant concerns that removing the central oversight of education and training currently exercised by the Department of Health will lead to a lack of consistency in the training provided.

1.4 We believe that it is vital that the new workforce development system is supported by sufficient funding to ensure that professionals can access the training they need, including cover for their posts where this is necessary.

1.5 FPA welcomes the recognition that there needs to be workforce planning and development specifically for the public health workforce, which includes the sexual health workforce, but there needs to be more clarity around how the training for the public health workforce and healthcare workforce will be integrated, planned and managed.
2. Local Skills Networks

2.1 FPA has significant concerns that training will no longer be delivered in a systematic and coherent way if responsibility for planning and commissioning it is devolved to local skills networks. Our concerns are based on the experience of the devolution of decision making on sexual health training for nurses.

2.2 Previously the English National Board for Nursing (ENB) and its equivalents in Scotland, Wales and Northern Ireland co-ordinated training for nurses in a variety of disciplines including sexual health. Following the dissolution of the ENB no other organisation took on this co-ordination and oversight role. Instead, individual institutions now make decisions about the training they offer with the result that there is not a single recognised curriculum for sexual health training and nurses who have attended different institutions may have a qualification with the same name but will not necessarily have all of the same knowledge or skills. This makes it difficult for employers to assess whether nurses have the competencies they require. In addition, the majority of courses are now delivered by higher education institutions which means the courses are too long and at too high a level for what many nurses need or want. There is also a lack of co-ordination for practical placements with some nurses struggling to get the clinical training they need because it is not always clear how to access it or who should pay for it or the places are so limited that other professionals are given priority. FPA is concerned that this lack of co-ordination will be replicated across the country if responsibility for training is devolved solely to a local level.

3. Protection of Funding

3.1 FPA has significant concerns about the funding available for training and education within the NHS. As a provider of non-clinical training we are aware that training budgets are often seen to be an easy target for cuts when budgets are under pressure. In some cases this means that there is not any funding at all available for training but in others that can mean that funding is available for the training but not for any cover to fill posts making it virtually impossible for professionals actually to undertake training. It is vital that the new workforce development system is supported by sufficient funding to ensure that professionals can access the training they need, including cover for their posts where this is necessary.

3.2 In addition, FPA is concerned that the proposals for a tariff for the delivery of training could deter some providers. For example, the vast majority of contraception training takes place in community contraception clinics. When training is taking place this can reduce the capacity of the clinic and therefore have an impact on the number of people who can be seen, unless there is funding for the post of the trainer to be covered during the training. The consultation document implies that the tariff will be developed based solely on the cost of the training provided and will not take account of the wider potential costs to services of providing training. We are concerned that this could act as a deterrent to providing training, especially in an environment where healthcare providers are competing with one another.

4. Public Health Workforce

4.1 In the Public Health White Paper, Healthy Lives, Healthy People comprehensive sexual health services were identified as part of public health. FPA welcomes the commitment in Developing the Healthcare Workforce that preventative medicine will remain a key area of work for all NHS staff. We agree that there needs to be workforce planning and development specifically for the public health workforce. We also welcome the further details on plans for the public health workforce that were included in Healthy Lives, Healthy People: Update and Way Forward. However, we are still awaiting the publication of a public health workforce strategy which will contain more detailed proposals on the public health workforce.

4.2 There is currently not any clarity around how clinical training for people delivering public health services will be planned and managed. For example, sexual health services will be part of the new public health structure but many of the skills required to deliver these services are clinically based, such as carrying out STI tests and initiating treatment. It is not clear how strong links will be made between public health workforce planning and healthcare workforce planning to ensure these training needs are identified and met.

4.3 We are also concerned about the potential loss of expertise in the non-clinical public health workforce through the transition period into the new public health structure. As the reforms will change the way sexual and reproductive health services will be commissioned we are concerned that experienced commissioners from Primary Care Trusts may be lost along with their local knowledge and expertise.

December 2011
Written evidence from the Academy of Medical Royal Colleges Patient Liaison Group (ETWP 16)

INTRODUCTION

1. The Academy Patient Lay Group (APLG) is a committee within the Academy of Medical Royal Colleges, whose membership is made up of the lay Chairs/Vice Chairs of the individual Royal Colleges and Faculty Patient Groups. The College/Faculty Patient Groups are forums where patients/careers work directly with the different types of clinicians to contribute a patients/carer point of view on a range of issues including standards within the specific medical profession, the training and education of doctors and the provision of services to patients throughout their treatment pathway.

Medical Education and Training—Patient and Public Involvement

2. The APLG welcomes the Health Committee’s inquiry into the different areas of Education, Training and Workforce Planning, but is disappointed that the Committee has not included in the key themes the important role that patients and the public play in medical training. We hope, therefore, that in making this submission that omission will be remedied and that consideration will be given to the patient and public role, alongside all the other participants in the medical education system.

Patients and Public—Current Involvement

3. There already exists direct public and patient involvement in the training and education of clinicians at many different levels, ranging from Medical Schools, within Royal Colleges/Faculties, GMC, DH, MEE and within the six different Academy Education and Training Committees. The GMC document Patient and Public Involvement in undergraduate medical training provides good examples of involvement in different educational activities, as does a recent Academy’s Patient Liaison Group internal survey of patient involvement in Colleges/Faculties in July 2011.

4. The GMC document spells out clearly why there should be public/patient involvement in the training & education of clinicians and the benefits it brings. It also lists the different areas of current involvement (both graduate and postgraduate level) such as:

   — the selection of medical students;
   — teaching;
   — assessment and feedback;
   — development of curricula and training materials;
   — assessments and examinations;
   — quality assurance processes; and
   — governance.

5. Research shows that patient/public involvement does make a beneficial difference (to trainee doctors and patients) as highlighted in paragraphs 23 to 25 of the report, which showed that:

   “Involving patients in medical education can be beneficial to learners: not only does it facilitate acquisition of skills such as communication, but it can also change professional attitudes positively and develop empathy and clinical reasoning”.

   “It provides context to the learning material and motivates learners”.

   “Patient feedback on encounters with students, if carefully designed and used formatively, is largely welcomed by students and appears to improve their performance, as measured by exam results”.

   “Some learners prefer the teaching they receive from trained patients to that from doctors”.

   “Many students comment on gaining new insights and confidence when practising examination skills on patients who give constructive feedback, and claim that such training increases their respect for patients and deepens their understanding of the experience of disease”.

   “Patients and members of the public involved in education have also described it as a largely positive process. Their motives range from the wish to improve services or ‘give something back’ to the satisfaction of helping, catharsis, increased knowledge, confidence and self-esteem.”

   “Patients appreciate sharing their knowledge, using their condition to facilitate learning and contribute to doctors’ training. Some patients feel empowered by their experience.”

   “For some people, involvement may provide a starting point towards ongoing employment.”

   “It has been noted by faculty and the medical school that when patients are given adequate support, training and remuneration, they can become colleagues in medical training rather than just a teaching resource, and offer experiences unavailable through other methods of learning.”

   “Different perspectives can inject new life into the course content; teaching staff may gain new knowledge and update their skills, for example if they are no longer actively practising.”

8 http://www.gmc-uk.org/Patient_and_public_web.pdf_40939
Patients and Public—Future Involvement

6. The APLG believes that as we enter the period of major change in the Health Service, it is crucial that existing patient/public involvement in the training and education of clinicians not only needs to be maintained at the current levels but further embedded into the training system. The aim should be to ensure improvements in current participation arrangements. Where no patient/public involvement exists there should be a requirement on such education/training bodies to change their policies to include such involvement in their activities.

7. The APLG believes that to bring about meaningful patient/public involvement in the creation of new training and education structures it is essential there is patient representation on the new Local Education & Training bodies and on Health Education England. The aim should be to have mechanisms in place for ensuring that patient perspectives are built into all levels of training and education including the direct involvement of “real” patients and carers. This will support the patient centred approach to service provision, based on using patient experiences as a major influencing factor.

8. Patient/public involvement in training must be seen as a crucial element in ensuring clinicians and other healthcare staff are given the skills and the ability not only to interact with their colleagues but also with patients and carers. Too often many clinicians and other health care employees are still patronising in the way they deal with patients and fail to recognise that patients want to be respected. Often patients feel “this is being done to us”, rather than it is about us”. It is therefore important that this issue is addressed during training.

9. Together with communication skills, teamwork and leadership training should be essential parts of every curriculum. There needs to be recognition of the positive and direct contribution patients and the public can make to education and training, promoting understanding of what people want from healthcare staff, in terms of the service and the quality of their care including empathy and compassion and the need to treat people with dignity. Involving “real” patients in training can help doctors to start to think that patients are people with a range of illnesses and conditions which have to be addressed holistically.

10. The involvement of the patients/public must be seen as constructive engagement, particularly in developing understanding of different cultures and non-discriminatory behaviours. This approach should be at the core of all curricula and training and has the potential to fundamentally change how healthcare workers view their relationships with patients.

11. It is also important to recognise that patient and public representatives, patients, and carers who are asked to be involved will need training and support. Consideration should be given to the most appropriate ways to recognise and reward their involvement. This must not been seen as tokenistic involvement for the sake of involvement, but as an essential element of training and education and resourced as such.

Patient and Public—Wider Workforce Issues

12. It should be recognised that patients and the public can make a contribution to the wider healthcare workforce topics, not just education. A clear distinction needs to be drawn between the involvement of patients and carers as users of the service and the public in their role as the moral owners of the service. In this capacity, the public may have a different perspective on service design and delivery to that of patients and education and training needs to recognise this difference as it affects the way in which the medical professions relate to different groups and individuals.

13. The involvement of patients and the public needs to be at all levels within the new healthcare system. Both groups, in different ways, should be an essential part in the clinical commissioning of services and within provision of services. They must have a very strong voice as part of safety and quality processes and in designing and in any reconfiguration of health and social care services.

Summary

14. The Academy Patient Liaison Group strongly believes that, as a consequence of the cultural shift to the recognition of the needs of patients and carers, patient and public involvement in training is now an essential contribution to medical education. At the beginning of a medical career and throughout, patients and carers should be directly involved in Doctor’s training. It is also important that if the Government’s stated policy of “No decision about me, without me” is to mean anything, then the patients’ voice and experiences have to be strongly embedded in the training processes.

15. Given that this was a topic not listed the APLG urges the Committee allocate an amount of time to consider this important patient/public issue.

December 2011
Written evidence from The Society of Chiropodists and Podiatrists (ETWP 17)

The Society of Chiropodists and Podiatrists wishes to respond to your invitation to submit evidence for its inquiry into education, training, and workforce planning. For ease of reference each paragraph of our response relates to a specific bullet point of your original statement. We have included a short summary as requested. We would also draw to your attention the fact that we have made a submission to the Centre for Workforce Intelligence.

SUMMARY OF RESPONSE

— Over the last three years there has been a 10% reduction in commissioned numbers across these 13 Schools. However, we are encouraged by the NHS London Board’s agreement that podiatry commissions be increased by 5% for 2012–13 and by a further 37% for 2013–14. This will however still not be sufficient to meet future demand.

— Our Faculty of Management estimates that the predicted increase in diabetes will require some extra 8,500 WTE podiatrists in the next 10 years to meet that need alone.

— There is no School of Podiatry in East Anglia, although need in that area is as great as any other of the UK.

The right number of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

We recognise the importance of having the correct numbers of staff in place, at all levels. Our current numbers of practising podiatrists are given below, together with an indication of age grouping. This information is drawn from our membership database. As of 1 December 2011, Society of Chiropodists & Podiatrists had 8,463 members in practice in the UK. In February 2011, there were 12,716 podiatrists on the Register of the Health Professions Council.

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Currently, there are 13 Schools of Podiatry who, between them, produce about 450 graduate podiatrists each year. Approximately 50% of all new podiatry graduates have chosen podiatry as a second career. Over the last three years there has been a 10% reduction in commissioned numbers across these 13 Schools. However, we are encouraged by the NHS London Board’s agreement that podiatry commissions be increased by 5% for 2012–13 and by a further 37% for 2013–14. This will however still not be sufficient to meet future demand—see below.

We believe a key point in commissioning is the need to do this at national level. For example, there is no School of Podiatry in East Anglia, although need in that area is as great as any other of the UK and there are Colleges in almost all other regions of the UK. Please note that all the above refer to pre-registration training.

That training curricula reflect the changing nature of healthcare delivery, including medico-legal context

The changing nature of healthcare delivery impacts upon training at both pre- and post-registration levels. The College supports a number of Special Interest Groups in subjects such as: biomechanics, rheumatic care, diabetes, dermatology, forensic podiatry, homeopathy, podopaediatrics, and therapeutic footwear. Through the College’s system of accredited courses for CPD, podiatrists may develop their knowledge and skills to extend their scope of practice and thereby meet identified foot-health needs. Additionally, we have a range of non-clinical programmes available and these include CPD courses in medico-legal work.

Within the field of podiatry is a separately certificated extended scope practice in podiatric surgery. This requires podiatrists to complete an MSc followed by clinical training resulting in the award of a fellowship and, after a period as a registrar, the Certificate for the Completion of Podiatric Surgical Training (CCPST) is conferred upon successful applicants. Outcome measures demonstrate the effectiveness of these surgical interventions and they offer cost savings for similar work carried out by medically-trained surgeons.

All our developments in training are needs-driven and, increasingly, podiatrists may be found working with long term conditions such as rheumatoid arthritis, and diabetes mellitus. Our Faculty of Management estimates that the predicted increase in diabetes will require some 8,500 WTE podiatrists in the next 10 years in order to meet that need alone. A recent American study\(^9\) concluded: “In a sample of commercially insured patients with diabetes and foot ulcers (non-Medicare and Medicare-eligible with employer-sponsored supplemental

insurance), care by podiatrists prior to the first evidence of foot ulcer appears to prevent or delay hospitalization and amputation.” The potential saving to the NHS by investing in podiatry is considerable, and must surely feature in any discussion of commissioning.

That all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

Our Faculty of Undergraduate Education is actively working with practitioners across the full spectrum of provision to assist in the development of the future workforce. With the increasing emphasis on high-end podiatry in the NHS, the Faculty has sought to encourage independent practitioners to offer placement opportunities, as well as requiring all pre-registration programmes to offer multidisciplinary experience.

Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialities and grades) at all levels

Principally through our Faculty of Management, we have had input into the National Leadership Council development of the competency framework for clinical professions. Additionally, podiatrists are employed in multidisciplinary settings such as musculoskeletal triage, and other multidisciplinary pathways where leadership and accountability are part and parcel of everyday work.

High and consistent standards of education and training

Through its quality assurance processes, the Society of Chiropodists and Podiatrists (SCP) has established an independent system which operates at a higher level than that required by the regulatory authority, the Health Professions Council (HPC), for pre-registration training. For full membership of the SCP an honours degree in Podiatry (or Podiatric medicine) is required. Under the auspices of the College of Podiatry a system of quinquennial review operates and all programmes are expected to develop and reflect the ever-changing foot-health needs of the population.

Regarding post-registration training and education, the SCP operates a system for the approval of CPD events, courses, clinical updates (including mandatory updates for those who use local analgesics, as well at least basic life support for all members), and other types of supported learning. The content of these learning events is always needs-driven, and members wishing to extend their scope of practice must do so by taking a Society-approved course. As mentioned above, we have a number of Special Interest Groups, which play a major part in the identification of education trends.

That the existing workforce can be developed and re-skilled for the future (through means including post-registration training and continuing professional development)

Some 56% of our current membership will probably be practising for the next 20 years, and 85% for the next 10 years. Against this background, we have invested in processes to provide updates for members, have contributed significantly to the project on independent prescribing for podiatrists, and our members have undergone two successful audits by the HPC to ensure adequacy of their CPD. Our annual conferences (normal attendance 1,200) are a popular source of updating, as are our two principal publications: Podiatry Now, and The Journal of Foot and Ankle Research. Should the independent prescribing project bear fruit, this will create another learning need for our membership. We have made preparations for this.

Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

As a Society we are committed to equality and diversity. All our policies are written to reflect this view, and we always seek to operate with these views in mind. The fact that bursaries are available to podiatry students does much to level the playing field for all aspiring podiatrists.

The other points of the consultation will be addressed through our contribution to the submission from the Allied Health Professions’ Forum.

December 2011

Written evidence from Association for Nutrition (ETWP 18)

INTRODUCTION

1.1 Association for Nutrition (AfN) is the professional body for qualified nutritionists. We protect and benefit the public by promoting nutrition and public health and championing high standards of practice in the nutrition profession. We maintain a competency-based register of individuals who are qualified and competent in nutritional science and practice and agree to uphold professional and ethical standards through a code of conduct. Only individuals who meet the highest standards in evidence based science and professional practice can join and remain on the Register.
1.2 Registered Nutritionists occupy important positions, often with strategic input, in policy and service functions throughout the NHS, private healthcare, academia and the food sectors (retailing, service, manufacturing and aspects of agriculture).

1.3 The Association also accredits 35 Bachelors and Masters courses in nutrition and promotes high standards of competence, skill and ethical conduct. Each year approximately 450 students qualified in the science of nutrition with a strong all round skill set and a firm understanding of and commitment to professional responsibility and accountability graduate from AfN accredited courses.

1.4 In addition, the AfN is in the final stages of a major project funded by the Department of Health under the Third Sector Investment Programme entitled Improving Capacity, Confidence and Competence in Nutrition across the Workforce, producing a blueprint for supporting the health workforce below professional level and health professionals, (GPs pharmacists, school nurses, health visitors, etc), who provide nutrition advice to individuals and populations where nutrition may not be a central part of their role, but an important element of it. A major focus of this project is exploring how to reduce nutrition-related inequalities by improving the capacity, confidence and competence of the frontline nutrition workforce.

1.5 Our strategic aim is to ensure consistent, accurate and evidence-based nutrition practice across the healthcare team, from professional to frontline worker, to improve nutrition-related health outcomes for public, patients and service users. We welcome the opportunity to provide evidence to the Health Select Committee on healthcare education, training and workforce planning, and our evidence centres on two areas. First, the role of professional bodies in securing employer and professional input into the standard setting and quality assurance of high-quality degree and postgraduate professional training and second, the need for a single point of influence to address perceived weaknesses in current statutory regulated professions. We will also provide comment on the work we are undertaking to integrate and quality assure nutrition skill across the frontline workforce and to provide career support and progression for workers at levels 3 & 4* across the health and social care sectors.

**OUR EVIDENCE**

2.1 We support the Government’s intention to encourage greater multi-professional leadership in the healthcare professions. There must be greater recognition of the skills of all healthcare professionals in achieving better health outcomes; not just the skills of those professionals who have statutory protection through government regulation. Registered Nutritionists, qualified and competent in nutrition science and practice, work as part of a team of healthcare professionals and have an equal commitment to improving health outcomes, often at a strategic or population level, for public, patients and service users.

2.2 High standards and relevant curricula in the education and training of Registered Nutritionists are achieved through a combination of risk-based voluntary regulation and by encouraging and sharing best practice. Employers and nutrition practitioners, together with academics and lay professionals set standards for the education and training of Registered Nutritionists at graduate and postgraduate level for entry into the profession. Degree standards are monitored by our course Accreditation Committee through an annual and five-yearly review cycle, led by employers, nutrition practitioners, academics and lay professionals to ensure decisions are made in the public, rather than the profession’s interest. We are confident Registered Nutritionists are both competent and capable members of the healthcare team, with the right mix of skills and abilities to test, communicate and advance nutrition science and practice.

2.3 However, research undertaken by us suggests the current training and support for frontline nutrition workers at levels 3 & 4* and other healthcare professionals in the provision of nutrition advice is inadequate. (For example, in a recent survey 47% of GPs said they did not have the necessary training to provide nutritional messages.) In addition, career development and/or opportunities for progression within the nutrition workforce below professional level are limited. Our concern is to ensure all members of the healthcare team have access to, and can communicate correctly, evidence-based nutrition advice to the public and service users.

2.4 Funded by the Department of Health, we are developing a single, coherent platform for all healthcare workers to demonstrate their competence in nutrition and to improve their capacity and confidence in providing consistent and accurate nutrition advice to service users and the public. Our objective is to encourage high and consistent standards of education and training (including continuing professional development) alongside robust support, recognition and progression mechanisms to ensure the nutrition workforce is sufficiently developed and skilled to deliver the government’s targets to reduce nutrition-related health inequalities.

2.5 We have developed and tested a comprehensive quality assurance framework entitled the “Workforce Competence Model in Nutrition” to benchmark nutritional skills and knowledge with the aim of improving the competence of the target workforce. The model features a set of core competences at differing levels, based on National Occupational Standards, which benchmark nutritional knowledge and skills and transferrable attributes fundamental to the frontline nutrition workforce. The model has been tested and validated at multiple workshops across England including Community Food Workers, Health Trainers and Nursery Nurses and their managers. Initial results from the workshops suggest the need to invest in lower level training and education to improve competence, morale, workforce support and retention. Our research with frontline nutrition workers indicate there are significant gaps in current training, with nutritional advice often conflicting between...
professional and workforce groups, and the need for workers to increase capacity to progress horizontally and/or vertically into nutrition related roles within the health and social care sector.

2.6 Our research highlights gaps in the education, training and continuing professional development of current statutorily regulated health professions (GPs, dentists, nurses, pharmacists, health visitors, etc). A single point of influence, whereby weaknesses identified in the skill and competence of fellow health professionals can be addressed quickly and cost effectively would be in the public and service users interest. This may be one function the Committee may wish to see incorporated into the functions of Health Education England.

2.7 We support the intention of the NHS Educational Outcomes Framework to invest in education and training to ensure that appropriate values, behaviours, attitudes and team-working are developed. Domains 4 and 6 are particularly important to support the Government’s public health agenda.

2.8 We disagree with the limited definition of Competence in the NHS Educational Outcomes Framework, “Competences focus only on the function itself, and not on the personal attributes of the individual performing the function.” Our research, using the very helpful definition of competence published by Skills for Health, demonstrates that competence must acknowledge transferrable skills, some of which rely on personal attributes.

December 2011

Written evidence from The Academy of Medical Royal Colleges (ETWP 20)

INTRODUCTION

1. The Academy’s membership comprises the Medical Royal Colleges and Faculties across the UK. This submission represents a combined view across Colleges and has been endorsed by members. Individual Colleges and Faculties may, of course, submit their own evidence which will highlight their particular concerns or issues.

2. The primary interests of Colleges and Faculties are postgraduate medical education and training (PMET) and standards of clinical practice, but they also have a general interest in healthcare policy. The topic of this Inquiry is, therefore, an issue of core concern to the Academy and its members. Comments focus on the medical workforce and medical education.

The Academy’s vision and principles for postgraduate medical education and training across the UK

3. The Academy has very recently agreed a short statement setting out its vision for PMET which underpins our submission:

Principles

The Academy believes:

— The quality of future medical care is critically dependent on the quality of current postgraduate medical training.
— Medical training must continually adapt to the changing needs of patients and services to train doctors who meet the highest clinical standards set by the profession based on research, audit and involvement from patients.
— Good medical training requires doctors to have practical experience of delivering care, making diagnoses, undertaking procedures and managing patients and the opportunity to develop leadership skills, and engage in research and audit.
— Rigorous patient safety standards must exist in the design and delivery of training programmes.
— Training must be provided by organisations and individuals committed to achieving excellence in training as a core objective rather than a by-product of service provision or an add-on to their clinical duties.
— Being a trainee doctor brings both rights and responsibilities as set out in the AoMRC Trainee Doctors Group 2011 statement of principles and, of course, Good Medical Practice.
— Funding for medical training must be identified, protected and not diverted into service provision or any other use.
— Medical training must be independently quality assured using robust professionally developed quality indices applicable across the UK.

Vision

The Academy sees a post-graduate medical education system of the future where:

— Doctors in training are in part “supernumerary” in a service where care is mainly consultant delivered and so not dependent on trainees to maintain services.
Those who train doctors have time to train, supervise and assess their trainees and themselves are appropriately trained to deliver high quality training and assessment.

Trainees and trainers work together to provide stability and continuity of training.

Formal postgraduate medical training is only provided in organisations committed to achieving excellence in training as a core objective and so there may be organisations or components of organisations which choose not to train or do not meet the standards to train.

Where training is judged not to meet externally quality assured standards, the relevant professional bodies should help Trusts achieve these standards failing which the right of an organisation to undertake training could be withdrawn.

Whilst not all NHS organisations may be appropriate training environments, all organisations using doctors should be contributing to the cost of their training.

Organisations which do train should be properly funded to do so which is recognised appropriately in commissioning contracts.

The role of Colleges in postgraduate medical education

See Section 8 for fuller explanation.

Context

4. The Academy pointed out in its initial response to the Government’s consultation document Developing the Healthcare Workforce earlier in the year¹⁰ that these changes have been required primarily as a consequence of other parts of the Government’s reform programme—explicitly the abolition of SHAs. Whilst the Academy has consistently identified a series of improvements it would wish to see in post-graduate medical education and workforce planning there has never been a clear articulation of the problems this wholesale re-organisation of education and training arrangements is seeking to resolve.

5. Therefore, whilst medical education and training can be improved it is important to recognise it is already generally of a very high standard in the UK. This is not a system that is dysfunctional and broken but rather a system that must be improved and further adapted to fit the needs of patients, the changing demography of disease, developing NHS patterns of service delivery and the requirements of trainees.

6. Our original submission also set out a number of principles that we felt should underpin any changes:

   — Workforce planning and the commissioning of medical education and training cannot be left to market mechanisms alone and co-ordination and planning is required to continue to deliver the right quantity and quality of future healthcare staff.

   — It is essential that clinicians and Colleges are fully engaged at all levels in discussions and decisions about clinical workforce planning and education commissioning and provide the professional leadership required in the process.

   — The functions currently carried out by Postgraduate Medical Deaneries are extremely important. They need to be retained in the new system, although there are a variety of ways in which this could be done.

   — There needs to be transparency about costs of undertaking postgraduate training and education and a proper price must be paid to all those who provide education and training.

7. The Academy is pleased to acknowledge that, to varying degrees, the current proposals have recognised these principles.

The role of Royal Colleges and Faculties in medical education, training and workforce planning

It may be helpful to explain the role that Colleges and Faculties currently have in PMET and workforce planning:

   — Curricula—Colleges and Faculties design and produce the curricula for each of the 61 specialties and, within these, 34 approved sub-specialty training programmes (including GP training) that doctors undertake to get their Certificate of Completion of Training (CCT). The curricula are approved by the GMC. The Academy, pulling together all the specialties, is responsible for the Foundation Programme Curriculum, Common Core training and the common competences across training.

   — Assessment—Colleges set and run national exams and College representatives undertake local assessments of trainees as they progress in order to quality assure doctors for the NHS.

   — Training of trainers—Colleges are responsible for ensuring that trainers and assessors have up to date specialist knowledge and skills to ensure they are able to train effectively.

¹⁰ http://www.aomrc.org.uk/publications/statements.html
— **Assuring quality**—Colleges help assure the quality of training and Continuing Professional Development (CPD) content. The Academy believes that there is an important further role that Colleges can play in assuring education processes and delivery locally. Without establishing additional inspectorate machinery we believe College expertise could be used to better effect possibly through the development of accreditation.

— **CPD**—Colleges have an important role in supporting and providing continuing professional development for doctors beyond formal training which will be essential for revalidation.

— **Clinical standards**—Colleges are responsible for the development of the specialist clinical standards which are the core of medical training.

— **Workforce planning**—Colleges probably have the most comprehensive and accurate information on workforce numbers in the specialties. This feeds into the Centre for Workforce Intelligence (CfWI). Colleges all input their professional expertise and judgement into decisions on speciality number requirements.

— **National level**—At national level Colleges and the Academy work closely with the four UK Health Departments, GMC and Conference of Postgraduate Medical Deans (COPMeD) on training and education issues. The Academy has representatives on Medical Education England (MEE) and its Medical Programme Board (MPB).

— **Maintaining professional standards**—Colleges review, advise and help departments and individuals that have issues with performance in any of a number of areas.

**Transition**

8. The Academy is concerned that, as in any re-organisation, uncertainty and individual anxiety leads to destabilisation and lack of focus. There is a balance to be achieved between the benefit of clarity of purpose and rapid progress, and the need for proper deliberation, effective involvement and agreement on long-term decision making.

9. The Academy believes it is important to progress as quickly as possible with the establishment of HEE and has welcomed the appointment of the Senior Responsible Officer and Chair of the Steering Group. The Academy is pleased to be represented on the Transition Steering Group and keen to begin discussions about the most effective structures for HEE.

10. The Academy believes the position at local level is less clear. The actual number of LETBs, let alone their organisational and governance structure, is unclear. The position for deanery staff is not resolved and we understand that some deaneries have had significant problems with the loss of staff. There are concerns as to whether arrangements can be effectively in place by April 2013.

11. Aside from the need to ensure that permanent structural arrangements are in place in 2013 the Academy would stress the importance of ensuring that the 2012 recruitment and rotation process for doctors in training is not destabilised because of lack of capacity or expertise in deaneries. That would cause significant problems to the NHS service, and directly to patients.

**Future of postgraduate deaneries**

12. The future of deaneries has consistently been a key concern for the Academy, and remains so. The Academy has strong views that in the reorganised training system Postgraduate Deans need to have significant independence from the LETBs, whilst working with them to deliver a multi-professional approach to patient care. This is for three main reasons:

— Postgraduate Deans must be able to move trainees from locations where training is not meeting the expected standard to those where training is better. This ability is key to maintaining and driving up the quality of training and may be at variance with the priorities of service.

— Postgraduate Deans have to be free to report to regulators when they have significant concerns either about the quality of training or about the quality of care. This again might not be seen by employers and service providers to be in the service’s best interests.

— Independence of the Postgraduate Deans from service will add a major additional means of ensuring that monies are not vired from training to service.

13. We believe that the best solution would be for Deans to be accountable to HEE and retain responsibility for the placement (and removal) of trainees.

14. The Academy has consistently fed this view into all discussions about the proposals as well as to the Future Forum. The Chairman of the Academy together with the Chairman of COPMeD and the Chair of English Postgraduate Deans wrote to the Secretary of State in these terms on 25 November 2011.

15. Whilst there appears to be recognition of the validity of our concerns, to date there has been no satisfactory response. The Academy would urge the Health Committee to address this issue.
Role of HEE

16. The Academy supports the establishment of HEE. It will be essential that there is clarity in the relationship between HEE and LETBs. It is right that HEE must be able to hold LETBs to account for their performance but that authority must be real. Clearly the Academy would hope there is a constructive relationship but HEE must have the authority to ensure that high quality education and training is being commissioned and delivered.

17. Secondly, it has to be ensured that HEE’s structure delivers what is required at national level. The correct balance of patient, professional, employer and education interests has to be achieved.

LETBs

18. The Academy supports the more active engagement of employers in education and training. However there are genuine anxieties, not that employers are unconcerned about training and education, but that the immediate demands of service delivery and financial pressures could threaten education and training and its funding. This is why the independent judgement of Postgraduate Deans is so crucial.

19. It is also crucial that processes and structures at employer and LETB level genuinely involve clinicians who provide the expertise and leadership on education and training and workforce planning issues.

20. Alignment of LETBs with Academic Health Science Networks may be sensible but the specific tasks of commissioning and delivering education must not be subsumed.

National Education and Training Quality Outcomes Framework

21. The Academy is absolutely clear that good quality education and training has to be rewarded and incentivised and poor quality has to be improved or removed. This can only happen if the quality of training can be measured and assessed. The Academy, therefore, has been involved with and supports the development of an Education Outcomes Framework underpinned by robust metrics. We do not underestimate the complexity of the task and recognise that it is unlikely to be right at the first attempt. However this should not halt progress.

22. The Academy is aware that there are a number of initiatives developing or looking at metrics or indicators for education and training. It is essential that that this work is co-ordinated to produce a single set of metrics for common use across the UK otherwise effective judgements on quality will be impossible.

Engagement in the development of curricula

23. Colleges have the lead responsibility in terms of the development of curricula for postgraduate medical training and we are absolutely clear that they remain best placed to do this. This process does not currently happen in a vacuum. The GMC has to agree curricula and will usually have been engaged throughout the process as will have deaneries and higher education representatives as appropriate.

24. Experience has shown it is not easy to engage healthcare providers and commissioners in the detail of curriculum development. The Academy recognises that curricula must adapt to changing service needs and is happy to explore how service provider engagement can be improved.

25. The Academy was surprised that patient input to curricula was not cited by the Committee. The Academy believes this is an important and valuable component to the process and seeks to ensure that this happens consistently. The Academy’s Patient Liaison Group has made its own submission.

The public health workforce

26. The Academy believes that workforce planning and education and training proposals for the public health workforce need to be co-ordinated with NHS arrangements as well as local authorities. The training of public health doctors must remain integrated with wider medical training. Detailed comments will be submitted by the Faculty of Public Health.

Relation to healthcare, education, training and workforce planning in the other countries of the UK

27. The Academy believes that it is essential that there is consistency across the UK in medical education. Whilst exact delivery mechanisms may differ, variation in standards of training for doctors in the four countries would have unacceptable consequences on services and the quality of care for patients. It is therefore essential that there is co-ordination between the four nations. Colleges, Deaneries and the GMC do operate or co-ordinate on a UK basis and HEE must ensure that it works with the relevant bodies in the other administrations.

28. Similarly, there needs to be co-ordination over medical workforce planning across the UK.

December 2011
Written evidence from St Andrew’s Healthcare (ETWP 21)

ABOUT ST ANDREW’S HEALTHCARE

St Andrew’s Healthcare is the country’s largest charity sector provider of NHS care, and a unique specialist teaching hospital based outside of the NHS offering unique educational opportunities across the health professions.

These opportunities are available for postgraduate doctors and psychologists, and students in nursing, medical and allied professions. We are a leading provider nationally for specialist areas of training like forensic mental health, women’s services and psychiatric occupational therapy.

The Charity is committed to training students and post-graduates across the professions and has a strong Continuing Professional Development programme. We have partnerships with King’s College London (Institute of Psychiatry) and the School of Health at the University of Northampton.

Our unique training opportunities are supported by over 100 senior psychiatrists and psychologists, many of whom have academic roles at King’s.

The Central Training and Education Committee of the Royal College of Psychiatrists has approved the role of the independent and voluntary sectors in training psychiatrists. We work closely the NHS Postgraduate Deaneries to meet the needs of trainees, particularly in specialist areas that can be difficult to provide on local training schemes.

Established as a charity more than 170 years ago, St Andrew’s offers services and centres of excellence across mental health, learning disability, autistic spectrum disorders, brain injury, and neurodegenerative conditions such as Huntington’s disease and dementia. The Charity provides secure care for over 1000 service users across four sites in Birmingham, Essex, Northampton and Nottinghamshire.

SUMMARY OF RESPONSE

As a charity, St Andrew’s Healthcare has worked closely with the NHS since its inception in 1948, and welcomes proposals to open up planning and provision of health education, training and development to the charitable and independent sectors.

We believe that the proposals offer a rare opportunity to take an innovative approach to professional healthcare training and development, and to enshrine personal qualities and competencies in the professional and clinical training of future leaders in healthcare services.

The Charity already demonstrates the practical benefits of providing high quality training and education outside of the NHS. We recommend that all training providers should be held accountable for the quality of the learning experiences they provide.

Decoupling Ministerial oversight and strategic planning for the health workforce is welcomed and will support a transparent and effective process to meet future needs for quality healthcare based on reliable data and comprehensive professional opinion.

We are, however, concerned how little clarity there is at this stage of implementation, and the impact that this is having on current training structures and provision for trainees in all disciplines. In particular we feel it is important to define how local, regional and national workforce requirements will be rationalised and how independent providers will play an effective role in this process.

We acknowledge that it is necessary to have open and frank debate about the future commissioning and delivery of health education and training. We call on the Minister to undertake the widest possible consultation with all levels of stakeholders in the country’s healthcare.

COMMENTS ON CONSIDERATIONS

1. Will the proposals support the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

1.1 St Andrew’s Healthcare welcomes the proposals. We consider that they represent an opportunity for a more flexible approach to healthcare training and workforce development.

1.2 Through widening and diversifying training opportunities, the brightest and best will be attracted into healthcare professions. As a charity our approach to multi-disciplinary mental healthcare is well established over many years and we can demonstrate the practical benefits of this way of training and development in the quality of our workforce.

1.3 We also have significant expertise in inter-agency working which we integrate into training programmes. Visiting undergraduate students have emphasised how St Andrew’s shows the real-life importance of their communication skills training.
Ev w44  Health Committee: Evidence

2. Will the training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

2.1 Working in partnership to plan and deliver workforce education and training is a constructive approach for service providers and professionals. Over its long history St Andrew’s has played a significant role in developing specialty training, with its School of Occupational Therapy becoming part of the School of Health at Northampton University, with whom we have a long-standing track record of professional training and development.

2.2 We believe that similar links should be developed across the whole healthcare sector, to create better communication between practising professionals, trainers, commissioning bodies and regulators to ensure and enhance the quality of patient care and professional standards.

3. Will all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce (see also 5 below)

3.1 As the model of healthcare commissioning changes it is essential that the NHS and independent healthcare providers work more closely together to provide streamlined and focused training that can deliver the best possible standards of patient care with limited resources.

3.2 If the methods of funding for this training are to be reviewed, then the approach must be transparent and reflect the relative contributions and benefits of different bodies to professional qualification and continuing development to meet national needs.

3.3 An essential part of this process will be an agreed and effective framework for quality assurance.

3.4 St Andrew’s Healthcare supports the creation of Health Education England and awaits further information about how the strategic and practical requirements will be coordinated.

3.5 St Andrew’s believes that the General Medical Council continues to be the appropriate body to assure the quality of medical education and training. The Royal Colleges represent the views of professionals in the public, private and charitable sectors and should continue to be responsible for the formulation and ratification of educational policy.

3.6 Ultimately it will be the responsibility of the training bodies to deliver education that meets the exacting standards required and will be fit-for-purpose in the context of modern and flexible health service.

3.7 St Andrew’s welcomes the openness of the proposals to training provided outside the NHS.

4. Will there be multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

4.1 St Andrew’s healthcare believes that leadership is essential to the success of the proposals. This quality needs to be included in the training programmes provided so that future potential leaders can be identified and supported throughout their careers. We offer leadership development to all of our employees.

4.2 In reality leadership is not something that can be created within formal structures, but is rather something that can be inspired by them. Trainers and trainees need to be aware that this is part of their role and quality assurance mechanisms are needed to be sure that this is part of the thrust of the new proposals.

5. Will high and consistent standards of education and training be maintained

See 3.1 above.

6. Will the existing workforce be developed and re-skilled for the future (through means including post-registration training and continuing professional development)

6.1 Having recognised the importance of providing overarching strategic direction to health education and training it is essential to recognise that this is not a static process. Some parts of the workforce will need to be re-directed or re-skilled now. Some may face this challenge in the future.

6.2 Crucially it is important for everyone in healthcare to know that they must keep up with the ever-increasing pace of change brought about by new research, new ways of working, improved treatments and a changing environment.

6.3 Adaptability and a capability to accept and respond to change though continuing research and training must be part of the essential skill set of future healthcare professionals.

7. How will the proposals provide open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

7.1 The proposals can give a wider and more comprehensive approach to establishing strategic need for core competencies and skills. This could mean that much greater clarity can be given to those considering a future in healthcare.
7.2 In this way more people can be aware that their personal qualities are needed in this profession.

7.3 Academic qualification need not be the only point of entry to the healthcare professions.

7.4 This could mean that those who might not currently achieve their full educational potential could still be considered for recruitment in healthcare. Employers and higher education partners could offer nationally recognised routes of formal accreditation for those wishing to develop but who did not hold professional status. This could be similar to the foundation degree developed for healthcare assistants by St Andrew’s and the University of Northampton, as a route to life-long learning.

7.5 At the same time some of our most academically talented young people could be encouraged to consider healthcare as a profession who would not have done so previously. Their early study choices need not prevent them from considering the option of healthcare, particularly where opportunities for formal accreditation and recognition are provided.

**Comments on Key Themes:**

1. **Plans for the transition to the new system, up to April 2013**
   
   In light of current progress and information available we are concerned that this timescale is very short. This may create uncertainty for students and trainees and affect future planning of training and education.

2. **The future of postgraduate deaneries**
   
   We believe that the deaneries will continue and have an important role to play in the planning and delivery of high quality training and education and will provide important continuity during the transition period. A number are already working with St Andrew’s to meet the need for training in speciality areas such as forensic psychiatry and are very open to the potential for innovation in the delivery of training and education requirements.

3. **The implications of a more diverse provider market within the NHS**
   
   For new trainees and continuing professional development, it will be essential to provide a wider understanding, as part of the educational experience, of healthcare outside of the NHS as the new approaches to commissioning come in to effect.

4. **How to balance the workforce requirements of providers of NHS and non-NHS healthcare**
   
   The challenge of planning for the future needs of the healthcare system is shared by NHS and non-NHS providers and must be tackled jointly. The process needs to be realistic and flexible and capable of responding to the changing environment. It must not only deliver the right numbers of appropriately qualified healthcare professionals, but also allow for retraining and redeployment as necessary.

   A new and more varied healthcare economy where finances are seriously constrained demands the flexibility for healthcare professionals to move between NHS and non-NHS organisations and across regional and national boundaries, receiving appropriate and consistent education and training wherever they are and to a recognised quality standard.

   The intelligence and risk assessments on which plans are made need to be shared, robust and independently verified. Levels of professional flexibility and access to training and retraining need to be agreed and supported throughout the healthcare professions.

5. **Protecting and distributing funding in the new system**
   
   Undergraduate qualification should continue to focus on demand-led learning that meets the verified requirements of the workforce plan and for which cooperative joint funding between the NHS and non-NHS healthcare providers and employers could be negotiated locally.

   Postgraduate training and retraining funding should be nationally funded and “follow the student” to the best learning environment to meet their needs and the requirements of the workforce plan at this level of expertise.

**Recommendations**

— The perspective of healthcare teaching centres outside the NHS is included in oral evidence to the Committee, to help balance the NHS view of future arrangements.

— All training providers are held accountable for the quality of the learning experiences they provide.

— An open consultation about the ongoing funding mechanisms to protect and enhance high quality education and training for the health workforce involving national and local government, NHS and non-NHS providers and professional bodies is initiated immediately.

— Personal qualities of leadership, flexibility and adaptability are included in the training programmes for all health professionals.
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— Personal dedication and commitment to quality healthcare is recognised in continuing vocational and professional development and early educational choices or performance should not unduly limit entry to healthcare professions.

December 2011

Written evidence from East of England Pharmacy Workforce Development Group (ETWP 23)

The East of England Pharmacy Workforce Development Group (EoEPWDG), is a subgroup of the Pharmacy East of England Network (PhEN).11

INTRODUCTION

The EoEPWDG is a specialist sub-group convened by PhEN to:


— Maintain close links and effective communications with commissioning teams and professional Advisors in the NHS East of England Multi-Professional Deanery.

EVIDENCE FOR THE HEALTH COMMITTEE INQUIRY

The Government’s plans outlined in the White Paper Liberating the NHS: Developing the Healthcare workforce, have the potential to deliver an improved healthcare educational system which is better aligned to the needs of employers, promotes multi-professional learning and closer links with academic organisations and professional bodies. However, there is insufficient detail, especially at regional and local levels, as to how the issues under consideration by the Health Committee will be achieved.

SPECIFIC CONSIDERATIONS

Right numbers of appropriately qualified/trained healthcare staff

1. The group is not assured that the HEE will be in a position to carry out this important function effectively and equitably across the country. It is not clear how the Centre for Workforce Intelligence (CfWI) will be able to ensure the quality and uniformity of the data across all healthcare professions and how meaningful qualitative clinical outcomes will be linked to numbers.

2. In the NHS Pharmacy profession there is robust numbers data (via a national staffing establishment and vacancy survey) conducted by the NHS Pharmacy Education & Development Committee annually.

   It would be very useful to have a national steer via the CfWI and HEE to map this data directly to healthcare outcomes which would inform numbers needed to train.

3. The government plans promote local level decisions by Local Education & Training Boards (LETBs). We need reassurances that there will be systems in place to ensure the following:

   3.1 each LETB receives clear guidance from the CfWI and the HEE regarding the strategic commissioning intentions of the Commissioning Board so that there is better integration between workforce planning and workforce development focussing on healthcare pathways and clinical outcomes;

   3.2 each LETB has access to the right expertise and other resources needed to make equitable and fair decisions;

   3.3 there is comparability between regions and benchmarking to drive improvement; and

   3.4 there is objective assessment via a national monitor (possibly the CQC) to ensure accountability and tackling of poorly performing LETBs.

Training curricula reflecting the changing nature of healthcare delivery

4. The enhanced communications and collaborative working between employers/service providers and education experts should support this. However, more assurance is needed in terms of ensuring that this collaborative working takes place and that training curricula focus on clinical outcomes.

11 PhEN is a clinical and professional network of Chief Pharmacists (in Acute, Mental health and Primary Care Trusts) and regional specialists in Clinical Pharmacy and Patient Safety, Medicines Information, Pharmacy Education, Training and workforce development (ET&D) and Pharmaceutical Quality Assurance.
5. Whilst the involvement of regulatory bodies in curricula development is described there is no mention of professional bodies and other professional associations which would be best placed to support development of curricula which reflect excellence in practice eg the Royal Pharmaceutical Society (RPS), the Association of Pharmacy Technicians (APTUK) and partner associations.

6. It is not clear how the government plans will ensure that all education and training programmes commissioned via the NHS, carry appropriate accreditation and conform to nationally set standards to ensure consistency and transferability of skills to different settings.

7. It is not clear how the government plans will monitor educational outcomes across the healthcare professions to ensure value for money and provide evidence that it adds value to the service.

8. It is not obvious as to how the models proposed in the government’s plans would allow and maintain timely development of curricula that match the rapidly changing nature of healthcare delivery.

   It would be useful to model curricula across healthcare pathways which would necessitate engagement of different healthcare disciplines and utilise multi-professional learning.

All healthcare providers (both NHS and non-NHS) should play their part in workforce development

9. Whilst the government plans address issues around direct costs to all employers, via a levy for the education and development of their workforce, they do not address issues relating to the responsibility of all employers to actually engage with and directly participate in the training ie via clinical placements.

   This aspect is particularly relevant to the training of the ‘non-NHS’ pharmacy workforce based in community pharmacies delivering NHS services. It would be useful to have systems in place to ensure that independent pharmacy employers (community pharmacies and private hospitals) have the responsibility for training built in to their contracts and that their engagement with LETBs is mandatory.

Multi-professional and multi-disciplinary leadership and accountability

10. Whilst listed, there is not sufficient detail in the plans as to how this aspiration will be achieved across the full range of healthcare professions/specialties and grades to evidence this outcome.

   It would be useful for the new system to make equitable provision for facilitation of leadership skills across the professions and to all grades of healthcare staff and also introduce systems (such as 360 degree appraisals) to achieve this culture shift for all grades.

High and consistent standards of education and training

11. The introduction of the ‘NHS Educational Outcomes Framework’ to ensure consistently high quality standards of healthcare education and training around the country and help healthcare staff meet clinical outcomes should evidence this.

   There needs to be more clarity around standardised outcome data and how the standards will be implemented and monitored. There should also be information on channels for feeding back to the HEE either via Professional Advisory Boards or LETBs.

Development and re-skilling of existing workforce

12. The plans provide high level concepts to achieve this. LETBs and local partnership groups would provide good fora for enhanced communication and interactions between different healthcare professions. This would gradually overcome issues around professional boundaries and the silo mentality which is still prevalent.

December 2011

Written evidence from the Wellcome Trust (ETWP 24)

Key Points

1. The Wellcome Trust funds a range of activities to relating clinical research, including research fellowships that support clinicians at all career stages and major investment to develop the UK Clinical Research Facilities. Our key messages:
   — We have major concerns about the Government’s proposals for the delivery of training and education for the healthcare workforce, particularly the proposed governance model for Local Education and Training Boards. These proposals fail to take into account the vital role that universities must play in a world-class education and training system.
— We support a system where Health Education England (HEE) offers clear national leadership, with local partnerships between higher education institutions and healthcare organisations delivering education and training. The governance arrangements must ensure a clear, central role for universities, maintaining essential links with research and innovation and undergraduate medical education.

— The education and training system must support research and the adoption of new technologies by incentivising healthcare professionals and providing them with sufficient education, training, time and resources.

INTRODUCTION

2. We are pleased to have the opportunity to submit evidence to the Health Committee’s inquiry and we welcome scrutiny of the Government’s proposals to reform the education and training system for healthcare professionals, as part of the wider reforms outlined in the Health and Social Care Bill. Given the Wellcome Trust’s remit, our comments focus primarily on the interactions between research, innovation, education and training.

3. We agree with a statement made in the NHS Chief Executive’s Review, Innovation: Health and Wealth, that “innovation is central to the future of the NHS”. The Review recognises the importance of the workforce in realising this ambition and we consider it essential that this is reflected in reforms of the education and training system. In order to ensure that new technologies such as genomics and stratified medicines are deployed effectively in the NHS, it is essential that healthcare professionals are given the education, training, time and resources needed to support research and innovation.

4. Improvements to the education and training system for healthcare professionals must be piloted and evaluated to ensure a smooth transition to an effective new system.

CAREER PATHWAYS AND CURRICULA DEVELOPMENT

5. The current career pathway for clinicians is highly inflexible. This lack of flexibility makes it difficult for young clinicians to develop a fully rounded set of skills and devote time to activities away from the bedside, such as research. The career pathway and curricula for clinicians must be reformed to ensure that they are clear but flexible, and avoid over-specialisation. The system must be designed to enable collaboration between academia and service providers in the development of curricula, to ensure that the workforce is fit for purpose. Furthermore, sufficient support and recognition for activities such as research must be embedded within the system and it is important that National Institute of Health Research (NIHR) funding for academic posts and Clinical Excellence Awards are maintained.

6. Healthcare provision is continually changing as new technologies and innovations emerge and the profile and health of the population changes. As such, it is essential that the healthcare system fosters a culture of lifelong learning for healthcare professionals.

A MODEL FOR A REFORMED EDUCATION AND TRAINING SYSTEM

7. We consider that the Government’s proposed model for reform of the education and training system is unnecessarily complicated and lacking in clarity. It should begin with a clear vision of the goals of education and training, and this vision should then inform the development of a new system of delivery. Form should follow function, rather than the other way round. We would argue that the goal is to educate, train, recruit and retain a diverse workforce that can deliver a first class health service. There are three key elements in achieving this goal:

— The NHS requires a well-educated and trained workforce that is flexible and capable of responding to evolving healthcare needs at both local and national levels.

— The best intelligence on educational and training needs must be gathered at local and national levels in order to match supply to need as closely as possible.

— There must be clarity around the responsibilities and accountabilities of the many staff that provide and oversee education, training and continuing development across the workforce.

8. We think this vision is best delivered through a system where Health Education England (HEE) offers clear national leadership, with local partnerships of higher education institutions and healthcare organisations delivering education and training. For the system to provide the best quality education; keep pace with advances in healthcare; and clearly define the roles of staff in education and training, it is essential that universities play a central role. The system must also minimise conflicts of interest and ensure clear lines of accountability between national and local components. The following sections set out the model that we consider would work most effectively.
NATIONAL COORDINATION

9. It is essential that HEE is empowered to provide national coordination for the education and training system, with this role including quality assurance and standardisation. In a complex system such as the NHS, national priorities and needs must be able to shape local education and training plans. HEE also must provide national-level engagement with key stakeholders in the education and training landscape, such as the Higher Education Funding Council for England, the General Medical Council and the Medical Royal Colleges.

10. HEE must be established with independent, non-executive members and be accountable to the NHS. The chair of HEE could sit on the National Commissioning Board to ensure coordination between national commissioning and education and training activities.

LOCAL DELIVERY

11. We are very concerned by the proposals to establish Local NHS Education and Training Boards (LETBs) without balanced representation of both service and education providers. It is absolutely crucial that universities play a central role in the delivery of education and training, to maintain links both to the academic research environment and to ensure seamless provision of undergraduate medical education. We therefore consider that education and training would be delivered most effectively by partnerships between local higher education institutions (HEI) and healthcare providers. The governance structures of the LETBs must reflect this.

12. The UK is alone among the advanced nations in lacking strong formal links between higher education institutions and postgraduate medical education. These reforms present an excellent opportunity to address this deficit. This will enable UK universities to build on their existing strengths in undergraduate education and biomedical research, to ensure that our post-graduate education and training is also world-leading.

13. The Government’s current plans imply that higher education institutions have a conflict of interest with respect to postgraduate training, whereas healthcare providers do not. We disagree and consider that neither higher education institutions nor healthcare providers are truly independent. We therefore suggest that the most effective option would be to have both of these stakeholders represented on the board of LETBs.

14. We support the Future Forum’s recommendation that LETBs should be established with an independent chair. We also consider that LETBs should have independent, non-executive members that would play an important role in supporting and challenging the executive members and therefore help to address the inherent conflict of interest. The LETBs should be based on existing examples of good practice, for example the Academic Health Sciences Centres (AHSCs), where a similar model has been successfully implemented. Academic Health Sciences Networks, proposed in Innovation: Health and Wealth, provide an exciting opportunity to link education and training with research and innovation, building on strong partnerships between centres of academic excellence and healthcare providers across England.

15. Set up in the way we describe, and building on existing relationships, LETBs will be well-placed to play a key role in connecting healthcare provision with research and innovation, therefore strengthening the global competitiveness of the NHS. Furthermore, these partnerships would enable UK institutions to compete for the best international talent, ensuring a steady income stream for the partners and, crucially, improving service provision for patients.

16. LETBs must be accountable to HEE, and could be established as part of HEE itself. This approach would remove the need for further legislation to establish the LETBs as separate legal entities. It is important that there is flexibility in the arrangements for LETBs to ensure that they are suited to the local environment. This flexibility could be compromised if the governance mechanisms are enshrined in legislation.

17. We envisage that the LETBs would coordinate local information collection and feed this back to the Centre for Workforce Intelligence or directly to HEE. This will enable HEE to monitor and assess the quality and quantity of education and training provision and in turn LETBs must be responsive to the national priorities set by HEE in order to implement this.

FUNDING DISTRIBUTION

18. It is essential that budgets for education and training are sufficient to ensure a high standard across the full range of professions within the workforce. HEE should hold a ring-fenced budget in order to ensure that this can be protected from other pressures. The budget should be allocated on the basis of quality and quantity of education and training and the successful NIHR approach to support for research could provide a useful model for this.

MIGRATION OF HEALTH PROFESSIONALS

19. As part of the Government’s policy to reduce net migration, the UK Border Agency (UKBA) has recently consulted on changes to the Tier 5 temporary workers immigration category. The NHS, with the support of the medical royal colleges, uses this immigration category to bring highly skilled, well-qualified and experienced doctors into the UK for up to 24 months, through a scheme known as the Medical Training Initiative (MTI). The MTI enables international medical and dental graduates to enter the UK to experience training and development in the NHS for up to two years, before returning to their home country. The MTI contributes to
NHS service delivery through the placement of highly skilled international medical graduates; makes use of spare training capacity in the NHS; provides relevant work experience in the UK to doctors from low- or middle-income countries; and saves NHS trusts money by reducing reliance on locums.

20. The UKBA consultation proposed a number of restrictions on the Tier 5 category, including reducing the maximum length of stay from 24 to 12 months. This would seriously threaten the viability of the MTI scheme, and push doctors from overseas into training opportunities in other countries. In our response to the consultation, the Trust argued that the current flexibility to remain in the UK for up to 24 months must be retained.13

December 2011

Written evidence from the British Geriatrics Society (ETWP 26)

EXECUTIVE SUMMARY

— The British Geriatrics Society is a multi-disciplinary professional membership association that seeks to promote better health and care for older people. We have over 2,500 members that specialise in the care of older people in a variety of hospital and community settings. Our members include doctors practicing geriatric medicine, old age psychiatrists, general practitioners, nurses, therapists and scientists. For more information please visit www.bgs.org.uk.

— We have an ageing population and older people are the main users of health and social care services:

  — People over 65 are the core users of acute hospital care—60% of admissions, 65% of bed days, 70% of emergency readmissions, over 90% of delayed transfers.

  — Older people have more long-term conditions. An estimated 3.9 million (33% of people aged 65–74 and 46% of those aged 75 and over) have a limiting longstanding illness. This equates to 39% of all people aged 65 and over.

  — People with long-term conditions are the major users of care services. They account for 55% GP appointments, 70% of outpatient and emergency attendances, 77% inpatient days, 90% drug spend in over 75s.

  — People over 65 account for 2/3 of acute and elective surgical admissions and a significant proportion of these are over 80—often with complex medical needs or frailty and are at higher risk of post-operative complications.

  — The systemic failure to provide healthcare staff with appropriate skills and training and in sufficient numbers to meet the increasing complexity of frail older people in hospitals and in care homes is one of the key factors contributing to the failure of hospitals and care homes to meet the needs of older people.

  — All health and social care workers should receive training on caring for and understanding the special needs of older people and how to provide dignified person-centred care as the majority will have regular contact with older people.

  — Training curricula for doctors, nurses, therapists and other health and social service professionals should contain key elements on the giants of geriatric medicine: confusion/delirium, continence, dementia, immobility and falls—as well as information about comprehensive geriatric assessment and end of life care.

  — We have reservations about the re-organisation of post-graduate training in geriatric medicine in England and are worried about the loss of the expertise and structures contained within deaneries.

  — We are concerned that the transfer of more responsibility and power to local providers threatens coherent workforce planning. It also removes external standard setting and scrutiny of training in the NHS.

1. We welcome the Committee’s decision to hold an Inquiry into Education, Training and Workforce Planning.

2. We are concerned that health and social care professionals do not currently receive sufficient training and support to enable them to provide older people with quality care, despite the fact that older people are the main users of the NHS and social services.

3. There are 10 million people aged 65 and over in England. Of the population aged over 65, 40% aged 65–74 have illness or disability, 55% aged 75–84 have illness or disability and 67% over 85 have illness or disability. Nearly 70% of men and some 85% of women over the age of 65 will need care at some time. Older people account for 70% of bed days in NHS hospitals and 60% of admissions.

4. It is imperative that we have the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels and that training curricula reflect the needs of our ageing population.

13 http://www.wellcome.ac.uk/About-us/Policy/Consultation-responses/index.htm
5. The prevalence of older people in health and social care, and the complexity associated with key aspects of care of the most frail, means that there must be suitable attitudes and skill levels in the general workforce in community and hospital settings. In addition, there must be a specialist skilled workforce available in both settings to support primary care, community services and other specialists, as well as being the main provider of care for the most complex patients.

6. The UK is a world leader in having developed the medical specialisms of old age medicine (geriatrics), old age psychiatry and, more recently, stroke medicine, all recognised by the GMC and relevant Colleges. Geriatricians should be at the centre of clinical management in countries where most hospital inpatients are older people with complex needs. They should be part of adequately staffed multi-disciplinary teams enabling appropriate care for patients with complex needs such as dementia, frailty and communication difficulties. Geriatricians should also be involved in accident and emergency and urgent care facilities in order to avoid inappropriate hospital admissions.

7. The number of consultants needed (and therefore the number of training posts) will vary over time and according to the characteristics of local populations and their services. However, despite significant expansion in recent years, we are concerned that the speciality of geriatric medicine does not have sufficient whole-time equivalent (WTE) consultants to cope with growing demand.

8. According to the 2010 Royal College of Physicians workforce census there were 1,201 geriatricians in the UK. In 2008, it was agreed with the RCP that there would most likely be a need for 1,643 geriatricians by 2009—based on the workforce requirements for specific components of necessary services for older people. Not only has this figure not been reached, but the female workforce is continuing to increase and this has an impact on the number of WTE consultant geriatricians as many female geriatricians work part time. Furthermore, the latest census shows an increase in the number of geriatricians whose job includes being involved in acute general all-age adult medicine and stroke medicine, for which geriatric medicine is the “parent” specialty. Thus there are fewer clinical sessions remaining for core geriatric medicine. Furthermore, and as a very positive development for patients, geriatricians are increasingly providing clinical input and leadership for older trauma patients (orthogeriatrics—as required by Payment by Results Best Practice Tariff), community care and dementia services.

9. Prior to these developments, the BGS has recommended that to care for the population older than 75 years, there should be a minimum of one WTE geriatrician per 50,000 population (approximates to one WTE for 4,000 people older than 75 years). The ratio by which the population is served by a WTE geriatrician varies considerably across the country from the lowest ratio in Wales, Yorkshire and Humber and Scotland, with one geriatrician per 46,000 of the population, compared to the highest ratio of 76,000 to 86,000 in the East and West Midlands. There is clearly a need for additional consultant posts. This needs urgently an increase in the numbers of medical graduates training to be geriatricians, as the latest survey of trainees conducted by the BGS Education and Training Committee shows that there are currently 52 unfilled consultant posts.

10. Other professionals allied to medicine, such as therapists, and nursing have developed some specialist posts and career paths but these are not firmly established by specialist qualification or registration with the relevant regulatory agency. For example, although the nursing skills required for high quality care of residents in care homes are considerable, there is no requirement at all for any specialist training or qualifications, even for those with senior clinical responsibility. We support the development of specialist training and of consultant level appointments of these professions in community and hospital settings. Such appointments have demonstrated quality improvement in other healthcare settings such as Intensive care and surgical services.

11. We responded to last year’s consultation Liberating the NHS: Developing the Healthcare Workforce, and expressed concern at the proposals to reorganise the way in which the NHS workforce is planned and trained. We still believe that the scale of the re-organisation of the education and training of the healthcare workforce is unnecessary and potentially highly damaging. The implications for post-graduate medical training are worrying and while the network model may be effective for some healthcare staff, we do not feel it is applicable to postgraduate medical training. We believe that postgraduate medical training requires skilled organisation and governance at more than one level, including a sub-national or regional level. The current geographical structure of deaneries is broadly appropriate, and the skill base contained in deaneries should be valued and preserved.

12. The training of the medical workforce has already undergone massive reorganisation in the past five years, including the introduction of Modernising Medical Careers, the development of PMETB (Postgraduate Medical Education Training Board), multiple new curricula and assessment systems for specialty training, a complex new system of quality management, the results of the Tooke report, the merging of PMETB with the GMC. It must now be protected from further upheaval in order to deliver its core aim of training doctors without distraction. Skilled staff in the field of medical training will be diverted from their core activities by the need to learn how to develop and work in a completely new structure at a time of financial constraints.
13. We are particularly concerned that networks of healthcare providers should be given primary responsibility for both co-ordinating and providing training. Trusts already have competing priorities in service provision and often research, and many trusts still fail to support educational supervisors by recognising training activities in job planning, and developing relevant skills in their career grade workforce.

14. The loss of co-ordination at a regional level with the abolition of SHAs and deaneries will also be damaging. While foundation and early specialist training can often be provided in one hospital or a small group, in conjunction with Primary Care, higher specialist training requires rotations between a number of centres, and the current geographical size of deaneries and SHAs is designed to co-ordinate and oversee this for most larger specialties. Furthermore, the skills, experience and professional leadership necessary to co-ordinate training takes years to develop, both on an individual and organisational level. These reside within deaneries and their associated structures and must not be lost.

15. We support proposals to improve workforce planning but this will require a co-operative effort between the Centre for Workforce Intelligence and specialist societies such as our own, the Royal Colleges, the Department of Health and the training organisations (ie local provider networks). The Centre for Workforce Intelligence should obtain data from all healthcare providers and also needs to understand trends in disease patterns and treatments to predict changing needs for different specialist areas. However, workforce planning is inherently approximate, and any improved methods will take years to evaluate, particularly in the medical specialist workforce, which takes 15 years to train from school to consultant grade. The Centre for Workforce Intelligence must always recognise the inherent uncertainties in its predictions and make allowance for them.

16. In our own specialty in recent years many of those graduating from training have obtained consultant posts not in geriatric medicine, but predominantly in stroke medicine or acute medicine, neither of which could have been predicted at the start of those individuals’ five year registrar training programme. Conversely, we are aware of other specialties where highly trained doctors have found themselves without career prospects, which is clearly damaging to the individual and wasteful of training resources.

17. In postgraduate medical training, the organisation is very different between a specialty widely represented in every district or hospital (such as geriatric medicine), and a regional or more nationally-based specialty. The current system of training within deaneries is broadly successful in accommodating these needs, and also co-ordinating service and training between large and small centres and between urban and isolated rural centres. Broadly speaking, the more highly-trained and specialised the staff, the larger the overall framework for training needs to be. Education and training includes quality management of the training and also assessment of the trainees.

18. “Top down” co-ordination at a national level is vital for both economies of scale and overall coordination, and is particularly important for smaller and regionally or nationally-based specialties. There is a need for a responsible leading body but we are nervous about the ability of Health Education England to replicate the current role of deaneries and concerned that we will lose the existing expertise and structures that exist within them.

19. It is right that the Secretary of State should have an explicit duty to maintain a system for professional education and training of the healthcare workforce as part of the comprehensive health service.

20. We also believe that Clinical Commissioning Groups and the NHS Commissioning Board should have a duty to promote the education and training. This should also be a mandatory part of commissioning contracts.

21. The implementation of Modernising Medical Careers, introduction of PMETB, national coordination of appointments at specific times of year and restriction in employment of overseas trained doctors, all introduced in 2007, resulted in an over-rigid system that was not flexible to training or service needs, and required a stifling level of “tick box” style quality management. The new approach must allow for greater flexibility and autonomy, and reduce the bureaucracy in quality management.

22. Accountability needs to occur at different levels. For training doctors, the current system whereby local education providers (such as hospitals) are accountable to their regional body (deanery) and thence to a national body (GMC) is a good one for generic aspects of quality management, but has become too detailed and cumbersome. There are also specialty-related quality matters that need to be overseen by specialist societies and medical royal colleges.

23. Local authorities and the private and voluntary sector employ both healthcare professionals and less highly trained carers that require skills that overlap with those in the NHS. Therefore, it is logical to work with them in the provision and planning of training. However, in practice it is likely that healthcare professionals working outside the NHS will have moved there after a period of training and employment within the health service, so the NHS should be the main focus of training and staff development. However, workforce planning must take into account these staff who move into the social, voluntary and private sectors.

24. Whatever the structure of the training system, an important principle is that each Trust should commit to training the full breadth of medical specialties commensurate with their patient population.

25. We welcome the principle of multi-professional training, but feel that this is, in practice, only rarely applicable to trainee doctors. For example, considering the assessment of mental capacity in the confused “older patient, the skills needed by a doctor, a nurse and a physiotherapist do overlap but also differ considerably and
a ‘one size fits all’ approach is not appropriate. Nonetheless, there are areas in which generic training may be shared between professions, and these include some of the basic skills needed to understand and care for frail older people which are relevant to a very wide range of health professionals as well as those involved in social care. For example, all health and social care professionals should have training about what compassion, empathy, dignity and humanity in routine care means to the patient, resident of a care home and their next of kin.

26. Two thirds of people in care homes have a form of dementia and up to one quarter of hospital beds are occupied by people with dementia. People with dementia stay in hospital up to twice as long as other people who go in for the same procedures. The failure to recognize their needs has contributed to the poor care that they often receive. It is important that individuals suffering from dementia receive timely and appropriate care. The acute care workforce must receive adequate training to understand the specific needs of people with dementia.

27. Geriatricians are ideally placed to provide a lead in promoting good care for people living with dementia. People with dementia may present with increased physical complaints long before their dementia diagnosis is made via current systems of care. Geriatricians may have opportunities to detect the signs of dementia at an earlier stage, when they see people presenting with other symptoms of frailty such as falls, declining mobility, weight loss and incontinence. Conversely, people with dementia may have more difficulty in accessing physical health care than other older people. Geriatricians with an interest in dementia are able to assess both mental and physical health problems and provide integrated and holistic care. Within the acute hospital they can act as role models in the provision of good inpatient care sensitive to the needs of those with dementia. It is therefore imperative that geriatricians should receive advanced training in the care of people with dementia so that they can act as leaders within their own hospitals. The BGS is supporting this training through its plans to provide training for dementia champions within acute hospitals.

28. There should not be an assumption that healthcare professionals are automatically empathetic and compassionate. This does not come naturally to all and role models are needed. There must be regular communication skills courses to keep all up to date and these should be put on the same footing as learning appraisal skills—something currently built into consultants’ job plans.

29. We recommend that the General Medical Council should look at undergraduate curricula across the UK in the context of geriatric training to ensure this is adequately covered. The BGS would be able to supply expert advice on curricula content but in addition to covering the giants of geriatric medicine—dementia/delirium, continence, dementia, immobility, falls -there should be content on human rights, comprehensive geriatric assessment and end of life care.

30. All medical undergraduates should receive training on comprehensive geriatric assessment—a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person’s medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow up.17 There should be multi-disciplinary training programmes covering CGA as the evidence demonstrates that those patients who receive comprehensive geriatric assessment have better outcomes.18 In the longer term CGA may save costs by reducing hospital readmissions and lowering the need for long term nursing home care.

December 2011

Written evidence from London Pharmacy Workforce Development Group (ETWP 27)

LONDON PHARMACY WORKFORCE DEVELOPMENT GROUP (LPWDG)

A network of pharmacists and pharmacy technicians delivering NHS pharmacy services across London; LPWDG represents Chief Pharmacists from NHS trusts and PCTs, and links with our community pharmacy colleagues contracted to deliver NHS pharmacy services in primary care.

The 31 PCTs and 41 NHS trusts in London employ some 1,650 pharmacists, 1,080 pharmacy technicians and 570 pharmacy assistants. In addition, a significant number of pharmacy staff work in community pharmacy. The drug spend across London (2010–11) is £1,958 million. Pharmacy staff throughout the NHS contribute significantly to ensure medicines optimisation, safe and secure handling of medicines, and to the QIPP agenda.

SUMMARY

— The overall prime concern is how to overcome the challenge of truly sharing information and reaching consensus regarding priorities for the development of the workforce delivering NHS pharmacy services, across a complex range of NHS and non-NHS organisations.

1. LPWDG is concerned that the proposals will not ensure the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels.

17 See Comprehensive Assessment of the Frail Older Patient, BGS Good Practice.
Effective workforce planning is challenging within the current arrangements; the NHS pharmacy network collects its own accurate pharmacy workforce data\textsuperscript{19} to inform workforce planning discussions, as other sources are inaccurate, incomplete or results are too collective to be meaningful. There is no evidence to suggest that there is sufficient capacity and capability within all NHS organisations to carry out effective pharmacy workforce planning; or indeed in independent providers of NHS services eg community pharmacies. Workforce planning is currently carried out in each SHA, with varying levels of expertise and dedicated resource; there is a danger that the available resource will be lost.

We know that collective pots of funding generate competition for limited resources, and sometimes the “smaller” professions have lost out (or even been left out of discussions). This evidence suggests that care must be taken to retain the ringfencing of training funds for each professional group (at post-qualification and pre-qualification level) in order to achieve this goal. It must be reviewed on a regular basis to ensure that trainee numbers are appropriate.

If sufficient staff are not available with the right skills in the right place at the right time, patient safety and clinical governance are put at risk, and expensive medicines resources are not used to optimum effect.

There is a lack of transparency within the current system and inconsistencies between professions in how education commissioning takes place and clinical placements are supported. The SIFT (Service Increment For Teaching) funding has only been available for medical and dental trainees. There is therefore little incentive to train for many professions, and the impact that trainees have on productivity is missed.

Finally, the mobility of trainees of all disciplines, both into and out of the capital must be considered holistically by HEE, as it has a significant impact on both the concentration of education and training activity and resource within the capital, and on training for the NHS as a whole.\textsuperscript{20}

2. In order to ensure that training curricula reflect the changing nature of healthcare delivery, including the medico-legal context, LPWDG suggests that the required outcomes need to be clearly defined and agreed with NHS service providers.

There are already systems in place to ensure that courses evolve to ensure that this is the case; however, evidence suggests that this does not always happen as effectively as it should, and the timescale for implementation of change is often slow due to the academic accreditation process; this needs to be addressed.

3. LPWDG has evidence to demonstrate a lack of engagement with some providers and commissioners of healthcare (both NHS and non-NHS) in playing an appropriate part in developing the future workforce.

This is either because they do not have the required resources (physical, human and financial) to meet the training standards, or because they are not motivated to do so, since they currently have to pay for all their own training or access it through a non-NHS, non-SHA route (eg community pharmacies access funding to support the training of pre-registration trainee pharmacists via the Contractual Framework for Community Pharmacy Services; the pharmacy undergraduate degree is funded via the Higher Education Funding Council for England rather than via the Non-Medical Education & Training part of the Medical and Professional Education & Training levy). See also comments under 1 above. This evidence indicates that clear mechanisms must be in place to ensure full participation.

4. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) is essential if the challenges of prioritisation and decision-making for fair and equitable allocation of resources are to be met. LPWDG understands that previous attempts to review the MPET levy have proved challenging due to the dominance of the medical profession; this evidence suggests that new and innovative solutions must be devised to ensure fairness and equity for all. Evidence also suggests that a lack of a chance to input means that some professional groups have missed out on accessing funds in the past; this must be overcome if the proposals are to be fit for purpose.

A balance must be reached whereby all professional groups have a voice, either by presence or representation and effective communication mechanisms, otherwise this ambition will not be realised.

5. We have evidence that standards of education and training are not always as high and consistent as required, particularly in the workplace. The proposals offer opportunities to address shortcomings; however, significant new infrastructure, and closer partnership working with key stakeholders, including education providers and professional regulators, will be required.

6. It is critical that the existing workforce can be developed and reskilled for the future (through means including post-registration training and continuing professional development). Our evidence suggests that a lack of funding is already impeding this activity. As above, the opportunity to access post-registration and CPD funding is often lacking; sometimes professional groups/service managers do not know what opportunities are available.

Local trusts are concerned that the loss of CPD funding would impact on the quality of services. Junior staff having to pay for all of their training and CPD may result in training not taking place due to the affordability

\textsuperscript{19} www.nhapdc.nhs.uk

\textsuperscript{20} King’s Fund Report In Capital Health? 01 July 2003 and interim report 13 May 2005.
of this on a London salary. If the service does pay, this will divert money and could impact on service delivery, particularly in times of austerity.

Career pathways need to support the creation of a flexible and adaptable workforce so that professionals can move more easily across boundaries to counter imbalances between supply and demand. This whole aspect of the proposals needs to be clearly defined and prioritised; with guidance by HEE, whilst incorporating local flexibility.

LPWDG supports the proposal for open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

7. Evidence suggests a lack of awareness of pharmacy career opportunities by schoolchildren and students; numbers of pre-registration trainee pharmacy technician applicants are low. Promotion of and access to information on various NHS careers needs to be addressed centrally in order to avoid duplication of effort.

Plans for the transition to the new system, up to April 2013

8. Evidence from other transitions suggests that rapid transition is often associated with the loss of organisational memory and skills, competences and capability, which then need to be re-developed. A clear transition plan to ensure that these losses are not suffered is required.

The future of postgraduate deaneries

9. NB This response also covers current SHA activity.

The current evidence suggests that Deanery roles vary; some are Multi-Professional, others are not. Some cover undergraduate as well as postgraduate multi-professional activity. Some Deaneries carry out roles which are carried out by SHAs elsewhere. The variety of approaches has produced a lack of consistency, widespread confusion and inequity. The range of approaches in workforce planning, education planning and education commissioning could be usefully addressed in guidance by the proposed HEE. LPWDG supports the Government’s proposal to retain the Deaneries within the NHS.

The future of Health Innovation and Education Clusters

10. LPWDG has worked with one of the HIECs in London. HIECs have varied in their approaches. The need to respond to local demand and innovate must be retained. Again, communication and engagement have not always been as effective as required, and this must be overcome.

The role of the Secretary of State for Health in the new system

11. Evidence suggests support for this responsibility and the need for responsibility to remain within the NHS infrastructure is high, and must be retained.

The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

12. In its response to Liberating the NHS: Developing the Healthcare Workforce, LPWDG noted that in order to support its high level aspirations it is of paramount importance that the detail supports the aspirations of the new infrastructure as a whole. As evidenced by subsequent discussions, the notion that “the devil is in the detail” continues; and this is still of concern.

The proposed role, 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

13. As under 4. and 12. above.

How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

14. See also under 2 above. It is important that HEE leads on such things best done nationally (eg with professional regulators on professional requirements), and that LETBs (or “lead LETBs”) collaborate accordingly where local need is being met. It is important to avoid duplication of effort as experience suggests that this is inefficient and does not support the QIPP agenda.

The implications of a more diverse provider market within the NHS

15. We have evidence that this can be detrimental where “niche”, highly specialist training is essential, and the trainee numbers are small; for example with a number of courses ceasing to be viable, and access being an
issue for NHS service providers. Care must be taken to ensure that service providers can develop their staff to meet service needs, in an accessible manner (curriculum content, delivery design and geography).

**How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced**

16. We have evidence that non-NHS organisations which deliver NHS services are unwilling to share workforce information. This will challenge the ability of the future proposals to meet this objective and must be overcome, perhaps by incorporating into service contractual arrangements. If information exchange is successful, there must be careful consideration and guidance form HEE if balance is to be achieved.

**The role and content of the proposed National Education and Training Outcomes Framework**

17. The preliminary outline seen by LPWDG is laudable and supported; as HEE develops the framework it will be important to engage with all key stakeholders in order to ensure that it achieves its objectives.

**The role of the Centre for Workforce Intelligence**

18. The CfWI’s current activity is insufficiently resourced/focused to provide sufficiently detailed, accurate data and guidance to support workforce planning and education commissioning; capability has also been lost. Its capability needs to be developed considerably if it is to fully support the new infrastructure, in collaboration with appropriate professional groups and networks.

**The roles of Skills for Health and Skills for Care**

19. Skills for Health has demonstrated achievement of consistent standards and benefits from economies of scale; this must be incorporated into the new systems.

**The role of NHS Employers**

20. No comment.

**How funding will be protected and distributed in the new system**

21. Evidence shows that current arrangements are inconsistent and confusing (see under 4 and 9 above). Clear guidance from HEE is essential.

**How future healthcare workforce needs are being forecast**

22. Our evidence shows that forecasting ranges from “How many did you have last year? Same again?”’, to considering numbers of NHS posts, vacancies and forecasts, to considering workforce demand aligned with care pathways, which is extremely challenging eg the pharmacy workforce is involved in every care pathway where medicines are involved, but to accurately consider required input and pool that information to define overall activity, where and when it is required, to inform accurate workforce planning is difficult. Again, a consistent and properly informed approach is required.

**The impact of people retiring from, or otherwise leaving, healthcare professions**

23. Our evidence suggests that this is not considered in current pharmacy workforce planning activity. We understand that it is an important issue which needs to be fully understood if it is to be properly addressed.

**The place of overseas educated healthcare staff within the workforce**

24. Nationally, the vacancy rate for newly-qualified Band 6 pharmacists was over 20% two years ago. Although this has improved, the use of overseas pharmacists, particularly in London, has facilitated service provision. Our evidence indicates that a change to reciprocity arrangements (albeit some years ago) with our Antipodean colleagues led to a “crisis” in delivering NHS pharmacy services across London. We have evidence to indicate the challenges of mobility of the professional workforce where their command of English is an issue. The ability to obtain work permits and duration of these arrangements is also an issue. All of these issues need to be carefully considered.

**How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK**

25. The LPWDG has members who link with the UK-wide NHS Pharmacy Education & Development Committee. Our evidence suggests economies of scale and consistent standards can be achieved by information exchange and collaboration; this must not be lost, especially where professional requirements straddle country boundaries. However, it is important to acknowledge that policies and funding arrangements in the different countries are becoming more “stand alone”. Consistency across England would be helpful.
How the public health workforce will be affected by the proposals

26. Many pharmacists have public health roles, ranging from a strategic remit, to the community pharmacist supporting smoking cessation. An ability to incorporate all of the activity, in collaboration with PHE as well as private contractors for NHS services is important if holistic workforce development is to be achieved.

December 2011

Written evidence from the British Association for Applied Nutrition and Nutritional Therapy (ETWP 28)

SUMMARY POINTS

• Tackling obesity and diet-related disease is a major priority.
• One-size-fits-all dietary guidelines are not supported by post-genome science.
• The nutrition workforce needs to be competent and up-to-date to prevent/combat diet-related disease.

1. Obesity and diet-related disease represent a major public health challenge which Foresight have predicted will cost society £49.9 billion per year by 2050 if not effectively tackled. A competent, up-to-date and effective nutrition workforce has an important role in shifting trends and relieving the economic burden posed by poor lifestyle choices.

2. Up until the last decade it was widely accepted that the primary role of diet was to provide sufficient nutrients to meet the metabolic requirements of an individual and to give a feeling of satisfaction. Evidence now shows that by modulating specific targets diet can have beneficial physiological and psychological effects beyond the previously accepted nutritional effects. It can not only promote optimal health and development but also play an important role in reducing the risk of disease, particularly the chronic diseases of ageing. The EU PASSCLAIM project which ran from 2001–05 surveyed the impact of nutrition on health in the following domains: cardiovascular disease; bone health and osteoporosis; physical performance and fitness; body weight regulation, insulin sensitivity and diabetes risk; diet-related cancer; mental state and performance; and gut health and immunity.

3. Prior to October 2010 the Food Standards Agency was responsible for nutrition and diet. It funded seven nutrition research programmes at approximately £6.5 million per annum, including some of the largest, well-powered intervention trials investigating the type of fat and carbohydrate (N02031), whole grains and fruit and vegetables on various CVD risk factors. In June 2009 an expert panel met to review nutrition research carried out by the Food Standards Agency. The panel recognised that “the publication of these appropriately powered studies is going to overturn some widely accepted relationships between diet and cardiovascular risk and help establish some new ones”. Commenting on projects N02029 and N02030 the five-a-day campaign: “different types of fruit and vegetable have different effects on CVD risk and that the dietary target may need focusing on specific types of fruit and vegetables.” The final reports of projects N02038 and N02039 have yet to be published by the Agency on their research website www.foodbase.org.uk.

4. On 11 May 2010 the Agency published the final report (dated January 2007) of Project T01022 on diet and colorectal adenomas which ran from October 2001 to December 2006. This project investigated the influence of dietary factors on susceptibility to colorectal adenomas and the factors that predispose certain adenomas to become colorectal cancers. The results showed that outcomes were dependent on individual genotype. This research was classified as “Food Safety” and therefore did not get considered in the June 2009 review which looked only at studies classified under “Diet and Colonic Health”.

5. Nutritional therapists represent a significant resource to tackle diet-related disease and promote optimal health in individuals and society. Nutritional therapy comprises individualised dietary, nutraceutical and lifestyle advice within a functional medicine framework to promote optimal physical and mental well-being. National Occupational Standards were published by Skills for Health in 2003 and updated in 2009. The Complementary and Natural Healthcare Council regulates nutritional therapy, reflecting that NT represents a new paradigm different from that which has hitherto underpinned dietetic and public health nutrition practice. In 2004 the Nutrition Society published a Department of Health funded report “Understanding the Differences between Nutrition Health Professionals” which anticipated merging of nutrition professions: “In the longer term, the research indicates a need to consider the possibility of having just one, regulated professional group speaking for nutrition. One possibility suggested was through the Health Professions Council, by expanding the Dietetics to encompass Dietetics and Nutrition, and including anyone (including nutrition therapists) who meet the HPC criteria.” (Section 14)
6. Nutritional therapists use plant, fungal and algal (ie herbal) products in their practice and are therefore concerned at the developments in the implementation of EU Traditional Herbal Medicines Directive and the perverse results of EU scientific substantiation of health claims, eg that “drinking water does not reduce the risk of dehydration”—as understood by the average EU consumer. As the European Commission and Member States have rejected the use of qualified health claims, the situation looks to become more confusing in the short-term.

December 2011

Written evidence from the Academy of Medical Royal Colleges Trainee Doctor Group (ETWP 29)

“The structure of postgraduate training proposed by MMC is unlikely to encourage or reward striving for excellence, offer appropriate flexibility to trainees, facilitate future workforce design, or meet the needs of particular groups.”

Prof John Tooke 2007

“unparalleled opportunities” in modern science could be lost unless a “talent pipeline” is created to train doctors to exploit them. 

Prof John Tooke 2011

INTRODUCTION

1. The ATDG’s membership comprises chairs and vice-chairs of the Trainees Committees of Medical Royal Colleges and Faculties across the UK. This submission represents a combined view across Colleges and has been endorsed by our members.

2. The Academy’s Trainee Doctors’ Group (ATDG) provides a coherent, informed and balanced view on generic issues relevant to College and Faculty registered trainees. Its main strength is to compare the experience of junior doctors in different specialties, forming the primary route of discussion between junior doctors of different medical Colleges and Faculties.

3. This short statement is an addition to and complements the submission from the Academy of Medical Royal Colleges (AoMRC).

THE ATDG’S VISION AND PRINCIPLES FOR POSTGRADUATE MEDICAL EDUCATION AND TRAINING ACROSS THE UK

4. The ATDG have recently produced a short statement regarding principles that should guide postgraduate medical education and training. This can be found at the end of this document.

Key Points

5. Currently medical education in the UK is adequate and produces competent consultants and general practitioners with regional variability in the quality of training. The ATDG would prefer to see excellent education regardless of locality with expert clinicians able to deliver high quality services on completion of training.

6. Doctors work in very different environments and require different skills sets. Training is therefore different for General Practitioners and Secondary Care Consultants and also within specialties (medicine versus surgery for instance). Although common competencies described in the GMC “Duties of Doctor” exist the aim to train all doctors in a similar regulatory and service environment produces conflict. The effect of working hours regulations disproportionally effects the surgical and acute medical specialties but solutions which solve them may have an adverse impact on other groups. The current one size fits all model of training is not a long term solution to the problems highlighted in the Temple\textsuperscript{1} and Collins\textsuperscript{2} report and noted in the most recent GMC Trainees survey.

7. Doctors in training learn by doing. It is essential they are able to provide, in a supportive and safe environment, care to real patients in real time. However traditionally the NHS has relied on trainees to deliver most of its service needs. If the current demand on NHS resources grows as expected the conflict between trainees being trained and providing a service will increase to the detriment of current and future patient care.

8. Difficult decisions on work force planning must be made. The current financial climate has made the concept of “invest to save” seemingly redundant. Yet an expansion of the consultant workforce would release cost savings through improved and more timely patient care, reduced litigation\textsuperscript{3} and aid problems highlighted by a recent report into care provided at the weekend.\textsuperscript{4} This would enable the excess of trainees who have the competencies to obtain CCT (Certification of Completion of Training) to not be lost to the system. This expansion is for a finite period to enable a restructuring of current training pathways to avoid unnecessary future overproduction of doctors and continue to provide a high quality service to patients. Finally in order to maintain the rigorous standards expected by patients and the public it will enable all consultants to deliver
quality clinical supervision to trainees and allow those recognised by the GMC as trainers to provide an excellent educational experience.

9. The ATDG welcome some of the reform of education and training proposed in the Health Bill. However, the uncertainty surrounding the purpose, function and regulation of LETBs is not helpful. The possibility of Foundations trusts running LETBs means they would both be delivering and governing training. This is not in the best interests of trainees or patients. One solution is colleges providing external Quality Assurance, not necessarily through site visits, but through setting standards as some have already started to do (RCPCH: Facing the Future). We wish to ensure that “any qualified provider” can deliver high quality services without compromising training.

10. If the government would like to see UK plc benefiting from the skills and experience of a highly motivated and trained medical workforce there must be protected time placed in training pathways for trainees to explore education, leadership, management and innovation opportunities. This should not just be for a select few but available to all.

High Quality Training: The Academy of Medical Royal Colleges Trainee Doctors Group (ATDG) position statement on principles to guide postgraduate medical education

— Patients should expect the highest standard of medical care regardless of the grade of the doctor treating them. Trainees should be conscious of the high levels of responsibility and trust placed in them by patients and staff.

— Those responsible for training must remember that Trainees are professionals whose engagement should be sought in all matters affecting them. Processes to enable trainees to raise concerns regarding the quality of their training in a confidential manner, and receive feedback on action taken, should be in place at both a local and national level. Trainees are expected to demonstrate professionalism including willingness to engage in the training process.

— Training is a right and not a privilege for specialty trainees. Patients expect Trainees to have been afforded appropriate opportunities by their trainers and training organisations to practice as independent practitioners by the completion of training. Trainees must be ready to access available learning opportunities in order for this occur and trainers must have the time to train.

— Rigorous patient safety standards must exist in the design and delivery of training programmes. A proportionate balance must exist between direct supervision and easily accessible support as training progresses.

— Medical training takes place in the context of a supervised service environment delivering safe patient care. Organisations which place Trainees in environments where service provision detracts from or regularly hinders education should have their training remit reassessed.

— It is a fair and justifiable expectation to have the opportunity to compete for substantive consultant positions on acquisition of CCT. Work force modelling must allow for this even if uncomfortable decisions regarding trainee numbers must be made.

The RPCE and RCPsych Trainees Committees and Association of Surgeons in Training (ASiT) have also produced trainees’ charters.

REFERENCES


3 AoMRC Report on Consultant delivered Care (to be released Jan 2012).

4 Inside your Hospital Dr Foster Hospital Guide 2010–11 http://www.drfosterhealth.co.uk (last accessed 10 December 2011).

5 RCPCH: Facing the Future (http://www.rcpch.ac.uk/facingthefuture). December 2011
Written evidence from the Royal College of Surgeons of Edinburgh (ETWP 30)

The Royal College of Surgeons of Edinburgh wishes to submit the following written response to the select committee focusing on the items outlined in your invitation and confining our comments in the main, to the surgical aspect of each item unless declared otherwise. Our fellowship and membership of 18,000 is spread across the United Kingdom and indeed globally. Surgical education and training and the implication for workforce planning within the United Kingdom are central to our purpose and actions; our structure, function and influence is directly relevant to surgical practice and patient care across the entire UK. A pan UK approach to training and education is essential in order to avoid potential differing educational provision and standards for a workforce that moves freely from country to country within the United Kingdom. Political and geographic boundaries should not be given the potential to translate into differences in quality of patient care.

An invitation to contribute to your deliberations failed to reach us directly despite the fact that our membership extends throughout the UK. The failure to appreciate the significance of contribution to and influence of the medical Royal Colleges based in Scotland to educational standards and process is an indictment of the approach to planning of both workforce and education strategies for British medicine. Whilst implementation of healthcare is devolved, we do not believe that there should be a similar restriction on the strategic approach to education and training of our workforce, hence our wish to contribute to your work on this key matter which ultimately dictates the standard of care for our patients. We trust, therefore, that this submission is contributory and facilitates the planning process in these strategically important areas.

1.0 The numbers of appropriately qualified and trained healthcare staff at national, regional and local levels

1.1 We would anticipate that the established trend of increasing consultant numbers (the consultant workforce has doubled in England from 18,000 to 36,000 between 1994 and now) and the more recent trend of migrating numbers from the training and specialist grade in to the consultant workforce, will continue until such time as there is a steady state between recruitment into training and exit from the consultant workforce. The potential for a mismatch between the product of medical school education in terms of UK graduate numbers and recruitment into all specialty training is a concern for us however since the projected reduction in training numbers will exacerbate this mismatch year-on-year. Policy for manpower planning therefore must include entry into the profession as well as attrition and departures from it.

1.2 Distribution at national, regional and local level is a responsibility for each jurisdiction coordinated through the respective human resource departments. However, particular consideration has to be given to supra-regional services where there is a dependency upon a small number of consultants who are nonetheless crucial to provision of high-quality specialist care.

1.3 However, due notice must be taken of the cross-border migration of staff in both consultant and non-consultant grade. Neither England nor Scotland are self-sustaining in any but particularly smaller specialties and any policy which deals with workforce training and education must recognise the reality that exists in cross-border flow and must ensure that both strategic and operational policies accommodate this pattern such that there is no obstacle to its continuation. Additionally, note must be taken that some training programs are pan UK and a policy emanating from one country should not compromise that program.

2.0 The need for training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

2.1 An increasing awareness of the presence of harm as an unintended consequence of patient care and a new emphasis on patient safety requires a specific addition to postgraduate curricula which will embrace the subject matter of human factors and improvement science as it relates to surgical practice. This college has a pre-eminent position in its contributions to both these fields witnessed by (a) the global success of our non-technical skills taxonomy developed with the University of Aberdeen (NoTSS), (b) our alliance with the NHS Institute in creating a Curriculum Creator Tool and (c) with our ongoing work to establish an in workplace assessment tool of non-technical skills (embracing behavioural aspects of surgical performance ) with the accompanying faculty training products. This underlines our commitment to maintaining a contemporary and “fit for purpose” approach for creating a surgical workforce for the future.

2.2 The medicolegal consequences of harm are best approached by a methodical and systematic study of its origins which we believe more likely to achieve mitigation than a policy based on a transactional top-down approach.

3.0 The contribution that providers and commissioners of healthcare (both NHS and non-NHS) play developing the future workforce

3.1 The role of providers and commissioners is key in that their support and commitment to education and training of the current and future workforce is obligatory and anything short of complete commitment is prejudicial to the delivery of education and training, (often delivered outwith contractual duties), but best developed with an endorsement from providers rather than in the face of apathy or frank opposition. The current lack of commitment to training and education by management results in it being undervalued and compromised. This contribution has to translate into more than an absence of objection, but must also call to
account those who fail to declare and display ongoing commitment to education and upskilling of their successors.

3.2 Better and more robust contracts/MOUs/SLA’s need produced to underpin the relationships between educational bodies and the NHS and reduce the discretionary approach taken by local management (often in response to short-term service pressures) which can compromise long-term investment in our workforce.

4.0 Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

4.1 We are committed to multidisciplinary and multiprofessional leadership. This college is currently piloting the development of the Faculty of Surgical Trainers specifically to look at the generic skills that need to be enhanced within the workforce in order to support the professional development of educational and teaching skills as well as improving the quality of patient care indirectly through this strategy.

4.2 The new faculty of Medical Leadership and Management instigated by the Academy of Medical Royal Colleges is indicative of the commitment of all colleges, to leadership and accountability. We would also highlight a number of our current and ongoing initiatives directed at multi-professional support eg development of non-technical skills in theatre scrub nurses (Splints) and our hosting of the Faculty of Prehospital Care which deals with the range of disciplines from the ambulance service, paramedic care, nursing, through to trauma surgery. We have additional educational provision for those working in remote situations (Diploma in Remote and Offshore Medicine)-all indicative of our commitment in this area.

5.0 High and consistent standards of education and training

5.1 This is amongst the highest of our priorities and responsibilities and a duty that we execute with care and diligence. As an equal partner within the intercollegiate network of surgical standards setting and examining across the United Kingdom (and farther afield,) we have a thorough and rigorous approach to summative and formative assessment such that through our joint committee structure, we are able to provide the General Medical Council with advice on the suitability of placement of a surgeon in training onto the specialist register.

5.2 Discontinuation of the visiting process carried out on behalf of all surgical colleges by the Specialty Advisory Committees (SACs) was a significant loss to the quality assurance of training as its prime goal and indirectly and by proxy an evaluation of the quality of the service. Recognising that this constituted a significant burden for deaneries and providers alike nonetheless has not been re-placed by a mechanism that approaches in any way the rigour, effectiveness and efficiency of that quality assurance process. Reintroduction of that mechanism is worthy of consideration.

6.0 Development and reskilling of the existing workforce for the future

6.1 Continuous Professional Development for the purposes of both professionalism and revalidation is a work stream at the heart of preservation of standards as well as a mechanism for recurrent training and advancement in the competencies and skill set of existing workforce. This college makes substantial commitment to CPD through course delivery, surgical skills enhancement, e-learning products (ESSQ-the Edinburgh surgical sciences qualification has received recognition as a front-runner in surgical education delivered online).

6.2 Investments in research also require integration into any policy designed to promote advances in competencies and skills. Whilst there are no specific questions in relation to research, research into applied healthcare is fundamental to progress within the United Kingdom and we would support its inclusion in the considerations of the health committee.

6.3 Financial support for CPD and study leave is inconsistent throughout the United Kingdom. They would suggest a policy be developed to remove the element of postcode lottery that is currently a feature of the financial support for professional and study leave.

6.4 Better recognition and accreditation of transferable skills between programs is currently under active consideration by all colleges.

7.0 The future of postgraduate deaneries

7.1 Using NHS Education Scotland as a reference point, we would strongly recommend preservation of postgraduate deaneries along these lines with HEE providing an overview as the umbrella organisation in England. The existing scale structure purpose of functionality has not been subject to any substantial criticisms or demonstrable inadequacies. The uncertainty surrounding future structures is potentially profoundly destabilising.

7.2 Deaneries in Scotland have demonstrated the value of local administration of training whilst at the same time the potential for integration and coordination at national level. We see no merit in revision of the current deanery structure in England recognising that governance responsibilities for training needs to be shared by Royal Colleges, Schools of Surgery and the deaneries.
8.0 The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the professional advisory boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

8.1 As indicated above, Health Education England would be well served by modelling much of its role, structure and governance on those functions as executed by NHS Education Scotland. There would be particular benefit in identifying responsibilities for foundation years (particularly the 2nd year) with greater clarity in relation to the role of the regulator. The lack of clarity around the new NHS system architecture in relation to education makes a more definitive response difficult beyond indicating that the more locally economy exists for delivery of education, the greater the potential for inconsistency and fragmentation of training schemes that need to be provided seamlessly across United Kingdom. The merits of commissioning in this area are unclear to us.

8.2 Also as indicated above quality assurance of training and education would be a task better engaging the colleges to provide externality, expertise and consistency, rather than residing in the duties of the regulator.

