Government Response to the House of Commons Health Select Committee First Report of Session 2012-13: Education, Training and Workforce Planning

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Introduction

1. On 23 May 2012, the House of Commons Health Select Committee published *Education, Training & Workforce Planning: First Report of Session 2012–13* (HC 6).

2. The report followed an inquiry by the Health Select Committee, which sought evidence from the Minister of State for Health along with other witnesses, including the Department of Health, health education providers and commissioners and health trade union representatives.

3. The Government has carefully considered the Committee's report and the issues that it raises, and this paper sets out the Government's response.

Government response to the Committee's conclusions and recommendations

4. The Government welcomes the Health Select Committee's thoughtful analysis of the evidence presented to them and we are grateful to the Committee for looking at this area in detail. We welcome the Committee's support for the changes to the education and training system, which was were also fully endorsed in the Future Forum report that was published shortly after the submission of written evidence to the Committee.

5. There has been a great deal of progress in establishing the new system of education and training since the evidence was presented to the Committee, which provides some of the detail and clarity that the Committee has reasonably requested:

    - Health Education England (HEE) was established on 28 June 2012 and held its first public Board meeting on that day to put in place the governance and agree standing financial instructions;
    - Sir Keith Pearson has been appointed as chair of HEE;
    - Ian Cumming has been appointed as the Chief Executive of HEE;
    - *Introducing Health Education England* was published on 22 June 2012, which set out the operating model for HEE and the Local Education and Training Boards (LETBs);
    - Local Education and Training Board Operating Principles were published by the HEE transitional team on 26 April 2012 and the LETBs are rapidly developing their governance and operational arrangements, with strong provider leadership and the engagement of clinicians and the education sector, and
    - The authorisation criteria and process for LETBs is in the final stage of development by HEE and the LETBs, and will be published shortly, so that LETBs can be supported to be operational and ready to take on education and training functions from April 2013.

The Centre for Workforce Intelligence

Effective workforce planning in the NHS depends on the availability of up-to-date, high-quality data and intelligence, yet only in recent years have steps been taken to ensure that this is fully and comprehensively available. We welcome the remit that has been given to the Centre for Workforce Intelligence; we also commend its ambition to tackle deficiencies in workforce data and to establish a core national minimum data set.
(HC 6-I, Paragraph 24)

It is clearly not sufficient for the Centre simply to collate and interpret data. It should also challenge data from individual health economies against current clinical standards to ensure their workforce plans make adequate provision for the best skill mix.
(HC 6-I, Paragraph 25)

We appreciate that the Centre is still a relatively new body and that its establishment pre-dates the full implementation of the new workforce planning system. However, we are concerned at some of what we have heard regarding its capacity and capability, in particular its capacity to test workforce plans against the requirement to match the best clinical standards. We are also concerned at the apparent lack of clarity about how it will fit into the new workforce planning system. The Department needs urgently to explain how it is ensuring that the Centre is adequately resourced to fulfil its remit, as well as to clarify the Centre's role in the new system, particularly its working relationships with Health Education England and the Local Education and Training Boards. It must also set out how the Centre will be effectively performance-managed in the new system and held to account.
(HC 6-I, Paragraph 26)

The Centre is substantially dependent for its success on data that are provided by employers. In future those employers will be autonomous organizations and Local Education and Training Boards will be responsible for gathering data from them. The Government must ensure that there are clear contractual obligations on all providers of NHS-funded services to provide full, timely and accurate workforce data; these obligations must be backed up by clear, strong and enforceable penalties. At the same time, there must be a clear complementary requirement on the local Boards in respect of gathering and passing on data—with a definite remit for Health Education England rigorously to performance manage the Boards in this respect.
(HC 6-I, Paragraph 27)

6. This Government is abundantly clear in its view that better workforce planning is essential in ensuring the appropriate skills and affordability of the health and social care workforce, and directing resources effectively to deliver better outcomes. The Centre for Workforce Intelligence (CfWI) was established precisely to provide workforce planning and development advice and information to the NHS, public health and social care system and represents increased investment in ensuring the health, public health and social care workforce is well planned and better able to adapt to changing demand and circumstances.

7. The CfWI was established on 1st Jan 2010 and is delivered through a contract held by the Department of Health. It is important that CfWI are able to bring together the best possible people with the skills and capability to support the health, public health and social care system. To reflect this, CfWI have significant resource, with an annual budget of £5m and since their inception have continued increased their staffing resource and build expertise. Developing capacity and capability to support the new education and training system is a core part of the objectives set for CfWI in 2012/13.