9.0 How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

9.1 Royal colleges currently have primacy in the duty of formulation and development of curricula. There is merit in extending this to a partnership approach through agencies responsible for service development (eg NHS Institute). The Arm’s-Length Review however has made the future of these agencies less secure and hence investment in partnership with them less predictable. A closer alliance with a standards agency (eg Nice) could provide additionality to the current mechanisms of curricular development.

10.0 The place of overseas educated healthcare staff within the workforce

10.1 Cognisant and supportive of the strategy of the United Kingdom being self-sufficient in its consultant workforce, and that that workforce is the one charged with and is responsible for delivery of healthcare, we would wish to note that the vacancy factor in terms of training numbers that accompany the reshaping of the workforce will open up educational opportunities that could be filled by overseas educated healthcare staff. This therefore provides opportunity for supporting healthcare education in other nations particularly developing nations and this country has a rich tradition in such endeavours. Indeed we would see the current exclusion of many doctors from the Third World as being an abrogation of our global responsibilities towards improvement in health care worldwide.

10.2 We would strongly support expansion of a well-managed International Medical Graduates Scheme that allows placement adequate supervision and planned exit in an accountable fashion, and wish you to note that we currently administer such a scheme on behalf of the UK surgical colleges.

11.0 How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

11.1 There are distinct differences in the case mix between surgical units within and outwith the NHS with the latter units being occupied with minor and intermediate complexity procedures in the main. The depletion of these cases from the NHS precludes access for training purposes and leaves training to be based upon a more complex caseload with the attendant challenges that that poses. Moreover the proportion of cases treated in non-NHS institutions varies from surgical specialty to surgical specialty (there are significant examples eg in cosmetic and aesthetic surgery as well as an orthopaedic surgery), and in these specialties the lack of exposure of trainees to the non-NHS institutions is deemed as prejudicial to training in the full spectrum of case complexity. This requires revision and better regulation.

12.0 The implications of a more diverse provider market within the NHS

12.1 related to our response in paragraph 3.1, we are concerned that diversity may translate into inconsistency in support of the educational process and the potential for lack of consistency in prioritisation and investment in the future of quality and safety of the workforce of the NHS through adequate education and training.

13.0 How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

13.1 As indicated above, it is crucial that a pan UK approach is taken to training and education to avoid the potential for postal code training provision in a workforce that moves freely from country to country within the United Kingdom and a workforce where the political and geographic boundaries do not and should not translate into differences in quality of patient care. Whilst implementation of healthcare is devolved, there is no such restriction on the strategic approach to education and training of our workforce (as witnessed by the Academy of Medical Royal colleges being a pan UK body) and the health select committee would be best served by a wider vision in its strategic approach.

December 2011
Written evidence from Lifeblood: The Thrombosis Charity (ETWP 31)

SUMMARY

— Lifeblood: The Thrombosis Charity is responding to this consultation with a focus on the need for improved, consistent and high quality education for healthcare undergraduates and professionals on the prevention of venous thromboembolism (VTE) in hospital patients—a national clinical priority for the NHS—and on the diagnosis and management of VTE in the community and in hospital.

— In 2005, the then Health Select Committee conducted an inquiry into the prevention of VTE in hospitalised patients. The inquiry recognised the scale of the problem of hospital acquired VTE alongside the cost effectiveness of preventing rather than managing VTE. Recommendation six centred on the need to improve health professionals’ education about VTE given that professional awareness was low.

— While national best practice and policy exists to support the implementation of best practice in the prevention of VTE, evidence collected by Lifeblood and the All-Party Parliamentary Thrombosis Group indicates that VTE education remains disparate and poor nationally and across the disciplines. The result is low awareness amongst health professionals about VTE prevention, diagnosis and management, leading to many unnecessary and avoidable deaths from the condition.

— Given the accepted clinical and financial significance of VTE to the NHS, Lifeblood recommends that the Health Select Committee investigates how a core education syllabus for healthcare professionals can be developed, which includes VTE as a national, mandatory requirement. Undergraduate education on VTE must be supported via professional revalidation and new staff induction. This is essential if we are to deliver a long-term legacy of high quality VTE prevention in the NHS and avoid thousands of preventable deaths each year from the condition.

SUBMISSION

1. Lifeblood: The Thrombosis Charity (Lifeblood) is delighted to submit evidence for the Health Select Committee’s inquiry into education, training and workforce planning.

2. This submission is made further to a meeting held with Rt Hon Stephen Dorrell MP on 5 July 2011 in his capacity as Chair of the Health Committee, about the urgent need to improve NHS health professionals’ undergraduate and postgraduate education, particularly around awareness of venous thromboembolism (VTE).

3. VTE—blood clots—includes both deep vein thrombosis (DVT) and pulmonary embolism (PE). Blood clots form in the veins deep in the leg, usually in the calf or thigh, although occasionally DVT can occur in other veins of the body. The majority of deaths from VTE are caused by part of the clot breaking off, travelling around the body and eventually blocking the pulmonary arteries (arteries in the lungs). This is known as a pulmonary embolism (PE).

Background (i): Health Select Committee 2005 inquiry into VTE prevention in hospitalised patients

4. On 8 March 2005, the Health Select Committee published an inquiry into VTE, “The Prevention on Venous Thromboembolism in Hospitalised Patients” (Second Report from the Health Committee Session 2004–05: HC99.)

5. The Report recognised that “each year, over 25,000 people in England die from VTE contracted in hospital. This is more than the combined total of deaths from breast cancers, AIDS and traffic accidents”.27

6. The Report went on to recognise the financial cost of VTE to the NHS, noting that “even more alarming than the scale of the problem is the fact that VTE in hospitalised patients is largely preventable through the use of thromboprophylaxis during the hospital stay of the patient and, in some cases, continuing after discharge.”28

7. The Health Select Committee published 12 recommendations aimed at improving VTE prevention in the NHS. These were all accepted by the Government in its response.29

8. Of particular significance is recommendation 6, focussed on the need to support improved professional awareness of VTE:

“We recommend that VTE and its prevention, including the implementation of, and adherence to, guidelines relating to thromboprophylaxis, counselling and risk assessment, be given more prominence in undergraduate medical education, continuing professional development (CPD), and other relevant aspects of medical and paramedical training. We further recommend that the Royal Colleges bring forward proposals to this end to raise awareness of the problems of VTE. In addition, NHS Trusts should ensure that all physicians and surgeons receive training about the subject.”30

27 House of Commons Health Committee (2004–05) “The Prevention on Venous Thromboembolism in Hospitalised Patients” (HC 99) p7
28 ibid
30 House of Commons Health Committee (2004–05) “The Prevention on Venous Thromboembolism in Hospitalised Patients” (HC 99) p29
Evidence of a Lack of Progress on VTE Education

10. DVT can be clinically very difficult to diagnose but early recognition and appropriate treatment can improve clinical outcomes. It is estimated that 18,000 deaths occur annually from undiagnosed VTE.

11. As a charity, Lifeblood is inundated with correspondence from distressed relatives and individuals where VTE had been missed on a visit to the General Practitioner (GP) or during a hospital visit.

12. The symptoms and signs of DVT and PE can be subtle. For example, in 80% of cases, there is no swelling or redness in DVT, just pain. These facts are not common knowledge among medical professionals and so many patients are sent away after seeing health professionals because they don’t fit the textbook case. As a consequence, some may some die, some may present acutely in secondary care later with a worse DVT or a PE. For the NHS, this treatment can prove costly—in both time and money. For the patient, an undiagnosed DVT can have tragic consequences.

Evidence of a Lack of Progress on VTE Education

13. The All-Party Parliamentary Thrombosis Group (APPTG) undertook a Freedom of Information (FoI) request in December 2010, asking the Medical Schools Council how VTE education is currently delivered by medical schools in the UK. The response, made available in early 2011, indicates that six years on from the Health Select Committee’s recommendation, there continues to be wide variation in VTE education across England. There is a clear lack of consistency in the amount of time allocated to VTE as well as in the format in which VTE prevention, diagnosis and management is taught and reinforced to undergraduate medical students.

14. The response to the APPTG’s FoI is supported by an independent academic study of the state of UK undergraduate haematology medical education, published in The Bulletin of The Royal College of Pathologists in April 2011. The study was based on a survey of medical schools in the UK to support a UK generic core curriculum for undergraduates being developed by the British Society for Haematology. While there is no specific data on teaching of VTE, the findings underlined that haematology undergraduate programmes vary widely across the UK. The study noted that a core curriculum will not only raise the profile of haematology, but it will provide a “solid grounding in the subject for all future clinicians”.

15. Lifeblood wrote to the Nursing & Midwifery Council in early 2011 asking them to outline how VTE is addressed in nursing and midwifery education. The response indicated that there is no national standard education on the issue, indeed for midwifery, “despite extensive consultation on the new standards VTE was not mentioned as something that ought to be included”.

16. However, Lifeblood is aware that a clear unmet need exists around nursing and midwifery education, particularly on VTE prevention. I have been supporting the UK Thromboprophylaxis Forum, Royal College of Nursing and National Nursing and Midwifery Network to run two workshops during 2011 on thromboprophylaxis in obstetrics, courses aimed at midwives and obstetricians. These classes were inundated with over 100 attendees each—and we have now agreed to continue running these classes during 2012 to meet the obvious demand and fill a clear unmet need.

17. Needless to say, the press continues to cover stories of failings in VTE prevention, diagnosis and management, often covering avoidable deaths from the condition. Indeed, as this submission is being drafted, Lifeblood is aware of three stories that have been covered in the press in the two weeks since the beginning of December, two relating to preventable hospital acquired VTE, the other relating to a death from VTE missed by a GP and later in hospital.

18. All the above clearly demonstrates that VTE education remains inconsistent across the UK. The issue is yet to be adequately addressed by medical schools and institutions offering medical and nursing education, despite a clear call for improvement from the Health Select Committee over five years ago on education around VTE prevention, and evidenced through the continuing calls that Lifeblood receives around missed DVTs.

Lifeblood’s Recommendations to Improve VTE Prevention Education

19. Lifeblood firmly believes that it is vital that our doctors, pharmacists and nurses of tomorrow be equipped with the knowledge and training to prevent further avoidable deaths from VTE due to hospital admission and missed DVTs.
20. Lifeblood advocates that VTE prevention, diagnosis and management must be adequately taught to all healthcare students, across the disciples, from the outset of their careers.

21. Lifeblood further advocates that basic principles of high quality VTE prevention must also be reinforced during professional development. All too often, avoidable instances of harm are not investigated and followed up adequately, meaning medical professionals fail to learn from these mistakes and are often free to repeat them with impunity. This is certainly the case in VTE, which often presents clinically once a patient has been discharged from hospital. This means those clinicians responsible for a patient’s care whilst in hospital are unaware of their failures in preventing a DVT, or more seriously, a fatal pulmonary embolism, which were contracted as a result of a patient’s hospital admission. Addressing this through a systematic approach to education and accountability will help embed VTE prevention as a minimum standard of safe quality care.

22. This is especially important during times of financial austerity, considering that VTE prevention is one of the top ten NICE recommended cost saving interventions. There are significant medico-legal costs associated with inadequate VTE prevention, diagnosis and management. Data presented at the joint Department of Health and All-Party Parliamentary Thrombosis Group VTE Prevention Leadership Summit in March 2011 estimated that successful VTE claims have cost the NHS Litigation Authority a staggering £112 million in damages and legal costs in approximately 140 claims made over the past five years. This equates to more than £22 million per year.

23. To address these concerns, Lifeblood fully endorses the relevant recommendations made by the All-Party Parliamentary Thrombosis Group (APPTG) in their latest research report on the various stages of education on VTE. The recommendations are copied below and are focussed on preventing VTE in hospital, though they apply equally to the diagnosis and management of VTE in the community and in a hospital setting. Lifeblood urges the Health Select Committee to investigate how these recommendations can be best addressed:

(a) The APPTG recommends that as part of a wider review of undergraduate education, all relevant Royal Colleges and Societies should establish a core syllabus for VTE prevention for undergraduate students across the medical and healthcare disciplines.

(b) The APPTG recommends that all Individual Royal Colleges and Societies should develop a core syllabus on VTE prevention for the revalidation of medical and healthcare professionals.

(c) The APPTG recommends that all NHS Trusts should ensure that local policies on VTE risk assessment and prophylaxis are included within their protocols for staff induction across the disciplines.

24. Lifeblood firmly believes that a mandatory, nationally consistent and high quality focus on VTE at undergraduate and postgraduate level is essential if we are to deliver a long-term legacy of high quality VTE prevention in the NHS, and avoid thousands of avoidable deaths each year from the condition.

25. Lifeblood would be more than happy to provide more evidence on the matter in writing or verbally for the Committee where required.

December 2011

Written evidence from the Intercollegiate Group on Nutrition (ETWP 32)

SUMMARY

— Nutrition is a key determinant of the health of people and of populations, and a critical component of care of the sick.
— It is therefore critical that doctors and other healthcare professionals receive an adequate undergraduate education in nutrition, and subsequent training to assure their safety and competence to practise.
— The current education and training of doctors and other healthcare professionals cannot assure that they are safe and competent to practise in respect of nutrition.
— The Intercollegiate Group on Nutrition, a group of the Academy of Medical Royal Colleges, is the only national professional body that has nutrition as its primary concern. Under its auspices an undergraduate curriculum in nutrition for medical students has been developed.
— We urge that this curriculum should be delivered to all medical students as an integral part of their undergraduate training.
— We further urge that all other healthcare professions include an appropriate element of nutrition in their undergraduate curricula, and that this training should be accredited by the Association for Nutrition.

1.1 The Intercollegiate Group on Nutrition (ICGN) was founded in 1996, following a report of the Royal College of Pathologists which recommended an initiative in postgraduate training in nutrition be established for doctors across the range of medical specialities. It was established as a collaborative venture between several Medical Royal Colleges, in collaboration with the British Dietetic Association, and with observers from the

Chief Nursing Officer and the British Pharmaceutical Nutrition Group, and has since inception been hosted by the Royal College of Pathologists. Current membership is from the Royal Colleges of Anaesthetists, General Practitioners, Obstetricians and Gynaecologists, Pathologists, Paediatrics and Child Health, Physicians (London, Edinburgh), Physicians and Surgeons (Glasgow), Psychiatrists, Radiologists, Surgeons (England and Edinburgh), the Faculty of Public Health, the Intensive Care Society and the British Dental Association.

1.2 The ICGN was set up in recognition of the importance of nutrition in medical practice for patient care and public health. The need for systematic education and training in nutrition was therefore considered a prerequisite to demonstrate safety and competence to practise. In contrast training in nutrition throughout the undergraduate and postgraduate medical curricula was absent or fragmented. The only national resource until recently has been the 1994 Department of Health document Core Curriculum for Health Professionals, which outlined 18 bullet points covering nutritional science, nutrition support and public health nutrition. More recently there has been a wider recognition of the need to incorporate nutrition in medical training both by the GMC at undergraduate level (Tomorrow’s Doctors), and the Royal College of Physicians at postgraduate level (Nutrition and Patients: a doctor’s responsibility).

1.3 Nutrition is an important determinant of the health of people and of populations, and of people’s response to illness. Thus, improving nutrition offers great scope for improving health, and reducing the impact of disease. In contrast, although nutritional issues are common in clinical and public health practice, they are all too often not recognised or adequately managed.

1.4 As a discipline, nutrition has its roots in the basic sciences, but its practical application in relation to human health presumes the delivery of a service. However, at the present time these services are not well characterised, nor adequately developed. There is considerable evidence that better nutrition before or during illness improves outcome and reduces hospital stay, but the application of this evidence in practice is not adequate. The services for the delivery of health, including public health, are provided by a variety of health professions who may have only modest, if any, nutritional education and training. Further, those who are currently engaged in delivering services in nutrition are not always trained to explicitly recognised standards, other than in the case of Registered Dieticians, and Nutritionists and Public Health Nutritionists registered with the Association for Nutrition.

1.5 Doctors in particular are critical to delivery of adequate nutritional care, but their education and training in nutrition are haphazard at best, and many doctors regard themselves as inadequately trained to give nutritional advice. This contrasts with the high regard that doctor’s advice (however poorly informed) enjoys: and with their impact on the rest of the health team as leaders and role models.

1.6 These two factors—inadequately defined standards across the health professions, and a range of greatly varying competences for those who need to access nutrition in their professional practice—limit the great potential offered by nutrition for health improvement and for economic savings. There is therefore a need to set standards for education and training for all health professionals so that they are trained to a level where they are safe and competent to practise. The current failure to achieve this leads to the widespread lack of recognition of nutritional problems (either of over or under nutrition) within the community and in hospital care, and in poor standards of nutritional management leading to adverse patient outcomes.

1.7 We believe that all health professionals should be able to demonstrate safety and competence to practise, including in nutrition at an appropriate level for their practice. We consider that medical curricula from undergraduate through the foundation years should include an explicit nutritional component. In the absence of this, the ICGN has set up the Intercollegiate Course in Human Nutrition as an opportunity for qualified doctors to reach the basic standard of nutrition education that should be expected from undergraduate experience. The course is designed to deliver agreed learning outcomes from each representative Royal College. A prototype course was held in 1997 and since then 22 courses have been held in Southampton, Nottingham, Durham and Scotland, with plans to continue two or three courses each year. Each Course comprises 20–30 delegates from a variety of specialities, and at different levels of seniority. Although some Royal Colleges now include elements of nutrition in their examinations this is not yet comprehensive.

1.8 The Intercollegiate Group has also considered the appropriate level of training that they would expect from newly qualified doctors to embark on postgraduate training in their specialties. They therefore developed an undergraduate core curriculum in nutrition for medical students, with the involvement of all medical schools in the UK, and this curriculum has been supported by the Heads of Medical Schools and the GMC. In addition this curriculum provides an explicit foundation to progress to achieving the learning outcomes of the Foundation years curriculum in nutrition, also developed with the Intercollegiate Group.

1.9 We regard the achievement of the core undergraduate nutrition curriculum and the nutritional elements of the Foundation Years curriculum as essential. Although some elements are covered in some places, this is not the norm and we urge that it should become so.

CONCLUSION

1.10 There is a need for an adequately trained workforce that includes doctors but encompasses all other health professionals, even if their main focus is not nutrition. In addition it should encompass those with specific expertise in nutrition ie registered nutritionists and dieticians. The current review is an opportunity. It
would add substantial value to doctor’s efforts, and save expensive time, if there were sufficient numbers of adequately trained nutritionists.

1.11 It is important to recognise that the needs for adequate provision of nutritional services within the NHS and public health systems, and within community services, require a comprehensive approach; and that education and training are but one necessary though not sufficient consideration.

1.12 We urge that the available resources detailed above are incorporated into the training of all medical students and doctors in training, to assure their safety and competence in professional practice in relation to nutrition. We also urge that other non-medical parts of the health workforce receive training in nutrition, accredited by the Association for Nutrition in respect of their nutritional components; and that resources are allocated to maintaining an adequately staffed and trained workforce to deliver a comprehensive national nutrition service.

December 2011

Written evidence from the Joint Epilepsy Council (ETWP 33)

SUMMARY


2. The shortage of Epilepsy Specialist Nurses in post. (paras 14–17)

3. The shortage of neurophysiological scientists, their training and the threat to the future supply of sufficiently qualified staff. (paras. 18–42)

WHO WE ARE

1. The Joint Epilepsy Council (JEC) is the umbrella body for 23 charitable and service provider epilepsy organisations operating in the UK and Ireland and is supported by leading clinicians.

OUR CONCERNS

2. Our concerns centre around the provision of neurologists in general (and epilepsy specialist neurologists in particular), epilepsy specialist nurses and neurophysiological scientists.

NEUROLOGISTS

3. We see a particular divergence between the Centre for Workforce Intelligence’s Report of August 2011 entitled “Shape of the medical workforce: informing medical specialty training numbers” and the Royal College of Physicians and the Association of British Neurologists Working Party Report of June 2011 entitled “Local adult neurology services for the next decade”.

4. The Working Party Report recites the large and growing demand for neurological services, poor organisation, particular problems with District General Hospital services and that “acute neurology services are of particular concern because they are rarely provided by neurologists, in contrast to those for stroke and other acute medical specialties, resulting in potential adverse outcomes.”

5. The Report notes that “ABN approved standards for the DGH management of acute neurological emergencies are rarely implemented”:

“Acutely ill adult patients with neurological disorders, who do not require immediate intervention, should be seen by a neurologist within 24–48 hours. If the patient is critically ill then they should be seen immediately. All such patients should be under the care of a neurologist.”

6. The Report continues: “despite these concerns, the central recommendation of the 1996 RCP report, to appoint neurologists with appropriate infrastructure support in every DGH, has not been achieved and has been outpaced by spiralling demand. Neurology remains a shortage specialty…”

7. To implement their recommendations, the Report concludes that: “Over the next decade...an increase in consultant UK neurologists from 600 to 880 (one per 70,000 population), most of the expanded workforce being based locally, and more equitably distributed. In turn, this will require expansion in the training grades.”

8. However the CfWI Report in relation to neurologists records that “existing supply appropriate: assume no change needed over the next 3 years”. Although, the Report does state that current growth will not meet demand by 2020 and proposes a review in 2013, the finding that existing supply is appropriate is in direct conflict with the Working Party Report.
9. In his evidence to this Committee on 15 November 2011, the Chief Executive of the CfWI, Peter Sharp, stressed that they worked closely with the Royal Colleges. We do not see that reflected on this issue in their Report.

10. It is not entirely clear to us what information the CfWI is required to take account of in reaching its conclusions, and whether in this instance it took account of:
   - The NICE clinical guidelines for the epilepsies of 2004 which requires a specialist appointment after a first seizure urgently, meaning within two weeks.
   - The Epilepsy Action survey of Trusts of January 2009 which showed that over 90% of Trusts by their own admission were failing to meet the two week requirement, some by a very wide margin indeed.
   - The likely inclusion of avoidable epilepsy mortality and avoidable epilepsy emergency admissions as specific indicators in the new Outcomes Framework and the anticipated drive to reduce the current unacceptably high levels.
   - The growing prevalence of long-term neurological conditions, placing extra demands on a service already widely recognised as inadequate.
   - European comparisons. The Working Party Report recites that “although by 2006 the number of UK neurology consultants had risen from one full-time equivalent (FTE) per 200,000 population in 1996 to one per 115,000, mostly in response to outpatient pressures, this still remains less than a third of the European average.”

11. We submit that the above considerations need to be taken into account by the CfWI if it is to provide accurate predictions of future workforce requirements, undertake the horizon-scanning and challenge functions that those giving oral evidence to your Inquiry have referred to and identify and factor in “megatrends”. If it relies for the most part on provider information, it will fail to take into account the external pressures that will alter provide behaviour.

12. In the case of epilepsy, epilepsy specialist neurologists are required to fulfil many functions, including the vital first specialist appointment, and the supply of these specialists is a particular concern. The Epilepsy Action survey of Trusts reported that in England 50% of trusts do not have an epilepsy specialist neurologist.

13. We recognise that the CfWI is a relatively new body. We have enquired recently if it will be looking at the supply of epilepsy specialist neurologists but have not had an answer as yet.

**Epilepsy Specialist Nurses**

14. It seems a matter of wide agreement that Epilepsy Specialist Nurses and specialist nurses providing support for other neurological conditions are both clinically- and cost-effective. They save money by reducing demands on consultants time and reduce emergency admissions by providing support to patients.

15. The NICE clinical guidelines consider ESNs to be a key part of the team, as does the Department of Health, who issued a Practice Note on the topic. No reputable voice has been raised against this view.

16. The overwhelming current problem is one of commissioning. The Epilepsy Action survey found that 60% of Trusts did not have one ESN. There are about 200 ESNs in post in England but to make the most of patient and cost benefits about 1,188 ESNs are required.

17. There are over 200 trained ESNs not currently employed in that capacity. If, as is hoped and expected, the new focus on epilepsy in the Outcomes Framework leads to the recruitment of more ESNs, then a more organised approach will need to be taken to their education and training to ensure a sufficient supply.

**Neurophysiological Scientists**

18. For this section, we are entirely indebted to Bridget MacDonald PhD FRCP, Consultant Neurologist.

19. We are concerned that we have failed to train enough neurophysiology scientists to replace our aging workforce. There is no other group who could take over this function.

20. Neurophysiological Scientists are one of five groups of physiological scientists who work directly with patients in the NHS. They are not medical doctors (who are often working in the same department and called neurophysiologists). They are rare—around 400 in UK—but their input is essential.

21. Neurophysiological scientific procedures have application in a range of neurological conditions including dementia, epilepsy, and other nerve and muscle diseases. Neurological conditions affect up to 6% of the population—about half of these involve conditions where neurophysiological information is clinically useful. Diagnosis of many neurological conditions can be difficult.

22. Electroencephalography (EEG) and similar procedures undertaken by specialist neurophysiological scientists are vital to diagnosis. A full complement of suitably qualified and competent specialist neurophysiological scientists is essential if proper standards are to be retained. The necessary competencies of
successful neurophysiological scientists extend well beyond the mastery of the technology and include a wide range of patient skills.

23. The demand for their services is high. Taking epilepsy as an example, a new diagnosis of an epilepsy is made in respect to one person in every 2000 of the UK population every year. This equates to 28,500 new diagnoses a year or 80 a day. An EEG will have been undertaken in many of them—aiming at 100% of young people up to the age of 30 years and a good proportion of those over that age.

24. In addition one in 200 people in the UK have an ongoing active epilepsy equating to 289,000 patients. A significant proportion of these patents require an EEG from time to time during the course of their chronic epilepsy or for pre-surgical assessment (this being an expanding area).

25. NICE guidelines require that all patients should have an EEG after a first seizure. Without a successful and accurate EEG result the clinician will not be able to make a properly founded and defensible diagnosis.

26. Training is changing in a way that seems likely to reduce both the quality and numbers of trained neurophysiological scientists. Very little attention seems to have been paid to the problem.

27. We are not convinced that the changes to training put forward by Modernising Scientific Careers will solve this problem. Indeed, they may worsen it.

28. A decision to combine the training of neurophysiological scientists with that of respiratory, gastrointestinal, cardiological and audiological scientists is likely to produce scientists who are overstretched across a wide range of technical matters and under-qualified and under-experienced in the patient skills needed in any neurophysiological scientist capable of delivering reliable test results.

29. It is inevitable that after qualification scientists will continue to specialise in one of the disciplines. Training in skills which are not used and thus redundant is wasteful financially. It may also be a barrier to the recruitment of highly motivated staff with an interest in only one of the branches of physiology.

30. It is important to recognise that the role of neurophysiological scientists is far more complex than just running a machine.

31. Electroencephalography (EEG) is the monitoring of changing electrical activity generated from the brain’s nerve cells. This activity is collected by attaching up to 25 carefully placed electrodes to the patient’s scalp. The neurophysiologists attach these electrodes and obtain the record. They will interpret the EEG as it is running deciding on the use of activation in order to elicit changes. This might include hyperventilation or flashing lights (photic stimulation). The physiologist often encourages the patient to relax sufficiently to fall asleep thus providing specific information for certain conditions such as nocturnal seizures. They need to manage and interpret behaviour during the recordings including seizures that occur during the test. Other behavioural disturbances which are inherent to some of the conditions for which the patient is having diagnostic testing. The state of a patient emotionally has an impact on the recording—being agitated will degrade the record. This is clearly more difficult in children—paediatrics and neonatal records account for over 25% of the work. One in four of the adults who need the test have behavioural disturbances eg dementia, learning disability or significant psychiatric problems.

32. The Epilepsy Action Survey of 2009 showed that most trusts failed to meet NICE guidelines for the use of EEGs.

33. NHS Workforce Planning reported that:
   — There is a current shortfall both in trained neurophysiologists and trainees (at least 4.5% posts failing to be filled, but as Trusts close unfilled posts this an underestimate and there is anecdotal evidence of great difficulty finding clinical physiologists at all).
   — Initial training numbers are reasonable but there are high fall out rates, currently the average number of students qualifying in recent years has been 15.7, but in 2011 there are only 11 students and in 2012 there will only be two qualifying.
   — Projected numbers for 2020 show fewer neurophysiological scientists will be working for a larger population with potentially higher service demands.
   — Increased demand for neurophysiological scientists as practice changes—this is an increased demand for higher skills ie nerve conduction studies are now suggested earlier in pathways in the “map of medicine” than previously and will increase demand, also NICE guidelines ask for EEG after all first seizures which will cause a massive increase in EEG use.
   — Concern about the impact of training on EEG capacity as to be competent in basic EEG in current training takes two years whereas the changes and “generic” physiology training (suggested by Modernising Scientific Careers—see below) will mean that trainees would not be EEG competent at Y2 of the three year degree course.

34. The Modernising Scientific Careers agenda was laid out by Sue Hill in 2004 in “Making the Change”. The proposals were broadly welcomed as appropriate. The 2008 Darzi Report also understood and recognised the nature of the service.
35. However, in September 2008 Marion Scott speaking for the National Research and Development Office at National Blood Service meeting on Modernising Scientific Careers commented that assessments had shown the current scientific workforce needed overhauling as it was unaffordable and inappropriate and that graduates were “not needed to run machines”.

36. When the Healthcare Science Programme Board met in March 2009 they expressed concern about the detail of course transition and also about the funding of the training. “NHS management driving this forward will depend largely on cost implications and capacity delivery.”

37. The outcome has been that all the physiological scientists are being lumped together -neurology, respiratory, gastro-intestinal, cardiology and audiology. Each group has important clinical roles but their skills are not necessarily generic or transferable as the current plans for their group training assumes.

38. The skills required to undertake for example an EEG on a baby who is crying and a echocardiogram on a patient with an unusual chest shape are basic skills for each practitioner (neurophysiological and cardiological scientists respectively) but not transferable. The idea that a generic and brief training would produce competence across this wide skill mix is incorrect.

39. Recognised statutory registration by a professional group allows regulation and governance of clinicians and is particularly important where patient protection and standards of care need to be maintained. It is feasible if there is consensus as to the way in which care should be delivered and to what standard.

40. Neurophysiological scientists have maintained a voluntary register with the other clinical physiologists the “Registration Council for Clinical Physiologists”. They applied to the Health Professions Council in October 2003 who recommended regulation for this group to the Secretary of State for Health in 2004.

41. This process does not appear to be advancing at all despite regulation being on the Modernising Scientific Careers plan and the evidence having been provided to the necessary standard.

42. In the absence of concerted centralised action, this small but valuable group of clinicians upon whom there is increasing demand will not be replaced at anything like the required rate. The impact on practice and patient care would be severely detrimental.

December 2011

Written evidence from Yorkshire & Humber Innovation and Education Cluster (ETWP 34)

1. INTRODUCTION

1.1 This response is provided on behalf of the Yorkshire & Humber Health Innovation & Education Cluster Board (HIEC). Our response addresses several of the key themes of the inquiry.

1.2 The Yorkshire and Humber HIEC is implementing innovation across the region at pace and scale, we are using education to support the adoption and spread of innovation in three theme areas: Long Term Conditions, Maternal & Infant Health & Care and Patient Safety. We have launched innovative educational materials to support the practical implementation of innovation. We have done this to achieve real and sustainable service change to improve quality and/or increase productivity. All NHS organisations and Higher Education Institutes across the region are members and we have worked with them to shape and deliver our work (further information is available at: www.yhhiec.org.uk

1.3 The HIEC programme has supported the development of the existing workforce to deliver the Quality Improvement Productivity and Prevention (QIPP) challenge. Changing behaviours and individual practice is critical to mobilise and equip the current workforce to address this challenge.

1.4 It is hoped that the experience and learning from establishing the YH HIEC can make a valuable contribution to the health committee, particularly in relation to the importance of using education as a mechanism to drive the adoption and spread of innovation and improvement in the NHS.

2. EDUCATION AND TRAINING REFLECT THE CHANGING NATURE OF HEALTHCARE DELIVERY

2.1 Education is one of the most important ways to develop the workforce to deliver the adoption and spread of innovation in the NHS. Education should draw upon the latest evidence in a way that meets the priorities of the NHS (eg impacts upon quality, safety and productivity).

2.2 Education must draw more heavily upon the latest evidence base, both in terms of content and mode of delivery to ensure that we are maximising the investment in the National Institute for Health Research (NIHR) research infrastructure in the NHS.

2.3 The “journey” from evidence to implementation is a complex one, which requires a wide range of skills: to search and review the evidence base to, identify the need or problem, determine what possible solutions there are, determine how they should be implemented (including consideration of the methods of change), and how to monitor and measure impact. It is important to grapple with this complex journey. We have found that a facilitated approach is the most effective way to do this. For example, we have developed a facilitated
programme underpinned by education resources to support an increase in the number of women discharged from labour wards breast feeding, to increase normal birth and to reduce caesarean sections.

3. **MULTI-PROFESSIONAL AND MULTI-DISCIPLINARY LEADERSHIP AND ACCOUNTABILITY**

3.1 Education commissioning should not only focus on the provision of skills for staff, to support the workforce to be able to adapt and change to meet new service demands, it is vital that education supports the workforce to innovate for themselves within their own environment, so that they are empowered to deliver tangible and sustainable improvements in services. For example, we have developed a team based approached that facilitates clinical teams to address “problems” in their current work. This approach has yielded significant impact, one of the teams that we worked with increased the number of clinicians conforming to NICE guidelines for feverish illness in children from 14% to 90% during a 20 week facilitated support programme.

3.2 The new system provides an opportunity to maximise multi-professional learning, particularly for post registration learning and CPD. For example, the networks could think more creatively about professional doctorates, as a pre-cursor to joint academic/NHS posts across the professions (not just for medics). This could be supported by NIHR investment where a joint approach has been agreed that support delivery of NHS services and of NIHR Portfolio studies for example.

3.3 The “journey” from evidence to implementation is a complex one, which requires a wide range of skills to search and review the evidence base to: identify the need or problem, determine what possible solutions there are, determine how they should be implemented (including consideration of the methods of change), and how to monitor and measure impact.

3.4 A key barrier to adoption and spread is insufficient adaptation to local context. Top-down enforcement of innovation priorities is not successful. Adoption and spread must always be linked to local priorities. For example, we are working with organisations to implement technology rapidly. This is a facilitated programme underpinned with business support resources along with an online module.

4. **HIGH AND CONSISTENT STANDARDS OF EDUCATION AND TRAINING**

4.1 Shared learning supported by metrics can be collected to draw out generic lessons regarding adoption and spread. We have found this to be important to maintain momentum and to enable teams to undertake other improvements in a rigorous way.

4.2 Our education materials increase knowledge, but focus also on how to implement the knowledge into practice. We have found that training staff to deliver innovation focussing on an issue they are living through in order to learn a new approach is very effective. This learning can then be applied to other issues which creates sustainable change skills in the organisation.

4.3 An innovative approach to both the method and content of the education facilitates spread and increases impact. We have not viewed the development of education resources as an isolated activity, but have taken a wider view about how the education would underpin developments across a system. For example, we are working with every maternity and neonatal unit across the region to deliver increases in breast feeding and reduction in caesarean sections.

4.4 Evidence based innovation and implementation of research findings must be seen as crucial to the business of the NHS and therefore the NHS work. We have designed, shaped and delivered our work collaboratively and have co-created our resources to ensure they are relevant and are in a language that is appropriate to the audience. We are also working outside formal education commissioning as it can be difficult to quickly address new or emerging priorities. For example, we are working with a private company to develop an online module to support professionals to change the behaviours of patients (to adapt to technology and tele-health service provision) that will be available across Yorkshire and the Humber free of charge. This has happened relatively quickly and will be available in April 2012.

5. **DEVELOPING AND RE-SKILLING THE EXISTING WORKFORCE**

5.1 Driving innovation through education is important to achieve spread at and scale. Using education as a tool to develop the workforce maximises the benefits from integrating evidence and research findings. With >60% of the NHS budget used to fund workforce (NHS Choices, 2010), it is critical that the workforce is equipped and skilled to spread innovation in their practice.

5.2 Our approach has been to train staff to deliver innovation focussing on an issue they are living through in the course of their work in order to learn a new approach which can be applied to other issues. This approach provides staff with the skills to implement innovation and manage the change associated with it. This means our approach can lead to sustainable changes in organisations.

5.3 Driving innovation through education is a way to ensure that the workforce is able to implement and spread innovation in a sustainable way; we have developed several creative ways of achieving this.
5.4 Facilitating collaborations between sectors and establishing partnerships is critical to achieve spread at scale. New innovations do not necessarily require new networks, engaging with existing networks and communities with a focus on working together to support service change is important.

5.5 Partnership working is critical to ensure appropriate understanding of both the problem, and the development and implementation of the solution. Buy-in from both senior leaders and staff on the ground is crucial to ensure sustainable change.

5.6 To achieve improvement across the system requires a coordinated strategic approach to priorities across a patch. The YH HIEC has achieved real change as a result of bringing different stakeholders together, we have focused on growth and improvement rather than compliance and standardisation.

5.7 Whilst there is a requirement to demonstrate a strategic and operational resonance with national objectives, there is a delicate balance between national standards/objectives and local ownership and control. The key to success is local engagement and relevance.

5.8 The workforce must be able to support both the “new” research, invention or innovation as well as the adoption and spread of existing (but not yet implemented) ways of working. The priorities for adoption and spread must resonate with the challenges of the workforce and the NHS, as well as being sufficiently adaptable to local context. This requires education around innovation science, improvement science and change management.

6. Conclusions

6.1 Education is a key vehicle to deliver transformational change in the way that the existing workforce deliver the priorities of the NHS, as well as shaping the new workforce throughout their pre-registration training.

6.2 Education plays a critical role in supporting the adoption and spread of evidence based and innovative practice in becoming “the norm”. Education that empowers the workforce to innovate for themselves in their own environment is important to deliver tangible and sustainable improvements in the services they deliver.

6.3 The adoption and spread of innovation must be commissioned, not just the innovation. There is a significant “journey” between innovation and implementation, it is important that the “journey” is systematically managed and facilitated to create real service changes.

6.4 The approach we have taken was carefully designed to ensure that we were working across disciplines and sectors, as such our approach is easily transferable to public health and/or social care.

December 2011

Written evidence from the Foundation Trust Network (ETWP 35)

1. The Foundation Trust Network (FTN) is the membership organisation for public providers and gives a distinct voice to NHS Foundation Trusts and those working towards FT authorisation. The FTN has 216 members from across the acute, mental health, community and ambulance sectors. In a recent survey of members, NHS providers clearly expressed the view that the FTN should be the means by which employer voice is heard.

2. FTs will represent the vast majority, some 95%, of providers in the NHS at the implementation of the system reforms and they have a critical interest in the success of the proposed workforce framework. We welcome the government’s proposals for reform of education and training as they are consistent with the direction of wider NHS reforms and offer employers the opportunity to work with professional stakeholders to shape a workforce that is attuned to the immediate and long-term needs of served populations.

Executive Summary

3. Our response focuses on the following issues that we hope are of interest to the Committee’s inquiry:
   — The importance of provider-led architecture.
   — System alignment.
   — Local Education and Training Boards.
   — The place of innovation and research in those Boards.
   — HEE governance and transition.
   — A more plural provider market and supportive funding flows.
   — Flexibility in training programmes.
   — Centre for Workforce Intelligence and NHS Employers.
   — Conclusions—what is needed?
DISCUSSION

Provider-led architecture

4. The government’s emphasis on a provider-led framework for the new workforce planning, education and training arrangements is welcome as it has the potential to give providers the autonomy to manage their staff resource appropriately, enabling a responsive system that is efficient, effective and best-gearied towards meeting patients and populations’ needs.

5. This is a once in a generation opportunity to design and implement an education and training system that embodies greater local accountability, decision making closer to patients, and heightened clinical engagement, to meet both immediate needs and longer-term workforce requirements.

6. Providers will want to work on this task with appropriate professional input and advice; if a professional interest or organisation is well placed to add value to consideration of workforce issues—such as standard setting and quality assurance of training—then they should have the opportunity to contribute as part of agreed processes. Foundation trusts recognise the need to ensure all relevant stakeholders are involved in creating the strategies and plans and feel that their voices are heard.

7. However, the importance of employer leadership on these matters should remain the focus of attention—employers need the freedom to plan and allocate resources in cost-effective, responsive and innovative ways, across new modes of delivering patient-centred care. Employers should articulate a vision and specification and professional advice should look to support this being realised.

A system in alignment

8. A provider-led architecture in the workforce domain provides the necessary consistency and alignment with the wider NHS system reforms, enabling providers to respond to clear service commissioning strategies by investing suitably and innovatively in a workforce that provides patient-centred care, increasingly out of acute settings.

9. NHS foundation trusts recognise that they need to demonstrate that they are ready to take on enhanced responsibility for workforce issues, but in areas where freedoms already exist, the track record of stepping up to the challenge is there to see. As we outlined in our original response to the DH workforce consultation, since becoming NHS foundation trusts providers have taken increasing responsibility for securing a successful, sustainable future for their services on behalf of the populations they serve. With their freedoms FTs have made unprecedented investments to secure long-term benefits from new facilities (driving quality and safety improvement), research support (prioritising innovation) and staffing (often in new roles such as theatre practitioners and acute physicians).

10. Healthcare providers working in the proposed Local Education and Training Boards (LETBs) are ready to take on full responsibility for planning and developing their own workforce with strong clinical and professional leadership.

Local Education and Training Boards (LETBs)

11. FTN members are currently working on appropriate shadow arrangements for LETBs. We consider that providers should have the freedom to determine organisational form, with suitable assurance arrangements in place to enable HEE to hold LETBs to account for planned outcomes. We advocate a localised approach that appropriately incentivises employer participation—LETBs need to demonstrate value to providers and a return on investment—in terms of senior management time and appropriately trained staff that are best placed to deliver productive quality care.

12. We consider that any perceived conflicts of interest can be managed through transparency of operation and clear contract management approaches.

LETBs and deaneries

13. LETBs should be positioned to commission a fit for purpose workforce that is aligned with providers’ demand—which includes ensuring that the LETBs determine the number of training places in a given specialty. The new LETBs need to look and feel different from the current SHA/Deanery commissioning functions as they need to be much more employer-led. However it is acknowledged that individual expertise exists and will need to be secured by the new system. LETBs should assume responsibility for the functions of deaneries as soon as practical, achieving the right balance between an important smooth transition and sustaining momentum.

Education and training linked with research and innovation

14. Innovation is closely aligned with education, research and service delivery—and leadership on the provider side is needed. There is a compelling case therefore to situate innovation funding and support with LETBs, building on the success of Health Innovation and Education Clusters (HIECs). HIECs have served better to engage NHS organisations with Higher Education institutions; and which, with relatively small
dedicated resource have been able to achieve traction on the ground (for example allocating Regional Innovation Funds), making progress towards the goal of diffusing innovation.

**Academic Health Science Networks**

15. These “enhanced” LETBs described above, fully enabled to work in partnership with Academic Health Science Centres and emerging Academic Health Science Systems/Networks where appropriate, offer a real opportunity to deliver the necessary capacity and incentives in the system for employers to come together with stakeholders and work to address long term strategic issues. They offer a means of ensuring a wider coverage of research orientation and culture within the system as a whole, supporting academic medicine, for direct patient benefit.

**HEE governance and transition**

16. The new system is designed around a number of principles including “doing at national level only what is best done at national level”. FTN considers that Health Education England (HEE) will be most successful by focussing on:

- (a) Outcomes and accountability for outcomes, rather than performance management;
- (b) Enabling flexibility of LETB design to meet local needs and inspire provider confidence;
- (c) Overseeing the national allocation of MPET resources and leading negotiations with DH and HMT on funding for healthcare education and training;
- (d) Identifying national workforce priorities and pressures drawn from the workforce plans of the LETBs;
- (e) Setting standards for the quality of healthcare education; and
- (f) Scrutinising LETBs’ plans and holding the Boards to account for meeting both immediate and longer term requirements and for addressing the needs of the whole healthcare workforce.

17. HEE should be independent of the NHS Commissioning Board in order to support provider confidence. Its reporting line should be to the Department of Health.

18. Workforce issues are currently being considered by the Future Forum and in our submissions on these matters we have argued for a strong continuing commitment to provider-led arrangements and an enabling framework that ensures that provider ambition can be properly realised.

19. This implies independence for LETBs and means that the national HEE infrastructure needs to have a strong scheme of delegation, exhibiting the governance and behaviours in transition to support ultimate LETB independence.

**A more plural provider market and supportive funding flows**

20. We welcome the direction of travel towards a tariff and provider levies (though the operational detail of the latter requires further discussion); this should be managed in a manner that promotes provider stability.

21. This approach will ensure fair distribution of funding over time and enable employers to exercise suitable control over commissioned outcomes. It will also facilitate new providers’ contributions to the costs of training.

22. The transition to tariff funding of educational activity should be completed before introducing the change from an allocation system to a provider levy to fund workforce development budgets. Levies should fund the LETBs and those levied should have appropriate controls—we should welcome further conversations on how funding formulae will be devised.

23. The described approach sends a strong message about the government’s will and supports all employers across the sector maintaining a strong and comprehensive interest in the suitable delivery of the education and training function. It is important to achieve a re-distribution of cost on a fair and proportionate basis.

24. The workforce requirements of non-NHS healthcare providers will need to be accommodated through the new system and what is proposed at the level of principle appears a reasonable way of achieving support for the whole healthcare workforce. Clearly further discussions are required. As a general point, we anticipate that the new NHS framework will prompt more partnership working between NHS and alternate providers and workforce questions will be addressed in part through navigation of these new partnerships.

**Flexibility in training programmes**

25. As the new architecture is put in place, it will be critical that providers are able to make best use of resources for the benefit of their served populations and staff. An important variable here is the flexibility to direct resources to meet demand, without undue delay. This flexibility will be critical, not least in clinical training programmes, so that the professionals trained today can respond suitably to the requirements of tomorrow.
26. Flexibility has an immediate importance as employers, particularly those (but not exclusively) who have recently acquired community services and who are looking to generate cost savings and staff re-deployment opportunities across their portfolio of services.

27. We understand that the Future Forum is looking supportively at the flexibility of training programmes and we hope that the Select Committee will consider strongly supporting flexibility in its recommendations.

Centre for Workforce Intelligence and NHS Employers

28. The Centre for Workforce Intelligence (CfWI) will be an important source of workforce data in the new system and the FTN is working with colleagues in the CfWI to ensure that the Centre has an appropriate understanding of employer priorities.

29. We are carrying out a survey of members to evidence base this work and will be contributing perspectives on the proposed CfWI business plan into Spring 2012.

30. NHS Employers has performed an important role in providing support and guidance to providers on workforce issues. They have been contracted by the DH to negotiate national agreements on behalf of the service. The shape of their offer in future should increasingly be determined by the needs of providers of NHS healthcare and their ability to meet that need.

Conclusions—what is needed?

31. FTN is enthusiastic about the proposed reforms as the issues of commissioning education and training and the planning of workforce requirements are the issues that have, hitherto, acted as one of the key barriers to NHS foundation trusts realising their full potential.

32. While some stakeholders in the NHS have expressed concerns about changes to the structures and funding flows associated with the workforce reforms, we consider that these can be managed and indeed are being managed. As we have noted, in areas where they already have freedoms, FTs have a track record of investing for the long term in quality and FTs as organisations have a clear and direct interest in a quality workforce.

33. We consider that for the proposals to have the best chance of success there is a need for a provider-led approach, suitably incentivising providers to participate. This is best achieved through a visible system commitment to locally-owned LETBs that are supported and encouraged by a HEE scheme of delegation that is assurance-based. Tariffs and levies, supported by robust contract management will ensure system transparency and a check on quality but transition should be managed sensibly and with regard to wider NHS changes.

December 2011

Written evidence from Committee of GP Education Directors (ETWP 36)

THE HEALTH COMMITTEE INQUIRY INTO EDUCATION, TRAINING AND WORKFORCE PLANNING

1. The Committee of General Practice Education Directors (COGPED) offers a forum for UK wide Postgraduate GP Directors to meet and share good practice

COGPED’s aim is to encourage and maintain a consistent approach to GP training across the United Kingdom. It is a focal point for communication between the Postgraduate GP Directors and other stakeholders such as Royal College of General Practitioners, BMA, GPC, GMC, NCAS, GMC and various sections of Department of Health.

COGPED has a record of achievement and leading partnership with other stakeholders in meeting its objectives eg National coordination and standard setting of Selection to GP Training, Higher Professional Education for newly qualified GPs, Out of Hours Training arrangement for GP Registrars, quality standards for training practices and a number of other initiatives related to medical education standards and workforce issues.

COGPED members are individually answerable to the postgraduate Deans in COPMED but work collaboratively to provide a national GP perspective. COGPED works both on behalf of, and with, COPMED to address issues in which GP expertise is required.

2. COGPED wishes to submit evidence concerning:

— 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;

— How funding will be protected and distributed in the new system;
— How future healthcare workforce needs are being forecast;
— The impact of people retiring from, or otherwise leaving, healthcare professions; and
— The place of overseas educated healthcare staff within the workforce.

3. *Provider Skills Networks/Local Education and Training Boards.* At a COGPED workshop on **Provider Skills Networks/Local Education and Training Boards held November 2011** COGPED recommended that:

— GP Directors, alongside Postgraduate Deans, should be members of the Executive of the Provider Skills Networks/Local Education and Training Boards.

— GP Primary Care provider representation on the boards should be at least 20% of the membership of the board reflecting the fact that almost 50% of fully trained NHS doctors are General Practitioners and because 90% of NHS care is delivered and coordinated from General Practice.

— The transition to Provider Skills Networks/Local Education and Training Boards should not disrupt core business of postgraduate deaneries: (i) commissioning suitable training placements and programmes for specialty training (ii) high level quality assurance of postgraduate medical education and training including assuring patient safety in training environments (iii) ensuring successful recruitment to specialty training programmes (iv) management of any performance concerns relating to doctors in training.

— The Provider Skills Networks/Local Education and Training Boards should ensure the provision of CPD (Continuing Professional Development) in all providers of NHS services and primary care should receive a transparent and equitable allocation of CPD resources. There is a specific risk in primary care, during transition and beyond as Primary Care Trusts are wound down at the same time as Strategic Health Authorities. Key areas such organizational memory and performance support mechanisms may be lost as the proposed architecture has little detail on this area of workforce support and development across the wide range of professionals providing key services through multidisciplinary teams. CPD is a catalyst for service development, and, in primary care, is frequently undertaken at individual practice level involving the wider clinical and administrative teams. There is a risk of increasingly narrow “localism” without input from medical and nursing educators who are currently supported by postgraduate deaneries and PCTs respectively.

— Provider Skills networks should continue and develop specific educational initiative supporting the assessment and retraining of UK qualified GPs after significant periods out of the primary care workforce, GPs from the EU and the rest of the world, and those identified as having performance concerns through appraisal or investigation by NCAS or the GMC. There should be a person specification for board members and the GP provider person specification should include: (i) experience of education in primary care (ii) board level experience as a primary care provider (partner or equivalent) (iii) good record of communication with key stakeholders such as Local Medical Committees, educator networks.

— There should be input to the Provider Skills Networks/Local Education and Training Boards regarding the population health needs of the population for whom the Provider Skills Networks/Local Education and Training Boards are commissioning the future NHS workforce

4. **Funding**

COGPED wishes to ensure that there is adequate funding to train the primary care workforce to meet the needs of patients recognising the allocative efficiency of training primary care generalists compared to the high total costs of training secondary care specialists.

5. **Future healthcare forecasts**

COGPED recognises that current GP training outputs are insufficient to meet the predicted need for GPs. COGPED recommends that training opportunities in oversupplied specialities should be reduced in order to create some push into GP Specialty training.

6. **The impact of retirement from General Practice**

COGPED has noted the significant proportion of GPs stating an intention to retire within the next two years in the recent BMA survey and has also the age profile of GPs from the NHS Information Centre which shows that the proportion of the GP workforce aged over 50 years has increased significantly in the past decade. COGPED believes that it is possible to increase participation and service contribution in the early years of a GP’s career by extending GP training to better prepare new GPs for their expanded roles and responsibilities in the NHS.

7. **The place of overseas educated healthcare staff within the workforce**

COGPED has been concerned that poor language skills from European Union graduates with no UK NHS experience have a potentially adverse impact on patient safety. COGPED would support the further
development of its robust system that resources and mandates consultation or communication skills training and competence testing in this group of doctors.

December 2011

Written evidence from the Royal College of Radiologists (ETWP 37)

1. The Royal College of Radiologists (RCR) has approximately 8,900 members and Fellows worldwide in the disciplines of Clinical Oncology and Clinical Radiology. All members and Fellows of the College are registered medical or dental practitioners. The role of the College is to advance the science and practice of Clinical Oncology and Clinical Radiology through a range of activities, including setting and maintaining standards in the specialties of Clinical Radiology and Clinical Oncology. This includes defining training curricula, reviewing training standards, setting specialty examinations and developing and delivering the arrangements for continuing professional development (CPD) in both specialties.

2. The RCR welcomes the opportunity to submit evidence to the Health Committee. This response draws on the College’s expertise in the field of postgraduate medical education. We especially focus on:
   — The need to recognise the pivotal role of the medical Royal Colleges in defining quality standards in training, developing postgraduate medical training curricula and defining the standards for the quality assurance of medical training.
   — The need for protected time for clinicians to carry out this type of work on behalf of the wider NHS.
   — The need to preserve the role and function of the Deaneries.
   — How Health Education England should be an independent, impartial body providing national oversight of medical education in England. To avoid potential conflicts of interest, it must not be employer-led and should liaise with all appropriate organisations.
   — Adequate funding for medical training and education must be in place and should be controlled centrally.
   — The importance of research to the RCR’s two specialties.
   — The fundamental role of the colleges in the development of standards for and delivery of Continuing Professional Development (CPD).
   — How effective medical workforce planning is essential for the future of the NHS and must be carried out on a national basis.

3. The RCR would like to emphasise that we see significant potential dangers, risks and detriment to the structure of medical education and training in the proposals. The organisational changes and multiple supplier delivery of healthcare in England envisaged by the Health and Social Care Bill will exacerbate this. In particular, the Bill has serious flaws, and the consequences of the suggested changes appear not to have been thought through fully. This can only lead to lower quality and more inconsistent patient care. Furthermore, medical training in England would become less attractive which would be a major loss to the country as a whole. The RCR believes that the Bill requires serious modification before enactment. If this is not achievable, the sections of the Bill with implications for education and training should be withdrawn.

Education and Training

Quality standards and patient safety, curricula

4. Excellence in training is at the heart of a high quality NHS. High quality training ensures the highest standards of care and patient safety. Any loss of national standards for medical training will result in variable standards in medical care. High standards are essential and must evolve to meet the needs of patients as medicine advances.

5. The RCR supports the Academy of Medical Royal Colleges (AoMRC) in seeking an amendment to the Health and Social Care Bill to include an explicit duty on the Secretary of State to maintain a system for professional education and training incumbent on all providers as part of the comprehensive health service as promised in the Government response to the Future Forum.

The role of the medical Royal Colleges

6. The medical Royal Colleges have extensive and unique experience in developing quality standards in training and CPD. It is essential to use this expertise if future plans for education, training and workforce development are to result in the highest standards for UK healthcare.

7. The curricula for postgraduate medical training defined by the medical Royal Colleges are GMC-approved as fit for purpose for each discipline. They are constantly updated to reflect changes in practice and the changing healthcare needs of the nation. For example, the RCR Clinical Radiology curriculum has been updated to incorporate the new imaging modality of PET/CT.
8. Senior doctors who deliver and develop healthcare services are best placed to develop postgraduate medical curricula to ensure that junior doctors are appropriately trained. Senior doctors are also the only group who are able to determine accurately the level of expertise required to deliver excellence in medical care.

9. The colleges (with the GMC) are the only organisations with experience of defining the standards for quality assurance of medical training.

10. The colleges are informed, proactive, expert organisations and essential components in high quality medical training. The voluntary input doctors make via the colleges is a hugely beneficial resource to the NHS and a very cost effective way of delivering the work.

11. These activities must be recognised for the value they bring with employers allowing medical professionals the time to be involved. The RCR has been working with the AoMRC to seek an amendment to the Health and Social Care Bill to ensure protected time for clinicians to carry out such work on behalf of the wider NHS. This is necessary as the work of the colleges is pivotal in supporting the NHS to ensure optimum, safe medical care for all patients.

The role of the Deaneries

12. The RCR believes that the role and functions performed by Deaneries is essential and they must be preserved if quality assurance of training is to continue to be effective.

13. Deaneries provide essential input into medical training and education. Their role has evolved over many years and is now fully embedded and functioning well. They ensure comprehensive training in a variety of environments to meet the needs of the NHS.

14. With the demise of SHAs, a satisfactory regional structure must evolve which allows Deaneries to continue to function well, without reducing or compromising their resources.

Training and trainers

15. Medical training is almost entirely delivered by doctors.

16. The medical Royal Colleges are the professional focus for doctors with major roles in training, education and CPD. The RCR ensures that trainers are equipped to offer optimum training in clinical radiology and clinical oncology. Specific education and training is delivered whenever new teaching or assessment methods are introduced—eg introduction of workplace-based assessments in 2010. There is also a rolling programme of updates for trainers cascaded nationally.

17. The colleges maintain and set national standards to be achieved by doctors by the completion of training to permit entry to the specialist register. They advise the General Medical Council (GMC) whether doctors in training have met these standards to ensure safety and quality of care in the NHS. Only specialists in the relevant clinical area are in a place to undertake this role.

18. The colleges support the GMC by reviewing the quality of medical training nationally across specialties.

National oversight

19. The RCR firmly believes that independent, impartial oversight of medical training in England is essential. From experience of working with Medical Education England, we consider an appropriately structured Health Education England (HEE) with the appropriate governance structure can fulfil this role.

20. HEE must be free from any inappropriate dominating majority that would threaten its impartiality.

21. NHS Employers has recently stated (NHS Employers bulletin 07/11/2011) that it believes “the HEE Board should be employer led”. The RCR considers it would be wholly inappropriate for any constituent organisation to “lead” or dominate the Board.

22. Similarly, the RCR believes that, for medical education, NHS Employers statement that “commissioning of services and education must be locally managed if employers are to lead significant changes in how services are delivered” is seriously flawed:

— Commissioning of training by those charged with hosting/providing it (Local Education Providers) would introduce inappropriate governance arrangements.

— Employers may wish to support education, but there is a conflict of interest between service delivery and education. Experience has shown that education suffers when services are under pressure.

— Employer organisations have no experience in the design or quality assurance of medical training.

— As the Government wishes to put doctors and nurses at the forefront of NHS service development, it is logical and appropriate that they should therefore lead change and deliver the training required to facilitate change.

23. An independent HEE liaising with all interested parties, including the medical Royal Colleges would be capable of ensuring that training to staff national initiatives eg cancer networks, major trauma services etc, is
taken into account. Training devolved to local level would have no such overview or mechanism for ensuring the totality of training requirements.

**Funding for education and training**

24. Adequate funding for medical training and education is essential. The RCR believes the Secretary of State for Health must take responsibility for ensuring this and funding must be nationally derived and transparent.

25. Funding should follow education and training outputs, ie funding must ensure that there is protected time for training and that training is a planned activity encompassed within the trainer’s job plan.

26. Specified time for doctors in training and education, both local and national, must form an integral part of the future NHS. *Lack of designated, funded supervision of doctors in training is a serious risk to patient safety.*

27. It is essential that doctors have time within their job plans throughout their careers to ensure that they can develop new knowledge and skills required to deliver optimal patient care through continuing professional development.

28. The value of training and education in the future NHS must be recognised. It must be planned and adequately funded. A national levy for training, though currently not perfect, is the best way forward.

29. Funding for medical training *must not* be devolved to local level where there is competition with funding for service delivery. The funding streams *must* be kept separate and distinct if standards of training are to be preserved.

**Privatisation and competition**

30. The RCR is concerned about private provision of medical education and training. It is untried and untested. Evidence suggests that non-NHS/non publicly funded providers are reluctant to become involved with no incentive for them to do so.

31. Privatisation of service delivery can lead to a reduction in training opportunities, despite independent providers being currently charged with providing this. In radiology this has occurred with outsourcing of image reporting and teleradiology.

32. All providers of health care, within the NHS or the private sector, should contribute to the cost of training and education.

**Research and academia**

33. Research is crucial for the NHS if it is to deliver world class healthcare. It drives healthcare advances and provides the evidence base for best clinical care. Training in research and research methodology is embedded in the curricula devised and implemented by colleges and approved by the GMC.

34. All doctors must be trained in research and able to support entry of patients into clinical trials if the NHS is to be at the forefront of treatment innovation. It is also essential that clinical academics are recognised for the value they bring to the NHS and supported by the necessary structure and funding.

35. Research is particularly essential to the RCR’s two specialties, with the re-emergence of radiotherapy as a leading cancer treatment, rapid advances in drug therapy for cancer and the constant development and technological innovation in imaging coupled with the central role it occupies in patient management. Our specialties are attractive to trainees because of this technological development and the pace of change.

36. National oversight of academic medicine and training is essential. HEE, in conjunction with the National Institute for Health Research and the Academy of Medical Royal Colleges, is in the best position to ensure that these needs are met and that local providers do not “opt out” in difficult circumstances. HEE, in facilitating a working relationship between medical and other health sciences researchers, should expand the use and implementation of evidence based practice.

**Continuing Professional Development (CPD)**

37. Medical Royal Colleges draw on the expertise of their members and Fellows to provide a range of training and educational activities for doctors post CCT, enabling them to offer optimal, up to date care to their patients. The RCR will facilitate this through a range of online CPD resources, along with a more traditional scientific programme of conferences and meetings.

38. The RCR is seeking to influence medical school curricula to ensure that newly qualified (Foundation) doctors have the necessary competencies to relate effectively with clinical oncology and clinical radiology. The RCR philosophy is to support a continuum of learning throughout a medical career.

39. Medical CPD has to be designed by the professions to be fit for purpose within a framework designated by the GMC for the maintenance of standards of practice and patient safety. The RCR has the expertise to support clinical radiologists and oncologists throughout their careers to ensure that they maintain and develop
the new competencies required in the modern NHS. This cannot be devolved locally if national standards are to be maintained, although local practice of individuals must be taken into account during assessment.

**Workforce Planning**

40. Effective workforce planning is essential for the future of the NHS. It needs to be more responsive to change. We currently have clear examples of where the medical workforce needs to change (reduction in general surgery, increase in primary care and psychiatry), but where change is slow to be implemented.

41. Employers must be prepared to invest in the workforce by expanding and contracting trainee and consultant numbers where required.

42. Skills mix is only one aspect of the answer to the new workforce. The RCR is a staunch advocate for skills mix and multi-disciplinary working, but, whilst ensuring that professional resources are used to best advantage, it does not negate the primary need for a medical workforce of appropriate size and training.

43. The Centre for Workforce Intelligence (CfWI) is beginning to mature as an organisation in workforce planning. This process will improve with further collaborative working.

44. CfWI should be a data processing resource and not be involved in developing policy.

45. The RCR has identified a need for increased capacity in the training numbers for its specialties in order to fulfil the changing and growing demands in areas such as acute oncology, technical radiotherapy and diagnostic and interventional radiology.

46. Medical workforce planning cannot be devolved to local level, especially for small specialties, as a fragmented, dysfunctional service will result. It is impossible to develop reliable local workforce planning models. HEE should take the lead in developing workforce policy, with support and data from the Colleges.

December 2011

Written evidence from De Montfort University (ETWP 38)

We are a University which provides quality and distinctive education and training in numerous healthcare professions. We currently have many courses directly commissioned by NHS commissioning bodies and we do this at both undergraduate and postgraduate levels.

— We have particular concerns about how universities will play a part in informing transition to the new system(s) and how universities will subsequently work in true partnership with education-commissioning bodies.

— We are unsure as to the routes of communication of all these new initiatives around changes in education commissioning. We have consulted widely with our stakeholders, NHS Trusts and partners, and knowledge of some of the bodies outlined below is patchy.

— The outcomes of the proposed National Education and Training Outcomes Framework must be linked to the health outcomes frameworks if we are to address health need and health inequalities within England; we need to fix the line of cohesive actions into one of seamless attention. At De Montfort University, we are doing this within our new pilot of communities of practice: for example our health visitor/children’s community of practice links the educational curriculum to breast feeding rates, safeguarding, speech and communication outcomes. This clear line of sight between education and outcomes for the people we serve is essential. If there is one item from this consultation response that is identified as crucial, it is this point.

We would welcome the opportunity to present evidence to the committee verbally.

1. Plans for the transition to the new system, up to April 2013

It is important to have clarity and a recognition of the time required to implement change as a number of bodies, both new and old are involved. Communication is paramount in gaining clarity of the transfer of functions and staff. At present communication on process leading to final destination is unspecified and therefore at the front line is unclear. HEIs and Trusts may deal with more than one SHA/LETB so a national overview of the transition process would be beneficial. Action must be taken to prevent loss of education and training expertise/experience and organizational memory in Strategic Health Authorities (SHAs) and Deaneries that has evolved over many years.

2. The future of Health Innovation and Education Clusters

It is difficult to fully evaluate the impact or importance of HIECs at this stage. It is too early to assess the individual project successes and hence the functionality of the HIEC. Locally projects are progressing well with innovation at the forefront. This cohesion is an important component of building relationships and outcomes for patients. Generally though, HIECs have been well received as their role has become clearer and their
operational structures have been embedded. It would be important to facilitate this local response to innovation, directed by clearly laid out local priorities.

3. The role of the Secretary of State for Health in the new system

The secretary of state for Health needs to remain fully and personally accountable for the education and training needs of the NHS. There must be no devolution of these responsibilities. There are suggestions that the precise wording of the Health & Social Care bill currently going through the legislature will remove ultimate responsibility of the SoS from duty and provision of care, but essentially it asks a fundamental question about where responsibility lies and whether politicians should or should not have a role in health care delivery—it could be said they shouldn’t, for fear of micromanagement, however realistically in a democracy and a publicly-funded system, what is the alternative; accountability to a non-elected head of a “quango”?

4. The proposed role, structure, governance and status of Health Education England and its relationship to professional regulators and to the other parts of the new NHS system architecture

This issue has a lot to do with professional standards and the institutional nature of professions. Professional regulators like the GMC, GPhC, HPC and NMC have significant influence over their member professions and how they want them to be trained. Some may argue this is about protecting professional interests, others may say it’s about maintaining standards. The “truth” probably lies somewhere in between, but there is no doubt that the traditional ways of delivering care are no longer appropriate given the underlying social causes of health (eg do we need as many specialists in traditionally-defined medical and clinical specialties working in a multitude of hospitals when one of the biggest threats to health is lifestyle and obesity)?

The Chair of HEE should be a senior academic with recent HEI experience of healthcare education. We feel strongly that the role of chair of HEE should be open to all qualified applicants, regardless of them being a “clinical academic”. The chair of HEE being a non-medical healthcare professional would send out a strong message that HEE is inclusive and reflecting the changing nature of UK health needs. HEE needs to appropriately balance the national and local picture of workforce development needs. Local workforce need may require commissioning of education that may not be a national priority and vice versa. The role of CIWI in informing HEE regarding these competing pressures is crucial but obtaining sufficiently robust information may be problematic.

5. The proposed role, structure, status, size and composition of local Provider Skills Networks/LETBs, including how plans for their authorisation by HEE 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

Care needs to be taken in the establishment of LETBs: there should be requirements to involve universities from the outset, including their formation in shadow format and to have an independent Chair. There needs to be two-way communication with universities (the reporting arrows need to be bidirectional, otherwise it does not reflect a true communication strategy). There is little doubt that CCGs are about to be given enormous spending power and how they are regulated is key, not to mention whether they have the skills to commission for large populations (hence DMU trying to develop education provision in Clinically-led commissioning). As purchasers but also providers of care, who is to say whether their decision not to refer and instead self-supply the treatment is the right thing for the patient’s well-being or part of a wider strategy to contain costs?

6. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

It is important that those who deliver the required professional leadership are clinical academics from all healthcare backgrounds who have a unique and valuable position of being involved in the delivery of healthcare and health education, and are at the forefront of relevant bioscience and healthcare research. It is essential that academics, educationalists, healthcare professionals and employers work together to create programmes that will be proper foundations for entire careers and which take account of patients’ requirements and the need to embrace scientific advances and innovation in healthcare. There is currently little respect for university planning, quality and delivery processes around commissioned education and this needs to be redressed.

There needs to be a clear understanding that HEIs have to straddle both public and private markets. Universities cannot take a passive stance and wait to see who wins contracts for services where, but need to be planning education provision from the outset of policy. This will need all governance mechanisms to be reviewed across the system. Locally we will use existing machinery in place and invite additional members (other education providers and professional regulators).

7. The implications of a more diverse provider market within the NHS

Has this consultation gone out to potential private providers? A large proportion of pharmacy graduates enter community pharmacy for example where there is extensive interaction. From a university point of view there appears to be a grey area of commissioning education for NHS workforce planning needs but graduates going
into the private sector (as with learning disabilities nursing for example). The move towards “any qualified provider—AQP” needs urgently reflecting in workforce planning.

How are we going to manage the cost of training our future clinical experts? If the public purse is concerned with value for money, efficiency and cost containment, alternative providers may not quite have the same moral commitment to providing training alongside ultra-efficient processes of care, eg training junior ophthalmic surgeons means you can’t reduce patients on a cataract waiting list, as training necessitates a focus on “learning” rather than throughput. The private sector markets itself on speed and efficiency. We do not feel, unless it goes into legislation, they have any incentive to take on training grades and therefore raise their cost-base through lower productivity. Another issue is continuity of care—there is a real danger of a loss of continuity as patients move around the system. We ideally need an integrated cross-sector approach to patients’ health care records, (such as the carte vitale in France) if we are to mitigate against continuity of care issues within a diverse market.

8. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

The needs of the patient population should be the first consideration above all else. Related to the above comments regarding diverse providers, there needs to be some form of agreement around training, ensuring that the skills required for the future are developed in those going through the peri-training grade part of their career, wherever they happen to work. Community pharmacy services in particular lie largely within the private sector whilst also delivering an important and growing NHS agenda that must be recognised in any future educational strategy.

9. The role of the Centre for Workforce Intelligence

The visibility and profile of the CfWI is poor, certainly amongst us, our partners and stakeholders. The ideology behind the CfWI is laudable but its aims may be hard to achieve in practice, and may end up being aspirational. Real time information in this kind of arena is impossible to keep accurate. Will the CfWI have effective systems of communication with those bodies it interacts with?

Workforce planning is currently subject to acute events. This means that there is no continuity or cyclical nature of workforce planning. Links with HEIs are poor or non-existent in some cases. There is a sense of apathy. Workforce planning should be centred on patient need. There should be a recognition that when HEIs plan courses that they are also planning provision for graduates to work outside the NHS/public sector but in arenas which will collaborate with the NHS/public sector. Better resources will be needed to allow CfWI to provide LETBs with the information required. Workforce planning must also take a four country approach. When considering “cross-boundary flows” thought must be given to movement within the four countries of the UK and into the UK from overseas.

10. The roles of Skills for Health and Skills for Care

The importance of utilising research as an informant is vitally important here: readiness to learn, to study and consequential readiness to work is a sequence of events that all contributing organisations need to work on. HEIs are well placed as a central place to assist with this progression.

11. How funding will be protected and distributed in the new system

Universities and service providers need to know how funds will be protected for such a dynamic agenda as healthcare education. How will these funds be protected and allocated with respect to the diversification of the workforce and in particular “any qualified provider” provision? There needs to be clarity and transparency about the equality of distribution across medical and non-medical areas. It is critical that DH understand that currently postgraduate provision and “Learning Beyond Registration” (LBR) is how universities react quickly and adapt to acute and new policies. Perhaps the most important factor in developing a workforce responsive to service need is this LBR type education. Devolution of funding to individual Trusts will need careful management to ensure education providers receive coherent commissioning intentions that offer sufficient economies of scale.

12. How future healthcare workforce needs are being forecast

It is extremely difficult to know what will be needed in the future. However, we expect diseases/conditions to come to the fore that relate to social determinants and lifestyle factors so we may need a balance which favours more generically trained staff and not specialist trained staff (of course, we will still need specialist experts to deal with acute medical/surgical issues). Where is the incentive for this to be done at population level for the benefit of the future population, if we devolve this responsibility to individual organizations, who will want to look after their own interests? How flexible and responsive a workforce can we have given the nature of collective bargaining and professional interests? There is currently little confidence that national agendas are being properly translated regionally. Local workforce planning is subject to knee-jerk reactions to acute policy events or workforce “gaps”.

13. The impact of people retiring from, or otherwise leaving, healthcare professions

Again linked to the above, this would give us an immediate skills gap and in the past we have recruited from overseas to plug such a gap. More needs to be done to attract young people into health careers, without frightening them with the skill levels required. We need to be creative about routes into employment—perhaps a proper apprentice-type scheme that eases them into it, or even given the likelihood of the future disease burden, more training on issues around generic health concerns (as we do on our Health Studies course at DMU), or those that are about nutrition/exercise/behaviour. As for retention, often staff leave because of frustrations with the system and the political nature of it (succeed at all costs or be put under enormous pressure to be seen to be successful). We feel it is timely that we have a robust debate about what we can afford to do or not and how much money we want as a country to spend on health care. Then we can start to all be a bit more realistic about what we can actually achieve and educate our politicians and public about the nature and purpose of our health service.

14. The place of overseas educated healthcare staff within the workforce

One of the main reasons we’ve stopped recruiting abroad is the concern over the “brain-drain” left behind in countries when we recruit overseas staff. Of course, there are also issues about acclimatisation and language/culture for overseas staff and those do lead to safety concerns. There is a large diversity of overseas staff coming to work in our healthcare sector—who makes the decisions about the amount of extra training required in each case? Education up-skilling for these staff is as much about cultural education as it is about clinical education. There needs to be a resource to allow overseas staff to adapt (ironically, currently there are restrictions to overseas entry on those countries who would need this kind of adaptation less—US/Australia/Canada).

15. How the public health workforce will be affected by the proposals

We feel strongly that there is a real requirement for Health & Wellbeing “promoters” for all healthcare education across all healthcare professions. The public health workforce includes third sector workers extensively and “public health” needs to acknowledge the whole agenda rather than simply secondary care (eg to cover the roles of social workers, youth workers etc).

December 2011

Written evidence from The Patients Association (ETWP 39)

SUMMARY

— There needs to be greater patient involvement in the development of curricula for healthcare professionals.
— Patients should also be involved in the teaching of courses where their insights can help improve understanding of relevant issues.
— Patients want curricula to include training to improve healthcare professionals understanding and communication skills.
— Lack of healthcare professionals communication skills is a major issue for the patients contacting the Patients Association.
— Research suggests improved communication skills can improve patient care.
— We are concerned that the role of the Secretary of State in setting priorities for education could lead to greater instability in the education of healthcare professionals.
— Healthcare professionals from overseas, including EU countries, should be proficient in the English language and NHS procedures before they begin practising.
— Care must be taken to ensure healthcare professionals trained in one country within the UK but working in another are given extra support where needed to provide effective and safe treatment wherever they are working.

1. Patient Involvement in the development of curricula

1.1 Patients are the reason why the NHS exists and patients must be an integral part of the education process of healthcare professionals and the ongoing professional development of healthcare professionals while they are practising.

1.2 The earlier the process of patient involvement begins in a healthcare professional’s career, the better the impact.33,34 As a result, education takes on a crucial role in ensuring new healthcare professionals are as best equipped as possible to engage with the diverse group of patients they will encounter in their careers.

1.3 Ultimately it is patients who will most thoroughly understand their own needs and they should have an important role in setting the priorities of the education and training of healthcare professionals.

1.4 In September 2010, the Patients Association held a focus group alongside University of Birmingham Medical School to investigate what the medical curriculum should include from a patient’s perspective and to identify where patients could become involved in the curriculum and could enhance the training of medical doctors. Two clear themes emerged from discussions on what patients wanted to see within the medical school curriculum—better understanding and better communication.

1.5 Patients want to be treated as real people and not seen as just a condition. The focus group suggested simple factors such as acknowledging family members or carers and listening to patients, would improve this. Patients also said there was a greater need for empathy and an ability for doctors to pick up on the behaviour of patients, in particular non-verbal communication skills.

1.6 The recommendations that emerged from that focus group were as follows:

— Improve empathy with patients through:
  — Organising a focus group in student doctors’ first year to discuss issues important to patients.
  — Exposing students to elderly and disabled patients earlier in the course.
  — Consider work placements for students in care homes or nursing teams in their first or second years.
  — Improve understanding of the patient journey by devoting curriculum time to teach post discharge care of patients, including how patients can care for themselves.
  — Improve communication by involving patients in teaching and assessing communication skills.

1.7 The General Medical Council’s (GMC’s) regulations for the training of medical professionals, does include stipulations on involving patients in the education of doctors but recognises that patient involvement in the development of the medical school curricula is relatively uncommon but says they is great potential for development. They call for greater attention to be given to the variety of perspectives that individuals can bring.

1.8 We further recognise and welcome the greater emphasis that has been placed on involved patients within the medical school curriculum. For example, a research paper published in 2005 asked a group of patients, “what should undergraduate medical students know about psoriasis?” and used group discussion with those patients to develop a curriculum relevant to them. The conclusion of this research was that using the views of patients to build the curriculum had been helpful and beneficial to patient care. The authors recommended that patients should be more closely involved in the development of curricula for other chronic diseases.

1.9 Furthermore, in 2009, the British Medical Association (BMA) recommended that, “Patients should be actively involved in the development, review and implementation of undergraduate and postgraduate medical curricula”. They also said that Patients should also be given adequate training and support.

1.10 When patients are being involved in the education and training of healthcare professionals, care must be given to ensure trainees are exposed to diverse groups of patients as they will need to have awareness of the differing needs of people from Black and Minority Ethnic groups and from Lesbian, Gay, Bisexual and Transgender group. In 2006, the BMA’s medical welfare survey found that just under half of medical students felt that they had been prepared for treating and understanding the needs of patients of different sexual orientations.

1.11 There is also some evidence that involving patients even more actively as teachers as well as contributors to medical education can help improve the acquisition of skills, increases respect for patients and place textbook learning in context.

1.12 Moving beyond doctors, patients must also have a part to play in the development and delivery of curricula of all healthcare professionals. There are tangible benefits to involvement patients in the education of healthcare professionals, including nurses, which are strongly associated with enhanced quality of care.

38 Role of the patient in medical education, Medical Education Subcommittee, British Medical Association, (2009).
2. Healthcare Professionals’ Communication Skills

2.1 Through our Helpline, the Patients Association (PA) receives numerous complaints about poor communication. These calls tend to be grouped around three crucial areas of communication: diagnosis, treatment and compassion.

2.2 In our recent report, “We have been Listening, Have you been Learning?”, the Patients Association documented 16 cases of poor care that we have heard through our Helpline. In one of these cases in particular, that of Sally Abbott-Sienkiewicz, poor communication skills played a major part in severely hindering Mrs Abbott-Sienkiewicz’s care and wellbeing. In Mrs Abbott-Sienkiewicz’s case, lack of communication between healthcare professionals including nurses and doctors meant that she was left in a great deal of pain despite clearly needing help. Staff were also not able to communicate effectively with her relatives when they tried to highlight the severity of her situation to the healthcare professionals looking after her.42

2.3 Other research undertaken by the Patients Association has revealed that while healthcare professionals were amongst the most commonly used sources of information, they were not considered to be particularly useful. GPs, for example, were the most regularly used source of information about health with 58.6% of patients saying that they had used them, but only 37.1% felt that they were useful sources of information. Similarly, 32.3% of patients we surveyed had used hospitals as a source of information, but only 19% had found them a useful source.

2.4 More emphasis should be put on communication skills during clinical training so healthcare professionals have the ability to communicate effectively with their patients. While efforts have been made to improve training in communication skills amongst doctors, our survey suggests that other healthcare professionals in particular may require further training in these skills. Nurses, pharmacists and other healthcare professionals were rated poorly as sources of information. This may be due to poor communication skills, gap in knowledge of the healthcare professional, not engaging effectively with patients or time constraints. It is essential that this needs to be addressed.43

2.5 In the Patients Association report, Public Attitudes to Pain, figures revealed that only 66% of patients felt that they had a good understanding of the side effects they may experience and only 33% felt they understood how to manage the side effects of medication prescribed for them. When asked whether they had always taken the prescribed dosage of their pain medication, 17% said that they had taken more than the prescribed dosage and 15% had taken less than the prescribed dosage.

2.6 NICE guidelines on Medicines Adherence state that there must be frank and open approach which recognises that over and under-medication is very common.44 However, it is clear that many patients do not feel comfortable or able to have such discussions with their healthcare professional. We believe that extra focus on communication skills during training would help make patients more comfortable about talking to their healthcare professional not only about side effects but also non-adherence to medicines. Those patients who took less than the prescribed dosage said they were very concerned about the side effects of their medication and with the possibility of addiction. Those who took more than the prescribed dosage said they did so because their medication was not effectively relieving their pain. Patients were generally afraid of being reprimanded for not taking their healthcare professional’s advice.

2.7 The importance of good communication cannot be overstated: it is essential in allowing patients to understand their condition and the treatment course to follow. Further, effective communication is a way of retaining patient commitment to their treatment path and good communication has been shown to lead to improved emotional and physiological outcomes.45

3. The role of the Secretary of State for Health in the new system

3.1 The Secretary of State for Health retains ultimate responsibility for providing and ensuring comprehensive NHS healthcare in England. This will naturally include the education of healthcare professionals as in order to ensure equal access to healthcare, their will need to be enough staff to provide the care patients need.

3.2 However, we would have concerns about any in depth role in deciding the priorities of healthcare professional education. When the Organisation for Economic Co-operation and Development (OECD) published its latest report comparing healthcare systems across the world, Mark Pearson, Head of Policy at the OECD said, ‘The UK is one of the best performers in the world. But outcomes are not what you expect because there is a big reform every five years. We calculate that each reform costs two years of improvements in quality. No country reforms its health service as frequently as the UK’.

42 “We have been Listening, Have you been Learning?”, Patients Association, (2011).
44 Medicines adherence: Involving patients in decisions about prescribed medicines and supported adherence. NICE Clinical Guidance 76, National Institute for Health and Clinical Excellence, (January 2009).
46 Coalition health bill will undermine NHS, says OECD thinktank, Guardian Newspaper, (Wednesday 23 November 2011).
3.3 Similarly, if the Secretary of State for Health set education priorities for healthcare professionals, would these change every time there was a new Government? Furthermore, we are also concerns would priorities may be set for political reasons rather than necessarily in the best clinical interests of patients.

4. Balancing workforce requirements of NHS and non-NHS providers

4.1 It is clear that there will be the need for strong guidance on this point. We are concerned that private providers might drain resources and staff away from NHS providers leaving a very unbalanced system. The system of education of healthcare professionals needs to ensure that all providers, whether they are NHS providers or non-NHS providers, have adequate levels of skilled staff to provide the care that patients need.

4.2 The clearest example is in dentistry where there has been an ongoing problem with ensuring high quality NHS dentistry as dentists move to the private sector. This has been attributed to falling income from the NHS compared to private dentistry.47

4.3 The NHS does provide the funding for courses including nursing, medical training and training of other healthcare professionals.48 Private providers should also be asked to help support the education of healthcare professionals directly as the NHS does to ensure that all providers who benefit from having well trained staff contribute to their education and training. This could be done by giving some responsibility for the training of healthcare workers to private providers as well as the NHS.

5. Place of overseas educated healthcare staff

5.1 Healthcare staff from overseas play a major role in the NHS. However, healthcare professionals from abroad must have a thorough understanding of the procedures and process of the NHS before they can begin to practice. We recognise the difficulties this presents with regard to the UK’s obligations through the European Union (EU) but we would urge the Government to ensure that changes are made urgently to protect patients.

5.2 The General Medical Council (GMC) published a report which has called for induction training for doctors new to the NHS.49 This was as a result of research which has shown that some doctors do not have a sufficient understanding of UK medical procedures. In 2008, the case of Dr Daniel Ubani shocked the UK when he caused the accidental death of David Gray due to his inadequate understanding of UK procedures. Dr Ubani was from Germany and was performing locum duties for the first time in the UK. It was ruled by a coroner’s inquiry that he was “incompetent” because he did not have a full enough understanding of NHS procedures yet he was still able to register as a doctor in the UK. This case has left some patients concerned about the training their doctors have received in UK procedures and shaken confidence in the qualifications and expertise of doctors from abroad.

5.3 Patient safety must be paramount and we are concerned that poor communication as a result of poor language skills could put patients at risk.

5.4 There should be a duty of care on the Government and the regulators to ensure that healthcare professionals are proficient enough in the English language to safely and effectively provide care before their first contact with patients.

5.5 We also note comments from the Nursing and Midwifery Council (NMC) about the registration of nurses from EU member states. They told a committee of inquiry in the House of Lords that they had to operate a two tier system to accommodate European Union rules on free movement of persons.50 This included having to allow the registration of nurses and midwives who had no professional experience for 20 years despite concerns about their understanding of modern nursing practices. This is patently unreasonable and we believe it has to potential to put patients’ lives and wellbeing at serious risk. Patients deserve to be treated by competent nurses who understand medical and administrative procedures as they currently stand, not what they were 20 years ago. We believe there should be provisions to bar the recognition of healthcare professionals who have been out of professional practice long periods of time without undertaking additional training.

6. Relationship with the other countries within the UK

6.1 The movement of healthcare workers across the UK is by no means an unusual phenomenon. It would not be uncommon for doctors or nurses to qualify in Northern Ireland or Scotland but work in England. However, as the four countries within the UK become more separate with greater devolved powers, efforts must be made to ensure that education standards remain at similarly high levels across the whole country.

47 NHS dentistry in crisis as record number of practitioners defect to private sector, The Independent, (Friday 11 January 2008).
48 For examples, please visit http://www.nottingham.ac.uk/studentservices/financialsupport/studentfunding/nursingnhsfundedcourses.aspx
50 HL Deb, 8 September 2011, c455.
6.2 If there are changes in practice in one country, doctors and other healthcare professionals moving to that country from within the UK to practise should receive extra training and support to ensure they understand changing practices across the UK.

December 2011

Written evidence from Birmingham Children’s Hospital (ETWP 40)

1. BCH recognises that in order to meet the challenges of the proposed changes for the NHS as a whole, education and training is the key to that success. Wholesale change must go hand in hand with an increase in training for leadership capability and change management, including examination of the culture within which they operate. To truly reflect an NHS that has a workforce that is fit for purpose and practice we must ensure that educational reform addresses the gaps that are currently displayed:

- Lack of professionalism in trainees eg need values based recruitment and training programmes.
- Lack of understanding of NHS and its wider context.
- “Loyalty” to NHS values and NHS constitution.
- Leadership capability not embedded in curricula and post graduate training.
- Team working capability/multi disciplinary training approach as a fundamental ingredient to clinical outcomes.
- Service transformation/redesign capability.

2. Education and training must attempt to address these gaps in a systematic and focussed way involving all users of the service. We have concerns regarding the proposed new tariff in terms of specialist provision and do not feel that the new tariff recognises the higher level of pay for medics that specialist Trusts have to fund to top up basic tariff funding. The timescales proposed for changes are of concern and we feel do not allow for a change in culture and leadership capability to deliver.

3. We would wish the Select Committee adhere to the words of Andrew Lansley in his speech in July 11:

“We will ensure a safe and robust transition for the education and training system. It is vital that change is introduced carefully and without creating instability, and we will take the time to get it right, as the Future Forum has recommended”.

Our more focussed comments are:

4. Engagement

We would wish:

4.1 Appropriate stakeholder consultation and involvement in determining the core functions of the new post-graduate deaneries, with recognition that they need to be all-inclusive of all MPET provision.
4.2 Appropriate engagement in LETBs enabling Trusts to truly influence the WFP and educational commissioning agenda.
4.3 Appropriate engagement of “specialist Trusts” to influence the agenda ensuring the workforce development needs of specialist elements are appropriately considered, funded and managed.
4.4 Mechanisms to ensure that local Trusts and PCTs have a greater say in how their workforce is educated.
4.5 Mechanisms to ensure local trusts, smaller professions and specialist trusts continue to influence the HEIs/Colleges and external training companies to provide education that is fit for purpose.
4.6 Roles of CFWI need to be articulated and utilised effectively for maximum impact to ensure robust intelligence for future working arrangements.

5. Capability/Leadership

5.1 Recognition that the development of LETBs will require investment in terms of capability and maturity. We would welcome a culture change in how the groups function with senior level buy-in, and a focus on workforce development in the truest terms to change services to meet the challenges facing the current NHS.
5.2 Appropriate leadership at the LETBs to influence the agenda locally, regionally and nationally for WFP/development and education commissioning.
5.3 Professional representation at board level is essential to ensure risks with activity; development and commissioning are debated and articulated to enable informed decision making for future provision.
5.4 Deanery presence at board level is key.
Ev w88  Health Committee: Evidence

6. Structure/Architecture

6.1 Appropriate arrangements to be developed for the “old SHA” boundaries to ensure consistency, equity and dissemination of best practice across the new SHA boundary for the modelling of LETBs.

6.2 Consideration of a Sub Group to shadow boards which will enable active participation from Higher education institutions rather than allowing a formal seat at board level. There is a perception that if the proposed model is implemented which allows representation from this group at board level, there will be a conflict of interest, especially in terms of allocation of funds, provision and quality.

6.3 The implementation of clear definitive structures to enable the CEO reference group to operate transparently with clearly defined structures, to ensure they have appropriate data/information to make informed decisions. Partnership groups are essential to this process. Their functions, TOR and membership are key to success and defined deliverable outcomes.

6.4 Structures below LETBs need to ensure commissioners and providers can influence the debate. There needs to be a truly capable team that can lead and direct future provision.

6.5 The focus for LETBs should be WFP and development influencing education commissioning plans, utilising partnership working to develop service redesign and transformation. Capability needs to be developed at this level to do this.

6.6 HEE must ensure that there is a comprehensive system of quality governance and explicit educational outcomes.

6.7 Appropriate systems to allow HEE to monitor, govern and influence LETB. Providing challenge and objectivity to ensure successful outcomes.

7. Funding

7.1 Recognition and commitment to develop a model of tariff funding for continuing professional development of staff.

7.2 Recognition of the need to strengthen and commit to widening participation with associated funding to implement appropriate activity, to shift the balance of the workforce to aid workforce redesign.

7.3 Recognition and commitment to address the gap in funding for, and support for ANPs and medics who are essentially fulfilling similar roles.

7.4 The need for continued and real investment in educational placements and assessment of trainees to be recognised and retained to ensure trainees have quality educational experiences that reflect the values, professionalism and constitution of the local Trusts and NHS.

December 2011

Written evidence from GMB (ETWP 41)

EXECUTIVE SUMMARY

— GMB welcomes the opportunity to submit evidence to the Health Committee’s inquiry into education, training and workforce planning. We are the third largest trade union in the country and represent 30,000 NHS workers, from nurses and paramedics to ancillary staff.

— GMB remains resolutely opposed to the Government’s NHS reforms, which have already begun to destabilise the health service in England.

— We fear that the vastly increased scope for privatisation of NHS services, combined with official encouragement of local pay bargaining, threatens to undermine the pay and conditions infrastructure within the NHS. This will have serious implications for workforce standards and planning.

— GMB is convinced that breaking-up public coordination of training and development, and shunting all responsibilities down to provider level, will significantly reduce the amount and quality of training available to a large proportion of the healthcare workforce.

— We are alarmed by the omission from the Department of Health’s Developing the Healthcare Workforce consultation of any mention of the Knowledge and Skills Framework (KSF). The imminent withdrawal of central funding from the e-KSF is further evidence of the worrying shift in official thinking away from nationally agreed and understood tools and guidelines.

— GMB believes that the Secretary of State should not duck his responsibilities for, and to, the NHS workforce. He and his new Commissioning Board should champion the rights of NHS workers to continuing professional development under the NHS Constitution and Agenda for Change.

— GMB further recommends that:
  — A portion of the Multi-Professional Education and Training Budget should continue to be allocated to the existing wider NHS workforce.
INTRODUCTION

1. We have serious concerns with the Government’s plans for healthcare education, training and workforce planning. In our response to the Liberating the NHS white paper, we commented that:

“The dismantling of the national training and development structure in favour of localised training will lead to variations in the provision and quality of training and education, and in many cases, especially in the private sector, no provision at all.”

2. Nothing we have heard since has changed this verdict. We are convinced that by breaking-up public coordination of training and development, and by shunting all responsibilities down to provider level, the Government will significantly reduce the amount and quality of training available to a large proportion of the healthcare workforce.

3. The wider context of organisational turmoil and financial cutbacks cannot be ignored. The NHS is now in the midst of a four-year budget freeze despite the Coalition having previously pledged to increase spending in real terms every year. PCTs are having to set aside £3.44 billion over two years to cover the costs of the Government’s reorganisation. Well over 50,000 planned job cuts have so far been documented. Many of our NHS members find themselves threatened with down-banding under the guise of workforce restructurings, while a short-term, cost-driven slashing of commissioned places across almost all occupations requiring professional training is taking place at the expense of long-term medical needs.

UNDERMINING “AGENDA FOR CHANGE”

4. There are frameworks and funding streams within the current system which have provided long-overdue training and development opportunities for non-clinical staff. GMB does not want them to fall into disuse. We hope that the Committee will acknowledge the importance of the Knowledge and Skills Framework (KSF) and Agenda for Change to ensuring a high-quality, fully staffed and safe NHS; and recognise how the Government’s reforms threaten to undo all the progress made on these measures in recent years.

5. As the Committee will know, the KSF provides a single comprehensive framework on which to base personal development plans, annual reviews and supported learning for all NHS Agenda for Change staff. It is a key driver supporting the NHS Constitution pledge to “provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed”. GMB is pleased that the 2010 NHS Staff Survey for England showed some improvement in KSF implementation, and we hope that the simplified KSF guidance will progress matters further.

6. The present Government at one point acknowledged that the system of pay progression linked to the KSF “provides incentives for staff to acquire and use new skills.”51 We are deeply concerned, however, by the omission of all mention of the KSF from the Department of Health’s Developing the Healthcare Workforce consultation paper. This sends entirely the wrong signals from the Government as to the KSF’s importance for staff training and development. The imminent withdrawal of central funding from the e-KSF is further evidence of the worrying shift in official thinking away from nationally agreed and understood tools and guidelines.

7. We fear that the vastly increased scope for privatisation of NHS services, combined with official encouragement of local pay bargaining, threatens to undermine the pay and conditions infrastructure within the NHS. This will have serious implications for workforce standards and planning. How much of the healthcare sector will in future be covered by national pay determination and the Agenda for Change agreement (including the KSF)? Quite possibly a rapidly diminishing proportion. GMB is opposed to this direction of travel. Agenda for Change is an effective, equality-proofed pay and conditions package which ought not to be marginalised.

8. In a paper submitted jointly by GMB and fellow NHS unions to the NHS Pay Review Body in September 2011, Dr Ian Kessler of Green Templeton College, Oxford, set out the advantages of national pay determination. Among other things, he found that:

“In combination with the infrastructure established by Agenda for Change a ‘level playing field’ is set for pay conditions which prevent a ‘race to the bottom’ or ‘the top’. The agreement makes provision for payment to address occupation and local labour market needs.”

“[T]he transparency and consistency of the arrangements have facilitated staff mobility, especially amongst the registered part of the workforce, so crucial to the functioning of a national service.”

Simon Burns, Hansard, House of Commons written answers, 10 February 2011.
Kesler goes on to highlight the dangers of a shift to local pay bargaining. He warns that:

“[L]ocal pay might well discourage skills development where trusts feel they can buy in skills developed elsewhere”.

“National pay determination is deeply embedded in the NHS, with high transactional, relational, and pay bill costs likely to be generated in a period of financial constraint if attempts are made to uproot it”.

9. In our submission the NHS staff side called on the NHS Pay Review Body to consider the impact of the NHS reforms on pay determination within the NHS and the long-term implications for the workforce, including as regards industrial relations, equal and fair pay outcomes, transparent pay setting, recruitment and retention.

10. The Chancellor in his Autumn Statement prolonged the period of public-sector pay “restraint” by another two years, without any consideration of its effects on workforce planning or standards. The NHS Pay Review Body process is being unduly constrained by these unfair and inappropriate diktats.

"DEVELOPING THE HEALTHCARE WORKFORCE"

11. The Department of Health’s Developing the Healthcare Workforce consultation paper promises “increased autonomy” for healthcare providers, with employer-run “skills networks” inheriting many of the workforce functions of Strategic Health Authorities. With the dismantling of public coordination of training and development, we fear that future investment in the workforce will be patchy at best. The Government says it will promote development opportunities for the wider workforce by means of apprenticeships and the work of Skills for Health. In reality, however, there are only a few thousand apprenticeships on offer within the NHS, and the Government is actually committed to significantly reducing its funding of Skills for Health.

12. The Committee seeks views on “the implications of a more diverse provider market within the NHS”. GMB contends that the obvious parallel to draw is with the heavily marketised social-care sector. The Centre for Workforce Intelligence recently observed that “workforce development is less well-resourced and led in adult social care when compared with the NHS”. The low pay and status of care workers stand in sharp contrast to the high levels of responsibility, trust and skill this workforce is required to show. The root cause is obvious: care is a mostly privatized sector. Profit-centered providers in need of public money to service their debts and amass profits off-shore are not likely to invest in workforce development. Conditions of employment in social care barely meet minimum standards. The NHS goes down this road at its peril.

13. GMB is opposed to the deepening privatization of the NHS and we intend closely to monitor the treatment of NHS workers and patients at Hinchingbrooke hospital following its outsourcing to Circle.

14. We agree with the Department that all providers (both NHS and non-NHS) should have a duty to consult, to provide data, and to cooperate around training and development. But the proposed duties on providers outlined in Developing the Healthcare Workforce only go so far. GMB is clear that if providers are to be solely responsible for funding the development of their existing workforce, the responsibility will have to be clearly written into tenders, budgets and contracts. If it isn’t budgeted for, in most cases it won’t happen.

STANDARDS FOR HEALTHCARE ASSISTANTS

15. The wider healthcare team is essential to the quality of patient experience. GMB wishes to place on record here that we look forward to engaging with Skills for Health and Skills for Care in their development of the standards for healthcare support workers and social care workers. In our view the standards ought to include entitlements to professional development. We also believe that the employer, not the low-paid employee, should cover any fee related to the new voluntary register(s).

CONCLUSION

16. GMB is convinced that breaking-up public coordination of training and development, and shunting all responsibilities down to provider level, will significantly reduce the amount and quality of training available to a large proportion of the healthcare workforce. We believe that the Secretary of State should not duck his responsibilities for, and to, the NHS workforce. He and his new Commissioning Board should instead champion the rights of NHS workers to continuing professional development under the NHS Constitution and Agenda for Change.

17. GMB further recommends that:

— A portion of the Multi-Professional Education and Training Budget should continue to be allocated to the existing wider NHS workforce.
— The proposed “skills networks” should be placed under a duty to consider the training and development needs of the whole workforce.
— If providers are to be made solely responsible for funding the development of their existing workforce, the responsibility must be clearly written into all tenders, budgets and contracts.

52 CfWI, Workforce Risks and Opportunities, August 2011.
18. GMB is adamant that privatisation is no way to raise standards of patient care in what is a life-and-death service. GMB has vast experience of the deleterious effects of privatisation on workforce investment and service standards—not least in the NHS’s sister service, the adult social care sector, where private providers have eroded conditions of employment to the point where they barely meet minimum standards. We greatly fear that the Government’s NHS reorganisation will badly undermine the healthcare workforce and reduce the ability of that workforce to deliver high-quality patient care.

December 2011

Written evidence from Skills for Care (ETWP 42)

ABOUT SKILLS FOR CARE

Skills for Care is a partner in the Sector Skills Council—Skills for Care and Development. The other partners in Skills for Care and Development are: Children’s Workforce Development Council, General Social Care Council, Scottish Social Services Council, Northern Ireland Social Care Council, and Care Council for Wales. Skills for Care and Development is the sector skills council for people providing social work, social care and children’s services across the UK. Skills for Care holds the licence with the UK Commission for Education and Skills on behalf of the Sector Skills Council.

In the UK, social care is devolved across the four nations and unlike Skills for Health, Skills for Care only operates in England. Skills for Care is active in collaborating with our partners in the devolved administrations and allied sectors wherever possible. Skills for Care’s ambition is to ensure that England’s adult social care workforce has the appropriately skilled people in the right places working to deliver high quality social care. To achieve this, we focus on the attitudes, values, skills and qualifications people need to undertake their roles.

We work closely with more than 48,000 establishments (81% are in the independent sector—2009) that employ adult social care workers, together with people who use services, including direct employers employing their own Personal Assistants, carers and other key partners to develop effective tools and resources that meet the workforce development needs of the sector. In 2010, the number of jobs in adult social care in England was estimated at 1.77 million. The actual number of people doing these jobs was estimated at 1.56 million.

EXECUTIVE SUMMARY OF SUBMISSION

Skills for Care is working with a range of health partners to support greater integration of health and social care workforce development & planning to support the broader ambition of greater integration of social care and health provision. This principally involves working collaboratively on initiatives around joint standards, training, qualification development and workforce planning data with a focus on delivering quality, productivity and innovation.

Skills for Care welcomes the increasing public and political general interest in social care and the increasing drive to integrate social and health care around the needs of people who use services and carers. However, we believe that adult social care has far greater potential to contribute towards the greater integration of health and social care workforce development and planning than has so far been realised. This situation is reflected in the current share of resource allocation and opportunity to be heard.

We look forward to continuing to working alongside our health partners and our key stakeholders—employers to explore new and innovative ways of working together to achieve improved outcomes for communities, care users, their families and for carers.

INTRODUCTION

Skills for Care’s role is to ensure that England’s adult social care workforce has the appropriately skilled people in the right places working to deliver high quality social care.

As social care faces the challenge of increasing both the quantity and quality of the social care workforce, it is imperative the investment in workforce development is prioritised to ensure that we attract a larger workforce which is skilled, flexible and professional. Our contribution to meeting this challenge is to:

— support investment in the right mix of skills to create a sustainable workforce;
— demonstrate the impact of qualifications on creating a quality service that meets the needs of people who use services;
— provide robust workforce intelligence on the sector and evidence for modelling demand for the future workforce; and
— support range and diversity in service delivery through evidence based research on new roles and ways of working.

We are working with employers towards a skilled and qualified workforce that is flexible and supported to deliver high quality services. Leaders, managers and commissioners in the sector will have strategic workforce information and intelligence, linked through practical tools to map out nationally and locally “supply and demand” of social care services.
Increasingly this includes exploring the ways in which we can promote greater integration between health and social care. To achieve this we are working on a number of initiatives with a range of health partners.

1. National Institute for Health and Clinical Excellence (NICE)

Skills for Care is working alongside the National Institute for Health and Clinical Excellence on a number of work streams in support of the greater integration of social care and health workforce and practice development.

1.1 Quality Standards Development—We are working with NICE on developing the new “Quality Standards”, including chairing one of the first social care quality standards topic working groups—Professor David Croudse-Appleby, Chair of Skills for Care. has been appointed as Chair for the Care of people with dementia Topic Expert Group.

1.2 Quality, Innovation, Productivity and Prevention (QIPP)—Skills for Care is acting as an external reviewer of social care submissions to the QIPP.

1.3 NHS Evidence & QIPP—Skills for Care is an active member of the quality & productivity working group which is reviewing NHS Evidence and the QIPP criteria & assessment processes. A significant part of our role is ensuring that the QIPP will be meet the needs of social care when in 2012 it is formally extended to include social care & public health.

2. Department of Health

Skills for Care continues to work closely with colleagues from the Department of Health on a variety of activities that include developing options that supports the greater integration of health and social care.

2.1 Social Care White Paper Team—seconded Skills for Care representative to join the Adult Social Care Workforce Team leading on engagement and policy development in relation to the workforce options for the new Care and Support White Paper.

2.2 Social Care Quality and Workforce—membership of the Care and Support White Paper engagement group for quality and workforce, exploring the ways in which the adult social care workforce development can drive quality improvement.

2.3 Developing Key Priorities for the Future—alongside membership of the quality and workforce engagement group, Skills for Care is working with the Department of Health to develop new key priorities for future workforce development that will promote quality improvement. This may include exploring options for joint workforce development across the health and social care commissioning workforce.

2.4 Local Education & Training Boards and Health Education England—Skills for Care is working in partnership with the relevant bodies to explore the opportunities arising from the development of the Educational Outcomes Framework and the new arrangements round Local Education & Training Boards (LETB), Health Education England (HEE) and local commissioning to support greater integration of workforce development across health and social care. Skills for Care have held an initial workshop attended by colleagues from DH (including HEE leads), Local Authorities, a Strategic Health Authority and a care alliance exploring how adult social care is integrated from the outset of the new HEE & LETB workforce arrangements.

2.5 State of the Adult Social Care Workforce in England—continue to publish regular reports on the state of the adult social care workforce in England. Skills for Care also publish an annual Report on the Size and Structure of the Adult Social Care Sector and Workforce in England and provide quarterly reports to DH.

3. Skills for Health

Skills for Care is jointly working with Skills for Health in a number of areas as well as exploring new opportunities for further partnership working to support integrated educational outcomes.

3.1 Standards, Qualifications and Apprenticeships—Skills for Care and Skills for Health work together in close collaboration where there are areas of common interest across the sectors. Together we develop standards such as National Occupational Standards and Core Principles for the social care and health workforce. We also work together to develop units and qualifications within the Qualification and Credit Framework that can be used by the social care and health workforces. Skills for Care and Skills for Health also share a joint Health and Social Care Apprenticeship framework.

3.2 Closer Integration of Skills for Health and Skills for Care—Skills for Health and Skills for Care are actively exploring the options for greater integrated working. It has been proposed that joint efforts should be focused on encouraging mass adoption of successful pilots to date, rather than re-producing more pilot sites. The basic approach will be:

— Assess the outcomes of pilots undertaken to date and identify those pilots that have the greatest potential for impact and replication.

— Develop joint health and social care networks to share outcomes, provide active support and operate as learning sets.
— Develop benchmark data and evaluate results for wider dissemination.

3.3 **Promoting Integration of Health & Social Care**—we are developing a paper that explores our options for promoting greater integrated working. This paper sets out three priority areas for shared working between Skills for Care and Skills for Health. These priority areas are proposed following extensive board and director level discussions between Skills for Care and Skills for Health. The priority areas are:

— Preventing avoidable Hospital Admission.
— Transitions to Nursing Care.
— Reablement and timely hospital discharge.

These areas recognise that assistive technology and integrated care & support are important to each proposal and form part of the underlying thinking. The purpose of these proposals is to identify areas of work whereby Skills for Health and Skills for Care can support a step-change in integrated working across health and social care. Both organisations believe that closer integrated working will:

— Provide substantial benefits to the individual client/patient through more streamlined services with fewer hand-overs, and by ensuring that the care provided better meets the individual’s needs.
— Utilise scarce resources more effectively by reducing/delaying hospital admissions and accelerating appropriate hospital discharge.

3.4 **Joint healthcare support workers and adult social care workers code of conduct & standards**—Skills for Care and Skills for Health have been commissioned by DH to develop a code of conduct and minimum standards for education for healthcare support workers and adult social care workers working in support of health and social care professionals, independently, for Care Quality Commission registered residential care providers, or as domiciliary care workers in England. Working with a range of partners SfC & SH will develop a framework that will ensure that workers are supported in delivering safe and effective care.

4. **Centre for Workforce Intelligence (CfWI) and the Information Centre for Health & Social Care**

Skills for Care is an essential major partner in the work of the Centre for Workforce Intelligence both as a major supplier of data on the adult social care sector in England and as a collaborator on moving towards a more integrated approach to joint health and social care workforce planning.

4.1 **Adult Social Care Workforce (England) Labour Market Intelligence (LMI) & Workforce Intelligence**—supporting the CfWI by collecting LMI and workforce data using the National Minimum Data Set—Social Care (NMDS-SC). Skills for Care also now collect workforce data from local authorities on behalf of the Information Centre for Health & Social Care through NMDS-SC.

4.2 **Future workforce demand forecasting & workforce planning tools**—continuing to refine the Skills for Care model on workforce estimates to project the future demand for the adult social care workforce in England. These estimates have made a significant contribution to workforce planning across the health and social care system. CfWI is building on the work undertaken for the Social Work Reform Board to develop a supply and demand model for social workers based on NMDS-SC data returns from local authorities. CfWI is modelling the larger social care workforce and data from the NMDS-SC is making a significant contribution to understanding the workforce challenges across health and social care.

4.3 **Workforce Modelling**—as partners of CfWI we made a significant contribution to The Workforce Risks and Opportunities in Adult Social Care report which sets out the major issues facing the social care workforce. We continue to explore with CfWI options for greater integration of health and social care workforce modelling.

4.4 **Education Commissioning**—We are contributing to the CfWI Workforce Risks and Opportunities Project Reference Group—this project is producing Education Commissioning Risk summaries.

5. **Social Work Reform**

Skills for Care is working in partnership with the Social Work Reform Board contributing to the development of products and supporting the reform of the social work profession.

5.1 **Assessed and Supported Year in Employment**—We are developing, in partnership with the Childrens Workforce Development Council, the proposals for the Assessed and Supported Year in Employment.

5.2 **Professional Capabilities Framework (PCF)**—We have played a significant role in the development of the Professional Capabilities Framework (PCF) for social workers.

5.3 **Continuing Professional Development and the reform of social work education**—We are working in partnership with the College of Social Work who have recently taken responsibility
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from the SWRB for taking forward the PCF, proposals for Continuing Professional Development and the reform of social work education, and proposals for partnership working.

5.4 Standards for Employers and Supervision Framework—We are working in partnership with Local Government Employers (LGE) to ensure that the Standards for Employers and Supervision Framework are available to all employers.

6. Workforce Development for Assistive Technology, Telecare & Telehealth

The emerging evidence from the Whole System Demonstrator (WSD) evaluation funded by the Department of Health (DH) suggests that, if used correctly, telehealth can deliver reductions in A&E visits, emergency admissions, elective admissions, bed days and tariff costs. On the basis of this evidence, DH has made a commitment to accelerate the use of telehealth and telecare technologies. A vital factor in successful delivery of telecare and telehealth is workforce confidence and skills to engage with available technology to its maximum potential.

In light of this, Skills for Care intends to build upon its recent small-scale research, which scoped the current landscape of workforce development for assistive technology, telecare and telehealth, to determine what more can be done in supporting integrated social care and health workforce development in this field. This work will be taken forward in discussion with Skills for Health, DH Long Term Conditions Team and representatives from training agencies, commercial partners, commissioners, academic and front line social care staff.

7. Other areas where SfC might be able to impact

In addition to the above, Skills for Care with appropriate support, can help to progress further integration in relation to:

7.1 Integrated Career Pathways—Developing more integrated Career Pathways across health and social care supported by integrated Education Outcomes Framework rather than an NHS only EOF.

7.2 Commissioning Workforce—Explore the options to support joint workforce development across the health and social care commissioning workforces.

7.3 Professional Capabilities Framework & NHS Educational Outcomes Framework (EOF)—Mapping the social work Professional Capabilities Framework to the NHS EOF and exploring how it might support cross health and social care career pathways, as well as exploring how it might be developed and extended to the wider social care workforce.

December 2011

Written evidence from the Royal College of Obstetricians and Gynaecologists (ETWP 44)

The Royal College of Obstetricians and Gynaecologists (RCOG) welcomes the opportunity to submit written evidence to the Health Committee’s inquiry into education, training and workforce planning, and notes that there have been some changes to the proposals in Liberating the NHS: Developing the Healthcare Workforce since it was published in March 2011. In this written evidence therefore we comment only on those issues which are new or on which we have a particular view, otherwise, our input has already been captured by our responses to Liberating the NHS: Developing the HealthCare Workforce53 and to the second phase of the Future Forum’s work.54

The RCOG understands that the Future Forum has not published interim findings and advice on education and training but will produce a full report soon. The RCOG looks forward to this report.

A SUMMARY OF THE RCOG’S VIEWS

— We support the rapid development of Health Education England (HEE).
— We are not in favour of the localisation of education and workforce and believe the national overview is vital.
— We believe the medical workforce should be managed nationally with the engagement of the Royal Colleges.
— We believe training should be controlled nationally via the HEE with the involvement of the Royal Colleges and local education providers.
— The financial resources for the education budget should be controlled nationally.
— Deaneries could be co-located with universities but must be independent in their governance.

54 http://www.rcog.org.uk/files/rcog-corp/RCOG%20response%20to%20the%202nd%20phase%20of%20FF_linked.pdf.
1. Plans for the transition to the new system, up to April 2013

1.1 The RCOG welcomes announcement that the Strategic Health Authorities (SHAs) will continue to be accountable for postgraduate deaneries until 31 March 2013; allowing time for a phased transition of their functions. This combined with the grouping of Primary Care Trusts (PCTs) into clusters will give some measure of stability to the system during the transition. However there is clearly still much to be done and widespread uncertainty about how the new system fits together.

1.2 Based on the recently published The Operating Framework for the NHS in England 2012–13, the RCOG notes that these SHA clusters, as part of the reform programme, will work with healthcare providers and the education sector to set up provider-led partnerships on education commissioning for 2012–13 and 2013–14. It is essential that the Royal Colleges, as custodians of the postgraduate medical training programmes and curricula, are included in these discussions either individually or through the Academy of Medical Royal Colleges (AoMRC).

1.3 The Select Committee seeks views on Health Innovation and Education Clusters (HIECs). We believe their functions should transfer to Health Education England (HEE) after the transition period. Although the RCOG has not had any direct involvement with HIECs, we are supportive of their aims and would wish to see the aspiration within them develop.

2. The future of postgraduate deaneries

2.1 The RCOG has made the point in its previous submissions along with many others that the Deaneries play a pivotal role in managing the complex machinery of postgraduate medical (and dental) education. It was therefore vital to have confirmation of their future. We welcome the recent announcement that the important work of the postgraduate deaneries will continue through transition and into the new arrangements from 2013. The RCOG expects to see, in the next iteration of the proposals for education and training, clarification of the postgraduate deans’ reporting line, whether to HEE or another body. The relationship of Deans and Deaneries to the new Local Education and Training Boards (LETBs) and other relevant bodies need to be defined but the RCOG strongly supports the independence of the deans in terms of governance.

This ensures that postgraduate deans continue to oversee quality assurance in medical education and training but more importantly, are in control of planning medical recruitment according to healthcare delivery needs and nationally and locally agreed workforce plans.

3. The role of the Secretary of State for Health

3.1 As the Health and Social Care Bill makes its way through the House of Lords, the RCOG is pleased to see the amendments to ensure that the Secretary of State retains oversight of the NHS. Similarly, it must be highlighted that the Secretary of State’s duty to provide NHS services must include equal emphasis on education and training. It is therefore crucial for the Health Secretary to have a role in advancing the scope and direction of NHS education and training.

Just as the National Commissioning Board (NHSCB) is accountable to the Department of Health and Parliament, similar reporting structures must be put in place for HEE and its relationships with the Secretary of State and health ministers.

4. The proposed role, structure, governance and status of HEE

4.1 The RCOG supports the functions for HEE as set out in the March consultation document and welcomes the forthcoming proposals on the accountabilities for the quality of education and training, as there is concern of how HEE will be responsible for “promoting high quality education and training that is responsive to the changing needs of patients and local communities”.

4.2 The roles of the GMC and the Royal Colleges in relation to the development of curricula need to be carefully borne in mind, as the latter already account to the former in this regard. Adding another layer of accountability about curricula is not appropriate. We believe that, with the proposed new reporting line of postgraduate deans, HEE will have a clearer remit for holding Deaneries to account and for working on system-wide medical issues with GMC. We noted the importance and potential of the O&G School structure for setting and maintaining standards. As these are joint deanery/college bodies, HEE will have access to national specialty advice. However, we are still uncertain about how the relationship between HEE and the NHSCB will work and more clarity is needed. There are significant risks to commissioning of services if education of the present and future workforce is not considered.

4.3 As stated in our previous consultation submission, we believe that the challenges of delivering medical education in the clinical workplace are such that the Medical Programme Board (MPB) should continue in some form as part of HEE.

4.4 With the Royal Colleges’ key role in developing education and practice standards in medicine, it is crucial for HEE to establish and maintain appropriate levels of engagement and interaction with the Royal
The RCOG believes that having significant representation is crucial for the Royal Colleges to have an active role in ensuring healthcare professionals working for AQPs undergo training, assessment and qualifications.

5. The proposed role, structure, status, size and composition of local Provider Skills Networks (PSNs)/LETBs

5.1 The RCOG is concerned about the profusion of bodies potentially managing the provision of education locally. There are a plethora of groups below the national level, more than envisaged in March. It is not possible to recommend anything about PSNs or LETBs until there is more clarity about the respective roles and responsibilities of Clinical Commissioning Groups (CCGs), Health & Wellbeing Boards and Clinical Senates. There is a considerable risk of confusion, duplication and stagnation in the sub-national structure unless great care is taken to design the governance system as a whole. There is also the question of increasing bureaucracy with the introduction of these groups when the original intention was to reduce red tape.

5.2 LETBs are probably best accountable to HEE but this assumption may not hold for PSNs. LETBs will also probably be best based on the current national SHA and Deanery structures, and should include representation from all stakeholders involved in education and training of the healthcare workforce, plus lay and trainee membership. The role of the LETB should be to oversee the delivery of high quality healthcare education and training in its area in accordance with the priorities specified by HEE; ensure that healthcare education and training is being appropriately delivered; take local remedial action where appropriate; and to liaise with local CCGs about education commissioning priorities. How the LETBs are supported and resourced is another question for consideration. The Deanery functions and governance through commissioning would have close relationships with LETBs but be independent and perhaps relate to several LETBs within a region.

6. The role and content of the proposed National Education and Training Outcomes Framework

6.1 Overall, the RCOG welcomes the commitment to education and training demonstrated by the production of this draft Framework but suggest that much of it will be covered by local commissioning and provider relationships and quality management responsibilities. What is needed is a clear, simple set of outcomes, such as: (1) safe and excellent quality care, (2) competent and capable professionals, (3) educational outputs aligned with workforce demand. Additionally, clarity is needed on how information will be collected or analysed—through existing report mechanisms or by a new one. Outcomes need measuring and reporting through lines of accountability in this model, which will add significantly to the burden. We do not see how the seven domains match to the five outcomes or why there are a different set of domains for HEE to hold the LETBs to account (which will already have to work with a variety of educational quality standards). It is not clear how Deaneries fit into this structure, unless they are counted in the LETBs which would remove their independence and the governance.

7. The role of the Centre for Workforce Intelligence (CfWI)

7.1 The RCOG supports HEE being the responsible body for all supply issues concerning workforce and hopes that this will lead to the CfWI working more closely with the Royal Colleges. As stated in our earlier response, the establishment of HEE will provide the opportunity to plan the medical workforce centrally in conjunction with other healthcare professionals and to coordinate both workforce numbers and educational opportunities from medical school through to completion of specialist training. Against this background, we hope the CfWI will be more robustly managed and its workplan better supported. From our perspective, involvement at all stages of the CfWI work is imperative, so that models developed by the CfWI reflect the intelligence provided by our membership working within the service.

Subpoints

- The RCOG hopes that the Medical Training Initiative scheme can continue in its current form. Reducing the length of attachment to just one year risks the loss of a long and respected tradition of training overseas doctors.
- Compliance with the EWTR continues to challenge service provision and can impact negatively on training. For a 24/7 specialty such as O&G, flexibility is needed and the drive towards a consultant-delivered service in high risk areas of practice such as Obstetrics needs support.
- Finally, the RCOG would like to reiterate the amount of good work that occurs in work undertaken by our doctors for the greater good of the NHS out with their employment contract. Provisions must be made to enable such goodwill to continue.

December 2011
Written evidence from Dr Tim Johnson, Salford Royal NHS Foundation Trust (ETWP 45)

Maintaining postgraduate deaneries, or at least the current functions of the deaneries, is vital to ensure the continued high standards of medical education for our junior doctors

I am senior hospital consultant working in a teaching hospital and have been responsible for the local delivery of medical education to junior doctors for the last 10 years. During this time there have been challenging and radical changes to both medical education and careers which have been implemented mostly by the deaneries.

Their objective, of supervising the highest standards of trainee development, has been increasingly threatened by competing interests from service delivery within hospitals and there is every reason to assume that this pressure will continue to increase. I am acutely aware of the tension between hospital consultants spending their time delivering education and delivering care.

Deaneries have evolved to exert critical and independent pressure on trusts to ensure that they comply with the best educational practice by means of their inspections and reports as well as providing faculty development and much other support.

There is clearly a risk that the influence and excellence that has been promoted by the postgraduate deaneries will be lost if their function is subsumed within any organisational structure that is unable to focus specifically on the needs of junior doctors.

The influence on the provision of postgraduate education by the deaneries is enormous and should be safeguarded fully.

December 2011

Written evidence from Heads of University Centres of Biomedical Science (ETWP 46)

The Heads of University Centres of Biomedical Science (HUCBMS) represents over 50 university departments offering degree programmes and engaged in research in biomedical science. It is affiliated to the Institute of Biomedical Science (IBMS) and the Society of Biology.

HUCBMS welcomes the opportunity to submit evidence to the Health Committee for its enquiry into Education, Training and Workforce Planning. Our remarks are confined to the education and training of biomedical scientists, the majority grouping of scientists in the NHS. We would wish to make two points, one generic and one which, we believe, follows logically from the first:

1. For obvious reasons including unpredictable external forces, internal pressures, policy shifts and innovation, workforce numbers planning has proved to be an extremely inexact activity in all professional areas in which it has been undertaken. It is essential therefore that the relationship between employers and providers (the universities) should be close and informed. It should also be based, where possible, on a model which seeks to avoid a fixed and expensive one-one relationship between university entrance numbers to specific programmes and the anticipated number of local NHS vacancies. This argues for the desirability of undergraduate programmes leading to careers in the NHS having structure and content such as to lead to other career outlets and thus avoiding “stop-start” university recruitment due to local funding perturbations. This is also desirable academically. (We accept that this is easier to achieve in the NHS-related science disciplines than in medicine, nursing or the therapeutic professions).

2. We have contributed to various discussions and deliberations relating to the Department of Health Modernising Scientific Careers (MSC) initiative and have welcomed its stated intention to “provide a career framework for healthcare science professionals by providing an education and training programme that is clear and coherent—enabling individuals to move throughout healthcare science without being sidelined and avoiding risk of career dead ends”. However, as set out in an article (attached) published in the January 2011 edition of The Biomedical Scientist, we feel that that there has been a slavish adherence by the MSC team to the introduction of degree programmes with the unattractive generic title “healthcare science” with insufficient attention being given to acceptance of other more marketable and financially less expensive programmes eg biomedical science. Biomedical science degree programmes meet, at least, the same learning and training outcomes proposed for “healthcare science” but because of their high demand and greater and more flexible career opportunities, can be offered at lower unit costs. This is particularly important at a time of financial stringency within the NHS and where recruitment to NHS posts is likely to be low.

Note: Biomedical Science degree programmes are extremely popular with students and employers as they produce highly skilled and flexible graduates and offer a wide range of career options, one of which is working as “biomedical scientists” in NHS laboratories. Biomedical Science degrees, approved by the Health Professions Council (HPC) as meeting their education and training requirements for registration as a biomedical
scientist, include professional training as an integral part of the programmes. There are 39 HPC-approved Biomedical Science undergraduate programmes available throughout the United Kingdom. There are also a range of Masters programmes and professional doctorates available in biomedical science as well as a comprehensive offering of continuing development programmes accredited by the Institute of Biomedical Science.

December 2011

Written evidence from Brook (ETWP 47)

1. EXECUTIVE SUMMARY

1.1 Brook is the UK’s leading provider of sexual health services and advice for young people under 25. The charity has over 45 years of experience working with young people and currently has services in England, Scotland, Northern Ireland and Jersey.

1.2 Brook welcomes the clear statement from the Government in Liberating the NHS: Developing the Healthcare Workforce consultation that, “education and training are integral to ensuring the values and calibre of staff”. We agree that training is vital to the delivery of safe and high quality sexual health services for young people. However, we have significant concerns that removing the central oversight of education and training currently exercised by the Department of Health will lead to a lack of consistency in the training provided.

1.3 It is vital that the new workforce development system is supported by sufficient funding to ensure that sexual health professionals who work with young people can access the training they need, including cover for their posts where this is necessary. There should also be clear career pathways for sexual health professionals.

1.4 Brook welcomes the recognition that there needs to be workforce planning and development specifically for the public health workforce, which includes the sexual health workforce, but there needs to be more clarity around how the training for the public health workforce and healthcare workforce will be integrated, planned and managed.

1.5 We believe that for improvements to be made in training and education for sexual health then provision for nurse training in sexual health must be addressed.

2. LOCAL SKILLS NETWORKS

2.1 Brook has significant concerns that training will no longer be delivered in a systematic and coherent way if responsibility for planning and commissioning it is devolved to local skills networks. Our concerns are based on the experience of the devolution of decision making on sexual health training for nurses.

2.2 Previously the English National Board for Nursing (ENB) and its equivalents in Scotland, Wales and Northern Ireland co-ordinated training for nurses in a variety of disciplines including sexual health. Following the dissolution of the ENB no other organisation took on this co-ordination and oversight role. Instead, individual institutions now make decisions about the training they offer with the result that there is not a single recognised curriculum for sexual health training and nurses who have attended different institutions may have a qualification with the same name but will not necessarily have all of the same knowledge or skills. This makes it difficult for employers to assess whether nurses have the competencies they require. Brook is concerned that this lack of co-ordination will be replicated across the country if responsibility for training is devolved solely to a local level.

3. PROTECTION OF FUNDING

3.1 Brook also has significant concerns about the funding available for training and education within the NHS. It is vital that the new workforce development system is supported by sufficient funding to ensure that professionals who work with young people can access the training they need, including cover for their posts where this is necessary.

3.2 In the document Liberating the NHS: Developing the Healthcare Workforce it stated that transparency will be introduced into the funding arrangements for training which will support a level playing field between providers. Brook warmly welcomes the proposal that would ensure funding reflected the cost of providing continuous professional development for staff.

3.3 In addition, Brook is concerned that the proposals for a tariff for the delivery of training could deter some providers. For example, the vast majority of contraception training takes place in community contraception clinics. When training is taking place this can reduce the capacity of the clinic and therefore have an impact on the number of people who can be seen, unless there is funding for the post of the trainer to be covered during the training. We believe that the tariff will be developed based solely on the cost of the training provided and will not take account of the wider potential costs to services of providing training. We are concerned that this could act as a deterrent to providing training, especially in an environment where healthcare providers are competing with one another.
4. PUBLIC HEALTH WORKFORCE

4.1 In the Public Health White Paper, Healthy Lives, Healthy People comprehensive sexual health services were identified as part of public health. Brook welcomes the commitment in Developing the Healthcare Workforce that preventative medicine will remain a key area of work for all NHS staff. We agree that there needs to be workforce planning and development specifically for the public health workforce. We also welcome the further details on plans for the public health workforce that were included in Healthy Lives, Healthy People: Update and Way Forward. However, we are still awaiting the publication of a public health workforce strategy which will contain more detailed proposals on the public health workforce.

4.2 There is currently not any clarity around how clinical training for people delivering public health services will be planned and managed. For example, sexual health services will be part of the new public health structure but many of the skills required to deliver these services are clinically based, such as carrying out STI tests and initiating treatment. It is not clear how strong links will be made between public health workforce planning and healthcare workforce planning to ensure these training needs are identified and met.

4.3 We are also concerned about the potential loss of expertise in the non-clinical public health workforce through the transition period into the new public health structure. As the reforms will change the way sexual and reproductive health services will be commissioned we are concerned that experienced commissioners from Primary Care Trusts may be lost along with their local knowledge and expertise.

4.4 Nurse provision of sexual health services is a vital part of accessing services for young people. We believe that to ensure that sexual and reproductive health services to fully meet the needs of young people then provision for nurse training in sexual health must be a priority when looking at the development of a public health workforce strategy.

4.5 Finally Brook believes that training must be a part of the commissioning process. This would recognise that commissioned specialist services such as Brook’s sexual health services for young people are part of training provision and cover the training needs of staff who will be delivering those specialist services.

December 2011

Written evidence from the Royal College of Pathologists (ETWP 48)

SUMMARY

— Transition to the new system must recognise the current stresses in the system, acknowledge developments in training and education that are already on-going and maintain current funding levels for medical training.
— Feasibility testing of the new structures and mechanisms should be considered before full implementation.
— Postgraduate deaneries should be wholly retained, preferably governed by and regionally representative of HEE.
— HEE should be embedded within a statutory framework that defines its role and responsibilities, and which ensures the engagement and participation within the new system of all bodies interacting with and taking advantage of health education and training.
— Commissioning and quality assurance and management of health education and training should rest outside of the responsibilities of LETBs.
— Formulation of medical and scientific curricula should remain the responsibility of the royal colleges, regulated as currently by the GMC/HPC.
— Provider diversity brings with it risks to the provision of training which should be addressed in contracts and statutory frameworks.
— The National Education and Training Outcomes Framework should include more comprehensive performance indicators to be of significant value, especially during this time of change risk to training provision.
— Funding for education and training should be controlled by HEE and allocated to LEPs through LETBs on a real time basis (see below).
— This system will struggle to stand alone in England without the cooperation and buy-in from the devolved nations.
— Public Health should be reconfigured as a specialist health authority directly accountable to HEE or DH.

SUBMISSION

1. Plans for transition to the new system, up to April 2013

(a) In transition, there are several issues that concern the College. The quality and commitment of trainers within the current system is fragile and must be supported and maintained. Medical training numbers have
been reduced, and financial pressures within the service delivery context are high. With the added difficulty of training within the European Working Time Directive (EWTD), delivery of high quality education is becoming increasingly difficult.

(b) Pathology specialties (along with others) are developing curricula and assessment systems for scientists wishing to progress via the Modernising Scientific Careers/Higher Specialist Scientific Training programme. Implementation of these systems and training posts will occur over a similar timescale to the changes to education and training. Transition should ensure that workforce planning and commissioning of education and training takes into account these on-going developments.

(c) The College is also still concerned that, in the transition to a multi-professional Healthcare Education England (HEE), the level of funding for Medical education and training is maintained (allowing for the current climate of savings), and not reduced in real terms.

(d) Feasibility testing of these new structures should be considered; one simple example would be testing the mobility of the workforce to access distributed training opportunities, responsibility for which has not been described. Excess haste in introducing the new system may disadvantage trainees in all professions.

(e) This College has serious concerns about the lack of continuity between heterogeneous undergraduate curricula in the teaching of basic disease mechanisms and Foundation programmes which fail to fill those knowledge gaps. The GMC shares our concern and has agreed we should study this problem in depth and make recommendations to them. Any suggestions will need careful integration, or these gaps will likely be exacerbated.

2. The future of postgraduate deaneries

(a) We were extremely concerned at the possible abolition of the Postgraduate Deaneries within the original consultation, even allowing for the recognition that “Deanery Functions” should be maintained within the Local Skills Networks (LSNs).

(b) Deanery functions are not solely related to quality assurance of postgraduate education and training. Deanery postgraduate schools are largely responsible for the improvements in postgraduate training over the last five years, and these structures must not be lost in any new system.

(c) Deaneries also manage trainees in difficulty, Annual Reviews of Competence Progression, remedial training, recruitment to training programmes (local and national), training for educators and supervisors and liaise with medical royal colleges to ensure our standards and curricula are translated into practice. Colleges and Deaneries work closely together and our work would be severely disrupted if these essential functions were diluted or lost.

(d) All of these functions must be maintained within the new structures. In our original feedback, we recommended that Deaneries were wholly retained, and could for example become regional offices of HEE. This would be a logical context in which to situate the quality assurance of training programmes. We also recommended that the commissioning function for education and training be returned to the Deaneries on behalf of HEE. These recommendations remain our preferred position; wherever the Deaneries are hosted however, it is their retained ability to function that is essential.

3. The future of Health Innovation and Education Clusters

(a) HIECs are potentially useful if they integrate local training initiatives and posts in Trusts with each other and with their local educational institutes. There is no clear evidence that this is working uniformly or well across the country and there is some doubt about the capabilities of the staff running them. This is a high level function requiring organisational and negotiating skills which could be operated jointly between HEE, LETBs, Deaneries, Universities and Trusts, not to mention the powerful potential of alliances with AHSCs.

4. The role of the Secretary of State for Health in the new system

How can the Secretary of State be responsible for postgraduate education in the context of Foundation Trusts who are allowed to decide how they deliver healthcare?

5. The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of MEE and the Professional Advisory Boards), and its relationship to regulators and to the other parts of the new NHS architecture

(a) The functions assigned to HEE are broadly appropriate, although curriculum review should remain in the hands of the GMC/Health Professions Council (HPC) as independent regulators. Accountability of the bodies within the new structures to HEE should be embedded within a statutory framework to ensure full cooperation and engagement.

(b) As previously suggested, HEE could regulate some functions of the LSNs through Deaneries (which would need to become multi-professional entities where this is not already the case) as local offices. HEE should remain independent of government, and should ensure cooperation through closer integration and
interaction with the GMC, GDC, HPC and other regulators. Lay representation is essential. HEE should have responsibility for enforcing the duties of providers for consultation, provision of workforce information, cooperation in workforce planning and the planning and provision of education and training.

6. 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

(a) We welcomed the explicit recognition in the original consultation that workforce planning and commissioning of training could not be left to market forces, and that healthcare professionals and the Royal Colleges would be engaged in these processes.

(b) However, we are still concerned that the new LSNs/Local Education and Training Boards (LETBs) are not appropriate forums in which to manage these two essential functions. An organization that is responsible for workforce planning, commissioning of training, local education providers and quality assurance mechanisms would be rife with conflicts of interest that could only be separated at best by “Chinese walls”. Commissioning of Education and Training and Quality Assurance functions would be better placed outside of the proposed LSNs/LETBs.

7. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

(a) The formulation of postgraduate medical and scientific curricula (and their associated assessment systems) should remain with the Royal Colleges who are attempting to integrate scientists into their ranks. The provision of input by all relevant bodies and individuals is already ensured by in the consultation mechanisms employed by all Colleges within the curriculum development process, and overseen and regulated by the GMC/HPC.

8. The implications of a more diverse provider market within the NHS, and how the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

(a) Changes to the provider market have removed some training opportunities from trainees who are currently limited to opportunities provided within NHS institutions. An example is ophthalmic surgery training in London, the South West and East Anglia where the introduction of independent contractor centres without educational contracts, the drive for economy and efficiency in NHS operating and variable visual acuity thresholds for cataract surgery imposed locally by PCT managers have all reduced training opportunities in these areas.

(b) Pathology service reconfigurations currently being undertaken bring with them opportunities for private providers to bid for these services. Even though most of these negotiations are at an early stage, there is already anecdotal evidence in several areas, eg South Central, of tenders being provided without any commitment to continue the current provision of training for medical and laboratory scientist trainees.

(c) The College has met CEOs of the main private pathology providers recently. All agree that training and education must be protected and they are mostly happy to protect trainers’ time but they all want funding to come from outside the service contract and NHS CEOs agree.

9. The role and content of the proposed National Education and Training Outcomes Framework

(a) The Framework should form the basis of the accountability mechanism between DH & HEE and will help to shape contracts between HEE & LETBs and LETBs and Local Education Providers (LEPs).

(b) The Framework contains appropriate outcomes and domains, however only two indicators are proposed for 2012–13, which makes it of very limited value for measuring the outcomes of both the Framework and the changes being introduced over the next two years, unless further indicators are developed for 2013–14.

(c) Future indicators of the quality of training might include: curriculum mapping exercises, quality assessment reports from Deaneries, examination results, ARCP outcomes, trainee progression rates, trainee and trainer surveys and patient and staff feedback.

10. The role of the Centre for Workforce Intelligence.

(a) The College previously had great concerns over the viability and fitness for purpose of the Centre for Workforce Intelligence (CFWI). The data that CFWI originally used was flawed and outdated. We were pleased to hear that it would engage with the private sector and major pharma companies in future, however we are unsure whether this has yet happened. We would applaud the fact that CFWI has engaged more comprehensively with the Royal Colleges since the release of the original consultation, and their recognition of our own comprehensive workforce data.

(b) The Department of Health (DH) has agreed to take its advice for short-term workforce planning and annual recruitment into pathology training posts directly from the College. CFWI has also interacted directly
with the College to obtain accurate data for its medium to long-term project looking at the future shape of training. We would encourage this system to continue.

11. The roles of Skills for Health, Skills for Care and NHS Employers

(a) These organisations can provide consultation on the scope for reshaping the workforce, developing expertise in workforce and recruitment planning, improving the quality of training within new frameworks and changes to working time and conditions.

12. How funding will be protected and distributed in the new system

(a) Funding for education and training has never been satisfactorily organised. These reforms present an ideal opportunity to simplify funding streams and provide transparency. The lack of operational detail in the Bill however represents an unacceptable degree of risk to the current level of funding, imperfectly organised though it may be.

(b) There is a clear risk, often stated by CEOs that Trusts under competitive commercial pressure will simply rid themselves of training posts which bring insufficient income. The Secretary of State could not stop them as the Bill currently stands, not even through Clause 17.

(c) Funding should be distributed to LETBs by HEE, and then to LEPs by LETBs on a “real-time” basis, ie funding should only be provided where posts are filled. This will protect funding for education and training, prevent Trusts from filling holes in their service budget with unspent training salaries, and allow for more efficient use of training funding. It will encourage Trusts to fill training vacancies and will also ensure equity of provision of study leave monies, levels of which are currently subject to local service financial pressures.

(d) LEPs through LETBs should be audited and accountable to HEE for education and training expenditure.

13. How future healthcare workforce needs are being forecast, and the impact of people retiring from, or otherwise leaving, healthcare professions

(a) Healthcare workforce forecasting is difficult in a stable system, due to the human nature of its constituent parts. However, in the context of a system that is undergoing dramatic change on an almost constant basis, it becomes virtually impossible. Logically, one should decide the structure of the healthcare system required, and by implication the balance of healthcare workers necessary to deliver such a system, before revising the structure of training and commissioning.

(b) In the transitional period of the next few years, it is essential that there is regular consultation between Colleges, CfWI and DH, that allows expertise and data developed within the Colleges’ workforce planning departments, and which is often multi-professional in nature, to be devolved to local recruitment programmes.

(c) The impact of retirements is grossly underestimated. The College’s current workforce database can be manipulated to show the impact of different retirement ages and rates on the numbers of new trainees needed to maintain an adequate pool of trained CCT-holders for vacancies arising across the country.

(d) Pathology service reconfigurations are already being manipulated by Trusts to encourage consultants to retire early, and are likely to increase and accelerate the use of Mutually Agreed Resignation Schemes (MARS), resulting in significant loss of clinical capacity, trainers and training opportunities. Workforce planning is further complicated by these schemes that were not previously foreseen.

14. The place of overseas-educated healthcare staff within the workforce

(a) Many medical specialties, including pathology have relied heavily on overseas-educated staff, in consultant, trainee- and non-consultant career-grade posts. Recent changes to immigration regulations have limited the ability of overseas-educated staff to take up posts, compounding service pressures in many departments.

(b) The focus on providing preferential access for UK-trained doctors to training-grade posts and reduced overall medical training numbers due to funding reductions have resulted in large numbers of vacant training posts in some specialties and Deaneries. This has led to training opportunities that could have been taken up by overseas-trained doctors being wasted.

(c) This College, like many others, is committed to increase overseas trainees’ opportunities through relaxation of the Tier 5 two-year restriction in line with the wishes of its 2,000 overseas Fellows and their governments. This has been the subject of discussions with DFID and UKBA. These trainees offer experience and skills not readily available to UK trainees who must deal with the changing profile of disease intrinsic to an increasingly diverse immigrant population. Such relaxation would also increase opportunities for UK trainees and trainers to work overseas to gain further invaluable experience. This reciprocity is fully compatible with UK government’s overseas aid commitments and an essential part of UK postgraduate medical education.
15. How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

(a) The College has expressed concern from the beginning that these proposals are aimed solely at England. A system that does not acknowledge the movement of trainees within and between the home countries is destined to be limited in its scope and ability to accommodate real-life workforce issues. The devolved nations’ Departments of Health already bypass many of the edicts issued by the English DH that relate to education and training; national person specifications are one prominent example.

16. How the public health workforce will be affected by the proposals

(a) This College and the Academy of Medical Royal Colleges supports the position of the Faculty of Public Health that current proposals for reorganizing Public Health in England would discourage further medical entry into the profession at a time when its involvement in the reorganization of the NHS and the prioritisation of the use of healthcare funding is more important than ever before.

(b) Public Health should be reformed as a specialist health authority reporting directly to HEE and/or DH.

December 2011

Written evidence from the Committee of English Deans (ETWP 49)

1. The Committee of English Deans welcomes the opportunity to provide written evidence to the Health Select Committee. The Committee of English Deans represents all the postgraduate medical deans in England. In formulating this response, the English deans are mindful of the collective responsibility to maintain the function of high level programme management and oversight of all 56,000 medical and dental trainees currently in training programmes across the UK, to ensure a high quality supply of medical and dental workforce: enabling them to enter the next stage of their training smoothly, exit into general practice, consultant or staff grade posts, facilitating their access to a carefully constructed and quality assured range of experiences and supervision to ensure that they complete their training with the competences and capabilities expected of them. In addition to this essential function in ensuring a secure supply of doctors and dentists (and in some cases other health care professions) with the right skills in the right place at the right time, postgraduate deans are also responsible in statute as Responsible Officers (RO) of the General Medical Council (GMC) for all medical trainees with respect to medical revalidation. The deaneries play a vital role in ensuring safe patient care.

Our evidence follows the questions set out by the Health Select Committee.

The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

2. All the English deans work at a national and regional level taking an active role in medical workforce planning. Each of us has responsibility as a Lead Dean, working with one or more medical royal colleges to manage the cohort of training numbers, leading selection and recruitment and working to manage aspirations in popular specialties and encourage medical students and trainees to consider less popular specialties. We work with NIHR to support and develop academic programmes. We manage the annual progression of all our medical trainees, to ensure that they meet the GMC and college standard to exit from their specialty with a certificate of completion of training.

3. Professor Sir Peter Rubin has most eloquently clarified the essential nature of role of the doctor. We must ensure that our future medical workforce is able to: synthesise conflicting and incomplete information; manage uncertainty; manage a range of competing priorities; identify and manage risk; be decisive deliver and be compassionate and accept ultimate responsibility for their actions.

4. The deaneries ensure that the doctors completing the programmes have clinical as well as research, education and leadership skills. We also work closely with our provider trusts and training practices to ensure that the senior doctors responsible for providing education and training have the necessary skills. We are working with the new shadow Local Education and Training Boards to match training output to future workforce needs and to develop the commissioning and delivery of multiprofessional education and training for the future workforce.

5. We have faced a series of challenges:
   — Funding to increase the numbers of doctors training for general practice has become increasingly difficult to secure. The funding streams for general practice training are different from those in hospital training and as we have expanded the opportunities to deliver the GP curriculum this has had an impact on service delivery.
   — Reducing the number of trainees in specialties where reductions are necessary has resulted in service gaps in that specialty.
— Allowing trainees time to widen their skills through out of programme opportunities to pursue research or health aid programmes has left gaps in the training programme and a service pressure.
— The doctors of tomorrow have difficulty attaining the experiences and skills that they will need to deliver the future health care because they are essential to health care delivery today. We have difficulty for example enabling more learning in the community and outpatients when trainees are needed to deliver service on the wards.

That training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

6. All English deans ensure that the training programmes within their deanery meet the standard set by the medical royal colleges and approved by the GMC. Each dean in their lead dean role reviews any changes to the curricula and ensures that they reflect the changing nature of healthcare delivery.

7. We continue to face challenges:
— Although we have increased the training opportunities in primary care, we still have insufficient capacity and funding to allow all foundation trainees an opportunity to include four months in general practice and thereby understand the complete patient journey.
— Much of out of hours care is delivered by doctors in training, this combined with the 48 hour week and insufficient consultant presence outside the normal working day reduces the opportunities for trainees to learn the full range of patient care, particularly the care of patients in outpatient setting.

That all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

8. All English deans work actively within their SHA boundaries to ensure that, where appropriate, all healthcare providers take an active role in medical education and training; this includes the independent sector, the third sector and primary care. We also work actively to engage those responsible for commissioning healthcare; we are concerned for example that a change in referral pattern can have a negative impact on the ability of our local health care trusts to deliver the curricula.

9. Postgraduate deaneries are in an unusual position. Most of our activity involves leading, managing and contracting for medical education at a local level. We work closely with commissioners of other healthcare education in Strategic Health Authorities. We hold local education providers to account through a learning and developmental agreement which encompasses the GMC standards for training. We also have a role in specialist activities for which there is a need for both a wide perspective and specific expertise. For example training the trainers and providing support for trainees in difficulty, particularly those of a complex nature as most local education providers have insufficient expertise and experience in managing the more complex cases and the work is time consuming with a high risk of litigation if handled inadequately.

Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

10. The postgraduate deans have already established a range of opportunities for doctors in training, and those who have completed their training to develop skills in leadership. Many of our programmes offer opportunities to learn alongside other professions. For example the Emerging Clinical Leaders Programme which has activity in most parts of the country specifically brings together a range of healthcare professionals. Other activity includes work between the deans and the Royal College of Physicians in their “Learning to Make a Difference Programme”.

High and consistent standards of education and training

11. All the English postgraduate deans are actively involved in ensuring high and consistent standards of education and training. We use a variety of methods, including questionnaires to trainees and trainers, site visits, focus groups and soft intelligence to identify the strengths and weaknesses of our training sites and through the Learning and Development Agreement set specific goals so that every medical training placement meets or exceeds the GMC standards. We work with the Academy of Medical Educators and the medical royal colleges to ensure that our trainers are striving to meet the agreed standards and in particular are leading through example in patient involvement. Many doctors associated with the postgraduate deaneries are GMC partners and associates, contributing to the quality assurance process. Although they will all receive training for their specific GMC role, much of their intrinsic knowledge has been developed through their work in the deaneries.

12. Postgraduate deans are responsible for ensuring the delivery of in training assessments and approval of completion of training for all doctors in training. Deans are the final point of appeal against assessment outcomes for trainees and the experience and expertise of the deans in this regard ensures that doctors entering the workplace are both capable and competent.
That the existing workforce can be developed and reskilled for the future (through means including post-registration training and continuing professional development)

13. Almost all the activity of the deaneries relates to post-registration doctors and dentists. Some deaneries have responsibility for other professions for example Kent Surrey Sussex is responsible for the pharmacy trainee workforce. Deaneries also work with provider trusts and practices in reskilling doctors who have been identified by the GMC or through appraisal as not meeting the expected standard.

Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

14. Postgraduate deans and deaneries are committed to equality of opportunity and many of our teams work actively in schools to widen participation.

With these key themes in mind, the Committee will look at:

Our response focuses on the areas where the deaneries have major responsibility:

Plans for the transition to the new system, up to April 2013

15. The postgraduate deans are most concerned to ensure that our key functions continue seamlessly through transition. We have been particularly concerned that our workforce who have a wealth of specialised knowledge to manage our functions are potentially depleting with the long period of uncertainty and the limitations on recruitment to permanent positions. Although this is being actively monitored through Medical Education England we are concerned that we are taking on new areas such as revalidation of doctors in training without additional resource.

The future of postgraduate deaneries

16. Medical training is very different from most other healthcare professions; doctors spend as long, sometimes twice as long in postgraduate/post registration training as in undergraduate training (some, those in less than full time training, may spend 20 years or more in postgraduate training). The regulation of postgraduate certification of doctors is heavily dependent on assessment of performance in the workplace which in turn is dependent on trainees having the opportunity to work with and learn alongside skilled clinicians who are also skilled in education and assessment. The work of deaneries is complex, ensuring that each of the 65+ specialty and 30+ subspecialty curricula are delivered to the agreed standard and managing a small cohort of individuals who, for whatever reason, are unable to progress through training.

17. Postgraduate deans have increasingly taken a national role, contributing to the strategic thinking on the medical workforce and with their detailed knowledge of medical education to the development of the profession.

18. The majority of our work relates to the NHS but each of us has close working relationships with our local universities and each deanery has delegated responsibility for the pre-registration year. We firmly believe that deaneries should be aligned with the NHS.

19. We are concerned that the dean in particular, as leader of the deanery, should be on the board of any provider led organisations within his or her geographical area. However, we remain concerned that the dean should be employed by or at least have clear accountability to Health Education England and should retain independence from the provider led organisations in order to effect change when standards are not being met.

20. Any future system design needs to resolve some of these issues and address where the following functions reside:

— Holding to account—increasing value through driving up quality and reducing cost. This includes an accountable point of contact for regulators.

— Ensuring capability and capacity—developing training and education providers where necessary.

— Developing and preparing for the future—through proactive workforce planning that works with, but looks beyond the workforce horizons of, clinical commissioners.

— Leading for and with the system—looking after smaller providers and professions and occupying the negotiating space between regulators, professional bodies, unions, the service and DH/Public Health England/HEE.

— Developing innovative solutions to workforce challenges.

The future of Health Innovation and Education Clusters

21. The Health Innovation and Education Clusters are still relatively new and many have not yet had an opportunity to complete their initial projects. We consider that their functions could be subsumed by the provider led organisations.
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The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

22. As service and training are inextricably linked there must be firm connections between commissioning of service and commissioning of training at all levels.

23. Health Education England needs a structure which will ensure that high quality education and training continues and is developed. Any regulatory standards must be met. The paragraphs above have described some of the local issues that postgraduate deaneries have encountered and they will continue despite architectural change. Doctors in training do not necessarily choose to work where there is the best training; many other factors need to be taken into consideration. Equally trainees do not always choose to train and then practice where there is greatest workforce demand.

24. The current process of quality assurance as set out by the General Medical Council is predicated on quality control of local education providers through their own internal processes, quality management by the postgraduate deanery and quality assurance by the GMC. If the deanery functions in relation to quality assurance are housed in the healthcare provider skills networks, which is made up of and is commissioned by the local education providers there is a significant risk of conflict of interest. This will not be the case for other professions where the main provider of education is a higher education institution. We therefore believe that the quality management function currently undertaken by deaneries must continue as it forms an essential component of the GMC Quality Improvement Framework.

25. The Medical Programme Board has established considerable harmony across the varied stakeholders involved in medical education and training, we hope it will continue. We also believe that there would be considerable merit in a modified form of the current Committee of English Deans becoming a subcommittee of HEE or Medical Programme Board.

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

26. As described above the relationship between the Local Education and Training Boards and the postgraduate deaneries is key. There may be merit is considering the deanery separately from the Postgraduate Dean. The deanery will need to be housed in a legal entity. For most of our activity this could be one of a number of organisations.

27. However, the level of litigation from doctors in training continues to rise; the postgraduate deans and their deaneries are seen as the key to entry to the specialist register or achievement of full registration. The consequences of losing a case are significant, not only because of the significant (often multi million pound claims) financial penalty but also the reputational damage. This responsibility may influence the willingness of NHS organisations to take on the hosting arrangements for the deanery. The whole will be made more complex if the dean and deanery is accountable to the organisations which were responsible for training provision for the litigant.

28. There are times when postgraduate deans have to stand firm over standards and times when we need to alert the General Medical Council to unacceptable practice/behaviour. We could find a conflict of accountability if we are employed by and report to a provider organisation.

29. Finally the Postgraduate Dean is the Responsible Officer for revalidation and must be licensed to practise to undertake this role. He or she will therefore need a Responsible Officer. It clearly could not be a medical director of one of the local provider organisations. One solution could be that the postgraduate deans report to and are revalidated by the Director of Education of HEE but this is only possible if that person is medically qualified and licensed.

How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

30. For the medical profession all the curricula are approved by the GMC.

The implications of a more diverse provider market within the NHS

31. As explained medical training is long and much is based in a clinical setting. If the diverse provider market limits the opportunities for training because the clinicians delivering the service do not meet the GMC standards for trainers or the environment is unsuitable the supply of the future workforce will be put at risk. The postgraduate dean is well placed to advise the provider networks what is and is not possible to ensure safe training and secure supply.
The role and content of the proposed National Education and Training Outcomes Framework

32. The Education and Training Outcomes Framework is still at a high level and is insufficiently detailed to determine whether or not it will marry with the expectations of medical regulation. The MEE Task and Finish Group on Medical Quality Metrics struggled to identify meaningful outcome measures for medical education where no single organisation is responsible for the duration of a doctor’s training.

The role of the Centre for Workforce Intelligence

33. The Centre for Workforce Intelligence is still relatively new. It is essential that HEE has an overview of workforce plans and ensures that small specialties and those with a national perspective including most of the medical specialties are managed through national coordination.

How funding will be protected and distributed in the new system

34. The English Deans consider that there must be protection of funding for education and training to include the direct costs as allocated through the MPET budgets and also the indirect costs. The latter includes all the consultant time invested in developing curricula and assessment methodologies, time invested in quality management and quality assurance and time invested in the annual review of progression, all of which are essential to securing the supply of the future medical workforce and most of which are achieved through good will. There is continual pressure to achieve greater clinical output at the expense of education and training.

The impact of people retiring from, or otherwise leaving, healthcare professions

35. The impact of potential loss of the Clinical Excellence Awards and changes to pensions could be an increase rate of retirement of senior doctors many of whom hold key positions in the deaneries and colleges. Replacing the expertise and the corporate memory will be extremely difficult.

December 2011

Written evidence from the Royal College of Surgeons (ETWP 50)

Summary

1. The Royal College of Surgeons welcomes the Health Select Committee’s inquiry into education, training and workforce planning. The College supports the emphasis on the multi-professional development of the entire healthcare workforce. There needs to be a national approach to the delivery of postgraduate medical education and training and workforce planning, to ensure that consistent standards exist. At the undergraduate level the College wishes to see a core national medical school curriculum and greater time spent in hospitals and other clinical care environments to ensure doctors entering postgraduate medical training have consistent skills. We also believe it is essential that the detail of the future of medical education and training is worked out within the next six months to ensure its delivery is not put at risk during the implementation of the health and social care reforms. The College believes there remains an unaddressed need for the independent setting, assessment and monitoring of national standards for education and training and impartial quality assurance both nationally and regionally.

2. If the changes proposed in relation to the Health and Social Care Bill to health education and training are wrong they will affect the stability of the healthcare workforce and impact ultimately on patient care. This response highlights specific areas of concern that need to be addressed in order to support the future healthcare workforce and deliver high quality care to our patients.

Surgical Education and Training

3. Education and training of healthcare professionals is fundamental to the delivery of quality of care and patient safety. For doctors training in the craft specialties, such as surgery where there is an emphasis on technical skills, it is the balance between education and training that is important. It is vital that the weighting given to training in the craft specialties is recognised and supported as this leads to the development and refinement of clinical judgement and technical skills which are essential for patient safety. This requires incentivising training throughout the service, making the most of training opportunities and ensuring sufficient time is available and that trainees and trainers are supported by the senior hospital management team. Effective working across relevant professional groups is essential to the delivery of high quality healthcare education and training and therefore patient safety.

4. In recent years many publications have suggested a reduction in the volume of practical training being undertaken by surgical trainees in comparison to those completing surgical training programmes prior to the full implementation of the working time regulations. Several such studies, based on reviews of logbook data, indicate that a direct effect of reduced working hours for surgical trainees has been a significant reduction in the volume of procedures performed and a dilution in experience and competency obtained at each level.
5. Surgical trainees are completing training and entering specialisation as consultants with diminished operative experience compared to previous generations. 77% of those trainees who replied to a recent Association of Upper Gastrointestinal Surgeons (AUGIS) survey stated that they would require additional training at the end of their programme with 95% of trainees wishing to undertake a fellowship after completion of training. Nationally the GMC’s 2011 training survey found that of all the medical specialties, surgery was the one where trainees were the least satisfied with their training and this position has changed little since 2006.

6. The College believes that professional bodies should have a greater role in setting specific standards for educating and training. Current quality assurance process is not sufficiently robust and should include independent professional groups such as Royal Colleges. Under the current education and training system the College is responsible for the training curriculum and for recommending trainees for accreditation to the respective regulator. The GMC sets and monitors standards for postgraduate medical training, scrutinises postgraduate curricula and examinations and quality assures training posts. The latter is based principally on an annual questionnaire/survey of trainees and trainers and triggered deanery-wide visits. At present, this system of monitoring and assessing training lacks the rigour of independent, specialist oversight. The medical Royal Colleges are ideally placed to provide this, as the bodies with ongoing responsibility for the curriculum.

Surgical Workforce Planning

7. The College as part of its commitment to maintain the highest standards of surgical practice and patient care supports the need for a clear workforce planning process for delivering the best possible care for the population. Workforce planning is necessary for making strategic decisions for the design and delivery of healthcare. Despite a wide range of workforce data being available, there is general agreement that this information is inaccurate and misrepresentative. A professionally led approach to collecting workforce data is the only reliable way to proceed to ensure robust data are obtained so that stakeholders can gain an in-depth understanding of surgeons’ working patterns and the services they deliver.

8. In 2010 the College, in collaboration with the surgical specialty associations, published the results of the first comprehensive census of the surgical workforce in England, Wales and Northern Ireland. The report provided data on workforce numbers as well as surgical subspecialty interests, working practices and retirement intentions. This information should improve workforce planning. It is essential that the Centre for Workforce Intelligence works in partnership with the profession and the proposed new structures with a remit to deliver education, training and workforce planning in order to achieve a step change in how workforce planning is undertaken and delivered. The Department of Health needs to recognise the cost of undertaking this work by the College and the value of the work to the CfWI and encourage closer collaboration.

RCS Concerns about the Impact of the Health and Social Care Reforms on:

(a) The education and training system

9. The College believes the proposed reforms of the education and training system have the potential to improve surgical training and address some of the fundamental problems that have been highlighted by both trainees and trainers, such as the availability of sufficient time in which to train/be trained.

10. Clinical representation on Health Education England—The College welcomes the establishment of Health Education England (HEE) and its responsibility for multi-professional development of the entire healthcare workforce. In the new system there needs to be strong independent clinical representation, standard setting and quality assurance from the professions through the Royal Colleges and those bodies responsible for the educational standards of colleagues in other healthcare professions.

11. Accountability of Local Education and Training Boards—We believe that at the local level the core functions such as contractual arrangements, rotations and running assessments need to be maintained. The core functions need to be laid out in the authorisation criteria and contractual arrangements with the Local Education and Training Boards (LETBs). There needs to be a specific consideration of research training for surgeons to ensure that all surgeons in training have an understanding of research and the option to participate further during their training. HEE will need to be assured that these functions are supported and delivered by the LETBs. It is essential that LETBs should involve a broad range of partners and be inclusive in their membership.

12. Delivering the Educational Outcomes Framework—The proposed Educational Outcomes Framework (EoF) has the potential to set standards and measure the quality of education and training. We believe there should be an enhanced role for appropriate Royal Colleges and other professional bodies in further developing this framework. The Colleges should be involved in the setting of standards relevant to training in a particular specialty within the EoF and this should be set in a context which includes consideration of the wider healthcare team and their respective educational standards. The profession, together with relevant partners, should also be fully involved in monitoring quality at both national and local level, for which both time and resource will be need to be provided. Robust externality is necessary to ensure the quality and consistency of national standards and delivery of training. Monitoring tools should include face to face feedback, surveys and logbook analysis. HEE should mandate the Colleges to do this work and fund them accordingly.
13. Funding of Continuing Professional Development—The College broadly supports the proposals that resourcing Continuing Professional Development (CPD) should become a responsibility of providers (employers) as well as remaining a responsibility of each individual surgeon. CPD is essential for the development of the existing surgical workforce in maintaining and improving standards across all areas of practice. Evidence of participation in CPD activity will be a compulsory requirement of revalidation in order for doctors to demonstrate continued fitness-to-practice. We support the proposed flexibility for providers to deliver this, such as collaborating with other providers. However we are concerned that funding for CPD does not appear to be protected and that funding for this is likely to be threatened by pressures on budgets. Providers will also need to provide time for CPD activities as well as funding. Oversight of CPD by HEE and the relevant Colleges/professional bodies is needed to ensure CPD remains accessible to the entire healthcare workforce.

(b) Workforce planning

14. It is our view that surgeons need to be trained to provide excellent patient care across the health service, not solely oriented to meet local workforce needs. Workforce planning is not sufficiently robust or sophisticated to ensure we train the right number of specialists to meet national, let alone local needs; freedom of movement by specialists between the trusts and devolved nations can only be supported if standards of training are uniform.

15. National partnerships with the Centre for Workforce Intelligence—The Centre for Workforce Intelligence (CfWI) should be accountable to Health Education England to ensure that it is fulfilling its role in data analysis and information provision. Many professional bodies such as the College have workforce data so it is essential that these organisations are suitably funded and are included in the work of the CfWI, rather than the CfWI duplicating data gathering that already exists. The CfWI should be open and transparent to ensure it has the confidence of the profession and can be effective in carrying out its role.

December 2011

Written evidence from the Royal Pharmaceutical Society (ETWP 51)

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain. The RPS leads and supports the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession’s policies and views to a range of external stakeholders in a number of different forums.

SUMMARY

The RPS believes that there is a need to ensure that provision of education, training and professional development mirrors the patient journey and that emphasis is placed on service delivery across the sectors of care. It is vital that workforce planning and development accounts for the entire workforce delivering services in the NHS including small providers, private providers and self employed healthcare professionals as well as considering the numbers of healthcare professionals needed for other roles such as regulation, academia and industry.

The NHS is attempting to make large efficiency savings whilst the demand for health services is increasing due to an ageing population and associated health burden and increasing complexity of medicines and rising number of prescriptions dispensed year on year. In taking these factors into account alongside the Government’s proposals, we have concerns about the pace of change and how the demands of the proposed timeline will be managed.

The RPS supports the principles of further integration of workforce, financial and service planning. However we believe that there is insufficient detail and clarity on how workforce provision will meet healthcare demand. We have concerns regarding long-term planning and how service integration will occur. We also feel that there is a lack of clarity about advocacy and engagement with Local Education and Training Boards.

The RPS welcomes the opportunity to respond to the Health Committee’s invitation to submit written evidence: education, training and workforce planning. The evidence we submit follows the structure of the Health Committee’s terms of reference and call for evidence.

KEY THEMES

Ensuring the right numbers of appropriately qualified and trained healthcare staff at national, regional and local levels

There is evidence that workforce planning needs to be more consistent across professions and organisations. Also, roles and responsibilities at each level currently lack clear definitions.

Current Government proposals describe the role of healthcare professional regulators however it is also important to consider the role of the professional bodies such as the RPS in planning the workforce. More
robust workforce planning at regional and local levels may be supported by workforce and capacity planning being aligned to professional standards.

The RPS has evidence of a decline in the number of pharmacists involved in pharmacy undergraduate courses and we believe that this is part of a wider decline in the number of clinical academics and teaching staff on healthcare courses. Appropriately qualified and trained pharmacists need appropriately qualified and trained pharmacists to educate them in order to ensure a workforce for the future.

Although there have been improvements in workforce planning in the healthcare system, more needs to be done, especially with respect to long term workforce planning, given the long lead time it takes to train pharmacists (four years MPharm degree followed by one year pre-registration training year = five years). There is insufficient evidence as to how Government proposals will support this. We are also anxious that a more market based approach will risk workforce imbalances in future.

Ensuring that training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

More attention needs to focus on linking training curricula to robust career pathways that produce high quality professionals but are also flexible and adaptable so that professionals can change direction if necessary in order to counter mismatches between supply/demand, comply with new medico-legal structures or the changing nature of healthcare delivery. Greater consideration is also needed of the impact of technology on training curricula eg centralised robotic dispensing and its impact on the education of community pharmacists. The RPS has an important role, working with specialist pharmacy groups to develop professional curricula for post-registration development that are focussed on clinical outcomes and that promote excellence in practice.

Ensuring that all providers and commissioners play an appropriate part in developing the future workforce

The RPS still needs to be assured of the full engagement of both NHS and non-NHS organisations in the proposed new system. Reassurance is also required about preventing conflicts of interest and that appropriate checks and balances are in place within a market of commissioning, funding and delivery of education and training.

Ensuring multi-professional and multi-disciplinary leadership and accountability at all levels

This is critical if an equitable distribution of funding is to be achieved and therefore smaller professions such as pharmacy should be included in the leadership of the new education and training system. It is also an opportunity to develop multi-professional leadership capabilities. The RPS would welcome more detail about leadership and accountability (across the professions, specialties, grades and levels) to be assured that the governance and function of the new system is appropriate.

Ensuring high and consistent standards of education and training

Current budgetary restrictions and the fragmented nature of the proposed new system put this at risk. Employers and education providers need to be given further incentives to work closely together to deliver high quality training. There is evidence that employers seeking to achieve short term financial savings may be inhibited from providing clinical placements. Pre-registration pharmacists’ needs for clinical placements must be considered alongside other healthcare professions and therefore a multi-professional approach is to be welcomed. However, we are not convinced that problems already existing with finding sufficient pre-registration trainee pharmacist placements (currently funded by the MPET levy (for NHS employers) and the community pharmacy contract) will be alleviated by the proposals. Smaller employers may find it difficult to provide the required infrastructure for clinical placements.

Ensuring that the existing workforce can be developed and reskilled for the future

Recent years have indicated that Continuing Professional Development funding streams have become more difficult to access and many professionals are unaware of options for professional development. Considerable progress has been made in pharmacy with skill mix and ensuring support staff are appropriately trained—it is not clear how the proposals will sustain this approach, indeed we are concerned that there will be much less support for developing support staff who are important for freeing up professionals’ time.

Ensuring open and equitable access to all careers in healthcare for all sections of society

Greater confirmation of joined up thinking is necessary between the Government’s proposals for developing the healthcare workforce and the higher education reforms which concentrate on traditional entry into Higher Education via A-levels. There needs to be an equal focus on other routes so that access from all sections of society is improved.

With the above key themes in mind the RPS welcomes the opportunity to comment on:
Plans for the transition to the new system up to April 2013

Experience from previous NHS reorganisations remind us that the transition period will need to be well resourced and managed with considerable care so that organisational memory is retained.

There is a danger that there will be a lack of integration between different parts of the system and a shortage of people with the right skills to do the job effectively.

The future of postgraduate deaneries

The RPS believes that the future of postgraduate deaneries must be to move to multi-professional within the NHS ie not just medicine and dentistry—evidence is lacking that this is currently the case.

The future of Health Innovation and Education Clusters (HIECs)

More needs to be known about the work of HIECs and their success in terms of outputs. The RPS would welcome a review of the HIECs continuing role and purpose within the healthcare system.

The role of the Secretary of State for Health in the new system

The RPS supports the proposal that it must be an explicit duty for the Secretary of State to maintain a system for professional education and training as part of a comprehensive health service.

The proposed role, structure, governance and status of Health Education England (HEE) and its relationship to professional regulators and to other parts of the new NHS system architecture

The creation of HEE is a good idea but the balance between local and national oversight is of critical importance to ensure success. The new framework for planning and developing the workforce includes professional regulators but does not include professional bodies. The RPS, as the professional body for pharmacy, is best placed to lead on professional standards for education and training and professional development.

There may be a role for HEE to commission national training programmes for the pharmacy workforce to ensure delivery of services can be maintained across geographical boundaries. We support the remit of HEE as a multi-professional body and we believe it will be important for HEE to be given responsibility for the education budget.

The proposed role, structure, status, size and composition of Local Education and Training Boards

It is unclear what the impact will be on private providers (such as community pharmacy) of Local Education and Training Boards especially how they will be funded and costs, including administrative costs, be allocated and shared. The line of accountability between Local Education and Training Boards and HEE are not apparent. Authorisation of Local Education and Training Boards by HEE to address issues relating to governance, accountability and potential or perceived conflicts of interest, and how Boards will relate to Clinical Commissioning Groups and the Commissioning Board needs further work.

How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

National accreditation and standards will need to be in place to ensure that the pharmacy workforce can move between geographical areas whilst still maintaining delivery of services. We also believe that it will be important to forge closer links between healthcare providers and academia and the proposals need to support this process. Healthcare providers need to understand the education supply chain and what HEIs are able to provide and vice versa.

The implications of a more diverse provider market within the NHS

Commercial considerations regarding data collection and workforce planning will be important for private providers such as those found in community settings or future Foundation Trusts. Pharmacy includes many smaller, private providers, eg small independent community pharmacies, who employ very small numbers of staff and there is evidence that workforce planning, including data provision, may be onerous for them.

How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

There are already a range of existing arrangements in place across the pharmacy profession. There is an opportunity to ensure that pharmacists in all sectors are able to consistently access quality training and education regardless of their sector or place of work.

Responsibilities for planning and developing the workforce must apply to all providers of NHS funded care. Greater clarity is needed however on how the proposals would be implemented and developed for private
providers of NHS services such as community pharmacies (including the roles of self employed professionals such as locum pharmacists), secure environments, private clinics and hospitals etc.

Healthcare providers have an obligation to plan thoughtfully for the whole workforce however it is vital that this obligation is measured and monitored and that mechanisms to address the situation are available if this obligation is not met.

The role and content of the proposed National Education and Training Outcomes Framework

The RPS supports a greater focus on education and training outcomes but there is limited evidence available and this is an area that requires further investment and development.

The role of the Centre for Workforce Intelligence (CfWI)

The RPS has been working closely with the CfWI providing valuable input and engagement in areas such as professional advice, scenario planning and benchmarking—these are essential for accurate workforce planning.

The roles of Skills for Health (SfH) and Skills for Care (SfC)

The RPS supports the continuing role of these sector skills councils. SfH and SfC should continue to focus their support for a more skilled and flexible workforce.

The role of NHS Employers

The RPS supports the continuing role of NHS Employers and would recommend that it works more closely with non-NHS employers providing healthcare.

How funding will be protected and distributed in the new system

We would urge that the funding system is ring fenced. Guidance needs to be developed by HEE so that funding is fairly and transparently distributed to provide consistent opportunities for multi-professional training and education. We also believe that the funding models need further consideration.

How future healthcare workforce needs are being forecast

Current workforce models appear to be inadequate with many professions over or under supplied. The government needs to provide greater support for workforce modelling so that future healthcare workforce needs are more accurately predicted.

Data currently collected and used for workforce planning is of either non-existent or of variable quality and accuracy. There are also issues with workforce planning for specialist healthcare professionals as the data collection may not be sophisticated enough to ensure workforce planning at a specialist level.

The impact of people retiring from, or otherwise leaving, healthcare professions

Better succession planning is needed. At present it is not clear how the Government’s proposals support this. The needs of all staff, including part-time and temporary staff as well as staff on maternity leave or a career break, need to be taken into account in the development of these proposals to ensure that no groups or individuals are disadvantaged and that the workforce is as flexible and adaptable as possible.

The place of overseas educated healthcare staff within the workforce

As registered pharmacists practising in the United Kingdom, overseas pharmacists play a role in the provision of healthcare, contribute to the economy. The 2008 pharmacy workforce census indicated that over 10% of the UK’s pharmacist workforce qualified overseas therefore adequate workforce planning and education provision should ensure that the reliance on staff trained overseas is reduced so that the UK is more self-sufficient and does not unintentionally cause skills shortages in other countries.

How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

Links to the devolved administrations need to be made stronger and healthcare workforce flows between England and the other countries of the UK more clearly understood.

How the public health workforce will be affected by the proposals

Pharmacists and their staff, in all sectors of the profession, have a vital role to play in public health and it is important that pharmacists are considered as part of the multi-professional workforce strategy for public
Specialist nurses are increasingly important in providing quality care for patients with chronic neurological illnesses, particularly for epilepsy, multiple sclerosis, motor neurone disease and Parkinson’s disease. The distribution of specialist nurses around the country is highly variable and we are not aware that there is any central planning from the Department of Health. The relevant disease specific charities have been very active in the distribution of specialist nurses around the country is highly variable and we are not aware that there is any health. We agree it would be useful for local authorities’ views to be considered, as commissioners of public health services, however this could be achieved via other routes.

December 2011

Written evidence from the Association of British Neurologists (ETWP 52)

1. Specialty Training in Neurology

1.1 Specialty training in neurology is a five year programme, entered by trainees who have completed their foundation training (two years) and core medical training (two years) and is undertaken within a curriculum approved by the GMC in 2010.66 The training, which is overseen by the Specialty Advisory Committee in Neurology, provides what is recognized internationally as a high quality clinical training in neurology.

1.2 Neurology in the UK is much smaller than in the rest of the world—in the UK there is on average one neurologist per 150,000 population as compared to 1 per 25,000 in the rest of Europe.57 There has been a modest increase in the number of neurologists in the UK to bridge this gap and improve the access of patients with neurological problems to specialist opinion. However, because of the shortage of neurological trainees in the UK, many of these posts were filled by neurologists from abroad, mainly other EU countries.

1.3 The recent review by the Centre for Workforce Intelligence (CfWI) concludes that the numbers of trainees are appropriate at the moment.58 Unfortunately their calculations included the “Hewitt-Johnson” posts, whose funding is running out over the next year. As a result the number of trainees will fall by about 10 per year resulting in a significant underproduction of trained neurologists in the next few years.

1.4 We anticipate that more patients and their GPs will want to access specialist neurology services, and that patients with acute neurological disease will require greater involvement of neurologists in their care explored in detail in Local Adult Neurology Services for the Next Decade.59 This will depend on an increase in training numbers beyond those anticipated by the CfWI in its review.

1.5 We are concerned that the central mechanisms controlling training numbers has tended to take a conservative view on potential changes of this sort likely to be brought about by the new commissioning mechanism. In the past they have not been flexible enough to respond to this type of anticipated change. As a result, the significant increase in number of neurologists over the last 10 years was not been met by consultants trained within the UK.

1.6 The training programmes are currently organized across regions to allow the trainees appropriate experience in the wide range of neurological subspecialties and to allow them to be involved in the care of patients with a wide range of neurological disease. With provision of clinical services potentially moving out of the current hospital settings to more diverse providers it is plausible that certain areas of clinical neurology will no longer be accessible to trainees—for example headache or epilepsy clinics. This would fragment training and potentially make it harder to achieve full curriculum coverage.

2. Training in Neurology for Those Other Than for Specialty Trainees

2.1 General Practitioners with a Special Interest (GPwSIs)

Some proposals have suggested that the shortage of trained neurologists may be mitigated by using General Practitioners with a Special Interest (GPwSIs) to provide some neurology out-patients. This is widely used in some other specialties, for example dermatology. However, very few GPs will have had any formal neurological training beyond the one to four weeks as medical students and as yet there is no curriculum or assessment mechanism in place for the training of GPwSIs. If the GPwSI works alongside a consultant neurologist providing clinical support and includes the GPwSI within the clinical governance structure of the neurological team, quality can be assured.

It seems likely that in some areas GPwSI may compete for the provision of services to some patients with neurological diseases outside a neurological team. Given the lack of a formal training and assessment framework the quality and nature of such a service would be uncertain.

2.2 Specialist nurses

Specialist nurses are increasingly important in providing quality care for patients with chronic neurological illnesses, particularly for epilepsy, multiple sclerosis, motor neurone disease and Parkinson’s disease. The distribution of specialist nurses around the country is highly variable and we are not aware that there is any central planning from the Department of Health. The relevant disease specific charities have been very active


57 Acute Neurological Emergencies in Adults http://www.theabn.org.uk/userfiles/file/AcuteNeurologicalEmergenciesinAdults.pdf


59 http://bookshop.rcplondon.ac.uk/contexts/pub354-2b209ee8-11f9-4259-9075-bd6a1accdb3e.pdf
in promoting specialist nurses as they regard them to be of high value for patients. While there are certain qualifications that specialist nurses can achieve, for example an MSc, there is no specialist registration process.

Specialist nurses work most effectively alongside the consultant with expertise in their disease area to allow appropriate support and clinical governance. There is a risk that this may be fragmented by the wider range of providers within the NHS.

December 2011

Written evidence from Education for Health (ETWP 53)

— Education for Health is a charitable educational organisation. We design and deliver educational products that meet the ever changing needs of primary care both across the UK, and further afield. We also believe strongly that one of the greatest levers for improving healthcare outcomes for patients and wider healthcare systems is education. To pursue these objectives we conduct and publish high level research, disseminate information and act as a voice for the nursing community.

— Whilst there is widespread appreciation for the case for reforming the NHS, there has been extensive debate over the shape of the proposed new architecture and the proposed timelines for implementation. This has caused great uncertainty and is currently undermining the commissioning and planning of education across primary care.

— A growing body of research evidence demonstrates the enormous impact that targeted and responsive education can have in improving health outcomes for health care users.

— Research is beginning to paint a picture of the health economic benefits that education can have. Better training means better diagnosis and management, means reduced hospital admissions. More research is needed in this area though and we would urge the committee to consider this need.

— The changing demographics of the nursing community add further impetus to the need for a far reaching educational strategy.

1. We would like to welcome this enquiry. For nearly 30 years now Education for Health have been successfully acting on our belief that education is one of the greatest levers available for improving healthcare outcomes. Education and training empower staff, improve patient outcomes and drive down costs across all health areas. Our courses successfully identify and target needs in primary care and we now offer a range of standardised and bespoke educational products which address major public health concerns such as COPD amongst working age populations as well as courses which meet the health needs of a changing demographic.

2. Whilst there is now widespread recognition of the need to reform elements of our health care systems, the passage of the current NHS White Paper has led to a period of inertia amongst the health care community which is having an adverse effect on training. Those who hold health education budgets are feeling unsure about where they stand and we have seen a subsequent dip in the take up of our courses. Enrolment onto our diploma modules, for example, is down 17% whilst take up of our workshops is down 41%, overall we have seen a 31% reduction in enrolment across the board for 2011 as compared to 2010. The “pause” in the passage of the bill only added to this uncertainty and we would stress the need for greater clarity and leadership in delivering reforms.

3. We would also urge the government to place educational needs at the centre of any on-going reforms. Our own experiences, as well as a growing body of research, show that a greater consideration of the educational needs of HCP’s has an enormous and beneficial effect in a range of long term disease areas. One such example of our research in this area is a randomised controlled trial we conducted into the quality of outcomes for patients with perennial rhinitis. We found a clear relationship between the educational levels of practice staff and the treatment patients received. When comparing a randomised control group of perennial rhinitis patients to another group of patients from practices where educational intervention had occurred, the results were telling. Health related quality of life (RQLQ) improved significantly in the intervention group but not the control group. Likewise there was a trend for greater improvement in RQLQ in the intervention group compared to the control group at the end of the study. A range of other studies support these findings. Most recently a wide ranging study from Peter Griffiths’ team at the University of Southampton, which collected data from more than 8000 English general practices, also indicated the profound role education has in improving healthcare outcomes.

4. It is not just patient outcomes which are enhanced by more focus on education however. By facilitating better diagnosis in primary care, education also reduces the number of people arriving in hospital—often unnecessarily and at great expense. The Nuffield Trust calculated in July 2010, for example, that the accrued

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cost of emergency admissions to hospital was £11 billion per year,\(^\text{63}\) a figure which is rising. Many of these visits are unnecessary however and could be avoided through better educational intervention at primary care level. Across a variety of long-term conditions, education of primary care staff can reduce hospital admissions and save the NHS money. All of this fits well with the QIPP agenda and, we believe, that by ensuring that staff across the health service have adequate training and educational levels, efficiency can be improved greatly.

5. One major issue that currently exists, and hampers the implementation of a better strategy for Education, Training and Workforce Practice, is a lack of research into the health economics of education. There is little appraisal of the value added to the NHS, through savings and patient outcomes (which in itself impacts upon other budgets such as that for social care and benefits), of proactive training and education. At the moment all that seems to exist is the fairly common sense argument that withdrawing educational funding is “false economy”, saving money now but accruing much greater costs down the line—not to mention contributing to a downward trend in patient outcomes. We believe there is pressing need for greater analysis and insight into the full scale of costs and savings involved in the continued education of health care professionals.

6. There have been a number of studies conducted since the 1990s, primarily in the US, which do shed some light on these trends. In terms of analysing patient outcomes, data analysis,\(^\text{64, 65, 66}\) has supported the belief that nurses with greater training levels lead to higher quality of care. This finding has been further supported by research\(^\text{67}\) which has suggested that, for each additional year of nurse experience in a clinical unit, there were four to six less deaths for every 1,000 patients. The economic benefits of a better trained workforce have also been explored\(^\text{68}\) who found that by increasing patient to nurse ratios from 8:1 to 4:1, a great deal more money was saved than through other measures such as screening. Similarly within the context of nursing homes research\(^\text{69}\) has discovered that savings of $3,000 per patient per year could be made by allowing patients just 30 to 40 minutes of registered nurse time. Likewise a Health Select committee investigation\(^\text{70}\) itself found adverse relationships between the employing of temporary staff and diminished patient satisfaction. All of this supports the view that, by investing in nursing education now, we can save money and improve outcomes in the longer term. We believe the government’s reform agenda presents the perfect opportunity to take this research forward and develop a better understanding of the relationship between education, training and patient outcomes, health economics.

7. Demographic trends within the NHS are also making the need for greater clarity of purpose around education a pressing one. The NHS, like many health systems around the world, faces a “retirement bulge”. Around 150,000 of the million people employed by the NHS are aged 50 plus and eligible for early retirement.\(^\text{71}\) These figures are even more pronounced amongst the practice nurse community with figures for 2009\(^\text{72}\) showing that 45% of practice nurses are aged 50 plus and nearly 70% are aged 45 or over. As a result, over the coming decade, the service can expect to lose some of its most experienced staff, leaving a major skills shortage. We believe this trend makes the need for education and training in primary care a vital one and one which cannot be ignored.

8. We would like to thank the Select Committee for instigating and driving this important investigation. We believe it is of vital importance that we now start paying the attention deserved to the economic and organisational logic of investing in better education and training for the nursing community. We have been educating healthcare professionals now for nearly 30 years and have seen first-hand the impact that well designed educational products can have in terms of taking the strain of GPs and hospitals, facilitating better self-management amongst patients and earlier, better diagnosis which means better health outcomes.

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\(^{72}\) Royal College of Nursing, Practice Nurses in 2009. Results from the RCN annual employment surveys 2009 and 2003.
Written evidence from Medical Schools Council (ETWP 54)

1. Background and Summary

1.1 Medical schools are the UK’s centres of excellence in medical education and training and should be the first port of call for any inquiry into education, training and workforce planning. Medical schools are clear that only through the alignment of academic endeavour with patient care can service transformation and improved quality be brought about in the NHS.

1.2 The Medical Schools Council represents the interests and ambitions of UK medical schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine. The membership of the Medical Schools Council is made up of the Heads or Deans of the 31 UK undergraduate medical schools, plus the postgraduate London School of Hygiene and Tropical Medicine.

1.3 Key issues for the Medical Schools Council relevant to the themes of the inquiry are listed below. However we suggest keeping the Inquiry open until after the DH has published its recommendations for Education and Training, in order that the Committee might receive views on actual rather than speculative plans. While many issues raised in our response refer to the context in England specifically, many challenges and solutions we identify are applicable across the UK. Addressing these common challenges will only be possible through sharing information and good practice across the UK, the Medical Schools Council is committed to this.

1.4 Summary:

— Health Education England (HEE) should be established as a matter of urgency to avoid damage to local relationships through the establishment of “shadow” Local Education and Training Boards (LETBs).
— HEE must relate to, and learn from, the Devolved Administrations.
— LETBs must include Higher Education Institutions (HEIs) as full partners with the providers of healthcare in order to achieve excellent and innovative education and training and thus improved patient care.
— Postgraduate deaneries and HEIs must be closely aligned, through honorary contracts and joint NHS/university appraisals.
— The transformative potential of Academic Health Science Networks, and the equivalent in the Devolved Administrations, should be harnessed for education, training and research as well as service delivery.
— The role of the GMC in curriculum development should be maintained. Curricula cannot be adapted piecemeal to meet local demands and the national regulator’s role in quality is vital.
— Clarity is needed on the relationship between “outcomes” and “domains” in the NHS Education Outcomes Framework and effective metrics must be developed if it is to be of practical use.
— Educational funding must be ring-fenced, must not be further diluted and should transparently follow the student.
— There must be a reasoned approach to workforce planning which ensures flexibility, especially in higher training.
— A properly resourced Centre for Workforce Intelligence (CfWI) (or equivalent body), working on behalf of HEE, should seek to develop long term plans based on realistic estimates.
— Changes to the immigration system should not remove the attractiveness of working and studying in the UK due to the importance of: diversity of our medical students, the overseas educated workforce to the NHS and the need to retain global competitiveness.
— The public health workforce needs clarity, stability and leadership to ensure it meets the challenges of health inequalities and an ageing society.

2. Stable Transition

2.1 LETBs must include universities as full partners with the providers of healthcare. This is necessary because:

— Medical education is a continuum from medical school to retirement, and medical schools need to be true partners of NHS colleagues in primary and secondary care—designing new systems together—and preparing doctors for the myriad, ever-changing roles required of them.
— Employers cannot quality assure the posts that they themselves provide to train the staff whom they also employ. Conflicts of interest are present for all involved in education and training, and partnership is the only way to overcome this.
— Medical schools are responsible for managing quality issues arising from GMC feedback on placements. Without high level input into LETBs, medical schools will not be able to discharge this function.
— Academic expertise is needed to both inform and transform education and training.
2.2 We are concerned that piecemeal establishment of “shadow LETBs” is taking place in the absence of national guidance. Medical school experiences have included:

— Active exclusion from discussions about the development of LETBs.
— Absence of consideration of quality assurance in LETBs’ design.
— Inconsistent communication between Strategic Health Authorities (SHAs) taking forward plans for LETBs, and HEIs.

While we recognise that HEE will be authorising LETBs to national standards, “shadow LETBs” pose a real threat to damaging local relationships.

2.3 HEE should be established as a matter of urgency, with close links with the Devolved Administrations to ensure a UK wide oversight is maintained.

— National quality requirements must be imposed on every LETB to ensure high and consistent standards.
— Good practice should be identified and adopted from NHS Education for Scotland and the nascent Welsh Board for Academic Medicine.

2.4 Action must be taken to prevent loss of education and training expertise in SHAs and Deaneries.

3. **National Structures**

3.1 We welcome the duty on the Secretary of State to maintain a system of education and training in the NHS.

3.2 HEE needs to link to DH directly, in the same way as the National Institute for Health Research (NIHR), rather than via the NHS Commissioning Board (NHSCB). This will ensure clear lines of accountability, reflecting the Secretary of State’s responsibility to maintain the education and training system. Additionally, HEE must be given “teeth” with the right to call on the NHSCB for support if local plans cannot be accommodated within national requirements.

3.3 HEE must have a defined relationship with the Health Education National Strategic Exchange (HENSE), with stronger links between both NIHR and HENSE and between HEE and the Office for Strategic Coordination of Health Research (OSCHR), to coordinate and maximise research outputs alongside consideration of education and training.

3.4 There must be strategic oversight looking at developments in all the Devolved Administrations to avoid opening any chasms between medical training systems in the UK, particularly if these might jeopardise free flow of graduates across borders. Such oversight is also necessary to inform possible changes in medical student numbers.

3.5 In terms of the role of Skills for Health and Skills for Care, we welcome the review of issues of the appropriate training, role and regulation of healthcare assistants being undertaken by these bodies.

4. **Local Structures**

4.1 Key principles developed by the Medical Schools Council (MSC) and Conference of Postgraduate Medical Deans (COPMeD) on the future of postgraduate deaneries are appended. In summary, we believe that:

— All postgraduate deans should have an honorary contract with their local university and should have joint appraisal with the university and NHS along Follett principles. COPMeD/MSC should work to develop a model contract for use locally, to ensure that this link is strong.
— England should align itself with developments in the Devolved Administrations on working relationships between postgraduate deaneries, HEIs and the NHS. This will ensure coherence within and between countries in the UK.
— Postgraduate and undergraduate medical deans should jointly ensure that academic training programmes, with their key role in innovation and growth, are of the highest standard.

4.2 As outlined above, less than full academic partnership on LETBs would mean that they fail to flourish and provide the NHS with the innovation it needs. We acknowledge that concerns have been raised that HEI involvement on LETBs will produce conflicts of interest. We think it should be recognised that NHS providers commissioning placements from themselves also present potential conflicts of interest. Medical schools are required by the GMC to act as Quality Managers for clinical placements. Without executive membership of LETBs and the capacity to change the distribution of placements, medical schools will not be able to discharge this function.

4.3 An independent chair and partnership on LETBs between HEIs and healthcare providers will produce stable entities and address any conflicts of interest. This replicates a model which has been found to be successful in Academic Health Science Centres.

4.4 The transformative potential of Academic Health Science Systems/Networks should be harnessed for education, training and research. These partnerships between academia, the NHS, the third sector and local authorities are designed to provide innovative solutions for service, education and research delivery and are
emerging as catalysts for change. Designation of “Academic Health Science Networks” (AHSNs) (as proposed by DH (2011) Innovation, Health and Wealth) is a welcome step, particularly as “every local NHS organisation should aspire to be affiliated to its local AHSN”. Criteria for AHSN designation must include the importance of education and training as well as research and service delivery and there must be sufficient funding to incentivise partnership. There will be variation across the UK in how AHSNs work, based on local factors, but all AHSNs must be integrated with LETBs.

4.5 Health Innovation and Education Clusters (HIECs) have delivered real benefits in transforming certain care pathways. We would argue that these initiatives and their funds should not be lost and that they should take their place as part of larger AHSNs.

5. Regulation, Quality Assurance and Outcomes

5.1 The role of the GMC in curriculum development (through setting standards in Tomorrow’s Doctors) should be maintained. Curricula cannot be adapted piecemeal to meet local demands and the national regulator’s role in quality is vital. There must also be respect for university processes, with acknowledgment that if something comes into the curriculum something has to come out.

5.2 We see AHSNs having a role in curricula development in partnership with the regulator. For example, one medical school is redesigning its medical undergraduate curriculum to align with the focus of the Academic Health Science Partnership to which it is attached. Building on practice such as this will help to develop training programmes that are increasingly sensitive to population healthcare needs. It is also the intention that AHSNs will share best practice.

5.3 Clarity is needed on the relationship between “outcomes” and “domains” in the NHS Education Outcomes Framework and effective metrics must be developed if the Framework is to be of practical use. The framework needs to recognise that without transparency in the detailed allocation of educational budgets, it will be impossible to raise the quality of education in Trusts and in primary care, meaning that desired educational outcomes will not be achieved. There must be the means to withdraw funding if independent quality assurance processes find that employers are failing to provide education of the required quality.

6. Protection and Distribution of Funding

6.1 Educational funding must be ring-fenced, must not be further diluted and should transparently follow the student. Trusts should provide detailed evidence of how SIFT and MADEL are spent, this should also apply to equivalent arrangements in the Devolved Administrations.

6.2 SIFT payment rates for primary care clinical placements must be set at a level sufficient to allow medical schools to continue to move placements out of secondary care into primary care, to align with the move towards community care.

6.3 As envisaged on the last review of the Multi Professional Education and Training budget (MPET), a proportion of MPET should be reserved, and awarded after successful provision of education and training to ensure that high quality is delivered in placements. We envisage that this could be coordinated jointly by undergraduate and postgraduate deans reporting to LETBs.

6.4 The outcome of the MPET Review should be proportionate and based on MPET income rather than trust turnover. Transition is key and changes need to be phased in. A transparent process for on-going review, allocation and determination of funding is essential to ensure protection of educational budgets in the context of a challenging financial environment.

7. Workforce Planning

7.1 There must be a reasoned approach to workforce planning which ensures flexibility, especially in higher training. This should not be driven by unrealistic workforce models which ignore trends of early retirement and feminisation of the workforce. Work with medical royal colleges will be important to ensure flexible career pathways for the workforce which are aligned with undergraduate curricula and delivered to a high standard.

7.2 CfWI (or an equivalent body) working on behalf of HEE, should seek to develop long term plans based on realistic estimates. We believe that greater resources will be needed to allow CfWI to provide LETBs and HEE with the information required. Workforce planning must take a UK wide approach.

7.3 The number of consultants taking voluntary early retirement has increased by 72% in one year. We are concerned that this may destabilise the system and may be an unintended consequence of NHS reforms and changes to the NHS pension.

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73 DH (2011) Innovation, Health and Wealth, p 19
75 Medical Service Increment for Teaching.
76 Medical and Dental Education Levy.
76 HSJ (2011) Number of consultants retiring early rises
http://www.hsj.co.uk/news/workforce/number-of-consultants-retiring-early-rises/5038103.article
7.4 A decision is still pending regarding Clinical Excellence Awards and we are concerned that changes to the way that excellence is rewarded will have a detrimental effect on the incentives for the highly mobile clinical academic workforce to remain working in the NHS.

7.5 Overseas educated healthcare staff members in medical schools contribute directly to the delivery of high quality healthcare services by providing patient care at the highest of levels, as well as through contributions to education, training and research. A large proportion of non-EU academic staff members teaching clinical medicine have not previously been students in the UK. This suggests the importance overseas educated staff to delivering medical education. We would argue that changes to the immigration system should not remove the attractiveness of working and studying in the UK due to the importance of the overseas educated workforce to the NHS.

7.6 The public health workforce needs clarity, stability and leadership to ensure it meets the challenges of health inequalities and an ageing society. Guidance on transfer of contracts for public health academics is required to ensure the protection of this vital workforce. We note that the timeline for PCT clusters to produce their plans is by the end of January 2012 and that a consultation on the public health workforce strategy is expected by the end of December 2011. We feel that this is a challenging timeline for views to be fully considered before plans are made. Medical schools have experienced difficulties with securing appropriate honorary contracts for academic GPs in the absence of national guidance and some PCTs have declined to offer these. It is essential that this is not also the experience of clinical academic members of the public health workforce.

7.7 The academic career structure for public health is lacking clarity and this may influence the sustainability of the academic public health workforce. Successes in the broader academic training pathway should be replicated. Medical Schools Council is seeking to work with the Faculty for Public Health and Academy of Medical Sciences on this issue.

7.8 A strong identity needs to be fostered for members of the public health workforce. Medical members of the public health workforce must feel that they have a unique and valued role in the public health team. This should be facilitated through ensuring NHS contracts for medical public health professionals.

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APPENDIX

COPMED/MSC JOINT WORKING BETWEEN UNDERGRADUATE AND POSTGRADUATE DEANS—AGREED PRINCIPLES

COPMeD and MSC members have agreed that the structures and guiding principles for the delivery of medical education and training must reflect a consistent, common approach across the UK. This will enhance the transition between the undergraduate and postgraduate arenas for the benefit of trainees and patient safety. In addition, it has the potential to allow the sharing and development of best practice which should allow for economies of scale and add value to the wider medical education continuum.

The fact that there is now a single regulator in the UK for medical education provides an opportunity to develop such a continuum. Indeed, the GMC has indicated that it wishes to see evidence of close collaborative working between medical schools and postgraduate deaneries. Joint working between medical schools and postgraduate deaneries would facilitate this broad aim.

We look to the Departments of Health UK Scrutiny Group, to the GMC and to the Academy of Medical Royal Colleges to support us in this. Benefits would accrue from greater commonality across the health educational and workforce development sector; the different health professions may wish to devise their own sets of similar overarching principles.

The Health Select Committee and Earl Howe in the House of Lords, have recognised the requirement for closer partnership and collaboration between Higher Education Institutions (HEIs) and the NHS. It is hoped that that the authorisation criteria for Local Education and Training Boards (LETBs) in England will reflect this.

KEY PRINCIPLES

— Collaboration between undergraduate and postgraduate medical education and training (pgmet) should be enhanced and a continuum developed between undergraduate and postgraduate education and CPD, as expected by the GMC as regulator. Such a system would enhance patient safety and deliver excellence in education and training.

— All postgraduate deans should have an honorary contract with their local university(ies), with joint appraisal developed with the University(ies) and NHS along Follett principles. COPMeD and MSC will work to develop a model contract for use locally, to ensure that this link is strong and consistent. The processes employed must also be able to support the revalidation of PG Deans.

— Consideration should be given to extending such arrangements to other roles within pgmet. For example, senior postgraduate medical education roles such as deputy or associate postgraduate Deans and similar. Any such arrangements will need to take account of the variation in organisation, roles and responsibilities across the UK.
MSC and COPMeD should work collaboratively to ensure the effective implementation of the GMC standards for the recognition and approval of trainers.

England should align itself with developments in the Devolved Administrations (DAs) on working relationships between postgraduate deaneries, higher education institutions and the NHS. This will ensure coherence within and between countries in the UK.

The Quality Management (QM) and Quality Enhancement (as part of the GMC’s Quality Improvement Framework—QIF) of undergraduate and postgraduate posts/placements should be managed collaboratively, with funding following quality and hence to placements/posts that offer demonstrable value in achieving defined educational outcomes. Such QM processes should include resolution of the tension between education, training and service requirements with appropriate time for these activities being formally recognised in all job plans of those with defined educational responsibilities. They should also recognise and take advantage of opportunities to share and develop best practice.

There should be transparency in the allocation of educational funds with trusts providing detailed evidence of how SIFT and MADEL are spent, or the equivalent arrangements in the DAs.

COPMeD and MSC should share quality data across undergraduate and postgraduate placements to identify issues with placements quickly and to align with the GMC’s move to single inspections for both undergraduate and postgraduate posts/placements. This will facilitate both QM (as part of GMC’s QIF) and quality enhancement. Particular attention should be paid to the transition from UG to PG education and training, ensuring that there is consistency in relation to both the competences of graduating medical students and the expectations of the service of such newly qualified doctors. This work should build on existing work on postgraduate quality metrics already commenced in Scotland and England.

Postgraduate and undergraduate medical deans should jointly ensure that academic training programmes are of the highest standard.

In order to facilitate the introduction of such improved working and enhanced collaboration, there should be regular meetings of the English UG and PG Deans similar to systems already in place in the DAs. MSC and COPMeD should meet on a regular basis to help ensure the continuing development of the partnership working envisaged in this paper.

We look to those designing the new structures in England to accept these guiding principles and to devise mechanisms to promote and facilitate their implementation within both the governance arrangements and the new systems’ architecture.

Written evidence from the General Pharmaceutical Council (ETWP 55)

1. Executive summary

Key themes in this submission:

1.1 The importance of the regulatory role in delivering high quality, contemporary healthcare.

1.2 The critical, statutory role of health professions regulators in setting educational and training standards and accrediting and appraising provision.

1.3 The importance of non-NHS education, training and healthcare.

1.4 The need for a balance between local, regional and national healthcare priorities in education and training.

1.5 The importance of effective structures for integrated, multi-disciplinary, postgraduate education and training.

1.6 Clarity on the roles and responsibilities of new bodies such as HEE and LETBs and how they will work with other stakeholders, including statutory professional regulators.

2. Introduction

2.1 The General Pharmaceutical Council (GPhC) is the statutory regulator for pharmacists, pharmacy technicians and registered pharmacy premises in Great Britain.

2.2 The principal purpose of the GPhC is to protect patients and the public. In part it does this by setting standards for education and training for pharmacists and pharmacy technicians, setting standards for contemporary practice, and ensuring pharmacy professions remain current in their practice through continuing professional development. In time, the GPhC will introduce a system for revalidation or continuing fitness to practise. A key theme in the education and training work of the GPhC is empowering professionals to develop and maintain their own practice and sense of professionalism.

2.3 The GPhC ensures that education and training standards are being maintained across Great Britain through a periodic professional and academic review process—accreditation—which supports providers in developing their education and training.
2.4 In addition the GPhC runs a national registration assessment. Passing the assessment is a requirement for initial registration.

2.5 We are pleased to be given the opportunity to submit evidence to the Select Committee. We have restricted our comments to regulatory matters.

3. The proposed role, structure, governance and status of Healthcare Education England...and its relationship to professional regulators and to the other parts of the new NHS system architecture

3.1 We are encouraged that the Committee intends to examine the role of HEE and have identified its relationship with professional regulators as being an important one. Our concern was that the regulatory role was significantly underplayed in Liberating the NHS: developing the healthcare workforce and did not recognise the important work regulators do with the professions and professionals they regulate. In the new system, HEE will have, clearly, a major role but it is not clear to us how that role will complement and work with the existing, statutory role of regulators.

3.2 Understanding the relationship between regulators and HEE is key. In particular, how will regulators be linked to HEE and its decision making? Will regulators advise HEE formally or will they be part of a looser advisory or consultative structure? We would request that clarity on the relationship is forthcoming at the earliest opportunity. It is difficult for us to be more specific about the nature of our concern given the current lack of detail about HEE’s relationships with other stakeholders. Whatever the envisaged relationship is, we hope that once the relationship is agreed, HEE will engage meaningfully with regulators on a regular basis.

3.3 We are concerned that the regulators have been grouped with “professional bodies” in illustrations of possible HEE advisory machinery when they are independent statutory organisations primarily concerned with patient and public safety.

4. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

4.1 The independent statutory regulators exercise the vital role of protecting the public partly by setting and upholding the standards of education and training for entering and remaining within the health professions. The statutory regulators have long understood that they must take account of the needs and concerns of a wide range of stakeholders and partners when setting standards, including those who commission, fund and provide professional education and training. However, if the potential for conflict and confusion in the future is to be avoided, the precise relationship between regulators and other stakeholders in setting standards and curricula must be clarified in the new system architecture.

5. The role and content of the proposed National Education and Training outcomes Framework

5.1 In common with most other regulators, the GPhC has a statutory responsibility to set standards for education, training and practice for the professional groups it regulates. We have a statutory obligation to consult when setting standards and must ensure that the standards we set produce registrants who are fit for purpose. We are unclear how this statutory role articulates with the proposed Educational Outcomes Framework (EOF). The EOF is reasonably generic and does not conflict with our standards but we need clarity on the role of the EOF in relation to statutory standards setting by regulators and welcome the Committee’s inclusion of the EOF on its agenda.

5.2 There are some important issues at stake, such as whether the EOF as interpreted by HEE or a LETB could be used as leverage to encourage or indeed require a regulator to alter standards. We assume that the key players will be expected to work together to achieve the necessary outcomes but we do need to know who takes the lead in setting standards for regulated professional groups. Given their statutory role, we assume this will be regulators, in consultation with stakeholders.

6. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

6.1 We note that the Committee will be exploring the provision of healthcare in NHS and non-NHS settings. From an education perspective, we have been concerned that non-NHS education and training did not feature prominently in the original proposals. In some health professions education and training at all stages is enmeshed with NHS structures and processes, but this is not true in all cases. For some professions, including pharmacy, private commercial education and training predominates, and this extends to pharmacy pre-registration training, much of which takes place outside NHS-managed and NHS-funded structures. For example, two major community pharmacy chains train a significant proportion of all GB pre-registration trainee pharmacists and they train far more pre-registrants than the NHS.

7. How funding will be protected and distributed in the new structures

7.1 A particular concern for pharmacy is how funding for pre-registration trainee pharmacists will be drawn down in both NHS and non-NHS contexts. As well as noting that parts of the current funding distribution chain are to be abolished (strategic health authorities, for example) we would like to know how key non-NHS providers will feed their views in about new funding mechanisms and at what level?
8. The future of postgraduate deaneries

8.1 We regard postgraduate deaneries—or rather structures for integrated, multi-professional postgraduate healthcare education and training—as vital. Liberating the NHS seems to call into doubt the future of deaneries without offering concrete proposals about how their work might be strengthened or taken over by other bodies. While we appreciate the localism agenda in Liberating the NHS, we feel that regional centres of excellence for postgraduate healthcare education and training (whatever they are called) should remain a feature of the new system architecture and should be strengthened.

8.2 One of the most positive features of deaneries is that they facilitate multi-disciplinary working, a central tenet of Liberating the NHS. It has been a frustration for pharmacy that to date it has been unable to join the deanery network for funding reasons. Joining the network is an aspiration for pharmacy and the Modernising Pharmacy Careers Programme Board has made this clear to Medical Education England. As with medical education, a new multi-professional deanery network could play a significant role in the QA of pharmacy postgraduate training.

9. How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

9.1 This is of particular concern to national regulators. Our view is that the public have the right to expect that healthcare professionals will be educated to the same standard across the United Kingdom and that professionals must be enabled to practice in the four countries—ensuring this is a key role for regulators. We make this point because Liberating the NHS emphasises local service delivery and the needs of local populations, but we contend that this must be viewed in the context of national standards for education and training. (Perhaps it is the emphasis on the local which explains why the national role of regulators is not as prominent as it needs to be). Mobility of both patients and professionals within and between the different parts of the UK must be underpinned by quality-assured national standards. These need to take account of “local” priorities but cannot in the end be exclusively driven by them; the ultimate key driver for the regulators is public protection.

10. Role of the Centre for Workforce Intelligence

10.1 We support the principle of developing the healthcare workforce on the basis of the best available intelligence about workforce needs. While we think the role of the Centre for Workforce Intelligence needs to be clarified, it has the potential to be a powerful planning tool. We note that for the Centre to be effective, it will have to gather (commercially) sensitive information from NHS and non-NHS sources. The importance of providing this information on a confidential basis will have to be made clear to employers.

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Written evidence from the Severn Deanery, NHS South of England (ETWP 56)

This submission will focus on Postgraduate Medical Education. Severn Deanery is a medium sized Deanery in the South West, which has approximately 2300 trainees and covers a geographical area from Swindon to Taunton. It encompasses eight cities and 12 Trusts including Dental and Primary Care. We believe ourselves to be educationally-strong and in the recent GMC trainees’ survey 80% of our specialties are in the Top 10 nationally, 43% in the Top 5 and 23% in the Top 3.

1. The right numbers of appropriately qualified and trained healthcare staff at national, regional levels

1.1 There are approximately 50,000 trainees in the UK who are being trained in 65 main specialties and 34 sub-specialties. We support the desire for UK to be self-sufficient. Since 2007, the Medical Programme Board has been able to produce national trainee and speciality specific data which has resulted in the recruitment process being more efficient and closely tiered to the workforce needs.

1.2 90% of workforce planning works well. Unfortunately when this is not the case then the remaining 5–10% attracts a lot of attention. This has particularly happened in recent years in Obstetrics & Gynaecology and Cardiac Surgery where over-production turned to drought very quickly.

1.3 There is a failure to understand how workforce planning is carried out. Some Trusts feel that within a Local Education Training Board (LETB) they will be able to expand their specialty posts. In fact to expand a speciality needs agreement of the Specialty Association, Centre for Workforce Intelligence (CFWI), the Specialist Advisory Committee (SAC), the Lead Dean, and national numbers with WAPPiG.

1.3.1 By 2020 we estimate that England will be producing around 5,898 CCT holders, of which 3,132 will be in General Practice and 2,766 in the remaining specialties.

1.4 CFWI is still developing and in the next two to three years will be able to deliver hard data.
2. That training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

2.1 All specialties and sub-specialties have a curricula that is approved by the General Medical Council (GMC) and produced by the Specialty Associations and the Royal Colleges. A key role for the Deanery is to ensure that the curriculum is being delivered and assessments take place.

2.2 Service models often tend to be five years behind the curve of technology. Therefore to be innovative and embrace service design, there needs to be a much more creative and slicker approach.

2.3 Although less than 5% trainees struggle and have to have their training extended, there is nevertheless a small cohort of 0.1% or less who may need to be removed from a programme because of failure to progress. To remove such trainees can result in employment tribunals which are expensive.

2.4 Medical postgraduate trainees and students attend a generic professional and skills course where medico-legal as well as ethical standards are taught.

2.5 Patient safety is the first domain of the GMC quality management process. Recent cases, such as the Mid-Staffordshire experience, have demonstrated that trainees also have a role in highlighting when patients are put at risk or given inadequate care. Therefore there needs to be a triangulation between the Care Quality Commission (CQC), the Trusts, GMC and Deanery reports from their quality management visits. Severn Deanery led on developing shadowing with a week-long induction for Foundation Year 1 doctors to reduce errors and improve patient safety.

3. The contribution that all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

3.1 Medical training programmes tend to be long and complicated. Primary Care is unusual in having a three-year programme; for most specialties it’s around about eight years. Oral Maxillofacial Surgery (OMFS) is at the other extreme where trainees have to have both a medical and dental degree and it can take almost 18 years to get a CCT and a Consultant position.

3.2 The concept of commissioners and providers is an inappropriate tool for education. Education commissioning is facilitated through Deaneries. There is no large scale commissioning as happens with non-medical numbers which are contracted with universities.

3.3 The second area of confusion is about how education is funded. The funding is not controlled by the Deaneries. Currently the funding comes from the Treasury to DH and then to Strategic Health Authorities (SHA) who pass on the funding to Trusts and PCTs through the Learning Development Agreements (LDA). The Deanery does not have any control over the funding and acts in an advisory capacity. This makes it difficult to move funds between specialties and Trusts. The current scenario is far too bureaucratic especially as to develop primary care some funding may need to be removed from secondary care. Given flexibility, the Deanery and the Postgraduate Dean as the senior responsible officer for this budget would be in a good position, to support and develop new innovative programmes which are cost effective and meet the service needs.

3.4 Trainees are under pressure to deliver the service commitment. This is increasingly more so because of the European Working Time Regulation (EWTR) and the David Nicholson challenge to reduce service costs of £20 billion over the next four years.

3.5 Education delivery depends on educational and clinical supervisors being given sufficient time to make sure that the curriculum is being delivered and the assessments are being carried out and trainees are being supported. This activity is usually part of the consultant SPA and job planning contracts. There is a real squeeze on this in the Trusts and use of SPA time needs to be more clearly defined, and where it is utilised for education, this should be strongly supported by the management.

4. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

4.1 We are committed to multi-disciplinary and multi-professional leadership however, the term multi-professional is misunderstood and for some people this means all professions learning together in a classroom. There are specialised curriculum and assessments which are appropriate for each healthcare workforce and then there is generic learning that is common.

4.2 A good way of developing multi-professional and multi-disciplinary learning is through simulation which includes communication skills, team working, and human factors training with a priority for patient safety.

5. High and consistent standards of education and training

5.1 This is our highest priority. A key way to ensure that high and consistent standards are being delivered is through the GMC trainees and trainer surveys. Severn Deanery has the highest national return in the trainee and trainer surveys.
5.2 Additional kite marks are:
   — Each postgraduate school’s annual reports.
   — Exam success rates.
   — Annual trainee assessment outcomes.
   — The GMC quality assurance of the Deanery.
   — Feedback from the generic and professional skills training and the appraisal for trainees and
     trainers.
   — Deans also have national roles.
   — Where there are red flags on the trainee and trainer survey, these are looked at by Quality
     Panels which also have trainee representation.

6. Developing the existing workforce and re-skilled for the future

6.1 Service design and workforce is about five years behind the technological and innovation curve that
occurs. In addition, innovation does not happen in a rigid top-down structure. For innovation to succeed there
is the need to create learning and working environments that allow freedom of thought, motivation, support,
engagement of staff through conversations, working in teams and give departments the ability to develop
and innovate.

6.2 A good example is the National Surgical Interface Fellowships which are led on by the Severn Deanery.

6.3 The NHS is good at coming up with ideas but embedding good practice takes far too long. The future
with academic health science networks and embedding of ideas which make for efficient and effective patient
care, particularly though integrated patient care pathways, would be the preferred way forward.

7. Open and equitable access to all careers in healthcare for all sections of society

7.1 Currently women make up about 60% of intake in medical schools. There is not only just the gender
change but also the Y generation who have portfolio careers and will not be working full time in medical
practice.

7.2 Therefore workforce planning needs to take this into account.

8. Plans for the transition to the new system, up to April 2013

8.1 We have concerns about this. The NHS Commissioning Board and Health Education England (HEE) are
still embryological, the Future Forum has not reported yet, the CfWI is also developing and the Health &
Social Care Bill is still going through Parliament. In the background is the David Nicholson challenge of
producing savings of £20 billion over four years. See hosting in section 9.

9. The future of postgraduate deaneries

9.1 One of the biggest challenges is the failure of the service, as well as DH, to understand Deanery functions
with request to host this in a service model. The majority of Deanery staff and virtually all of its functions are
carried out in the service. All the clinical supervisors, educational supervisors, heads of schools, training
programme directors, directors of medical education are all based in the service. This lack of understanding
has created misconceptions about what a Deanery really is.

9.2 The Severn Deanery paper on Deanery Functions is attached with this submission. There has been huge
support nationally for Deaneries, in particular, from the trainees, the GMC, the BMA, the Academy and the
Future Forum.

10. The future of Health Innovation and Education Clusters (HIEC)

10.1 This has had a limited impact primarily because the scale and funding was reduced to £1 million. With
the future being developed more in innovation and academic health science networks, then our expectation
would be that the HIEC would be subsumed into that organisation.

11. The role of the Secretary of State for Health in the new system

11.1 We welcome the statement from the Education Outcomes Framework that the Secretary of State should
have a responsibility/leadership role to deliver on education and training.

12. The proposed role, structure, governance and status of Health Education England

12.1 We welcome that the HEE will be responsible for the Multi Professional Education and Training
(MPET) budget. This should prevent some of the top-slicing that happens due to pressures on service delivery.
We also welcome that delivery of education and training would have a educational and finance governance
line to HEE. It has already been suggested that one way of Postgraduate Deans having externality with the
local delivery arm is to have employment by HEE. This may overcome the issue about hosting of Deaneries. Hosting in this context refers to employment contract, terms and conditions of service and HR support.

12.2 We believe that the Chair of HEE should sit on the NHS Commissioning Board to make sure that education and training has a strong voice.

12.3 Medical Programme Board as an advisory group to HEE should be maintained.

13. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

13.1 The Royal Colleges have primacy and the duty of formulation and development of curricula. Engagement with the service and also local needs would be important to integrate to ensure that the curricula are fit for purpose. The regulator GMC has a key role in this.

14. The implications of a more diverse provider market within the NHS

14.1 Education and training has suffered due to poor planning within different sectors. For instance, the first generation of Independent Sector Treatment Centres (ISTCs) did not have education and training as part of their development. The next generation did and 30% of their payment was to support education. However, this funding should not have been made available until the ISTCs were able to deliver education and training. Many never achieved this status.

15. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

15.1 Non-NHS does benefit greatly by the training and education delivered in the NHS sector. One must be cognisant of the fact that many non-NHS sectors do wish to engage with education and training and are willing to provide placements. This has been our experience for instance with aesthetic reconstructive surgery.

16. The role and content of the proposed National Education and Training Outcomes Framework

16.1 We agree with the five domains of the Education and Training Outcomes Framework.

17. The role of the Centre for Workforce Intelligence

17.1 CfWi is still developing and it will probably take another couple of years to bed down and start making a real contribution. Their ability to provide data analysts and start developing sophisticated models for the future is essential.

18. The role of NHS Employers

18.1 They are an important and key stakeholder in the delivery of patient care as well as education and training and this relationship needs to be given a high priority.

19. How funding will be protected and distributed in the new system

19.1 The £5 billion education and training budget will be hosted by HEE and then be devolved to local/ regional organisations such as LETBs. Exactly how LETBs will engage with the academic health science network is not clear and it is possible that it will be the Academic Health Science Network that drives the LETB. However, there needs to be a very clear finance governance arrangement between HEE and the provider organisations to make sure that the funding for education and training is utilised for that purpose. The role of the Postgraduate Dean is critical in this matter. To be innovative we feel that the Deaneries should be empowered to have more freedom in how the budget is utilised such as developing different training models including simulation which complement service models. (See Section 12)

20. How future healthcare workforce needs are being forecast

20.1 See sections 1–3.

21. The impact of people retiring from, or otherwise leaving, healthcare professions

21.1 The traditional male doctor who worked full time is being replaced by new generation of both female and male doctors who have portfolio careers and will be contributing part time. Some of the work pressures, particularly bureaucratic pressures, mean that innovation is restricted and productivity goes down. It is estimated that something like 13% of the Consultant/GP workforce plan to retire over the next two years. The other forecast is that possible 26% of the workforce will retire over the next five years.
22. The place of overseas educated healthcare staff within the workforce

22.1 This is an area of high importance. If the UK wishes to be at the leading edge of research, integrated care pathways and innovation then it has to develop good relationships with the rest of the world. In recent years, the UK has lost out to North American and Australian universities.

22.2 The GMC does engage with International Medical Graduates but can do much more particularly over registration.

Written evidence from the Royal College of Paediatrics and Child Health (ETWP 57)

INTRODUCTION
1. The Royal College of Paediatrics and Child Health is responsible for training and examining paediatricians in the UK. The College has over 12,000 members in the UK and abroad and sets standards for professional and postgraduate medical education. The College's key roles include:
   - A professional advocacy role for paediatricians across the UK, and for paediatricians in international countries.
   - Standard setting.
   - Workforce intelligence and strategic advice.
   - Strategic service planning.

2. The RCPCH is a member of the Academy of Royal Colleges and has been party to the Academy’s submission to your inquiry. We are fully supportive of the vision and principles put forward in that document, and would particularly wish to add our weight to the following points:
   - The service should be, in the main, consultant delivered and not dependent on trainees.
   - The service should enable trainers to have time to train, supervise and assess trainees effectively.
   - Postgraduate Deaneries and the independence of the Postgraduate Deans needs to be retained in order to maintain their vital quality assurance role.
   - There is lack of clarity around the governance and structure of Local Education and Training Boards (LETBS) and there are potential conflicts between service demand and training and education which may arise in an employer led body (paras 11 and 19).
   - There is support in principle for the establishment of Health Education England, and the need for its authority over LETBs to be established (para 17).
   - There is a need for involvement of clinicians with expertise in education and training at employer and LETB level (para 20).
   - The proposed National and Training Quality Outcomes Framework needs to have effective metrics which can be applied in a consistent way across other parts of the UK (para 23).
   - Medical workforce planning needs to be coordinated across the UK (para 30).

3. Future workforce requirements—RCPCH principles

3.1 The College’s publication Facing the Future (April 2011) gives a vision and strategy for service delivery, predominantly in acute general and neonatal paediatrics which entails continued consultant expansion to develop consultant delivered care models before a reduction in training numbers can be put in place.

3.2 Paediatrics is a specialty with service delivery in acute, community and subspecialty settings. There are 17 paediatric subspecialties which make training and workforce planning particularly complex.

3.3 Community paediatric service provision has shifted to acute, social enterprise or bespoke community providers. It is not clear how providers (via LETBs) with few doctors will ensure that adequate training opportunities are in place to develop the specialists needed. Community paediatrics and child mental health services must be an integral part of the future paediatric workforce. Mental health morbidity/co-morbidity makes up 40% of general outpatients activity and the RCPCH needs to reflect this in a future workforce skilled in Paediatric Mental Health issues. In the UK there are very few adolescent health specialists and we are falling behind the USA and other European countries in this regard.

3.4 There are significant concerns about the falling numbers in the academic workforce, compared to other specialties. There is a need for succession planning and encouragement to trainees to take an academic career path.

3.5 Many paediatric services use a needs based approach to ensure the most appropriate pathway of care and to meet required standards. These pathways of care are commissioned. Neonatal managed clinical networks
are a prime example of effective and safe services. Future structures delivering healthcare, education and workforce planning therefore should include the operational arrangements for clinical networks.

3.6 In planning the future workforce the NHS Outcomes Framework and its five domains need to be taken into account as they are all applicable to babies, children and young people.

**Themes**

4. **Health Education England**

4.1 The College supports the establishment of HEE and its role to hold the LETBs to account. There must be robust governance, quality assurance and reporting arrangements not only for LETBS to HEE but with strong links to Royal Colleges, CCGs, the NHS Commissioning Board and to Public Health England.

4.2 The proposals to change the arrangements for education and training are in principle sound because they enable staff across specialities to train together. Because funding and placement arrangements are not clear however, the College is cautious that without detail, there are risks which may affect the capability of the paediatric workforce.

4.3 The differences between medical education and other health professions need to be recognised. HEE must recognise that medical training is different from other health professions, ie doctors are not autonomous practitioners when they graduate as is the case, for example, for physiotherapists.

4.4 Training in the paediatric subspecialties including neonatology is organised on a national grid providing competition for places which are matched against service need. This function must be sustained at national level.

5. **Local Education and Training Boards**

5.1 If education and training roles and responsibilities are taken over by Trusts, there is potential conflict of interest with the requirements of service delivery, ie need to fill gaps in rotas at expense of training.

5.2 LETBs need to work closely with the Royal Colleges to understand the drivers towards developing safer services and the need for reconfiguration. For the RCPCH in particular, the new structures need to take on board the breadth of paediatric training and the variety of environments in which training takes place eg community, DGH, specialist centres. Decisions should not be taken in isolation and must acknowledge that some paediatric specialist services need to be commissioned at national level.

5.3 Excellence in training will attract excellent trainees. This must be supported by the NHS and act as a guiding principle. Our concern is that financial pressures will make it difficult for consultants and trained staff to contribute to training, and that any qualified providers may not regard Training and Assessment as high priority.

5.4 In hospital based medical training, the vast majority of consultant and trained doctors provide clinical supervision, and a large proportion of doctors provide educational supervision, structured delivery of training and education and carry out work based assessments of trainees in work based placements. About 10% are involved in the delivery and assessment of structured examinations. A further small number are further involved in quality management and assurance of training. These roles need to be protected to continue improvement in education, training and assessment when faced with service provision priorities of commissioners.

5.5 Health and Wellbeing Boards should include the views of parent/guardians, children and young people. These views can in turn influence the model of service and workforce delivery and of training and should link to LETBs.

5.6 The voice of trainee doctors needs to be heard, included in education, training and workforce planning structures. Trainee doctors have valuable insight into the quality and delivery of training, and in paediatrics have significantly contributed to the development of our strategic service and workforce models.

6. **The future of Postgraduate Deaneries**

6.1 The key roles for deaneries are recruitment to, delivery and quality assurance of training. These roles must not be lost in the new structure. Their role in the organisation of rotations is crucial and they must work closely with the Royal Colleges to ensure that training numbers reflect actual and planned changes in service configurations.

6.2 The independence of postgraduate deans is essential to drive up the quality of training.

6.3 There are opportunities in any potential restructuring for postgraduate deaneries to align medical training, not only between the Royal Colleges of General Practice and Paediatrics but also with the Royal College of Nursing in order to expand the numbers of General Practice Specialty Trainees (GPST) and trained nurses with advanced or extended roles so that the RCPCH Facing the Future vision can be implemented effectively.

6.4 More foundation trainees need to be exposed to paediatrics as highlighted in Foundation for Excellence (Professor John Collins, October 2010).
6.5 Specialty, Staff and Associate Specialist Grade (SSASG) doctors are an important part of the paediatric workforce, and a consistent approach to their training, competency development, CPD and deployment should be adopted by postgraduate deaneries and LETBs. Each postgraduate deanery already has a nominated lead for SSASGs. The core functions and roles carried out by these doctors are particularly relevant for paediatrics which is a highly feminised profession. A significant number of consultant equivalent roles are currently filled by these staff and a new system needs to be flexible enough to develop these doctors, and enable transition back into training grades where appropriate.

7. How the new system will relate to healthcare, education and training and workforce planning in the other countries of the UK

7.1 The RCPCH has a remit for training, education and planning in all four UK countries and will apply the same standards in each UK country.

8. Participation in the Development of Curricula

8.1 RCPCH support the Academy stance that Colleges remain best placed to have lead responsibility for development of curricula for postgraduate medical training.

8.2 We also support the Academy’s assertion that patient input to curricula is important and valuable. Our engagement with patients and parents has for example, been an integral part of e-learning packages developed for child protection and adolescent health.

9. Balancing the workforce requirements of NHS and non-NHS healthcare

9.1 Currently private providers do not contribute to the cost of specialty training and use NHS trained staff so they are likely to be cheaper. It is important that all providers pay a national levy.


10.1 We support the Academy view that metrics for education and training should be common across the UK to ensure consistency of quality. They also need to capture the impact of service and workforce redesign.

11. Centre for Workforce Intelligence

11.1 CfWI should be accessible to the professions and take account of the evidence provided by RCPCH and other Colleges. Current systems of collection may not be accurately monitoring the current workforce, and so the College needs to agree a methodology with CfWI to ensure that we have a high quality workforce of the future.

11.2 There need to be formal governance arrangements between CfWI and the RCPCH so that we have a system for mutual agreement and understanding of the methodology for workforce modelling and planning which is based on sound evidence.

11.3 CfWI should work collaboratively with HEE and LETBS to ensure they fulfil their duties regarding sharing of data. They will also need to take a lead in facilitating that such data collection exercises are meaningful, streamlined, consistent and accurate.

12. How future healthcare workforce needs are being forecast.

12.1 Currently the emphasis in workforce planning appears to be based on supply side modelling ie how the existing workforce and those in training can be utilised. The College believe a longer term view based on standards and the maintenance of safe services is more sustainable in the longer term and will allow for the development of a non “boom or bust” approach to numbers. This is at the root of our vision in Facing the Future.

12.2 The RCPCH regularly collects a range of good quality workforce planning data eg the biennial census which has in 2009, a 98% return from its members. This data has informed the Facing the Future strategic vision for its paediatric service and workforce and we consider that College data can be an effective tool for both providers and commissioners of education, training and services.

12.3 It should be recognised that workforce planning in paediatrics has probably been more influenced than other large medical specialties by the growth in the number of female doctors and its impact on working patterns. Nearly 47% of paediatric consultants and around three-quarters of new trainees are women.

13. Impact of retirement and leavers from healthcare professions

13.1 Early retirement is not currently a major issue in paediatrics, but there are anxieties that proposed pension changes may force earlier retirement, or drive experienced consultants into private practice. The RCPCH is currently researching this among its members.
13.2 A cohort study the RCPCH is undertaking has shown that attrition from the first three years of training is approximately 5% per annum. We are also aware of regional variations where attrition is higher. This means that there needs to an awareness that the number beginning their training in a specialty needs to be higher than those completing their certificate of training (CCT).

13.3 Early data from a study of new CCT holders indicate that almost 10% of newly qualified paediatricians obtain posts outside of the UK.

14. Overseas Healthcare Staff

14.1 Overseas healthcare staff have been an integral and important part of the paediatric workforce. The RCPCH Census of 2009 shows that 29.8% of consultants and 48.3% of SSASG doctors are non-UK graduates.

14.2 Recent changes to immigration laws combined with the EWTR have left serious gaps and recruitment problems in paediatrics and neonatal care. The RCPCH survey of December 2010 indicated that 20% of all middle grade posts were vacant.

14.3 The RCPCH support a re-introduction of the Medical Training Initiative (MTI scheme) and has re-introduced the scheme to begin recruiting from March. The RCPCH believe this scheme will enhance knowledge transfer internationally in addition to contributing to workforce solutions without generating over-supply of trained doctors, and should be widely supported.

December 2011

Written evidence from the Optical Confederation (ETWP 58)

SUMMARY

We welcome the opportunity to contribute to the Committee’s inquiry on the Government’s plans for NHS education, training and workforce planning.

In many ways, when compared to the NHS, the planning and delivery systems for the optical workforce are considerably well developed. They already encompass the principles of best practice proposed by the Government in its White Paper, “Liberating the NHS: Developing the Healthcare Workforce”. Crucially, over the years, as a sector, we have managed to avoid chronic, workforce shortages or significant over-supply, always with a view to deliver an appropriate work force supply, earning a decent salary and with good career prospects.

We have been able to do this consistently as, in our sector, front-line needs are very closely connected to planning and supply and, by working with the seven UK optical universities, the College of Optometrists and the Association of British Dispensing Opticians College, we are able to flex numbers in training to meet likely future demand. As the same time, as optical professions, we have continually increased practitioners’ skills and competences to the benefit of patients and the NHS. Our ambition is to continue that trend and to play an even greater role in the delivery of NHS eye care.

The system has served us, patients and the NHS community service far better than any central planning system would have done. For these reasons, we would wish to remain outside the proposed NHS planning system and its funding mechanisms, for community optometry and optics.

Nevertheless, there are areas for development where greater synergy between optical workforce planning and the wider NHS workforce planning could be developed with regard to public health, leadership development and in hospital optometry. In the latter case we would like to see the number of entry level and basic grade training posts for optometrists in hospitals, which has halved in recent years due to financial pressures, reversed to meet growing eye health needs.

As we indicated in our past response to Liberating the NHS: Developing the Healthcare Workforce,78 we hope that the Department of Health will work with our sector on all of the abovementioned areas, in order to see where we might mutually support one another for the benefit of all.

1. Public health

1.1 Historically neither the Department of Health, nor the NHS, has invested in the development, training or recruitment of ophthalmic public health specialists. As a result, ophthalmic public health is under-developed at all levels within the NHS and at local authority level.

1.2 Every day one hundred people begin to lose their sight in the UK. It is estimated that up to 50% of sight loss could be avoided through early diagnosis and early treatment, according to the Royal National Institute of Blind People. The historic absence of any ophthalmic public health expertise has resulted in a significant, expensive and expanding burden of visual impairment and blindness much of which could, through timely cost-effective intervention, have been avoided or reduced. This burden of preventable sight loss imposes significant downstream financial costs on both the NHS and social services, leaving aside the personal misery imposed on individuals and their families.

1.3 We would like to see what options there might be for including ophthalmic public health training within the wider Department of Health’s programme with a view to increasing the availability to the NHS of these essential public health personnel.

2. Leadership Development

2.1 We have welcomed the Government’s recognition that the clinical professions play a leading role at both at the local and national level in ensuring investment and skills through continuing professional and personal development and maintaining the structure and content of education programmes.

2.2 This is already the case in optics and the clinical training that is in place helps raise the standards of education and training at every level, securing safe and high quality care for patients. This, however, is slightly different from leadership development per se and, to date, the optical sector has been not invited to participate within the work of the National Leadership Council. We would welcome an invitation to participate, if possible, in this area at reasonable cost, e.g. by buying into placed on training schemes.

3. Funding

3.1 We have found that the most effective and efficient means of planning, recruiting, training and developing the optometric and optical work force—entirely in line with the ambitions of Developing the Health Care Work Force—has been to fund the arrangements ourselves outside the Department of Health and NHS arrangements. As mentioned above, for many years this has been very successful in delivering an appropriate, trained, workforce to meet the needs of the sector and our patients. For this reason, we would be strongly opposed to being brought within the levy system on health care providers which will fund the new national arrangements.

4. Hospital Optometry

4.1 Training for hospital optometrists is the one area in which, as professions, we have had to interact with the NHS planning system and unfortunately our experiences have not been happy. Despite ever growing need, the number of entry level and basic grade training posts for optometrists in hospitals has been in decline in recent years due to financial pressures.

4.2 Specific training funding for around 50 two year hospital optometry training posts is needed to support postgraduate preregistration optometrist entry level, year 1, posts and a corresponding number of linked basic grade, year 2, training posts along with an appropriate element of funded supervisory time in order to develop a high level sustainable and effective optometry workforce of the future.

4.3 Optometrists can and do benefit from training in a hospital environment by gaining the widest possible experience of abnormal ocular conditions, diagnosis, treatment and management. This would help to modernise the delivery of hospital eye care through multidisciplinary working and would assist in developing the wider optometry workforce.

4.4 The previously available 50 hospital based pre-registration optometrists posts has reduced in recent years to fewer than 25 posts, despite the number of optometry students graduating continuing to increase. It is essential to see this reviewed and for training numbers to be increased and brought more in line with Foundation Trusts’ likely future needs.

About Us

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians, the Association of Contact Lens Manufacturers, the Association of Optometrists, the Federation of Manufacturing Opticians and the Federation of Opticians. As a Confederation, we work with others to improve eye health for the public good.

December 2011

Written evidence from the British Dental Association (ETWP 59)

1. The British Dental Association (BDA) is the representative organisation for dentists in the UK, with nearly 19,000 dentist and 4,000 student members. Members work in all spheres of dentistry, including NHS, private and mixed NHS-private practice, as well as in salaried services, hospitals, universities and the armed forces.

2. We are pleased to see that the Select Committee has undertaken to review the proposed arrangements for education, training and the workforce but are concerned that the Government has not yet published a response to its Developing the Healthcare Workforce consultation. Much of the evidence provided here draws on our response to the consultation and references issues raised in the consultation document.
The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

3. We were disappointed to note that Developing the Healthcare Workforce did not include dentists or dental care professionals (DCPs) in its workforce calculations. Commissioned by Medical Education England, the Centre for Workforce Intelligence (CFWI) is currently undertaking an important review of dental intake numbers and we seek reassurance that numbers in training will continue to be monitored to ensure that the dental workforce is appropriate for need and demand for services, whether NHS or provided by the private sector. The Department of Health is piloting a new dental contract which will see a significant shift in the way that oral healthcare is delivered and the way in which patients access care. Data from evaluation of the pilots should be used to ensure that any impact on access to dental services is countered by intelligent planning of future student numbers.

4. Planning must be undertaken based on evidence of need and not on existing numbers in post. The dental public health workforce, for example, is considerably under-resourced (in England there are currently 20 lost or frozen consultant posts (out of a total workforce of 63) and requires investment. Although we appreciate the need for efficiency savings to be made across the NHS, this should not compromise the provision of core services. We have stressed to Public Health England’s transition team that workforce numbers should be calculated on pre-2011 statistics as present staffing levels are an inappropriate baseline for future planning.

That training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

5. The General Dental Council regularly reviews the training curricula of dental professionals and has recently completely changed the focus to one of outcomes rather than inputs. Changes in patient expectations, needs and aspirations must also be reflected in training, particularly where the patient contribution to costs is significant. Prevention, both in-practice and through supporting patients to follow good oral health practices, and communication skills are particularly important in dentistry.

That all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

6. We agree that the needs of providers and commissioners are vital to ensuring that the workforce is fit for purpose and that all providers should play a part in developing their workforce. But we were alarmed by the prospect, suggested in Developing the healthcare workforce that all providers of NHS care will, among other things, have to take part in skills networks and fund clinician education and training by way of a financial levy. The dental provider mix and the nature of university-based dental training do not fit into the proposed model. Primary care dental services make up 80% of dental services and are, in the most cases, provided by small independently-owned businesses. If this model is applied to general dental practices, it will create a totally unnecessary financial and administrative burden and a requirement for small units to contribute to an activity which is completely outside their experience, capability and competence. We discuss below the essential role of deaneries.

Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

7. We support the commitment to improve leadership training and believe that this should be embedded in the undergraduate curricula.

That the existing workforce can be developed and reskilled for the future (through means including post registration training and continuing professional development)

8. We agree with a flexible approach to the planning and development of the healthcare workforce. In the transition to the new system, it is essential that relevant and affordable courses currently provided by deaneries and PCTs continue to be available to professionals.

Open and equitable access to all careers in healthcare for all sections of society by means including flexible career paths

9. The BDA welcomed the Browne Review and subsequent statements in Parliament that dental courses would be safeguarded in the same way as medical, engineering and science degrees. Parliamentary statements have guaranteed that the government will continue to subsidise “part” of the cost of dental courses. We are concerned, however, that there is a lack of clarity about the proportion of subsidy that will be provided.

10. The increased levels of debt facing dental students on graduation as a result of the funding reforms and the unclear contribution of the NHS bursary beyond 2012–13 could hamper the aims of widening access and participation in the dental profession for those from lower socio-economic groups. The BDA’s Student Debt Survey 2010 showed that the average dental student debt was £25,545. This is based on fees of £1,200, rather than the increased £3,375, the effects of which will not be known until next year. If fees increase to £9,000 for dental courses, debt will become even higher. While we understand that fees are to be increased to £9,000

79 Developing the Healthcare Workforce, DH, page 20, para 3.2
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only following an agreement with HEFCE and OFFA to increase access, we are concerned that increased debt
will be a sufficient deterrent to students from lower socio-economic groups. Debt could potentially rise to
around £60,000 for dental students. This is a huge figure and the BDA is concerned that students are being
asked to take on this significant burden to study a course that is of direct public benefit.

The future of postgraduate deaneries

11. The BDA remains unconvinced of the need for any change to the way in which postgraduate education
and training is delivered.

12. Dental and medical postgraduate deaneries are highly valued and their function, competence and
experience must be preserved through the transition and beyond. Dental Postgraduate Deans and their teams
provide services that directly contribute to patient safety and ensure that all members of the dental team have
access to the relevant education and training. There are good economies of scale which would be lost if training
was provided on a smaller geographic scale.

The proposed role, structure, governance and status of Health Education England (including how it will take
on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to
professional regulators and to other parts of the new NHS system architecture

13. We support the plans for HEE as outlined in the consultation document, Developing the Healthcare
Workforce, and are pleased to see that the Dental Programme Board (DPB) will be retained. The DPB has
made significant progress on key issues affecting the dental workforce, and its considerable expertise will be
an important resource for future planning.

14. Although there must be strong links between the Board and regulatory bodies, we do not agree that the
Board should be responsible for setting standards for education and training in areas that are currently the
responsibility of the profession-specific regulators.

15. One of the key challenges for the new NHS architecture will be to ensure that workforce planning is
undertaken with the input of all relevant bodies, and the duty to consult must be embedded within HEE.
Effective collaboration with Public Health England, the Department of Health and the NHS Commissioning
Board will be the first step in ensuring that each aspect of the workforce is appropriately commissioned.

The proposed role, structure, governance, 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. Although we commend the government’s ambition to put practitioners at the heart of the system, it must
be acknowledged that there is a limit to the time that practitioners can dedicate to providing services and
developing infrastructure in the new system. It is clear that there are benefits to a clinician-led service, but this
must be tempered with appropriate strategic oversight and guidance from HEE.

17. The proposals for the introduction of Provider Skills Networks as outlined in Developing the Healthcare
Workforce are of some concern. The list of suggested functions in this document appears to suggest a GP-led
service, and this would be inappropriate for the other healthcare professions, including dentistry. We would
support the introduction of a small number of dental Skills Networks to ensure national consistency of
postgraduate training provision, but do not see great value in a multi-professional structure. There has been
some progress made on the development of the wider NHS infrastructure, and a review of these proposals in
light of the emerging structure of the National Commissioning Board would be pertinent.

18. We are concerned that the proposed Skills Networks would be unable to attract the appropriate expertise
and indeed, that small providers would not be appropriately represented within these organisations. It is also
unclear what funding would be made available and how this would be managed. Overall, we are not assured
by these proposals and await further details.

The role of the Centre for Workforce Intelligence

19. The CfWI must have adequate resources to employ and engage appropriate experts. It must work closely
with stakeholders to understand existing issues and plan for future challenges.

How funding will be protected and distributed in the new system

20. We support the continuance of the Multi-Professional Education and Training (MPET) but do not agree
that money should only be used to fund the next generation of healthcare staff. The transition to a revised
system must ensure that it accounts for those who are currently providing services and invests in those
practitioners to ensure that they have the required skills.
21. In an environment where dentists’ expenses are rising year on year and income is static, we do not believe it is appropriate to shift the financial burden of education and training to practitioners. We appreciate the challenges of the current financial climate, but do not believe that practitioners should be responsible for absorbing the impact of government cuts. We are entirely opposed to the imposition of a levy on providers to fund education and training.

**How future healthcare workforce needs are being forecast**

22. We believe that forecasting should be a cross-organisational exercise, utilising the existing expertise of the professional Boards of HEE and with the relevant representative organisations. We are concerned that the emergence of new organisations will result in a more complex structure than existed in 2010, and it is vital that new organisations conduct their planning in conjunction with one another to avoid duplication.

**The impact of people retiring from, or otherwise leaving, healthcare professions**

23. The Dental Schools Council reports that 48% of Clinical Teachers and Senior Clinical Teachers, and 62% of Professors, Senior Lecturers and Lecturers are aged over 45. Succession planning must be a priority as 25–30% of the academic workforce in dentistry is expected to retire in the next five to seven years.

24. The public health workforce faces similar challenges. There are 32.5 whole time equivalent (WTE) consultants in practice, 10.4 WTE academic consultants with 5.2 WTE pending retirement. Worryingly, there are 9.4 WTE frozen posts and 9.8 WTE lost posts. There is an urgent need to address staffing levels in public health, particularly to ensure a smooth transition to local authorities.

25. During the transition, public health staff will be transferred into local authority structures, and will become civil servants rather than NHS employees. Existing staff will be transferred by TUPE to local authorities, although future arrangements remain unclear. We understand that a TUPE transfer relates to the transfer of the staff member rather than the post, and therefore seek assurances that posts will be protected by local authorities.

**The place of overseas educated healthcare staff within the workforce**

26. Dentistry, like other areas of healthcare, has a diverse workforce and overseas educated practitioners play an important role in the delivery of care. The current system allows for non-UK qualified graduates to take up a dental foundation training place, a requirement for practice in the NHS, and we have concerns about the potential for the displacement of UK graduates.

27. We are aware that 30 graduates did not take up a foundation training place last year, although the reasons for this were not captured, and it is anticipated that there could be more serious problems in finding foundation training places for all graduates this year. The significant financial investment made by individual students for their education and by the taxpayer for training suggests that there should be a commitment to achieving value for money through a guarantee that all UK graduates who wish to take up a dental foundation training place are able to do so.

**How the public health workforce will be affected by the proposals**

28. The public health workforce will face additional challenges to those identified above. The BDA is concerned that the decision to locate Consultants in Dental Public Health (CsDPH) in local authorities will mean that education, training and continuing professional development will be fragmented. There is a need to ensure that robust systems are in place to safeguard career development opportunities are safeguarded, and that public health remains an attractive career choice for young dentists.

29. Current proposals suggest that trainees will begin their career in the NHS and move to the civil service when they complete their training. Public health is a core element of the NHS, and underpins the government’s proposals for the health service. To remove the public health workforce from the NHS means that CsDPH will no longer have access to core NHS data, and we believe that this presents an additional challenge for an already overstretched workforce. It is essential that all members of the public health workforce are able to work with their NHS colleagues to deliver against the Public Health Outcomes Framework, and we believe that this separation means that the workforce will be required to spend significant time working across organisations, networking and rebuilding an infrastructure that exists and functions well in the current system.

December 2011
Written evidence from the Society and College of Radiographers (ETWP 60)

1. The Society and College of Radiographers is pleased to be able to submit written evidence to the above enquiry, in addition to contributing to that submitted by the Allied Health Professions Federation. In the interest of brevity, we have confined ourselves to our major concerns aligning these to relevant themes of the inquiry.

2. The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

   (a) Radiographers and the wider radiographer workforce are vital front line clinical staff in the delivery of effective and timely cancer treatment (radiotherapy); and clinical imaging to enable important health screening (breast, fetal anomaly, aortic aneurysm), early diagnosis (for cancer and other significant conditions such as heart disease and stroke), disease and condition monitoring, and interventional image guided procedures.

   (b) Early treatment and diagnosis is cost effective in terms of provision of health care services, and beneficial to the population in that it reduces both mortality and morbidity so enhancing both length and quality of life.

   (c) We agree that it is essential to ensure that there are appropriately qualified and trained healthcare staff including academic and research staff but we have real concerns that this is in jeopardy at present for a number of reasons.

   (d) Inadequacy of workforce planning; despite considerable investment in the Centre for Workforce Intelligence this, as yet, has not delivered the new/better approach that is needed. In particular, it has not sought to derive workforce need from service delivery and healthcare need (which seemed to us to be the right starting points), but has used current workforce numbers and affordability as the main influences. This perpetuates the short-term approach to workforce planning which drives a boom/bust (or glut/famine) cycle in relation to workforce supply, and fails to help deliver long-term skills-mix based solutions to cost and quality effective health care delivery.

   (e) The establishment of Local Education and Training Boards (LETBs) ahead of Health Education England (HEE) is unhelpful and has the potential to destabilise education and training commissioning further, especially in the area of the support and assistant level workforce (bands 1–4) and in post-registration education and training. We have concerns that the already small amount of investment in the bands 1–4 workforce will decrease further, leading to a reduction in the necessary development of assistant practitioners in, for example, radiotherapy, breast screening and clinical imaging. These staff are essential to enable the skills of radiographers to be utilised more effectively such that radiographers are able to support medical staff to spend proportionally more of their time with patients with complex radiotherapy and clinical imaging or intervention needs.

   (f) There is also a disconnect between the roles of LETBs and HEE, and the funding flows. Collectively and historically, employers have not shown themselves to be responsible in terms of education and training as is evidenced by the very low investment in the bands 1–4 workforce, the failure to invest in developing advanced and consultant practitioners to deliver both “routine” service needs (there is a severe and chronic shortage of sonographers, a band 7 workforce, to deliver ultrasound imaging services, yet plenty of staff wanting to train in ultrasound and plenty of education places available—the gap is a failure by employers to invest in the required training posts), and to deliver service innovations that have been shown to improve quality and effectiveness (for example, cancer site specialist radiographers, reporting radiographers). Radiographers and sonographers remain on the Migrations Advisory Committee (MAC) list of shortage professions and we do not see this changing in the foreseeable future.

3. All providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

   (a) This is essential in our view, and its vital that they play appropriate and full parts in developing the whole workforce (ie bands 1–9 inclusive), and including the research and academic workforce. Without these latter groups there would not be the continuing development of an evidence base for practice, and the continuing development of a sufficiently educated and trained clinical workforce.

   (b) Our experience is that both NHS and non-NHS providers have been low investors in developing the healthcare workforce but the non-NHS healthcare provider sector has overly relied on recruiting NHS funded and trained staff at all levels, especially at post registration advanced and specialist practice staff, for example, sonographers and magnetic resonance imaging radiographers. We believe this has contributed to NHS employers being reluctant to train these groups. Unless there is obligation placed on non-NHS employers to contribute to education and training in clear, meaningful and regular ways (by payment of a levy and/or by providing high quality clinical placements), we feel this inequity will continue. Indeed, it is likely to worsen as the “any qualified provider” (AQP) policy takes root (this is intended to take effect in the first wave in relation to provision of ultrasound and magnetic resonance imaging services).

   (c) Education and training requires high quality clinical placements, and an expectation that all service providers accept that they have vital roles as education providers alongside their healthcare services provider roles. We have noted an increase in “complaints” from student radiographers about their clinical placements, with students stating that there is little or no time for clinical staff to help them with their clinical learning.
objectives and needs as there is a constant stream of patients and fewer trained staff available to deal with them. In our view, the quality of clinical education and the expectation that this is a role that healthcare service providers must deliver has never been addressed satisfactorily, especially in relation to the non-medical workforce. We welcome the idea that the new architecture will deliver this and trust that HEE will be able to use funding flows to bring about the much needed improvements and to introduce equity across the whole system. Attempts to do this in the past have always been thwarted by the large (medical) teaching NHS healthcare providers as for such organisations the funding support is significant, and funding that has gone to NHS organisations to support clinical education and training has almost wholly been directed at medical education and training.

4. The existing workforce can be developed and re-skilled for the future (through means including post-registration training and continuing professional development)

(a) This is essential in our view but we are not confident that the new architecture will deliver this. We have already voiced our concerns about the development of LETBs ahead of HEE, and our concern that LETBs will be the bodies determining all but the pre-registration workforce education and training, and re-state these here. Investment in the bands 1–4 workforce and in the post-registration workforce is essential if cost effective, high quality healthcare is to be delivered. At present, there are some very good examples in individual NHS Trusts of innovations that deliver the highest quality of care through excellent development of its whole radiographic workforce (eg Pinderfields and Pontefract NHS Trust’s trauma and emergency care imaging services, Countess of Chester Hospital’s breast imaging service, United Bristol Hospital’s radiotherapy service, North Bristol Hospital’s gastro-intestinal imaging services, Addenbrooke’s Hospital’s radiotherapy service, Medway Maritime Hospital’s magnetic resonance imaging service) but there is little to encourage widespread take-up of these innovations, and the new architecture could make this situation even worse if there is to be no real oversight of LETBs by HEE across the whole of education and training development and provision.

December 2011

**Written evidence from the Chartered Institute of Housing (ETWP 61)**

**SUMMARY**

1.1 Many CIH members are engaged in supporting vulnerable people within communities, through the delivery of services that play a significant role in minimising or preventing the need for costly and intensive health and care interventions, and support recovery.

1.2 Over a number of years, CIH has championed the role of housing to achieving health and wellbeing, and has sought to engage health and care professionals in a greater understanding of how this can contribute to their own aims and targets.

1.3 Providing training and education on the connections between housing and health for health professionals working in the community and involved in patient discharge from hospital would strengthen the overall context to support effective medical and clinical interventions. It would ensure that housing provides part of the solution to delivering health services in the community and ensuring safe and secure environments in which to recover health and independence. Poor housing conditions lead to health problems that cost the NHS an estimated £600 million a year to treat.80 It can also make medical intervention less successful and result in wasted resources, as well as impacting negatively on the individual and households involved.

1.4 A stronger understanding of housing and its impacts would contribute greatly to a wider awareness of the social determinants of health. The importance of housing as a determinant for health inequalities was reinforced most recently by Professor Sir Michael Marmot’s report: *Fair Society, Healthy Lives* and one recommendation was to prioritise policies and interventions that reduce health inequalities and address climate change, including improving the energy efficiency of home.

1.5 A few of the ways in which housing can impact health, or support health and recovery are listed below:

- **Homelessness** leads to premature deaths—47 for men and 43 for women—and increases the use of accident and emergency services, due to the inability to register with GPs.81 A study by the umbrella organisation homeless Link in 2010 estimated the costs on homelessness to the NHS at £85 million, with twice as many homeless people admitted to Accident and emergency as the general population.82

- **Cold and damp homes** contribute to respiratory and cardiovascular problems, and are a factor in excess winter deaths. Cardiovascular disease costs £14.4 million to the NHS of which 72.1% is inpatient costs.83 Respiratory disease costs £6.6 billion to NHS and society.84

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80 M Davison *et al* (2010). *The Real Cost of Poor Housing*, BRE.
81 Crisis/ Sheffield University (2011). *Homelessness: A silent killer*
82 Homeless link/ Inside Housing, 12/11/2010.
83 NICE, Preventing cardiovascular disease: costing report, p4.
84 British Thoracic Society (2006). *Burden of Lung Disease*
Aids and adaptations that increase the accessibility of housing increase safety and reduce the risks of accidents and falls. The report, *Better Outcomes, Lower Costs* compared the cost of an average adaptation, costing £6,000 with the average cost to the state of a fractured hip, of £28,665. Improved housing is a significant factor in improved mental health—significant when depression is connected with a 30% increased risk of a hip fracture in women. The lack of safety in the home is a key contributor to delayed discharge from hospital.

**INTRODUCTION**

2.1 The Chartered Institute of Housing (CIH) welcomes the opportunity to make this submission to the Health Committee in relation to their inquiry into the education, training and workforce planning of health professionals.

2.2 CIH is the professional body for people involved in housing and communities, with over 22,000 members across the UK and Asian Pacific. We are a registered charity and not-for-profit organisation. Our mission is to maximise the contribution that our members make to the well being of communities. Our vision is to be the first point of contact for—and the credible voice of—anyone involved or interested in housing.

2.3 CIH has worked in partnership with other organisations over many years to demonstrate the contribution of housing to prevention and recovery—including the Housing Learning and Improvement Network, formerly part of the Department of Health—and our most recent report covered how these connections could be made in the light of a drive towards localism from DCLG and the changes to the NHS being taken forward in the Health and Social Care Bill: *Localism: delivering integration across housing health and care*.

2.4 CIH also participates in the Learning for Public Health network in the West Midlands, which organises regular interdisciplinary events to focus on aspects of public health, and involves local authorities, public health professionals, environmental health officers and others with an interest in public health.

**HOUSING’S ROLE IN PREVENTION AND RECOVERY**

3.1 Many CIH members are involved in delivering support services through accommodation based schemes such as supported and sheltered housing, or through floating support to people in general needs tenancies or owner occupation. The support covers a range of client groups including people who are homeless, people with alcohol and substance misuse, mental health problems, learning disabilities and older people with varying levels of vulnerability and support requirements.

**Support**

3.2 Housing related support services play a significant role in reducing the need for more intensive health or care interventions, and can facilitate a quicker and more successful recovery from episodes of ill health or hospitalisation. Studies undertaken for DCLG have demonstrated how effective these are in saving money for other public services, with the health service in particular gaining from housing related support interventions. Overall, for investment of £1.55 billion, estimated savings to the public purse reached £2.77 billion including some of the highest savings among groups that make significant call on health services, such as older people. Investment in sheltered housing at a cost of £258.7 million saved £1,090.9 million, and for frail older people the figures were £31.4 million costs for £138.7 million savings.

3.3 Housing with care for frail older people (extra care or very sheltered housing) has been demonstrated to enable older people to remain in their own home successfully for longer, avoiding institutional/residential care. The use of flats within such schemes can also provide a useful and natural setting for reablement and rehabilitation after hospital.

**EXTRACARE CHARITABLE TRUST—ENRICHED OPPORTUNITIES PROGRAMME (EOP)**

Extracare charitable trust developed EOP as a way of supporting older people with dementia to remain living independently for longer in their own homes, in extra care schemes, through the introduction of specialist training and support. It involved 10 schemes (including five schemes to act as placebos) in a two year study, which was independently evaluated. It demonstrated that people in the sites with the EOP:

— Were 50% less likely to move into residential care.
— Had a 42% decrease in hospital stays.

This has now been rolled out to the other schemes.

**Housing conditions**

3.4 Decent housing that is energy efficient and accessible plays a critical role in the safety and health of older and disabled people, and those suffering respiratory and cardiovascular problems.

86 Cap Gemini (2008). Research into the financial benefits of the Supporting People programme
87 More about this scheme can be found at UKHA 2007
3.5 A recent report from the Marmot Review Team into *The Health Impacts of Cold Homes and Fuel Poverty* has highlighted the direct impacts of cold homes including:88

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- The relationship between cold temperatures and both cardiovascular and respiratory diseases, which account for 40% and 33% of excess winter deaths respectively.
- The increased incidence for children in cold homes to suffer respiratory problems compared to those in warm homes (more than twice as likely).
- Mental health is negatively affected by fuel poverty and cold housing for any age group.

Indirect costs include:

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- Increased risks of accidents and falls.
- Impacts on the educational and emotional development and resilience of children.

**Sandwell MBC’s Housing for Health**

Under a Housing for Health strategy, Sandwell developed a number of initiatives, including a Repairs on Prescription scheme. Housing interventions were targeted at helping people with respiratory problems, cardiovascular disease and falls, and older people admitted to hospital. The main intervention has been work on central heating and insulation.

Other repairs, such as decoration, bathroom refitting and carpeting were used for people using mental health services.

An evaluation, focused on children with asthma, reported significant improvements including:

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- Reduced illness.
- Fewer visits to doctors and stays in hospital.
- Reduced need to use medication.
- Increased access to school and play.
- Reduced incidence of flu and colds in the family.
- Reduced financial stress.
- Reduced anxiety.

**Adaptations**

3.6 Many reports have demonstrated the value of investment in preventative services such as adaptations, to prevent accidents and falls that involve more personal distress and injury as well as increased cost to the NHS. Two Audit Commission reports89 and the previously mentioned Better Outcomes, Lower Costs all demonstrate the savings that can accrue from investment in DFGs. Many people benefit from adaptations including older people; a group that incur significant health spending—40% of the NHS budget and two-thirds of acute beds are used by people over 65.90

3.7 However, demand for these services far exceeds availability of funding. In particular there is a risk for older people in home ownership (75% of the older population) given that no further funding for private sector housing renewal is now available; people of 75, primarily home owners are the age group most likely to live in poor housing and more than one million live in non decent homes. It is unlikely that health professionals fully understand the potential impacts for services from the increased risks of falls and ill health that could result.

**Commissioning and Training**

4.1 Although evidence about housing’s contribution to health and wellbeing exists, it is not sufficiently well known by health professionals. As it concentrates largely on attempts to prevent ill health and accidents, it can be difficult to model the impacts and savings in the same way as with trials for drugs or clinical interventions. The difficulty of engaging health professionals was experienced by other partners in the previous commissioning structures under the Supporting People programme. A fresh opportunity for better awareness and integration may now be offered through Health and Well being Boards, and it is important that expertise on the social aspects that influence health are incorporated into the strategies and commissioning structures locally.

4.2 The example from Blackpool below demonstrates why cross professional training on housing and environmental factors is so productive. It has shaped the culture of the public sector organisations and made a shared referral process successful. All visiting officers whether from a health or housing background, can consider the impacts for colleagues and effectively connect the individual or household into the right services. This has now been extended to include local GPs.

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BLACKPOOL—TAKING INTEGRATED WORKING FURTHER

In CIH/Housing LIN’s report on Housing Health and Care in 2009, Blackpool was an early case study of integrated working across the sectors. Public services in Blackpool had developed integrated networks at chief officer, strategic and operational levels that resulted in a joint training programme for frontline workers across the sectors, based on the effect of the environment on people’s health. It also led to the development of a shared referral process.

The ongoing demand for services and the constrained financial settlement across the public sector means the partners are working together to develop services, find new funding, and increase their “reach” to more members of the community. Facilitated by its unitary status, co-location of key services, and driven by the obvious impact of poor housing conditions on health, its PCT has provided continued investment in the delivery of Affordable Warmth through the Home Improvement Agency, Care & Repair.

Working with GPs

A critical development has been to ensure that customers that are common to all the services only have to engage once, to open the door to all the services they require. Recognising that more socially isolated people are likely to engage with GP services and related community health professionals such as community matrons and district nurses etc, the HIA and public health professionals have been keen to connect to GPs to reach more people requiring affordable warmth and highlight issues of poor housing conditions.

As part of that objective, Blackpool PCT and HIA have worked hard to engage GP partners to pilot a mechanism for referrals through the GPs’ IT system, which will trigger queries about the person’s housing, when assessing cold related illness. Referrals will be directed into the HIA who will coordinate interventions using shared referral process previously developed across the partners.

The approach to GPs has been supported by local Public Health professionals, who have provided the way in to engage practice managers. Housing and PCT staff have gone prepared to give answers and demonstrate how involvement in the project will directly deliver the GP/practice’s own key objectives—addressing ongoing respiratory problems, reducing repeat visits, reducing need for medications. In the long term, by developing a system that is easy to use and that produces results, they hope to win the commissioning argument with GPs and be able to continue/increase the service.

4.3 CIH would advocate that the committee looks beyond the core elements of education and training, in particular for GPs, for health professionals working in the community and for professionals who work in hospitals on discharge arrangements. We believe this is a missing link in terms of how well people are supported to maintain their health and well being and to recovery more quickly and effectively following ill health or hospitalisation. We would be pleased to discuss this further with the Committee or with appropriate officers of the Department of Health.

December 2011

Written evidence from Heart of England NHS Foundation Trust (ETWP 62)

1. CONTEXT AND BACKGROUND

The Heart of England NHS Foundation Trust is one of the largest hospital Trusts in the country with over 10,000 staff, a diverse workforce including 6,000 clinical professionals and a workforce spread across three acute hospital sites and community services. The organisation makes a multi-million pound investment in education annually. However, in recent years the organisation became increasingly dissatisfied with the return on this investment in terms of impact on workforce and organisational performance.

In 2009 the organisation, in order to resolve this problem, initiated development of a new Learning and Development Strategy. In order to ensure the strategy was explicitly linked to service enhancement and workforce development needs an extensive action research project was undertaken; engaging staff at all levels within the organisation. The emergent strategy entitled Learn Lead was framed by seven deliverables for learning and development that directly reflected the outcomes of the staff engagement process:

— A clearly defined, accessible education service.
— Eliminate fragmentation, duplication and variability of learner experience.
— A centrally managed education portfolio explicitly linked to business needs, workforce plan and clinical vision.
— Effective educational frameworks and curricula that have high impact on service quality and safety.
— Effective educational governance and quality management.
— Education interventions measured against intended impact and return on investment.
— A self sustaining service that generates and uses its income to expand access to a full range of education and development opportunities for all staff.
The strategy was underpinned by a workforce model for developing healthcare careers “the HEFT 6 C’s strategy”. The aim of this model was to provide a framework for recruiting individuals from our local communities and developing them through lifelong careers in healthcare; identifying and growing talent so that any member of the organisation, with the desire and potential, can progress through to an executive level.

As part of the “6 C’s strategy” a foundation year was introduced for the whole workforce. This provides front loaded support for development of core skills and behaviours; staff stepping off this foundation year with a personalised development plan.

The key feature of the new strategy was the development and launch of the Heart of England NHS Foundation Trust Faculty of Education. The “HEFT Faculty” provides a strategic umbrella for the education and development of employees. Drawing on learning from successful US corporate models, the Faculty is central to disseminating the organisation’s culture, fostering the development of not only job skills but also core workplace skills such as learning-to-learn, leadership, creative thinking and problem solving. This marks a shift in focus from employee training to employee education. The HEFT Faculty, in partnership with its accrediting partners, enables the organisation to provide a portfolio of service focussed and patient centric education for employees that can evolve with ever changing organisational needs.

By maximising investment, and securing best value, we have increased access for staff to high quality education that ultimately will enable us to achieve our strategic goals and secure ongoing service improvement.

2. Early Achievements

— In house “one stop shop” prospectus-linked with annual training and learning needs analysis offering in house development ranging from key skills to Masters level modules.

— Work related learning unit offering placements to young people and others including a successful campaign to increase placement availability entitled “be engaged shape tomorrow”.

— Work with local schools to collaboratively deliver the School Health and Development Diploma. Facilitating delivery of integrated learning; work experience and health promotion messages to local communities.

— Employment and support of over 400 apprentices.

— Launch of a dedicated Healthcare Careers Development Unit. This unit offers readily available information advice and guidance on work related learning to all employees, as well as supporting development and career progression for all non clinical staff and professionals.

Recruitment of the long term unemployed people onto a bespoke healthcare support worker apprenticeship programme; recruited for values and behaviours rather than educational qualifications. Evaluation research has demonstrated enhancements in levels of performance; engagement and positive personal and social outcomes from those moving through the programme.

Development of a range of in house career development frameworks for administration; finance; and HR staff.

First group of in house academically accredited programmes increasing the value of the organisations existing educational spend by the equivalent of 1.2 million pounds. We have halved the cost of academic modules by using this in house delivery approach.

Development of in-house Masters level leadership programme delivering over 100 service improvement projects.

Growth in service situated education offering mentorship; preceptorship and on the job coaching.

Implementation of new development programme for SAS Doctors and skills development for Junior doctors.

Introduction of VITAL for nurses—this is an on-line learning and assessment programme focussed on fundamental nursing care which has contributed to improvements in patient safety and nursing care standards. VITAL has delivered £833,400 savings as compared with traditional methods of training and enabling 65,000 hours to be reinvested back into front line care.

3. Faculty Awards 2010–11

— National HPMA excellence in HR management awards—for workforce development strategy.
— National HR Excellence awards—for workplace diversity “steps to work apprenticeship programme”.
— Nursing times awards—for patient safety (VITAL for nurses).
— HSJ awards 2011—for workforce development.
— Job centre plus skills development award—large employer.
— Personnel today awards—finalist workforce development.

4. Transferable Learning

The NHS, as other public sectors, faces a financially challenged future and as service providers we will need to deliver quality at the same time as realise efficiencies and improve productivity. The NHS needs to be an employer of choice attracting and retaining the talent it needs to deliver the vision of quality healthcare for all. We will need to foster and retain skills and talent through these challenging times, developing the solutions the NHS needs through the people who will deliver them. The NHS has a chance now to take a long term view of the challenges ahead, tackling immediate financial challenges alongside designing a workforce for the future. High quality and accessible learning and development will be key in achieving this.

We believe that the HEFT Faculty is an innovative and real example of how this can be achieved enhancing qualitative outcomes as well as realising over one million pounds in benefits in the first year. We believe that this is an example of how transferring responsibility for workforce development to service providers and allowing them more freedom of choice for education commissioning and delivery can deliver both quality enhancement and efficiency in workforce development.

To enable us to continue our work we need to have more influence and control of educational investment so that we can ensure that we can commission and provide education flexibly and at a pace that keeps up with the dynamic nature of contemporary service delivery and workforce planning.

5. Relevant Considerations

— It is imperative that workforce planning is better integrated with finance and service planning in order to more effectively manage workforce risks.
— The changing service provision priorities eg delivery of care in the community and changes in skill mix within acute and community settings need to be more locally engaged and driven.
— Collaborative working will be important with respect to development of LETBs and we are of the view that this should include social care. This will ensure that workforce development is aligned to commissioned services and the respective care pathways. This should enable the provision of improved and sustainable services that are not developed in isolation; thus informing integrated local health economy planning.
— Service providers should have a significant level of control of their own education commissioning. They should be given authority to commission with any willing education provider that will deliver high quality and good value education and training.

Service providers must feel they have a “voice” at LETB level and that the size and governance of these does prevent this or stifle choice. There is a real risk that if service providers feel that they do not have this level of authority that will disengage from the process.

December 2011

Written evidence from NHS South of England, Workforce Development Directorate (ETWP 63)

BACKGROUND

South of England Strategic Health Authority (SoE SHA) welcomes the opportunity to submit written evidence to the House of Commons Health Select Committee Inquiry on Education, Training and Workforce Planning in the form of this written submission. The SoE SHA was formed recently by bringing together, under a single leadership team, staff from the South West, South Central and South of England Strategic Health Authorities. SoE SHA believes that any future education commissioning and workforce planning system needs to:

- move from being predominantly supply led (HEIs and professions determining numbers via historical commissioning patterns), to being more demand led, based upon the needs of NHS service providers determining the numbers (in collaboration; with HEE), type of professional and skills and knowledge required of newly qualified staff;
- be planned, commissioned and provided in an integrated and multi-professional way that prioritises patient needs above those of individual professions;
- better integrate workforce planning—across the workforce (medical and non-medical), across the NHS (finance and service), and across healthcare (NHS and non-NHS organisations);
- deliver a more productive workforce; and
- deliver a more flexible workforce.

SUMMARY

- Education and training should not be seen as an end in itself but integral to achieving the NHS and Public Health Outcomes Frameworks and demonstrably improve the patient outcomes and experience.
- NHS Commissioned services (organisations commissioned to provide NHS services including Social Enterprises, voluntary and private companies etc) should hold responsibility for the planning and commissioning of education and training for all parts of their workforce with Local Education and Training Boards (LETBs) providing leadership, co-ordination and brokerage between all stakeholders (inc Higher Education Institutes, Local Authorities and other agencies) to inform “sub-national” plans.
- Local networks need to be authorised and managed based upon outputs not only infrastructure. Whilst the final form of the legal entity should be the same for all LETBs, the local structure should fit local circumstances.
- The interdependent role of innovation, leadership development, and quality improvement to the attainment of the best workforce possible are significant and clarity of their role within LETBs and between HEE and the NHS CB is critical. The assumption is that there will be clear guidance about the relationship and roles of LETBs and Academic Health Science Centres/Networks to avoid duplication.
- A clear definition of the terms “workforce planning” and “current and future workforce”, would be extremely helpful to build a clear and shared understanding, as the terms do not mean the same thing to all people. Clarity is required as to where the responsibility and accountability for these activities lie in the new system. LETBs, and HEE, should not be accountable for both supplying the future workforce and being held accountable for assuring the current workforce.

ISSUES FOR CONSIDERATION

1. Education and training should not be seen as an end in itself but integral to achieving the NHS and Public Health Outcomes Frameworks and demonstrably improve the patient experience

   1.1 High quality patient care is dependent upon robust service planning underpinned by effective workforce development which informs educational investment and workforce productivity, improvement and innovation.

   1.2 Education and training should not be seen as an end in itself but one way of contributing to the patent experience and Quality, Improvement, Productivity and Prevention (QIPP), through increased productivity, quality and effectiveness (getting it right first time) and not divorced from service, therefore it is integral to achieving the Outcomes Framework, Operating plans and improving patient safety. The new structure should be deliberately designed to achieve excellence, retaining what currently works well and addressing and improving areas of weakness, it should not be designed as a by product or to merely fit into other system changes.
1.3 Educational quality mechanisms are complex and often bureaucratic and Health Education England (HEE) is well placed to address areas of similarity and commonality to reduce duplication and increase efficiency. The role of the Care Quality Commission (CQC)—monitoring workforce/education and training: standards 12, 13 and 14—should be seen as a critical component of the educational workforce assurance process not just assurance of service delivery. Currently local arrangements are being strengthened with CQC but the future relationship with HEE and Local Education and Training Boards (LETBs) needs to be clarified.

2. NHS Provider services should hold responsibility for the planning of education and training for all parts of their workforce with LETBs providing a co-ordinating role between all stakeholders (inc Higher Education Institutes, Local Authorities and other agencies) to inform “regional” plans

2.1 Strengthening demand led planning and commissioning requires all NHS service providers to assume responsibility for workforce planning, including Continuing Personal and Professional Development (CPPD) for existing staff (ie NHS Trusts work on a one to three year financial timeframe). For undergraduate and Post Graduate Medical and Dental education (PGMDE) it is more likely that service commissioners (Clinical Commissioning Groups with Health and Well Being Boards through Joint Strategic Needs Assessment & Clinical Senates) should influence how many of what type of undergraduate/pre-registration students to commission for their strategic service development plans. Therefore the role of the NHS Commissioning Board (CCGs, Health and Well Being Boards and Clinical Senates) in providing guidance for the workforce of the future (four years and beyond) needs to be considered.

2.2 There are two obvious constraints that continue to make it difficult for medical workforce planning to be as flexible and responsive to employer demand as non-medical workforce planning, these are:

— The setting of undergraduate medical numbers at national level—these numbers then flow through into F1, F2 and specialty training, the decisions that can then be made locally are about the spread of training across the specialties not the overall number of trainees which has already been set.

— The long lag time between setting the specialty training numbers and completion of training which means medical workforce planning is done over a longer time frame than all other areas of health care workforce planning.

2.3 At the moment there is no demonstrable connection between service needs and the number of medical undergraduate entering University and PGMDE Deaneries (within LETBs) have no control over the number of F1s entering the system. It is essential that service considerations are taken into account and considered when determining the number of medical undergraduate places available at University and therefore the relationship between the Department of Business, Innovation and Skills (BIS), Higher Education Funding Council for England (HEFCE) and HEE is critical if oversupply of doctors in the future is to be tackled and avoided.

2.4 The future architecture needs enable more dialogue between service and traditional ownership of curricula and specialty roles by Royal Colleges. The landscape of NHS delivery of care going to change rapidly from hospital to intermediate to community and changing service must be anticipated and not delayed by training pathways.

2.5 The inclusion of strategic partners (HEIs, LA and other non NHS providers of NHS services) is critical to the work of the LETBs in the future. Local LETB structures should include representation of these bodies in the infrastructure of the organisations. Each LETB will need to have clarity over how, specifically, the strategic partners are incorporated into the decision making structure of LETBs, be it as a member of the Board or Partnership Council without compromising their ability to bid for business from the LETB or present a conflict of interest.

3. Local networks need to be authorised and managed based upon outputs not infrastructure. Whilst the final form of the legal entity should be the same for all LETBs the local structure should fit local circumstances

3.1 Local networks need to be authorised and managed based upon outputs not infrastructure: it should be the responsibility for the local LETB to determine if running costs demonstrate value for money. If local providers want LETBs to be ambitious and take the lead on new ways of working and be innovative, then the NHS providers should determine (via the Board) if the running or management cost represent value for money, not DH on a % of MPET.

3.2 Further clarity of role of the Centre for Workforce Intelligence (CFWI) and HEE and the contribution of the NHS Commission Board to ensure that regional plans are balanced with national demand would be welcomed. The impact upon LETBs and NHS provider organisations (resources, funding, and availability of placements) of any “additional” nationally required commissions over and above those locally required needs careful consideration as does the ability of the LETBs to resist central imposition of targets when appropriate.
4. The contributory role of innovation, leadership development, and quality improvement to the attainment of the best workforce possible are significant and clarity of their role within LETBs and between HEE and the NHS Commissioning Board (NHSCB) is critical. The assumption is that there will be clear guidance about the relationship and roles of LETBs and Academic Health Science Centres/Networks to avoid duplication.

4.1 The future of innovation and leadership are key components of service transformation through getting the right people to work in the most effective ways. If LETBs are to do more that merely replace SHAs under a different name, by continuing to do the same with less and be truly patient focussed, we need to raise the ambition of the guidance to date.

4.2 There is uncertainty over the precise role and ambition of LETBs, ranging from providing “pre-registration education commissioning” (procurement and contract management) and “Deanery” activity through to a more sophisticated and responsive transformational role that includes innovation and leadership development as significant components of the LETBs. A key advantage of the LETB will be the ability to see across the whole system and understand how different elements (service providers, commissioners, and education providers) are impacting upon each other. The LETB will be capable of taking a wider perspective and, using workforce and education intelligence and sharing good practice, it can take a strategic approach to developing transformational change at scale across several agencies and sectors.

4.3 LETBs should work in partnership with both academic and research focussed organisations and networks and should have senior representation in decision making forums from these organisations. HEE has a remit to developing the whole workforce and due consideration has to be given to the 40% or so of staff that are neither “professional” nor “academic” and their learning, training and development requirements should be addressed and met by the LETBs as much as they are for the former.

5. A clear definition of the terms “workforce planning” and “current and future workforce”, would be extremely helpful to build a clear and shared understanding as the terms do not mean the same thing to all people. Clarity is required as to where the responsibility and accountability for these activities lie in the new system. LETBs, and HEE, should not be accountable for both supplying the future workforce and being held accountable for assuring the current workforce.

5.1 The previous House of Commons Health Select Committee (2007) signalled three areas in which better integration of NHS workforce planning was required:

- across workforce, financial and service planning;
- between medical and non-medical workforce planning; and
- between NHS and non-NHS providers.

5.2 All LETBs in the South of England cluster are signed up to an integrated inter-professional, multi-agency entity (taking into account education commissioning, workforce, leadership, innovation and transformational service development) and recognise that whilst local infrastructures may vary, any devolution of these component parts from the main business of LETBs, eg by making Deaneries independent of LETBs and service, will compromise this ambition and potential.

5.3 A clear definition of the terms “workforce planning” and “current and future workforce”, would be extremely helpful to build a clear and shared understanding as the terms do not mean the same thing to all people. Workforce planning can be separated out into:

- workforce planning as an element of an integrated business plan (operating plans one to two years);
- workforce planning across a health system (QIPP plans three to five years); and
- workforce supply planning (training and development plans—short term) and education commissioning plans (longer term).

5.4 Whilst integration of workforce planning is seen as essential, responsibility for workforce performing/assurance is not seen as a function of the LETBs.

- Service commissioners hold contracts and should therefore have the performance responsibility for service provider’s workforce—balancing the competing requirements of quality and financial constraints.
- HEE and LETBs would be held to account for the workforce supply element of any national ambitions such as health visitors.
- HEE and LETBs would be responsible for performance/assurance of education and training through for example eg Learning and Development Agreements (LDA) and quality assurance of training placements. It should be noted that, in addition to SHAs and Deaneries, the CQC, Royal Colleges, and HEIs currently all have a role here.

5.5 The use of the terms “current and future workforce” is vague? For example: are PGMDE trainees the current or future workforce, given that they are employees of the NHS providing a valuable contribution to service yet are also considered trainees? Most other students are supernumerary and therefore delivery of service is not dependent upon them and there is little impact upon patients if students are withdrawn from the
clinical area, for whatever reason, the same is not true for medical trainees where withdrawal of placements impacts greatly upon service provision as rotas are likely to be compromised.

5.6 The most challenging part of medium/long term planning for providers is understanding the implications of future commissioning intentions on the workforce that they need to employ. It would also be helpful if CCGs, health and wellbeing boards (H&WB) and Clinical Senates had a specified role in workforce strategic planning as their role is developed. The SHA would not want to see a separation between the workforce work led by HEE and the commissioner work led by the NHSCB. Workforce development plans will need to be closely linked to policy and strategic planning as well as embedded in provider responsibilities. The NHSCB strategic commissioning intentions need to be part of the longer term strategic workforce planning process.

5.7 These types of planning are inter-related but also distinct approaches. In the new system we need to be clear which type of workforce planning we are talking about and therefore how it will be done by whom and at what level.

December 2011

Written evidence from Fresenius Medical Care (ETWP 65)

1.1 This submission is from Fresenius Medical Care. We have been working in partnership with the NHS for over 20 years to deliver high quality dialysis services, for NHS patients. We provide over 530,000 dialysis treatments to almost NHS 4,000 patients a year. Our partnership model for dialysis services ensures that clinical care is shared between the NHS consultant and our nurse-led satellite units. We have worked with the NHS to help increase capacity for the NHS quickly, cost effectively, whilst ensuring NHS patients have access to the latest innovative dialysis treatments, close to where they live. We currently provide 56 dialysis satellite clinics in England and Wales for the NHS. As part of the Fresenius Medical Care group of companies we have a longstanding history in the development of innovative dialysis treatments, products and therapies.

2. SUMMARY

2.1 As the leading independent provider of NHS dialysis services and the largest independent employer of renal nurses, we would like to highlight our contribution to the training and education of healthcare professionals. There has been a long history of independent sector involvement in the provision of NHS services, yet the contribution of independent providers in delivering high quality care as well as training for staff has often been overlooked. We hope that the Committee will find it helpful to hear of our experiences in providing training and ongoing development for clinical staff, as well as gain a clearer understanding of the level of training provided by the independent sector.

2.2 As an employer we are committed to providing ongoing training and development for all our staff, including clinical staff, throughout their employment with us, because we understand the benefits of motivating staff and supporting their professional development. We provide a range of e-learning and training in-house as well as funding external training courses for staff, study days and time off to take exams. We also provide clinical and technical training on dialysis treatments, our dialysis machines and products for NHS staff as well as NHS staff seconded to some of our satellite dialysis units. We have also funded general nurses to take further training to become renal specialist nurses, due to a shortage of renal specialist nurses.

3. OUR COMMITMENT TO THE TRAINING AND EDUCATION OF HEALTHCARE PROFESSIONALS

3.1 We currently employ over 400 nurses, and 80 healthcare assistants. All staff who begin employment with us, including healthcare assistants, nurses, receptionists and other support staff, undertake a thorough induction programme which is tailored to their job role and covers infection control, a detailed course on dialysis treatment, health and safety, clinical governance, quality guidelines and standards, how we gather and respond to patient feedback, data protection and our clinical patient data management system. Through our appraisal process, staff are encouraged to take ownership of their own professional development. The training requirement of each person is discussed and an action plan is agreed with their line manager.

3.2 All staff have access to our comprehensive e-learning programme which covers a wide range of topics including infection control, data protection and nursing education, related to kidney disease.

3.3 Our dialysis products division provides both face to face training and online e-learning courses for NHS renal units as well as for our staff working in our dialysis clinics. We support all clinical, product, technical and device training for the NHS. As well as running therapy and clinical training courses in-house and locally in NHS renal units, we also run technical training to support the technical aspects of the dialysis equipment used in NHS units.

3.4 We currently have over 1,600 users enrolled on the Online Learning Centre, which supports the training on dialysis treatments carried out on site at NHS units. The online training complements the face to face training and reduces the time needed to be dedicated to traditional training, improving productivity and patient contact time. It also allows staff to train at their own pace and chosen location.
3.5 We currently run around four to six technical training courses each year, depending on demand, for technical staff both from the NHS and for our own in-house technical services team. On average we have 49 people attending our technical courses which includes those on new training and refresher courses on our haemodialysis treatments.

4. IMPROVING CARE QUALITY AND PATIENT SATISFACTION

4.1 In our experience, providing training for staff improves staff satisfaction, which in turn has been shown to improve patient care. Research carried out by the Aston Business School has demonstrated that high levels of staff satisfaction are linked to high-quality patient care.93

4.2 In a recent staff survey (November 2011) Fresenius Medical Care staff satisfaction was rated at 4.1 compared to NHS staff surveyed in 2010, who rated 3.51 out of 5 on the staff satisfaction index.94

4.3 We fund numerous training courses for staff each year. There are over 250 study days available for staff to attend throughout the year and all staff are able to attend. Our staff have attended courses and training days on a wide range of subjects including:

— Attending UK and European Conferences.
— Management courses through Open University.
— Healthcare assistants have attended the level 3 NVQ in health and social care.
— Registered Nurses have obtained Post Registration Course in Nephrology Nursing.
— All courses are fully funded by Fresenius Medical Care.
— In the last year over 50 staff have attended external courses fully funded by Fresenius Medical Care.

4.4 Many of these courses attract CPD points.

5. WORKFORCE PLANNING

5.1 We believe that all providers should be involved in workplace planning and developing the future workplace for appropriate services. Through our investment in the provision of satellite dialysis units we have helped the NHS to increase capacity quickly and without the burden of capital investment for NHS Trusts. However in some areas we have experienced a shortage of renal specialist nurses and have therefore had to invest in training registered nurses to gain the additional expertise and knowledge required for this specialist service. We have also recruited clinical staff from overseas to fill the shortage. We therefore believe that there could be greater collaboration between commissioners, NHS and independent providers in the planning of services and future workforce requirements.

6. CREATING A LEVEL PLAYING FIELD FOR ALL PROVIDERS

6.1 We believe that all providers including those in the independent and voluntary sector should be encouraged to provide ongoing training for staff. Providers of NHS-funded services, whether they are NHS, independent or voluntary sector providers, should be treated on a level playing field. Throughout their careers, many healthcare professionals move around the health care sector, moving to other Trusts and between the independent, voluntary and public sector. For all providers to invest in training when they will not know how long a member of staff will remain with them, providers must not be penalised from recruiting from one particular sector over another. Many independent providers like ourselves are already investing in training and development programmes for clinical staff, beyond the minimum requirements and we believe that all providers should be encouraged to do the same.

6.2 Placing a duty on providers would help to ensure that all staff working in NHS funded services have access to a minimum level of training and stimulate a culture of CPD. Through the tendering process to provide NHS dialysis services we are able to demonstrate our commitment to funding training and development courses for staff. In the tender document we are able to outline the training we can provide and fund for clinics’ staff locally. The tendering process also ensures that providers employ clinical staff with a minimum level of qualifications, experience and/or standards. For example, specifying that a Registered Nurse has 1st/2nd level registration and is licensed to practice with the NMC and a Healthcare Assistant has a minimum of GCSE qualifications and a NVQ II or III level qualification would be desirable. We believe that this process should continue because it ensures that minimum standards are met whilst encouraging providers to go beyond the mandatory requirement.

December 2011

93 Department of Health, NHS Staff management and health service quality, 2011
94 2010 annual NHS staff survey, co-ordinated by the CQC http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_125155
Written evidence from University of Cumbria (ETWP 66)

INTRODUCTION

The University of Cumbria welcomes the opportunity to comment upon Health Select Committee Inquiry on Education, Training and Workforce Planning.

KEY THEMES

1. The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

   This is best addressed by workforce planning and effective partnership with Universities.

2. Training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

   Again, partnership working between regulators, service providers and education establishments will address this area.

3. All providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

   Effective partnership can assist in this process.....between service providers (NHS and non-NHS) and with HEIs. Regular dialogue and monitoring currently exists; there is no reason why this should not continue.

4. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

   Universities such as Cumbria have effective frameworks for such multi/inter-professional agendas at registration and CPD levels. Further engagement is welcomed between medical and non-medical education. This takes place increasingly in placement settings as well as on university premises. This is monitored through effective governance arrangements between universities and our Health Service commissioners.

5. High and consistent standards of education and training

   As a University we have key high-level review and monitoring through the QAA, the SHA, professional and statutory bodies. Our reports are public and there is every opportunity for public scrutiny. User-carer involvement is also welcome.

6. The existing workforce can be developed and re-skilled for the future (through means including post-registration training and CPD)

   We have effective liaison with senior education/training managers at regional and local level. There are effective mechanisms for new types of practitioner (eg Advanced and Assistant Practitioners) to be introduced.

7. Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

   We are a “widening participation university” with a strong record of engaging students from low-participation neighbourhoods. Assistant practitioner programmes help in this process; ditto foundation degrees and their integration into part-time/work-based learning programmes.

SPECIFIC ISSUES

8. Plan got the transition up to April 2013

   We have concerns that universities are not represented on the Network Leadership Groups. Without such engagement it will be difficult to plan effective partnership working.

9. The future of postgraduate deaneries

   They have a key role in the Network Groups; however, there is no evidence so far that they relate to broader non-medical education agendas.

10. The future of Health Innovation and Education Clusters

   They provide an excellent example of close/partnership working between service education providers. They have provided work “outside the traditional boundaries” of education or research commissioning/funding. Their continuation should be encouraged.
11. The role of the Secretary of State of Health in the new system
   Overall accountability.

12. The proposed role, structure, governance and status of HEE
   Multi-professional body that will be important for setting national agendas for local networks and for education providers. It is important that registration programmes are commissioned with a national, as well as local, workforce in mind.

13. The proposed role, structure, status, size, composition of Provider Skills Networks/LETBs
   Subregional groups are appropriate (e.g., covering Cumbria and Lancashire). However, the lack of direct university engagement is of concern.

14. How professional regulators, etc will all participate in the formulation and development of curricula
   Universities work well with the broad range of stakeholders; we envisage that this will continue under the new structures. However, as in 13 above, the lack of direct involvement in the proposed networks makes such engagement less easy.

15. Implications of a more diverse provider market within the NHS
   Already there are arrangements that universities work with such providers. Our work in Social Work/Social Care already provides much engagement with this sector.

16. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced
   Effective planning and engagement by local Networks and HEIs.

17. The role and content of the proposed National Education and Training Outcomes Framework
   Education governance arrangements already effective between the Health Service and HEIs. This model is encouraged to be continued and developed in the future.

18. The role of the Centre for Workforce Intelligence
   Good quality workforce data.

19. The role of Skills for Health and Skills for Care
   These Sector Skills Councils should be merged—they provide valuable advice and some innovative work.

20. The role of NHS Employers
   Pay/Conditions of Service.

21. How funding will be protected and distributed in the new system
   National and local priorities need to be identified and recognised through future allocation processes. Greater parity between medical and non-medical priorities should be realised. For future protection of the health workforce the needs of universities should be recognised (some degree of stability is required to ensure continuation of the necessary infrastructure to support health care education).

22. How future healthcare workforce needs are being forecast
   Enhance workforce planning at local/subregional level as well as the role of the Centre for Workforce Intelligence at national level.

23. Impact of people retiring from, or otherwise leaving, healthcare professions
   Good workforce planning should address this.

24. Place of overseas healthcare staff within the workforce
   Limited at present due to immigration controls. Few EU students enter health care professions in the UK.
25. How the new system will relate to healthcare, education and training and workforce planning in other countries of the UK

HEE will need to work with the partner agencies in the other countries. However, as a “Border University” with Scotland we are very mindful of the some of the cross-country issues and need to ensure a parity between English and Scottish frameworks in future.

26. How the public health workforce will be affected by the proposals

Part of the local networks and will act as the main link with local authorities. Health professions will also retain their key health promotion role.

December 2011

Written evidence from the General Osteopathic Council, the Council of Osteopathic Educational Institutions and the British Osteopathic Association (ETWP 67)

Summary

1. This submission represents the collective response from the General Osteopathic Council (the UK statutory regulator for the osteopathic profession), the Council of Osteopathic Educational Institutions (representing all accredited osteopathic training providers in the UK) and the British Osteopathic Association (the osteopathic profession’s representative association).

2. In summary, we wish to emphasise the following:
   — Osteopathy, as a statutorily regulated profession with an effective contribution to make to patient-centred healthcare, should contribute to working in partnership in education, training and workforce planning initiatives, and to the governance of Health Education England.
   — It is important for smaller health professions to be represented effectively at national level in order to support the aims of the Liberating the NHS White Paper. With an increased focus on self-care and personal responsibility, independent healthcare provision and capacity should be viewed alongside the NHS to ensure that services are available to reduce the pressure within the NHS. It will be important that provision and capacity is not merely left to market forces, but has some input from a planned approach.
   — Statutory regulation of osteopaths provides an effective lever to set and maintain standards of education and training across the four countries and across the continuum of education and training for registered professionals.
   — There should be mechanisms to promote and replicate examples of good practice.
   — There should be close links between undergraduate and postgraduate data to ensure that a full picture feeds into workforce planning.
   — Efficient and effective pathways should be developed by multi-disciplinary teams that include statutorily regulated professions not currently trained in the NHS, like osteopathy, which in turn should feed into commissioned education and training.
   — We attach an annex providing further information about osteopathy, osteopathic education and training and continued fitness to practise of registrants.

The proposed role, structure, governance and status of Healthcare Education England

3. The role of the statutory regulators, like the General Osteopathic Council (GOsC), in setting, maintaining and assuring standards for education, entry to registers and for continuing registration of healthcare professionals—whether they work in the NHS or the independent sector, within or outside an employer and team structure—is crucial to ensure that standards are met, maintained and enhanced to ensure patient protection. This is the foundation of the provision of high quality healthcare professionals to meet the health needs of the population.

4. We believe that it will be important for all the statutorily regulated professions to be able to feed into the governance structure of Health Education England (HEE). This includes those statutorily regulated professions, such as osteopathy, that do not currently benefit from NHS-based training, in order to give effect to the policy objectives of the Liberating the NHS and the Developing the Healthcare workforce papers. In particular, the following objectives:
   — Putting patients and the public first and in particular, patient choice.
   — Focusing on improvement in quality and healthcare outcomes.
   — Autonomy, accountability and democratic legitimacy.
   — Cutting bureaucracy and improving efficiency.

5. To date osteopathy has not been involved in existing NHS arrangements linking workforce planning and education. While a number of NHS bodies fund osteopathy, for example in Essex, East Sussex, parts of
London, Nottinghamshire and Devon, the majority of osteopathic care is delivered in the independent sector. All undergraduate clinical education and training is currently provided in teaching clinics situated mainly in the Osteopathic Educational Institutions (OEIs) or at charitable outreach centres. Postgraduate education and training is predominantly self-directed and self-funded by individual osteopaths and takes place in a variety of settings.

6. Ensuring all health professional regulators are involved in the governance and accountability mechanisms within Health Education England will ensure a more efficient multi-professional approach to the development of shared standards and patient care pathways and effective approaches to quality assurance. This in turn will more effectively inform workforce planning needs.

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

7. If new clinical pathways are developed by multi-disciplinary teams, there is an incentive to provide a service to satisfy the new clinical pathway. Local networks should also include employer groups, the Department for Work and Pensions (DWP) and other relevant agencies as well as third sector bodies with local knowledge so that the detailed health needs of the local area could be established.

8. Many “allied health professions” are currently funded to train in the NHS as part of their training. In this way, their role in the provision of healthcare is perhaps more visible locally because of the current financial requirements of training.

9. However, there are also health professions like osteopathy who are not currently funded to train in the NHS, but do have a role to play in the provision of the “Liberating the NHS” agenda and in particular patient choice and choice of delivery of services. This has already been recognised in the current work on Any Qualified Provider for musculoskeletal services for neck and back pain95 and previously within the Musculoskeletal Services Framework (2006)96 and the National Institute for Health and Clinical Excellence guideline on low back pain (2009).97

10. It will remain important to ensure that health professions like osteopathy are included in the local environment. This will help to ensure that all healthcare and healthcare education providers are aware of each other’s knowledge, skills and practice to contribute to more efficient patient pathways and in turn informing decisions about future commissioning of education.

11. However, like other small professions and specialties, there will also need to be a national overview to ensure appropriate provision and also to share and replicate examples of good practice. See for example, http://healthandcare.dh.gov.uk/back-and-neck-pain-services/ where a pilot involving provision of manual therapists enabled swift patient appointments and a 25% reduction in referrals to spinal surgeons.

How professional regulators, healthcare providers and commissioners, universities and other education providers and researchers will all participate in the formulation and development of curricula

12. In order to achieve the broad policy objectives outlined in this paper, we believe that it will be essential for all these organisations to work effectively in partnership together.

13. The GOsC has statutory responsibility for:
   — Setting standards of competence and safe practice and conduct.
   — Assuring the quality of undergraduate qualifications.
   — Setting and monitoring CPD requirements.

14. Like all healthcare regulators, the GOsC, consults widely on the development of standards and curricula to meet registration requirements. A body like Health Education England could help to facilitate feedback into national standards more effectively with access to real time data and current issues. The statutory regulators set undergraduate, postgraduate training and CPD to ensure better delivery of standards for registration across the four countries. Although it is also important to note that fit for registration and fit for work within a particular context are different concepts.

15. The GOsC is keen to work in partnership with education providers, universities, healthcare providers and commissioners so that practitioners are able to meet contemporary requirements.

The implications of a more diverse provider market within the NHS

16. Diverse provision of services should be available to meet the policy aim of patient choice and to ensure the effective and efficient use of resources.

17. The key opportunities of developing a new approach will be realised only by involving all statutorily regulated healthcare professions (not just those currently trained within the NHS) in the development of effective patient pathways and improved patient outcomes. This will enable a better appreciation of the knowledge and skills of different healthcare professions, improving referral and therefore effective and patient centred pathways. In turn this knowledge could also help to improve the efficient commissioning of services where a fully multi-disciplinary team is involved.

18. While it is important to ensure that resources are in place for acute care. It is also important to allocate resources to the management of chronic conditions to ensure that these are managed as efficiently and effectively as possible.

19. However, diversity poses challenges in relation to the setting and maintaining of standards of practice. Statutory healthcare regulators like the GOsC are required by law to set and maintain standards of practice in relation to undergraduate education and CPD (or postgraduate education). This provides a particular level of assurance in relation to these professions. It will be important for statutorily regulated professions to be included in the accountability and governance structure to ensure the maintenance of professional standards across all four countries of the UK.

How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced?

20. It will be important to collect a wide range of data, including from those professions that do not have a long-established presence within the NHS, to ensure that the whole variety of care available to patients can be taken into account in determining the most effective care pathways and requirements of healthcare professions. This data should include information about patient outcomes. Cost benefit analysis may need to be undertaken to demonstrate the utility of this.

The role and content of the proposed National Education and Training Outcomes

21. There is a role for external “inter-professional” standards to be developed to contribute to the delivery of an aligned workforce. However, these should be developed in partnership with the regulators, as well as education and healthcare providers, to ensure that mechanisms for implementation across the healthcare professions are efficient and effective. This will also ensure that standards are integrated throughout the training pathway of healthcare professionals ensured and overseen by statutory regulators.

22. Identification of emerging best practice and the establishment of mechanisms to communicate this across the country would be very helpful.

The role of NHS Employers

23. NHS Employers should engage (and be engaged with) effectively with other bodies to ensure that feedback about education and training needs in that context is shared effectively.

How future healthcare workforce needs are being forecast?

24. We highlight the role of the independent sector in relation to the management of chronic conditions and the reduction of the burden on the NHS. In order to gain a complete picture of healthcare needs, it is important to be aware of the full picture as this may increase the burden on the NHS in the economic downturn as well as offer potential efficiencies in the management of certain conditions.

25. Forecasts could be focused on the implementation of examples of good practice (see for example the North East Essex pilot above) with efficient and effective resources being replicated across the country if implementation mechanisms were effective.

How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

26. Like most healthcare regulators, the GOsC sets and maintains standards in all four countries of the UK.

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Annex

About Osteopathy

1. Osteopaths are trained to be primary healthcare practitioners. This means that they are able to undertake an initial consultation with any patient. This includes taking a case history, performing an examination of the patient, formulating a differential diagnosis and undertaking treatment where appropriate. Osteopaths are
trained to refer patients to other healthcare professionals when they are not the most appropriate professional to manage an underlying condition (although they may still provide treatment to the individual referred).

2. Osteopaths are able to treat patients exhibiting a significant number of symptoms with a range of osteopathic approaches.

3. Most osteopaths work in independent practice. However, up to 15% do provide primarily musculoskeletal services within an NHS setting and within multi-professional local teams.

BACKGROUND TO OSTEOPATHIC REGULATION

4. The General Osteopathic Council (GOsC) is the statutory regulator (by virtue of the Osteopaths Act 1993) tasked with “developing…and regulating the profession of osteopathy”. Like all healthcare regulators we exercise our statutory functions to protect patients.

5. By law osteopaths must be registered with the GOsC in order to practise in the UK.
   — The GOsC keeps the Register of all those permitted to practise osteopathy in the UK.
   — We work with the public and osteopathic profession to promote patient safety and we set, and monitor the maintenance and development of standards of osteopathic training, practice and conduct.
   — We also assure the quality of osteopathic education and ensure that osteopaths undertake continuing professional development.
   — We help patients with any concerns or complaints about an osteopath and have the power to remove from the Register any osteopaths who are unfit to practise.

THE OSTEOPATHIC EDUCATIONAL ENVIRONMENT

6. There are two publicly funded Universities—Oxford Brookes University and Leeds Metropolitan University delivering Bachelors and Masters degrees in osteopathy.

7. There are also six independent colleges (the British School of Osteopathy, the British College of Osteopathic Medicine, the College of Osteopaths (at Keele and Borehamwood), the European School of Osteopathy, the London School of Osteopathy and the Surrey Institute of Osteopathic Medicine) awarding Bachelors and Masters degrees from validating universities including the University of Greenwich, University of Bedfordshire, Staffordshire University, Keele University, Middlesex University, University of Surrey and Anglia Ruskin University. Most of these colleges currently receive public HEFCE funding allocated via their validating university.

8. There is one other college which awards a postgraduate qualification: Member of London College of Osteopathic Medicine. This postgraduate diploma is only awarded to medical practitioners who already have a primary medical degree allowing registration with the General Medical Council.

9. All these Osteopathic Educational Institutions are required to deliver academic and clinical education that meets our standards in order to obtain and retain recognition. The standards are available on our website at www.osteopathy.org.uk.

10. The award of a GOsC Recognised Qualification (RQ) means that the holder is capable of practising, without supervision, to the standards expected in the GOsC Code of Practice and the Standard of Proficiency (from 1 September 2012 the Osteopathic Practice Standards) capable of meeting the required standards of conduct, competence and ethics. These standards are available on the GOsC website at: http://www.osteopathy.org.uk/practice/standards-of-practice/

11. Once a RQ has been awarded, an osteopath is able to be registered on the GOsC’s Register, subject to satisfying statutory character and health requirements. There are currently around 4,600 osteopaths on the GOsC Register, practising throughout the UK and abroad.

12. Educational Institutions are able to award “Recognised qualifications” following a decision by the General Osteopathic Council to enable them to do so. The process of recognition is a detailed process overseen on our behalf by the Quality Assurance Agency for Higher Education. RQ decisions are also subject to approval by the Privy Council. Quality assurance is also overseen through an annual monitoring report and action plan along with targeted requests for information and visits if information provided requires this. Further information is available on our website at http://www.osteopathy.org.uk/about/our-work/ and http://www.qaa.ac.uk/health/gosc/consultation/

CONTINUED FITNESS TO PRACTICE

13. Once registered, osteopaths are fully responsible for their own training and development (as well as that of their employed staff).

14. All osteopaths are required to undertake regular CPD both by themselves and with others and to submit an annual summary form to the GOsC. Each year a sample of these forms and the folders underpinning them
are audited by the GOsC. Information about our CPD scheme is available on our website at: http://www.osteopathy.org.uk/practice/standards-of-practice/continuing-professional-development/

15. Currently 10% of the osteopathic profession are piloting a revalidation scheme designed to formalise structures of clinical governance in osteopathic practice. The tools being piloted include patient feedback, colleague feedback, clinical audit tools, structured reflection and significant event analysis among others. Further information about our revalidation pilot can be found at: http://www.osteopathy.org.uk/practice/Revalidation/Piloting-the-scheme/

16. The pilot will conclude in October 2012. We expect to report on the findings of our Revalidation Pilot and our CPD review in 2013.

Written evidence from VSO UK (ETWP 70)

VSO AND HEALTH WORKERS

1. VSO is an international development agency with over 50 years of experience working in poor countries around the world. We take a unique approach to tackling global poverty, by placing committed volunteers with carefully selected partners—from grassroots groups to government ministries. Our 1,600 volunteers use their skills to improve the impact of aid efforts for poor and marginalised people. By working closely over time with partner organisations, they provide the right support to help ensure that local development efforts deliver greatest impact and value for money.

2. VSO recognises that the health crisis in many countries is one of the key barriers to development and to countries moving out of poverty. VSO is responding to this inquiry because:

   — VSO recruits UK-trained health professionals to volunteer overseas to train local health workers and strengthen local health systems. VSO would recommend that the Department of Health continue to view overseas volunteering placements as beneficial for professional development and that it supports efforts by trusts and other organisations to facilitate them.

   — Recent research by VSO concluded that developing countries can benefit from their health workers spending a period of time training in a foreign health system such as the NHS. The research concluded that the Medical Training Initiative (MTI) provided a suitable route to provide such training. VSO has a particular concern about the Government’s proposal to reduce the duration of a Tier 5 visa from 24 months to 12 months. This change would decrease the number of doctors willing to participate in the MTI, increasing staff costs for the NHS and potentially leading to further “brain drain” from developing countries. VSO has responded to the UK Borders Agency consultation (closed 17/09/2011; results not yet published). VSO would recommend that the Government retain the length of the Government Authorised Exchange category of the Tier 5 visa at 24 months, and not reduce it to 12 months.

SUBMISSION

3. Our short submission will focus on two aspects of the inquiry:

   — The impact of people retiring from, or otherwise leaving, healthcare professions; and

   — The place of overseas educated healthcare staff within the workforce.

THE IMPACT OF PEOPLE RETIRING FROM, OR OTHERWISE LEAVING, HEALTHCARE PROFESSIONS

4. VSO currently has 120 UK-recruited health professionals, including 44 doctors, serving as overseas volunteers. The majority of returned volunteers agree that their VSO experience has provided a valuable learning opportunity and had improved their personal capacity, for example by making them more resilient, flexible, improving problem-solving skills, and improving their ability to work with and care for people from different backgrounds. A survey by the Chartered Management Institute showed that 94% of employers agree that long term overseas voluntary activity broadens skills and experience.

5. The Department of Health, through Primary Care Trusts and Hospital Trusts currently supports overseas volunteering by promoting opportunities, approving sabbaticals and guaranteeing jobs on return, and paying NI contributions for the duration of placements. VSO would recommend that the Department of Health continue to view overseas volunteering placements as beneficial for professional development and that it support efforts by trusts and other organisations to facilitate them.

THE PLACE OF OVERSEAS EDUCATED HEALTHCARE STAFF WITHIN THE WORKFORCE

About the Medical Training Initiative

6. The MTI is “a temporary scheme designed to enable a small number of international medical and dental graduates to enter the UK to experience training and development in the NHS for up to two years—before returning to their home country.” The latest figures VSO has been given (April 2011) show that there are 340
doctors working in 149 trusts across the UK through the MTI. The purpose of the scheme is to make use of spare training capacity in the NHS, while providing relevant work experience in the UK to doctors from low- or middle-income countries. The three largest countries of recruitment are Sri Lanka, India and Egypt. Participation in the MTI does not lead to settlement or a prospect of a career in the UK. At the end of the maximum period (two years), the individual is expected to return home.

**Benefits of the MTI to the UK**

7. The NHS’s reliance on locums to staff their hospitals has grown considerably in recent years. Utilising the International Medical Graduates (IMGs) recruited through the MTI saves trusts money. MTI doctors are paid the same as UK trainees and do not incur additional charges for the trust from locum agencies. Using the MTI also enables more efficient workforce planning by hospitals. It allows them to plan ahead for MTI positions instead of using last-minute locum appointments.

8. VSO is proud that the NHS is highly regarded internationally and seen as a place where the best medical graduates across the world want to receive education and training. IMGs who train in the UK return home with loyalties to the UK and links to NHS Trusts. These well-established training links give the UK additional influence internationally. The MTI also supports the UK’s international development objectives by facilitating the sharing of knowledge and best practice to strengthen developing country health systems.

**Benefits of the MTI to sending countries**

9. As training in some developing nations can be quite basic, the MTI provides overseas doctors access to a higher-quality structured training programme. Some countries, for example Sri Lanka, rely on it as their only route for advanced training. The MTI and other Tier 5 training schemes for health workers run by the medical royal colleges and other organisations represent the few remaining routes for overseas health workers to access training within the NHS.

10. The majority of health workers interviewed expressed their desire to come to the UK on a temporary basis to work or train in order to increase their skill levels. Many VSO volunteers, leaders of professional associations, and other stakeholders expressed the view that health workers with experience of working in the NHS were better placed to take up positions of responsibility within their home health system and brought back additional skills and expertise. The safeguards of the MTI ensure doctors do return to their home countries to practice and do not contribute to “brain drain”.

**MTI Safeguards**

11. The MTI scheme has robust safeguards to ensure the highest quality IMGs are working in the NHS. IMGs who come to the UK on the MTI must demonstrate a high level of English language and communication skills in order to be registered with the General Medical Council (GMC). The RCP and other royal colleges ensure candidates have excellent medical expertise by interviewing them in their home country before they are able to start working in the NHS.

12. There are also robust safeguards to ensure IMGs cannot prolong their stay in the UK. Tier 5 visas limit an individual’s stay to 24 months. At the end of this period the IMG cannot be employed legally and is required to leave the UK. There is no option for extension or switching of visa categories. Once the IMG returns home, they are not permitted to apply for another Tier 5 visa for five years.

**Proposed changes to Tier 5 visas**

13. The MTI is currently administered under Tier 5 of the “points-based system” of the UK’s immigration rules. It falls under the specific sub-category of a Government authorised exchange (GAE), which has the support of a Government department and an “overarching sponsor” who can manage the scheme. The Government has set a target to reduce immigration to the UK. As people who stay in the UK for 12 months or less are counted as “temporary visitors”, and are not regarded as immigrants, the UK Borders Agency (UKBA) is considering reducing the maximum length of stay under the Tier 5 visa from 24 to 12 months. VSO believes this change would jeopardise the MTI and push doctors from overseas into training opportunities in other countries that do not guarantee return to their home country. VSO would recommend that the Government retain the length of the Government Authorised Exchange category of the Tier 5 visa at 24 months, and not reduce it to 12 months.

December 2011
Written evidence from the Institute of Biomedical Science (ETWP 71)

SUMMARY

— The Institute of Biomedical Science (IBMS) is the professional body for biomedical scientists working in the United Kingdom. Biomedical Scientists form by far the largest professional group in healthcare science. There are approximately 15,000 HPC registered biomedical scientists employed mainly in the national health, blood, and health protection agency services in the UK.

— The education and training of biomedical scientists is well established and is based on an accredited vocational honours degree leading to statutory HPC regulation which is designed to meet the needs of the UK pathology service.

— The implementation of the Modernising Scientific Careers project is causing difficulties for laboratories, which are experienced in undergraduate placement training, due to the inflexibility of the project model and the absence of a clear regulatory outcome from the new healthcare science undergraduate degrees.

— The intention to introduce a new system of education and training for biomedical scientists in pathology simultaneously to the biggest reorganisation of pathology services since the inception of the NHS has the potential to impact adversely on biomedical scientist training. Any meaningful attempt at workforce planning for the next three to five years is difficult, if not impossible, due to the uncertainty over the number and location of future pathology providers and whether the services commissioned will include a commitment to train.

— The recruitment, education, training and development of the biomedical scientist workforce is not based on commissioned training places therefore workforce planning is conducted at the local level to meet local service needs and as such is not part of a national planning process. This combined with the confusion over workforce titles (biomedical scientist, healthcare science practitioner) and the reconfiguration of pathology services renders any attempt at meaningful workforce planning doubtful and could have serious consequences for future service stability and sustainability.

1. Pathology Modernisation and Transformation

1.1 The reasons for reconfiguring where and how pathology services in England are delivered are recognised and accepted. Scotland is taking the same decisions regarding pathology service reconfiguration and a similar exercise is happening in Northern Ireland. There is duplication of services and the potential for savings to be made. The intention to grow the support worker workforce to deliver a proportion of the work currently undertaken by registered and qualified staff is supported for both economic and logistical reasons but the IBMS would wish to draw attention to the consequences for pathology if the education, training and workforce planning of biomedical scientists in pathology is destabilised.

1.2 Loss of senior posts: The existing workforce is key to delivering training within the workplace. The success of this depends upon appropriately trained trainers supported by sufficient and protected time to deliver training. This will become an increasing challenge within pathology due to the combination of financial constraint and service reorganisation. There is serious concern that the loss of senior experienced biomedical scientist staff through a combination of retirements and reorganisation of pathology services with the sole aim of reducing pathology staff costs will lead to a loss of high level knowledge and skills leading to a reduced service to patients and greater cost inefficiencies further down the patient care pathway. The maintenance and development of the existing workforce does not appear to be adequately recognised or featured in plans for future service delivery.

1.3 Provision of pre-registration training: The production of registered biomedical scientists is dependent upon the completion of a period of training either as a placement part of an undergraduate degree programme or post -graduation in a paid trainee post. The reconfiguration of pathology services coupled with the shift in skill mix towards greater use of support worker grades throws in to question the sustainability of training. Many laboratories currently do not have substantive trainer posts and rely on this role being subsumed by experienced and senior individual alongside other senior level responsibilities. The continued ability to train is thrown in to doubt by the uncertainty as to which elements of pathology services will be provided in which location (small specialist laboratories or large general service laboratories) and whether adequate resources (human and financial) will be available to train.

1.4 Qualified staff and support worker ratios: Currently 70–80% of pathology non-medical staff are regulated by statute (biomedical and clinical scientists). Of this number, biomedical scientists account for approximately 95% of the regulated pathology workforce. It is accepted that the number of support workers will increase and the need for qualified graduate staff will reduce. If, however, the biomedical scientist workforce is replaced over time with a support worker and practitioner workforce subject only to voluntary regulation or “local licensing”, the statutory regulated workforce in pathology could drop to as low as 5%—ie the healthcare scientist/clinical scientists workforce. This cannot be regarded as improved educational outcome for service or employees.
2. Modernising Scientific Careers (MSC)

2.1 Biomedical scientist education and training has evolved to meet service needs. This has led to the introduction of integrated degrees, which involve a laboratory based practical placement element within the degree course and allows statutory registration. Graduates of these courses may have practical experience in one or more pathology disciplines (dependent upon the duration and configuration of the placement) but will have theoretical knowledge of ALL disciplines. This gives the flexibility to permits subsequent employment as a registered biomedical scientist in any of the pathology disciplines and would support mergers and service reconfiguration involving cross-discipline working.

2.2 The Modernising Scientific Careers project has taken a “green field” approach and has not recognised the merit of any existing training and qualifications or attempted to accommodate them within the structure. The consensus opinion from managers and trainers UK wide is that the biomedical science degree is the superior qualification, a view that has strengthened as the MSC project has evolved. The HCS degree requirement for mandatory 10, 15 and 25 block placements over a three year course is causing considerable concern among laboratory managers, training officers and facilitators experienced in managing the BMS degree placements. This inflexibility does not accommodate variations in local resource availability and casts doubt over the feasibility and sustainability of delivery. This concern is further exacerbated by the QIPP and pathology transformation programmes which make unclear how and where pathology services are to be delivered.

2.3 HPC Registration: The original intention of the MSC project was the opening of two new registers—Healthcare Science Practitioner and Healthcare Scientists to eventually replace the current biomedical and clinical scientist registered workforces. In the wake of the DH Command Paper on statutory regulation this will not now happen with the risk of graduates from the new MSC degree courses, some of which may not meet the HPC Standards of Proficiency (SoPs) for biomedical and clinical scientists and therefore ineligible for statutory registration with the HPC. This is not an acceptable outcome in terms of effective workforce planning and is a direct risk to service stability and patient safety. There is a need for a clear statement of intent that the existing biomedical scientist register can be used for both biomedical science and healthcare science degrees providing the latter are responsive to local placement arrangements and that the curriculum satisfies the HPC Standards of Education and Training and SoPs. The inflexibility of the undergraduate healthcare science degree model is the greatest impediment to the implementation of MSC in Life Sciences.

2.4 Support worker training: Pathology has a strong history of support worker development through the availability of part time accredited biomedical science degrees leading to HPC registration. Also many laboratories combine the recruitment of new graduate trainees with a “grow your own” approach. For these two staff groups this involves the combination of laboratory training and day release to attend part time accredited biomedical science degree courses. There is no provision within the healthcare science degree model for part time study, which would be considered by laboratories as an inflexible and retrograde step in what is purported to be a more flexible approach to workforce education and development. Additionally, there are reports of HEIs being forced by their local SHA to withdraw their accredited part-time biomedical science degrees due to refusal to recognise these courses as acceptable training routes.

2.5 Post Registration Education and Training: A significant number of the biomedical scientist workforce operate at a senior level and hold a combination of vocational and academic qualifications (Masters degrees). There is an apparent absence of recognition of the value these qualifications bring to healthcare. There is much concern among laboratory managers, training officers and facilitators experienced in managing the BMS degree placements. This inflexibility does not accommodate variations in local resource availability and casts doubt over the feasibility and sustainability of delivery. This concern is further exacerbated by the QIPP and pathology transformation programmes which make unclear how and where pathology services are to be delivered. The consensus opinion from managers and trainers UK wide is that the biomedical science degree is the superior qualification, a view that has strengthened as the MSC project has evolved. The HCS degree requirement for mandatory 10, 15 and 25 block placements over a three year course is causing considerable concern among laboratory managers, training officers and facilitators experienced in managing the BMS degree placements. This inflexibility does not accommodate variations in local resource availability and casts doubt over the feasibility and sustainability of delivery. This concern is further exacerbated by the QIPP and pathology transformation programmes which make unclear how and where pathology services are to be delivered.

3. Workforce planning

3.1 The local “ownership” of biomedical scientist education and training has enabled effective workforce planning whereby graduates from IBMS accredited biomedical science degrees leading to HPC registration have a very high rate of employability in the NHS which is beneficial from all perspectives. Biomedical science education, training and recruitment has a track record of efficiency and effectiveness. Approximately one third of the current UK pathology workforce is over 50 years which makes any short term views unwise.

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Written evidence from Macmillan Cancer Support (ETWP 72)

SUMMARY

— Macmillan hopes that the changes proposed to the NHS education and training system will allow more integrated workforce planning that responds more effectively to the needs of patients locally.

— Key core skills should be agreed and set nationally. If not, standardisation of courses and hence skills and competencies of the workforce will be lost leading to differing standards of care that patients receive.

— We are pleased that Health Education England will develop a National Education and Training Outcomes Framework.

— Macmillan is extremely concerned that some employers have established complete embargoes on anything but mandatory training. Education and training budgets must be protected. Neglecting the continued development of the workforce will damage patient care in the short and long term.

— We are concerned that Local Education and Training Boards (LETBs) include fair representation from all professions and sectors as well as users. The population size covered by LETBs will also be key to ensure economies of scale.

— We would recommend that LETBs work closely with cancer networks to make use of their cancer workforce development expertise. We also believe networks will have a role to play in bringing LETBs together to plan at a more macro level for less common cancers.

— LETBs will need to develop the cancer workforce to meet the changing needs of people with cancer, with a greater number of generalists helping to support people who have finished cancer treatment but may have ongoing needs.

INTRODUCTION

1. Macmillan Cancer Support welcomes the opportunity to respond to this inquiry. We have offered views and recommendations where we feel best placed to comment.

2. Macmillan Cancer Support improves the lives of people affected by cancer. We provide practical, medical, emotional and financial support and push for better cancer care. Cancer is the toughest fight most of us will ever face. The Macmillan team is there every step of the way. We are the nurses and therapists helping people through treatment. The experts on the end of the phone. The volunteers giving a hand with the everyday things.

3. Macmillan Cancer Support commends the Government’s attempts to ensure more integrated workforce planning that responds to local needs. We hope that these changes will facilitate inter-professional education (by and with other professionals), improve availability and access to courses, highlight local education and training needs and remove the secondary/primary divide; promoting a more patient centred approach to planning and training. We believe this is highly preferable to the development of different professions in isolation. Such an approach would help to address issues of shortages in the workforce by allowing up-skilling or development in one profession to fill gaps in other professions. For example up-skilling radiographers has helped to address shortages of radiologists. It should also help to ensure the training needs of all roles are addressed, such as those of practice nurses.

4. However, we are concerned that there are some potential difficulties with the plans as they stand. The effects of instability and poor workforce commissioning now could have devastating effects for healthcare provision in the future and in the long term.

PREVENTING POSTCODE LOTTERIES IN QUALITY OF CARE

5. We are pleased that the Government accepted the NHS Future Forum’s recommendation for Health Education England to develop a National Education and Training Outcomes Framework. We hope that this would help to ensure consistency across the country. However, we are concerned that under the new system standardisation of courses, and hence skills and competencies of the workforce, will be lost. We suggest that key core skills should be agreed and set nationally, then commissioned locally, allowing for adaptation according to local need. For example much work was undertaken to nationally agree the National Connected Programme which has helped to standardise advanced communication skills across England.

6. Macmillan has several concerns resulting from devolution which we believe must be addressed:

   (i) Local services may opt for short-term fixes to workforce issues and development rather than longer-term, more strategic options.

   (ii) Services may opt to buy in services as this would prove cheaper than commissioning training to fill any workforce gaps. Areas of high staff turnover, such as London, will be disadvantaged by these new arrangements, having invested in staff who then move on.
There is a real danger that this could lead to a postcode lottery for patients in terms of both outcomes and experience. The NHS Commissioning Board and Health Education England will need to ensure that this does not happen.

7. We were also heartened by the Government’s acknowledgement that “Health Education England would need to build strong links with partners in Scotland, Wales and Northern Ireland to ensure consistency across the UK and better information for staff”. Both staff and patients travel across borders for work and treatment. Changes to the education and training system for the workforce in England can and will affect skills and knowledge in the other three nations. Transferability of skills for health professionals and consistency of patient experience must be assured across all four UK nations.

PROTECTING EDUCATION AND TRAINING

8. Macmillan is extremely concerned that under the current financial constraints education and training budgets are being cut. In addition there is not the capacity or funding to free up professionals to attend such training. Neglecting the continued education of professionals hampers their ability to advance their knowledge to meet the new and emerging needs of people with cancer and threatens the future supply of specialists. Macmillan is aware through its partner organisations and Macmillan professionals that some Trusts have established complete embargoes on both external and internal training (apart from mandatory training). Such actions undermine the culture of continued professional development and threaten the capability of the future workforce to meet patient needs. We are heartened that the Government will “consider how best to ensure funding for education and training is protected and distributed fairly and transparently”.

9. More needs to be done to link education and training to patient outcomes, service improvements and increased efficiencies. For example it may be possible to link specific outcomes in the National Cancer Patient Experience Survey to communication skills training. This would help incentivise commissioners and providers to invest in the continued development of staff.

10. In addition the Royal College of Nursing (RCN) has voiced concern that entry to register numbers should be centrally planned and accompanied by sufficient funding to ensure delivery of both theoretical and practical aspects of education (A Decisive Decade: mapping the future of the NHS workforce). While we support local determination of entry to register places, a central system to monitor applications, admission, attrition and outcomes is required to provide reliable and consistent information for workforce planning.

LOCAL EDUCATION AND TRAINING BOARDS

11. Firstly, we would stress the need to ensure that expertise present in the existing system is not lost. In particular cancer networks have played a crucial role in facilitating the development of the cancer workforce. We would be extremely keen to see this continue. “Cancer” is a set of 200-plus different diseases—most of which have highly complex care pathways. Cancer is an acute sector disease dealt with by consultants and nurses in hospitals and, at the same time, a terminal illness and, increasingly, a long-term condition—both of which require care and support in the community. This means those responsible for developing the cancer workforce need to understand and be able to ensure that they meet both the clinical and longer-term needs of people living with and beyond cancer.

12. The success of local workforce planning, education and training will be dependent on the configuration and capabilities of local education and training boards (LETBs). Domination by, for example, secondary care or particular specialties will hinder attempts to join up education and planning. We fear that the medical profession may continue to dominate education and training planning. In addition there may be tensions between professional and local pull. We are also concerned about potential conflicts of interest with those sitting on the boards being tied too closely to the organisations they represent; in particular those healthcare providers that also provide education or training placements and/or courses will have a vested interest in the commissioning of these places/courses. Macmillan would recommend that Health Education England provides advice to local stakeholders to ensure there is balanced representation on boards with nursing, allied health professionals, social care and users all well represented.

13. Involving patients in the planning process would help to ensure that professionals have the skills that patients value but that are often not prioritised. For example the 2010 National Cancer Patient Experience Survey demonstrated that patients valued good communication skills. However, we are concerned that a duty to consult would result in tokenistic exercises by providers and would like to see patients and the public more fully involved in the development of commissioning plans. Allowing the public to fully engage and influence the process may prove difficult as the issues are complex and so we would recommend that providers...
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make use of the expertise in SHAs and cancer networks. LETBs will also need to work closely with other partners such as charities like Macmillan who provide education and training programmes and grants.

14. The size of the population covered by LETBs will be crucial to the success of the Government’s reforms. It would be helpful if they were coterminous with other healthcare structures such as local Health and Wellbeing Boards and Clinical Commissioning Groups. If they are too small, economies of scale will mean costs rise and it will be hard to justify specific training or education. Health Education England and the NHS Commissioning Board will need to ensure that highly specialist training and education is not lost or hindered under the new system. Conversely they must ensure that macro-level training and education, not provided at a national level, is not considered too big and hence expensive to be commissioned by LETBs. Similarly we are concerned that cancer units, that provide cancer services on a smaller scale to the specialist cancer centres, will not prioritise and invest in the cancer workforce due to low numbers. Helping LETBs to come together to jointly commission such training may be required. Again we would suggest that cancer networks have a role to play here.

The Cancer Workforce

15. The nature of cancer care has changed dramatically over the last few decades, with two million people in the UK now living with or beyond cancer. 103 This number is set to rise to four million by 2030. Many of these people are living with the long-term consequences of cancer and treatment and in many ways cancer can be compared to other long-term conditions. 104 New skills are needed in the cancer workforce to meet the changing needs of people with cancer and the new system must address these. In particular they require:

— the skills and knowledge to manage cancer as a long-term condition; and
— the skills and knowledge to support patients to self-manage their condition.

In addition the wider, general workforce requires greater cancer awareness and skills to aid early diagnosis and support care in the community alongside other co-morbidities.

16. People with cancer require different levels of support throughout their cancer journey, depending on their individual needs and circumstances. This includes after treatment has finished when many patients continue to have ongoing, unmet needs. The system of aftercare therefore needs to change to meet these needs. Support may be provided by a number of different professionals, both specialists and generalists, working as a team, and will depend on the level and type of need of each patient. What is vital is that the person receives support from the right person at the right time and with the right level of skills to meet their needs. Macmillan is looking at how this support can be provided and how the cancer pathway and workforce will need to be redesigned to meet the future needs of patients. This will lead to improved outcomes at no additional cost. We will be trialling new roles, including a nursing role based in primary care. Primary care nurses will have a crucial role to play in helping patients to self manage but retirement figures suggest the practice nurse workforce will shrink in the future (research from the Royal College of Nursing shows that one in three community nurses are over 50 and one in five practice nurses are over 55 years old 105). Improved understanding of demographics within the nursing workforce is urgent; as well as an effective selection and fast track process out of the acute setting and into the community. We would suggest that the Centre for Workforce Intelligence has a role to play in helping all those involved in workforce planning to better understand the changing workforce.

December 2011

Written evidence from Yorkshire and the Humber Strategic Health Authority (ETWP 73)

The Yorkshire and the Humber Workforce and Education Directorate of the North of England SHA Cluster welcomes the Health Select Committee (HSC) Inquiry on Education, Training and Workforce Planning and the opportunity to contribute in the form of this written submission. The inquiry is wide ranging in its examination of the Government’s plans regarding the future healthcare education arrangements.

Our comments below reflect what we have already submitted through the Future Forum, following consultation with all NHS employers and key stakeholders in Yorkshire and the Humber and covers the key themes and specific issues as set out in the Committee’s terms of reference.

1. The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

This will be addressed by strategic workforce planning, effective partnership working and use of planning models. Employers are more likely to take workforce planning seriously if they also have some responsibility for training budgets as they will then be able to more directly link priorities and risks.

103 Cancer Prevalence in the UK, King’s College London, Macmillan Cancer Support, National Cancer Intelligence Network (2008).
105 RCN 2009
2. Training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

This will be addressed by continuing to work in partnership with regulators, service colleagues and education providers.

3. All providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

This will be addressed by engagement, partnership working and providers own desire for an effective and efficient workforce. The governance arrangements and statutory duties will also play an important role as non-NHS organisations will need to sign up to training commitments in order to benefit from outputs of training in order to create a more level playing field.

4. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

Learning in and from teams on clinical placements is being actively promoted. The significant investment in clinical skills facilities across Yorkshire and the Humber is an example of how Multi-Professional and Education (MPET) funding has been used to promote multi-professional training and development as this is only really successful if focused on the patient pathway rather than professions, though it is absolutely right that specialist skills are acquired separately as appropriate and professional identity is created.

The most successful initiatives also tend to be where traditional hierarchy has been levelled and all grades of staff are encouraged to contribute to discussions about patient care and where there is the potential for it to be less than excellent.

Accountability is first and foremost from the individual to their employer and, where regulated, to their profession. This requires a focus on good team management where every individual is held accountable for their contribution regardless of whether regulated and professionally qualified or not.

Patient safety is also enhanced by ensuring all staff have good levels of literacy and numeracy, accessing SfA/NAS funding as required to achieve basic skills as required.

5. High and consistent standards of education and training

High and consistent standards are promoted through the use of Learning and Development Agreements and formal contracts with education providers. Regular reviews against these agreements take place.

There is a huge amount of quality assurance that takes place through regulatory bodies, including the Qualifications and Curriculum Authority (QCA) in the case of Higher Education Institutes (HEIs) and OFSTED in the case of colleges and other education providers funded by SfA/NAS.

A large amount of activity takes place to gain feedback on the student/trainee experience and there has been a great increase in the involvement of patients and carers in devising training, taking part in training and feeding back on trainees.

More consistency and portability in training has been achieved through more standardisation of qualifications where possible, with much greater widening participation in learning to support skills development and provide better standards of care.

The Education Commissioning for Quality and Medical Quality Indicator frameworks recently introduced are going some way towards even greater consolidation of quality markers across professions. The Education Outcomes Framework, whilst in early stages of development, is attempting to make a more explicit link between training provided and outcomes for patients and service delivery, utilising the domains of the general outcomes framework for NHS services.

6. The existing workforce can be developed and re-skilled for the future (through means including post-registration training and continuing professional development)

A key emphasis for workforce modernisation is the development of support workers (AfC Bands 2–3) and Assistant Practitioners (AfC Band 4). Current areas of work include pharmacy technicians, Operating Department Practitioners, maternity support workers, higher level apprentice scientists, mental health support workers as well as those in intermediate care and primary care. Roles at this level are seen as key to improving skill mix within teams.

Training for non-medical prescribing is also much in demand to enhance the patient experience and avoid delays, with very specific training and responsibilities given in specific areas and for specific drugs.

Work is also continuing on developing Advanced Practitioners, particularly in areas where there may be vacancies in traditional roles and more innovative solutions are required. This has been particularly successful in primary care, where practice nurses take on many of the roles that were previously seen as those of GPs with clear boundaries and protocols set. There is increasing usage of paediatric and neonatal specialist nurses,
7. Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

SHAs are focusing on widening participation initiatives, ie both widening access to Higher Education through access/bridging/foundation courses, but also in widening participation in learning—particularly where the individual’s experience of school or personal circumstances meant that they did not gain many formal qualifications. There are now several assistant roles that can provide the stepping stones into registered training at graduate level and above, and many stories of individuals starting out with no GCSEs and ending up at PhD level study through their course of their working life within health care.

The use of flexible training routes and part time courses are often important ways of providing equitable access to career progression, with accumulation of learning credits in smaller chunks rather than one continuous qualification.

8. Plans for the transition to the new system, up to April 2013

Plans for the transition to the new system are being actively developed, ie Interim Boards of Local Education and Training Boards (LETBs) are being established with providers looking at plans for next year.

9. The future of postgraduate deaneries

Postgraduate Deaneries are a critical element of LETBs and their work alongside other professions and the wider health workforce is critical in the focus on patient centred learning and development and the quality management/assurance systems in place across the board.

10. The future of Health Innovation and Education Clusters

It will possibly be for LETBs to find funding to support HIECs if it is considered that they have been effective—should focus on share and spread of existing innovation and developments rather than trying to create other things.

11. The role of the Secretary of State for Health in the new system

It will be important for the Secretary of State to have overall accountability and to ensure that MPET funding is appropriately protected in the new system.

12. The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

The multi-professional nature of Health Education England (HEE) will provide important opportunities to address the changing nature of healthcare and the requirements of workforce development. It is recognised that clear accountability arrangements between LETBs and HEE are essential but that HEE must acknowledge and respect the need for appropriate local determination. A key enabler will be the ability to utilise some funding to meet training needs around patients and service needs in addition to meeting a specific training number in regulated professions in undergraduate or post-graduate medical/dental. Also to be able to utilise unused funding within traditionally allocated numbers across different professions to support more skill mixing and, therefore, appropriate use of skills and expertise for more of the time.

This is possible as, despite national numbers, trainees do not opt to distribute themselves according to theoretical geographical allocations, resulting in some shortages (often in rural areas) whilst popular cities and locations have a wide choice of employees.

13. 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

Conflicts of interest will be dealt with by all board decisions being based on principles rather than application to specific organisations. Members of LETBs will be representative of their constituencies rather than organisation and board members will withdraw if a decision is specific to their organisation. The key issue is having strong and effective governance arrangements. HEE will have to have appropriate links to the NHS Commissioning Board to ensure triangulation of service, finance and workforce plans with appropriate links to the Care Quality Commission (CQC) and Monitor. Clinical Commissioning Groups will need to have appropriate local links to LETBs.
14. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

As they do now but with even greater involvement of providers. Examples: HEI partnership boards for placements, NMC consultations on curricula.

15. The implications of a more diverse provider market within the NHS

There has always been a diverse provider market eg Nursing Homes, independent healthcare providers. It is acknowledged that that there have been difficulties with engaging with the independent sector, particularly as social care does not have an equivalent of SHAs. Networks will need to involve wider partners to ensure there is maximum collaboration, eg training of care home staff in End of Life Care—a joint programme to meet patient needs driven by SHA, service partners (including care home managers) and skills for care. Will focus on training to prevent unnecessary emergency admissions at end of life by increasing confidence in staff and creating sustainable training programmes given high staff turnover prevalent in this sector.

16. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

By effective workforce strategy and planning for NHS commissioned care rather than specific providers. Always limited when looking at social care requirements.

17. The role and content of the proposed National Education and Training Outcomes Framework

Good high level but now needs further development for detail so appropriate metrics and/or indicators are developed that allow linkage to patient outcomes. There is already a lot of evidence and data to support the training process, but less analysis of its effective application. ROI type methodology is useful here so employers are clear about why staff are undergoing training, what expected product or outcomes will be and how these will be applied in practice.

18. The role of the Centre for Workforce Intelligence

To provide high quality workforce intelligence data, particularly the national picture and any meaningful benchmarking or comparative data that is useful in more local planning.

19. The roles of Skills for Health and Skills for Care

Both sector skills councils should continue. There is a view that they should not be merged as the workforces are distinct though it is possible for some joint working.

20. The role of NHS Employers

NHS Employers should play a key role in pay and conditions national negotiation. It also has an important role as an independent body for providers.

21. How funding will be protected and distributed in the new system

By funding going to HEE and LETBs, HEE can build in control and accountability to LETBs for use of funding through the authorisation process and formal contract. However, this cannot be overly prescriptive as needs will differ locally but usage should be transparent with clear accountabilities.

Education funding is sometimes carried over to the following year, which is not unusual in a business of this scale where some contingency funding is required to cope with in-year pressures and any emerging priorities. This element of public spending requires robust management within LETB arrangements by those familiar with the likely pressures and pitfalls as many new to this area of work can be caught out by short termist reactionary measures that cause unintended consequences due to the time lag from commissioning to qualification and, therefore, potential impact on services in the longer term.

Differential tariffs being proposed for medical and non-medical training have the potential to de-stabilise pre-registration training provision for the non-medical professions as the medical tariff is much greater so may lead to employers choosing not to support other areas. These have always been supported without direct payment for placement support and training so, whilst the introduction of a tariff that follows the student is helpful, measures should be encouraged that do not allow employers to only offer medical training as this would seriously restrict the number of trainees in other professions due to the limited number of training placements available.

22. How future healthcare workforce needs are being forecast

Good strategic workforce planning—this will require a strengthened approach within employers to co-ordinate all workforce needs. This has not been strong in the past as the responsibility for education and training budgets largely rested with SHAs, so the new system should strengthen interest and understanding.
Employers within LETBs will quickly need to get to grips with the advance planning that is required to address the service issues several years hence rather than thinking about today’s issues and, therefore, commissioning education on that basis. This will require a strong senior commitment to high quality OD work to help determine service models of the future around which workforce planning can then take place.

23. The impact of people retiring from, or otherwise leaving, healthcare professions

This is taken into account by effective workforce planning and modelling to align with education commissioning.

24. The place of overseas educated healthcare staff within the workforce

This is very limited now due to immigration controls. It is important to enforce regulator standards of language fluency, credentialing of qualifications—the NHS is experienced in doing this. There is a potential risk of greater recruitment of overseas students by HEIs onto health courses in future to help compensate for reduced commissions and other financial changes in Higher Education. This may pose some difficulty in that overseas students may be willing to pay more to participate in placements, which would disadvantage MPET funded students and apply more pressure to this already difficult aspect of training to organise in ensuring sufficient placements. Whilst non-EU students may have to return to their country of origin, EU students will be in the market, but there will be limited information about them to take account of in workforce planning and education commissioning.

25. How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

It will be the role of HEE to link with the other countries of the UK and sector skills councils which cover the UK. Links already exist between UK countries in education commissioning and workforce planning networks, which should be continued.

26. How the public health workforce will be affected by the proposals

This will be part of what LETBs will do, linking with local authorities. The Public Health workforce is as important as other parts of workforce and will be treated the same. Important that both specialist and non-specialist public health training taken into account as non-specialist roles still have a health promotion responsibility. Making Every Contact Count competence framework developed in Yorkshire and the Humber is helping to embed a greater awareness of this across a range of health professionals.

December 2011

Written evidence from the British Association for Adoption and Fostering (ETWP 74)

1. This response is being submitted on behalf of the BAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.

2. We are submitting this response with regard to the roles of doctors and nurse providing services for looked after children, including those with a plan for adoption. Doctors provide three distinct roles which are described in detail in the attached document Model job descriptions and competencies for medical advisers in adoption and fostering. In summary these are:

   — The designated doctor who provides a strategic role, advising health trusts and commissioners, and overseeing services.
   — The named doctor who provides direct service delivery and assists in strategic planning.
   — The medical adviser for adoption who assists adoption agencies and advises the adoption panel.

3. Although the model job descriptions and competencies document published by BAAF did not address the roles of specialist nurses for looked after children, their contribution is equally significant and all of our comments apply equally to their posts.

4. Our members tell us that paediatric colleagues, trusts and commissioners have a poor understanding of the complexity of health needs of looked after children, and the health services required to meet these needs. Yet these children are amongst the most vulnerable in society, as evidenced by the well known poor outcomes of low educational achievement, high teenage pregnancy rates, and higher rates of mental health burden, and over representation amongst prison populations.
5. Our members also tell us that these services are often inadequately resourced relative to the needs of this population. Furthermore, this vulnerable group requires specialised services which do not fit well with the prevalent outpatient model of service delivery.

6. Health professionals providing services for these children have often received no training specific to their role. It is only recently that the Royal College of Paediatrics and Child Health (RCPCH) has included any specific training requirements for adoption and fostering in their syllabus for Higher Specialist Training. Most paediatricians appointed to these roles have had no specialised training prior to undertaking this work and are expected to “learn on the job”. Historically BAAF has been the sole provider of health training for this work, through national conferences and organising and supporting regional health groups which provide medical advisers with training and peer support.

7. Workforce surveys by BAAF have revealed that many experienced medical advisers and specialist nurses are approaching retirement age and there is a lack of trained medical advisers and specialist nurses to continue this work. BAAF has been in dialogue with the RCPCH to address this through training, and has also contributed to the Intercollegiate Competencies for health professionals in adoption and fostering which should be published soon.

8. It is critical that the specialised nature of this work is understood, so that sufficient emphasis is given to recruiting, training and supporting the continuing education of medical advisers for looked after children.

December 2011

Written evidence from the Lancashire Public Health Network (ETWP 75)

1.0 BACKGROUND

Current activities to support the NHS reforms in the North West, and the Health Select Committee interest

The Health Select Committee has issued an invitation to submit written evidence for its inquiry into Education, training and workforce planning. Alongside the passage of the H&SC Bill through parliament, national and North West Health Care systems are being prepared for the expected directions and vision contained in the bill. This is as true for the workforce planning, training and education systems for health and social care professionals, as for the commissioning architecture of the NHS. For example, the clustering of SHAs, and formation of local provider skills networks across the region is well under way.

Three skills networks (Cumbria & Lancashire, Greater Manchester and Cheshire & Merseyside) have been declared. The North West networks are called Network Leadership Groups, and each one includes Director of Public Health membership.

2.0 THIS RESPONSE

The North West School of Public Health is one of the training teams and structures responsible for ensuring the supply of future public health experts and leaders in the North West. The School has 50 people in training and a large community of public health experts who are also educators. Several universities in the North West offer Master’s levels qualifications in public health for those who are already working as public health practitioners in a number of areas. Some of these may eventually seek recognition of their specialist skills and knowledge through Public Health registration (UKPHR).

2.1 Plans for the transition to the new system, up to April 2013

— There is a high risk of loss of public health experts to the system, and loss of public health expert posts that are essential to the establishment of a strong new public health system. Over the past two years the number of advertised consultant posts has dropped to less than a third of previous levels. The result is that trained, expert individuals are unable to secure appropriate posts on completion of training. This is a waste of the £250,000 investment of public money in their training; it means that the right expert professionals are not in place to work in the new public health teams, and it means that recruitment to specialist training in the future will become less attractive.

— The new structures do not include senior public health leadership at regional, sub regional or supra regional level. The loss of equivalent posts to that of regional director of public health is a serious threat to public health.

— Experts and professional leaders have to maintain their skills in order to effectively serve the public and their host organisations. In the workforce planning and guidance so far released, there is absolutely no commitment to continuing professional development for public health teams transferred to local authorities. Our understanding is that the NHS culture, which supports CPD as an essential part of a professional’s duties, may not currently be replicated in most local authorities.

An earlier draft of the response was developed collaboratively with the North West School of Public Health and the Cheshire and Merseyside Public Health Network.
— There are many positive opportunities and attractions linked to transfer of public health functions to Local Government. However, the financial climate within the NHS (that is, the pressure to rapidly reduce running costs prior to April 2013) is resulting in significant threats to public health capacity and capability in some local areas. This has a direct effect on training, CPD and the ability of public health teams to meet the wider training and education needs.

2.2 The future of postgraduate deaneries
— Post graduate medical specialty education, including public health specialist training, needs a strong infrastructure and a resourced team at sub regional level to ensure equality, satisfy regulators, and deliver tomorrow’s senior doctors and public health specialists.
— Post graduate medical specialty education teams should also carry responsibility for ensuring public health skills and knowledge is in every specialty curriculum and every specialty practice.

2.3 The future of Health Innovation and Education Clusters
— We are unsure of what the Health Innovation and Education clusters are achieving for public health education and training. We have not seen evidence of them having a community, prevention or public health impact at this juncture.

2.4 The role of the Secretary of State for Health in the new system
— The Secretary of State for Health, as an integral part of their responsibility to deliver a fit for purpose health and health care system, must have responsibility to ensure that training and education delivers a highly expert health care professional work force. This includes a dedicated public health specialist and practitioner work force. It also requires a wider work force that understands basic health principles: for example, the importance of evidence and evaluation; the effectiveness of screening and immunisations; the need to promote healthy environments and lifestyles.

2.5 The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture
— We fully support the proposed role of Health Education England (HEE) and see Public Health England (PHE) as one of the key partners in advocating for specialist and practitioner training within HEE.
— Public Health England will be a principal employer of public health professionals at specialist and practitioner level in the future system. With this in mind, PHE should have a specific remit for public health professions in other organisations such as local authorities, Health Education Institutions, NHS foundation trusts and elsewhere. PHE may in effect be the “guardian” of public health standards in training and education. Advantages to this approach include a fit for purpose public health workforce with education and training plans that are coordinated and meet the needs of the communities in which they serve. They will also be responsible for providing an organised and modelled approach to continuing professional development to secure consistency and a high quality workforce.
— There needs to be National leadership for the public health workforce—this will assist local authorities to meet their statutory responsibilities around public health delivery and protect them from the risks associated with an inadequately trained workforce.
— Knowledge and skills for building for health improvement need to be accessed by many professional groups. This needs to be driven forward within the planning and development of the workforce at local level.

2.6 The implications of a more diverse provider market within the NHS
— Local skills networks must have local authority input in order to ensure that local commissioning decisions reflect local health priorities and need.
— Local authorities are community champions and are also significant employers of social care staff—health literacy needs of social care and wider workforce can be addressed through local skills networks with support from local authorities.
— Similarly, CCG’s and NHS commissioning boards need public health skills and awareness with public health commissioners having an active role in health commissioning decisions through these bodies.
— Local skills networks will secure standard setting which will become increasingly important in the environment of “Any Willing Provider”.
2.7 How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

— Regulation will protect employers and the public in the new system, where multiple providers and smaller independent public organisations such as local government will need assurance that the people they employ are safe, and can be trusted. The experience of GP out of hour’s providers employing doctors in the UK illustrates the risk involved.

— All Health Care and Social Care Professional groups and regulators have a responsibility to articulate and develop public health content in their respective undergraduate/post graduate curricula.

— Professional registration for medically qualified public health staff’s should continue to be via the GMC and for non medically qualified the UKPHR working as part of the Health professional Council.

— Education providers including universities must be fully integrated into workforce planning and curriculum needs for health care professionals, so that they can deliver what is needed.

— The workforce for those services commissioned and delivered by Local Authorities will need to include public health skills and competencies to deliver on the prevention agenda and to tackle health inequalities. Their education and training is best integrated within locality-based Skills Networks as part of the wider health care education system.

— As a multidisciplinary profession, the registration mechanism needs to be robust. There is a single standard setting body (the Faculty) which has half its active members form backgrounds other than medicine. If there cannot be in the same vein a single registering body for all public health specialists, then there must be as much equivalence as possible in registration with different bodies. This is the case now with the GMC and UKPHR. There is a risk not only to non-medics, but also to Drs that the standing of the registration will suffer if half of trainees on the training scheme do not have a robust body to register with.

2.8 The implications of a more diverse provider market within the NHS

— There is a need for national leadership to continue to set standards for public health practice. Public Health England must be a major player in this.

— Local skills networks/Local Education and Training Boards have responsibility also to set standards that local providers can then be held to account for delivering.

2.9 The role of the Centre for Workforce Intelligence, and how future healthcare workforce needs are being forecast

— The only national body that collates and publishes comprehensive workforce data on the medical specialties, including public health, is the Centre for Work Force Intelligence (CfWI). Unfortunately the statistics published by CfWI regarding public health posts have been flawed. For example, CfWI reports have claimed scores of “public health associate specialists” in Acute Trusts across the North West. These posts do not exist.

— It is accepted that ESR has not easily (or accurately) identified the PH practitioner and wider workforce partly because of the variety of job titles used to describe public health roles and partly because of the complexity, and subjectivity of estimating the proportion of time given to public health functions, where this is a secondary or tertiary role.

2.10 The roles of Skills for Health and Skills for Care

Case Study

— The development of an initiative initially developed in the NW, “The core Skills Framework” could provide a structured and systematic approach to raising awareness of the three domains of public health and the individuals own public health role across a wide range of organisations and settings including the NHS, LA and the voluntary sector. There are significant organisational benefits to this approach not least the realisation of financial savings associated with a “one stop” approach to statutory and mandatory training. The approach is currently being developed for use across the NHS in the North West and Skills for Health are taking this forward nationally. It would seem timely and useful to ensure a public health element is included in the Core Skills framework.

2.11 How funding will be protected and distributed in the new system

— As the tariff is reviewed the need for public health education and training needs to be acknowledged and protected to avoid losing public health capacity to acute, apparently urgent, educational needs in acute health care in acute trusts.

— Need to ensure that local Skills Networks work with HEIs to ensure the sustainability of specialist subject areas where numbers are very small eg virologists.
2.12 The impact of people retiring from, or otherwise leaving, healthcare professions

— We have already relayed the serious and continuing reduction in numbers of senior professional posts in public health across the NHS. We have described the reduction to less than one third of advertised consultant vacancies. This is in stark contrast to official guidance and statements from the centre. For example, Sir David Nicholson wrote to NHS chief executives in February 2011:

“During the transition year 2011–12 the NHS must continue to lead on improvements to public health, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities. As we deliver the very significant cost savings required of us, it is important that our plans reflect the need to retain staff with scarce specialist public health skills.”

And later in 2011, the East Midlands Regional Director of Public Health wrote similarly to NHS organisations instructing that no screening infrastructure should be lost.

2.13 How the public health workforce will be affected by the proposals

— There are three recognised groupings of staff in the public health workforce;

— Specialists—eg DsPH, consultants, specialists;

— Public health practitioners eg remainder of public health workforce, whose main job role is public health (either of these two roles could sit in health protection, health improvement or health care quality domains of public health); and

— The wider workforce which includes clinical staff, voluntary workers, social care staff and anyone who has the potential to provide “public health input” in their daily work/role.

We have described the very serious reduction in the specialist/consultant public health establishment that has accompanied the first period of transition in the NHS. However, we are aware of similar threats to the practitioner and wider workforce, sometimes related to staffing reviews seeking efficiency and cost gains that are short term (for example, reducing community awareness work that reduces the burden of late presentation of disease). Sometimes the cull in management posts has similar effects: for example, when key programme management posts are lost to screening programmes then a very short term saving can quickly lead to a reversal of the positive benefit/harm balance that is essential in screening.

Public Health England needs to have a specified role that is recognised fully by Health Education England the local provider skills networks to champion public health workforce development for public health professionals, clinical and non clinical workforce and the wider workforce.

December 2011

Written evidence from Association of British Healthcare Industries (ETWP 76)

SUBMISSION

1. ABHI lead the advocacy of the UK medical technology industry. Our mission is to champion the benefits and use of safe and effective medical technologies to deliver high quality patient outcomes. We advocate policies that allow members to operate in favourable business environment:

— In the UK Market: Policies that support the rapid evaluation, reimbursement and adoption of medical technologies by UK healthcare systems.

— In the International Markets: Policies to provide an effective gateway to foreign markets.

— With appropriate Regulations and Standards: Simple and smart regulation, providing patients with safe, effective, high quality and innovative medical technologies.

— With appropriate Ethics and Principles: Policies to ensure business is conducted in the right manner.

EXECUTIVE SUMMARY

2. This submission focuses on the criteria identified in the terms of reference set out by the Select Committee, focussing specifically on:

— Establishing a culture of innovation through training.

— The role of the medical technology sector in providing training for NHS professionals on medical technology. How will the Government ensure that medical technology manufacturers are granted the appropriate level of access to NHS professionals to ensure that they have the necessary training levels?

— How the Government will ensure that frontline clinicians are given the appropriate levels of training in new and innovative products.

107 Sir David Nicholson 17/02/2011 Equity and Excellence: liberating the NHS- managing the transition. Gateway 15594 1553
Implementing the measures in “Innovation Health and Wealth: Accelerating the Adoption and Diffusion in the NHS”.

Establishing a Culture of Innovation through Funding

3. The way healthcare is delivered is a constantly evolving process. Many of these developments are as a result of technological developments supplied by the medical technology industry. The medical device industry and the NHS have a history of close collaboration.

4. If this relationship is to continue to thrive the Government must provide training structures that support clinicians to work with industry to innovate. This will require facilitating industry access to frontline clinicians and giving members of the NHS the time and space to develop new treatments.

5. The culture of innovation must be embedded in the NHS by encouraging and supporting clinicians to spread best practice to other healthcare systems. This could be facilitated in a number of ways:
   - A system of secondments were healthcare practitioners are supported to move to different Trusts to help them understand and utilise innovative technologies and practices.
   - Encouragement of the OLIA on-line interactive learning tool.
   - Supporting collaborations between different Trusts to facilitate joint working that can bring both Trusts to the same level of understanding.

The Role of the Medical Technology Industry in Providing Training and Education

6. The NHS spends around £5 billion per year on medical technology and the UK has a thriving medical technology industry.

7. The UK has a strong track record of inventing new technology, much of which has been supported by the medical device industry, either at the point of discovery or to help spread the innovation following invention. Examples include:
   - The portable defibrillator was invented by Frank Pantridge, an Irish physician and cardiologist in 1965.
   - First human MRI performed by Sir Peter Mansfield’s team in Nottingham in 1977.

8. These innovations have spread across the NHS via the medical technology industry.

9. The medical technology industry provides training and education on the safe and effective use of products, including recommended operating techniques and guidance on care pathways where relevant. This training is generally carried out by employees of the medical technology industry.

10. This training takes place in a number of locations- hospitals of GPs surgeries, through supporting clinicians to attend the relevant educational congresses and conferences or providing specialised training at purpose built training facilities. This training is generally provided for free.

11. Industry has an important role in supporting healthcare professionals in theatres during procedures. This support is crucial to the training and development of healthcare professionals and should be encouraged. ABHI recommends the Government look at how they will support this relationship.

12. Medical device manufacturers have a legal obligation to provide training for their products. This requires close working with NHS Staff. This relationship can be jeopardised by the NHS managers placing blanket bans on industry talking to the frontline NHS staff. This interaction should be encouraged by managers.

13. Without the thousands of hours of training provided by medical technology manufacturers every year many treatments would be unavailable to patients.

14. The Government must support the medical technology industry to continue to support the NHS by implementing the proposals set out in the NHS innovation Review that aim to establish a jointly funded industry and NHS training and education programme.

15. The joint education programme should be accessible at all levels of the NHS, from senior managers to frontline clinicians.

Ensuring Clinicians Get Training in New and Innovative Products

16. As the NHS Commissioning Board establishes Clinical Guidelines for healthcare providers they must also provide guidelines as to how clinicians can get appropriate training. These guidelines should also provide guidance on appropriate providers of this training.

17. All innovation training, whether provided by industry, professional trainers or peers, should be built into managerial and clinical curricula CPD.
18. All NHS Trusts should develop a clear strategy as to how they are going to train their staff. This strategy should set out the number of hours that staff are committed to undertake and who will provide this training—NHS peers, professional trainers or industry.

19. Medical technology is constantly evolving, well established devices are frequently developed and new devices are regularly produced. Training programmes must take this into account and provide enough flexibility to allow for training on new products.

20. Innovative models of service delivery could be created to allow the provision of training delivered jointly via partnerships or joint ventures between the public and private sectors that could lever the expertise of both sides.

December 2011

Written evidence from the Royal College of Midwives (ETWP 77)

THE ROYAL COLLEGE OF MIDWIVES

1. The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives and for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and we also provide professional leadership for one of the longest established of all clinical disciplines.

SUMMARY OF MAIN POINTS

— The RCM broadly welcomes devolving policy direction.
— The RCM is, however, concerned that national, strategic oversight might be lost.
— The Government must maintain effective workforce intelligence; achieving this should include providing the Centre for Workforce Intelligence with the resources it needs to do its job properly.
— Central funding for some national education and training initiatives—such as Return to Midwifery practice programmes—(which have proven their worth and for which the need remains) need to be maintained.
— Health Education England must reflect the whole healthcare workforce.
— Any new structures should initially be run in tandem with existing structures so that the best of the old can be maintained.
— Mechanisms must be in place to ensure that continuing professional development (CPD) is not further eroded, and it should also be ensured that midwives and other professionals mix with their colleagues from across the country not just their local area to ensuring sharing of best practice.
— Policies should be brought forward that enable midwives to move more easily and more frequently between positions in midwifery education practice to boost the turnover of staff within education and bring other practice benefits.

OVERVIEW OF POLICY DIRECTION

2. The RCM broadly welcomes the direction of policy on education, training and workforce planning towards greater professional ownership. We recognise that this will necessitate some devolution of current arrangements but we are concerned that the drive to local determination will, as happened in the past, lead to a short-termist approach and a lack of coordination, to the detriment of future healthcare provision.

LOSING STRATEGIC OVERSIGHT

3. Devolving responsibility for education, training and workforce planning will make it harder, for example, for politicians to deliver on promises they make to the general public, such as the one made by the Prime Minister (the then Leader of the Opposition) in January 2010 to recruit an extra 3,000 midwives. The Prime Minister remains committed to wanting to see more midwives in post—telling MPs in November 2010 that, “We do want to see an increase in the number of midwives”—but a hands-off policy on education, training and workforce planning runs totally contrary to being able to deliver on it.

4. Not being able to deliver on political pledges is not the only inherent problem with this approach. Simply maintaining an adequate workforce may become a challenge. A policy of devolving decision making runs the risk of repeating the mistakes of the 1990s, the last occasion on which workforce planning was devolved, when midwife education programmes were subject to severe and damaging cuts. The logic of this outcome is sensible enough. At a time when savings have to be made, it might seem reasonable for a local health employer to decide to avoid the expense of training a new midwife by simply “poaching” a newly-trained midwife from somewhere else; in short, becoming a free rider. This is not on its own a strategic problem, but if a sufficient
number of employers take this approach, and such an outcome does not seem to us to be unlikely, then the number of new midwives drops precipitously. This is the RCM’s experience of how a devolved approach operated in the 1990s.

5. It is for these reasons that the RCM strongly recommends that the Government ensures that strategic oversight and governance of education, training and workforce planning is not lost when strategic health authorities (SHAs) are abolished. This is critically important in ensuring the continuing availability, training and development of a skilled workforce able to provide high quality, safe and effective care to women. Retaining national oversight of workforce intelligence and of the needs of the service in different parts of England is fundamental to ensuring that the system is sufficiently responsive and flexible to changes in demand for services. We hope that the lessons of the 1990s, mentioned above, will be learnt and that localisation of arrangements is not purely at the expense of national strategic considerations.

6. A national and strategic view of the knowledge and education of practitioners such as midwives is critical in ensuring a skilled workforce able to provide a high quality, safe and effective level of care to women, their babies and families through the continuum of pregnancy, labour and the postnatal period, including early support for parenting. Midwives are the only professionals who have access to women and their families at a crucial window in their lives, with a unique opportunity to influence the present and future health choices for them and their families.

7. Having specific and effective measures for workforce intelligence, and being clear on the numbers of workers at all levels being prepared throughout England, and indeed the UK, is fundamental to balancing the ebb and flow of the workforce in relation to providing new jobs for those completing their education and training, and to replacing those who are leaving the service either for other roles, or through retirement or career breaks. Even the current system does not always address this, in that some newly-qualified midwives, trained at public expense, have been unable to obtain immediate employment or have had to take part-time posts immediately after their programme. This is frequently a result of local financial strictures unrelated to clinical need. The RCM is aware of research that indicates that not being able to practise after qualification will often cause those practitioners to never practise, and this is a shameful waste of public money and talent. Some midwives who have not been able to obtain employment immediately after qualification have applied to complete the RCM Return to Midwifery Practice programme, having been in that situation.

8. Some programmes and educational initiatives need a national strategy, including protected and targeted funding; the RCM would recommend that the Government reviews what these programmes should be. An example is the Return to Midwifery programmes, which allow midwives to update their theory and practice in order to be competent and indeed confident enough to return to NHS practice. This is a cost-effective route usually taking anything from four weeks to one year to bring back an experienced practitioner. There remains considerable interest from midwives who have left the NHS to undertake these programmes, but it is often difficult to identify funding to support the course fee, bursary, and clinical placement. The experience of the RCM has been that initiatives such as that used by NHS London have streamlined the process, and ensured that monies are available to facilitate this return. This is a huge benefit to local maternity services.

THE NEW STRUCTURES

9. The Centre for Workforce Intelligence (CfWI) will clearly have an important role to play in developing workforce intelligence and supporting local providers and Health Education England (HEE). It is vital that the Government ensures that the CfWI has the requisite resources to undertake these responsibilities.

10. Structures and the architecture of any new system will of course be of vital importance. The proposed new system requires the design and development of new structures, including the clinical networks and HEE. This will require robust new governance, systems and processes to oversee the whole education and training system, including an effective legal framework. HEE must reflect the whole healthcare workforce, with equal representation across the professions, including colleagues from nursing, midwifery and the allied health professions (AHP). There is considerable experience and expertise within these groups that will add to the work of this group. The chair of the group could usefully be an independent person, with the appropriate expertise to contribute to the work. There are significant concerns that as HEE will be a successor to Medical Education England, it will follow a medical model. This would not be acceptable as midwives, nurses and AHPs provide the vast majority of hands-on care within the NHS and independent sectors.

11. The RCM believes that the Government should consider whether it might be possible for any new system to be set up and run in tandem with the existing system to enable any teething problems to be identified and addressed before closing the old system. The RCM would recommend that in preparation for this change, a careful review and evaluation is undertaken clearly to establish what systems and processes can be translated or utilised in the new system. We are concerned in particular that existing expertise of those at the SHA level might be lost, and this will adversely affect the commissioning of education and training.

12. The RCM supports the principle that healthcare providers have a duty to cooperate on planning the healthcare workforce and providing professional education and training. Where there is a strong and effective partnership between education and service providers, students are more likely to have a rewarding educational experience, and be confident entering practice as new midwives.
13. The RCM welcomes the establishment of HEE and expects that the commitment to promoting multi-professional education and training is reflected in the participation in its governance systems and processes of representatives from all sectors of the healthcare workforce. When it comes to the development of training and education programmes for midwives, we would strongly recommend accessing advice from a wide range of professional representation, including the Nursing and Midwifery Council (NMC), the RCM, and midwives in a Supervisor of Midwives or Local Supervising Authority role.

CONTINUING PROFESSIONAL DEVELOPMENT

14. The RCM is concerned that proposals for localising the funding of continuing professional development (CPD) risks further eroding the opportunities for midwives and others to update their knowledge and skills. The midwifery profession has a long history of CPD—dating back to 1936—and this has allowed midwives to maintain and develop their knowledge and skills in line with changes to women’s expectations and needs, technological developments and emerging research and evidence. Many midwives find their development opportunities are now largely confined to mandatory training only. Whilst training in, for example, an update on lifting and handling, is of course useful, it is also imperative that midwives and other practitioners should meet and learn with colleagues from other areas, as this can be an important means by which they learn and share good practice, and generate new ideas and approaches to care. Any new arrangements must be predicated on the principle that all groups within the NHS workforce are dealt with equitably and are able to access sufficient education and training opportunities, including access to CPD.

MIDWIFE TEACHERS

15. The RCM is also unclear how the future development needs of midwife teachers will be addressed under the proposed new arrangements. Experienced midwifery lecturers are essential for teaching and facilitating learning, and assisting in the development of students as reflective, effective decision-making practitioners, and support of qualified staff. Regrettably, the midwife teacher workforce is ageing, turnover is stagnant, and class sizes on the rise. HEE and other bodies concerned with education and training will need to address this issue as a matter of urgency.

16. The RCM believes that there needs to be greater emphasis within the education sector on recruiting skilled and experienced midwives into lecturing roles at universities. To achieve this, there will need to be an improvement in the conditions in which they work, including pay and access to clinical practice. Employment conditions for midwife teachers are often less appealing than for those in practice roles, such as consultant midwives.

17. All midwifery lecturers are practising midwives and spend a proportion of their time working clinically, alongside student midwives and also qualified midwives. This provides an ideal opportunity to support clinicians, and also identify issues that might need inputting into parts of the midwifery curriculum, for example record keeping skills, or communication. The RCM would welcome a system that enabled the clinical service providers to work in tandem with higher education colleagues, enabling the education and practice of students and qualified staff to be supported and developed, enriched by research and evidence that academic colleagues can bring to their service partners. It is also important to recognise the huge contribution of service providers to the support and nurturing of student midwives. Especially at this time with significant pressures on the system it would assist if arrangements were made to reimburse employers so that they could “back fill” for the clinical time expended on student support.

18. Mechanisms need to be developed to facilitate movement of midwives between the NHS and Higher Education Institutions, as this would encourage secondments, and shared working between both to the benefit of the NHS and to students and qualified staff.

19. The NMC’s Midwives in Teaching (MINT) project (2011) demonstrated the value of clinical practice in midwifery education. For example, students were able to develop competence and familiarity with clinical settings and build confidence with early practice placements and where lecturers effectively integrated practice and theory. This highlights the critical importance of the link between education and practice which is easily lost as academic institutions increasingly focus on research excellence.

20. The RCM would also highlight that there is a need for further research and evaluation work into the sphere of education, training and workforce planning, in order to ensure that good practice is identified and built upon, and evidence based practice is truly imbued into all spheres of the health service.

December 2011
Written evidence from Assura Medical Limited (ETWP 78)

ABOUT ASSURA MEDICAL LIMITED

Assura Medical Limited (AML) improves health outcomes for patients by enabling a greater range of services to be delivered in primary care and community settings. We achieve this by partnering with groups of GPs to develop provider companies (GPCos). We have now formed 25 GPCos with GPs representing over three million patients and these are providing a wide range of services including diagnostics and out-patient day care services, GP surgeries, walk-in and urgent care centres as well as providing convenient high quality services for patients. Our services have also generated significant savings for PCTs.

Our GPCos are working closely with a wide range of providers from across the NHS, social care and independent sectors. We have formed a range of innovative models to provide integrated services that span primary and intermediate care which we see as essential to developing joined up and cost effective services.

1. Ensuring providers and commissioners play an appropriate part in developing the future workforce

1.1 The report of the Future Forum on education and training, Chaired by Julia Moore of University Hospitals Birmingham NHS FT, made some very helpful recommendations about ensuring that the training and education system for staff reflects the changing needs of healthcare and the Government’s proposed market-based reforms to the NHS. AML fully supports attempts to modernise the training system so that it better meets the needs of a reformed health service and ensures that all providers have access to high quality staff.

1.2 The Government’s proposal to levy a charge on all providers to cover the costs of training is important and we believe requires widespread consultation prior to implementation. AML understands the intention behind the proposal but is concerned to ensure that there is a level playing field applicable to all providers and that the sums involved are transparent and are not so large as to act as a major barrier to entry. Managing the costs down with subsequent cost savings focused on keeping the levy to a minimum rather than going back into the central pot. In addition, we believe that the levy must already take account of work done by the independent sector, which the NHS has often found difficult to track.

1.3 In developing a training levy AML believes that it will be important to provide clarity about who needs training to ensure that the fees reflect the training requirement. Current requirements on training are too often vague and it is difficult to set a budget for the costs of training. The new system must be far more robust in determining who needs training, the numbers of staff involved and the level of training required, being more comprehensive than the current arrangements. In addition, the ongoing training needs of locum staff who are not aligned to an employing organisation such as an agency must be considered to support both professional development and professional regulatory requirements.

1.4 Transparency of costs is going to be critical in ensuring that providers understand what their contribution to training and education will be. As part of its consultation into provider licensing Monitor has made clear that the cost setting process for registration will be transparent and as noted in section 1.2 AML believe that the Department of Health should consider aligning the training levy to the wider provider licensing process, thereby ensuring that training requirements are explicitly written in to the commissioning process, both in the bidding stage and the contracts themselves.

2. Leadership and accountability

2.1 Effective clinical leadership within the NHS and its partners is going to be vital in meeting the Government’s Reforms, including the Outcomes Framework and the QIPP scores on efficiency. The quality of the current arrangements for clinical leadership are mixed which is why AML has developed its own approach to mentoring senior clinicians and supporting them develop a range of skills associated with running provider organisations and operating within the wider NHS marketplace. This includes elements of clinical management and clinical governance supported by “on the job” mentoring, more formalised face to face training and processes and procedures.

2.2 High quality leadership will be needed from the various education and training organisations being established by the Government, particularly Health Education England and the Provider Skills Network. The current fragmentation of training and education organisations and the lack of clarity around their roles can be difficult to navigate and we would hope that greater coordination can be introduced.

2.3 Leadership within the NHS and ensuring there is a constant stream of high quality graduates coming into the system will be crucial and AML believes that much more could be done to reach out beyond the traditional routes. In particular, we would like to see the NHS adopt commercial best practice by pursuing a policy which reaches out to schools and colleges to explain careers in healthcare and enthuses young people about their opportunities and potential career paths, as is done by other large-scale public sector recruiters such as the armed forces.
3. Training curricula and Continuing Professional Development

3.1 Julia Moore’s Future Forum report raised some particular concerns with the Post-graduate Deanery system and AML supports many of the points made, in particular the fact that Deaneries often operate differently across the country, have very different systems and practices and implement their own policies. With staff leaving the Deaneries and the workforce planning functions of SHAs closing down there is a potential training vacuum and the Government need to come forward with specific proposals for eradicating the existing fragmentation and making Deaneries far more outward facing and inclusive in the way they do business.

3.2 In both initial graduate training and postgraduate education we believe that much more emphasis should be placed on patient communication and customer service. Clinical skills are rightly the main priority of the training system but there is currently very little in the system which helps staff understand how to talk to patients, explain issues that have arisen or just to ensure that their experience is a positive one. Patient satisfaction is not just about the treatment that is provided by the clinician, it is also includes engagement and respect, access, choice, convenience and safety, and the NHS should recognise that much can be learned from the independent sector. Aligned to the Government’s plans for a Duty of Candour, our position is that staff are not always going to have the communication skills required to manage delicate situations or stressed patients and putting a more commercial focus on training could lead to patients having a far better experience of the NHS.

3.3 Continuing Professional Development is a vitally important way of improving individual clinicians’ skills and keeping up to date with changes to medical practice and technology. AML also believes that training can be a helpful way of integrating care provision by running modules across organisational boundaries and structured in such a way that the package mirrors the integration required under Monitor’s licensing regime. This could be a very helpful lever for improved integration across the service and developing innovative packages of care delivered by different entities.

December 2011

Written evidence from the Royal College of Psychiatrists (ETWP 79)

1. Introduction and Summary

1.1 The Royal College of Psychiatrists (RCPsych) is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

1.2 We welcome the opportunity to submit evidence to this important Inquiry. Our submission highlights issues of particular concern to the Royal College of Psychiatrists, including the urgent need to address the future of Deaneries, and the danger that where Acute Trusts form Local Education and Training Boards there is the possibility that psychiatry could be marginalised.

1.3 This submission should be read as an adjunct to the submission from the Academy of Medical Royal Colleges, which represents a combined view across Colleges and is endorsed by the RCPsych.

2. The future of postgraduate deaneries

2.1 The RCPsych believes that the Deaneries should remain as independent bodies which sit separately from the Local Education and Training Boards (LETBs). They should provide both external quality assurance of training across the specialties and expertise in supporting trainees in difficulty.

2.2 It is important that Psychiatric training is resourced to the same level as other training and that it does not become isolated from other specialties.

2.3 At present Deaneries are responsible for recruitment. There is sometimes a lack of engagement with the employers, and there would be some sense in moving this function to LETBs. However, this would depend on the size of LETBs as it would be difficult for the National Recruitment teams to deal with large numbers of LETBs.

2.4 The Schools of Psychiatry currently sit within the Deaneries. The RCPsych is very keen that the Schools should continue. We believe the development of Schools has helped to drive up standards and improve consistency. The Heads of School work closely with each other under the auspices of the College to set standards and to share good practice.

3. Plans for the transition to the new system, up to April 2013

3.1 The uncertainty about the future is affecting Deaneries, which are finding it hard to retain staff and in some places are not allowed to recruit to permanent posts. The danger is that this will destabilise quality assurance and recruitment with a consequent effect on patient safety. It is urgent that decisions about the future of Deaneries should be made and implemented.
4. Ensuring the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

4.1 Local bodies have a better understanding of local health needs than central bodies and will be more able to predict and manage the numbers of staff that need to be trained. Most trainee psychiatrists eventually take up a permanent post in the Deanery in which they train. The relatively short training time in Psychiatry with the un-coupled training pattern makes workforce planning easier than in some specialties.

5. Ensuring that all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

5.1 All providers should contribute towards training. There are training opportunities in the private sector but the quality assurance of training in this sector is problematic and a financial levy on non-training and private organisations might be the best way forward.

6. 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

6.1 At present the size and structure of the LETBs is unclear. There are some advantages and opportunities in making training more the responsibility of the employers but there are also some risks attached to this, as money may be diverted from training to other areas. Training budgets (both salaries and other costs) should be ring-fenced.

6.2 There is a particular issue for Psychiatry, as Psychiatric Trusts tend to be separate from the rest of acute care. If Acute Trusts form LETBs and become responsible for psychiatric training, there is a very real danger that psychiatry will be marginalised.

6.3 Alternatively, a LETB might be Psychiatry only. Historically, spends on psychiatry training have been lower than on some of the other specialties and recently the investment in simulators has not helped psychiatry. A psychiatry-only LETB should ensure that Psychiatry does not receive less funding than other specialties and would provide some interesting opportunities for multidisciplinary training which has always been the strength of the specialty. The risk would be isolation from the other specialties.

6.4 We recommend that particular attention is paid to where psychiatry sits when the LETBs are formed.

7. How professional regulators, healthcare providers, and researchers will all participate in the formulation and development of curricula

7.1 The College would expect to continue writing the curricula prior to submission for approval by the GMC. We are committed to ensuring input to the curricula from all relevant stakeholders including LETBs.

8. The role and content of the proposed National Education and Training Outcomes Framework

8.1 The College supports the development of a National Education and Training Outcomes Framework. However, this needs to be relatively simple to apply, as there is no spare capacity in the system for large amounts of extra data collection. It should also be standardised across specialties and areas.

9. The place of overseas educated healthcare staff within the workforce

9.1 A large number of psychiatric trainees originate from overseas. Initially their training needs may be greater than those of UK graduates and the resources must be available to support them. Recently there have been reports of Deaneries reducing spending on extra help for this group as a result of the need to cut costs.

10. How the new system will relate to healthcare, education, training, and workforce planning in the other countries of the UK

10.1 There needs to be consistency within the UK. The Heads of School from England, Northern Ireland, Wales and Scotland meet regularly at the RCPsych which helps to ensure common standards.

11. How the public health workforce will be affected by the proposals

11.1 There is a skills overlap between public health doctors and psychiatrists and a closer integration of their training would be helpful to both specialties. This might be more difficult if public health training becomes separated from the rest of medical training.

December 2011
Written evidence from the Chartered Society of Physiotherapy (ETWP 80)

1. SUMMARY OF MAIN POINTS
   — Effective workforce planning and provision of high quality qualifying and post-qualifying education is vital to ensure NHS-funded healthcare is able to meet changing patient/population needs in clinically- and cost-effective ways.
   — The CSP believes that all providers of NHS funded healthcare must contribute to the future of the workforce. This includes student placements and learning opportunities.
   — Physiotherapy is made up of a national workforce, with staff moving around the UK throughout their careers. As a result, effective co-ordination and future planning cannot be co-ordinated solely at a local level. Nor can the NHS only commission for an NHS Workforce when competition will result in increasingly diverse health provision.
   — Investment in the existing workforce is essential to sustain and improve standards and quality of care. It is important to ensure due recognition/support of Continuing Professional Development (CPD) for sustaining service delivery, delivering a quality service and supporting staff development.
   — The CSP believes that if decisions about the numbers of healthcare professionals being trained are made locally it will become increasingly difficult to achieve a national overview and avoid piecemeal cuts being made by an increased number of commissioners. There is a clear danger that a more fragmented approach to workforce planning will lead to a boom and bust in staffing provision which has been so damaging to the health service in the past.

2. THE CHARTERED SOCIETY OF PHYSIOTHERAPY (CSP)
   2.1 The CSP is the professional, educational and trade union body for the UK’s 51,500 chartered physiotherapists, physiotherapy students and support workers.
   2.2 Physiotherapy staff offer clinically effective and cost-efficient services for patients, across healthcare sectors and along the whole patient pathway. Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being.
   2.3 Physiotherapists facilitate early intervention, support self management and promote independence, and help prevent episodes of ill health and disability developing into chronic conditions. Reduction in sick leave and maintenance of independence is a major focus of physiotherapy care.
   2.4 Physiotherapy is ideally placed to provide solutions to current healthcare challenges. It can play a strong role in addressing healthcare priorities in a rapidly changing health and well-being economy, maximising productivity and efficiency while providing high quality care. Physiotherapists are already developing and focusing their practice, demonstrating both clinical and cost effectiveness. They are assuming greater responsibility for complex, non-routine caseloads, taking on activity previously undertaken by medical colleagues and overseeing the delivery of care by others. There are areas where physiotherapy can extend its reach and deliver quality patient care and outcomes in a clinically and cost efficient manner.
   2.5 Many physiotherapy services across England have successfully innovated and introduced initiatives to increase productivity. NHS Evidence has recently included self-referral to physiotherapy for musculoskeletal conditions in QIPP, based on evidence of its ability to improve quality and productivity. However efforts to continue to develop such initiatives are being hampered by both the demand for short-term efficiency savings and the speed with which the Government reforms of the NHS are being implemented. In our 2010 survey of NHS physiotherapy service managers 41% of respondents agreed or strongly agreed with the statement “Inadequate physiotherapy staffing levels are obstructing me from redesigning and modernising our service”.

3. FUTURE WORKFORCE PLANNING
   3.1 All providers of NHS funded healthcare must contribute to the future of the workforce. However, the CSP is concerned that the scale of the new clinical commissioning groups will be too small to provide the big picture context needed to effectively plan the future demand and workforce need. It is also unclear how, at this level, the breadth of physiotherapy skills and practice could be preserved.
   3.2 Physiotherapy is made up of a national workforce, with staff moving around the UK throughout their careers. As a result, effective coordination and future planning cannot be managed solely at a local level. National leadership with coordinated, accountable, regional decision-making is needed.
   3.3 Service development should be aligned with financial and workforce planning and the involvement of clinical service managers, who can provide accurate data about the existing workforce and expert assessment of future staffing requirements at a local level, is imperative to achieving stronger, more effective workforce planning. This local level assessment must be co-ordinated in both regional and national level assessments of workforce need.

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3.4 It is our view that the Centre for Workforce Intelligence (CfWI) has an important role to play in providing leadership and expert advice on workforce planning at a national level across the whole healthcare economy. In our opinion, it is imperative for there to be an overview of workforce supply and demand and we have been concerned that CfWI recommendations are not consistently taken into account in workforce planning decisions at local and regional levels.

3.5 It is critical that the quality of data and analysis produced by the CfWI is of the highest standard and it is then consistently taken into account by commissioners when making decisions about the future demand/ workforce planning. However, recently we have been concerned about the quality of reports from the CfWI, because for a reduction in the CfWI staff resources available to produce them. We have been unable to support their conclusions based on inadequate time and professional resources. It is essential that the CfWI is properly resourced by the Department of Health.

3.6 CSP believes that all healthcare providers should have a mandatory duty to provide data on their current workforce and their future workforce needs. This duty should apply to all providers and not only those providing care to NHS patients. This is the only way to ensure effective workforce planning and training support in an increasingly fragmented provider environment. There is an increasing danger that the NHS locally will only commission for its own NHS local needs and ignore the needs of the growing independent sector. These mistakes were made in the early 1990s and should not be repeated today. However, we acknowledge that there is potential for data about workforce to be misused and would argue that access and purpose will need to be explicit and regulated to ensure accountability.

3.7 Moves towards increasing the opportunities for flexible local implementation and innovation should be done within the context of ensuring that there is consistency in service provision and workforce development at local level. This will help to prevent a postcode lottery in the range and quality of services available to any local population. We support the need for professional engagement at local and national levels, but have concerns that this could be dominated by the larger professions of nursing and medicine. It is very important that there is an opportunity for smaller professions to have a voice at both levels.

4. ROLE OF COMMISSIONERS AND PROVIDERS IN EDUCATION AND TRAINING

4.1 The CSP would like to see alternative providers of healthcare services taking their fair share of responsibility for student placements, for the funding of both qualifying and post-qualifying education and CPD, and for providing rotation posts for newly qualified staff. This is essential in order to ensure that the policy of “any qualified provider” is truly based on a level playing field. It is not enough to impose a “training levy” on independent providers which leaves the NHS with the role of providing placements. The responsibility of placements should be shared by providers.

4.2 We would argue that the provision of education and training for the future workforce needs to be a standard to be delivered by any qualified provider wishing to provide NHS services and therefore set and monitored within contractual requirements. We would also wish to see those health providers that do not currently provide NHS services contribute, as they benefit from public sector funding of all the costs involved in training and supporting healthcare professionals and support workers throughout their careers.

4.3 It is important that funding budgets include the costs of allowing all staff time to attend CPD training and development particularly at a time when efficiency savings and cuts to staffing are making it increasingly difficult for staff to be allowed this time.

4.4 It is unlikely all healthcare providers will volunteer to contribute in this way in an increasingly competitive provider market, so robust and transparent mechanisms must be introduced to ensure that each provider takes their fair share of the costs and responsibility. Smaller providers may not have the capacity to contribute directly in terms of providing placements, so we support the concept of a levy as an alternative means of contributing towards these costs, however, safeguards must be put in place to avoid a situation where all providers opt to pay the levy and there are no organisations prepared to offer the training.

5. STANDARDS OF EDUCATION AND TRAINING

5.1 CSP believes it is important to introduce a mandatory requirement that all healthcare providers should contribute to practice-based learning for students, while ensuring rigorous quality standards are upheld. Within the NHS Knowledge and Skills Framework, expectations on employers were explicit. These standards should form a mandatory minimum for staff CPD and training.

5.2 The CSP has well-established expectations of both practice-based learning and practice educators. Processes for implementing both sets of expectations are an integral part of our quality assurance and enhancement activity. Recognising the need for practice-based learning opportunities to develop students’ learning experience and outcomes in ways that reflect changing patterns of service delivery, CSP expectations of practice-based learning also complement the threshold standards for education and training as set out by the Health Professions Council as the statutory regulator.

5.3 The CSP is concerned that the Government’s proposals make no recognition of the role of professional bodies in education and standard setting etc CSP accreditation of education programmes is a clear quality
standard, particularly in the context of a potential for greater diversity in education providers and given parallel policy directions in higher education reform. CSP is concerned that without the involvement of professional bodies the quality of education programmes will fall.

6. Developing the Existing Workforce

6.1 Investment in the existing workforce is essential to sustain and improve standards and quality of care. Staff who are empowered, engaged and well supported provide better care and we welcome the Government’s aspiration to support everyone in the healthcare workforce to realise their potential. We believe that the Government should place a requirement on all providers of NHS-funded healthcare to fund CPD for all healthcare staff.

6.2 It is important to ensure due recognition/support of CPD for sustaining service delivery, delivering a quality service and supporting staff development (including lateral career shifts to meet changing need). This has to take place at all levels of the workforce, recognising the diversity of practice and development that needs to be supported.

6.3 Although newly qualified physiotherapists are autonomous practitioners, appropriate clinical supervision is needed to support new graduates to consolidate and develop their learning. Broad based rotations are needed to ensure that the newly qualified are able to develop their skills in a variety of clinical settings, including to support their subsequent progression to advanced and specialist roles. This ensures that the physiotherapy workforce will have the necessary transferable skills and flexibility needed to be able to adapt to changes in health care provision rather than specialising too early in their careers. For this reason, it is also vital that senior physiotherapy roles of band 7 and above continue to be funded in order that this clinical supervision and leadership can be provided.

6.4 CSP is concerned that the positive investment made by Strategic Health Authorities in CPD for healthcare staff is at risk of being lost in the reforms.

6.5 We believe that all staff providing NHS-funded services should have access to appropriate forms of learning and development which supports service development and delivery, meets changing patient/population needs and provide appropriate opportunities for professional and career development.

6.6 We would argue that Higher Education Institutions need to have an expanded role in CPD to ensure the supply of high-quality evidence based learning that provides structured opportunities for professional and career development and the sustainable fulfilment of clinical service needs.

7. Proposed Reforms of the Healthcare Education and Training System

7.1 The CSP is concerned by the proposed dismantling of existing workforce planning structures, particularly the loss of expertise at national and regional level as a result of this. We do not believe that the capacity and skills needed to take this forward currently exist at the local level and, if this proposal is adopted, we would like to see plans put in place to ensure these skills are developed within local networks. We are also very concerned that proposed Local Education and Training Boards (LETBs) will lead to extensive and unnecessary duplication in the commissioning process for student places (for those in commissioning roles, those informing the process and education providers). This will work against high-quality workforce planning and create added expense.

7.2 The CSP is very worried by the potential collapse in vital workforce data collection for AHPs and other smaller professions under the new local plans and national structures. It would appear that the detailed national workforce data collection for medical specialities will continue but not for AHPs or other professions. The growing diversity of healthcare providers should mean an increased need for effective workforce data collection and analysis not less. This issue must be addressed and resolved in the new structures being created for workforce planning.

7.3 The CSP is concerned that the proposals really only consider entry to the profession. It is vital that the education and training system looks at the workforce across the board and considers the education needs of all staff, including the education needs of support workers and CPD for all staff.

7.4 Support from employers is vital to ensure effective education, training and CPD, but it is not enough in itself. In order for the system to be sustainable support is needed at a regional and national level from NHS managers, commissioners and the Government.

7.5 The CSP welcomes the creation of Health Education England (HEE) to provide sector-wide leadership and oversight of workforce planning, education and training. We believe it is positive that the proposed structure should enable an integrated approach at national level to identify the education and workforce needs across the health professions and to achieve this across medicine/other professions for the first time. However, we believe this raises questions about how the new structure will be set up and implemented in line with the principle of a “level playing field”, so that the contributions and needs across all professional groups are looked at in an equitable and measured way. The benefits achieved under the AHP Professional Advisory Board should not be lost.
7.6 The CSP is calling for Health Education England to have an independent Chair and a broad interdisciplinary membership, as well as service user involvement. The CSP believes it is essential for the Allied Health Profession (AHP)/physiotherapy voice to be strongly heard at national (HEE) and local level and would like to see a clear role for AHPs on HEE.

7.7 The CSP believes that if decisions about the numbers of healthcare professionals being trained are made locally it will become increasingly difficult to achieve a national overview and avoid piecemeal cuts being made by an increased number of commissioners. There is a clear danger that a more fragmented approach to workforce planning will lead to a boom and bust in staffing provision which has been so damaging to the health service in the past. (See all the research into the huge mistakes of nurse workforce planning in the 1990s.)

7.8 We believe it is essential that the proposed LETBs remain as part of the NHS and work with strong accountability to Health Education England, with access to quality data about national and local workforce needs, and ensuring adherence to rigorous quality standards.

7.9 In terms of structure, national requirements are essential to mandate how LETBs are established, hosted and held strongly accountable for both the commissioning decisions that they make and their evaluation of the effectiveness of their commissioning decisions. As part of this, achieving standardisation and consistency in how the LETBs perform their role (including avoiding partial, perverse and destabilising decision-making) is imperative.

December 2011

Written evidence from Help the Hospices (ETWP 81)

1. **About Help the Hospices**

1.1 Help the Hospices is the leading charity supporting hospice care throughout the UK. We want the very best care for everyone facing the end of life.

1.2 The majority of hospice care in the UK is provided by our member hospices—local charities rooted in the communities they serve. Care is given free of charge to the patient and their friends and family. It can be at home, in the hospice and in the community and can be for days, months or years. We are here to represent and support our members. We work with our members and other organisations as they strive to grow and improve hospice and palliative care throughout the UK and across the world.

1.3 Our services are here to support hospice people and champion the voice of hospice care. They include a wide range of training and education programmes, informative and practical resources for hospice staff, work to influence government policy and support for quality care and good practice.

2. **Introduction**

2.1 This memorandum draws on the experience of independent charitable hospices around England, and is supplemented by references to research conducted by Help the Hospices and others.

2.2 In addition to this submission, we highlight some examples of the contribution that local hospices make to the delivery of education, training and workforce planning in an appendix. We would be pleased to provide further examples and information if it is needed.

3. **Summary of Key Points**

— The constitution of both provider-led networks and Health Education England (HEE) should include hospice and palliative care representation. *(Paragraph 4.3)*

— The Department of Health should work with the relevant professional bodies to ensure that all trainee doctors, nurses, allied health professionals, and registered social care staff receive an appropriate level of training in the delivery of end of life care. *(Paragraph 4.5)*

— There must be a clear link between the role of HEE and the NHS Commissioning Board. *(Paragraph 4.7)*

— The contribution of hospices to education and training should be recognised and supported. *(Paragraph 5.2)*

— The DH should clarify how the commissioning of social care education and training will interact with the proposed healthcare education and training system. *(Paragraph 7.1)*

— The transitional arrangements for the new education and training system must be carefully monitored. *(Paragraph 8.1)*

— The DH should clarify the powers that HEE will have over local skills networks. *(Paragraph 8.2)*

— The DH should develop specific guidance on healthcare provider “skills networks” and areas of collaboration between networks, which recognises the importance of palliative and end of life care. *(Paragraph 8.3)*
— The DH should clarify the expected number of skills networks and the implications for smaller education providers such as hospices. (Paragraph 8.4)
— CPD should continue to be funded through the central education and training budget. (Paragraph 9.3)
— HEE should have a role in monitoring and reviewing the CPD of the NHS workforce as part of its remit. (Paragraph 9.5)
— HEE should ensure provider quality and monitoring systems, for example staff appraisal systems, are responsive to and form the basis of the development of education and training. (Paragraph 9.6)
— The DH should strengthen the existing standards against which care homes are assessed to include a requirement to demonstrate that staff have received such training. (Paragraph 9.7)
— placements should be managed multi-professionally across a network of healthcare providers, not by individual providers (Paragraph 10.1)

4. The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

4.1 Every year, independent charitable hospices care for more than 360,000 people affected by terminal illness, including carers and families. Specialist palliative care nurses and other professionals are vital to the quality care and support that hospices provide.

4.2 Education and training in the new system should recognise the integral role that hospices can play in helping to shape the workforce of the future, and the importance of taking a long-term view of workforce and education and training. As the population ages and people approach the end of life with ever more complex care needs, flexible and adaptive hospice and palliative care services, with an appropriately trained workforce to support this care, will need to be available.

4.3 We strongly recommend that the constitution of both provider-led networks and Health Education England (HEE) includes hospice and palliative care representation. If properly professionally integrated, these structures should direct and enable workforce planning to be centred on patients’ care, including palliative and end of life care.

4.4 The hospice and palliative care workforce is ageing, particularly in nursing, and a new workforce needs to begin training as soon as possible. The recently published National Council of Palliative Care Specialist Palliative Care Workforce Survey highlights that 39.2% of all nurses working in the specialism are recorded as being aged over 50, as are 44.7% of social workers, 36.3% of physiotherapists and 25.3% of occupational therapists. 110 27.5% of specialist palliative care consultants are aged over 50, higher than the national average. 111 There are also significant staff shortages, with an average vacancy rate amongst the specialist palliative care nursing workforce of 8.7% and consultants of 7.8%. 112 Given many senior staff are reaching retirement age, in the context of already high vacancy rates, there is an urgent need to address the training of less senior staff.

4.5 The new education and training system must ensure that the wider healthcare workforce, from healthcare assistants to doctors, appreciate the importance and principles of end of life care and are better equipped to deal with patients as a whole in a much more sensitive way. The continued failure of health and care professionals to effectively engage with patients, their carers and families about their end of life choices limits choice and control. Hospices are challenging this through their work with the health and social care workforce to develop their knowledge and confidence to support people’s preferences at the end of life, enabling them to make appropriate referrals and to access appropriate support for their patients and service users. The experience of the hospice movement suggests that providing additional education and training for the health and social care workforce can help to improve the quality of care for people. We recommend that the Department of Health work with the relevant professional bodies to ensure that all trainee doctors, nurses, allied health professionals, and registered social care staff receive an appropriate level of training in the delivery of end of life care.

4.6 All hospice and palliative care providers, including hospices, will need to be more proactive in their recruitment and training of staff to meet the changing and often complex needs of patients and their families.

4.7 It is vital the new education and training system is in line with the wider system design for the commissioning and provision of services. Furthermore, the system should be appropriately integrated with the approaches to planning and developing the public health and social care workforce. In addition to the relationship between local provider led networks and clinical commissioning groups, we recommend that there must be a clear link between the role of HEE and the Commissioning Board.

5. All providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

5.1 Proposals currently focus on education and training provided by academic institutions at the cost of community-based education providers such as hospices. Hospices are co-producers and co-providers of

111 Ibid.
112 Ibid.
education and training with the NHS; if they are integrated more closely into the healthcare system, they are better placed to share their knowledge and expertise with others.

5.2 Hospices play a vital role in developing and supporting the health and social care workforce through education and training. This contributes significantly to the development of a high quality, flexible, palliative care workforce in both their organisation and in the wider care community. Local hospices have developed education and training programmes for the staff of providers of other types of care, such as care homes. We recommend that the Department of Health develops specific guidance on healthcare provider networks are properly governed and performance is managed to ensure the best quality healthcare workforce is developed. We recommend that the Department of Health develops specific guidance on healthcare provider networks are properly governed and performance is managed to ensure the best quality healthcare workforce is developed.

6. Training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

6.1 As recognised in the National Audit Office’s report on End of life care, there are significant gaps in the education and training curricula for health and social care professionals. End of life care must be integrated and embedded in training curricula for health professionals. We recommend that the Department of Health provides greater clarification over the powers that HEE will have over local skills networks as their responsibility, and the perspective and oversight that HEE should take. We recommend that the Department of Health provides further clarification of how the proposed relationship between HEE and local skills networks is still unclear. If HEE is to have a medium to long-term view of workforce planning, there could be a tension between the short to medium-term priorities that provider skills networks would see as their responsibility, and the perspective and oversight that HEE should take. We recommend that the Department of Health provides greater clarification over the powers that HEE will have over local skills networks.

7. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

7.1 Hospice education and training is generally inter-professional, recognising the service model of multi-professional hospice and palliative care. Hospices are dependent on development of both the health and social care workforce to deliver quality care, and hospice education and training activity reflects the activity of hospices as providers of integrated health and social care, for example end of life e-learning through e-learning for Healthcare, and competences through Skills for Health and Skills for Care. Hospices have highlighted concern that there is not more joined up development between the health and social care workforce, and that there is no reference within the proposed changes to the interaction with social care education and training arrangements. We recommend that the Department of Health provides further clarification of how the commissioning of social care education and training will interact with the proposed healthcare education and training system.

7.2 The governance arrangements and structures of HEE should ensure equitable representation of all the professionals; to achieve this, HEE can build upon existing expertise in the nursing, midwifery and allied health professions professional advisory bodies as well as Medical Education England. However, HEE should look to ensure a new and multi-professional approach to workforce training.

8. High and consistent standards of education and training

8.1 The current timetable put forward to have new systems and processes in place by 2012 does not allow enough time to pilot and evaluate changes to the provision of education and training. It is imperative that any changes to education and training commissioning ensure advances made in end of life care in recent years through the End of Life Care Strategy are not lost, and do not further destabilise the system. Going forward it will be important to “lock in” the knowledge and experience of those who are currently commissioning education and training. Previous reports of the Health Select Committee reflected on the lack of knowledge on education commissioning prior to strategic health authorities taking a leading role and this should not be lost going forward. We strongly recommend that transitional arrangements for the new education and training system are carefully monitored.

8.2 Consistency and quality need to be supported by clear lines of accountability and strong principles of good governance in the new system for education and training. The proposed relationship between HEE and local skills networks is still unclear. If HEE is to have a medium to long-term view of workforce planning, there could be a tension between the short to medium-term priorities that provider skills networks would see as their responsibility, and the perspective and oversight that HEE should take. We recommend that the Department of Health provides greater clarification over the powers that HEE will have over local skills networks.

8.3 We remain concerned at the continued lack of clarity on the constitution of skills networks and how their success will be measured and evaluated. The Department of Health has a responsibility to ensure that skills networks are properly governed and performance is managed to ensure the best quality healthcare workforce is developed. We recommend that the Department of Health develops specific guidance on healthcare provider “skills networks” and areas of collaboration between networks, which recognises the importance of palliative and end of life care.

8.4 The fact that skills networks will not be coterminous with clinical commissioning groups will have implications for the bureaucracy and transparency of the new system. The DH must make sure that the right checks are in place so that the number of new skills networks does not create extra bureaucracy in the new education and training system, especially for smaller providers such as hospices. We recommend that the
Department of Health clarify the expected number of skills networks and the implications for smaller education providers such as hospices.

9. The existing workforce can be developed and re-skilled for the future (through means including post-registration training and continuing professional development)

9.1 Continuing professional development (CPD) is critical for enabling health professionals to take greater ownership of their education and training and to continue to develop to meet the health and social care challenges of the future. Hospices play a crucial role in delivering cost-effective professional development in their organisations, alongside developing education and training programmes for those working in the public and private sector, such as in care homes. This contributes significantly to the continuing professional development of a high quality, flexible palliative care workforce—both now and for the future.

9.2 CPD in the NHS must be sustained and protected. In the past CPD budgets have often been cut first and, given the current financial climate, there is a real risk to the development of the existing workforce. In a recent survey of Royal College of Nursing members, by sector, 29% of respondents in the NHS had received no continuous professional development and training in the last 12 months, compared to 23% of those working in the independent and voluntary sectors and 19% of those working in other sectors.113

9.3 There should also be greater transparency about the overall level of investment across the system. We recommend that CPD continues to be funded through the central education and training budget.

9.4 We recommend that the Department of Health should also investigate how current professional requirements, for example the NHS constitution and standards for professional regulation could be strengthened with regards to education and training. For example, the NHS constitution pledges to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed, and staff have responsibility to “aim to take up training and development opportunities provided over and above those legally required of your post”.114

9.5 As the Government’s response to the NHS Future Forum report acknowledges, HEE will have national oversight of education and training and so be best placed to ensure that providers are operating effectively within a wider context. We recommend that HEE should have a role in monitoring and reviewing the CPD of the NHS workforce as part of its remit.

9.6 Professional ownership of education and training that meets the need of employers is also dependent on good employer engagement. We recommend that HEE ensures provider quality and monitoring systems, for example staff appraisal systems, are responsive to and form the basis of the development of education and training.

9.7 For example, few care home staff have sufficient training in providing end of life care. We recommend that the Department of Health strengthen the existing standards against which care homes are assessed to include a requirement to demonstrate that staff have received such training.

10. Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

10.1 Student placements play an important role in both encouraging healthcare professionals to undertake a career in palliative care and supporting the work of hospices. We recommend that placements are best managed multi-professionally across a network of healthcare providers, not by individual providers, as smaller providers such as hospices may have capacity issues in providing opportunities.

10.2 Financial support is vital for ensuring placements at hospices continue. We recommend that the funding arrangements of undergraduate clinical placements (both medical and non-medical) be established as soon as possible to support placements in hospice and palliative care, and to ensure a level playing field between providers.

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APPENDIX

CASE STUDIES

West Cumbria Hospice at Home—educating care homes

Hospice at Home West Cumbria has appointed a facilitator to instigate a programme of education in local care homes. This project grew out of discussions with the End of Life Network which agreed to fund an education programme for care homes that is managed by the hospice.

The facilitator will work with champions appointed by care homes. Through the education programme champions will take on responsibility for implementing the “six steps for success”.

These include identifying where people are in their disease trajectory, how to talk to engage in end of life conversations, advance care planning, co-ordinations of care, use of end of life care pathways and hot to achieve quality care for people at the end of life.

The facilitator is an ongoing resource to support champions to deliver the plan, and to spread what they have learnt among their colleagues in order for the care home to better meet the needs of people at the end of life.

St. Luke’s Hospice, Basildon—improvements through education and training

St. Luke’s Hospice won a tender from Essex County Council through Essex Works Brokerage to provide a 2 day End of Life Care training course for social care staff including, social care practitioners and facilitators and social carers.

The course will be repeated six times across the area and reach a minimum of 150 people. The principles of good end of life care for all outlined in the End of Life Care Strategy will be threaded throughout each session, allowing delegates to recognise key principles within care delivery.

The aim is for delegates to gain knowledge, understanding and confidence about the principles of palliative and end of life care and how these can be applied in their roles. It will include identifying end of life situations, ensuring holistic assessment, initiating discussions and documentation about planning and choice at end of life and supporting clients and carers in those choices.

The course is delivered by hospice staff from the inpatient and hospice at home settings, who have sound clinical and hands on experience. Plans are currently in place to put on a further module for those with additional interest over four days.

The course evaluation is proving positive:

“The course has up skilled the EOLC confidence to raise awareness, engage people before, during and at end of life etc, and most importantly having the knowledge of local services available.” Course delegate

Written evidence from the Department of Public Health, Liverpool Primary Care Trust

How the public health workforce will be affected

1. The public health workforce in its widest sense will encompass anyone receiving healthcare or social care training in as much as it is vital that the principles of population health, health improvement and the reduction of health inequalities should form an element of the basic curriculum.

2. The public health workforce that has registration either through the medical, dental and non medical professional training programme or registration through a recognised voluntary assessment process, must retain registration through appropriate continuing professional development and revalidation.

3. Where public health workers are to be employed by local authorities, the evaluation of job roles undertaken in the NHS should not be devalued because there are no equivalent elements within local authority roles.

4. The only public health role that is to pass to the local authority that has any defined link with Public Health England is that of the Director of Public Health. If PHE is to negotiate on education and training for public health in partnership with HEE then its relationship with public health workers in local authorities, universities etc, must be clarified and a dialogue set up to allow input from those workers.

5. There has been recent developing recognition of “practitioner” status for public health workers who have measurable public health skills but are not at ‘specialist’ level. This needs to be further developed and supported through education and training. However, it is currently unclear how entry can be made to the public health field for workers outside the professional training programme, and especially within local authorities. There is a danger that the existing dedicated public health workforce will not be replenished except at the level of consultant/specialist, and that new specialists will prefer to work within PHE rather than in local authorities.
6. The local authority role as a “provider” in provider led networks is unclear in regard to the continuing professional development of public health staff to be hosted and then employed by them, while PHE are partners in HEE.

December 2011

Written evidence from Dr Judith Evans, Consultant Surgeon, Plymouth (ETWP 83)

I am a member of Council of the Royal College of Surgeons of Edinburgh, but these comments are my own.

The President of RCS Edinburgh has submitted a full document to you. He is aware that I am also writing.

Part time training or flexible training schemes as currently in existence have not yet addressed the issue of women reaching the top of the Profession.

As there are now in excess of 50% female medical students in year one (in some schools over 60%) this issue has to be addressed.

For many years I was regional representative on the WIST “Women in to Surgical Training” Committee. This was part funded by the Department of Health.

Recently, I believe about four years ago, this funding was stopped. When we asked “Why?” We were told this was because we had been so successful, we had doubled the number of female consultants. But this was only from 3% to 6%. Nevertheless it was a good statistic for those who chose to hide behind it.

I have advised young women who are keen to enter surgery since 1990. I was in a position to tell them, that if they wanted to go part time or work flexibly for some of their training it could be arranged, through the various schemes.

In the 90s part time training posts were centrally funded, and were supernumerary.

Nowadays there is open competition and anyone who admits to wanting to be part time for some of their training puts a host unit at an immediate disadvantage.

The advice we all give to those who wish to train part time is now “Don’t tell anyone until after the interviews.”

I strongly believe that if part time training were to be re-instated as a supernumerary opportunity, many of the problems of retaining women in hospital medicine and surgery would be resolved.

In the current situation it would also have a positive effect on medical workforce unemployment, and prevent expensively trained graduates from giving up medicine altogether, or leaving the country.

I am happy to provide more details should there be any interest.

This issue is not gender specific, there are also men who need to train part time for some of their careers, who are currently similarly disadvantaged.

December 2011

Written evidence from Lincolnshire Health and Social Care Community (ETWP 85)

SUMMARY

— The Lincolnshire Health Community welcomes the opportunity to develop a system where there is greater employer ownership and accountability for workforce planning and education commissioning.

— It is essential that employers are able to influence the supply of staff to the health community and generate innovative solutions to workforce and skills shortages.

— The proposals have the potential to both strengthen and improve the value of workforce planning through a shift in emphasis to local needs.

We wish to draw attention to a number of risks including:

— The narrow focus on “the healthcare workforce” and very limited consideration of the need to integrate health and social care planning.

— The allocation of funding needs to be equitable across the country and needs to reflect the shift in location of service delivery.

— The relationship between HEE and the LETBs should facilitate local ownership and accountability for determining future workforce requirements within a national governance framework.
RESPONSE

1. In 2007, the Lincolnshire Workforce Advisory Board and team were established as a result of Creating a Patient Led NHS and the creation of East Midlands SHA. The workforce board was established to deliver a number of workforce functions which were devolved from the SHA workforce and education commissioning team and has a remit to work with local healthcare and education providers, service commissioners, clinical staff and the SHA to implement the recommendations of the Health Select Committee report on Workforce Planning. The board is chaired by a Chief Executive from the health community.

2. Since the establishment of the board, some progress has been made against many of the recommendations from the previous select committee report in 2007:

   2.1 Some of Lincolnshire’s achievements include:
   
   2.1.1 Development of an annual workforce plan based on care themes for the health and social care community; this incorporates organisational plans and is utilised to inform pre-registration education commissioning and priorities for workforce development.
   
   2.1.2 Linking service commissioning with workforce planning. The board works closely with service commissioners to identify workforce implications of commissioning plans and provides advice about risks and workforce assurance; this leads to provider workforce plans that include the commissioning intentions and outcomes.
   
   2.1.3 Supporting clinical involvement in the development and implementation of workforce plans.
   
   2.1.4 Workforce planning experts within local health community teams support individual organisations with capacity and capability for workforce planning, however the uptake of this resource is varied across organisations and can be considered a threat rather than an opportunity.
   
   2.1.5 Trusts who are Foundation Trusts and aspiring FT’s understand the significance of workforce and service planning being integrated into financial plans. This is now reviewed by Monitor as part of the application process and evidence can be provided in individual organisations’ annual plans.
   
   2.1.6 Developing county wide approaches in a number of areas including the management of practice learning and the development of the Assistant Practitioner role.

   2.2 Some areas which require further development are:

   2.2.1 Planning for the whole workforce; planning for the medical workforce is difficult to influence at county level; additionally non-clinical support staff are often not included in plans as the focus is on delivering a care theme eg long term conditions.
   
   2.2.2 Increasing the capacity and capability of workforce planning in organisations; whilst organisations often have capacity for workforce information reporting; expertise in workforce transformation and workforce modelling is often restricted to one or two individuals per organisation. The board provides additional capacity to support organisations through a local health community team.
   
   2.2.3 There is limited freedom within centralised budgets and there remains a regional hierarchical system which still is predicated by a medical model.
   
   2.2.4 The commissioners responsibilities for workforce planning and the amount of scrutiny they should have in provider plans is still unclear, this will become more complex in the new commissioning arrangements.
   
   2.2.5 Further work is required to incentivise individual organisations to work collaboratively across care pathways to determine future healthcare workforce requirements, particularly when moving services from one organisation to another.
   
   2.2.6 Lincolnshire has a number of demographic challenges in terms of the health and social care workforce and the population that we serve; the current system for workforce planning and education commissioning does not provide sufficient flexibility at a local level for us to generate solutions that meet the needs of Lincolnshire.

3. In compiling this response to the call for evidence. The Lincolnshire health community have reflected on the strengths of the current system, the areas where improvements are required and the outcomes within the new system that would indicate “success” for our local health and social care economy. The comments reflect the priorities of service providers and the PCT cluster and therefore the submission is restricted to those points that the health and social care community felt were appropriate for comment.

Plans for the transition to the new system, up to April 2013

4. Through the East Midlands wide transition steering group; plans are underway which will enable transition to the new arrangements in April 2013. However there are a number of areas which will require clarification during the transition process including organisational form, functions of the LETB at East Midlands and county level, the role of HEE and retaining the knowledge and expertise from the current system.
5. More local consultation is required to ensure that all the stakeholders in the LETB are engaged and have the opportunity to create and own a locally responsive organisation.

6. The role of service commissioners needs to be clearly established in the new architecture; it is the view of the health community that the commissioners need to determine outcomes and quality: the providers need to innovate and skill mix to meet the challenges in the current climate.

7. The PCT cluster in Lincolnshire has supported the development of the CCGs and GP leadership to prepare them for their future roles.

The future of postgraduate deaneries

8. Whilst it is recognised that there are significant risks to the medical training programme if transition of the deaneries is not managed appropriately; there are also risks if the work of the post-graduate deaneries is not provider-led.

9. Providers need to be able to influence medical training and speciality numbers to ensure that we are developing a medical workforce that meets the needs of the population eg We have trained a whole cadre of highly specialised secondary care physicians yet neglected to train sufficient numbers to meet the needs of an increasingly elderly population with co-morbidity.

10. The current workforce planning system does not enable planning for the whole workforce and there remain supply and demand issues in a number of medical specialities. Whilst there is no guarantee that the new system would solve the difficulties in recruiting either doctors in training or staff grade/consultants to Lincolnshire; it is essential that employers are able to influence the supply of appropriate medical staff to the health community and generate innovative solutions to medical workforce shortages. It is the view of the local health economy that this has a greater chance of success if the Post-graduate deanery is part of the provider led LETB.

The future of Health Innovation and Education Clusters

11. Whilst it is recognised that HIECs have funded a number of innovative projects locally, regionally and nationally; the broad engagement of service in HIEC activity and dissemination of innovative practice has been limited and it is the view of the health community that the outcomes that HIECs were expected to deliver have not fully been achieved. Consideration should be given to how the functions of the HIEC are delivered through the LETBs and what the interface with CLAHRCs should be in the new system.

The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

12. The delay in establishing the role and function of HEE has the potential to add risk to the timescales within the transition programme.

13. The emphasis within the LETB must be local ownership, accountability and responsiveness to its members. The framework for authorisation by HEE should recognise that provider organisations are the best placed to articulate their workforce issues and requirements for the future.

14. HEE should work on earned autonomy based on the maturity, financial management arrangements and involvement of all partners in the LETB. Where there are national policies regarding specific professional groups, the LETB should have the opportunity to provide an evidence base and rationale for adopting alternative solutions to that policy.

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

15. The size and structure of the LETB in the East Midlands has been based on consultation with stakeholders and an examination of what works and what can be improved in the current system. Governance structures including the resolution of conflicts of interest are being developed.

16. The diverse geography of the East Midlands and the size of the LETB will make meaningful dialogue and partnership with a wide range of stakeholders difficult. In the East Midlands, there will be structures at local health economy level enabling interface with Health & Wellbeing Boards, local authorities, other providers of NHS services and Clinical Commissioning Groups.

17. In order to assure best value for money and better outcomes for patients; The LETB should be responsible in relation to the allocation of resources; this is best achieved through provider ownership and accountability. This will provide flexibility for the LETB to undertake specific activity mandated by members but perhaps outside of the core functions of LETBs.
18. The system needs real protection of funding streams which offer flexibility to study routes for all ages eg apprenticeships, vocational, foundation degrees etc. The flexibility of funding is a key issue for Lincolnshire where “growing our own” is a successful workforce development strategy.

The implications of a more diverse provider market within the NHS; and how the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

19. The LETB and local health community structures will need to develop partnerships with a wide range of providers and will quickly need to understand to their issues and engage with them in a meaningful dialogue. The building of relationships and the generation of health and social care workforce discussions; rather than NHS discussions will be critical to the success of the LETB. The benefit of engaging a wider range of providers could be better workforce planning and education commissioning for the whole system—particularly in areas where there is currently a significant amount of non-NHS provision eg Learning Disability services.

The role of the Centre for Workforce Intelligence and how future healthcare workforce needs are being forecast

20. The role of the CfWI as envisaged in the Next Stage Review has considerable potential to support the role of LETBs; however the function of the organisation currently has focused on profession specific information and has had little engagement at organisational level. Unless we create an integrated healthcare system it will always be difficult to express workforce needs in anything other than profession specific terms; however there is insufficient use of scenario planning and competence based planning when future workforce needs are articulated.

21. For the centre to contribute effectively to workforce planning and education commissioning—there is a need to confirm the core role and for the LETBs (perhaps through HEE) to commission the work of CfWI in the future.

How funding will be protected and distributed in the new system

22. The governance arrangements of the LETB must include accountability for the way in which funding is spent—ensuring that the funds allocated for education and training are spent for that purpose.

23. Funding needs to be allocated fairly across the country, and whilst a funding formula for allocation may be helpful; it also preserves the status quo and may not facilitate the training of the workforce for future service delivery eg increased service delivery in primary and community care. It is recognised that this may have a disproportionate effect in some organisations—but the shift in resources does need to take place and prolonged transition may not be helpful.

How the public health workforce will be affected by the proposals

24. The partnerships developed at health community level should ensure that the needs of the public health workforce are identified and planned for; however there is a risk that there will be a lack of clarity around the role and responsibilities of the LETB and the local authorities in relation to commissioning and developing the public health workforce.

Conclusion

25. The priority for Lincolnshire is have a system for workforce planning and education commissioning that gives employers greater accountability for, and ownership of, the development of the healthcare workforce and the success of the system is dependent on the funding flows, the role of Health Education England, the function of the LETB and the level of accountability and autonomy of healthcare providers (which may vary depending on FT status).

26. The staff of the NHS are its greatest asset but employers have had constrained influence in the education, training and development of their workforce. Lincolnshire wants to ensure that we are part of creating a system that is accountable, responsive and transparent, which will deliver excellence in outcomes and in patient experience.

December 2011
Over 6,500 babies die just before, during, or soon after their birth every year in the UK. More babies die during this period of their early lives than at any other stage of childhood.

The number of stillbirths has not changed in more than a decade. Yet many hundreds of babies’ deaths could be avoided with better care and more research. Around 500 babies die every year because of a trauma or event during birth that was not anticipated or well managed.\(^{115}\) These deaths, when they occur at term, should never happen and almost always could be avoided with better care.

Without adequate training, staffing and skills mix, Sands has great concerns over whether services can be safe. Under-resourcing across the board in maternity and neonatal care has very real and tragic consequences. Yet calls to achieve even minimum staffing levels in these areas are still not being met.

In addition to this, in those events that end in the tragic death of a baby, the quality of the care given to bereaved families is crucial and can have long-lasting effects. At a time of overwhelming distress parents need the right support from trained staff in making important choices about the precious and painfully short time they have with their baby.

**A. Background: About Sands**

Sands, the stillbirth and neonatal death charity, was founded in 1978 by a small group of bereaved parents devastated by the deaths of their babies, and by the total lack of acknowledgement and understanding of the significance and impact of their loss. Since that time, Sands has supported many thousands of families whose babies have died, offering emotional support, comfort and practical help.

Today Sands operates throughout the UK and focuses on three main areas:

- supporting bereaved families;
- working in partnership with health professionals to promote awareness of perinatal mortality and provide professional training in bereavement care. (Our widely acclaimed publication *Pregnancy Loss and the Death of a Baby: Guidelines for Professionals* is now in its third edition); and
- funding research that could help to reduce the loss of babies’ lives.

**B. Case Studies/Personal Experiences**

It is well recognised that many aspects of perinatal and neonatal service delivery are under-resourced but few will acknowledge publicly that under-resourcing, when unsafe, can lead to a death.

**Baby Louie**

Between her arrival at the hospital, just after 9.00 am on 17 May 2011, and the birth of her baby Louie, just after 11.00 pm that day, Michelle Hemmington was under the care of eight different midwives but developed a relationship with none of them.

Michelle was offered a warm bath to cope with the pain and then moved to triage because there were no beds free. During that time—nearly five hours—no one came in to monitor mother or baby. Michelle’s sister tried to call for more gas and air because it had run out. When a midwife did arrive 45 minutes later Michelle was 8cm dilated.

Michelle was moved to the labour ward where Louie’s heart began to decelerate. The midwife asked for assistance but the obstetric registrar was in theatre. The consultant wasn’t called, and there was no “fresh eyes” protocol for the CTG. By now Louie’s heart rate was deteriorating further.

“I kept saying, ‘I can’t get him out’. I asked several times for an emergency section but they told me I was too far gone.”

The paediatric registrar arrived, stayed in the room for only three minutes, and left without giving any instruction, leaving the midwives bewildered. Within minutes Louie was born and put on Michelle’s chest but then swiftly taken away. “There was lots of commotion suddenly and I heard them shouting for a new resuscitaire”. Nearly half an hour later Michelle and her partner Paul were told Louie had died. The post mortem indicated Louie had been starved of oxygen and had signs of a pneumonia infection.

The hospital initiated a Serious Incident investigation and concluded among failures in communication, team work and training, that the lack of continuity of care and the 12-hour work shift of the labour ward co-ordinator, during “a high-activity day”, had affected her ability to allocate risk. There had been several warning signs to escalate Michelle’s care, but they were all missed by every speciality.

The current mantra in maternity care delivery is choice but every woman’s first choice is to have a healthy baby. Michelle chose a hospital birth because she thought it would be safer than being at home: “But I felt totally left alone. It's not just one person who failed us, it’s the whole system.”

Safety and quality are currently threatened by under-staffing in every area of perinatal care, from midwives to specialist pathologists.

**Baby Amaari**

On 18 August 2011, Dharmistha Patel gave birth to her stillborn daughter Amaari on a busy labour ward. Although the pain of hearing other mothers welcome their new babies into the world when Dharmistha knew her own was dead was unbearable, she was also moved by the dedication of her midwives. “One of the midwives didn’t leave my side for 13 hours. She went out to get things for my care but didn’t stop for lunch. I’m indebted to her. I’ve spoken to other people who had terrible experiences and I think it makes it 10 times harder to deal with.”

The Patels were told they could have a memory box for Amaari, if they wanted. Initially they said no but then changed their minds, taking hand and foot prints, a lock of her hair and photographs and dressing their daughter. The hospital helped arrange Amaari’s funeral and a bereavement midwife remained in touch when the Patels had questions later.

The Patels consented to a full post mortem which revealed Dharmistha had blood clots in her placenta, information that will impact the management of a subsequent pregnancy.

Compare the Patels’ experience with that of Anna and Andrew Milloy, just 100 miles away. Like the Patels, their baby girl died with no warning during labour at home. It was New Year’s Eve 2008 and Anna was transferred by ambulance to hospital where Philomena was finally delivered.

After a sleepless night, Anna, tired and devastated, asked to take Philomena home but was told by hospital staff that her request was “very strange” and would create more paperwork for the hospital. “I wanted to go home but I just couldn’t leave her at the hospital. I just couldn’t be separated from her”.

Anna’s wishes were eventually met but she and Andrew did not have a post mortem “I just assumed that by wanting to take Philomena home I’d effectively turned down the opportunity of having a post mortem,” says Anna.

The care that thousands of bereaved families receive every year around the time of their baby’s death is extremely important. Good care cannot remove the pain of loss, but care that is inadequate or poor makes things worse and affects a family’s wellbeing both in the short and long-term.

**C. Staffing for Quality and Safety**

The Royal College of Midwives (RCM) is petitioning the government for 5,000 more midwives across England and warns that current shortages are affecting both quality and safety:

“Births are also becoming increasingly complex needing more of midwives’ time. The combination of this and the rising birth rate is a dangerous cocktail threatening the safety and quality of maternity care. It means that too many maternity units across England are under-staffed and under-resourced to meet the demands made of them.”

Cathy Warwick, General Secretary, RCM

At the same time, warns Cathy Warwick, “the midwifery workforce is ageing dramatically, and student training numbers into the future are not guaranteed.”

Safe, high-quality maternity care also requires the right skills mix so that staff can respond to problems when they arise." In its latest report High Quality Women’s Health care: A proposal for change, the Royal College of Obstetricians and Gynaecologists (RCOG) states its concern about the continuing lack of 24-hour obstetric cover on wards:

“Despite the expansion in (consultant) numbers, consultant presence on the labour ward still falls woefully short of the recommendations made in multi-professional standards.”

The potentially tragic consequences of under-resourcing are borne out by research into the risk of perinatal deaths during the normal working week versus at night and weekends. A recently published analysis concluded that the risk of neonatal death increased by 45% for babies born out of hours. Although 70% of babies are born at night, maternity units are not a 24/7 service.

In 2010 Bliss, the special care baby charity, reported a desperate shortage of 1,150 neonatal nurses. However, in July 2011 Bliss’ survey of neonatal units found that one in three hospital units caring for premature infants was woefully short of the recommendations made in multi-professional standards.

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117 The State of Maternity Services Report, Royal College of Midwives, 23.11.2011.
118 High Quality Women’s Health Care: A proposal for change, Royal College of Obstetricians and Gynaecologists 2001.
121 The chance of a lifetime?, Bliss 2010.
and sick babies: “have or will be making cuts to their nursing workforce over the past year or in the coming 12 months". 

“Already more than half of units do not meet the Department of Health and NHS’s Toolkit for high quality neonatal services (Toolkit) standards...122 Cuts will have an impact on the survival rates and long-term health of children in neonatal care.” 123

Resource pressures extend through to the provision for families after a death. The Royal College of Pathologists estimate that a 20% increase in the numbers of perinatal pathologists is needed to deal with even the current low rates of post mortem uptake. A recent survey reported 30% of the perinatal pathology workforce will retire between 2013 and 2018. 124 It is not clear what strategies there are to replace them.

The resourcing of perinatal pathology services varies widely between regions meaning that babies often have to travel long distances for a post mortem and that post mortem reports are often unacceptably slow in reaching parents.

Staff training is a further concern. Stillbirths barely feature in undergraduate or on-the-job training for doctors and midwives. It is left to Sands to provide this information through our multi-disciplinary training days in bereavement care. During these sessions clinicians routinely admit their lack of awareness of both how common stillbirths are and how profound the impact a baby's death is.

As the NHS undergoes the upheaval of re-organisation and financial constraints against the backdrop of a changing population with greater health needs, the care of babies must not be even further demoted. Women and their families expect and deserve safe care, delivered by the right people at the right time, and co-ordinated across all specialities.

D. Care After A Death

Based on research evidence, discussions with professionals and parents' experiences, Sands' Pregnancy loss and the death of a baby: Guidelines for professionals sets out standards for care for parents whose baby dies during pregnancy, labour and shortly after birth. Widely-acclaimed, the Guidelines are now in their 3rd edition.

In 2009, Sands ran an online survey of maternity units in the UK with the aim of finding out how far units were following recommendations set out in the Guidelines. While there have been improvements in care in the past few decades, it was clear from the results that not all units feel bereavement care is a priority. In around 20% of the units that responded care is still poorly resourced and organised. In other units care is patchy. 125

The survey found, for instance, that 52% of units have no designated bereavement support midwife. Nearly half of all units (45%) have no dedicated room on the labour ward for mothers whose baby has died to give birth, and a quarter of all units have no room away from the postnatal ward where bereaved parents can be cared for after the birth without hearing the sounds of other mothers and their live babies.

Some parents want to take their baby’s body home or to a place that has significance for them. There are no legal reasons to stop parents from doing this, but 31% of units did not offer parents the option.

We know that many parents suffer a significant drop in income following the death of their baby 126 and that perinatal deaths disproportionately affect parents in poorer socio-economic groups. Yet in 56% of units parents are given no information about their entitlements to time off work, benefits and payments.

When a baby dies almost every parent will want to know why. But a parent’s need to know what happened is often in conflict with a feeling that post mortem investigation is invasive and their child has "already been through enough." 127

Coupled with this, the organ retention scandal of a decade ago generated a good deal of negative publicity for pathology services, and post mortem uptake rates fell from 55% in 2000 to 45% in 2009 for stillbirths and from 29% to 18% for neonatal deaths. 128 Meanwhile confidence in the value of post mortem has fallen, not just among the public but among professionals too.

Research recently funded by Sands, and undertaken by the University of Manchester aimed to gauge how confident and well trained doctors and midwives are in taking consent for post mortem by asking professionals as well as parents about the experience. 129

122 Principle 2.2.3: A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care" Toolkit for high quality neonatal services, Department of Health and NHS 2009.

123 SOS: A Bliss report on cuts to frontline care for special care babies, Bliss 2011.

124 British Paediatric Pathology Society and the Paediatric Special Advisory Committee survey of retirement intentions, Royal College of Pathologists 2008.

125 Bereavement Care Survey, Sands 2010.


The survey found that 36% of midwives who have had training in taking consent, were dissatisfied with it. While 50% of obstetricians have actually seen a post-mortem, as recommended by the Human Tissue Authority, only 4% midwives have seen one. As many as 32% of midwives and 36% of obstetricians underestimate the value of a post mortem.130

There is huge variation in post mortem consent forms around the country; many are long, complicated and distressing to read. At least half of the parents surveyed by Manchester University weren’t satisfied with the information they received when asked for consent.131 Sands and the University of Manchester are developing a national post mortem consent form in consultation with stakeholders as well as the Department of Health and the Human Tissue Authority.

But if it is to have any impact the new form must go hand in hand not just with training but also with improvements to the resourcing of perinatal pathology services. Lack of workforce planning in this area suggests investigation into perinatal deaths is simply not valued.

Sands’ vision is for a Bereavement Care Pathway which sets out minimum standards for every aspect of care from bereavement to post mortem and support in another pregnancy.

E. Recommendations for Improvement

— Urgent action is needed to ensure minimum levels of staffing and the right skills mix in all areas of perinatal life and death—in maternity, in neonatal care and in specialist pathology services—as outlined and in consultation with the relevant professional bodies.
— Medical training for doctors and midwives must include a module on the risks and impact of perinatal death to improve awareness and understanding.
— Managers and service commissioners must fund and organise bereavement services in line with Sands’ Guidelines for Professionals, and to include high quality perinatal pathology services.
— There must be support for the development and implementation of a Bereavement Care Pathway, outlining minimum standards of care for bereaved families.
— Trusts should adopt the national perinatal post mortem consent form and improve training in consent taking in tandem with the form.

IN CONCLUSION

We have real concerns about the potentially devastating impact if there are not the right numbers of appropriately qualified and trained healthcare staff looking after mothers during their pregnancy and birth. Failure to provide or plan for adequate perinatal pathology services suggests these deaths are swept under the carpet as unimportant. We urge the Government to consider the facts presented in this evidence when developing workforce planning recommendations. We would also urge the Government to consider that training curricula is updated with the support of third sector organisations such as Sands to include the risks and impact of perinatal death to improve general awareness and understanding, bereavement care and support, and post mortem consent for bereaved parents.

December 2011

Written evidence from NHS North West (ETWP 87)

INTRODUCTION

The North West Workforce and Education Directorate of the North of England SHA Cluster welcomes the Health Select Committee (HSC) Inquiry on Education, Training and Workforce Planning and the opportunity to contribute in the form of this written submission. The inquiry is wide ranging in its examination of the Government’s plans regarding the future healthcare education arrangements.

Our comments reflect our submission to the Future Forum, following consultation with all NHS employers and key stakeholders in the North West and covers the key themes and specific issues as set out in the Committee’s terms of reference.

KEY THEMES

1. The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

This will be addressed by strategic workforce planning, effective partnership working and use of planning models. Employers are anticipated to more directly link priorities and risks when given responsibility for workforce planning and training budgets. Providing effective learning environments (see paragraph 6) is a

crucial part of this and we have developed educational governance guidance to help North West organisations meet the appropriate high standards.

2. Training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

This represents a significant challenge, particularly in the current financial climate and the complexities of shifting service provision to the community, whilst maintaining current hospital infrastructures safely. It will be addressed by continuing to work in partnership with regulators, service colleagues and education providers.

3. All providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

This will be addressed by engagement, partnership working and providers’ own desire for an effective and efficient workforce. The governance arrangements and statutory duties also play an important role as non-NHS organisations will need to sign up to training commitments in order to benefit from outputs of training and create a more level playing field.

In the North West, both the workforce and the education and training commissioning plans are tested out annually with service commissioners as well as all the employer organisations.

4. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

Learning in and from teams on clinical placements is being actively promoted. The significant investment in education, training and clinical skills facilities, including those in primary care across the North West, is an example of how Multi-professional Education and Training (MPET) funding has been used to promote multi-professional training and development. This is only really successful if focused on the patient pathway and service improvement rather than professions, though it is absolutely right that specialist skills are acquired separately as appropriate and professional identity is created.

The most successful initiatives also tend to be where traditional hierarchy has been levelled and all grades of staff are encouraged to contribute to discussions about patient care and where there is the potential for it to be less than excellent. Accountability is first and foremost from the individual to their employer and, where regulated, to their profession. This requires a focus on good team management where every individual is held accountable for their contribution regardless of whether regulated and professionally qualified or not.

Patient safety is also enhanced by ensuring all staff have good levels of literacy and numeracy, accessing SFA/NAS funding where eligible, to achieve the appropriate basic skills and competence and help stimulate a learning culture across the whole workforce.

5. High and consistent standards of education and training

High and consistent standards are promoted through the use of Learning and Development Agreements (LDAs) and formal contracts with education providers. Regular reviews of these agreements take place, serving to inform regional benchmarks and create opportunities to share practices.

There is a huge amount of quality assurance that takes place through regulatory bodies, including the Qualifications and Curriculum Authority (QCA) in the case of HEIs; OFSTED in the case of colleges and other education providers funded by SFA/NAS and our two Deaneries, through their visits and reporting to the GMC on the quality of postgraduate medical education and training.

Great importance is given to feedback on the student/trainee experience and there has been a great increase in the involvement of patients and carers in devising training, taking part in training and feeding back on trainees. More consistency and portability in training has been achieved through increased standardisation of qualifications where possible, with much greater widening participation in learning to support skills development and provide better standards of care.

The Education Commissioning for Quality and draft Medical Quality Indicator frameworks recently introduced, are going some way towards even greater consolidation of quality markers across professions. The Education Outcomes Framework, whilst noting is in the early stages of development, is attempting to make a more explicit link between training provided and outcomes for patients and service delivery, utilising the domains of the general outcomes framework for NHS services.

6. The existing workforce can be developed and reskilled for the future (through means including post-registration training and continuing professional development)

We consider ensuring employing organisations taking on a learning organisation culture is the best way to achieve this. This is supported by a good evidence base and could be undertaken as a standard for taking on placements. This also supports better staff involvement and engagement, further supported by good evidence and as part of the NHS constitution pledges. Our most successful organisations are also those that are good at
education, both at GP practice and large organisation level. We have developed education governance guidance for our organisations to help them with this.

Ensuring good CPD for the workforce is a crucial part of the work of the future provider led networks as that has been the feedback from our own Delivering the workforce programme board and stakeholder forum. We would therefore naturally be concerned about any cuts in CPD, both because of the risk this could pose to the quality and safety of patient care, as well as the wider individual and organisational benefits of on-going personal and professional development. CPD activity is increasingly a focus of regulatory and assurance monitoring processes and any reduction or withdrawal of funding would only exert further burden on what are already often pressurised budgets.

Our patient forums report the caring nature of staff with appropriate behaviours and attitudes is particularly important to them. Ensuring this culture is part of all education and training and is a task and duty for provider led networks, through placement standards and education contracts. This is important for the whole workforce not just the registered professions. It will be helpful if this focus on the NHS Constitution's values and behaviours, is reinforced by HEE, by making it a key part of its approach to quality, in meeting the Educational Outcomes Framework.

A key emphasis for workforce modernisation is the development of support workers (AfC Bands 2–3) and Assistant Practitioners (AfC Band 4–5). Current areas of work include pharmacy technicians, ODPs, maternity support workers, higher level apprentice scientists, mental health support workers as well as those in intermediate care and primary care. Roles at this level are seen as key to improving skill mix within teams. Training for non-medical prescribing is also much in demand to enhance the patient experience and avoid delays, with very specific training and responsibilities given for certain areas and drugs.

Work is also continuing on developing Advanced Practitioners, particularly in areas where there may be vacancies in traditional roles and more innovative solutions are required. This has been particularly successful in primary care, where practice nurses take on many of the roles that were previously seen as those of GPs with clear boundaries and protocols set. There is increasing usage of paediatric and neonatal specialist nurses, trained by consultants in the workplace setting as well as having underpinning academic learning, to take on the duties that might previously have been done by junior doctors.

7. Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

SHAs are focusing on widening participation initiatives ie both widening access to higher education through access/bridging/foundation courses, but also in widening participation in learning—particularly where the individual’s experience of school or personal circumstances meant that they did not gain many formal qualifications. There are now several assistant roles that can provide the stepping stones into registered training at graduate level and above, and many stories of individuals starting out with no GCSEs and ending up at PhD level study through their course of their working life within health care.

The use of flexible training routes and part time courses are often important ways of providing equitable access to career progression, with accumulation of learning credits in smaller chunks rather than one continuous qualification.

Specific Issues the Committee will Look at

8. Plans for the transition to the new system, up to April 2013

A key issue is establishing the legal entity of the provider led networks/LETBs.

SHAs are awaiting detailed guidance from the Department of Health (DH) but are establishing interim arrangements eg the North West Programme Board is overseeing the establishment of three Network Leadership Groups, as formal sub-committees of the North of England SHA Cluster Board. The Groups are chaired by a Provider Chief Executive and have strong employer representation and there is wide stakeholder involvement. The impact of uncertainty is being dealt with by strong leadership locally, staff communication and engagement and progressing the development of provider led networks/LETBs. However there are inevitable strains being put on the system in coping with all the changes.

We have concerns about the proposed social enterprise model which would put expertise and corporate memory at risk. It is unlikely to get NHS staff to transfer into the function in the future, though current staff would be protected, and it is also likely to split medical and non-medical training at a time when it is working more closely than ever.

It is important that current SHA responsibilities are transferred safely to the provider led networks/LETBs. These include:

(a) Workforce strategy and planning.
(b) Education commissioning and workforce development.
(c) Postgraduate medical and dental education.
(d) HR Strategy.
9. The future of postgraduate deaneries

Postgraduate Medical and Dental Deaneries are a critical element of provider led networks/LETBs, and they are a core part of SHAs. The Postgraduate Deans are key members of their respective Network Leadership Groups in the North West. The size of these Groups and robust governance arrangements means that no single healthcare organisation has the ability to dominate. This combined with the requirement to meet the standards set by the professional regulatory bodies (GMC for medicine) and robust contractual arrangements, will mitigate concerns about conflict of interest, which is one of the issues raised during the consultation period. Whilst SHAs and in future provider led networks/LETBs, are bound by national plans in some areas such as junior doctor training numbers, there is the necessary flexibility to reflect local priorities. Strides have been made in recent years with healthcare employers in considering skill mix more fully and looking to ensure that specialist skills are used for more of the time, with general support provided where it makes sense and a blurring of boundaries around tasks.

It is critical that the whole workforce can be considered in one place, (as now in SHAs), as there are very strong messages from service managers that they are happy to plan on patient pathways to consider the most appropriate workforce and that the focus should be around the patient, drawing on general caring and more specialist skills as appropriate. SHAs have very much been the conduit to positive work between professions and also between service and education colleagues in meeting needs through devising suitable training that provides appropriate qualifications (though not necessarily regulation) to reflect skills required, including leadership and management skills. The new arrangements will enable this approach to continue but with the benefit of greater employer involvement and accountability.

The MPET SLA (see paragraph 21) sets out the key elements of the Service Level Agreement between the DH and SHAs for the utilisation of MPET funding. It also sets out how key NHS Operating Framework requirements eg Health Visitor numbers will be met.

The Learning and Development Agreement (LDA) is critical for holding employers to account for the delivery of training and development and its quality across the board, complementing contracts with education providers so that both academic and placement quality is maintained, and also complementing professional regulator activity. This helps to ensure consistency and portability of qualifications to help with patient safety, avoidance of repeating elements of learning and, therefore, maintenance of staff morale and maximum value for money from training.

There needs to be some flexibility in any national planning to allow for regional variation and particular priorities at any one time. Employers are also less likely to engage in training if they do not perceive that there is some recognition of local issues and local involvement. This represents a major challenge in planning the future medical workforce requirements given the long lead in time for training doctors across a wide range of medical specialties. It will need to be managed effectively between HEE and the provider led networks/LETBs.

10. The future of Health Innovation and Education Clusters

Health Innovation Education Clusters (HIECs) were established in 2010 with two years pump priming monies. Their primary purpose is to bring together all partner organisations in an area, with the aim of securing adoption and diffusion of best practice, innovation, research and development through education and training. In the North West the three HIECs, which are coterminous with the three Network Leadership Groups, have initiated a range of projects and facilitated effective partnership working between NHS Organisations, the HEIs and other partner organisations in the localities. It will be for the new provider led networks/LETBs to find funding to support HIECs if it is considered that they have been effective—the decision will focus on the share and spread of existing innovation and developments rather than trying to create other things.

11. The role of the Secretary of State for Health in the new system

It will be important for the Secretary of State to have overall accountability and to ensure that MPET funding is appropriately protected in the new system.

12. The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

The multi-professional nature of HEE will provide important opportunities to address the changing nature of healthcare and the requirements of workforce development. It is recognised that clear accountability arrangements between LETBs and HEE are essential but that HEE must acknowledge and respect the need for appropriate local determination. A key enabler will be the ability to utilise some funding to meet training needs around patients and service needs in addition to meeting a specific training number in regulated professions in undergraduate or post-graduate medical/dental. Also to be able to utilise unused funding within traditionally...
allocated numbers across different professions to support more skill mixing and, therefore, appropriate use of
skills and expertise for more of the time.

This is possible as, despite national numbers, trainees do not opt to distribute themselves according to
theoretical geographical allocations, resulting in some shortages (often in rural areas) whilst popular cities and
locations have a wide choice of employees.

13. 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

We believe that the right balance between HEE and Provider led Networks is to ensure functions are done
as locally as possible unless they need to be done a level up. We think that most good education and training
needs to be undertaken at organisation level. At provider led network, we would expect only those things that
are best organised at a regional level, such as contract management, doctors in training coordination and overall
workforce needs assessment. We believe that HEE needs to provide a strategic framework for provider led
networks to work within but should not commission or organise education and training directly. It should
commission the networks to undertake this including lead commissioning on behalf of other networks for
smaller professions.

We think that it is vital that the provider led networks are part of the NHS either as new NHS statutory
bodies or through hosting by Foundation trusts. We do not consider the social partnership approach will enable
us to keep sufficient staff to carry out the planned responsibilities at provider led network level. The
authorisation framework will define the relationships, roles and responsibilities for providers as members of
the networks. We would emphasise the statutory duties on providers to provide workforce plans and to
participate in the networks. We believe that each provider led network as part of its authorisation should have
an overarching workforce and education and education commissioning strategy for its area which would ensure
a complete portfolio of education and training for the workforce in its area.

Conflicts of interest will be dealt with by all board decisions being based on principles rather than application
to specific organisations. Members will be representative of their constituencies rather than organisation and
board members will withdraw if a decision is specific to their organisation. The key issue is having strong and
effective governance arrangements with effective stakeholder arrangements. In the North West HEIs and other
key partners are involved with the provider led networks. HEE will have to have appropriate links to the NHS
Commissioning Board to ensure triangulation of service, finance and workforce plans with appropriate links to
CQC and monitor. Clinical Commissioning Groups will need to have appropriate local links to LETBs.

14. How professional regulators, healthcare providers and commissioners, universities and other education
providers, and researchers will all participate in the formulation and development of curricula

As they do now but with even greater involvement of providers. Examples: HEI partnership boards for
placements, NMC consultations on curricula and GMC for approving learning environments.

In the North West we believe we have had a strong focus on partnership working which has been invaluable
in achieving our aims. This has included research through our alliances with Universities and promotion of our
AHSC, other research and innovation activities and strategy and maintaining a regional R&D team to support
local R&D alliances. The three HIECs in the North West have full HEI membership as well as all NHS
organisations in each of the localities and therefore capture all stakeholders including the AHSC.

Our partnership working has been based on our values, shared with stakeholders; clear and transparent
communications on a regular basis with all stakeholders; long term trust relationships using many forums,
meetings, shared membership and face to face individual work; clarity of roles and a thrust towards promoting
collaboration between our stakeholders not just between us and them. This can be evidenced by national
feedback from our local Council of Deans and regional staff partnership forum as well as the willingness of
our providers to become engaged in these changes at executive director level. Our emphasis has been on
partnership and collaboration rather than competition. This has meant our provider organisations and
universities explicitly setting aside their competition aims for specific collaborative work.

In the North West we have a strong tradition of partnership and collaborative working, not just in education.
Our Leadership Academy, Quality Observatory: AQuA and HIECs are good examples of this approach. We
feel these approaches should be embedded in the authorisation criteria and model governance frameworks
produced by HEE for provider led networks.

15. The implications of a more diverse provider market within the NHS

There has always been a diverse provider market eg Nursing Homes, independent healthcare providers. It is
acknowledged that that there have been difficulties with engaging with the independent sector, particularly as
social care does not have an equivalent of SHAs. Networks will need to involve wider partners to ensure there
is maximum collaboration, eg training of care home staff in End of Life Care—a joint programme to meet
patient needs driven by SHA, service partners (ie care home managers) and skills for care. The focus is likely
to be on training to prevent unnecessary emergency admissions at end of life by increasing confidence in staff and creating sustainable training programmes given high staff turnover prevalent in this sector. A risk that will need to be carefully managed will be medical training, if the service in acute Trusts remains dependent on medical trainees for delivery and a range of alternative providers deliver elective care.

Equally, the terms and conditions under which clinical placements are facilitated/managed should be consistent across all Providers (NHS and non) to maximise both flexibility of use and breadth of student experience and avoid the any risk of disadvantage.

16. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

By effective workforce strategy and planning for NHS commissioned care rather than specific providers. There are particular challenges when looking at social care requirements.

17. The role and content of the proposed National Education and Training Outcomes Framework

The draft education outcomes framework provides good high level domains which can provide the necessary granularity to improve both the quality of education and transparency of information about that quality. This now needs further development on the detail so appropriate metrics and/or indicators are developed that allow linkage to patient outcomes. There is already a lot of evidence and data to support the training process, but less analysis of its effective application. ROI type methodology is useful here so employers are clear about why staff are undergoing training, what expected product or outcomes will be and how these will be applied in practice.

We believe quality of education and training will be driven by education governance in each provider organisation. We are happy to send you our guidance on education governance if the Committee would find this helpful. By ensuring board level activity in education, we think publication of standards will follow. Transparency about CPD provision, take-up and outcomes will ensure quality improvement. We think there are currently many means of achieving good feedback on quality including student experience, trainee surveys and PROMs but that these should be bound together by some HEE development work to provide consistency nationally.

There may be a role for the Centre for Workforce Intelligence in collecting and comparing education outcomes framework information of specific provision such as education providers either for placements or within University programmes.

18. The role of the Centre for Workforce Intelligence

To provide high quality workforce intelligence data, as reflected in their contract with DH and their business planning process.

19. The roles of Skills for Health and Skills for Care

Both sector skills councils should continue. There is a view that they should not be merged as the workforces are distinct though it is possible for some joint working.

20. The role of NHS Employers

NHS Employers should play a key role in pay and conditions national negotiation. It also has an important role as an independent body for providers, supporting HR strategy as well as joint activities with SHAs across England.

21. How funding will be protected and distributed in the new system

By funding going to HEE and LETBs, HEE can build in control and accountability to LETBs for use of funding through the authorisation process and formal contract. However, this cannot be overly prescriptive as needs will differ locally but usage should be transparent with clear accountabilities.

**Multi Professional Education and Training (MPET) Service Level Agreement (SLA)**

An SLA exists between the Department of Health and the Strategic Health Authorities (SHAs) for the utilisation of the Multi-Professional Education and Training (MPET) Budget. This SLA sets out the Department of Health’s main expectations for the use of this funding. The document details the expectations and key performance indicators for MPET under the five headings of:

1. Undergraduate medical and dental education placement funding;
2. Postgraduate medical and dental education funding;
3. Nursing, Midwifery, Allied Health Professions and Healthcare Scientists education funding;
4. Student Bursaries; and
5. Wider workforce.
MPET investment planning and decisions of SHAs should also take into account the NHS Operating Framework for 2011–12. MPET allocations are negotiated nationally as part of the CSR process and are managed by Executive, commissioning and finance staff employed in SHAs and postgraduate deaneries, in consultation with NHS service providers and non NHS providers of education and training.

National/Regional MPET Allocations

The national MPET allocation for 2011–12 was £4.8 billion and is split between its three sub levies as follows: SIFT (Undergraduate training) £923 million; MADEL (Medical and Dental) £1.8 million; and NMET (Non Medical Training) £2.1 million. The allocation for NHSNW is £688 million in 2011–12 which reflected a cost pressure of c3% given the allocation was a flat cash settlement, with the requirement to fund a number of new in year cost pressures such as Health Visitors, IAPT, BMP price inflation and GP expansion in line with DH targets. Any under spending of previous years has been carried forward and not lost to the local MPET levy. This reflects good business sense as contingency funds are always required, especially in a complex environment involving funding for training from MPET, HEFCE, SFA/NAS, employers themselves and other sources—most of which are in the process of major change and review and involve many variables.

It is critical that robust governance arrangements are in place to manage these material allocations and ensure public money is used cost effectively with training and education not being prioritised for cuts above other areas. Such actions would potentially compromise the ability to train the workforce of the future with all its associated consequences.

Future MPET allocations policy should address the disproportionately lower resources available to SHAs/LETBs outside of London. Part of this will be introduced with the standard education placement tariff for medical students, which will redress the 40% funding currently in London.

Secondly, the distribution of doctors in training posts needs to be addressed, recognising the service implications of moving junior doctor posts. The North West remains under doctored, especially for GPs and needs more training numbers, which are more likely to then work within the North West. The North West has the highest retention rate after training in England, of doctors in training at 90%.

Potential Future Reductions in MPET Funds

As previously advised the allocations have been rolled forward from 2010–11 and this is again anticipated for 2012–13. Pressures such as training more health visitors, contractual Bench Mark Price (BMP) increases with Universities and improving access to psychological therapies (IAPT) have been funded from within these monies.

The cost pressure will be the sum of:

(a) cost shifts from other budgets to MPET—some transfers expected;
(b) M price inflation on University contracts (approx 2%);
(c) price inflation on NHS contracts where salary support provided—medical pay freeze should limit this but also applies to other professions, eg scientists;
(d) volume reductions—some MMC posts are due to fall off this year;
(e) volume increases we are committed to—undergraduate placements, GP expansion, Health visitors, IAPT, increased numbers of students already in training (due to improved retention/reduced attrition rates); and
(f) other—eg cost of extended GP training due to increase failure rate, transfer of funding to BIS to fund additional student loans under new bursary scheme, payment of £9k tuition fees for medical/dental students in final years of training.

The options to manage the pressure are:

(a) reduce training volumes—especially Non-Medical CPD type spend as produces a saving in a shorter time frame (NB this applies to 91% of the health workforce);
(b) reduce rates paid to the NHS for salary support of placements;
(c) reduce management and administration costs;
(d) reduce or remove additional support funding to students in training for travel to placement, etc; and
(e) cease any developmental activity or innovation other than that delivering core training, eg clinical skills facilities and co-ordination to maximise usage, apprenticeship support, pilots to develop new learning models, eg making every contact count for public health awareness, leadership development and change management, return on investment training.

As identified the management of these issues requires robust governance arrangements utilising qualified, well trained and dedicated workforce and education staff into the future who can work
with HEE to deliver national objectives in local areas liaising closely with service providers who ultimately benefit by recruiting the right numbers of well trained staff.

**Implementation of a training tariff**

Proposals for the introduction of a full training tariff are now in an advanced stage. This has been in response to the fact that there is evidence of wide variances in the placement rates paid for undergraduate medical students in NHS organisations and there are no placement payments for other trainees or students. The salary contribution rates offered to medical and dental trainees are also in need of review due to inconsistencies.

Tariffs are a good lever for improving quality (for undergraduate medical students) and ensuring a consistent benchmark for delivery against a set price for training in practice. Discussions are continuing for postgraduate trainees, who form an essential part of the delivery workforce, to assess the appropriateness of the tariff. The aim should be equal reward for taking students/trainees with a standard tariff and money following the student/trainee.

A tariff system does currently operate for tuition payments to Universities covering non-medical education commissions and is negotiated nationally as a benchmark price. Clear benefits have been apparent since this was implemented, which have resulted in transparency of contractual details, reduced administration and improvements in planning capability.

Whilst tariffs would allow funding to follow trainees it may also result in perverse incentives to just invest in medical training (due to higher tariffs proposed) and opt outs of training for other professions. They are currently reliant on good will, professional responsibility and subsidised funding from other areas within service provider organisations.

There are real benefits to be obtained from the introduction of a tariff which is a key part of the Workforce and Education proposals which will assist in the creation of a package of training to encourage the development of NHS staff across the whole range of professions. Ensuring successful implementation will require strong leadership and decision making over a transitional period led by the new Workforce and Education organisational structure bearing in mind the interests of local provider bodies.

**How funding will be protected and distributed in the new system**

By funding going to HEE who will allocate resources to LETBs, HEE can build in control and accountability to ensure LETBs meet national objectives whilst also having the local flexibility to manage local issues.

22. **How future healthcare workforce needs are being forecast**

Good strategic workforce planning—will require a strengthened approach within employers to co-ordinate all workforce needs. This has not been strong in the past as the responsibility for education and training budgets largely rested with SHAs, so the new system should strengthen interest and understanding. A five year workforce planning horizon is required to allow for the time between education commissioning and the production of new graduates for non-medical courses. Foundation Trusts (FTs) work on five year planning, but there is uncertainty about funding in the next CSR round.

The delay between commissioning undergraduate medical education and achievement of CCT is significantly longer (five years undergraduate plus two years foundation followed by three to eight years specialty training to certificate of completion of training (CCT)). There are pitfalls with long term planning due to service changes as evidenced for example, by a significant number of cardiac procedures now being carried out by interventional radiologists as opposed to cardio-thoracic surgeons.

There are considerable concerns about the high numbers of doctors in training currently and completing over the next three years, when there are limited numbers of service posts becoming available. Work to address this material problem is being taken forward nationally with MEE, DH, CIW1 and the Royal Colleges.

Having local partnership groups and various networks does help to raise awareness of this and it is critical that these remain and that there is even greater strategic focus on longer term workforce planning with mechanisms to be fleet of foot when necessary.

23. **The impact of people retiring from, or otherwise leaving, healthcare professions**

This is taken into account by effective workforce planning and modelling to align with education commissioning.

24. **The place of overseas educated healthcare staff within the workforce**

This is very limited now due to immigration controls. It is important to enforce regulator standards of language fluency, credentialing of qualifications—the NHS is experienced in doing this. Potential risk of greater recruitment of overseas students by HEIs onto health courses in future to help compensate for reduced commissions and other financial changes in HE. This may pose some difficulty in that overseas students may be willing to pay more to participate in placements, which would disadvantage MPET funded students and
apply more pressure to this already difficult aspect of training to organise in ensuring sufficient placements. Whilst non-EU students may have to return to their country of origin, EU students will be in the market, but there will be limited information about them to take account of in workforce planning and education commissioning.

25. How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

It will be the role of HEE to link with the other countries of the UK and sector skills councils which cover the UK. Links already exist between UK countries in education commissioning and workforce planning networks, which should be continued.

26. How the public health workforce will be affected by the proposals

This will be part of what the provider led networks/LETBs will do, linking with local authorities. The Public Health workforce is as important as other parts of workforce and will be treated the same. It is important that both specialist and non-specialist public health training is taken into account as non-specialist roles (indeed, the whole healthcare workforce) still have a health promotion responsibility.

December 2011

Written evidence from the Faculty of Medical and Human Sciences, University of Manchester and the Manchester Academic Health Science Centre (ETWP 88)

1. BACKGROUND AND SUMMARY

1.1 The Faculty of Medical and Human Sciences (FMHS), University of Manchester, with its NHS partners educate and train healthcare professionals across a comprehensive range of disciplines at both undergraduate and postgraduate pre and post qualifying levels and makes a significant contribution to preparing and honing the skills of the NHS workforce.

1.2 The Manchester Academic Health Sciences Centre (MAHSC) is a federation of the University of Manchester and six partner NHS Trusts. Academic Health Sciences Centres such as MAHSC exemplify partnerships working across Higher Education Institutions (HEIs) and service providers and provide a model for the integration and alignment of research, education and training with service transformation, workforce planning and patient care.

1.3 We welcome the opportunity to provide written evidence to the committee in relation to the crucial issues under consideration. We would be happy to provide further evidence, in writing and/or through oral evidence, if this would be helpful to the committee.

1.4 We note that the committee have requested evidence in advance of the Government ‘autumn’ publication—although we now understand that the proposals will not emerge until early 2012. These will hopefully set out in more detail the roles and responsibilities of key players within the new system as well as the system structure to take forward education, training and workforce planning.

1.5 We would therefore suggest that it would be helpful if the Committee were able to take further evidence from organisations on the new system following actual publication. The points below address key issues that we consider need to be addressed within the new system rather than our comments on the actual system itself or the roles and responsibilities within it which are as yet unconfirmed at the time of writing.

1.6 A summary of the key issues for FMHS/MAHSC are as follows:

— Local Education and Training Boards (LETBs) must include HEIs as full partners with the providers of healthcare in order to achieve excellent and innovative education and training and thus improved patient care.

— In establishing LETBs there must be consideration and co-ordination between the organisational networks that have within their remits service improvement and workforce development, such as the AHSCs and the HIECs. There should also be co-ordination in establishing LETBs and the recently proposed regional Academic Health Science Networks.

— The experience of AHSCs in integrating education, research and innovation to improve patient care and service delivery should be central to informing the working arrangements of LETBs as integrated HEI/NHS partnerships essential to the transformational agenda.

— Postgraduate deaneries and HEIs must be closely aligned to ensure a continuum in medical education, clinical training and academic development.

— Health Education England (HEE) should be established as a matter of urgency with transparency as to the roles and remits of Professional Bodies and HEIs in curriculum development and quality assurance and how this should be co-ordinated to ensure consistently high standards. Thus constituted, this activity should be integral to the commissioning arrangements of LETBs.
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— A properly resourced Centre of Workforce Intelligence or equivalent body working on behalf of HEE should develop long-term workforce policies and commissioning decisions informed by high quality research. This body should ensure coherence across different organisations in identifying funding priority areas for workforce research. There should be co-ordinated multi-professional workforce planning and commissioning for pre-registration education across all professional groupings.

— Education funding (including that for CPD) must be ring-fenced with clear systems of accountability for its use by those in receipt of finance to provide placement learning as well as HEIs.

— Consideration of Clinical academic workforce planning must be an integrated component of workforce planning in the NHS

2. An Inclusive Approach to Partnership Working

2.1 The opportunity to change the education and training system offers a significant opportunity to ensure that effective partnership working transcends relationships between the NHS and Universities in the delivery of a world class workforce to deliver the highest standards of care for patients and service users going forward. However, there is also a need to ensure that the system architecture is able to support true partnership between HEIs and the NHS.

2.2 In line with others who have already given oral evidence to the committee we would strongly emphasise the importance of direct HEI representation (medical and non-medical education) on LETBs. This is essential to true partnership working in the co-production of the workforce and offers the opportunity to forge relationships and ways of working which focus more on transformational workforce change rather than transactional relationships between commissioners and providers.

2.3 We recognise that there are arguments about the need to avoid conflicts of interests. However, such arguments also apply to Teaching Hospitals (THs) who are at the same time commissioning education from HEIs whilst also providing significant components of practice education. In the proposals to date THs who are well represented on emerging LETBs will also be responsible for decisions about substantial financial flows for MPET to themselves related to placement tariffs as well as monitoring quality—some of which relates to their own educational provision/contribution through placements. Rather than excluding HEIs, such potential conflicts of interest (for HEIs and THs) can be managed through each LETB having an independent Chair and setting up commissioning sub committees to deal with commissioning issues. Partnership working is the way to overcome potential conflicts of interest.

2.4 In the NW the function of the Deaneries has been mapped onto the shadow LETBs. As HEIs are not represented on the shadow LETBs there will be further disconnect between HEI and Deanery functions and between undergraduate and postgraduate medical education and training. Our views on the future of postgraduate Deaneries are consistent with those of the Medical Schools Council, the Conference of Postgraduate Medical Deans and as outlined in the excellent commentary by Ovseiko and Buchan (2011). We support their key recommendations to establish formal interactions between HEIs and Deaneries through joint employment, governance and contractual procedures.

2.5 As well as the need for LETBs to include direct HEI representation there is also a need to ensure the system architecture as a whole is able to support and nurture the health professional education and research sector in order to ensure better outcomes for patients supported by an expert workforce. As part of the new system we would argue that there should be an explicit 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 should be agreed at national level, renewed every five years and form an integral part of the authorisation and monitoring arrangements between HEE and LETBs.

2.6 With reference to 2.4 above, in the NW establishing the shadow LETBs has been led by the Strategic Health Authority (SHA) but in the absence of clear national guidance. Whilst this approach has advantages in ensuring that key functions of the SHA are not lost in transition, broader issues such as the integration of the congruent activities of the HIECs and AHSCs have not been fully taken into account. This has meant that the valuable experience of such organisations in integrating education and training with workforce planning and innovation with the aim of improving patient care and outcomes has not informed the transitional process. Coupled with this is the recent proposal to establish Academic Health Science Networks which will extend the reach of the HIECs and the AHSC to include all regions and build on their progress. The development of LETBs should dovetail with such developments.

3. Workforce Planning—Robust Processes and Accurate Information

3.1 The House of Common Select Committee identifies key themes including how the proposals will ensure the right numbers of appropriately qualified and trained healthcare staff at national, regional and local levels

and how future healthcare workforce needs are being forecast. Successful workforce planning is dependent upon reliable and comprehensive information. This will be particularly important for the medium-long term overview that HEE is being asked to provide in the future. 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%.

3.2 At present there is little oversight or debate on the education and training requirements of the whole multi-professional workforce at a national level in England. No single body is able to suggest the right direction of travel for the NHS workforce in the medium-long term or who is responsible for long term planning.

3.3 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 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 (the largest component of the workforce) and specifically the cuts to education commissioning numbers and whether this meets long term workforce needs or is a short-term measure to control costs.

3.4 We need to avoid the “boom and bust” approach to workforce commissioning that has characterised recent times. 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 a proper focus on ensuring an appropriate balance between short term requirements and long term sustainability for the provision of education and training in Universities.

3.5 There are problems with the current method used for workforce planning in the NHS in England:

- It is often based on false assumptions about the effects of an ageing population and takes no account of changes in population need and productivity.
- It is also undertaken separately for each specialty and staff group and is rarely related to service and financial planning.
- Current mechanisms for identifying and funding priority areas for workforce research lack coherence and are fragmented across different organisations such as CfWI and various NIHR research programmes.

3.6 There needs to be a clear system to determine the workforce planning data required and a co-ordinated approach from the national bodies that will request information in a national minimum data set—HEE, CfWI, National Information Centre, NHSCB etc.

3.7 Workforce policy and planning decisions need to be informed by high quality research with these research outputs translated into evidence-based policies and commissioning decisions at national, regional and local levels. Such policy-relevant workforce research could be secured by establishing a national Workforce Policy Research Unit alongside the other policy research units established by the DH to support policy and planning decisions. Such a PRU requires long-term, substantial funding to develop the next generation of workforce planning tools based on “need” as opposed to “demand” for care, and to provide authoritative syntheses of available research into key areas of concern to policy makers such as how to improve workforce efficiency without compromising quality.

3.8 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 Information. 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.

3.9 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-long 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. We 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.

4. Sustainable and Ring Fenced Education and Training Funding

4.1 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 where it already exists.
4.2 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 MPET Budget must be truly Multi-Professional based on a principle of equitable funding in relation to future workforce commissioning rather than the separate funding streams within the existing MPET. We fully support continued funding for junior doctors’ salaries and postgraduate medical-education placements but would also argue that there should there be similar funding for non-medical education post graduate pathways including preceptorships, career pathways structure and advance learning to deliver equity.

4.3 We have 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. HEIs already deliver cost-effective CPD, building on their high-quality research. Too often 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.

4.4 CPD must not become superficial or of poor quality in response to wider short-term priorities and needs to include the staff release costs for development and training. The proposed new duties on any provider of NHS care should be extended to ensure a duty on providers to deliver CPD to its workforce. It will be crucial that HEE has a role in monitoring and reviewing the CPD provision for existing staff as part of its remit. This will become increasingly important as revalidation requirements are prescribed by professional regulatory bodies.

5. CLINICAL ACADEMIC WORKFORCE PLANNING

5.1 HEI’s must also be consulted on future workforce plans as this will impact on their own provision and the overall development of the clinical academic workforce. There is, both currently and in the proposed arrangements, a major lack of attention to Clinical Academic workforce planning particularly for the smaller disciplines. Without consideration of, and investment in, Clinical Academic Planning within overall NHS workforce planning and commissioning the future the academic workforce will be lacking in terms of quantity and quality and therefore unable to deliver the plans of LETBs which will ultimately impact on the quality of patient care.

5.2 HEE could take forward the development of the existing and future clinical academic workforce as another function. The cuts to planned student numbers and the ageing academic workforce could lead to a shortage of teaching skills and evidence based practice/research in the future. 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 nurture leaders in the research and development workforce.

6. PLACEMENT LEARNING—MPET PLACE MENT TARIFFS AND QUALITY MONITORING

6.1 Within much Education and training a significant amount of learning is undertaken in practice. The new systems and processes must ensure greater engagement and ownership of practice placements and other learning opportunities by all health care providers. This should be a statutory duty for all those in receipt of funding for education and training. Whilst this has been increasingly well embedded in local Trusts and hospital settings, as care and treatment moves increasingly to community and other non-hospital providers, there must be greater commitment to and participation in providing high quality learning experiences within such contexts.

6.2 The transition to an MPET placement tariff, with greater transparency and clearer links between funding and education provision, provides ideal opportunities to incentivise participation and high quality education in practice provided that rigorous performance and quality assurance mechanisms are in place. However, it is essential that Universities, with students undertaking significant periods of learning in practice, are central partners to the quality and performance management of placement providers and the use of MPET placement funding (SIFT/DSifT/NMET etc). Whilst some consultation by SHAs who currently monitor this takes place University engagement and influence has to date been largely vicarious. We would argue that any future arrangements directly include universities in such performance and quality monitoring of placement providers.

December 2011

Written evidence from Merseyside and Cheshire Health Innovation Education Cluster (ETWP 89)

DIFFUSION OF INNOVATION AND EDUCATION—THE I AND E OF HIEC

Innovation and Education Clusters have been a recent attempt to energise adoption of innovative/best practice into mainstream frontline health care delivery. The key characteristic of the HIEC concept is the fusion between spreading innovative practice and the provision of novel approaches to educational programmes. The aim ultimately is to integrate the best examples of these into both undergraduate and postgraduate curricula. Whilst there are a range of excellent organisational structures across the NHS which focus on research and nurturing innovation in health, few ask the simple question “What are your good ideas, show us how they have made a positive impact on patient care, and we will help you to bring these benefits to more patients, more quickly”.

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December 2011
HIECs are set up to do this. We hope that this concept and the very early learning from the existing HIEC network across the NHS in England will be sustained in the new innovation and educational architecture currently being established.

**HIECs—Fusion of NHS and HEI**

Our second point is to underline the significant value of the NHS and the University sectors coming together as equal partners under the banner of the HIEC. Whilst these relationships pre-existed HIECs, in this HIEC we have the relevant Deans of all our regional Universities involved in the development of the NHS workforce sitting alongside the Postgraduate Medical Dean, and senior representatives of the local NHS provider organisations. This has supported a joined-up approach, and critically, openness in consideration of workforce planning and development issues which we would be concerned to lose, and which we do not see replicated currently in the new Education Network arrangements in this area.

We hope the committee finds these comments of some value in its considerations.

*December 2011*

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**Written evidence from the Council of University Heads of Pharmacy Schools (ETWP 90)**

**Background and Summary**

1. The Council of University Heads of Pharmacy Schools (CUHOP) represents the collective interests and views of the Schools of Pharmacy. The membership of CUHOP comprises the heads of the presently 26 UK schools of pharmacy which enrol students to read for a Master of Pharmacy (MPharm) degree with the expectation of registering as a pharmacist in the UK. These schools of pharmacy also deliver a range of Clinical Pharmacy postgraduate programmes for NHS and other pharmacists in clinical and technical services pharmacy, GPhC accredited non medical prescribing courses, and research degrees and doctorates.

2. Key issues for Pharmacy Schools relevant to the themes of the inquiry are:
   - Academic expertise is needed to both inform and transform education and training, any new structures and systems should seek to harness this expertise.
   - Pharmacy schools need to be true partners of NHS and private healthcare providers and commissioners in primary and secondary care.
   - Where possible existing structures should be incorporated and developed in to the new system.
   - High quality education requires national coordination and regulation.
   - Any infrastructure for managing and assuring the quality of workplace-based pharmacy training must provide clear accountability and responsibility for delivery of quality teaching, learning and assessment.
   - Curricula cannot be adapted piecemeal to meet local demands. There must be respect for university processes, and an acknowledgment that if something comes in to the curriculum something has to come out.
   - Quality assurance for pharmacy education and training needs to build on current HEI QA frameworks and the General Pharmaceutical Council (GPhC) standards for pharmacy tutors and premises.
   - Any workforce planning needs to encompass the full range of pharmacy roles.
   - CfWI, working on behalf of HEE, should seek to develop long-term plans based on realistic estimates.
   - Pharmacy and pharmacy education and training must not be overlooked in the development of public health.

3. While many issues raised in our response refer to the context in England specifically, many challenges and solutions we identify are applicable across the UK. Addressing these common challenges will only be possible through sharing information and good practice across the UK.

4. It will be important to keep the Inquiry open until after the DH has published its recommendations for Education and Training, in order that the Committee might receive views on actual rather than speculative plans.

**Stable Transition**

5. It is absolutely crucial that this be an evolving process, and where possible existing structures should be incorporated and developed in to the new system. Throughout transition, risks should be identified and managed and transparency maintained. This is particularly important in relation to pre-registration training posts (in NHS hospitals and in community pharmacies contracted to provide NHS services) that allow pharmacy graduates to complete their professional training.
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6. Academic expertise is needed to both inform and transform education and training, any new structures and systems should seek to harness this expertise.

7. Health Education England (HEE) should be established with close links with the Devolved Administrations to ensure a UK wide oversight is maintained.

8. Action must be taken to prevent loss of education and training expertise in Strategic Health Authorities (SHAs) and Deaneries, especially to support pre-registration and postgraduate training frameworks.

9. Greater care needs to be taken in the establishment of Local Education and Training Boards (LETBs); there should be national requirements to involve Higher Education Institutions (HEIs) and to have an independent Chair. In the absence of national guidance, unhelpful local developments have been reported, with HEIs experiencing:
   — Active exclusion from discussions about the development of LETBs.
   — Absence of consideration of quality assurance in LETBs design.
   — Poor communication between SHAs taking forward plans for LETBs and HEIs.

National Structures

10. Pharmacy education is a continuum from the undergraduate level to retirement, overseen by the GPhC, and involves NHS hospitals and independent providers (contracted to provide NHS services) in the community sector. High quality education requires national coordination and regulation. We welcome the duty on the Secretary of State to maintain a system of education and training in the NHS.

11. Pharmacy schools need to be true partners of NHS and private healthcare providers and commissioners in primary and secondary care—designing new systems together and preparing pharmacists for the myriad of ever-changing roles required of them. For example, pharmacists have an important patient safety role in medication safety and reducing hospital admissions; as well as roles in public health and medicines optimisation through targeted Medicine use reviews and the first prescription service.

12. Health Education England, role, responsibilities and relationships with other bodies:
   — HEE needs to link to DH directly like the National Institute for Health Research (NIHR) rather than via the NHS Commissioning Board. This will ensure clear lines of accountability, reflecting the Secretary of State’s responsibility to maintain the education and training system.
   — HEE must be given “teeth” with the right to call on the NHS Commissioning Board for support if local plans cannot be accommodated within national requirements.
   — HEE should ensure that educational funding is ring-fenced and transparently follows the student. It will also need to establish a process for on-going review, allocation and determination of funding to ensure protection of educational budgets.
   — HEE should have the responsibility for enforcing duties on providers with financial penalties to enforce compliance. To support HEE in this endeavour the regulators of the healthcare professions (including GPhC), CQC and Monitor must inform HEE of concerns they have picked up.
   — HEE must have a defined relationship with Health Education National Strategic Exchange (HENSE), with stronger links between both NIHR and HENSE and between HEE and the Office for Strategic Coordination of Health Research (OSCHR), to coordinate and maximise research outputs alongside consideration of education and training.
   — The Chair of HEE should be a highly regarded senior clinical academic with recent experience of healthcare education. HEE should have a small board that includes non-executive directors with a background in healthcare and academia, and we would wish pharmacy to be represented on this board.
   — It is vital that HENSE is maintained and its role enhanced, notably with the inclusion of representatives to cover all healthcare professions (there does not appear to be pharmacy representation currently). The Chair of HENSE should work closely with HEE.
   — HEE would be in a position to look for opportunities for promoting inter-professional education and training wherever appropriate.

13. Pharmacy input at a national level:
   — Multi-professional oversight of the workforce such as through HEE must be accompanied by single professional oversight, such as currently facilitated by the programme boards. Pharmacy is largely unique in its level of interactions with independent providers; this introduces a layer of complexity to the development of the pharmacy workforce that needs to be considered at a national level.
   — The Modernising Pharmacy Careers Board, as a driver for enhancing professional education and training at both pre-registration and post-registration levels, involving representatives of professional practise and higher education, should be maintained and strengthened.
— In order to ensure true professional leadership, there need to be places for elected representatives of the professions on Programme Boards and HEE.

— The Chief Pharmaceutical Officer (CPO) should sit on both HEE and the NHS Commissioning Board.

14. In creating the governance structures account should be taken of the systems in place in the other three nations; there must be strategic oversight looking at developments in all the Devolved Administrations.

**LOCAL STRUCTURES**

15. Many of those best placed to deliver the required professional leadership required are clinical academics from the healthcare professions and those in the related sciences, who have a unique and valuable position of being involved in the delivery of healthcare and health education, and being at the forefront of bioscience and healthcare research. It is essential that academics, educationalists, healthcare professionals and employers work together to create programmes that will be proper foundations for entire careers and which take account of patients’ requirements and the need to embrace scientific advances and innovation in healthcare.

16. Local Education and Training Boards:

— As outlined above, less than full academic partnership on LETBs will mean that they fail to flourish and provide the NHS with the innovation it needs.

— Whilst we acknowledge that concerns have been raised that HEI involvement on LETBs will produce conflicts of interest. We think it should be recognised that NHS providers commissioning placements from themselves also presents a conflict of interest.

— As envisaged in the last review of MPET, a proportion of the Multi Professional Education and Training budget (MPET) should be reserved, and awarded after successful provision of education and training to ensure that high quality is delivered in placements.

— In establishing LETBs it will be essential to build on existing local partnerships established through AHSCs, BRCs and BRUs, HIECs and CLAHRCs.

17. Any infrastructure for managing and assuring the quality of workplace-based pharmacy training must provide clear accountability and responsibility for delivery of quality teaching, learning and assessment. This infrastructure must include employer representation and commitment from hospital and community pharmacy and possibly industry, be in partnership with pharmacy schools and properly resourced.

18. To develop a stronger multi-professional approach to postgraduate education and training it will be important to build on what works by enhancing current governance structures; for example by integrating a pharmacy dean into the existing deaneries.

**REGULATION, QUALITY ASSURANCE AND OUTCOMES**

19. Pharmacy education and training must prepare students and trainees for a wide range of career pathways, and the fast developing healthcare landscape. In order to deliver high quality training and to achieve responsiveness to patient needs and changing service models, NHS colleagues in primary and secondary care together with leaders from the community pharmacy sector and the pharmaceutical industry must be true partners of pharmacy schools, designing new systems together and preparing pharmacists for the myriad of ever-changing roles required of them.

20. Curricula development: curricula cannot be adapted piecemeal to meet local demands. There must be respect for university processes, and an acknowledgment that if something comes in to the curriculum something has to come out.

— Pharmacists are a national resource with educational requirements that must meet national and international standards and which, for all pharmacists, must be rooted in a deep understanding of the science of medicine design, mechanisms of drug action and evidence based healthcare.

— The role of the General Pharmaceutical Council (GPhC) in curriculum development through setting the requirements for initial pharmacy education and training through the university-based programmes to completion of the preregistration year should be maintained.

— In England the Pharmacy Programme Board under the aegis of HEE will be in a position to play a central role in curriculum development in concert with individual HEIs. Equivalent bodies in the devolved nations and UK wide professional bodies such as the Royal Pharmaceutical Society of GB should also be involved.

21. Quality assurance for pharmacy education and training needs to build on current HEI QA frameworks and the General Pharmaceutical Council (GPhC) standards for pharmacy tutors and premises.

22. Education and Training Outcomes Framework: clarity is needed on the relationship between “outcomes” and “domains” in the NHS Education Outcomes Framework and appropriate metrics must be developed if it is to be of practical use.
WORKFORCE PLANNING

23. It should be recognised that pharmacists are an integral part of the healthcare workforce in the community, in hospitals, in industry as well as through their involvement in public health. Improving the quality and safety of primary and secondary healthcare, delivering the self-care and public health agendas, and secondary care specialisations all require effective pharmacists. Pharmacists, opticians and dentists in the community should not be viewed or treated as peripheral; these professionals are numerically important for workforce planning and contribute greatly to patient care and public health.

24. Any workforce planning needs to encompass the full range of pharmacy roles:
   — Two thirds of pharmacists work in the community these pharmacists are not employed directly by the NHS, but do perform essential NHS activities. The government wishes to expand the scope of the pharmacist contract to provide a range of new enhance services, including managing chronic conditions, supplementary and independent prescribing, the new medicines service and the “healthy living pharmacies” initiative,
   — Pharmacists are essential to delivering the self-care and public health agendas (such as vaccinations, sexual health, smoking cessation etc), and secondary care specialisations. In addition a small number of pharmacists work in industry and academia both on a full time and part time basis.

25. Role of healthcare providers: all healthcare providers should have a duty to provide data about the current workforce their future workforce needs. These data must be accurate with a clear indication as to whether they refer to headcounts or full time equivalents. The private sector and otherwise independent employers must also be involved, in particular:
   — Community providers need to be more open about their pharmacist workforce requirements for training in order to continue to be supported through the Community Pharmacy Contractual Framework.
   — We emphasise again the importance of understanding the whole pharmacist workforce and not just those employed by the NHS. Whilst providing NHS pharmaceutical services, the majority of pharmacists are neither NHS contractors nor NHS employees throughout their professional careers.

26. Overseas pharmacy students and staff: a key strength of the current system is the quality of the healthcare workers produced in England and the rest of the UK. The UK also currently benefits from the ability to generate wealth from the delivery of high quality healthcare education and training to overseas students.
   — In pharmacy the numbers of overseas students represent a significant minority and many such students have entered the UK pharmacy workforce, at least for early years’ experience and professional development, as highly capable practitioners. This has been good for them, good for the NHS, good for universities and the UK economy.
   — We would argue that changes to the immigration system should not remove the attractiveness of studying or working in the UK.

27. Centre for Workforce Intelligence (CfWI) and forecasting future needs:
   — CfWI, working on behalf of HEE, should seek to develop long-term plans based on realistic estimates.
   — Workforce planning must take a UK wide approach. When considering “cross-boundary flows” thought must be given to movement within the UK and into the UK from elsewhere.
   — Pharmacy as a profession attracts large numbers of women and ethnic minorities, so forecasting needs to consider the equality agenda.
   — The CfWI should take time to ensure that it has accurately determined the nature of the information it is seeking to collect from employers and must require that the data be presented to it in a consistent manner to facilitate accurate and effective analysis.
   — It would also be advisable for the CfWI to work with the professional regulators, which hold varying levels of data; in some cases it may be appropriate to provide funding to support a regulator to enhance its own data collection.
   — Greater resources will be needed to allow CfWI to provide LETBs with the information required.

28. Public health workforce:
   — Pharmacy and pharmacy education and training must not be overlooked in the development of public health, noting that pharmacists working in community pharmacy in the primary care setting are front line providers and readily accessible by the public.
   — Guidance on transfer of contracts for public health academics is required to ensure the protection of this vital workforce.
— We note that the timeline for PCT clusters to produce their plans is by the end of January 2012 and that a consultation on the public health workforce strategy is expected by the end of December 2011.

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**Written evidence from the Huntercombe Group and Four Seasons Health Care (ETWP 91)**

Key points covered in this submission by the Huntercombe Group:

— The Huntercombe Group is one of Britain’s leading specialist independent healthcare providers and hosts accredited placements for trainee NHS clinical psychologists and trainee nurses. However, NHS medical deaneries have not routinely organised placements for trainee doctors (psychiatrists) with independent providers. Only NHS trusts have been approved to provide such psychiatrist training.

— This status quo must change to reflect the contemporary NHS landscape for patients. NHS deaneries must be encouraged to recognise that independent providers not only have suitably-accredited consultant psychiatrists to supervise placements, but that such doctors lead clinical innovation in particular specialist fields. In the Huntercombe Group this includes brain injury rehabilitation, eating disorders and secure care for detained mental health and learning disability patients, including young people.

— The status quo must also change in order to ensure (i) the provision of a flow of suitably-trained specialist psychiatrists for the benefit of NHS patients, and (ii) that NHS-trust employed psychiatrists (as well as independent-sector psychiatrists) gain vital knowledge and experience of specialised services offered by independent providers.

— Working alongside Skills for Health and Skills for Care independent healthcare providers such as the Huntercombe Group are well-placed to advise on specialist mandatory training for healthcare support workers/healthcare assistants in specialised healthcare environments.

**Part One**

1. **Introduction—The Huntercombe Group’s provision of specialist healthcare services for NHS patients**

   1.1 The Huntercombe Group is one of Britain’s leading independent specialist healthcare providers. The Group runs 60 care units and hospitals in England, and Scotland, offering a total of 1,658 beds.

   The Huntercombe Group provides specialist services for NHS patients in the areas of (i) forensic learning disability and complex presentations of autism (ii) specialist child and adolescent services including eating disorders (iii) addictions, and (iv) acquired brain injury and rehabilitation. Such services meet the needs of patients where local NHS provision is unavailable.

   1.2 The Huntercombe Group patients are, almost exclusively, NHS patients. The Huntercombe Group, part of Four Seasons Health Care, proudly sees itself as working in full partnership with the NHS.

   1.3 The Huntercombe Group works with over 80 NHS primary care trusts, 50 local authorities and specialised commissioning groups in England, and health boards in Scotland, Wales and Ireland.

   1.4 The Huntercombe Group employs over 3,000 clinical staff, including psychiatrists, clinical psychologists, nurses, speech therapists, occupational therapists, support workers and healthcare assistants.

**Part Two**

*Independent healthcare providers must have a bigger role in specialist training for doctors (psychiatrists)*

1.5 Leading specialist independent healthcare providers, such as the Huntercombe Group, already provide valuable NHS-accredited placements for trainee clinical psychologists and makes a substantial contribution nationally to the training of nurses through approved student placements. However, NHS medical deaneries have not historically offered post-graduate doctors (psychiatrists) clinical training placements with independent providers.

1.6 This is a particular anomaly when considering that (i) psychiatrists tend to be clinical leads of multi-disciplinary healthcare teams which include psychologists and nurses, and (ii) independent providers are leading clinical service innovation in particular specialist clinical fields. To provide just one example—46% of all care for detained NHS patients with a learning disability is now provided by the independent sector.133

1.7 This status quo on the training of psychiatrists needs to change because:

   (i) Leading independent providers, such as the Huntercombe Group, now have over 40 experienced, suitably-qualified and accredited consultant psychiatrists to manage such clinical placements.

133 The Mental Health Act Commission 13th Biennial Report 2007–09. (In 1998 15% of individuals with a learning disability were detained within independent hospitals. This had grown to 46% of individuals (545 of 1,184) in 2008)
(ii) The NHS as whole needs to ensure that patients benefit from a steady flow of suitably-experienced consultant psychiatrists specialising in areas such as eating disorders and secure care for detained adults and young people. As highlighted above, the independent sector provides a significant proportion of such services to the NHS, and so has a wealth of expertise.

(iii) To ensure an ongoing productive partnership between the NHS and independent services, NHS psychiatrists need to gain experience of specialist independent-sector services. This will help patients move effectively between NHS-run and independent-run services. The independent sector should no longer be seen as running an “unknown” clinical service, especially considering again that its patients are almost entirely NHS patients.

1.8 To bring about this change, NHS medical deaneries should be leveraged to create more productive partnerships with independent providers.

1.9 The Huntercombe Group will, for its part, be proactive in securing partnerships with NHS medical deaneries, and to be proactive in offering approved specialist training placements for junior psychiatrists.

**PART THREE**

*The need for specialist training for support workers/healthcare assistants*

1.10 We note that the Skills for Health and Skills for Care has been charged with producing minimum training standards for healthcare support workers and adult social care workers in England. This is with a view to establishing a voluntary register for healthcare support workers and adult social care workers in England. We entirely support this initiative, and welcome the opportunity to be involved in ongoing discussion with the Skills for Health and Skills for Care.

1.11 We note that the Health Secretary Andrew Lansley has said it is “absolutely critical” that employers take a leading role in supporting Skills for Health and Skills for Care in developing such standards to ensure they meet the needs of service and patients.

1.12 It is essential that the independent sector is engaged directly in providing such support. To this end, The Huntercombe Group, which employs over 2,000 support workers/healthcare assistant, will be stressing to the Skills for Health and Skills for Care that support workers/healthcare assistants for specialist, often highly-challenging, environments as outlined above should have appropriate specialist mandatory training to supplement their statutory mandatory training.

1.13 Examples of this type of supplemental training would include communication skills training for staff working with individuals with autism, behavioural management strategies for staff working with individuals with highly-challenging and outwardly aggressive behavior and specialist training in symptom management in child and adolescent services.

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**Written evidence from the Faculty of Pharmaceutical Medicine (ETWP 93)**

**SUMMARY**

— The transition to a new system must occur carefully and gradually.

— Healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce.

— Educational supervision must be prioritised, with ES roles recognised in job plans.

— Experienced professionals must be re-incentivised and encouraged to engage in innovative medicines research and development.

— The Medical Royal Colleges and Faculties can play a pivotal role in the quality assurance of education and training.

— Due attention must be paid to education and training occurring outside the NHS.

— Under a levy system, there should be no distinction between NHS and non-NHS providers.

**INTRODUCTION**

1. The Faculty of Pharmaceutical Medicine (“the Faculty”) welcomes the opportunity to submit evidence to the Select Committee’s inquiry into Education, Training and Workforce Planning. The Faculty is a registered charity and exists to advance knowledge and promote the science of pharmaceutical medicine by working to develop and maintain competence, ethics, integrity and the highest professional standards of practice in the specialty for the benefit of the public. In short it concerns itself with postgraduate education of pharmaceutical physicians and with standards of practice of pharmaceutical medicine in medicines development. Hence, the Faculty has a strong interest in ensuring that the integrity and rigour of medical education and training continues through the proposed structural transformations.
2. Pharmaceutical medicine practitioners in the UK are approximately 1,500 doctors (approx. 1.5% of the medical workforce) who are employed in pharmaceutical companies, regulatory authorities and contract research organisations, and in independent consultative roles. After completing at least four years of postgraduate clinical training and reaching the competences of S2, further training & education is undertaken outside the NHS through a four-year workplace-centred, competency-based programme of Pharmaceutical Medicine Specialty Training (PMST). Successful completion of PMST leads to specialist registration (in Pharmaceutical Medicine) with the GMC.

3 The Faculty understands that the changes at the heart of the Government’s proposals concern the devolution of planning and development of the healthcare workforce from the centre (DH) to healthcare providers, with responsibility for education & training and development to be delivered locally by multi-professional Skills Networks (legal entities), replacing postgraduate deaneries. Skills Networks, accountable to, funded and audited by healthcare providers, will in turn manage local workforce data and planning as well as the funding for training. A new board, Health Education England (HEE) will replace all current bodies to focus on workforce matters (coordination, harmonisation) at the national level.

THE TRANSITION

4 Whilst the Faculty broadly agrees with the Government’s proposals we do have concerns about the organisational challenges inherent in such an upheaval. Postgraduate medical education and training linked to workforce planning and effective implementation has been in flux for the last six-seven years, and perhaps only now is beginning to settle again. Now this fundamental reorganisation of the structures and processes of education and workforce planning through devolution to local healthcare providers is a major upheaval on top of the content changes. This will be compounded by the financial considerations, and the change of fiscal arrangements (from top-slicing to tariffs and levies). At best this will all take a long time to work through, and it is to be hoped that during this time, the standards and quality of PG E&T are not diminished. We are concerned that there must be an appropriate transition plan between systems and a defined period before launch rather than a sudden change.

5 During the transition to a new system the Government must ensure that there is effective dialogue between Skills Networks and HEE. If HEE is not established before Skills Networks are implemented, then it will be up to the Skills Networks to help develop the relationships, roles and responsibilities, framework for joint working andaccountabilities with and for HEE. In turn this will be an opportunity for Skills Networks to have an oversight body that they can work with and that delivers for them the benefits of a national advisory body without the bureaucracy and lack of local involvement which could eventually weigh on them adversely.

6 The Faculty believes that all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce. Whilst this process might impact on the duration and complexity of the reorganisation, in addition to the issues raised in paragraph 4, we believe that this is a vital step in the process.

7 The Faculty believes that many healthcare providers do not have a great record for prioritising education & training against service provision and healthcare research; so, investing them with all the high principles and high expectations of devolved responsibility for E&T without many safeguards built into the plan may at best see many delays to implementation, and at worst see the whole plan falter irretrievably.

EDUCATION AND TRAINING UNDER THE NEW FRAMEWORK

8 The Faculty wishes to ensure that, in a new system, both local and national requirements for recognition of trainees’ needs for workplace-centred opportunities for E&T, training time, and fulfilment of the new specialty-based curricula and assessments, including the many general and transferable skills and medical leadership, are coordinated. We are keen that educational supervision (ES) to be prioritised, with ES roles recognised in job plans. It is also vital that accurate workforce planning is carried out to avoid under—or over-supply; this might be better done at local level than national and avoid the traumas of eg MTAS.

9 The Faculty believes that education and training must meet designated standards, which must be adhered to and compliance assured. Whilst healthcare providers themselves have a responsibility for this (QC), there must also be external bodies to bring fair assessment of adverse findings, remediation and compliance to bear. The first stop for this will be the Skills Networks (QM). Oversight of the whole, as mentioned in the consultation, will be through regulators (eg GMC for medical education matters), CQC and Monitor. It is also believed that Colleges and Faculties can play a role in this matter through early intelligence and identification of problems; this information must then be routed appropriately and responsibility for the necessary action taken.

10 We are concerned that there does not appear to be enough mention of information technology (IT) in the proposals. Particularly, increasing effective use of IT represents automation of activity and often can reduce the numbers of people needed in a workforce. IT also provides continuity of knowledge and care in the NHS, which is value to the workforce. IT also allows monitoring of performance.

11 Healthcare provider Skills Networks and HEE can best secure clinical leadership by encouraging clinicians to be engaged in leadership matters at all stages and their participation shown to relate to improved outcomes in both care and, if possible, the economics of care. In turn Medical Leadership is now embedded in
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specialty training curricula. The Faculty, through its specialty training programmes, now PMST, has fostered Interpersonal and Management Skills as part of the training, and this has now been enhanced by the addition of the Medical Leadership “curriculum” as part of this. It is worth highlighting that there are many aspects of training and education and that they can be beyond the traditionally accepted ones as they are role specific and relate to skills updates, knowledge acquisition/generation and behaviours amongst others. Medical leadership training (via Medical Leadership Forum and continued through new initiatives such as the Faculty of Medical Leadership & Management) and its demonstration through acquisition of competency and assessment must be actively encouraged. Both HEE and Skills Networks will have to play a part in bringing this about.

12 The Faculty would recommend that through the new system E&T and workforce planning and deployment are used to re-incentivise and encourage experienced and expert professionals to engage in innovative medicines R&D (especially development), by allowing time for this activity which does not conflict with service requirements.

THE LEVY

13 The Faculty takes the view that the doctors (and other healthcare professionals) working within the pharmaceutical industry, whilst operating wholly outside the NHS, are nevertheless part of the medical workforce that is delivering healthcare for the benefit of patients and the public health. The postgraduate training of these doctors, through the four-year CCT programme, PMST, is paid for largely by the employer, and thus indirectly through the taxpayer (public purse) through sale of the industry’s medicines. The collaborative work between these non-NHS doctors and NHS healthcare professionals brings great benefits, through the provision of new medicines and other treatments, to the NHS and patients in the UK, as well as to the nation through a net exporting industry. There should be no consideration of a levy on those UK-trained doctors working outside the NHS but in the interests of the NHS, patients and the nation.

FLEXIBLE CAREER PATHS

14 We believe that medical students and foundation doctors should be made aware of the full range of medical careers available to them. PMST is undertaken outside the traditional training structures of the NHS and this and other training programmes must be given the same acknowledgement and priority as more mainstream career choices. The new proposals must reflect the importance of flexibility between careers in industry, NHS and academia, and secondments as learning opportunities and as such that the groups cannot be silo’ed.

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Written evidence from the Cheshire & Merseyside Public Health Network and the North West School of Public Health (ETWP 94)

1.0 BACKGROUND

Current activities to support the NHS reforms in the North West, and the Health Select Committee interest

The Health Select Committee has issued an invitation to submit written evidence for its inquiry into Education, training and workforce planning. Alongside the passage of the H&SC Bill through parliament, national and North West Health Care systems are being prepared for the expected directions and vision contained in the bill. This is as true for the workforce planning, training and education systems for health and social care professionals, as for the commissioning architecture of the NHS. For example, the clustering of SHAs, and formation of local provider skills networks across the region is well under way.

Three skills networks (Cumbria & Lancashire, Greater Manchester and Cheshire & Merseyside) have been declared. The North West networks are called Network Leadership Groups, and each one includes Director of Public Health membership.

2.0 This response

There follows evidence to the Health Select Committee from the Cheshire and Merseyside Public health Network (ChaMPs) and the North West School of Public Health.

ChaMPs is a well established, respected local public health network owned by the NHS and Local Government. It includes current Directors of Public Health, academics, and the wider community of public health professionals, including those working in local government.

The North West School of Public Health is the training team and structure responsible for ensuring the supply of future public health experts and leaders in the North West. The School has 50 people in training and a large community of public health experts who are also educators.
2.1 The Role of the Secretary of State for Health in the New System

   — The Secretary of State for Health, as an integral part of their responsibility to deliver a fit for purpose health and health care system, must have responsibility to ensure that training and education delivers a highly expert health care professional work force. This includes a dedicated public health specialist and practitioner work force. It also requires a wider work force that understands basic health principles: for example, the importance of evidence and evaluation; the effectiveness of screening and immunisations; the need to promote healthy environments and lifestyles.

2.2 The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

   — We fully support the proposed role of Health Education England (HEE) and see Public Health England (PHE) as one of the key partners in advocating for specialist and practitioner training within HEE.

   — Public Health England will be a principal employer of public health professionals at specialist and practitioner level in the future system. With this in mind, PHE should have a specific remit for public health professions in other organisations such as local authorities, Health Education Institutions, NHS foundation trusts and elsewhere. PHE may in effect be the “guardian” of public health standards in training and education. Advantages to this approach include a fit for purpose public health workforce with education and training plans that are coordinated and meet the needs of the communities in which they serve. They will also be responsible for providing an organised and modelled approach to continuing professional development to secure consistency and a high quality workforce.

   — There needs to be National leadership for the public health workforce—this will assist local authorities to meet their statutory responsibilities around public health delivery and protect them from the risks associated with an inadequately trained workforce.

   — Knowledge and skills for building for health improvement need to be accessed by many professional groups. This needs to be driven forward within the planning and development of the workforce at local level.

2.3 The implications of a more diverse provider market within the NHS

   — There is a need for national leadership to continue to set standards for public health practice. Public Health England must be a major player in this.

   — Local skills networks/Local Education and Training Boards have responsibility also to set standards those local providers can then be held to account for delivering.

2.4 How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

   — Regulation will protect employers and the public in the new system, where multiple providers and smaller independent public organisations such as local government will need assurance that the people they employ are safe, and can be trusted. The experience of GP out of hour’s providers employing doctors in the UK illustrates the risk involved.

   — All Health Care and Social Care Professional groups and regulators have a responsibility to articulate and develop public health content in their respective under graduate/post graduate curricula.

   — Professional registration for medically qualified public health staff’s should continue to be via the GMC and for non medically qualified the UKPHR working as part of the Health professional Council.

   — Education providers including universities must be fully integrated into workforce planning and curriculum needs for health care professionals, so that they can deliver what is needed.

   — The workforce for those services commissioned and delivered by Local Authorities will need to include public health skills and competencies to deliver on the prevention agenda and to tackle health inequalities. Their education and training is best integrated within locality-based Skills Networks as part of the wider health care education system.

   — As a multidisciplinary profession, the registration mechanism needs to be robust. There is a single standard setting body (the Faculty) which has half its active members form backgrounds other than medicine. If there cannot be in the same vein a single registering body for all public health specialists, then there must be as much equivalence as possible in registration with different bodies. This is the case now with the GMC and UKPHR. There is a risk not only to non-medics, but also to Drs that the standing of the registration will suffer if half of trainees on the training scheme do not have a robust body to register with.
— In Cheshire & Merseyside the four universities that train under graduate nurses collaborated to add healthy lifestyle training into the core curricula as part of a pilot project that is currently the subject of a longitudinal evaluation. This is a good example of a large scale approach to public health workforce development of the future clinical workforce that could be extended and built upon with support from PHE and the professional regulatory bodies.

2.5 The future of postgraduate deaneries
— Post graduate medical specialty education, including public health specialist training, needs a strong infrastructure and a resourced team at sub regional level to ensure equality, satisfy regulators, and deliver tomorrows senior doctors and public health specialists.
— Post graduate medical specialty education teams should also carry responsibility for ensuring public health skills and knowledge is in every specialty curriculum and every specialty practice.

2.6 The implications of a more diverse provider market within the NHS
— Local skills networks must have local authority input in order to ensure that local commissioning decisions reflect local health priorities and need.
— Local authorities are community champions and are also significant employers of social care staff—health literacy needs of social care and wider workforce can be addressed through local skills networks with support from local authorities.
— Similarly, CCG’s and NHS commissioning boards need public health skills and awareness with public health commissioners having an active role in health commissioning decisions through these bodies.
— Local skills networks will secure standard setting which will become increasingly important in the environment of “Any Willing Provider.”

2.7 The role of the Centre for Workforce Intelligence, and how future healthcare workforce needs are being forecast
— The only national body that collates and published comprehensive workforce data on the medical specialties, including public health, is the Centre for Work Force Intelligence (CFWI). Unfortunately the statistics published by CFWI regarding public health posts has been very seriously flawed. For example, CFWI reports have claimed scores of “public health associate specialists” in Acute Trusts across the North West. These posts do not exist.
— It is accepted that ESR has not easily (or accurately) identified the PH practitioner and wider workforce partly because of the variety of job titles used to describe public health roles and partly because of the complexity, and subjectivity of estimating the proportion of time given to public health functions, where this is a secondary or tertiary role.

2.8 How funding will be protected and distributed in the new system
— As the tariff is reviewed the need for public health education and training needs to be acknowledged and protected so as not to lose public health capacity to acute, apparently urgent, educational needs in acute health care in acute trusts.
— Need to ensure that local Skills Networks work with HEI’s to ensure the sustainability of specialist subject areas where numbers are very small eg virologists.

2.9 Plans for the transition to the new system, up to April 2013
— There is a high risk of loss of public health experts to the system, and loss of public health expert posts that are essential to the establishment of a strong new public health system. Over the past two years the number of advertised consultant posts has dropped to less than a third of previous levels. The result is that trained, expert individuals are unable to secure appropriate posts on completion of training. This is a waste of the £250,000 investment of public money in their training; it means that the right expert professionals are not in place to work in the new public health teams, and it means that recruitment to specialist training in the future will become less attractive.
— The new structures do not include senior public health leadership at regional, sub regional or supra regional level. The loss of equivalent posts to that of regional director of public health is a serious threat to the public health.
— Experts and professional leaders have to maintain their skills in order to effectively serve the public and their host organisations. In the workforce planning and guidance so far released, there is absolutely no commitment to continuing professional development for public health teams transferred to local authorities. Our understanding is that the NHS culture, which supports CPD as an essential part of a professional’s duties, may not currently be replicated in most local authorities.
There are positive opportunities and attractions linked to transfer of public health functions to Local Government. However, the financial climate within the NHS (that is, the pressure to rapidly reduce running costs prior to April 2013) is resulting in significant threats to public health capacity and capability in some local areas. This has a direct effect on training, CPD and the ability of public health teams to meet the wider training and education needs.

2.10 The impact of people retiring from, or otherwise leaving, healthcare professions

We have already relayed the serious and continuing reduction in numbers of senior professional posts in public health across the NHS. We have described the reduction to less than one third of advertised consultant vacancies. This is in stark contrast to official guidance and statements from the centre. For example, Sir David Nicholson wrote to NHS chief executives in February 2011:

“During the transition year 2011–12 the NHS must continue to lead on improvements to public health, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities. As we deliver the very significant cost savings required of us, it is important that our plans reflect the need to retain staff with scarce specialist public health skills.”

And later in 2011, the East Midlands Regional Director of Public Health wrote similarly to NHS organisations instructing that no screening infrastructure.

2.11 How the public health workforce will be affected by the proposals

There are three recognised groupings of staff in the public health workforce:

- Specialists—eg DsPH, consultants, specialists;
- Public health practitioners eg remainder of the public health workforce—whose main job role is public health (either of these two roles could sit in health protection, health improvement or health care quality domains of public health);
- and the wider workforce which includes clinical staff, voluntary workers, social care staff and anyone who has the potential to provide “public health input” in their daily work/role.

We have described the very serious reduction in the specialist/consultant public health establishment that has accompanied the first period of transition in the NHS. However, we are aware of similar threats to the practitioner and wider workforce, sometimes related to staffing reviews seeking efficiency and cost gains that are short term (for example, reducing community awareness work that reduces the burden of late presentation of disease). Sometimes the cull in management posts has similar effects: for example, when key programme management posts are lost to screening programmes then a very short term saving can quickly lead to a reversal of the positive benefit/harm balance that is essential in screening.

Public Health England needs to have a specified role that is recognised fully by Health Education England the local provider skills networks to champion public health workforce development for public health professionals, clinical and non clinical workforce and the wider workforce.

2.12 The roles of Skills for Health and Skills for Care

CASE STUDY

The development of an initiative initially developed by C&M tPCT “The core Skills Framework” could provide a structured and systematic approach to raising awareness of the three domains of public health and the individuals own public health role across a wide range of organisations and settings including the NHS, LA and the voluntary sector. There are significant organisational benefits to this approach not least the realisation of financial savings associated with a “one stop” approach to statutory and mandatory training. The approach is currently being developed for use across the NHS in the North West and Skills for Health are taking this forward nationally. It would seem timely and useful to ensure a public health element is included in the Core Skills framework.

2.13 The future of Health Innovation and Education Clusters

We are unsure of what the Health Innovation and Education clusters are achieving for public health education and training. We have not seen evidence of them having a community, prevention or public health impact at this juncture.

December 2011

134 Sir David Nicholson 17/02/2011 Equity and Excellence: liberating the NHS—managing the transition. Gateway 15594 1553
Written evidence from current and former participants on the Postgraduate Certificate in Strategic Workforce planning (ETWP 95)

1. CONTEXT

This response reflects perspectives of a network of over 300 clinicians, social workers/social care leads, workforce analysts, planners, and development leads, service transformation managers and HR business partners. Members come from England, Scotland, Wales, Northern Ireland, Republic of Ireland and the Channel Islands. We responded to the 2006–07 House of Commons Select Committee, Workforce Planning.\(^{135}\) We have responsibility for developing and/or assuring workforce plans at local, regional and national levels and are uniquely placed to offer a perspective on the proposals. This summary reflects output of a focus group and survey to members.

2. SUMMARY

— We welcome greater employer involvement in the skills system. Bottom up planning may encourage innovation and creative thinking. The proposals have the potential to strengthen and improve workforce planning by shifting emphasis to local needs and away from the silo thinking noted by the previous Committee.

— We are concerned at the lack of detail around a number of issues including:
  — Transition arrangements.
  — Funding for CPD and non-registered workforce (particularly health and social care assistants).

— We wish to draw attention to a number of risks including:
  — The possible domination of LETBs by professional bodies and secondary care organisations. This may limit a focus on the training and development needs of non-registered and non-clinical workforce.
  — The narrow focus on “the healthcare workforce” and very limited consideration of the need to integrate health and social care planning.
  — The loss of workforce planning leadership following the recent healthcare systems reforms.
  — The potential impact of the workforce planning and education reforms on systems in the devolved administrations.

3. DETAILED RESPONSES

3.1 Right numbers

We are concerned at the tone of the proposals and much of the published debate. We note a continuing focus on planning by staff groups rather than by care pathway or by taking person and community centred approaches. Comments received include: “(provider organisations) no longer want to count beans by professions but describe workforce by services/outcomes for patients/workforce functions such that they have a workforce to deliver high quality care.” A focus on numbers will not provide a solution to the challenges that face us in the 21st century (provision of services for people with long term conditions, dementia, children, or for people with complex learning disabilities). Provision doesn’t necessarily require more professional staff, “Local government, along with social care, are our new partners and offer a lot of care to the same patients as the NHS. With the transition of public health teams to local authorities how will NHS organisations plan for and deliver a workforce which facilitates health and wellbeing of individuals, families, communities and populations rather than just the treatment of illnesses/conditions”

3.2 All providers and commissioners play an appropriate part

We are concerned at the dominance of the medical (& largely secondary care) agenda—as demonstrated both in the proposals. In particular, Social Care provision, which could make a significant difference to demand for services, cost, efficiency and supporting care pathways, is not integrated into the thinking.

“Where is social care?”

“The consultation exercise seems to be entirely focused on the Health Service and the health service workforce. There is an urgent need to expand and develop education and training in social care. Local authorities are struggling to implement the Social Work Task Force recommendations because they do not have the resources required to support and develop social workers. If it is not possible to provide the support and development needed for professional staff in social care, what hope is there for support staff— who are by far the largest staff cohort in social care?”

“ It (DH) has not taken sufficient account of the place of social care in changing and supporting care pathways beyond the end of medical intervention (or) potential role of social care in reducing costs by managing long term conditions in the community, avoiding unnecessary admissions etc.

\(^{135}\) Fourth Report of Session 2006–07, Volume 1 pp 37
“This has an associated risk of workforce shortfall, particularly across the traditional boundaries of Acute, Community and Social care, resulting in potential over-reliance on short notice, temporary workforce solutions such as high cost agency. Implementation of a flexible workforce retention strategy is needed.

3.3 Leadership AND High and consistent standards of education and training (with respect to workforce planning across health and social care systems)

Over the past five years we have noted the real investment in education and training by the Workforce Project team (now part of Skills for Health), NHS West Midlands, NHS South West and the Department of Health, Social Services and Patient Safety in Northern Ireland. This has produced a cadre of staff with the knowledge, skills and experience to lead workforce planning and workforce reconfiguration. We have seen significant improvements since our response to the 2006–07 Select committee, including:

— an investment in training and development such as:
  — The Postgraduate Certificate in Strategic Workforce Planning, delivered by the University of West London.
  — Local cascade of the national six-step tool (developed by National Workforce Projects) to support professional and managerial leads.

— Investment in the development of shared tools/techniques and common processes, for example:
  — national investment in a range of nursing and AHP workload and workforce planning tools covering areas in both Acute and Primary Care.

— More robust data and information which can be accessed at a local level. There is consensus that over the past 5 years there has been emphasis on gathering good workforce intelligence and using this in planning—for example:
  — In social care—the development & promotion of the National Minimum Data Set (NMDS) and use of NMDS by central government for resource allocations following the Comprehensive Spending Review.
  — In health—the continuing development of the NHS Benchmarking database and establishment of the Information Centre.

This investment has enhanced skills, knowledge and capability and has helped organisations make substantial productivity savings. “Within my own organisation we identified the need to reduce our workforce by approximately 1,470wte over the period 2010 to 2012 and are ahead of target with over 1,250wte achieved to date. These reductions have been achieved through c300 “bottom up” schemes to change the workforce and also a number of system-wide initiatives. I strongly believe that the investment in workforce planners and workforce planning capability has helped support this process.”

However over the past 12 months we note a loss of workforce planning expertise. Some parts of England have lost core workforce planning competence and, for example, have struggled to deliver plans to support the Transforming Community Services programme. One member comments “many experienced practitioners, me included, took the option to depart the NHS. ... now working on freelance basis. (My) current client has had to go out to external short term contract to get the necessary skill in workforce planning ... there is not an internal culture of valuing this role. Mr. Lansley’s management scythe did not assist workforce planning and many who were needed were allowed to go—now NHS has to go out for this expertise.”

Central funding to support the training of workforce planners has been withdrawn. A small number of NHS organisations can fund staff development but no funding has been provided to support our colleagues working in social care. Without continuing shared learning opportunities we risk a failure of integrated planning across the health and social care sectors.

There may be longer term benefits of investing in shared learning opportunities:

“Whatever shape the replacement levy for healthcare providers takes, it should contain the requirement to invest in and plan for the learning and development (CPD) of the whole workforce—with explicit mention of bands 1 to 4.”

3.4 Development and re-skilling of the existing workforce

Arrangements need to be spelt out with some urgency. We consider the retention and re-skilling of our existing workforce a priority. The majority of our staff will still be delivering care in 10 years time. In a period where we are required to make large reductions in headcount, funding is needed to support current staff to work differently.

“Whatever shape the replacement levy for healthcare providers takes, it should contain the requirement to invest in and plan for the learning and development (CPD) of the whole workforce—with explicit mention of bands 1 to 4.”
“The proposals do not take account of how social care is changing with personal budgets, and an increasing number of Personal Assistants. It is challenging enough to count how many there are and build up a picture of that part of the sector. In addition, we should be identifying and resourcing their development needs and these proposals don’t begin to do that.”

3.5 Transition arrangements

The transitions arrangements are not sufficiently detailed to inspire confidence. We believe that the DH has underestimated the challenges of pulling together organisations with diverse and competing interests. We see risks associated with the abolition of SHAs. “SHA workforce planners are currently responsible for both workforce planning that underpins education commissioning and MPET investment, and also workforce planning that is part of the national integrated business planning process.

Although distinct, and covering different time horizons, these two planning processes are linked and should make sense together. Both run on an annual cycle, and both have related assurance and performance work.

It seems fairly clear how MPET workforce planning will operate in future, and how this can be further improved by the development of HEE and LETBs.

What remains unclear is operational workforce planning in the future system, how this will be done, what the future assurance/performance for this will be and also how these two aspects of planning can remain aligned and complementary.

The strong alignment of MPET workforce planning with provider organisations, whilst operational planning (service, financial and workforce) is likely to be led by the national commissioning board. The future system needs to be designed to ensure that there are mechanisms in place to draw these two worlds together; otherwise we are in danger of trying to plan the future workforce supply (MPET) in splendid isolation from strategic service redesign and financial realities—a criticism made by the previous health select committee.”

We are not confident that the proposed arrangements are more efficient—“Any split between Service Commissioning (Commissioning Board) and Education Commissioning (LETB) could lead to complex sharing arrangements of planners or duplication of function/roles.”

3.6 Role, structure, status and size of the LETBs

LETB’s have the potential to:

— engage service providers, get them to be more responsible/accountable;
— forge and strengthen the links between service providers and education providers;
— increase the knowledge about workforce planning and education commissioning/contracting from small few to a more collective approach;
— offer a fresh start and more equitable approach based on what is needed rather than what professional bodies dictate; and
— pool funding for the whole workforce not simply professional groups.

However we need clarity around structures, powers, operational details and relationships. Will the system deliver as intended?

3.7 Roles of Skills for Health and Care and CFWI

We recognise the real contribution of National Workforce Projects/Workforce Projects Team (now part of Skills for Health). Their role in building a common approach to workforce planning and in supporting the development of staff with a workforce planning remit has been invaluable. We are less confident about the contribution of Skills for Health and Care or the Centre for Workforce Intelligence—“feels very cumbersome and not easy to navigate”. If these bodies are to play a relevant role in the system they will need:

— To challenge, not just accept or respond to, DH instruction.
— Greater accountability to health/social care employers, who should define their remit and drive assessment of their priorities.
— To have access to workforce utilisation data for all staff groups, including temporary staffing utilisation and spend in order to provide a holistic workforce planning overview and assess the impact of flexible workforce models, particularly during the transition.

We understand that these organisations may charge for services—this may encourage financially challenged organisations to look to other sources of support and could result in a raft of competing products. We believe this may undermine the consistency of approach that we regard as important to effective integrated workforce planning (see 3.3 above).
3.8 Funding distribution and protection

The proposition is that MPET funding should be used to fund the next generation of clinical staff only. The term clinical excludes other key occupations such as health sciences, management, estates and facilities. The focus on next generation is misplaced (see 3.4 above).

“The risk ... with plenty of evidence to support it—is that budgets for learning and development for existing staff will be squeezed when times are financially tight. Budgets for the learning and development of staff in bands 1 to 4 (health) in some regions have disappeared altogether in times of financial crisis-2006 for example.”

“The key difference now (in comparison to previous reforms to workforce planning and education commissioning) is that the health and social care systems are cash-strapped. There is a real risk of a return to the “slash and burn” approach of the early 90s and, in my experience, it took us 10 years to recover from the supply shortages that resulted.”

“Funding sources are drying up for the band 1–4 in this sector (social care) as Local authorities cut back and very little support now available from the Skills Development Agency.”

(I have a) “great concern that the proposals don’t take account of the requirements of the Social Care, Private & Independent sectors. It is difficult to see a) how arrangements could be made to charge them a levy b) The vast majority are SMEs, and have no spare cash to invest in staff development. This gap in the considerations is particularly significant, as the private & independent sector (largely SMEs) employs at least as many social care staff in this borough as health staff. It is vital in enabling the flow of people through hospitals and supporting them so that they are less likely to have unplanned hospital admissions.”

3.9 Impact on the devolved administrations

We ask for further analysis of the impact of the proposals on the wider healthcare system. A Scottish member comments “Differences in approaches to training numbers within foundation and specialty training in the medical workforce have the potential to impact on the medical workforce.”

An English member reflecting on skills shortages in the labour market notes “I also think we need to consider beyond UK, as healthcare and workforce planning are a global market. The UK is often looked to (for skilled staff)—there is risk that many of our talents will go outside UK.”

December 2011

Written evidence from the Academy of Medical Educators (ETWP 96)

1. Executive Summary

The proposals for education training and workforce planning include bold and radical measures to implement principles that should be widely supported: security of supply; responsiveness to patient needs and changing service models; high quality education and training that supports safe, high quality care; greater flexibility; value for money, and widening participation. The Academy was concerned that little acknowledgement was given to the substantial reorganisations in education and training within the NHS occurring in the past decade, and were noted only as “piecemeal”. When set alongside an ambitious timescale for implementation of different new structures, the Academy views this as a cause for concern. This concern qualifies our support for some of the advantages set out in our response. It would be one more major setback for the NHS if hastily introduced reforms created problems that led to another round of increased central control and bureaucracy.

2. Academy of Medical Educators

2.1 The Academy of Medical Educators is the professional standard-setting organisation for all those involved in medical education. It is a registered charity whose aims are to improve patient care by providing leadership, promoting standards and supporting all those involved in the broad discipline of medical education, through all stages of a career.

2.2 The Academy is pleased to submit these comments to the Inquiry, based on our expressed response to the Government on publication of the White Paper Workforce proposals.

3. Comments for the inquiry

Established in 2006, the Academy (AoME) exists to improve patient care by providing leadership, promoting standards and supporting all those involved in the broader discipline of medical education. Through its Professional Standards, which serve as a guide to curriculum and professional development, the AoME provides a recognised framework for those involved in teaching to demonstrate their expertise and achievement. The AoME is committed to patient centredness in education and training as well as patient care; and to interprofessional learning and the development of new and changing roles for health care. In the context of this consultation paper, the AoME is keenly interested in the implications of the proposed new structures. Many of our Members and Fellows have been involved in the numerous centrally driven changes of recent years, particularly in Postgraduate Medical Education and Training. In this regard we welcome broad comments
that emphasise the Government’s commitment to the highest possible standards of healthcare education and training. The AoME supports proposals that will enable an appropriate workforce to deliver better patient safety, patient experience, quality improvement as well as value for money. Such outcomes are easier to describe than to deliver.

The principles for workforce planning, education and training set out in the preceding White Paper are laudable, and the consultation paper provided some detail on how it is proposed to enact these. The creation of health provider skills networks, now LETBs, will be another major restructuring exercise for the NHS—one that will be disruptive, time consuming, expensive and challenging (particularly at this time of major reorganisation and economic challenge). It would be good to know that learning has been assimilated from the Workforce Confederations that were set up to do this in the 1990s. It will be important to have some key baseline indicators that will enable us to judge whether new proposals achieve their aims. The perennial challenge of balancing “top down” versus “bottom up” reorganisation seems to have been addressed by conviction regarding the principles rather than substance. The significant developments of recent years within the NHS, including Agenda for Change; Knowledge Skills Frameworks; PMETB and subsequent developments; Modernising Medical (and other) Careers programmes; and the commissioning of education and training. Many of the underpinning details are unclear, which is understandable, but of concern given the ambitious timescale for the proposals. Currently, SHAs and Deaneries hold significant responsibilities in relation to quality, funding and workforce planning. Any future system design needs to be clear about where lie: accountability (for driving up quality and reducing cost); ensuring capability and capacity (developing providers and the “market” where necessary); and innovative planning for the medium and long term. AoME is concerned that HEE will have sufficient capacity to do this for all England without some “meso-structure” currently provided by the Deaneries and SHAs.

The crucial interrelationship between Higher and Further Education Institutions and the NHS in all matters relating to education and training for the healthcare workforce needs full attention from the LETBs.

Broadly, the Academy is positive about the establishment of HEE, and its four main, high level, functions are welcome. Much will depend on the scope of its coverage; the complexity of its interrelationships with established (and yet to be established) groups of regulators and commissioners; and its representativeness of and credibility to professions and stakeholders. The worst possible outcome would be an increase in regulatory bureaucracy. Less clear is HEE’s relationship with HPC, GMC, NMC rather than with Monitor, CQC and Skills Councils. It seems that meaningful discussions about these interrelationships will be required, and that respective roles and responsibilities will need to be clarified before other questions about relationships with HPSNs or any “meso-level” structures can be clarified. A transparent and constructive relationship between HEE and the NHS Commissioning Board will be essential, with a degree of cross-representation to ensure education and training is not left to find its own solutions to strategic shifts in commissioning policy.

Successful establishment of Public Health England will be important to the future of the health of the population and to the NHS. It is axiomatic that it should be integrated into the education and training of the healthcare workforce.

The challenges of transition are considerable. What is proposed is another radical reorganisation, notwithstanding the lessons learned about costs, inefficiencies and morale damage in previous reorganisations. This might argue for a short implementation phase as proposed, but we would prefer staging of the changes in order to give HEE more opportunity as an established Executive to oversee the implementation.

December 2011

Written evidence from NHS South of England (ETWP 97)

— South West Strategic Health Authority
— South Central Strategic Health Authority
— South East Coast Strategic Health Authority

1.1 Apprenticeship leads response to the Health Select Committee inquiry on education, training and workforce planning.

1.2 Please accept evidence to support the investigation of the Health Select Committee inquiry on education, training and workforce planning around apprenticeships and how they can support some of the challenges occurring in the development of the Healthcare workforce.
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<tr>
<th>SHA</th>
<th>High and consistent standards of education and training</th>
<th>That the existing workforce can be developed and re-skilled for the future response</th>
<th>Open and equitable access to all careers in healthcare for all sections of society</th>
<th>Other comments</th>
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<td>1.3 South Central</td>
<td>In May 2009 a Continuing Personal and Professional Development Framework for Bands 1–4 was published across NHS South Central. It was identified that flexible and accredited pathways of learning, both personal and professional, are needed to enable transferability of skills and competences between organisations and improve quality assurance, monitoring and enhancement of education provision. Staff members working within bands 1–4 were found to value education and training which is of high quality, is relevant to their role, and is nationally recognised and therefore transferable and delivered in a consistent manor. QCF Certificates and Diplomas and Apprenticeships do provide an element of consistency in education and training for staff in bands 1–3. However this cannot be said for staffs who work at band 4. Little consistency exists around education and training at academic levels 4 and 5 and therefore the Assistant Practitioner role varies greatly. Opportunities exist for implementing high and consistent standards of education and training via higher apprenticeships.</td>
<td>Apprenticeships are being used to secure relevant, service focussed education and training opportunities for staff in bands 1–3. Value for money is secured via development of economies of scale across Trusts. Apprenticeship demand is pooled to drive down costs of provision. This is essential to secure future development opportunities for staff in bands 1–4.</td>
<td>Apprenticeships are a valuable tool to upskill and educate members of the existing and future workforce, helping to ensure staff employed across the career framework is working to the best of their ability. Apprenticeships can be used as a tool to address youth unemployment, which has reached a record high. They open up career opportunities to people who may not have considered the NHS as a viable employment option in the past. Apprenticeships offer Trusts an opportunity to develop their relationships with local communities and effectively represent the views and interests of the people living within them.</td>
<td>Is there nothing that this committee could do to ensure employers had an obligation to take on young apprentices as part of their funding criteria. Concerned on implications of FE loans on the future of education and training.</td>
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<td>1.4 South East Coast</td>
<td>— Recognition is need of bands 1–4 within any plans created and continued funding ring fenced provision, needs to stay on agenda.</td>
<td>— Robust monitoring and evaluation of quality levels including the development of national Return on Investment tools to establish value for money.</td>
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<td>— Further work done on developing a system that fairly recognises vocational training and academic study putting them on a the same rating system, e.g. moving on with UCAS recognition of apprenticeships.</td>
<td>— Need to encourage organisations to build apprenticeships into workforce planning.</td>
<td>— The Future Jobs Fund worked well down in Brighton (not so great in others) in particular could they look to develop national, regional or localised schemes that could work to encourage employers to take on young apprenticeships.</td>
<td>— Robust monitoring and evaluation of quality levels including the development of national return on investment tools.</td>
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<td>— Increasing the kudos of apprenticeships as a viable career route.</td>
<td>— The Future Jobs Fund worked well down in Brighton (not so great in others) in particular could they look to develop national, regional or localised schemes that could work to encourage employers to take on young apprenticeships.</td>
<td>— Encourage the development of career pathways using traditional academic routes and further development and recognition of vocational routes via specific pathways. Recognise that the academic route doesn’t suit everyone.</td>
<td>— Workforce plans should be encouraged to include apprenticeships.</td>
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<td>1.5 South West</td>
<td>With the introduction of the Specific of Apprenticeship Standards for England, apprenticeships are now able to deliver frameworks which are consistent and able to support an equitable service delivery across England’s health service. Using Apprenticeships in the health sector can support patient safety and deliver consistent service outcomes.</td>
<td>The components of the apprenticeship framework through the employer rights and responsibilities part of the apprenticeship can ensure a workforce which is flexible and adaptable to support service delivery. Apprenticeships can be used to support the re-deployment of staff and up skill the workforce to be responsive to service needs; this in turn can reduce the need for costly redundancies.</td>
<td>Apprenticeships can be used to actively recruit from local communities, contributing to a workforce that reflects the population it serves.</td>
<td>Further development work is required by Skills for Health and the National Apprenticeship Service with employer ownership to support progression and access into academia, particularly around a fair and equitable comparison of functional skills against Maths and English GCSE routes.</td>
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<td>There is a requirement to support the development of a Health Higher Apprenticeship framework Level 4/5 which could potentially secure patient safety and ensure an increase in productivity in the “support” healthcare workforce. These productivity gains are not being explored fully as the current policy document, “Liberating the NHS” is focused only on the registered workforce.</td>
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<td>There is a requirement from the Department of Health to encourage healthcare organisations to engage with the ‘Getting Britain working’ campaign and use this initiative to change the ageing demographics of the healthcare workforce.</td>
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*December 2011*
Written evidence from The Newcastle upon Tyne Hospitals NHS Foundation Trust (ETWP 98)

Liberating the NHS: Developing the Health Care Workforce

Thank you for the opportunity to contribute to the Health Select Committee Review of the above. In principle, we welcome the opportunity for the employer led approach to workforce development and education commissioning and we support a process that will enable us to achieve our required outcomes for a fit for purpose workforce, responsive to changing service needs and one that provides value for money. We acknowledge that it is a complex area, with many historical variables that require addressing.

With reference to your information on the Internet detailing your areas of interest for the inquiry, we have provided a response on aspects that we have specific concerns about.

1. The proposed 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

   We have a number of concerns in relation to the impact of the role, responsibilities and structure of LETB at a regional level.

   In particular we are concerned that the proposed structure will not fully facilitate the goal of employer engagement. This specifically pertains to our ability to ensure our Trust workforce and education needs are met through an effective and proportionate representation within the process. As a major provider of specialist services, and often being the only available area for teaching in some fields, we consider that the LETB needs to operate in a manner that it cognisant of this requirement and we would need the ability to work outside the regional framework as required to meet our specialist workforce development and supply issues.

   The balance of the Executive team roles within the proposed LETB is a matter of concern in particular ensuring that it is able to address the wider workforce requirements and not become focussed on medical issues, including Deanery business. We are concerned that both the LETB and the HEE have a strong medical workforce focus which would not represent the wider NHS workforce including Nursing, Allied Health Professions and non clinical and support staff. We have a number of apprehensions about the proposed supporting groups including ensuring wider workforce needs are addressed, and preventing silo thinking/working. The possibility that the Partnership Council, as detailed in the draft North East LETB Model, may only meet infrequently adds to this concern.

   We are as yet unclear as to how HEE will address issues of conflict and what authority they will have and if there will be a process for arbitration if required either between the HEE and LETB or within the stakeholders in the LETB. The relationship between LETB and Clinical Commissioning is not clear.

2. How future healthcare workforce needs are being forecast; the role of the Centre for Workforce Intelligence; how the workforce requirements of providers of NHS and non-NHS healthcare will be balanced; the implications of a more diverse provider market within the NHS

   The original vision for the networks was a focus on the “future generation” and we raised the issue of the definition of this staff group in our response to the national consultation. We require clarity on the scope of the definition in relation to new and advanced roles and how these might be commissioned and the education of these roles would be funded. As a major provider of specialist clinical services, both regionally and nationally, this is a key requirement to enable us to keep pace and also drive service delivery and improvement. This includes requiring clarity on the proposed arrangements for both the processes to manage this need and funding/resources that will be available.

   We consider that there is a role for CfWI, but that clarity is required on where accountability for taking action in respect to any significant findings from their work will lie.

   The need to ensure workforce demand and supply issues across the whole healthcare economy are addressed is welcomed. Historically the NHS has funded and supported in training a number of professional groups and individuals whose destination is the non NHS sector. This will require access to the LETB structure and processes, but also a commitment by Any Qualified Providers in relation to providing quality teaching and learning environments and support.

3. The future of postgraduate deaneries

   It is the clear view of this organisation, endorsed by our Board, that the Deanery should be hosted by Newcastle University, not part of the LETB, and that the LETB should only employ a small Executive team and that the existing SHA workforce should be subject to a process of rationalisation before transfer to a suitable hosting organisation.
4. The future of Health Innovation and Education Clusters

We consider that there needs to be evidence of return on investment from HIECs and that they would, if continued, be a supporting role in the development of the healthcare workforce in relation to reviewing evidence and facilitating innovation in education and adaptation of it within education provision.

5. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

We consider that current good practices should be continued and developed, on the basis of there being a clear requirement by education providers for employer engagement and evidence of action in response to reasonable requests for changes to provision and quality improvements in line with service needs.

6. The role and content of the proposed National Education and Training Outcomes Framework

The principle of the ETOF and its link to patient care outcomes is welcomed. There is currently limited information on the ETOF in respect of the detailed performance measures to be used, though the proposal to use existing NHS quality measures is supported. Further details are required including clarification of whether the ETOF achievements by organisations will be linked to clinical commissioning and any contracted income.

7. How funding will be protected and distributed in the new system

We require clarity on intentions regarding current funding available for CPD from the regional MPET allocation as to whether this will be redistributed and available to employers to enable them to meet the proposed requirement to meet their own workforce CPD requirements.

We consider there is both an opportunity and a requirement to address the true cost of providing education and training in clinical practice and this includes ensuring recognition and reward of time for all training supervision and supporting infrastructure.

We remain significantly concerned over the plans to change the current arrangements for MPET, though accept a review is necessary, and require assurance in respect of securing value for money, equity of process and to avoid destabilising individual organisations within the LETB.

There is currently additional activity locally, reducing available resources within the MPET levy for non medical staff groups which will impact on future workforce needs, particularly in addressing the widening participation agenda. This raises concerns regarding whether there is sufficient funding investment on a recurrent basis to support our future workforce requirements.

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Written evidence from the Health Protection Agency (ETWP 100)

SUMMARY

— Health Protection is an integral part of the public health workforce in the UK and thus closely aligned with the NHS and wider healthcare community.

— The health protection workforce is highly specialised and covers various disciplines and professions each with unique training and education needs, that must be recognised within any new education and training system.

— Public Health England (PHE) will be the only specific organisation responsible for specialist health protection; unique skills and expertise will be required that will not be provided through other NHS routes.

— Currently the Health Protection Agency (HPA) trains and develops its own staff and trains the wider workforce in health protection, a responsibility which should continue as part of PHE, making it a significant stakeholder in the future education and training landscape.

— HPA’s health protection training is delivered via its Health Protection Academy, an example of good practice that is easily transferable into PHE.

— Existing links with professional bodies involved in training and education for health protection need to be maintained and developed.

— Authority and responsibility for future commissioning and provision of health protection training needs to be clarified, in particular the relationships between PHE, Health Education England (HEE) and the NHS Commissioning Board.

— Future education and training solutions must recognise the cross-boundary nature of public health, and provide planned, transparent and flexible career pathways delivering the health protection leaders of the future.

— Arrangements as we move to the new education and training system must ensure a “safe and robust” transition with an emphasis on the maintenance of quality.
HEALTH PROTECTION IN ENGLAND

1. Specialist Health protection in England is currently delivered by the HPA, which employs some 3,800 specialist staff including doctors, nurses and approximately 2,200 scientists. The function will transfer to PHE in April 2013. It is important to note that PHE will be the only specific organisation with responsibility for specialist health protection and this function will not be provided through other NHS routes.

2. HPA's role is to provide an integrated approach to protecting public health through the provision of services support and advice to the NHS, local authorities, emergency services, other arms length bodies, the Department of Health and the devolved administrations and as such, is an integral part of public health, closely aligned to the NHS and wider health economy. The HPA operates through local Health Protection Units, a network of laboratories and four specialised microbiological, epidemiological chemical and radiological centres with a local, national and international remit.

3. Integrated HPA/PHE and NHS working is demonstrated in the support (epidemiological, reference microbiological, and specialist advice) HPA provides to NHS trust-based infection control teams in the prevention and control of healthcare associated infections. Furthermore, health protection staff work in close partnership with environmental health officers in local authorities, providing microbiological and epidemiological support in managing outbreaks of food-borne diseases.

THE HEALTH PROTECTION WORKFORCE

4. The health protection function incorporates a variety of professional disciplines:
   — Public Health/Epidemiology.
   — Public Health Microbiology/Virology/Infectious Diseases.
   — Chemical and Clinical Toxicology.
   — Radiation Protection.
   — Emergency Planning and Preparedness.
   — Research and development.

5. The workforce associated with these specialist areas includes:
   — Consultants in Public Health or Specialist in Public Health.
   — Epidemiologists.
   — Modellers/health economists and bioinformatics staff.
   — Consultant Public Health Microbiologist.
   — Consultant Infectious Diseases.
   — Nurses in HPUs.
   — Biomedical scientists.
   — Clinical Scientists and other laboratory scientists.
   — Medical Consultant Toxicologists and environmental scientists.
   — Radiation protection specialists eg radiation dosimetry scientists, radiochemistry and other scientists.
   — Emergency planning officers.

6. In some areas, for example toxicology and radiation protection, the HPA is the sole repository of highly specialised experts. Often small in number, they have an internationally recognised reputation that places the UK in a unique position to contribute significantly to the global response for such events as the Fukushima nuclear incident.

UNIQUE SKILLS REQUIRED FOR HEALTH PROTECTION

7. The health protection workforce protects the public from a broad range of threats, each with their own unique considerations. However, key common functions underpin the delivery of tangible health outcomes, notably: surveillance and monitoring; developing standards and best practice; research; providing expert advice; and responding to incidents and emergencies. In practice, this means developing public health intelligence and translating it into action at international, national, regional and local levels.

8. The remit of the health protection workforce is to provide a coherent, flexible, resilient and rapid response to public health emergencies such as disease outbreaks, chemical and nuclear accidents, and natural disasters such as floods.

9. In order to do this, the workforce operates and maintains the UK’s high-containment laboratories and facilities for essential research on the world’s most dangerous bacteria and viruses, protecting the nation’s biosecurity and translating this research into action. The horizon is scanned for new and emerging threats to the health of the people of the UK, and staff work closely with international organisations such as the World Health Organization.
10. Furthermore, staff provide the highest-quality, research-driven and evidence-based information possible. This includes data and advice to government and professionals working in healthcare and advice to the public on how to stay healthy and avoid health hazards.

11. Examples of how this translates into practice include:
   - At the local level, Consultants in Communicable Disease Control (CCDC)/Consultants in Health Protection together with health protection nurses, epidemiologists and emergency planning officers, deal on a daily basis with communicable disease, environmental hazards and other health protection incidents. Their activities include prevention, preparedness and control and management of outbreaks/incidents.
   - Public Health Microbiologists/Virologists and Infectious Diseases consultants use their skills in the diagnosis and management of outbreaks and incidents at local, regional, national and international levels. They provide the risk assessment on which the public health response is predicated—based on their specialist scientific expertise and experience. Examples of joint working across national and international borders include the swine flu pandemic in 2009 and the German *E.coli* O104 outbreak in 2011.

12. The unique skills required in order to continue to deliver this function must be recognised and met through a robust, integrated education and training system underpinned by effective workforce planning. Importantly, the educational needs of small and therefore vulnerable specialties and disciplines must not be overlooked, and forms a significant aspect of managing this major educational change.

**HPA/PHE Contribution to Health Protection Training**

13. HPA’s specialist training and education activities represent a unique and valued resource for the health protection workforce in the United Kingdom and internationally. Currently the HPA is either the sole or the significant provider of training in all of the above mentioned specialist areas, holding the National Treasure status for the health protection and epidemiology element of the Public Health Specialist Training Scheme and for Toxicology specialist training. The HPA is also an accredited training provider by the Institute of Biomedical Science (IBMS) and holds the Affiliated Research Centre (ARC) status with the Open University. In addition, many senior staff are contracted with universities as Visiting Professors or Senior Lecturers, and toxicology course material is published as textbooks.

14. Our ability as an organisation to incorporate and develop important evolving disciplines such as bioinformatics and whole gene sequencing into the education of health protection and public health staff, provides an opportunity for the HPA to lead future workforce development in these disciplines.

15. Specifically, HPA provides the training for tomorrow’s specialist health protection staff through its contribution to Specialist Training Schemes (Public Health, Microbiology/Virology and Toxicology), on-the-job training for biomedical and clinical scientists, the UK Field Epidemiology Training Programme, PhD Studentships and through development and delivery associations with professional bodies and universities (including the Faculty of Public Health, and, the Royal College of Pathologists). The HPA also provides training places for international trainees on the European Programme for Intervention Epidemiology Training (EPIET).

16. HPA is also commissioned by the Department of Health to provide emergency and resilience training (through courses and large-scale multi-agency exercises) for the NHS and for European colleagues funded by European grants.

17. HPA has recently drawn all their specialist education and training elements under the Health Protection Academy in order to assure quality, identify training needs and facilitate future workforce development. The academy model consists of topical themes (for example: Epidemiology, Microbiology and Emergency Planning) providing training and development across professional groups (doctors, nurses, scientists) rather than within the usual unidisciplinary professional silos. The proposed education and training system, could consider applying a similar model.

18. It is anticipated that health protection workforce training, development and delivery will transfer to PHE on formation. This means that PHE will be a significant stakeholder in the development of the new education and training system and needs to be fully involved particularly in the development of HEE.

**The New System**

19. Within the new system, authority and responsibility for commissioning and provision of health protection training needs to be clarified, in particular the relationships between PHE, HEE and the NHS Commissioning Board.

20. In order to ensure appropriate succession planning, we see PHE adopting a leadership role in defining health protection training needs and delivering appropriate specialist education for the future workforce.

21. Current delivery of training and contribution to curriculum development by HPA is inextricably linked to other bodies, including professional associations such as: deaneries, Faculty of Public Health, Royal College of Pathologists, Royal College of Emergency Medicine, Institute of Biomedical Science and the UK Public
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Health Register. These existing links and the collaborative working that ensues must be retained in the new system.

22. Future education and training solutions must be comprehensive and integrated and build on these existing relationships and structures. Moreover, it must recognise the cross-boundary nature of public health and health protection work, resulting in transparent and flexible career pathways, attracting and retaining the top scientific and medical talent. This will ensure that public health, and health protection in particular, remains a career of choice. A key consideration for the new system will be in creating the health protection leaders of the future, essential in order to prevent and, if required, respond to increasingly-frequent national and international health protection incidents (for example: extreme events such as flooding, heatwaves and emerging infections and potential bioterrorism).

23. Finally, as we move to the new education and training system it is essential that a “safe and robust” transition is implemented, with an emphasis on the maintenance of quality.

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Written evidence from Work Futures Research Centre (ETWP 101)

The committee must contextualise changes in health care services and workforce within wider social and economic changes. Uncertainty about the demands of the NHS workforce are mirrored in wider uncertainties surrounding deindustrialisation, globalisation, scientific and technological developments and population change. Each of these play out in social and working lives and influence workforce and the economy. We note the following factors worth considering:

— *Shifting inter-professional boundaries:* modern healthcare and services require different and new forms of work. What nurses, doctors and other health professionals is changing. The old speciality and professional boundaries are being eroded—for example by extended scope practice in physiotherapy where these allied health professionals now have the skills once only used by orthopaedic surgeons. Changes to skill mix and job roles cannot be understood outside the wider changes to nature of work—the shifting boundaries of what it means to be a Doctor or a Nurse. We are seeing increasing *labour substitution*—nurses for doctors, healthcare assistants for nurses, clerical for health-related staff and this may be in addition to *artefact or technical substitution*—the introduction of equipment or IT to augment or “replace” roles. (We have undertaken studies of the deployment of computer decision support to enable clerical staff to undertake triage—NIHR SDO projects: Turnbull et al 2011–13 and Pope et al 2008–10) The changes in turn change the kind of workforce we need—one important gap at present (given the increasing digitisation of healthcare) is in IT specialists necessary to build and sustain digitised services effectively.

— *Recruitment and retention:* huge demographic changes—notably the ageing workforce in the developing world are having an impact. There is currently a serious lack of qualified healthcare workers, with prognosis indicating an increasing shortage in the context of rising demand from an ageing population. We need to understand how to attract and retain an ageing workforce into healthcare (some public services have traditionally had early retirement—the UK Police for example often sees retirement at 50–55).

— *Dealing with high sickness rates:* sick leave rates are higher in healthcare sector than in most other industries or services. We have recently begun exploring the “long-term-healthy” approach (translated from Swedish “långtidsfrisk” developed by and described in Johansson et al (2003)) to shift the focus away from counting sickness rates to understanding potential solutions—how and why people thrive at work and stay healthy, and the circumstances, strategies and interventions, which build and sustain well-being at work.

— *The need for lifelong learning:* healthcare work is changing so rapidly that in order to retain an optimum workforce we must constantly retrain and up skill our workers. This challenges some traditional models of healthcare education in which training and skills are front-loaded in the early part of adult lives and which can exclude mature entrants who acquired few qualifications at school but who with training and development have great potential to contribute to the quality of health care. Fuller et al have undertaken innovative work looking at work-based learning, apprenticeships and the characteristics of healthcare workplaces as learning environments which may provide solutions to this need for widening participation, continual development and career progression (Fuller et al 2010).

— *Migrant and Immigrant labour:* Attention must be given to the recognition of non-UK qualifications—there is evidence that consigning or overseas trained healthcare workforce to career/non-progression grades is demotivating and negatively impacts on retention. (Halford and Leonard—BMA work). We must equally recognise the additional and continuing training needs of migrant workers.
— Non-traditional career paths: with women now accounting for over 50% of doctors in training, on top of a predominantly female nursing and healthcare workforce, we must address the needs for flexible and part-time working. Many female doctors self select into specialties (General Practice) that offer work cultures and work-life balance to fit with domestic and familial arrangements. If we are to sustain the range of health care services and specialties we must find ways of making this kind of work pattern possible in other areas (this will also address the ageing workforce issue).

— New organisational forms: we may need to look outside the UK to other contexts to explore different/new modes of service delivery and organisation. For example very specialised and centralised Indian hospitals which focus on a single specialty or procedure. We need to understand the impact of these models on an increasingly globalised and competitive workforce. We may also learn from best practice elsewhere.

— Need for review of the relationship between the AfC pay banding structure, the NHS career framework and National Qualification Levels: to identify how the rigidities of the banding structure may be acting as a disincentive to individuals to pursue education and training and to employers to pursue progressive workforce development and progression strategies.

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Written evidence from Royal College of General Practitioners (ETWP 102)

INTRODUCTION

1. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care.

2. The College has a direct role in devising and delivering a high-quality GP postgraduate curriculum, and supporting the continuing training and development of GPs throughout their careers.

3. Whilst due to space constraints this submission does not cover all issues raised in the terms of reference, the College would be more than happy to provide additional written or oral evidence to the Committee.

EXECUTIVE SUMMARY

4. There are huge challenges ahead for all those working in the NHS—and for the primary care workforce in particular—as the Government’s reforms are implemented in England. As the new system emerges it must adequately support and involve medical generalism, ensuring that GPs and other members of the primary care workforce have the training they need to deliver improved outcomes for patients.

5. The College identifies four key elements that are needed to ensure the primary care workforce can adapt to meet the challenges ahead. These are; the development and use of effective generalist care to support patients who have multiple problems without undue fragmentation and duplication of care provision; extending GP training, boosting the number of GPs and establishing a national framework for education, training and workforce planning that involves GPs in making decisions, taking a long-term approach.

A VISION FOR THE FUTURE OF HEALTHCARE EDUCATION, TRAINING AND WORKFORCE PLANNING

6. The College believes strongly that a clear vision is needed—shared by patients, professionals and policy makers alike—for the future of postgraduate education, training and workforce planning, in primary care and the health service as a whole.

7. Evidence strongly suggests that good primary care—led by a well-trained medical generalist workforce—has a very positive impact on outcomes throughout the health service, reducing emergency and elective admissions and referrals, and providing preventative care in a community setting. Medical generalism and primary care as a whole is associated with high patient satisfaction, low medication use and care related costs. The importance of medical generalism to the health service as a whole has been explored in depth by the Independent Commission on Generalism. It is critical to the future of the NHS that we get generalist—and wider primary care—medical education, training and workforce planning right.

8. The College believes that this vision should include the following broad goals:

— Delivering safe care and better health outcomes to patients by ensuring the mix of skills, workforce numbers and level of training within the system are all geared to support the best possible people delivering the best possible care.


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— A primary care workforce equipped with a level of high-quality training that reflects the increasingly complex challenges facing GPs and the NHS as a whole.

— A well-tested, stable national framework for education and training that enables primary care clinicians to lead decision making at a local or regional level—tailoring provision to local circumstances—whilst also providing adequate levels of national oversight.

— Consistent standards in postgraduate medical education and training, with quality assured across the UK, the number of training placements monitored and coordinated centrally, and health inequalities are tackled effectively.

— A system which provides the incentives at all levels for decision makers to take a long-term approach.

Delivering this Vision—The Challenges

9. It is important that we do not underestimate the challenges to delivering this vision, particularly at a time of huge change for the NHS as a whole. There is compelling evidence to show that action is needed to ensure that the GP workforce is able to adapt to meet the needs of the future.

10. In the context of an ageing population and the increasing movement of particular treatments and care into primary care, GPs have a growing and increasingly demanding role. Alongside their role as providers of care, GPs in England are now also being asked to take on commissioning responsibilities, which is a major addition to the GP curriculum.

11. The College urges the Committee to consider three important areas in which we believe action is needed to ensure the primary care workforce of the future can deliver the above vision: (1) extending GP training; (2) boosting the number of GPs; and (3) ensuring that in the new landscape of the NHS, education, training and workforce development is “fit for purpose”, with decisions about primary care medical postgraduate training being led by GPs.

Extending GP Training

12. General practice has the shortest postgraduate training of any speciality—amongst the shortest in the EU. There is now a long list of high profile evidence which supports the need for extending GP training, including The Tooke report, The Commission on Generalism, Birmingham University’s Evaluation of the GP Curriculum and the APPG on Dementia. The NHS Future Forum also stated in November 2011 that it will be publishing a report recommending that GP training be extended before the end of the year.

13. The College is calling for an initial increase in the length of GP training from three to four (and eventually five) years. General Practice has always evolved and adapted to meet the challenges and expectations of a modern health service. Now, the need for extended training is greater than ever. In addition, there is a need to enhance postgraduate GP training to ensure that trainees gain sufficient exposure in the areas of child and mental health.

14. The role of the GP is evolving, encompassing not only GPs’ ongoing commitment to delivering care to patients on the front line but also newer roles as a “navigator” of the wider care system and now also “commissioner” of care. To perform these responsibilities successfully the GPs of the future will need a growing range of skills, for example in care planning, service redesign and leadership.

15. We believe an additional year would allow the already “squeezed” curriculum to be delivered in more depth, equipping GPs to work in all environments, including working in under-doctored and high-deprivation areas.

16. Next year the College will be submitting a business case for the extension of GP training to Medical Education England.

Increasing the Number of GPs

17. Changes in the gender and age profile of the GP workforce, to job roles and in patterns of working are all driving up the number of GPs needed. If the number of GPs is not increased, the positive outcomes we aspire to cannot be achieved, and there is a risk of a negative impact on access to primary care.

18. Since 2000, according to the NHS Information Centre, the full time equivalent GP workforce in England has grown by 18% (dropped slightly between 2009 and 2010). In comparison, the number of hospital consultants grew by 61% over the same period.138 Attracting newly qualified doctors into GP training is proving challenging, with 2011 figures showing that only 20% of recent medical graduates indicating general practice as first choice of medical career.139 The Centre for Workforce Intelligence has recommended a 17% increase in recruitment into GP specialty training, phased over the coming four years.140

140 Shape of the Medical Workforce: Informing Medical Specialty Training Numbers, Centre for Workforce Intelligence (2011).
19. At the same time, demand for GP services has been growing. Figures from the Centre for Workforce Intelligence show that between 1995 and 2008 there was an increase of slightly over 40% in the number of consultations per patient, reflecting the fact that GPs are increasingly seeing patients with long-term care needs, requiring an increased level of case management.\textsuperscript{141}

20. The College urges the Committee to consider the issue of GP numbers in relation to this Inquiry. Working with the medical profession and informed by the work of the Centre for Workforce Intelligence, Medical Education England—and Health Education England when it comes into being next year—should make it a priority to consider potential solutions to this problem and how investment in the workforce needed for the future will be funded. Two potential solutions include:

- Attracting more postgraduate doctors into GP training by developing the status of generalism as a career choice. Extending GP training as outlined above in line with other medical specialties would be one step to achieving this. In addition, promoting the importance of generalism during the medical undergraduate years and increasing exposure to primary and community care should be part of this process.
- Encouraging more doctors who have left general practice (for example to start a family) to return, with appropriate training and professional development support.
- Measures to tackle the shortage of GPs in under-doctored areas should also form an important part of the overall solution.

**The New NHS Landscape**

21. In its March 2011 response to the Government’s consultation on *Liberating the NHS: Developing the Healthcare Workforce*,\textsuperscript{142} the College expressed serious concern that the proposed system would fall significantly short of delivering a fair, effective and efficient approach to education, training and workforce planning. The College continues to be concerned that the proposals lack an evidence base to support such large-scale uprooting of the existing system, which is seen to broadly work well.

(a) Health Education England (HEE) and Local Education and Training Boards (LETBs)

22. The College remains concerned that the proposed new system of LETBs overseen nationally by HEE may fail to deliver the high quality postgraduate medical education and workforce planning needed to achieve the best outcomes for patients. The College is particularly concerned about the impact on primary care training.

23. In the College’s view a key challenge for HEE will be to ensure that there is comprehensive national oversight of standard setting, monitoring of training numbers and quality assurance across the system. The College has supported proposed amendments to the Health and Social Care Bill to strengthen the role of HEE and the NHS Commissioning Board to provide national oversight on the number of training places. The College notes that the Government has committed to revisiting this area of the legislation at Report stage in the House of Lords.

24. The College remains concerned that LETBs are not the right vehicle to drive forward education and training in the coming years. If LETBs do go ahead, however, it is important that the relationship between HEE, LETBs and deaneries is properly defined with clear lines of responsibility. There is a real risk that a weak relationship between HEE and LETBs will result in an uncoordinated system lacking the right incentives for decision makers to take a long-term approach.

25. The College is concerned that the new system may be dominated by secondary care providers such as Foundation Trusts, further exacerbating problems regarding GP workforce supply described above. Whilst GP-employed staff only account for 10% of the NHS workforce (according to the NHS Information Centre), the College believes that as a minimum GP provider representation on LETBs should be in excess of 10% because:

- There are many more GP provider organisations and GP provision is heterogeneous, so general practice is a more complex sector to represent.
- GP provision covers 90% of patient contacts and primary care has a disproportionate effect on the whole system.
- Within the postgraduate medical workforce, GP CCT holders are almost as numerous as secondary care CCT holders.

26. In addition, the College feels that stakeholder involvement in LETBs could be improved by the creation of reference groups which would inform their work. A primary care reference group, for example, would enable other significant players from the primary care workforce to input their views.

27. The College remains concerned that introducing significant new market forces into healthcare education and training will produce a similar effect to the “inverse care law”, with training quality varying from area to area, potentially impacting on patient outcomes and, ultimately, exacerbating health inequalities.

\textsuperscript{141} Medical Specialty Workforce Factsheet, August 2011, Centre for Workforce Intelligence.

\textsuperscript{142} RCGP response to *Liberating the NHS: Developing the Healthcare Workforce*: http://www.rcgp.org.uk/pdf/%20Developing%20the%20Healthcare%20Workforce%20%282%29.pdf
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(b) The future of postgraduate deaneries

28. Postgraduate deaneries must play a central role in the new system given the importance of their function and the expertise they provide. Postgraduate deaneries must have sufficient autonomy to continue to deliver clinical postgraduate training without unnecessary interference.

29. As well as GP representation within LETBs, postgraduate deans should also sit on the Board of any such organisations.

30. In addition, postgraduate deans should also be closely involved in the work of HEE so that their knowledge of local and regional training needs feeds into the national view taken by this body.

(c) Funding the new system

31. The College feels that more clarity is needed as a matter of urgency on how the proposed levy funding model would work in practice. Such a system could have significant unintended consequences for small providers, including GP practices, who have previously not been required to pay for training. Such payments could cause an exodus of senior staff, destabilising the system as a whole.

(d) Transition to the new system

32. The College is concerned that whilst LETBs are expected to be established by April next year, HEE will not come into being until October. Without national oversight LETBs could begin to develop in an uncoordinated way, leading to instability.

33. The College is supportive of the work of the Centre for Workforce Intelligence (CfWI). As we enter a period of transition and uncertainty, the information gathered by the Centre should be used to ensure that decisions about education, training and workforce development are based on detailed evidence.

34. The Centre should inform the work of HEE, the NHS Commissioning Board, LETBs, providers and others under the new system. The Centre needs to be provided with adequate resources, appropriate powers (eg obliging healthcare providers to provide information on their current and anticipated workforce needs) and relationships with Clinical Commissioning Groups and Health and Wellbeing Boards.

The Future of Training Curricula

35. The Royal Colleges should retain lead responsibility for developing curricula for postgraduate medical training. The RCGP is continuously working towards a living, dynamic GP curriculum which reflects patients’ changing expectations; the needs of the service; current evidence of best practice; the needs of the training community; and changes in society. Our vision for the future is that curricula should increasingly be influenced by, and influencing, those who deliver and receive training, and other stakeholders in the process, including patients. The College would like to see more funding for evaluation of curricula based on participator research.

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Written evidence from The Health Foundation (ETWP 103)

SUMMARY

— Today’s health services require that health professionals learn improvement science, so that the continuous improvement of healthcare is rigorous, systematic, reproducible and based on best evidence, and that their approach is reoriented to share power with patients.

— This is a fundamental change which demands a significant shift in both the content of education and training and in the way that it is taught.

— HEE has a key role in acting as a champion for change across the education and training system. LETBs need the knowledge and skill to commission education and training for quality improvement.

— This submission draws upon learning from our research and programmes.

1. INTRODUCTION

1.1 The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

1.2 We want the UK to have a healthcare system of the highest possible quality—safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

1.3 We are here to inspire and create the space for people to make lasting improvements to health services. Working at every level of the system, we aim to develop the technical skills, leadership, capacity and knowledge, and build the will for change, to secure lasting improvements to healthcare.
1.4 The Health Foundation welcomes the inquiry by the Health Committee. Our submission, based on our research and experience of supporting healthcare professionals to improve healthcare quality in the NHS, focuses on the questions of ensuring:
   — the training curricula reflects the changing nature of healthcare delivery; and
   — the existing workforce can be developed and reskilled for the future.

2. WHy IMPROVING QUALITY MATTERS IN EDUCATION AND TRAINING

2.1 In order to provide patient-centred, safe care and provide value for money, health professionals need more than clinical skills; they also need to be developed so that as well as providing high quality care now, they are also developed in how to continuously improve healthcare quality.\(^{143}\)

2.2 Traditionally, professionalism has been seen as a quality of the individual clinician; health services today require a new professionalism with changed relationships between healthcare professionals and patients, other health professionals, and the health system.\(^{144}\) We need to develop a workforce that:
   — embraces improvement science alongside evidence based medicine;
   — seeks to constantly improve the quality of their own practice and the practice of the team and the organisation;
   — takes responsibility for the patient journey, not just the consultation, and does so collectively with colleagues; and
   — works in partnership with patients, for example making decisions with them rather than for them.

2.3 This demands a significant shift in education and training with:
   — curricula and training that develop competence in improvement science, systems thinking and motivational training, and a willingness to adapt practice to the needs of the patient and to take responsibility across the system;
   — a rapid expansion of multi-professional education and training; and
   — a greater role for patients at every level of the education and training process to help drive an understanding of the patient as a person.

2.4 We should not underestimate the demands this will place on a highly qualified workforce—trained as experts and as carers, who understand their responsibility is to intervene and take responsibility for curing illness—in order for them to shift towards this new way of thinking, feeling and working. The process cannot be taken for granted. It requires strong partnerships between the organisations that determine curricula and exams, service organisations and academic institutions so that learning and training is rooted in best evidence from hard and soft science and evidence from practice. LETBs and HEE must consciously use their leadership roles to develop and model a different mindset; one that values patient autonomy, is open to non-traditional academic learning and methods of teaching, and respects inter-disciplinary and inter-professional working. The measure of success of the new architecture will be the extent to which it delivers these changes.

2.5 The government’s proposals set the ambition to ensure a continuous improvement in the quality of education and training. The skills to continuously improve quality of services must also be a focus of the education and training for health professionals.

3. SKILLING AND RE-SKILLING THE WORKFORCE FOR QUALITY IMPROVEMENT

3.1 To inform our response to the Committee, we commissioned a rapid review of published information about training in quality improvement. It identified that:
   — the focus on quality improvement is less explicit in undergraduate training in the UK and there appears less integration of quality improvement concepts into pre-registration courses, than in other countries;
   — there are diverse conceptualisations of quality improvement, and content of courses and approaches to teaching vary widely;
   — whilst outcomes such as patient-centred care or outcomes may be talked about, formal techniques for implementing improvement are less pervasive;
   — most training of students is unidisciplinary; and
   — education tends to operate within a change management paradigm, focused on making one off improvements, rather than training in how to think critically about improvement and how to continuously improve health services.

\(^{143}\) This is in line with the description by W Edwards Deming, one of the founding fathers of the quality improvement movement, that in order to improve outcomes, people need not only the specialist knowledge of their profession, but also an understanding of how to create a conducive environment in which to both deliver and to continuously improve their work.


3.2 There are some signs that things are beginning to change, with some undergraduate modules addressing critical appraisal, measurement for improvement and quality assurance. There are more signs of development in CPD, through the work of the NHS Institute for Innovation and Improvement, Workforce Deaneries, Leadership Academies and SHAs. HEE must ensure not only that progress is not stalled, but also that momentum is built so that all LETBs, regulators and professional bodies pull together to rapidly extend the opportunities for the workforce to acquire knowledge of improvement science and skills in continuously improving quality.

3.3 Whilst everyone in the NHS needs to have a basic knowledge of improvement science, not everyone needs the same level of skill in applying it. NHS Scotland’s Quality Improvement Curriculum Framework may provide a model for appropriately skilling the workforce according to their role. HEE could provide the leadership and space to develop a similar framework for England which would inform LETBs’ education and training commissioning.

4. SKILLING AND RE-SKILLING THE WORKFORCE FOR WORKING IN PARTNERSHIP WITH PATIENTS

4.1 To realise a genuine shift in the dynamic between patients and professionals will require supporting clinicians and patients to move towards a new relationship, characterised by collaboration. Training needs to reorient and re-skill professionals to take a supportive, power sharing rather than a caring, power holding approach, developing the skills to increase patient activation and use of information. This is not just about adding a new set of clinical skills to the curricula, but a fundamental change in what it means to be a health professional, requiring leadership from HEE to bring together the professional, educational and service stakeholders.

4.2 Involvement of patients and carers in education is patchy, particularly in medical education and in postgraduate and continuing professional development. It tends to be low on the agenda of influential leaders in health education. Whilst there is little evaluation on the long-term impact, there is strong evidence that patient/user involvement has short-term benefits for learners, educators, institutions and the patient/users themselves across knowledge, skills, attitudes and behaviours.

4.3 The Health Foundation’s MAGIC programme is demonstrating how to embed shared decision making in practice. Education and training is a key component of the approach, developing both knowledge and practical skills. The programme links together academic expertise, front-line services and educational institutions.

4.4 The Health Foundation’s work in Co-Creating Health has demonstrated how patients can be involved in multi-professional training, co-facilitating training. The Practitioner Development Programme supports clinicians to acquire and strengthen the skills that best support self-management by people with long-term conditions.

4.5 Local provider-led models are emerging. For example, two London teams are exploring how to mainstream the skills and approaches taught in the Practitioner Development Programme with the deans of their local medical school, their Health Innovation and Education Cluster and the Academic Health Sciences Centre; Addenbrookes Hospital has integrated the approach into the GP Vocational Training Scheme; and NHS East of England has rolled out training to whole GP practices, community teams and clinical specialist teams. These examples are both a model of how LETBs can work together locally to develop and deliver training in new skills and a test bed of joint working. The challenge is mainstreaming such evidence-based training, particularly with the potential disruption as structures are transformed. HEE can play a key role in ensuring that best practice is shared across the LETBs.

Skilling and re-skilling clinicians in multi-professional working

4.6 A recent summit on clinical commissioning demonstrated commitment to multi-professional working, for example producing standards of care along patient pathways. Best care is delivered to a patient by a multi-disciplinary and multi-professional team. However, currently siloed education and training does not develop professionals with the skills to work effectively with other professions. Creating a stronger system of inter-professional development will not be easy. Status expectations will need to be challenged through HEE leadership and LETB commissioning of robust pedagogic methodologies.

4.7 Evaluation of the Health Foundation’s leadership programmes highlights the importance of developing leadership skills which focus on the needs of the patients and which promote system improvement, multi-disciplinary approaches to leadership development, and the fundamental importance of enhancing the emotional


148 The Health Foundation, Academy of Medical Royal Colleges and RCGP Clinical Commissioning Group hosted a summit on clinical commissioning which was attended by representatives of a comprehensive range of professional bodies.

149 Training in Quality Improvement. Rapid review for the Health Foundation’s submission to the Health Committee.
intelligence of leaders. The Foundation is putting this into practice through a masters level programme to develop the quality improvement leaders of tomorrow.

5. The Importance of Re-skilling the Current Generation of Healthcare Professionals

5.1 As the main deliverers of care, the existing workforce will have a greater impact on the quality of health services over the next 10 years than new staff. They have been trained to hold certain values, certain expectations and certain behaviours. They also educate, train, mentor and manage the next generation. It is therefore doubly important we invest in the development of the existing workforce to ensure that they have the aptitude and attitude to meet the needs of tomorrow’s health service.

5.2 One way to support this will be through revalidation. Revalidation aims to ensure that doctors can practice safely and deliver modern health services. Revalidation standards can promote competence anchored in continuous improvement, shared decision making, support for self-management, system responsibility, improvement science and multi-professional working. The GMC and HEE will have an important role to guide LETBs in commissioning CPD that meets these ends.

6. Teaching the New Skills

6.1 Learning about quality improvement requires a different approach to the traditional “fact based” learning of many clinical disciplines and a new set of knowledge and skills to put this approach into practice. Development needs to instil a desire within clinicians to constantly improve what they do, accepting change as an asset rather than a threat.

6.2 Co-Creating Health and MAGIC have demonstrated it is not simply the content of courses that needs to change, it is also the means by which skills are acquired. There is strong evidence that blended approaches that include active learning strategies where participants put quality improvement into practice are more effective than didactic classroom styles alone, and that role play and simulation can help in the learning process.

6.3 Including patients and carers in the co-design and delivery of training has a positive effect on trainees understanding of the psycho-sociological aspects of illness. This is particularly valuable in relation to long term conditions. A fundamental change is needed in medical education to shift the patient role from that of “exhibit” to teacher at the earliest stages of clinical education.

6.4 The Foundation funded Learning to Make a Difference project, led by the Royal College of Physicians of London and the Joint Royal Colleges of Physicians Training Board, introduces quality improvement into core medical training and models a way of aligning professionally relevant development that delivers service improvements in line with provider priorities.

6.5 This project reinforced the importance of trainers understanding the changing needs for tomorrow’s workforce and having the competence to supervise them as they learn new skills. Ensuring there is a sufficient faculty of teachers and supervisors skilled in improvement science and shared decision making will be an essential task for the new architecture to deliver.

6.6 Good care is delivered by teams. Training needs to prepare clinicians for the practice of working together. We think the best way to do this is by training teams as a whole, enabling each team member to support the aptitude and attitude to meet the needs of tomorrow’s health service.

6.7 The new architecture provides an opportunity to strengthen the links between training and service needs. Integrating services across hospital and community settings demands integrated working, which in turn demands professionals learning together across traditional boundaries.

6.8 It will be important for HEE to support LETBs in promoting multi-professional team training both within and between service settings.
6.9 The nature of the environment within which the learning takes place has a big impact on the effectiveness of learning. By bringing together commissioners and providers of learning, LETBs offer the opportunity to become learning communities, creating an environment conducive to effective and service-oriented learning. The Health Foundation is exploring the key characteristics, drivers and ways of working of learning communities.157

7. System Leadership

7.1 HEE has a key role in acting as a champion for change across the education and training system. We highlight the following areas where we believe the HEE could make a significant difference by acting as champion for:

— patient/user involvement in education and training;
— multi-professional training and development; and
— continuous improvement/improvement science.

7.2 HEE also has a role to:

— ensure that England learns from international best practice, including systematised methods of teaching; peer review and structured feedback; and work-based learning;158 and
— build the knowledge base on the impact of training on health outcomes, so that the training budget is used most effectively.

7.3 The HEE needs to take a strong and authoritative national lead to ensure that education and training is preparing the workforce for tomorrow’s demands as well as delivering for today’s service needs. The CfWI needs to have the competence to deliver a strong foresight function for HEE, understanding social and cultural changes; technological and demographic change; and biomedical advances. This will underpin the role of HEE as system leader: a foresight function 20 years ago might have reshaped education and training to meet today’s health needs.

7.4 As the single leader across the system, HEE will have the opportunity to create the space where the regulators and professional bodies can discuss and agree how to introduce standards for training providers that provide a proper training environment for quality improvement. These standards should be met in order for a provider to be a training establishment.

December 2011

Written evidence from HCA private hospital group (ETWP 104)

The purpose of this submission is to outline HCA's ongoing training programmes and our commitment to the training of its entire staff, and in so doing to contribute to the Government’s plans for the long-term education, training and workforce placement of healthcare staff.

Key areas covered in this submission to include:

— EDUCATION AND TRAINING: HCA spends on average £1.2 million a year on the education and training of staff. Many non clinical roles are performed by nurses. HCA is committed to the training of all staff not just clinical staff.

— HCA also recognises that we need to focus on shortage areas in nursing and have implemented a highly successful Operating Department Practice development programme and we are currently developing for September 2012 a Paediatric Intensive Care course in conjunction with Birmingham University.

— 60% of our nursing staff was trained outside the UK and 40% NHS trained in the UK. Although we do not monitor radiology staff training, we estimate the same 60/40 split as with Nursing.

— HCA is committed to maintaining links with many of the London and surrounding based universities. We currently link with The University of West London for a number of our academic programmes as well as London South Bank and Kings College. Our speciality areas also have links with other professional bodies. Apart from the Nursery and Midwifery Council (NMC), many of our staff are members of other professional bodies. For example, a number of oncology nurses are members of the UK Oncology Nursing Society (UKONS) and have become trainers in UKONS Telephone Triage.

— EDUCATION AND TRAINING AND THE ACQUISITION OF NEW AND MORE SOPHISTICATED MEDICAL EQUIPMENT: HCA continues to be innovative in purchasing new equipment for our facilities and this involves specialist training on new equipment. HCA spends upgrades its medical equipment at great cost and regularly acquires new and more sophisticated medical equipment.

157 The Health Foundation is funding a two year study of learning communities in Sheffield and Tayside in the areas of dementia, chronic obstructive airways disease (COPD) and medicine for elderly people, with the aim to getting a better understanding of the key characteristics of learning communities, their drivers and ways of working
158 For brief notes on the differences between countries see de Silva, ibid
— NON NHS AND NHS COOPERATION ON EDUCATION AND TRAINING: A practical link would be working in greater partnership with the NHS in regards to training opportunities. A flexible two way system of sharing knowledge and innovations would be beneficial to both parties, as well as a structured exchange of placements.

INTRODUCTION

1.1 HCA is a private healthcare provider for the treatment of serious and complex medical conditions. We achieve some of the highest patient outcome and survival rates in the UK and our hospitals are virtually MRSA free.

1.2 HCA has six world class hospitals and four outpatient medical centres in London. Our hospitals are, The Harley Street Clinic, The Lister Hospital, London Bridge Hospital, The Portland Hospital, The Princess Grace Hospital and The Wellington Hospital. We also run the highly specialised private cancer treatment unit at University College Hospital (Harley Street at UCH) in London.

1.3 HCA has internationally recognised Centres of Excellence for cardiac care, neurology (brain and spine injuries), women’s health, IVF and fertility. We also run the largest and most advanced private cancer network in London. HCA buys the very latest equipment, drugs and therapies to ensure that our patients always have access to the best possible treatment that is available anywhere.

1.4 HCA International employs 3,794 staff—1,504 of them are nursing staff (many non clinical roles are also performed by nurses); 158 Radiographers; and 599 other clinical professionals.

LEARNING AND DEVELOPMENT

2.1 Each nurse undertakes a 37.5 hour week training course upon commencement of their employment encompassing Corporate and Clinical Induction. Every nurse would then have a two week supernumery period of which a large part is dedicated to undertaking ward based training and supervision.

2.2 Each nurse must then attend a 7.5 hour day at the local hospital induction. This local hospital induction must be compulsorily repeated each year.

2.3 Every nurse is also required to complete compulsory e-learning packages. These sessions take on average two to three hours to complete. Examples of these packages are: Safe Guarding Children Level 1 and 2, MUST Nutrition training, the Safer Use of Insulin, Radiation Protection training, and Safeguarding Vulnerable Adults.

2.4 A nurse can also access any of our in house clinical training via the local intranet. These sessions take place over either a half or full day. Examples of courses on offer are: Cannulation, Venepuncture, ECG Basic and Advanced Study Day, and Palliative Care and Diabetes.

EDUCATION AND TRAINING

3.1 HCA spends on average £1.2 million a year on the education and training of staff.

3.2 HCA is committed to the continual development of nurses and has recognised that we want to attract, engage and retain our best talent within the organisation. To enable this, in 2011 we launched the highly successful HCA Sister and Charge Nurse Development Programme. This development programme focused on developing nurses to become the managers/leaders of the future. This innovative programme was nominated for the Laing and Buisson award and has spurred HCA in developing a number of other development programmes in 2012. These are: the Grade four-five Nursing Development Programme, Management Development Programme and the Leadership Development Programme.

3.3 Each HCA nurse also completes a yearly Performance Plan, with the focus on developing their skills and competencies related to their role. This time also allows for managers to have a career discussion and for the nurse to ask for any training opportunities. The nurse has access to our HCA Study Leave agreement, located on the local intranet and is able to apply for both some internal and external courses.

3.4 HCA also recognises that we need to focus on shortage areas in nursing and have implemented a highly successful Operating Department Practice development programme and we are currently developing for September 2012 A Paediatric Intensive Care course in conjunction with Birmingham University.

3.5 60% of our nursing staff was trained outside the UK and 40% were NHS trained in the UK. Although we do not monitor radiology staff training, we estimate the same 60/40 split as with Nursing.

3.6 As with our Nursing staff, all radiographers undertake the mandatory training in post. The only difference is HCA offers Intermediate Life Support training for radiographers that also focuses on anaphylaxis training and competencies.

3.7 HCA is committed to maintaining links with many of the London and surrounding based universities. We currently link with The University of West London for a number of our academic programmes as well as London South Bank and Kings College. The speciality areas also have links with other professional bodies. Apart from the Nursery and Midwifery Council (NMC), many of our staff are members of other professional
bodies. For example, a number of oncology nurses are members of the UK Oncology Nursing Society (UKONS) and have become trainers in UKONS Telephone Triage.

**Education and Training**

3.8 There is a cost implication associated with recruiting and training new staff. However, HCA is committed to ensuring that all staff receive the training they need to fulfil their roles. In addition, we seek to increase the retention of employees by offering our own training programmes and career development opportunities.

3.9 HCA looks at predicted patient volumes and growth in order to forecast staffing requirements for the coming year.

3.10 HCA offers a number of opportunities for staff to access our many varied educational and training sessions. The focus is on standardising clinical skills and ensuring best practice is utilised in every clinical setting. HCA does this by sharing ideas within the HCA Group and by working in developing a corporate strategy towards training.

3.11 HCA is a private organisation and our patients expect to be treated by consultants. However, we are in the process of developing programmes to support the development of Resident Medical Officers (RMOs) in partnership with NHS Trusts.

**Education and Training and the Acquiring of new and more Sophisticated Medical Equipment**

4.1 HCA continues to be innovative in purchasing new equipment for our facilities, and thus undertakes specialist training on new equipment. HCA regularly acquires new and more sophisticated medical equipment.

**Non NHS and NHS Cooperation on Education and Training**

5.1 It is important to HCA that it is continues to be abreast of the continuing professional development of our treating consultants and relevant changes to practice within a clinical setting. Our organisation makes funding available to develop state of the art practice in accordance with national standards and research that is carried out nationally as well as at the HCA research centre.

5.2 A practical link would be working in greater partnership with the NHS in regards to training opportunities. A flexible two way system of sharing knowledge and innovations would be beneficial to both parties, as well as a structured exchange of placements.

*December 2011*

**Written evidence from the Chartered Management Institute (ETWP 105)**

**Executive Summary**

The Chartered Management Institute (CMI) welcomes the Committee’s timely inquiry into education, training and workforce development in the health sector. CMI has consistently called for a much greater emphasis on leadership and management skills development in the NHS, and is encouraged that this important subject is now gaining more attention.

However, we believe that much work is still to be done if the Government is serious about achieving its Quality, Improvement, Productivity and Prevention (QIPP) efficiency targets and introducing a completely new structure of commissioning, education, training and workforce development at the same time.

We very much welcome the creation of the National Leadership Academy, the successor body to the National Leadership Council, but urge Government to pick up the pace in its implementation so that the achievements of the National Leadership Council are not lost. We are also keen to learn more about the new arrangements for education and training, and how the new structure will deliver much-needed improvements in leadership and management skills, both for clinical and non-clinical managers, particularly in terms of demonstrating what good management and leadership looks like.

With the crucial recommendations of the Mid Staffordshire inquiry keenly anticipated in the first half of next year, the pressure is on Government, NHS employers and staff to raise the bar in terms of leadership and management skills, so as to deliver improved patient care and to allay the public’s perception of alarming variations in care standard levels, particularly at the acute hospital trust level.159

We look forward to working with Government and its agents towards better leadership and management skills at all levels, and in all professions, throughout the NHS.

159 See, for example, the recent media coverage of problems at Barts and the London NHS Trust (http://www.bbc.co.uk/news/uk-england-london-15983985)
ABOUT THE CHARTERED MANAGEMENT INSTITUTE

The Chartered Management Institute is the only chartered professional body in the UK dedicated to promoting the highest standards of management and leadership excellence. CMI sets the standard that others follow.

As a membership organisation, CMI has been providing forward-thinking advice and support to individuals and businesses for more than 50 years, and continues to give managers and leaders, and the organisations they work in, the tools they need to improve their performance and make an impact. As well as equipping individuals with the skills, knowledge and experience to be excellent managers and leaders, CMI’s products and services support the development of management and leadership excellence across both public and private sector organisations.

Through in-depth research and policy surveys of its 90,000 individual members CMI maintains its position as the premier authority on key management and leadership issues.

CMI has an extensive network of approved centres around the UK, which are authorised to deliver our qualifications. To date there are 680 centres, many of which are FE or HE institutions, including Oxford University, Edinburgh Napier University and London South Bank University. Many leading employers are also registered CMI Approved Centres, such as Virgin Atlantic Airways, National Express UK and PriceWaterhouseCoopers. We also work closely with leading business schools to develop our research and knowledge of the management and leadership profession, including Cass, Warwick, Henley, Cranfield and Ashridge Business Schools.

We offer our qualifications to a wide range of learners through a flexible system of credit based learning units, which allows learners to study at their own pace, and in manageable chunks. We also develop new qualifications in response to the needs of employers, such as the CMI Level 3 in Neighbourhood Management and the CMI Level 5 Diploma in Leadership for Health and Social Care and Children and Young People’s Services.

CMI conducts a wide range of activities in the health sector. We have around 3,000 members in the sector, and work with a range of NHS employers to deliver skills training, eg. qualifications, coaching and mentoring and accreditation services. Some examples of our clients include Nottingham University Hospitals NHS Trust, the General Medical Council, the Royal College of Physicians and the Heart of England NHS Trust, Birmingham.

1. Workforce development: prioritising leadership and management skills

Improving leadership and management skills ultimately saves the NHS money, as problems and mistakes are avoided and efficiencies gained. For example, the NHS Institute for Innovation and Improvement estimates that its work has potentially saved the NHS £6 billion over the last few years. Therefore all NHS managers, whether clinical or non-clinical, should have the opportunity to develop and professionalise their leadership and management skills. By doing so, they will be better equipped to deliver the ambitious reforms being introduced by the Government.

We therefore urge Government and NHS employers to place a much greater emphasis on improving the leadership and management skills of staff, both clinical and non-clinical. Much of the Government’s reform programme (including integrated care pathways, clinical commissioning groups, any qualified provider and the QIPP efficiency programme) will depend on these skills for success. We therefore continue to encourage Government to place a greater emphasis on leadership and management skills as part of the education and training agenda for the NHS.

While we understand that the Government is limited in its powers to compel employers to prioritise these skills, we believe much more could be done by Government to encourage employers and individuals to improve their leadership and management skills. We are encouraged that others are now beginning to join our call for leadership and management skills to be put on a professional par with clinical skills (for example, the King’s Fund, and various witnesses to the Mid-Staffs Inquiry). However, the slow progress in establishing the new Leadership Academy (see page 5) and the lack of detail regarding Health Education England’s (HEE’s) responsibilities in this area are frustrating for those wishing to raise leadership and management skills in the NHS. Much more time and resources need to be invested in this area if Government are to succeed in transforming the NHS structure, introducing clinical led commissioning and achieving the QIPP efficiencies at the same time.

160 The King’s Fund are working on a Review of Leadership in the NHS, which will be launched in May 2012. Several of their senior executives, including CEO Chris Ham, have recently highlighted the need for Government to support leadership and management skills more, for example see Chris Ham’s blog, Is good NHS management a waste of money? dated 29.11.11
161 For example, see HSJ article from 27.10.11 (Mid Staffs inquiry hears calls for regulation of managers) or the Guardian article, “Doctors are the best hospital managers, study reveals”, dated 19/07/11
2. High and consistent standards of leadership and management education and training

Alongside the lack of policy emphasis on leadership and management skills, CMI is also concerned that there are no professionally accredited standards for leadership and management development in the NHS, although we welcome the Department of Health’s recent launch of a Leadership Competency Framework. The code of conduct for NHS managers is widely criticised as insufficiently robust in terms of professional standards, ethics and accountability, as the findings from the first Mid-Staffs inquiry revealed.

We would therefore strongly recommend that a voluntary system of leadership and management accreditation be introduced, so that managers who have undertaken accredited management and leadership development, whether it be a full-scale diploma or bite-sized units of on-the-job learning, are recognised and rewarded for their skills by employers. The Leadership Framework also needs to be much more embedded in managers’ work, eg via induction programmes, appraisals and reward programmes.

We have recently contributed to a pilot programme to accredit training programmes in the NHS, which was carried out by the National Leadership Council, and which was very successful. We are also planning a research project in the New Year to help further demonstrate the value of accredited learning to employers and individuals, the findings of which will hopefully facilitate the wider introduction of accredited learning in the NHS.

We are also concerned that under the current system, much of the leadership and management education and training which is carried out is not accredited, meaning that no national standards are maintained from Trust to Trust, profession to profession and around the UK. In a clinical profession this would be unacceptable—but management and leadership development is often neglected by employers, and staff are left to become “accidental” managers when they are promoted.

Unaccredited learning is not necessarily inferior, but given the current pressures on budgets it would surely be better for the training which does take place to be recognised and benchmarked as meeting national professional standards, ensuring better value for money for the employer and greater commitment to study from the learner.

From our own research and employer feedback, we have identified the following benefits of providing accredited learning:

— For all types of management qualifications, a clear majority of employers agreed that productivity gains, staff attraction rates and professional reputation are improved;\(^{162}\)
— 81% of managers disagreed that offering qualifications causes a high turnover among qualified staff;\(^ {163}\)
— Learning is made more attractive to employees and thus encourages uptake and commitment to the development programme;
— The employer’s reputation is improved, thereby supporting recruitment and retention of staff;
— Minimum standards of competence are established, against which managers and leaders can be measured;
— High-flyers are identified, thus supporting talent management programmes; and
— A more strategic approach to leadership and management development can be taken, enabling integration with career frameworks.

Accredited leadership and management learning also promotes social mobility, so that those wishing to take a professional qualification can do so without facing significant barriers to entry which exist in some professions. Through providing higher external recognition of the development programme, accredited learning can improve the confidence and engagement of the learner.

Contrary to some perceptions, accredited learning does not have to involve a significant commitment to study, or time away from the workplace. With the introduction of Qualifications and Curriculum Framework, many leadership and management courses can be taken in units, delivered via distance learning or “blended learning” (ie a mixture of face-to-face and distance learning). This makes them more attractive to learners and employers alike.

Accredited learning could play a significant role in helping to restore trust in the quality of leadership and management in the NHS. Whilst no patient would wish to be operated on by a surgeon who did not hold full medical qualifications, surely no taxpayer would wish to hand over significant public funding and management decisions (which could affect peoples’ lives) to an unqualified manager.

3. Infrastructure for professionalising leadership and management skills

As mentioned above, the transition from the National Leadership Council to the National Leadership Academy is slow and complex. There are many workstreams which the NLC has embarked on which must be

\(^{162}\) The Value of Management Qualifications—The perspective of UK employers and managers. Chartered Management Institute, 2007

\(^{163}\) Ibid
A whole systems approach to enable multi-disciplinary leadership

An important objective of the Government’s overarching public sector education and training strategy should be to share learning and best practice across different parts of the public service network. As a professional body working across all sectors, we believe there is an essential role for the transfer of best practice and case studies in terms of improving leadership and management, especially in times of severe financial constraints. For example, we work with organisations in the health, education, local authority, police, and defence sectors and can highlight some excellent examples of innovation and best practice.

A shared approach to leadership and management is also important in terms of integrating service delivery, which is a particularly important challenge in the NHS. The need to have clear integrated care pathways, which may involve a commissioning care group (CCG), an acute hospital trust, social services, voluntary sector care providers and the patient’s relatives, will be an increasing challenge in the NHS over the next decade. By providing open management and leadership programmes to managers from all these sectors, they are able to develop a shared understanding and approach to management challenges. This in itself helps to break down unnecessary boundaries across different service providers and can promote the effective partnership working that underpins many complex care pathways.

A whole systems approach\textsuperscript{165} to leadership and management development would also reduce duplication and improve value for money. We have heard anecdotally from learners in the NHS that they receive

\textsuperscript{164} http://www.gmc-uk.org/guidance/ethical_guidance/management_for_doctors.asp

\textsuperscript{165} http://www.nationalschool.gov.uk/downloads/wholesystemsgopaper.pdf
unaccredited leadership and management training from one employer, only to find that when they change jobs they have to undergo very similar training from their new employer. This is not only a waste of valuable development budgets, but also wastes valuable staff time which could be better spent dealing with patients.

7. Conclusion

During this Inquiry the Committee has a good opportunity to raise the importance of leadership and management skills of NHS staff with Government and key stakeholder representatives. We hope its members will stress the importance of raising leadership and management skills in the NHS to Government witnesses and will probe them for answers to the queries we have raised in this paper.

December 2011

Written evidence from the NHS Pharmacy Education and Development Committee (ETWP 106)

INTRODUCTION

The Committee exists to provide co-ordination in pharmacy education, development, and training within National Health Service (NHS) organisations primarily, but not exclusively, in secondary care. Members of the committee usually have responsibility for education and training across a geographical area equivalent to several counties and between them cover all staff groups within pharmacy and the whole of the UK. Further information about the work of NHS Pharmacy Education and Development Committee is available at http://www.nhspedc.nhs.uk/

OVERVIEW

1. The NHS PEDC generally welcomes the key principles of the government’s plans proposed in the White Paper “Liberating the NHS: Developing the Healthcare workforce” and agrees that there are potential benefits in a new system which is more flexible and responsive to the changing needs of the service providers and new patterns of healthcare delivery. We also welcome the proposed improvements for workforce planning and commissioning of healthcare education and training at national level.

RIGHT NUMBERS OF APPROPRIATELY QUALIFIED/TRAINED HEALTHCARE STAFF

2. The committee is keen to ensure that, in order to maintain the supply and quality of key elements of the pharmacy NHS workforce, current arrangements are underpinned and maintained during any transition period.

3. The NHS spends in excess of £12 billion pounds on medicines (70% primary care and 30% secondary care). Pharmacists and pharmacy technicians are central to delivering the QIPP agenda in relation to medicines management. Medicines are one of the most common healthcare interventions. Not surprisingly medication related incidents are the third most commonly report incident reported to the NPSA, and the GMC’s own study shows there are errors on 9% of all prescriptions written by junior doctors in hospitals. The report also identifies that pharmacy staff are the main safeguard, which prevents these errors reaching patients.

4. The pharmacy workforce is large with over 43,000 pharmacists and 18,000 pharmacy technicians registered with the General Pharmaceutical Council (GPhC). There is also a large workforce of qualified (but unregistered) pharmacy assistants. The NHS pharmacist workforce has remained broadly the same in the last 12 months but the numbers of pharmacy technicians has continued to rise. This is set against a backdrop of decreasing numbers of pharmacy technicians in training.

5. The professional input of the pharmacy workforce contributes to improved medicines use at the level of the individual patient and the organisation. It is recognised that one of the greatest risks to patients in relation to their medicines is at the point of transfer of care, and indeed NICE has issued guidance on medicines reconciliation to minimise these risks. A recent systematic review of the literature has shown that the pharmacists reduce these risks and indeed result in net savings of £3,000 per 1,000 prescriptions written.

6. Community pharmacy services are playing an increasingly important role in public health and services in smoking cessation and sexual health are embedded in many communities. Yet despite this and their significant numbers, the wording of the proposals still implies they outside of the NHS. As services move from hospital to community settings, the need for joint training and workforce planning is essential.

7. There is not sufficient information in the government plans as to how existing infrastructures for commissioning and delivery of Pharmacy education and training would fit into the new structures. The committee feels that existing expertise should be appropriately utilised to inform the new ways of working. Our experiences with previous organisations such as the Workforce Development Confederations, has resulted in working models, which we have maintained and developed. The resulting SHA-wide Pharmacy Education Programme Boards or Education and Training Committees, may be useful examples to use in delivering the planned changes and would link to the Deanery structures.

8. The NHS PEDC currently facilitates a national staffing establishment and vacancy survey for all levels and bands of pharmacy staff in primary and secondary care. It would be useful to have some reassurance that
there will be systems in place to enable this data to be fed into the CfWI and HEE to inform future commissioning of pharmacy education and training in terms of numbers needed to train.

9. The NHS PEDC seeks reassurance as to the mechanisms by which the CfWI and the HEE would be able to provide clear guidance to each LETB in terms of strategic commissioning intentions at a national level. It’s also important that each LETB is adequately resourced and has adequate expertise to perform their functions effectively. There should be systems in place to ensure that each LETB is accountable for their commissioning decisions to the CfWI and the HEE and that their performance is objectively assessed via a national monitor such as the CQC. The current funding of training for pharmacy staff varies considerably and in times of budgetary constraints for providers, training places become vulnerable. Short term local losses of training posts, can have very long term impacts on service provision. Some very specialised training fails to attract funding. An NHS wide overview of training is therefore essential.

Training curricula reflecting the changing nature of healthcare delivery

10. The NHS PEDC welcomes the government’s plans to promote improved communications and collaborative working between employers/service providers and education experts to ensure that the training curricula reflect current models of healthcare delivery. This has always been a priority in pharmacy education and training programmes commissioned by the NHS.

11. We also agree that the curricula of all education & training programmes must carry appropriate accreditation and conform to national standards (set by regulatory/professional bodies) to ensure consistency and transferability of skills to different settings.

12. The NHS PEDC would like more clarity as to how the proposed government’s plans would ensure timely development of curricula. This would necessitate a more flexible commissioning process to enable close links between employers and healthcare education experts eg via joint appointments between the NHS and HEIs. We have examples of Programme Boards developing the curricula to respond to new ways of working, and to help drive these by their post-registration training.

All healthcare providers (both NHS and non-NHS) should play their part in workforce development

13. The NHS PEDC seeks assurance that this is a feasible aspiration for the pharmacy profession where only one third of the workforce is employed directly by the NHS. The other two thirds are predominantly based in community pharmacies delivering NHS services. It is not clear as to how the new system would ensure that independent pharmacy employers (community pharmacies and private hospitals) would play their part in workforce development via payment of appropriate levy as well as equitable engagement in training of the workforce. A significant part of the pharmacy workforce is supported professionally by the MPET levy funded national Centre for Pharmacy Postgraduate Education (CPPE) based at the University of Manchester.

Multi-professional and multi-disciplinary leadership and accountability

14. The NHS PEDC acknowledges that the government plans give sufficient emphasis on multi-professional and multi-disciplinary leadership and accountability. It would be useful to have more details as to how this would be achieved across the full range of healthcare professions/specialties and grades. The use of care pathways may be one way in which multi-disciplinary training can be developed and in particular, doing so across care boundaries.

High and consistent standards of education and training

15. The NHS PEDC fully supports the proposed introduction of an “NHS Educational Outcomes Framework” to ensure consistently high quality standards of healthcare education and training around the country. We feel that there needs to be more clarity as to how these standards will be implemented and monitored across the country on an equitable basis. More information is also needed regarding the accountability structures for LETBs and how “poor performance” would be addressed.

Development and re-skilling of existing workforce

16. The NHS PEDC welcomes the government plans to support ongoing development of healthcare staff and also provide funding for re-skilling of the existing workforce where appropriate. It is our hope that the proposed new structures ie LETBs and local partnership groups will be able to deliver this aspiration fairly and equitably across the different healthcare professions. This will only be achievable if the groups overcome issues around professional “silos” and achieve the culture shift towards multi-professional working. At this stage we also seek reassurances that the existing variations between different regions will be minimised via robust national steer from the HEE and CfWI.
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Open and equitable access to all careers in healthcare

17. The NHS PEDC welcomes these principles. December 2011

Written evidence from the Allied Health Professions Federation (ETWP 107)

Introduction

The Allied Health Professions Federation (AHPF) is a federation of twelve Allied Health professional bodies representing over 130,000 professional members across the UK of whom 84,000 work in the NHS in England. The purpose of the AHPF is to promote the value of AHPs and integrated professional working. The AHPF believes that AHPs, as key specialist clinicians, are an essential part of the health and care workforce who are well placed to deliver high quality care to patients, clients and service users across the whole of the health and social care sectors. The AHPF also believes that in the emerging health and social care environment there will be a need to involve AHPs in all spheres of decision making and therefore maintaining and developing professional expertise over time will be important to ensuring the sustainability of the system.

The AHPF is uniquely placed to draw on the expertise and experience within the professional bodies in order to inform and engage with consultations, issues and opportunities impacting upon Allied Health Professionals across the health and social care sectors.

This consultation response has been put together on behalf of the whole of the AHPF by the Education Leads within the federation. It has deliberately been confined to broader comments. Individual professional bodies have submitted separate responses where a profession specific response adds value to the consultation process.

Summary

1. Our primary points can be summarised as concerns about the following:

   — The continued trend for student commissions for the allied health professions (AHPs) to decrease; for some professions, this has been up to 30% over recent years, with there being no assurance that cuts will be halted.

   — Cuts to AHP student commissions do not fit with the strong case for increasing, or at least maintaining, student numbers, based on the professions’ contribution to meeting patient and population needs and helping to address government-identified health care priorities in clinically- and cost-effective ways (eg in areas of health promotion and illness prevention, management of long-term conditions, and addressing the needs of an ageing population), and their being excellently placed to lead the integration of services across sectors and settings, deliver care closer to home, and minimise hospital re-admissions.

2. Our more detailed points relating to these concerns are outlined below, with an indication of how each relates to the Inquiry’s themes.

Appraising Workforce Needs

Forecasting future workforce needs/Role of Centre for Workforce Intelligence

3. We have particularly strong concerns about how far projections of future workforce needs are currently being based on high-quality data and how far the data that is being obtained is being subject to high-quality analysis. Both quality data and analysis are essential if an evidence-based approach to workforce planning and decision-making can be achieved. Within this, fulfilling projections of patient and population needs in clinically- and cost-effective ways must be put to the fore, with realistic forecasts made of workforce requirements predicated on evidence of need and taking account of skill mix. We lack confidence that this approach is currently being taken by the Centre for Workforce Intelligence through its contractual role with the Department of Health.

Forecasting future workforce needs/implications of more diverse provider market/requirements of NHS and non-NHS healthcare providers

4. Related to this, we have strong concerns that AHP workforce needs across the whole health care economy are not being factored into commissioning decisions, despite rapidly changing models of service delivery; as patient care is delivered increasingly outside the NHS—and with NHS-funded care set to be delivered by increasingly diverse providers under enactment of the “any qualified provider” (AQP) policy—there is increasing risk that only partial account will be taken of workforce needs, exacerbating a shortfall in supply.

See Appendix for full list of member organisations
UK context/requirements of NHS and non-NHS healthcare providers/public health workforce

5. There is an on-going risk that student commissioning arrangements and decisions do not take account of the AHP professions being a national (UK-wide) workforce, having important roles that extend beyond the purely clinical (including leadership and management, education and research roles) and having a significant and vital role to play across sectors and broad policy areas in meeting population needs and addressing government priorities (including public health, social services, education, criminal justice and industry).

Forecasting future workforce needs/implications of more diverse provider market/requirements of NHS and non-NHS healthcare providers

6. Current financial pressures are impacting negatively on staffing trends and hiding workforce needs and scope for workforce development: as senior posts are downgraded and frozen, this is eroding services’ capacity to take on newly-qualified AHPs and AHP students on placement; in turn, this is impeding the development of sustainable staffing and service models focused on delivering high-quality patient care and with strong clinical leadership. This is likely to have a direct and adverse effect on the quality of patient outcomes and experience and on productivity (including in relation patient waiting times and admission and re-admission rates).

Forecasting future workforce needs/international context

7. Insufficient account is being taken of the international context of workforce planning relating to AHPs (and health professionals more broadly). Projected shortfalls in some countries and within the European Union need to be factored in, so that a full understanding can be gained of how these labour markets will affect supply and demand and migration patterns in ways that will impact on how the UK is able to meet its workforce needs (recognising the traditionally strong reliance upon overseas-qualified health professionals to fulfil staff needs in the NHS).

Education to Meet Workforce Needs: Quality and Sufficiency

Quality/universities/funding

8. There is a strong risk that current health care and higher education reform in England will combine to have a significant and destabilising effect on the commissioning process and the on-going development and delivery of AHP education. We are particularly concerned that the level of uncertainty and volatility created (including by fragmented decision-making regarding commissions, and the pursual of an “open market” approach to competition within higher education) will erode the quality, sustainability and sufficiency of AHP education provision and lead to achievements over recent years unravelling (including the development of strong arrangements for inter-professional education as a platform for future practice, and mutually-beneficial links between AHP education and research and between higher education and clinical services in support of education, research, continuing professional development [CPD] and service evaluation and innovation).

Quality/universities

9. There is a particular trend currently for part-time and flexible study AHP routes to be de-commissioned. This works against the fulfilment of the agenda—which AHPs strongly support—of widening participation in higher education and broadening entry to the professions.

Implications of more diverse provider market/requirements of NHS and non-NHS healthcare providers/ quality/funding protection and distribution

10. There is the strong risk that opportunities for practice-based education—a crucial element of AHP students’ preparation for safe professional practice—will become increasingly limited as service provision becomes more fragmented. There is the related risk that students’ practice-based learning opportunities will fail to reflect future practice contexts, especially if contractual requirements for AQP do not oblige all service providers to contribute to educating the future workforce. It is therefore essential that criteria and contracts for AQP define this contribution to educating the future workforce (through provision of practice-based learning opportunities and/or payment of a levy). If not done, there is a strong risk that the overall quality and sufficiency of practice education will be significantly compromised.

Quality/funding protection and distribution

11. There is an increasing risk that opportunities for high-quality CPD for qualified and support staff will be compromised by planned commissioning arrangements and the proposal simply to leave support for CPD to employers. Again, this will impact negatively on the quality of patient care and outcomes and services’ long-term productivity and sustainability.
Future healthcare workforce needs/overseas-educated staff

12. There is a growing trend for individual HEIs to recruit increasing numbers of self-funding international students onto AHP qualifying programmes as a way of shoring up student numbers and programme viability. However, this is unlikely to contribute to meeting future workforce needs in England (or the UK), thereby exacerbating further shortages in meeting workforce needs (please also see our point 8 above).

Governance and Structural Issues

Transition arrangements/HEE/LETBs/funding protection and distribution

13. While we recognise that the full detail of new structures and processes are yet to be fully worked out, we have strong concerns about governance and lines of accountability in what has so far been put in place. In particular, we are uncertain about how the role of Health Education England will be enacted to ensure that the local education and training boards (LETBs) are duly accountable for the workforce commissioning decisions that they make (and, as part of this, have a clear and common status). Our concerns on this front are fuelled by the apparent disjuncture between the HEE’s planned policy remit (all levels of education, for the whole workforce) and the much more limited oversight it will have in terms of how funds are used (only in relation to entry of qualified personnel to the workforce).

Transition/quality/development of curricula/outcomes framework

14. We welcome the strong emphasis on ensuring quality in health care education, and its development and relevance to meeting changing patient and service delivery needs. However, we are unsure from developments to date how the quality of education will be enhanced and assured (particularly when so many factors of reform are set to erode quality through the volatility and uncertainty that they are creating). Related to this, we are concerned that the central role that professional bodies have to play in enhancing and assuring the quality of health care education, including through providing strong leadership in curriculum development, is being ignored. At the same time, we are concerned that the proposed National Education & Training Outcomes Framework yet has a cohesive approach, and are uncertain about what its implementation will achieve, without modification, in strengthening quality.

HEE/LETBs/quality

15. We are also strongly concerned that the voice of AHPs will not be sufficiently heard within the new workforce planning and commissioning arrangements (including HEE and the LETBs) in ways that will impact negatively on the completeness and quality of decision-making.

Transition

16. There is a risk of increasing uncertainty and volatility in workforce planning as established (SHA) arrangements unravel before new arrangements are fully defined and implemented. This risks disjointed, partially-informed commissioning decisions being made that will compromise the quality and cost-effectiveness of patient care.

Roles/quality/funding protection and distribution

17. We recognise that different models for education for different professions have developed over time, with inevitable variations arising for a host of historical reasons. However, we see a strong value in achieving greater parity and equity in how professions, including the AHPs, are supported and funded, with this approach being extended to include the smaller health professions (eg the arts therapies) that are not currently funded through Multi-Professional Education & Training (MPET) monies, but that have established roles in many services. The new arrangements—which apparently have the principles of patient need, quality and “level playing field” at their centre—provide a prime opportunity to seek to achieve equity and parity.

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APPENDIX

The Allied Health Professions Federation (AHPF) member organisations are:

- The Society of Chiropodists and Podiatrists (SCP).
- The Society and College of Radiography (SCoR).
- The Royal College of Speech and Language Therapists (RCSLT).
- The College of Paramedics (COP).
- The Chartered Society of Physiotherapy (CSP).
- The British Association of Occupational Therapists/College of Occupational Therapists (BAOT, COT).
- The British and Irish Orthoptic Society (BIOS).
Written evidence from the Southampton NIHR Biomedical Research Unit (Nutrition, Diet & Lifestyle) (ETWP 108)

SUMMARY
— Nutrition is a fundamental determinant of the health and wellbeing of people, populations and patients receiving care and all health professionals need to be appropriately trained in nutrition to assure their safety and competence to practise.
— There is a need to improve current standards of education and training in nutrition across the health workforce in order to improve the delivery and effectiveness of the nutritional aspects of clinical care and public health interventions.
— Central to this ambition, is the need for clinical and academic leadership in nutrition to drive forward education and training across the health workforce, to build the necessary nutrition-related research infrastructure and to stimulate research into the most effective means of enhancing nutritional wellbeing.
— We urge that future education, training and workforce planning consider the need to enable academic career opportunities for those required to lead on education, training and research in nutrition, and who can improve the safety and effectiveness of clinical care and public health interventions.

1.1 Southampton is recognised internationally for its basic and translational research in nutrition, diet and lifestyle and its commitment to developing a health workforce competent in nutrition, in terms of both public health and clinical care. Working together, the University of Southampton, the MRC Lifecourse Epidemiology Unit and the University Hospitals Southampton Foundation NHS Trust have pioneered a life-course approach to the prevention and treatment of major non-communicable diseases (NCDs), and have played a lead role in developing nutrition training for health professionals and the integration of nutrition into the clinical care of patients across the NHS. Since 2008, these interests have come together with the establishment of the Southampton NIHR Biomedical Research Unit (Nutrition, Diet & Lifestyle) which will become the NIHR Biomedical Research Centre in Nutrition in 2012.

1.2 Nutrition—what we eat, how active we are and how we live our lives—is an important determinant of the health and wellbeing of people and of populations, and of people’s needs during and responses to illness. Improving diet and lifestyle are key public health targets for improving health across the lifecourse, and reducing the impact of disease.

1.3 There is a nutritional dimension to most aspects of clinical care as poor nutrition may cause ill-health and disease may lead to undernourishment. There is considerable evidence that attention to nutritional care before, during and after illness improves outcome, reduces the costs of clinical care and hospital stay, and is associated with improved quality of life and patient satisfaction. Improving the way that the nutritional aspects of care are recognised and delivered is a core function of all health care professionals, not just those with a specialised role such as Registered Dieticians, and Nutritionists and Public Health Nutritionists registered with the Association for Nutrition.

1.4 Nutritional issues are common in clinical and public health practice, but are often not recognised or adequately managed by doctors, and other health professionals, leading to increased costs and adverse outcomes. Competence in nutrition varies widely across all aspects of the health workforce as there are insufficient opportunities to learn about nutrition, and become competent in the basic aspects of nutrition during pre-registration training as well as limited accredited training opportunities after qualification. We endorse the call by the Intercollegiate Group in Human Nutrition to introduce a core curriculum in nutrition within pre-registration training and the need for accredited learning and defined professional standards in nutrition made by the Association for Nutrition.

1.5 We believe that there is a need to build capacity in nutrition across the health workforce and improve the quality of nutritional advice and care offered to people, populations and patients. Central to this ambition is the need for clinical academics and researchers who will be able to demonstrate clinical leadership in nutrition, to drive forward education and training in nutrition for health professionals, enhance the capabilities for the assessment of nutritional status, and conduct research that will build the evidence base for safe and effective clinical care and public health interventions. We acknowledge the support of the NIHR to build infrastructure for translational research in nutrition within the NHS and academic sector, such as at Southampton, but urge consideration of the need to build academic careers in nutrition, both for clinicians who access nutrition in the delivery of public health and clinical care and for nutritionists with the necessary core understanding and skills in nutrition needed to support research and service development.
CONCLUSION

1.6 There is a need for a health workforce that is appropriately trained in nutrition to assure their safety and competence to practise.

1.7 There is a need to improve the education and training of all health professionals in nutrition, both at pre-registration and post-qualification levels.

1.8 We urge that there is a need to build capacity in nutrition, and that central to this ambition, is the need to develop career pathways for clinical academics and researchers in nutrition to drive forward education, training and research who will improve the safety and effectiveness of clinical care and public health interventions.

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Written evidence from the Dental Schools Council (ETWP 109)

BACKGROUND

1.1 Dental schools are the UK’s centres of excellence in dental education and training and should be the first port of call for any inquiry into education, training and workforce planning. Dental schools are clear that only through the alignment of academic endeavour with patient care can service transformation and improved quality be brought about for patients.

1.2 The Dental Schools Council represents the interests and ambitions of UK Dental Schools as they relate to the generation of national health, wealth and knowledge acquisition through research and the profession of dentistry. Members are the Heads or Deans of the UK’s 18 Dental Schools.

SUMMARY

— Dental Schools are concerned that they might have been overlooked in the current structural changes. Whilst the original plan was for dentistry to be commissioned by the NHS Commissioning Board, no mention has been made of Dental Education.

— Dental Schools work closely with their partner university medical schools and associated Trusts. It would seem natural to wish to see them working collaboratively within Local Education and Training Boards.

— The Dental Programme Board has brought substantial improvements and should be retained.

— Health Education England (HEE) should be established as a matter of urgency to avoid damage to local relationships through the establishment of “shadow” Local Education and Training Boards (LETBs).

— HEE must relate to, and learn from, the Devolved Administrations.

— LETBs must include Higher Education Institutions (HEIs) as full partners with the providers of healthcare in order to achieve excellent and innovative education and training and thus improved patient care.

— Postgraduate dental deaneries and HEIs must be closely aligned, through honorary contracts and joint NHS/university appraisals.

— The transformative potential of Academic Health Science Networks, and the equivalent in the Devolved Administrations, should be harnessed for education, training and research as well as service delivery.

— The role of the GDC in curriculum development should be maintained. Curricula cannot be adapted piecemeal to meet local demands and the national regulator’s role in quality is vital.

— Clarity is needed on the relationship between “outcomes” and “domains” in the NHS Education Outcomes Framework and effective metrics must be developed if it is to be of practical use.

— Educational funding must be ring-fenced, must not be further diluted and should transparently follow the student.

— There must be a reasoned approach to workforce planning which ensures flexibility, especially in higher training.

— A properly resourced Centre for Workforce Intelligence (CiWI) (or equivalent body), working on behalf of HEE, should seek to develop long term plans based on realistic estimates.

— Changes to the immigration system should not remove the attractiveness of working and studying in the UK due to the importance of: diversity of our dental students, the overseas educated workforce to the NHS and the need to retain global competitiveness.
— The dental public health workforce needs clarity, stability and leadership to ensure it meets the challenges of health inequalities and an ageing society.

December 2011

Written evidence from the Cheshire & Wirral Partnership Trust (ETWP 110)

INTRODUCTION

The Cheshire & Wirral Partnership Trust welcomes the Health Select Committee (HSC) Inquiry on Education, Training and Workforce Planning and the opportunity to contribute in the form of this written submission. The comments made below are entirely those of the Trust.

KEY THEMES

1. The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

The Trust whole heartedly endorses proposals for making workforce planning more local employer led—but recognises that both education and training of some parts of the healthcare workforce realistically needs to be organised at regional/national levels. The Trust works hard at developing sustainable local partnerships (both between and beyond healthcare organisations) and also believes that this approach will be absolutely fundamental to making new arrangements effective. To be effective, partnerships require openness, dialogue and preparedness to adapt on the part of all parties: those attributes will be key in making new arrangements work.

2. Training curricula reflect the changing nature of healthcare delivery, including the medico-legal context

This represents a significant challenge, particularly in the current financial climate and the complexities of shifting service provision to the community, whilst maintaining current hospital infrastructures safely. It will be addressed by continuing to work in partnership with regulators, service colleagues and education providers.

3. All providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce

Agreed that this is a cornerstone to success. The challenge for the future is that, whilst many organisations have articulated their support to this in the past, limited progress has been made. The opportunities opened up by this new era of major individual health and social care employers having individual responsibility for forming the planning of the future workforce will need to be grasped in practice in a time when support resources are being severely curtailed.

In particular, NHS organisations (whether commissioners or providers) will need to show leadership in growing local partnerships and turning links into real engagement within local education, training and workforce planning bodies.

4. Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels

Locally, there is already an emphasis placed on trainees growing their personal skills within both patient pathway and service improvement settings, in addition to acquiring the specialist skills which are core to professional identity. Learning in and from teams on clinical placements is part of that. All grades of staff are encouraged to contribute to discussions about patient care and where there is the potential for it to be less than excellent.

Patient safety is also enhanced by ensuring all staff have good levels of literacy and numeracy, accessing SFA/NAS funding where eligible, to achieve the appropriate basic skills and competence and help stimulate a learning culture across the whole workforce.

5. High and consistent standards of education and training

Locally, standards of education and training for medical and nursing staff are promoted through the use of Learning and Development Agreements (LDAs) and formal contracts with education providers. These tend to be inflexible and one of this Trust’s expectations of new arrangements is that providers will have greater input to their content.

6. The existing workforce can be developed and reskilled for the future (through means including post-registration training and continuing professional development)

As a mental health and community services provider, this Trust is very focused on best ensuring that all parts of its workforce are enabled/encouraged to develop and is concerned that what appeared to be the very broadly based ambitions for the role of local workforce development partnerships seems to have become mainly focused
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around deaneries. Efforts will need to be made in practice to ensure that the more widely written original expectations of a more holistic “employer led” approach are delivered.

In this Trust’s view, ensuring good CPD for the whole of the health and social care workforce should be a crucial part of the work of the future provider led networks. That includes having a focus on staff in AfC job bandings below band 5.

7. Open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths)

See comments at section 6 above. This should be one aspect of the work of local networks.

SPECIFIC ISSUES THE COMMITTEE WILL LOOK AT

8. Plans for the transition to the new system, up to April 2013

Given the key role to be played by the network groups, it is vital that all role/responsibility and governance related issues are resolved at the earliest possible stage so that the focus of activity during transition can be on engaging with key partners—which will inevitably take time.

9. The future of postgraduate deaneries

No additional comments.

10. The future of Health Innovation and Education Clusters

No comments.

11. The role of the Secretary of State for Health in the new system

It will be important for the Secretary of State to have overall accountability and to ensure that MPET funding is appropriately protected in the new system.

12. The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture

The multi-professional nature of HEE will provide important opportunities to address the changing nature of healthcare and the requirements of workforce development. It follows that, as part of putting in place clear “accountability” arrangements between LETBs and HEE, the need for appropriate local determination of matters of key local concern should be formally recognised by the HEE—and respected in practice.

13. 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

This trust is of the view that the sensible balance between HEE and provider led networks is to ensure that functions are done as locally as possible unless there is a clear “business case” for them being done at a higher level. It follows that most education and training is best done at local organisation level. Provider led network level should focus upon only those things that are best organised at a regional level, such as contract management, doctors in training coordination and overall workforce needs assessment.

This trust supports the local SHA’s view that HEE needs to provide a strategic framework for provider led networks to work within—but should not commission or organise education and training directly. It should commission the networks to undertake this including lead commissioning on behalf of other networks for smaller professions.

CWP also supports the view that provider led networks are part of the NHS, either as new NHS statutory bodies or through hosting by Foundation Trusts. Clinical Commissioning Groups will need to have appropriate local links to LETBs. There is a risk that a social partnership approach will not enable us to keep sufficient staff to carry out the planned responsibilities at provider led network level.

CWP is of the view that each provider led network (as part of its terms of authorisation) should be required to have in place an overarching workforce and education and education commissioning strategy for its area. That should incorporate a comprehensive portfolio of education and training for the workforce in its area.

However, this trust does not share the view that there needs to be a statutory duty placed on provider organisations to submit workforce plans and otherwise participate in the new networks—that will inevitably be driven by the twin “organisational survival” imperatives of securing a supply of competent staff and accessing funding for training.
14. How professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula

It is considered key to the success of the new arrangements that there is a broadly based involvement of all provider organisations in the formulation and development of curricula.

15. The implications of a more diverse provider market within the NHS

It is considered important that the widest possible range of footprint health and social care providers are accorded the opportunity for active involvement in the work of local networks—ranging from individual independent health & social care providers to bodies such as Skills for Care. Experience indicates that only through such a collaborative will it prove possible to maximise potential benefits, addressing local workforce planning issues and creating sustainable models of training.

Equally, the basis upon which clinical placements are facilitated/managed should be consistent across all providers (NHS and none) to maximise both flexibility of use and breadth of student experience.

16. How the workforce requirements of providers of NHS and non-NHS healthcare will be balanced

Over time, by engendering confidence in the robustness of the work of the local networks by demonstrably focusing on the key challenges emerging from the adopted workforce strategy and planning. It has to be acknowledged from the outset that, for historic reasons, it may take time to produce totally integrated health and social care plans.

17. The role and content of the proposed National Education and Training Outcomes Framework

The draft education outcomes framework needs further development on the detail so appropriate metrics and/or indicators show linkages to patient outcomes.

There is potentially a role for the Centre for Workforce Intelligence in collecting, comparing and reporting upon education outcomes framework information.

18. The role of the Centre for Workforce Intelligence

To provide high quality workforce intelligence data, as commissioned by the HEE/local networks.

19. The roles of Skills for Health and Skills for Care

The view of this Trust is that, as their central funding is continually constrained, consideration should be given to combining the current roles of these 2 organisations. Such an amalgamation would add further some impetus to promoting joint working between the sectors.

20. The role of NHS Employers

NHS Employers should play a key role in pay and conditions national negotiation. It also has an important role as an independent body for providers.

21. How funding will be protected and distributed in the new system

HEE will need to build in formal controls/accountability for funds allocated to LETBs. Ideally, funds allocated to local networks should be a) based on the needs identified within each network’s workforce and training plans and b) planned over a multiple year period (the latter to aid planning continuity). In reality, allocations may be made for identified “core” and “local discretionary” needs.

22. How future healthcare workforce needs are being forecast

This trust’s view is that, although the importance of workforce planning has been much talked about in the past, local practice has often fallen short of expressed ambitions or been overtaken by more immediate matters—the result being reliance falling back on the SHA. The opportunity within the new local networks (coupled with the very real workforce challenges ahead over the next five plus years) will help incentivise a much strengthened approach within participating employers. A five years workforce planning horizon is required to allow for the time between education commissioning and the production of new graduates for non-medical courses: that could helpfully form the foundation upon which comprehensive planning is built.

23. The impact of people retiring from, or otherwise leaving, healthcare professions

Almost 17% of this trust’s workforce is aged 56 or over, so the challenge of continuing workforce supply is very real. The proportion of the nursing workforce falling into the same category is even higher.

24. The place of overseas educated healthcare staff within the workforce

No comments—this is not a major issue for this trust.
25. How the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK

No comments.

26. How the public health workforce will be affected by the proposals

No comments.

December 2011

Written evidence from the General Dental Council (ETWP 111)

ROLE AND PURPOSE OF THE GENERAL DENTAL COUNCIL

1. The General Dental Council (GDC) is the regulator of dental professionals in the UK. Our purpose is to protect the public by regulating all members of the dental team. The dental team comprises dentists, dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists (the latter six referred to as dental care professionals or DCPs). We fulfil our regulatory purpose by:

— registering qualified dental professionals;
— setting standards of practice and conduct;
— assuring the quality of dental education;
— ensuring professionals keep up to date through mandatory continuing professional development; and
— dealing with complaints from patients and others about dentists and DCPs.

THE DENTAL REGISTER

2. All dentists and dental care professionals are required by law to register with the GDC in order to practise in the UK. There are currently some 38,000 dentists and 59,000 DCPs on the register.

EEA Registrants

3. The UK is a net importer of dentists who undertook their dental training and qualified elsewhere in the European Economic Area. Approximately 16% of dentists on the register obtained their primary dental qualification in other parts of the EEA, and over the last five years an annual average of 870 EEA-qualified dentists joined the register for the first time. Based on current data, EEA dentists come to the UK most commonly from Sweden, Poland, the Republic of Ireland and Spain. European mobility is less apparent amongst DCPs; only 0.4% of DCP registrants trained elsewhere in the EEA—mostly in Sweden, Denmark and Poland.

Registrants from Outside the EEA

4. There are approximately 4,500 dentists on the register who qualified outside of the EEA, representing 12% of registered dentists. There are also approximately 120 DCPs who qualified outside of the EEA, representing 0.2% of registered DCPs—so far fewer DCPs from outside Europe are coming into the UK than dentists from outside Europe. DCPs who qualified within Europe or outside make up only 0.6% of the register compared to the 28% of dentist registrants that have a non-UK primary qualification in dentistry.

TIME ON THE REGISTER

5. While the above figures indicate that the UK is a net importer of dentists in a given year, it is important to take account of the length of time that individuals remain registered with the GDC. While we do not have sophisticated data in this area, the figures available suggest that 5% of EEA-qualified dentists who join the register leave it again within just six months, while 50% leave within five years.

6. As a snapshot across the various routes to registration, the following percentages of 2005 entrants had left the register by the end of 2010:

<table>
<thead>
<tr>
<th>Registration Route</th>
<th>% leaving register in 2010 following 2005 registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>EEA qualified</td>
<td>44.8 %</td>
</tr>
<tr>
<td>Overseas qualified</td>
<td>54.4 %</td>
</tr>
<tr>
<td>Statutory examination</td>
<td>9.1 %</td>
</tr>
<tr>
<td>UK qualified</td>
<td>14.8 %</td>
</tr>
</tbody>
</table>
**Education And Training Requirements For GDC Registration**

*Education standards and quality assurance*

7. The role of the GDC in education is to ensure that those who join our registers possess the knowledge and skills to practise dentistry safely, and to have the range of professional skills required to work independently and effectively as part of a dental team.

*L earning outcomes approach to pre-registration qualifications*

8. In recent years we have moved from setting detailed curricula for dental education and training to put the focus on the learning outcomes which students must achieve. The outcomes were developed in collaboration with the training institutions with a focus on safety, quality of care for patient, and the current and future oral health needs of the UK population. They set out clearly what an individual should be able to demonstrate at the end of their training period.

9. The outcomes are grouped into four categories: clinical; communication; professionalism; and management and leadership.

10. The learning outcomes approach will be implemented within training institutions in 2012–13. To reflect this new approach, the GDC is developing a new quality assurance regime that will test whether the learning outcomes have been achieved.

**Ensuring Continuing Fitness To Practices**

*Setting Standards*

11. The GDC sets the standards of conduct and performance required of registrants and takes action where those standards are not met. The current standards are set out in Standards for Dental Professionals. These are currently the subject of a comprehensive review which will lead to revised standards being agreed by December 2012. The views of patients and the public, employers, commissioners, educators and registrants are actively being sought as part of the review. We are also exploring workforce implications, for example seeking to establish whether EEA graduates coming into the UK to practise have different needs in terms of understanding what is expected of them.

*Continuing Professional Development (CPD)*

12. A registrant’s skill and knowledge will develop, through experience and learning, throughout their professional career. The GDC requires that registrants maintain their professional knowledge and competence, through continuing professional development.

13. Our compulsory requirements for CPD are set out in secondary legislation and have been in place since 2002. They were extended to the whole dental team in 2008. There is a high rate of compliance with our requirement that dentists undertake 250 hours and DCPs undertake 150 hours of CPD during a FIVE year cycle. Any registrants failing to comply are administratively removed from the register. We have removed approximately 147 registrants from the register for non-compliance since 2002.

14. The amount of time a registrant commits to CPD is important because it maintains a discipline of ongoing learning throughout professional life, but we believe that it is also important to focus on impact of such learning. In July 2011 we launched a review of the current CPD scheme and as part of this we are developing proposals for outcomes-based approach to measuring and monitoring CPD activity. We are also conducting research and undertaking extensive engagement activity to provide the fullest possible evidence base for designing a future CPD scheme. It is essential that our scheme continues to develop and makes a key contribution to the continued fitness to practise of dental professionals.

15. Our preliminary research indicates value in encouraging blended learning, that learning is most effective when reiterated at regular intervals, and that appraisal and personal development planning should drive learning and development needs. Our compulsory requirements for CPD are set out in secondary legislation and have been in place since 2002. They were extended to the whole dental team in 2008. There is a high rate of compliance with our requirement that dentists undertake 250 hours and DCPs undertake 150 hours of CPD during a five year cycle. Any registrants failing to comply are administratively removed from the register. We have removed approximately 147 registrants from the register for non-compliance since 2002.

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17. Our preliminary research indicates value in encouraging blended learning, that learning is most effective when reiterated at regular intervals, and that appraisal and personal development planning should drive learning and development needs.

Provision of CPD activity

18. Dental professionals will only be able to meet our requirements if appropriate opportunities are provided by those that have a core role in education, learning and development of dental professionals. These include the Dental Postgraduate Deaneries, dental schools, employers and commissioners, and commercial CPD providers. If learning and development is to be effective there must be on-going investment and innovation by providers to ensure quality and value for money.

19. In considering the role of postgraduate deaneries and the establishment of Health Education England it will be important that the professional regulatory imperative is recognised, that is ensuring individual dental professionals are up to date and continue to be fit to practise. There must be recognition of the complementary roles of health education policy makers in resourcing and planning; dental schools, deaneries and others in delivery; and professional regulators in setting the standards for education and on-going learning to ensure patient protection. The future architecture of health education in England must reflect this range of roles and responsibilities, including healthcare professional regulators.

Remediation and return to practice

20. Dentists whose performance has been judged to be lacking, either by a local body such as a Primary Care Trust or by the GDC, can be required to undergo a period of remediation in order to bring them up to the required standard. The Postgraduate Dental Deaneries play a vital role in scoping and providing this training. As a result, practitioners who are successfully remediated can be retained on the Performers’ lists and/or GDC register.

21. The Deaneries also facilitate the return to work of dentists who have taken a career break by providing “Getting Back to Practice” training for those who have been off the register for some time and whose knowledge and skills may therefore need to be refreshed.

Scope of practice

22. As well as keeping knowledge and skills up to date, registrants may use their continued learning to expand their scope of practice, extending their range of skills to the benefit of their patients. The GDC publishes a Scope of Practice guidance document which sets out clearly for each registrant group the skills which they are expected to have on qualification and further skills which they may go on to develop during their careers.

23. Given the rapid pace of change in dentistry, the GDC has given a commitment to keep the Scope of Practice document under review to ensure that it does not unnecessarily restrict practice or stifle innovation in working methods within the dental team. The Scope of Practice guidance is currently being reviewed as part of a larger piece of work examining the skills mix in the dental team, the availability and assurance of training to develop skills after initial qualification and the possibility of patients having direct access to treatment by DCPs.

Direct Access

24. Dental care in the United Kingdom is largely delivered under a system which requires patients to see a dentist for an examination first and then, depending on what treatment is prescribed; some or all of it may be delivered by a DCP. ‘Direct Access’ in this context, would mean giving patients the option to see a DCP without having seen a dentist first. One of the concerns voiced in relation to this is whether or not DCPs have the skills required to ensure patient safety. At present the only DCPs to whom patients have direct access are Clinical Dental Technicians, who are able to see edentulous patients (those with no teeth) direct for the provision of dentures.

25. The main reason that this was felt to be a safe alternative for patients was that CDT training includes specific instruction on the recognition of clinical abnormality and appropriate referral. Should the concept of direct access be extended to other registrant groups it is likely that they would be required to demonstrate a similar level of skill to avoid the risk of serious oral conditions (or other medical conditions which may have oral symptoms) being missed. A decision on direct access could have significant implications for DCP training at both pre- and post-registration levels.

Revalidation for dentists

26. We are further developing our proposals for the revalidation of dentists in the light of the 2011 Government Command Paper “Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff”. In October 2011, in a statement on revalidation of dentists, we made a public commitment to develop a workable, proportionate and cost-effective scheme of revalidation. We have commissioned an evaluation of risk in dentistry which is due to be completed in March 2012 and will inform the design of our model of revalidation for dentists. We are also closely observing the progress of revalidation for doctors to inform our
work. We are committed to working with all key stakeholders, including education and training providers, employers and commissioners in developing an effective model of revalidation.

27. We expect that the further development of our CPD requirements will represent a significant step towards the introduction of revalidation for dentists.

**European professional mobility**

28. Currently the European Directive 2005/36/EC on the Recognition of Professional Qualifications does not acknowledge CPD. The GDC’s position is that it is fundamental to patient safety that all dental professionals, wherever they trained and irrespective of how long ago they achieved their qualification, maintain competence through CPD. We believe it is imperative that dental professionals joining the register from other parts of the EEA should demonstrate to us that they have kept their skills and knowledge up to date. That assurance should be backed up by evidence that all regulators of dental professionals in Europe have systems in place for monitoring CPD activity. We are encouraged by the European Commission’s current interest in extending the RPQ Directive to acknowledge CPD.

29. Throughout the European Commission’s review of RPQ Directive the GDC has also argued that it is crucial to patient safety that healthcare professionals should be able to communicate effectively in the course of their professional life. We have also argued that professional healthcare regulators should be able to test language proficiency where there are genuine concerns about their English language competence.

30. We also advocate mandatory proactive information alerts between European regulators in relation to dental professionals about whom there are serious concerns or who have been barred from practice elsewhere. We believe the infrastructure to enable this already exists in the European commissions’ Internal Market Information System (IMI). We already issue proactive alerts to other regulators in Europe and overseas when investigations of allegations made about registrants begin and when they end. We also proactively advise other regulators of fitness to practise outcomes that impact on an individual’s registration status. We would like this approach to be taken by all other regulators of dental professionals because this will provide further assurance to patients, the public and those that employ and commission dental professionals that those on our register are fit to practise.

December 2011

**Written evidence from the UK Faculty of Public Health (ETWP 112)**

**INTRODUCTION**

1. Public health is a multidisciplinary specialty in the UK. Training is overseen by two Regulators; the General Medical Council (GMC) and the UK Public Health Register (UKPHR). The role of the GMC is to maintain a register of qualified doctors, promote standards and accreditation for education and training including posts, programmes and curricula. The UKPHR is responsible for regulating and keeping a register of accredited PH specialists from disciplines other than medicine. It is essential that there is a robust statutory regulatory system that oversees the public health workforce and protects the public.

**SUMMARY**

— Public Health (PH) is a shortage specialty. Recent evidence shows that there has been a significant reduction in the advertisement, and by extrapolation, recruitment to Public Health consultant posts in England since the publication of the government’s reform plans.

— Presently there is a high quality, well-structured multi-disciplinary PH training programme with relevant curriculum developed by the Faculty of Public Health and approved and reviewed by the General Medical Council (in line with other medical specialities) and the UK Public Health Register.

— The delivery, quality assurance and quality management of public health specialty training should remain firmly within postgraduate deaneries to ensure continuation of high standards in PH training.

— The proposed transfer of public health teams from the NHS to LAs presents new challenges. These include the rapidly expanding employment market for public health specialists by other public and private providers and commissioners of health and social care, appropriately accredited training locations and robust appointment processes and revalidation.

**ABOUT THE UK FACULTY OF PUBLIC HEALTH**

2. The UK Faculty of Public Health (FPH) is the standard setting body for public health in the UK, maintaining professional and educational standards for specialists in public health and quality-assuring professional standards. FPH provides advice to employers and other bodies on statutory and good practice processes for senior public health appointments. In addition, FPH advocates on key public health issues and provides practical information and guidance for public health professionals, aiming to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement.
3. The GMC, UKPHR and FPH are UK organisations, and thus the roles, responsibilities and standards are applicable across the four countries of the UK. It is important to note that proposals affecting education and training systems in England will have an impact across the whole of the UK.

4. In its initial response to the Government’s consultation document “Developing the Healthcare Workforce”, FPH underlined the following overarching principles:
   — The public health workforce should remain fully integrated with the healthcare professions.
   — Specialist public health workforce planning should be undertaken alongside other clinical specialities.
   — There must be expert public health input into Health Education England.
   — Public Health England should have a key role in workforce planning.
   — Local authorities, GP Consortia, higher education institutions and if appropriate the private sector must be included as part of the environments that provide accredited and relevant training in PH.
   — The current functions of postgraduate deaneries must be preserved during the transition.
   — The importance of Health Protection and Academia functions and skills for PH specialists must be underlined and training in these areas must be delivered in appropriate placements.

**Specialty Training**

5. In order to be registered as a specialist in PH on the GMC register and as a specialist for those from disciplines other than medicine on the UKPHR, a structured training programme is available in common with training in other medical specialities. The curriculum and assessment methods are developed by the FPH and submitted to the GMC. The GMC has a statutory role to approve, review and monitor the curricula to ensure it reflects the changing nature of the knowledge and skills required.

6. Public health specialists must achieve competence across nine key areas as outlined below, identified within the public health curriculum.
   (1) Surveillance and assessment of the population’s health and wellbeing.
   (2) Assessing the evidence of effectiveness of health and healthcare interventions, programmes and services.
   (3) Policy and strategy development and implementation.
   (4) Strategic leadership and collaborative working for health.
   (5) Health Improvement.
   (6) Health Protection.
   (7) Health and Social Service Quality.
   (8) Public Health Intelligence.
   (9) Academic Public Health.

   These are the requirements included in the curriculum for PH training and acquiring competence in these areas is mandatory prior to inclusion in the GMC or UKPHR specialist register for PH.

7. There are various organisations that will have responsibilities for the delivery and planning of education and training in the UK. These include Health Education England (HEE), Public Health England (PHE), Local Education and Training Boards (LETBs), Deaneries and training locations in service PH, health protection and academia. It is important to note that rules, regulations and standards for public health training are applicable to the whole UK. Mechanisms for UK wide engagement and interaction of these organisations into education and training structures should be made clear. It is important that the roles and responsibilities of all of these organisations are clearly articulated and developed in collaboration with FPH and other stakeholders to ensure roles and functions are complementary to each other.

**Training and Deaneries**

8. PH specialty training is structured in three phases ((1) knows how/Academic; (2) Basic shows/application; (3) advanced shows/consolidation) lasting five years. Training includes acquiring learning outcomes as outlined in the curriculum and assessment through a range of methods including FPH exams (in common with other Royal Colleges) and work based assessments.

9. The progression of specialty registrars in training is monitored and approved by an Annual Review of Competence Progression (ARCP) panel, convened by the local Deanery. This panel assesses a Registrar’s satisfactory progress in training and reports to FPH. On completion of training a recommendation is made from the FPH to the Regulators for inclusion onto the appropriate specialist Register.

10. The delivery, quality assurance and quality management of public health specialty training should remain firmly within postgraduate deaneries. As public health (in common with other clinical specialities) is a structured training programme for inclusion to the specialist register, the planning and commissioning of public
health training must be undertaken alongside the other medical specialties and healthcare professions and be subject to the same quality standards of delivery. FPH welcomes Health Education England (HEE) as the overarching body to inform workforce planning and monitor standards for training in medical specialties. It is important that there is clarity in the relationship between HEE, LETBs and deaneries to ensure that training is delivered to a high standard.

11. It is important that Deaneries and their functions such as recruitment, human resource management, remediation, training, coaching, formal review of progression and formal reporting to the Regulators are maintained locally to ensure that Registrars are provided with the appropriate infrastructure to enable them to undertake training. Whilst there may be a desire to create economies of scale for these services, it is important that there are responsive functions such as HR, coaching and remediation that are maintained within local deaneries.

12. Deaneries have a responsibility to deliver training in line with nationally approved standards of the Regulators and the relevant colleges/faculties. Whilst working to national standards deaneries must be allowed local autonomy and flexibility to encourage and enable innovation.

TRAINING IN THE NEW PH STRUCTURES BASED IN LOCAL AUTHORITY

13. Previously training for the service components of PH was obtained mainly in PCTs. Registrars usually spent a year in PCTs getting experience of basic skills at the start leading on to developing more advanced skills related to dealing with complex PH projects. With the imminent move of some of these functions from the PCT to the Local Authority (LA) it is important to ensure that LAs are set up as appropriate training locations (in line with the requirements of the regulators) to deliver the range of opportunities to enable registrars to gain the appropriate experience and skills. This will require appropriate educational supervisory and training capacity and quality control within LAs.

14. It is therefore important that LAs are encouraged to engage with local deaneries and LETBs to ensure high quality training is delivered by public health professionals. Widespread opting out by LAs of their training function would present a risk for future public health training, with lack of experience of new consultants to work and operate in an important and essential area of PH delivery as envisaged by the government reforms.

15. To ensure public health education and training continues to be delivered to a high standard, it must be adequately resourced which would involve protected and ring-fenced funding for training.

ADVANCING CONTINUING PROFESSIONAL DEVELOPMENT

16. FPH, employers and individuals have an important role in supporting and providing continuing professional development (CPD) for doctors and specialist from disciplines other than medicine beyond formal training. The proposed transfer of public health teams from the NHS to LAs and the rapidly expanding employment market for public health specialists by other providers and commissioners of health and social care, including those in the private sector, presents new challenges, particularly with regard to the appointments process. The current statutory appointment system—the Appointments Advisory Committee (AAC)—provides a robust system of monitoring applications for specialist public health posts. Through this system, candidates’ qualifications, training and experience are scrutinised by experts in the field of public health, (FPH Assessors), to ensure that only appropriately qualified and trained people are appointed.

17. Currently, the system covers appointments in the NHS. The move to LAs would mean this safeguard may be lost. Extending the AAC process to cover appointments to LAs is essential to maintain the existing level of public protection in the public sector. This would not however cover appointments to organisations in the third or private sectors, many of which now provide publicly-funded services and support public sector commissioning.

18. The AAC process assesses and assures standards at appointment. However, it does not confer timeless assurance, immunity from personal or professional misconduct or protection for the employee, employer or public in the case of fitness to practice issues. For example, if a local authority dismissed someone because they were considered unfit to practice, that information would not necessarily be available to future employers. Similarly, it is possible that a public health specialist removed from a specialist register for professional misconduct could successfully obtain a public health specialist post within a local authority, where there is no requirement for them to be statutorily registered. It is crucial that all public health specialists, whether medically qualified or not, are regulated by an appropriate body.

19. The AAC process is also unable to ensure that professional standards are being maintained. For this purpose, CPD and revalidation are essential. Revalidation will ensure that the CPD and practice of public health specialists will be closely scrutinised and high standards maintained. Currently, it is suggested that this will only be a statutory requirement if they are on the specialist registers of the GMC or GDC, and hence it is essential that revalidation is mandated by law for all public health specialists, including those registered with the UKPHR, who are presently developing a parallel process of revalidation.
PUBLIC HEALTH WORKFORCE

20. Whilst workforce planning is notoriously difficult, it is unlikely that in the medium term the need for consultants required in public health will decrease especially, given the prominence that the government has given to the importance of public health in its plans. The recent NHS Future Forum concluded that "the need for a strengthened public health system at local and national level is clear". The forum recommended that this should be supported by "an independent, expert public health advice at every level of the system".

21. Ensuring that we have a public health workforce which is robust, cohesive and continues to attract the very highest calibre of applicant, it is vital that the wider lack of clarity with regards to public health specialists’ terms and conditions of employment, is addressed and does not lead to a loss of morale, and vital expertise and knowledge from the service, not least with regard to those public health specialists directly involved in the provision of education and training.

22. As the FPH’s Summary of Professional Standards activity 2008–11 demonstrates, public health is a shortage speciality. Statistics from the previous three years of AACs reveals an unambiguous downward trend. In 2008, 208 AACs were held, by comparison with 169 in 2009, 79 in 2010 and so far this year 31. Of the 31 AACs held this year, 12 have so far been filled.

23. Recent data analysis confirms the anecdotal concern that there has been a significant reduction in the advertisement, and by extrapolation, recruitment to public health consultant posts in England around the time of the publication of the government’s reform plans. Public health consultant posts are disproportionately affected by this reduction compared to hospital consultant posts. This contradicts the Government’s commitment to the maintenance of a “well-trained, highly motivated Public Health workforce”.

24. Fowler et al (Fowler et al, “Changes in recruitment to public health consultant posts and hospital consultant posts in England: potential impact on the sustainability of the public health system", Journal of Public Health, Volume 33, Number 4, December 2011) found a highly significant reduction in the mean number of advertisements for public health consultant posts from 27.9 posts per month in the period October 2008 to November 2009 to 6.3 posts per month between December 2009 and May 2010. The ratio of public health: hospital consultant posts fell sharply from 3.3 to 0.9 public health consultant posts per 100 hospital consultant posts. The 2007 Faculty of Public Health workforce census suggested that 20% of the public health specialist workforce were planning to leave the profession during the 2007–11 period, over half of whom were 55 years of age or over at the time of the survey. In previous substantial reorganisations of public health, around 20% of the workforce has taken early retirement. Workforce data suggest that, even with current recruitment to specialist training programmes, there is likely to be a shortage of qualified individuals over the next few years. In addition, at present ~15% of DPH posts are vacant.

25. From October 2008 to November 2009 inclusive, there were 3.3 PH posts advertised for every 100 hospital posts and from December 2009 to April 2011 there were 0.9 PH posts for every 100 hospital posts. The difference in this ratio was a reduction of 2.4 advertised Public Health posts per 100 hospital number of advertised public health consultant posts (England).

26. More significantly, it demonstrates that advertisement, and by extrapolation, recruitment of public health consultant posts have been disproportionately affected by this reduction in recruitment compared with hospital consultant posts. This drop in advertisement, and by inference recruitment, potentially poses a considerable threat to the integrity of local public health departments and the ability of PCTs, LAs and emerging clinical commissioning groups to tackle the needs of health improvement, reduce health inequalities and successfully manage the transition of public health over the next two years.

POSSIBLE IMPACT OF THE PROPOSED MOVE OF THE PH FUNCTION TO A NON-NHS BODY

27. The move of public health away from the NHS could potentially make it a less attractive career choice, particularly for clinicians. In turn, the provision of public health specialists within an education and training context may—and indeed is, given the figures above—be negatively impacted. It is vital that the highest quality applicants are attracted to these posts. The Government’s proposed workforce strategy, will not make specific proposals on terms and conditions. This will be left to individual employers. There is a real risk that the public health workforce could become fragmented in the new system, with public health specialists being employed in a number of different settings, including Public Health England, LAs, some retained in the NHS and others will move to the voluntary or private sectors. This would undermine the cohesion of the profession, and disrupt education and training.

December 2011
Written evidence from the Royal College of Physicians (ETWP 113)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. As an independent body representing over 26,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

SUMMARY OF THE RCP’S RESPONSE

The RCP believes the following fundamental principles should underpin medical education and training:

— National standards.
— National planning.
— Ring-fenced funding.
— Independent quality management and assurance.

The RCP believes that the roles and responsibilities of bodies in new structure should be as follows:

— Health Education England should lead the national planning process for all postgraduate medical education, working closely with the medical royal colleges and the Centre for Workforce Intelligence (CfWI).
— Postgraduate deaneries should be responsible for independent quality management of medical education and training and trainee management.
— Local Education and Training Boards (LETBs) should advise HEE and bring together the local health and social care community.

The RCP is calling for the health service reforms to have stronger safeguards to protect medical education and training. Commissioners, both local and national, should be required to consider education and training and it should be part of Monitor’s licensing conditions. To prevent problems with transition HEE should be established under the Health and Social Care Bill.

The delivery and content of medical education and training should be reviewed. While there should be improved inter-professional education, the RCP is concerned that trainee medical specialists have particular education needs which would not be met in multidisciplinary training sessions. We also want time for work that contributes to the wider NHS to be recognised and respected by employers, as recommended by the Future Forum.

The RCP is aware that there are changing workforce demands and requirements. The RCP is establishing a Commission on the Future Hospital in early 2012 that will explore issues such as generalism, providing a consultant delivered service, medical career paths and improving the flexibility of rotas to mediate against problems caused by EWTD and the New Deal.

FUNDAMENTAL PRINCIPLES THAT SHOULD UNDERPIN MEDICAL EDUCATION AND TRAINING

1. The RCP believes the following fundamental principles must underpin medical education and training structures.

NATIONAL STANDARDS

2. Medical education and training must adhere to national standards. We must be able to trust that doctors trained in different parts of the country are able to deliver the same high standard of care. This will prevent variation in standards and facilitate movement of doctors working around the UK.

3. Specialist societies must have a central role in setting and developing the curriculum for training doctors in their specialty. This must be centrally planned. As the umbrella body for 31 medical specialties, the RCP can act as the conduit for this work. The RCP will work to develop strong links with HEE to develop strong national standards for medical education and training.

NATIONAL PLANNING

4. The medical workforce must be nationally planned. Training must consider both service needs and the whole pathway of medical school to specialism, which is often 15 years or more. Medical training is expensive, and the right balance must be achieved between specialties. Experience tells us that this requires constant national supervision and intervention. This is most obviously the case for smaller specialties, but it is clear that planning for all medical specialties, such as cardiology, requires long term vision. The number of trainee placements for medical specialties should be set at a national level, with scope for flexibility in local implementation. HEE should be responsible for approving local plans and have sufficient powers to take action where necessary.
5. National planning requires good quality data. Attempts to plan the medical workforce in recent years have been hampered by the lack of reliable information about the numbers and location of doctors in training.\textsuperscript{167} The RCP supports the further development of the Centre for Workforce Intelligence (CFWI) and the promotion of more integrated ways of working. The RCP’s Medical Workforce Unit currently works with the CFWI to improve the data available to facilitate workforce planning.\textsuperscript{168}

6. There are currently challenges facing the medical workforce that illustrate the need to nationally plan based on good quality data. There is currently an oversupply of trainees in some medical specialties. Renal medicine is the worst affected, but gastroenterology, respiratory and cardiology are “at risk”. Conversely, there is also an undersupply of consultants in small specialties such as audiovestibular medicine and some large specialties such as dermatology. This has created a large variation in service provision across the UK. Under and over supply of both trainees and consultants has exacerbated the variation in medical staffing levels both at junior and senior levels throughout the country.\textsuperscript{169}

RING FENCED FUNDING

7. Funding should flow directly from the national commissioner to deaneries, medical schools and other Higher Education Institutions. This ensures that as far as possible funds allocated centrally for education reach regional education bodies intact and are not, for example, siphoned off for service.

8. The RCP supports the concept of an NHS training levy paid by all providers, including providers to the NHS, directly to HEE. This should include those providers who do not provide NHS services, but do use NHS trained staff, ie the independent sector. Experience tells us that it is difficult to establish the true cost of training doctors and it is too easily underestimated. Work must be started now, which engages a full range of bodies, including royal colleges, to establish the level of the levy. However, the RCP is concerned that the levy is not a sufficient safeguard to ensure that there is sufficient training provision in the health system to produce the amount and types of doctors that is required to meet the needs of the NHS (see the Health Service Reforms section for more detail).

9. The RCP supports the review of the Multi Professional Education and Training (MPET) budget and agrees that the current system should be reformed. Currently, the link between the quality and quantity of education and training, and the funding that pays for it, is weak. There are insufficient incentives for excellence, and inadequate, or non-existent, penalties for failing education providers. There must also be sufficient incentives to ensure that education and training are improved when outcomes are shown to be poor. The RCP suggests that HEE consider adopting a system of financial incentives for quality similar to the Commissioning for Quality and Innovation (CQUIN) payment system used within service commissioning.

INDEPENDENT QUALITY MANAGEMENT AND ASSURANCE

10. Postgraduate and undergraduate deans must be the “responsible officer” for quality management of medical education. The GMC has a clear structure for holding deaneries accountable at a local/regional education training board level to ensure quality management, while individual providers undertake quality control. This is a strong and logical system that combines understanding of service pressures at a regional level and proper external scrutiny.

11. The RCP believes that personal contact with trainees can improve quality management and supplement the data generated from surveys. We believe it is crucial that quality management looks at supervision and training, and has the teeth to withdraw funding and trainees. Postgraduate deaneries must maintain sufficient independence and autonomy to undertake their quality management functions effectively, and should therefore not be part of LETBs (although the dean would sit on these boards).

12. Close contact with trainees also has the potential to detect wider safety and quality issues, which can be discussed/monitored/acted upon/referred to regulators, as appropriate. It is important that any changes to structures take account of the findings and recommendations from the Public Inquiry into Mid Staffordshire NHS Trust, due to report in spring 2012.

13. There has been much debate about metrics to support the development of medical education (or as a financial incentive). Measuring, publishing and incentivising quality is vital but new proposals must be piloted and subject to academic scrutiny, and proper prospective academic study. The RCP should be involved in developing this evaluative framework.

\textsuperscript{167} At present, the size of an individual workforce is decided based on the prediction of its needs by a specialty (as outlined in “Consultant Physicians Working With Patients”), the number of training posts decided by the Medical Education England (MEE) Medical Programme Board, the Workforce Availability Policy and Programme Implementation Group (WAPPIG), the deaneries and the local finances of trusts. Centre for Workforce Intelligence advises the Programme Board and WAPPIG, and was hoped to be a facilitator in the planning process.

\textsuperscript{168} In addition to our Medical Workforce Unit, which can continue to advise CFWI on numbers and measurement, we also have a well-developed regional system embedded in the Schools of Medicine and hospital trusts. This is well-placed to facilitate the provision of expert advice on medical specialties to any localised workforce planning functions.

\textsuperscript{169} These conclusions are drawn for data generated by the annual RCP Census. Please contact the RCP directly if you would like more information on the data available.
ROLES AND RESPONSIBILITIES OF BODIES IN NEW STRUCTURE

14. To secure high quality medical education, the RCP suggests the following role for bodies in the new health system.

HEALTH EDUCATION ENGLAND

15. The national planning process for all postgraduate medical education should be led by Health Education England (HEE), working closely with the medical royal colleges and the Centre for Workforce Intelligence (CfWI). The number of trainee placements for medical specialties should be set at a national level, with some scope for flexibility for local implementation. HEE should be responsible for approving local plans and have sufficient powers to take meaningful action where necessary. HEE must retain strong professional ownership and influence. The RCP strongly recommends the retention of the Medical Education England’s Medical Programme Board, which supports an inter-professional approach.

16. The professional advisory boards and MEE’s Programme Boards should be absorbed into HEE’s structure. This will ensure continuity throughout and beyond the period of transition. The Medical Programme Board will advise the main HEE Board on the development of their respective education and training arrangements and on workforce planning matters. It—together with the other programme boards—will play an essential role in scrutinising the local plans of provider networks and drawing attention, for instance, to any issues that may not be in the overall national interest of the right workforce supply.

17. The RCP recommends that the Medical Programme Board carry out the functions originally described in the Tooke report, which includes holding the ring-fenced budget for medical education and training for England and defining the principles underpinning postgraduate medical education and training (PGMET). There must also be lay involvement at a strategic level within HEE.

POSTGRADUATE DEANERIES

18. Postgraduate deaneries undertake crucial functions that cannot be delivered as effectively elsewhere in the system—including independent quality management function and trainee management—and must be retained. We welcome both the Future Forum’s and the government’s recognition of the importance of postgraduate deaneries. There has been growing partnership at regional level between royal colleges, deaneries and medical schools through the development of specialty schools. Developing academic training partnerships need to be fostered and enhanced.

19. Postgraduate deaneries should be made accountable to HEE at a national level, and continue to be accountable to the General Medical Council (GMC) for the delivery of the postgraduate medical curriculum. Postgraduate and undergraduate deans must be the “responsible officer” for quality management of medical education.

20. Local hosting arrangements for postgraduate deaneries will need to be set up following the abolition of Strategic Health Authorities (SHAs) in 2013. There are a number of potential models for the hosting of postgraduate deaneries, including as an autonomous, independent body hosted within universities, a teaching trust, academic healthcare centre or in sub-national HEE or NHS Commissioning Board structures. Hosting arrangements could be determined locally depending on local needs and relationships. However, the routes of accountability (to HEE) and funding (from HEE) should be common across the system, and postgraduate deaneries must maintain sufficient independence, control and autonomy to undertake their quality management functions effectively.

21. Royal colleges and deaneries have worked together recently to deliver deanery-based schools to create and effective visiting processes. Over the last three years, heads of school have become an enormous source of workforce knowledge and expertise at a regional level. They understand where the trainees are, they know the service pressures and they know the workforce undertaking the training. They should be one of the most powerful sources of local workforce expertise at a regional level to support local education and training boards in the future.

LOCAL EDUCATION AND TRAINING BOARDS (LETBs)

22. It is vital that local needs are understood, and that providers are engaged in education and training. This information must influence the national commissioning programme if it is to make sense at a regional level. It is widely understood that it has been difficult to engage local education providers in either national or local workforce planning.

23. Local Education and Training Boards (LETBs) should provide information and advice to the national commissioner (HEE). In relation to postgraduate medical education, their role should be to advise the national commissioner, as well as acting to bring together the local health and social care community. In medicine, local needs tend to focus on months to a year. Training, however, must consider the whole pathway of medical school to specialism—often 15 years or more. There are already examples of inter-professional educational

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bodies, such as deaneries, being hosted outside Strategic Health Authorities helping to develop strategy and inform local delivery. We would advise learning from these non-bureaucratic solutions and can provide examples on request.

24. There needs to be greater clarity on the arrangements for ensuring that providers participate in LETBs. Developing the healthcare workforce suggested that Monitor is likely to have a role in ensuring provider participation in LETBs. There needs to be a clearer vision of the sanctions and action that will be available if providers do not participate. Likewise, there must be clear guidelines setting out what meaningful participation will look like.

**Delivery and Content of Education and Training**

**Inter-professional training**

25. There should be improved inter-professional education, and there is a role of LETBs in ensuring this happens. Developing clinical leadership, team working and a real focus on improving patient care is fundamental for the NHS. This is not, however, the same as multidisciplinary/multi-professional education. Multi-professional education at the undergraduate level, other than for groups requiring the same scientific basis to their studies or where there are certain shared needs, has not been demonstrated to have any impact or saving, for the different professions have different requirements. Trainee medical specialists have particular education needs which would not be met in multidisciplinary training sessions.

**Time for work that contributes to development and the wider NHS**

26. The RCP particularly welcomed the Future Forum’s recommendation that there be recognition of the importance of time for training and work that contributes to the wider NHS, including college work, such as curriculum development, training and the development of clinical standards. This should be formally recognised by the government.

**Health service reforms**

27. The RCP welcomes the government’s amendment to the Health and Social Care Bill that gave the secretary of state a duty to secure education and training, introduced in Committee stage in the House of Lords. However, the RCP believes that the Health and Social Care Bill should have further amendments to ensure education and training and the future workforce is safeguarded.

28. The RCP is concerned that the training levy will not be sufficient to ensure enough training is being provided to meet the future needs of the health service. There needs to be national oversight to ensure that enough commissioning contracts are awarded to providers that offer sufficient medical training. The RCP is therefore suggesting an amendment to clause 23 to give CCGs a duty to promote the education and training of the current and future health care workforce. This should also be a mandatory part of commissioning contracts. Trainee medical specialists have particular education needs which would not be met in multidisciplinary training sessions.

29. The RCP also believes the Monitor should be required to consider education and training when licensing providers. Clause 93 of the Health and Social Care Bill should be amended to ensure that education and training is a mandatory licensing condition, with certain explicit exceptions.

30. To prevent transition problems, we also recommend that Health Education England is established under the Health and Social Care Bill, as are the four principles it will adhere to when carrying out its functions—namely there will be national standards for education and training, the workforce will be nationally planned, there will be ring-fenced funding and an independent quality management system.

**Changing Workforce Demands and Requirements**

31. The medical workforce must meet the need—and future need—of patients. The RCP will be launching a Commission on the Future Hospital in the New Year that will explore how address the issues raised above. The RCP will keep the health select committee informed of the progress of this work.

**Generalism**

32. We need to assess whether the current balance between physicians trained in a speciality and those trained in general internal medicine and/or geriatric medicine is right. Acute hospitals need a workforce appropriately trained to deal with the acute medical intake and aftercare of these patients. This means looking at who is best placed to look after the increasing number of complex patients who do not neatly fit within a single speciality. Generalist skills must be valued.
FLEXIBILITY OF MEDICAL CAREER PATHS AND TRAINING

33. There needs to be greater flexibility in medical career paths. The medical specialty workforce needs to be more flexible to the needs of the NHS, and trainees need to be able to move between specialities more readily to facilitate this. There should also be flexibility (including in existing deaneries) for doctors to move from one specialty or region to another to meet training needs. This could be hindered by increasing the amount of local planning. HEE could provide oversight of this and work with partners to ensure that curricula are not overly restrictive.

CONSULTANT-DELIVERED SERVICE

34. RCP advocates consultant-delivered care and the provision of better out-of-hours care for hospital patients. We believe the mounting evidence of sub-standard care delivered to patients who are admitted to hospital during these times is related to the difficulties in providing sufficient input to these patients from consultants. The lack of senior input at these times also adversely affects the supervision and training of junior doctors. There is an urgent need to review rotas and the structure of the entire medical team to ensure that inpatients receive direct input from consultant physicians seven days a week. Service reconfiguration will be necessary to achieve this goal. The RCP statement on care of medical patients out of hours in 2010 advocated hospitals undertaking the admission of acutely ill medical patients should have a consultant physician on-site for at least 12 hours per day, seven days per week, at times related to peak admission periods. The consultant should have no other duties scheduled during this period.

EWTD AND NEW DEAL

35. Doctors’ working patterns have been significantly affected and working hours considerably reduced by both the European Working Time Directive (EWTD) and the New Deal for junior doctors. Although the RCP supports the aim of preventing doctors working excessively long hours, there has been an unintended increase in staffing pressures and other consequences that need to be addressed. The RCP is calling for greater flexibility of application of both the EWTD and New Deal as a solution to these problems.

December 2011

Supplementary written evidence from the Royal College of Physicians (ETWP 113A)

SUMMARY

The Royal College of Physicians (RCP) submitted evidence to the Health Select Committee’s Inquiry into Education, training and workforce in December 2011.

The government published Liberating the NHS: Developing the healthcare workforce—from design to delivery on 10 January in response to the Future Forum’s report on education and training. The RCP has some considerable concerns with the government’s proposals and have therefore decided to submit supplementary evidence to the Health Select Committee.

The RCP believes the following fundamental principles should underpin the medical education and training system:

(a) National standards.
(b) National planning.
(c) Ring-fenced funding.
(d) Independent quality management and assurance.

The RCP is concerned that the government’s proposals — do not commit to adequate and necessary national planning of the medical workforce; — do not recognise the need for or commit to independent quality assurance; — rely on basic minimum standards for quality and fails to establish a system that will continually improve medical education; and — fails to recognise the need for the professions and royal colleges to be formally embedded in the governance structures of both national and local bodies responsible for medical education and training.

The RCP’s suggestions that we believe will improve the government’s proposals are below.

RCP’S CONCERNS WITH MEDICAL EDUCATION AND TRAINING PROPOSALS AND SUGGESTIONS FOR IMPROVEMENT

Lack of national planning

1. The medical workforce must be nationally planned. Training must consider both service needs and the whole pathway of medical school to specialism, which is often 15 years or more. Experience tells us that this
Ev w260  Health Committee: Evidence

requires constant national supervision and intervention. This is most obviously the case for smaller specialties, but it is clear that planning for all medical specialties, such as cardiology, requires long term vision. The number of trainee placements for medical specialties should be set at a national level, with scope for flexibility in local implementation. HEE should be responsible for approving local plans and have sufficient powers to take action where necessary.

2. The career path of doctors must be set nationally, drawing on national planning and horizon scanning data from bodies such as the Centre for Workforce Intelligence and royal colleges. The responsibility for setting and reviewing the medical career path must lie centrally, with HEE.

3. The education and training proposals argue that the current model of postgraduate medical training drives a degree of specialisation that does not fit with the needs of a population that is living longer with more long-term disease and co-morbidities. The RCP welcomes the government’s recognition that a more flexible model for postgraduate training may be more appropriate, with more training in the community. The RCP would also agree that we need to assess whether the current balance between physicians trained in a specialty and those trained in general internal medicine and/or geriatric medicine is right and generalist skills must be valued. However, developing generalist skills must not be at the expense of training highly skilled specialists who are often best placed to make difficult diagnoses and provide the best care for chronically ill patients.

4. From design to delivery suggests that the Centre for Workforce Intelligence (CIWI) will play a key role in using workforce information to provide expert advice and support on workforce planning at a national and local level. The RCP produces an annual census which provides data on the register and consultant physician workforce. We are therefore able to provide robust data that supplements CIWI's work, which will allow the medical workforce to be nationally planned.

Lack of independent quality assurance

5. The RCP is concerned that quality control will be the responsibility of local education and training boards (LETBs), which will have conflicts of interest. From design and delivery states that LETBs’ governance should reinforce collaborative, provider-led arrangements. The RCP welcomes a collaborative approach, but is concerned that providers cannot quality assure the training they deliver. The RCP is not confident that greater levels of transparency on quality and cost together and/or evidenced metrics will help manage any perceived conflicts of interest and the appointment of an independent chair will adequately deal with any conflicts of interest, as From design to delivery suggests.

6. The RCP believes postgraduate and undergraduate deans must be the ‘responsible officer’ for quality management of medical education. The GMC has a clear structure for holding deaneries accountable at a local/regional education training board level to ensure quality management, while individual providers undertake quality control. This is a strong and logical system that combines understanding of service pressures at a regional level and proper external scrutiny. We believe HEE should appoint a Director of Medical Education England and the postgraduate deans should report directly to them. The Director of Education and Quality, which HEE and LETBs will employ, should be a Board member, medically qualified and ideally should also be the postgraduate dean.

Role of royal colleges in setting both minimum and aspirational educational standards

7. The RCP welcomes the introduction of on education outcomes framework (EOF). We believe this will be a valuable tool for education providers. Royal colleges, who set the curriculum, must be fully involved in developing the EOF.

8. However, the RCP is concerned that there will not be a body responsible for continuous quality improvement in education and training. The RCP believes it is crucial that standards throughout every aspect of health care are continually improved. While we welcome the EOF as a tool to ensure minimum standards in education and training are met, we suggest that royal colleges are well placed to fill the gap in setting aspirational quality standards and accrediting providers.

9. This is a model RCP currently use for raising clinical standards. We run a wide range of specific programmes focused on measuring and improving quality—including developing and delivering clinical audits, clinical guidelines, service accreditation and quality improvement support. This includes accrediting services—a formal process using agreed national standards with the aim of improving quality—and undertaking Invited Service Reviews (ISRs) to provide independent advice on issues that are proving difficult to resolve in trusts. We propose that this model is applied to education and training. This would ensure that independent quality management and assurance are embedded into the medical education and training system.

Royal colleges must have a formal role at the top of Health Education England’s (HEE) and LETB’s governance structures

10. From design to delivery states that HEE will set up advisory structures to provide professional input and bring together all the stakeholder groups and that HEE will have relationships with national bodies including the royal colleges. This is welcome, but the RCP stresses that royal colleges and the professions must have formal input mechanisms at the highest structural levels of HEE and LETBs. We suggest that there be a
reserved place for a doctor on the board of HEE and that HEE’s Professional Advisory Board should include
the royal colleges. The boards of LETBs must also include a doctor.

Positive aspects of the proposed education and training system

11. The RCP welcomes some other aspects of the proposed changes to medical education and training. These
are detailed below.

Flexibility of the Medical Career Path

12. The RCP is pleased the government has welcomed the need to increase the flexibility of the medical
career path. We believe that the medical specialty workforce needs to be more flexible to the needs of the
NHS, and trainees need to be able to move between specialities more readily to facilitate this. There should
also be flexibility (including in existing deaneries) for doctors to move from one specialty or region to another
to meeting training needs. This could be hindered by increasing the amount of local planning. HEE could
provide oversight of this and work with partners to ensure that curricula are not overly restrictive.

13. The RCP produced a report, Women and Medicine in 2009, which can be referred to for best practice
for the medical profession that has increasing numbers of female entrants.

Funding

14. The RCP welcomes the commitment that the MPET budget should be confined to funding education and
training for the next generation of clinical and professional staff only. The budget for education and training
should not be siphoned off to pay for service delivery. We believe that funding should flow directly from the
national commissioner to deaneries, medical schools and other Higher Education Institutions.

15. We are pleased in principle that there will be an education levy. However, experience tells us that it is
difficult to establish the true cost of training doctors and it is too easily underestimated. The levy must be
constantly monitored and reviewed to ensure this is not the case.

16. The RCP believes there needs to be national oversight to ensure that enough commissioning contracts
are awarded to providers that offer sufficient medical training. We welcome the commitment in From design
to delivery that the education and training system should be responsive to strategic commissioning ambitions,
but believe clinical commissioning groups (CCGs) and the NHS Commissioning Board (NCB) should have a
duty to promote the education and training of the current and future health care workforce. This should also
be a mandatory part of commissioning contracts. The RCP also believes that Monitor should be required to
consider education and training when licensing providers.

January 2012

Written evidence from Greater Manchester Directors of Public Health Group (ETWP 114)

The 10 Directors of Public Health in Greater Manchester (GM) work together when appropriate to
complement local action as part of the NHS Greater Manchester, and also as independent advocates for Public
Health in the conurbation.

Summary

This submission looks at the Government’s proposals in relation to the public health workforce and the
wider public health workforce. To create sustained health improvements and tackle health inequalities, the
Public health workforce needs to be part of the healthcare training and education system.

Key Recommendations

1. Public Health England (PHE) needs to be represented on the board of Health Education England (HEE).
This would provide PHE with a strategic influence on national training and education. It would provide a
mechanism to ensure preventative medicine/healthcare is embedded in all healthcare’s professions education
and training.

2. PHE needs to have a specific remit for public health professions in other organisations such as local
authorities and NHS organisations. PHE will in effect be the “guardian” of public health workforce in terms
of training, education and workforce planning. It is essential that there is a co-ordinated approach of education,
training and workforce planning for the public health workforce (specialist and practitioner workforce).

3. There needs to be public health representation (Director of Public Health) on the local skills network;
ensuring local education commissioning decisions reflect local health priorities and needs. They will be the
local advocate for the education, training and workforce planning of the public health workforce.

4. As a multidisciplinary profession, the registration mechanism needs to be robust.
5. Public Health Knowledge and skills need to be embedded in the training and education of professional healthcare groups. This needs to be at a local level through the skills networks.

6. The Government must guard against a reduction in public health capacity.

7. New training locations will need to be established in Local Authority, PHE, NHS Commissioning Board (NCB) and Clinical Commissioning Groups (CCGs).

8. Accurate, robust and up to date national and local workforce data is essential to effectively workforce plan. A minimum Public Health workforce dataset is needed that relates to expected Public Health outcomes and essential Public Health functions.

9. The Centre of Workforce Intelligence’s data needs to be fit for purpose.

10. A co-ordinated approach forecasting the workforce needs of the public health workforce (Specialist and practitioner workforce). We would envisage PHE fulfilling this role aided by the local PH teams.

1. How the public health workforce will be affected by the proposals

1.1 The Public Health workforce is multi disciplinary but also multi professional. There are three recognised groupings of staff in the public health workforce—the specialist, the practitioner and wider public health workforces.

1.2 The Specialist workforce—posts such Directors of Public Health (DPH), Public Health Consultants and specialists. These posts would carry out a strategic PH function and are the PH leaders. These posts hold professional registration for medical staff via the General Medical Council (GMC) and for the non medical staff via the UK Public Health Register (UKPHR).

1.3 The public health practitioners—these roles deliver a public health function, eg health protection practitioner’s role would investigate and prevent outbreaks of infectious diseases or a Public Health Intelligence Analyst.

1.4 The wider workforce is those who are able to influence the health of the population through their roles. This wider workforce can be found in a range of organisations and professions such as clinical staff and social care staff. In many cases, they would not identify themselves first and foremost as working in public health but rather by other professional category such as a respiratory nurse.

1.5 In the new public health system, local authorities will be responsible for the three domains of public health. There is a danger that the involvement of local authorities, PHE and the NCB in various facets of public health commissioning will produce a lack of coordination and cohesion in public health services. This lack of cohesion will impact on the present and future Public Health workforce.

1.6 There is also a concern that a large proportion of public health workforce will be outside the healthcare system which will have major implications for accessing education and training. Public Health experts and leaders have to maintain their skills in order to effectively serve the public and their organisations. In the workforce planning and guidance so far released, there is no commitment to continuing professional development for public health teams transferred to local authorities. Continuing Professional Development is within the NHS constitution and may not be replicated in local authorities. CPD is seen as an essential part of a professional’s duties and an important aspect of quality assurance, decreasing risk and revalidation for Public Health Specialists.

Recommendations

1. PHE needs to be represented on the board of HEE. To provide strategic influence on national public health training and education and ensure preventive medicine/healthcare is embedded in all healthcare professions education and training.

2. PHE needs to have a specific remit for public health professions in other organisations such as local authorities and NHS organisations. PHE will in effect be the “guardian” of public health workforce in terms of training, education and workforce planning so there is a co-ordinated approach.

3. There needs to be public health representation on the local skills network, ensuring local education commissioning decisions reflect local health priorities and needs. They will be the local advocate for the public health workforce. Ideally this would be a local Director of Public Health.

4. As a multidisciplinary profession, the registration mechanism needs to be robust.

5. Public Health Knowledge and skills need to be embedded in the training and education of professional healthcare groups. This needs to be at local level through the skills networks.

2. Plans for the transition to the new system, up to April 2013

2.1 In the North West, three skills networks have been declared (Greater Manchester, Cheshire and Mersey and Cumbria and Lancashire) and named Network Leadership Groups. The Greater Manchester Network Leadership Group, includes representation from a Director of Public Health (DPH) representing the 10 Greater Manchester DsPH.
2.2 Across Greater Manchester, public health workforce capacity has been lost and continues to be lost. This is seen both in the specialist and practitioner workforce. The losses have been felt across the three domains of public health; health improvement, health protection and preventive healthcare.

From June 2011 to October 2011, 9% reduction in health protection workforce of Greater Manchester was noted. This poses significant risks to the resilience of the PH system to respond to infectious disease outbreaks across the conurbation.

2010 and 2011 has seen a decline in advertised consultant public health posts. This has resulted in speciality registrars have taken short term appointments or locum positions. These consultants will be the future Public Health leaders.

Across the North West, the total number of public health analysts appears to have fallen by nearly 50% compared with the public health intelligence workforce assessment carried out by Liverpool John Moores University in March 2010. The decrease is particularly evident in posts at Agenda for Change Bands 6 and 7.

2.3 The current NHS Transition presents new opportunities and challenges to the speciality registrar training for public health, in respect of where training takes place; where consultants are employed; and the organisation of training and education for health professionals as a whole. Public health training is aligned with other postgraduate medical training. Currently specialist registrar training takes place in Primary Care Trusts and Strategic Health Authorities (SHAs) which will cease during 2012–13.

2.4 Local Directors of Public Health are completing transition plans to be scrutinised by the SHA.

2.5 Healthy Lives, Healthy People—the new public health system released on 20 December 2011 states that PHE will be a new, integrated and expert public health service to support the new public health system. One of its key functions will be: Developing the workforce—by supporting the development of the specialist and wider public health workforce.

**Recommendations**

1. Public Health membership is essential to development of the local network skills group.

2. The PCT transition plans must include intentions for PH education, training and workforce planning.

3. The Government must guard against a reduction in public health capacity.

4. New training locations will need to be established in Local Authority public health teams; PHE local teams; NCB and CCGs.

3. **The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture**

3.1 The proposed new system brings challenges and opportunities. We support the proposed role and overarching accountability of HEE. We believe the four functions of leadership, responsive, scrutiny and allocation are crucial to the success of the skills network and overall system.

3.2 We see PHE as its key partner in advocating for specialist and practitioner public health workforce training, education and workforce planning. In relation to the new architecture, PHE and Local Authorities will be the principal employers of public health professionals at specialist and practitioner level. Both being integral parts of the new public health system. PHE would provide national leadership for the public health workforce which is a multidisciplinary profession.

**Recommendations**

1. It is essential that HEE, that has an overarching role for education, training and workforce planning for Healthcare professionals in England.

2. PHE needs to be represented on the board of HEE.

3. PHE needs to have a specific remit for public health professions in other organisations such as local authorities and NHS organisations.

4. **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**

4.1 Greater Manchester Skills Network is in its early stages of development. Structure and composition are taking form, which includes membership of a DPH. The advantage of this representation will ensure local education commissioning decision reflect local health priorities and needs and embed public health in the local training and education plans of healthcare staff.
4.2 The local authority is currently represented through the DPH. As the integration of health and social care becomes a reality, the LA as the main employer of social care staff will need to be represented on the skills network.

**Recommendations**

(1) There needs to be public health representation on the local skills network.

5. **The role of the Centre for Workforce Intelligence (CfWI)**

5.1 The Centre for Workforce Intelligence is currently the only national body that collates and publishes comprehensive workforce data on the medical specialties, including public health. Recent statistics published by CfWI regarding public health posts were seriously flawed. For example, CfWI reports claimed a considerable number of “public health associate specialists” in Acute Trusts across the North West. These posts do not exist.

5.2 Currently the Centre for Workforce Intelligence is not able to collate sound, up to date and accessible data on the public health workforce (specialist and practitioner workforce). In the absence of accurate national data, the North West region has created a local Public Health workforce database to aid the region and sub regions with workforce planning.

**Recommendations**

(1) Accurate, robust and up to date national and local workforce data is essential to effectively workforce plan. A minimum workforce dataset is needed.

(2) The Centre of Workforce Intelligence data needs to be fit for purpose.

6. **How future healthcare workforce needs are being forecast**

6.1 In forecasting future workforce needs, it is necessary to understand and identify the present workforce. The current NHS Electronic Staff Records can not accurately identify the current PH specialist and practitioner workforce. This is due to the difference in job titles and the background of the staff members. For example, a Public Health Consultant from a medical background will be categorised under Medical, whereas a Public Health Consultant (Non Medical background) will be categorised as Administration and Clerical or a senior Manager.

6.2 This identification of staff could be made potentially more difficult under the proposed new public health system, as the workforce will be employed predominately in either PHE or in a Local Authority. Staff in the Local Authority will therefore no longer be employed in the NHS and will sit outside the healthcare system and its staffing records system. To plan future workforce needs, the whole of the workforce needs to be considered. Regular public health workforce audits are already in place in some Public Health Directorates in the UK, giving an accurate and rapid picture of current capacity and loss of skills.

6.3 The Healthcare workforce has a pivotal role in public health. The level of complexity and subjectivity involved in measuring the wider public health workforce is great. This would involve estimating the proportion of time given to public health functions, where this is a secondary or tertiary role.

**Recommendations**

1. A co-ordinated approach forecasting the workforce needs of the public health workforce (specialist and practitioner) is needed. We would envisage PHE fulfilling this role aided by the local DPH.

2. At a local level, Public Health Directorates should take part in a regular workforce audits. These will provide an accurate and rapid picture of current capacity and areas of risk.

7. **The impact of people retiring from, or otherwise leaving, healthcare professions**

7.1 On 17 February 2011, Sir David Nicholson wrote to NHS Chief Executives stating that:

> “uring the transition year 2011–12 the NHS must continue to lead on improvements to public health, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities. As we deliver the very significant cost savings required of us, it is important that our plans reflect the need to retain staff with scarce specialist public health skills.”

7.2 The financial climate within the NHS has created significant threats to public health capacity and capability in some local areas. Greater Manchester and the North West have already noted losses in public health capacity. If Public Health outcomes are to be delivered with a significantly reduced workforce, then getting the right people, with the right skills and competencies fulfilling the right role is paramount. Effective PH education, training and workforce planning will aid this process.

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Recommendations

(1) The Government needs to be aware that public health capacity and capability has been lost contrary to David Nicholson’s pledge.

December 2011

Written evidence from Professor Alan Maynard, University of York (ETWP 115)

Alan Maynard is a Professor of Health Economics in the Department of Health Sciences and the Hull-York Medical School at the University of York. He was involved in a non-executive capacity in NHS management for 27 years, and from 1997–2010 he was Chairman of York Hospitals NHS Foundation Trust. He has worked as a consultant for the World Bank, the World Health Organisation, the European Union and the UK Department for International Development in over 20 countries.

He has been a critic of NHS workforce planning for over 30 years. In a series of publications with Dr Arthur Walker he has advocated, inter alia, more sophisticated methods of forecasting and investment in the evaluation of skill mix options (eg nurses replacing GPs in primary care). Some relevant publications by Maynard and Walker are: “Doctor Manpower 1975–2000” (Merrison Royal Commission on the NHS, HMSO, 1978); “Too many doctors?” (Lloyds Bank Review, 1977); “Managing the medical workforce: time for improvement?” (Health Policy, 1995).

More recently he has worked with Dr Karen Bloor on a programme of work on NHS consultant productivity. The results of the work she has led are discussed below.

The lack of impact of such work on practices and policies in “Whitehall Village” may be indicative of the old American saying “what’s regular ain’t stupid”! Or that improved productivity in the use of the NHS labour force cannot enter the policy agenda as it is both too great a threat to existing restrictive practices and yet another demonstration of the failure of research to impact on policy making in the “London bubble”!

Introduction

Planning the NHS workforce is a crucial task. Ensuring that the right numbers of the right staff are educated, trained and available to work in the right areas of the NHS at the right time is extremely challenging. Forecasting the medical workforce is perhaps the most difficult task, due to the long time lag between entry to medical school and emergence of a fully trained GP or consultant. Historically, medical workforce planning has been undertaken separately from planning other NHS roles, but this is increasingly inappropriate given changes over time in skill mix and role development.

In this note I approach NHS workforce planning mainly from the supply side, raising a number of persistent issues relevant to planning the supply of doctors, nurses and other health care professionals. It is however essential to consider the demand for health care in order to model and forecast an appropriate workforce for the future.

1. Supply Side Issues

1.1 Changing skill mix

Over recent decades there has been considerable discussion of and some development of an evidence base for, changes in the skill mix of health care provision. This is particularly evident in primary care, where nurses have taken on tasks such as immunisation, screening and health promotion, and are increasingly developing roles further with nurse prescribing and case management in chronic disease. In hospital care there has perhaps been less change in skill mix, and there are fewer research studies to inform change. Overall, it is essential to remember that as workforce roles develop, this tends to be accompanied by grade inflation and wage increases, so that simplistic assumptions of ‘cost savings’ from skill mix change rarely apply.

1.1.1 Skill mix in primary care

The Burlington experiment was a Canadian randomised clinical trial of the comparative effectiveness of nurse practitioners and physicians in the delivery of primary care. Its authors found that mortality was similar between the two groups of providers and there was no difference in the physical, social and emotional quality of life of patients in the two groups. Patient satisfaction with nurse practitioners and physicians was similar (NEJM, 1974).

A systematic review of this and subsequent research found that nurses tended to offer patients more advice and often achieved higher levels of patient satisfaction, but the depressing fact is the relative absence of well-designed studies. The Cochrane reviewers (Laurent, Reeves et al (2004)) reviewed the literature systematically. They initially found 4,253 studies but after applying tests of scientific robustness they included only 25 papers in their review and these were products of only 16 studies. As with most Cochrane reviews, their work reveals lots of opinion and poorly designed studies: a nice example of the fact that academic publications are often of poor quality and R&D funds are often squandered!
These reviewers concluded that nurses had the potential to deliver high quality care with good outcomes for patients, but the few existing studies did raise concerns about nurses tending to operate more slowly than physicians and to order more tests. Furthermore the short follow-up periods associated with the available studies (usually less than 12 months) and methodological problems in the design of many studies means that their conclusions, though optimistic, were also cautious.

An important policy issue is whether nurses are complements or substitutes for physicians. Does the employment of nurses extend the scope of care with little or no effect on physician workload? Or can nurses take over physicians’ tasks freeing them to extend services or be made redundant?

The Burlington authors (1974) noted that altering skill mix was not financially profitable for doctors and thus the development of nurse practitioners was likely to be limited. So it was and is in Canada. The way in which Canadian physicians are funded (payment by fees for service) ensure that potential nurse competition is emasculated. Despite these obstacles there is evidence of increased use of nurse practitioners in Canada and of patient satisfaction with the services they offer. With often inadequate access to physicians, Canadians appear to be voting with their feet (see Mythbusters: seeing a nurse practitioner instead of a doctor is second class service, Canadian Health Services Research Foundation, 2010).

In the UK as a result of the GP Quality and Outcomes Framework (QOF) nurses have been used to ensure practice success in achieving activity targets. The resultant rewards, of course, accrue to GPs as their employers. This may not always facilitate the development of nursing services in primary care eg a recent RCT demonstrated that diabetes care could be transferred to practice nurses but such substitution remains limited (Houweling et al, Journal of Clinical Nursing, 2011)

Thus nurses in primary care, particularly the 30,000 who have full prescribing rights, have the potential to replace GPs in the delivery of much of primary care. This has been emphasised by clinical analysts (eg Fry (1977) in C I Philips and J N Wolfe 2007); and the current author for decades (eg Richardson, Maynard et al, Health Policy, 1998).

Why hasn’t there been more substitution of nurses for doctors in primary care? The incentive and contract structures and conservatism and relative power of the professions is such that change in roles and real substitution has been slight, but investment in nurses as complements has been substantial. Now, in an age of austerity, can a policy of nurse substitution be implemented? As in Canada, increasing frustration with access to GPs may drive change. My understanding of NHS primary care practice design is that at least one qualified medical practitioner has to be involved in service delivery by a practice. If this is correct, will it need the NHS and/or the private sector to establish a primary care practice with, for example, one GP and 10 nurses serving a population of 30,000 or more? If such change were to emerge, the National Commissioning Board and any CCGs involved should ensure the conduct of a well designed research study to identify clearly the costs and benefits of change.

Similar arguments apply to primary care dentistry where dental assistants may have the skills and expertise to carry out many tasks currently monopolised by dental practitioners. This is even more reminiscent of the Canadian situation of fee for service payment, as the ability to replace dental practitioners is again restricted by contracts and payment mechanisms in the UK, as in North America.

1.1.2 Skill mix in secondary care

The paucity of nursing skill mix evidence in the hospital sector is remarkable, and many research questions remain. For instance:

(a) What is the efficient staffing level for wards in a hospital? An American literature initiated by Aiken and further developed by Needleman has asserted a positive relationship between higher levels of qualified nurse staffing and improved outcomes for patients. This literature does not identify either where diminishing returns in effectiveness set in or the level of staffing that is cost effective. However, it has been influential eg it resulted in the California legislature mandated minimum nurse staffing level (recently abandoned due to their cost). This work used cross section data and as is often found when this method is compared with time series information, the results alter. The few time series analyses carried out show weaker relationships between nurse staffing volumes and patient outcomes (see Lankshear, Sheldon and Maynard, Advances in Nursing, 2005).

(b) Nurse staffing and staff and patient outcomes. A recent Cochrane review again shows the paucity of research (Butler, Collins, Halligan et al, 2011). This review identified 6,202 papers written about the topic but after applying rigorous standards of selection (eg RCTs and difference in difference modelling) only 15 studies met the usual Cochrane inclusion criteria. The authors concluded that the evidence was extremely limited(!) They were positive about the potential of some specialist nurse staffing but emphasised that their findings should be treated with “extreme caution” due to the limited evidence currently available. As with the primary care evidence base for nursing the failure of research funders and researchers to commission, design and carry out rigorous studies is indicative of poorly focused policy research.
(c) What is the scope for nurses replacing doctors in hospital care? Simplistic international comparisons show that for instance nurse anaesthetists work in Swedish, Dutch and American hospitals. In the UK, the Royal College of Anaesthetists has guardedly and reluctantly begun to ease restrictions on the scope of practice of nurse anaesthetists. A study of the use of nurse endoscopists found no significant differences in clinical outcomes between doctors and nurses but conclude that doctors were more cost effective (Richardson et al, BMJ, 2009, doi:10.1136/bmjb270). As ever in seeking to answer to the question of nurse-doctor substitution in hospitals the problem is paucity of good evaluative studies of effectiveness and cost effectiveness and the dominance of faith based opinion.

(d) In many areas of hospital care specialist nurse employment has increased. Again the issue is whether these are complements (extending capacity) and/or substitutes providing care and reducing the employment of eg consultants. If the latter where is the evidence of relative cost effectiveness. The reluctance to articulate and address these questions in policy analysis and research ensures reform is largely without an evidence base.

1.1.3 The challenge of “grade inflation”

In a period of austerity critical attention should be paid to advocates of “more” and “better” training. These siren calls posit vague benefits and ignore the opportunity costs of such investments.

Two comments are particularly pertinent. Firstly, before investing in more training for doctors, there is a need for the reform of medical school education whereby instead of each school examining in approximate relation to GMC guidelines, there should be national examinations so that, for example, training in management, finance and health economics for practitioners is mandatory. Note that there are national exams and increased management training in the US medical schools. Many UK medical schools still deny students education about the health care system in which they will work and it is increasingly essential for them to acquire knowledge of funding systems and rationing devices such as technology assessment.

Secondly, the decision to make nursing a graduate profession is costly and benefits are unclear. Many tasks on the ward (eg feeding, cleaning and other aspects of physical care of patients) do not require a degree and can be carried out by nursing assistants and Assistant Practitioners. However there is qualitative evidence that the skills of APs are underused (Spilsbury et al, JHSRP, 2011). This reinforces the case for questioning the progression to a wholly graduate profession and to evaluate carefully the cost effectiveness of competing nurse skill levels in relation to patient needs. Modest numbers of graduate nurses are needed for tasks requiring complex skills but many (the majority) of patient needs in hospitals may be met cost-effectively by a non-graduate workforce. With RCNs controlling staffing, skill substitution may be inhibited.

1.2 Variations in consultant productivity

Planning the future doctor workforce continues to ignore evidence of considerable variations in consultant clinical activity, for example research by Bloor, Freemantle and Maynard (2004 and 2008). This demonstrates that the activity rates of consultants are highly variable (Bloor et al, JHSRP, 2004). This creates the potential for incentivising improvements which remove poor outliers and shift the mean of the distribution. If such incentives were introduced cost effectively they could increase productivity from the existing workforce. It is to be noted that data about theses variations were commissioned by DH from Bloor and circulated several times by the Department and the NHS Institute of Innovation and Improvement to all trusts in the last decade (see “Delivering quality and value: consultant clinical activity”, at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082903). Its impact has been limited due, inter alia, to lack of incentives to change for managers and clinicians.

It should also be noted that Bloor’s research demonstrated that the activity rates of female consultants across 10 specialties is 10–20% less than their male counterparts (Bloor et al, JRSM, 2008). With the “feminisation” of the medical workforce the implications of this work of investment in new consultant posts and/or nurse substitution are obvious but ignored by Whitehall and workforce planners.

The slow permeation of the DH funded research findings such as these into routine workforce planning is unfortunate.

2. DEMAND SIDE ISSUES

The focus on supply side issues (eg skill mix) must be complemented by more sophisticated modelling of the demand for health care. The starting point for demand side estimates of workforce forecasting is demographic projections, in particular the ageing of the population and the resources demands these processes are likely to make. This usually involves the application of fixed coefficients (eg a GP-population ratio).

This approach is a contentious area, where the conventional view is that ageing will add 1% or more to health care demand. This number is a “guesstimate” and has been contested for several decades by radicals such as the American physician James Fries (eg Fries et al, 2011, Journal of Ageing Research, 2011, 261702). He asserts that there is evidence that successive cohorts of Americans are increasingly healthy and likely to be
less demanding over the life cycle as their death in old age will be swifter and less resource intensive. This he labels the “compression of morbidity”. While there has been good evidence supporting this hypothesis, it may be that “healthier” cohorts are now in the past, and other researchers emphasise the potential impact of increasing rates of dementia/Alzheimer’s and particularly the increase in obesity and diabetes, which may drive up the demand for health and social care.

The usual assumption in UK workforce forecasts (eg the Centre for Workforce Intelligence, 2010) is a constant relationship between population increases and patient “need”. An alternative has been proposed by Birch et al (2007), Canadian Public Policy, 207, 33 (supplement). This suggests a fourfold approach to demand estimation:

(i) Demography: using data on the size, age and distribution of the population including emigration and immigration over time.

(ii) Epidemiology: develop an assessment of the normatively assessed health care needs of the population.

(iii) Estimate the level of service to be provided.

(iv) Incorporate forecasts of productivity of health care providers, which are products of incentives/workforce contracts and skill mix.

Despite the initial involvement of Manchester University (where Birch works part time) in the Centre for Workforce Intelligence these suggestions do not appear to have been taken trialled in government forecasting.

3. Modelling the NHS Workforce

Despite recent assertions in Whitehall of “world class workforce policies”, practice has remained relatively static and poor. One example of the lack of progress in workforce planning is the failure to model all labour inputs rather than primarily focus on doctors. Such an approach would facilitate more explicit consideration of substitution possibilities. Instead forecasting tends to be insular, dominated by forecasting of medical practitioners and poor in dealing with between and within sector substitution opportunities.

Overview

(1) Despite sustained advocacy of improvements in workforce planning practice remains myopic, inadequate and dominated by the market for physicians.

(2) On the supply side, the reluctance to model, innovate and evaluate skill mix options is remarkable and sustained by limited awareness on the NHS of research findings and the failure of R&D to enhance knowledge significantly, particularly in the last decade when funding has been generous.

(3) Demand side modelling remain dominated by un-evidenced assumptions about fixed ratios and a reluctance to complement demographic and epidemiological data with forecasts of trends in productivity and level of service to be provide.

(4) Whitehall could and should do better in NHS workforce planning!

December 2011

Written evidence from the Faculty of Sexual and Reproductive Healthcare (ETWP 116)

In responding to the Committee’s inquiry, the FSRH has addressed selected areas of relevance instead of the entirety of the inquiry.

Introduction

1. Effective training, ongoing education, and maintenance of skills are essential to achieve high quality and safe care. For the provision of contraceptive care, this delivers cost averted, personal and public health benefits through the prevention of unplanned pregnancies. This does require that all women requesting contraception are offered a choice of all contraceptive methods by trained clinicians. The most effective contraceptive methods, which are the long acting methods (LARCs) require specific training to be able to fit them. Evidence shows that without properly trained clinicians to fit, follow-up, and reassure women about their contraceptive choice, women often do not continue with their contraceptive method for long enough for the NHS to realise those savings.

The future of postgraduate deaneries

2. The Government response to the NHS Future Forum report June 2011 highlights that the post-graduate Deans and SHA staff involved in planning and developing the workforce will continue to manage education and training. The FSRH welcomes this assurance.
The proposed role, structure, governance and status of Health Education England/Local Education and Training Boards

3. The Royal Medical Colleges, Faculties and professional associations play a large part in setting the quality standards in education and training which are set within an overarching governance framework, and the FSRH welcomes the commitment by the Government that Health Education England (HEE) will work with colleges and other professional bodies to maintain and improve national standards for the content and delivery of education and training.

4. As part of quality improvement, there are plans to develop a national education and training outcomes framework, setting out the outcomes that HEE would expect providers to meet. Further detail on how this outcomes framework will work is required.

5. We do know that at the local level, Local Education and Training Boards (LETBs) will be instrumental in the coordination and commissioning of training, and as part of this it is vital that sexual and reproductive health (SRH) is represented at these boards. Further clarity is needed on how LETBs will work together with Local Authorities to plan and implement training for those services which fall under the remit of public health.

6. Concern has also been raised about whether HEE and the LETBs will be truly multi-professional with appropriate representation for all professionals.

The proposed role, structure, size and composition of local Provider Skills Networks

7. It is currently unclear how training will be coordinated for those medical specialties which, under the new system, will sit across both the NHS and the Public Health Services. In the case of SRH, which will be provided by both GPs sitting in the NHS, and by sexual and reproductive health consultants based in the community, and commissioned by the Public Health Service, it is not very clear how ongoing training and education will be managed or commissioned at the local level. Furthermore, it is not currently clear where the responsibilities for coordinating training will lie, how needs mapping exercises to assess levels of training need will be overseen, how funding will flow between the two service sectors, and where ownership of essential administrative coordination of training posts will lie.

8. Clearly, the multi-professional healthcare provider skills networks (PSNs) will be instrumental in coordinating and managing training at the local level, and the FSRH welcomes the reassurance in Government response to the NHS Future Forum report June 2011 that, as part of these networks, the post-graduate deans and SHA staff involved in planning and developing the workforce will continue to manage education and training. However, it is vital that systems are put in place to ensure that training for services provided across the NHS and public health, as is the case for SRH services, is joined up.

9. Finally, the FSRH welcomes the assurance that SHA and Deanery successor organisations, such as PSNs, will remain part of the NHS and will have regard to the NHS Constitution and NHS values.

Implications for a more diverse provider market within the NHS

10. With an increasing service provider population, robust reporting mechanisms must be put in place to ensure the collection of comprehensive workforce and needs assessment data at the local level, which will help ensure a workforce capable of meeting the future challenges of the NHS.

11. It is essential that, unless alternative provision is made, all providers, NHS, third sector and private, have training included specifically within their contracts. This obviously requires the competence to deliver and provide recognized training.

12. It is also important that education and training in sexual and reproductive health meets nationally recognised standards. Royal Medical Colleges and Faculties must be actively involved in advising and approving education and training provided by all service providers.

13. Where training is required for services provided across both the public health service and the NHS, training must be co-ordinated in a joined up approach, taking into account local needs and training requirements across all sectors involved in service delivery.

How future healthcare workforce needs are being forecast

14. Using the example of the fitting of contraceptives, many Primary Care Trust (PCT) areas do not have a record of the number of trained clinicians working in the locality, and needs mapping exercises were not routinely being carried out to inform the commissioning of training posts. Without consistent, high quality workforce information to underpin effective workforce planning, it is almost impossible to identify skills shortages and training needs. The FSRH recommends that all local authority areas are required to carry out needs mapping exercises, so that targets to increase capacity accordingly could be set and sufficient training provided.

15. The commissioning and coordination of training, for services that operate across both the public health service and the NHS, need to be joined up both locally and regionally. This should be facilitated through the new “Local NHS Education and Training Boards” (LETBs).
16. All commissioners for SRH training must be appropriately trained and sufficiently knowledgeable in the area of SRH to ensure the smooth commissioning, coordination and provision of training. Therefore commissioning plans for training must be developed with input from the local sexual health lead consultant, who is best placed to understand the requirements of training at the local level.

The place of overseas educated healthcare staff within the workforce

17. As stated in their Future Forum response on Training and Education, The Royal College of Obstetricians and Gynaecologists (RCOG), is concerned about the viability of the Medical Training Initiative if the Home Office reduces its length of appointment to a year of attachment in the UK. International Medical Graduates play a crucial role in the NHS and in Obstetrics and Gynaecological (O&G) service provision. They plug the gaps unfilled by local doctors. The UK has a long and respected tradition of training overseas doctors and gains much from the contribution of these professionals. These doctors will pursue other opportunities elsewhere if the MTI process is unattractive.

How public health workforce will be affected by the proposals

18. With increased pressure to deliver efficiency savings in the NHS, the FSRH is concerned about the effect that this may have on training budgets, and thus the quality of and scope of education and training provided. This will be accentuated if the transition of Public Health commissioning to Local Authorities occurs without clarification on how education and training in cross sector disciplines like Sexual Health can be co-ordinated, funded and managed. There is a risk that with sexual health commissioning being fragmented between the National Commissioning Board, CCGS and local public health that training could also be fragmented.

About the Faculty of Sexual and Reproductive Healthcare

The Faculty of Sexual and Reproductive Healthcare (FSRH) has a membership of nearly 16,000 doctors, approximately 80% of whom work in General Practice, the remainder working in the specialties of Community Sexual & Reproductive Health, Genitourinary Medicine or Obstetrics & Gynaecology. The FSRH sets training and clinical standards in sexual and reproductive healthcare in the UK, including the specialty of Community Sexual & Reproductive health.

In 2010 the medical specialty of “Community Sexual and Reproductive Health” was established, to enhance leadership in community based women’s health services.

Although primarily a medical organisation, in response to requests from our nursing colleagues the FSRH has Associate Nurse Members and is working with them to actively support the development of nurse training and education in the specialty of sexual & reproductive healthcare.

January 2012