8. The Department and CfWI are continuing to work together and with HEE and the shadow LETBs to ensure that CfWI is appropriately resourced and to agree its role in supporting the new system. The CfWI will provide expert advice to HEE and support workforce planning and commissioning at a national and local level. It will support and advise LETBs on the delivery of their workforce plans and provide information to the Department of Health to inform resource allocation.

9. The Department of Health recognises the importance of the workforce information required to underpin education and training commissioning. The DH has been working with a number of stakeholders, including the SHAs and the Health and Social Care Information Centre, to develop a national minimum data set for workforce information to support the new system. The requirement to provide workforce information is in the current standard NHS contract, in addition to legislative obligations set out in the Health and Social Care Act 2012.

Changing skill mix

Innovation in skill mix and clinical roles is crucial to achieving a more efficient and flexible workforce. However, it is important for policy to be grounded on solid evidence—both to overcome restrictive practices in support of sectional vested interests and to prevent inappropriate de-skilling in pursuit of mere cost-cutting.
(HC 6-I, Paragraph 40)

Effective workforce planning requires effective training and professional development. Given the increasingly important role of healthcare assistants, it is essential that the Department of Health develop proper guidelines for the training requirements of this group of staff; and commissioners should take these requirements into account when commissioning care from healthcare providers.
(HC 6-I, Paragraph 41)

We note that the Government has announced arrangements for the voluntary registration of healthcare assistants. However, in the absence of a professional regulator, we urge the Government to keep under review the requirements of this key element of the workforce for training and professional development. In the longer run, we reiterate our view that independent professional regulation of this group of staff provides the best assurance to patients.
(HC 6-I, Paragraph 42)

10. We have always been very clear that local healthcare providers are best placed to decide how to organise the mix of workforce and skills they need to achieve better outcomes in both patient care and value for money. Health service managers, clinicians and employers, while required to conform to national standards, must be free to manage their own workforce and clinical teams to meet the health service needs of the communities they serve.

11. The Department of Health supports a number of initiatives and programmes to improve workforce planning and strike the right balance between medical and other health professionals across a range of care settings. The Quality, Innovation, Productivity and Prevention (QIPP) Programme is a key driver for getting skill mix right. Strategic health authorities (SHAs) develop integrated QIPP plans that address the quality and productivity challenge, and these are supported by the national QIPP workstreams, which produce tools and programmes to help local change leaders in successful implementation.

12. The Government's view is that the case has not yet been made for imposing further statutory regulation to mandate the registration of healthcare assistants, given the tiers of existing regulation and duties; including the vetting and barring scheme and duties on professionally qualified staff to take responsibility for supervising unregulated workers and for delegating appropriately to them. Guidelines are being developed on training requirements for support workers, which should be taken into account by those commissioning care from healthcare providers, and the Government should keep under review the requirements for training and professional development of this key element of the workforce.

13. We recognise however that there is need to drive up standards and for this reason we have commissioned Skills for Health and Skills for Care, in partnership with unions, employers and regulators, educators and others, to develop a code of conduct and recommended minimum training standards for healthcare support workers and adult social care workers in England before the end of 2012.

14. We expect the standards will cover recommended minimum training or induction standards for a range of support tasks including personal care, patient moving and handling, undertaking basic observations, importance of nutrition and hydration. We also expect them to clarify the recommended training requirements and level of accountability for those workers undertaking more advanced tasks.

15. The Health and Social Care Act provides for a system of external quality assurance for voluntary registers and it is our intention to develop an assured voluntary register for healthcare support workers to enable employers to identify appropriately skilled and qualified workers. This will allow unregulated workers to demonstrate they meet a set of minimum standards and signed up to a code of conduct. It will also provide health and social care providers who choose to use workers on voluntary registers and their commissioners further assurance about the suitability and competence of workers.

16. We recognise that the debate about the most appropriate way of driving up standards of care provided for this part of the workforce is an issue at the heart of the patient experience and we need to continue to ensure that system and process remains fit for purpose. Once a system of assured voluntary registration has been established for support workers, and has been operational for three years to enable it to demonstrate its effectiveness, then the Government will commission a strategic review of the relative benefits of assured voluntary registration, compared with statutory regulation. This

will include consideration of any further measures needed to assure the safety of patients and the public.

Changing medical specialism

Four years ago Professor Tooke set down a clear agenda on the future of the medical workforce which was widely accepted. An acid test of the effectiveness of the new education and training arrangements will be their ability to deliver the more flexible medical training programmes which were described by Professor Tooke and endorsed by the NHS Future Forum.
(HC 6-I, Paragraph 57)

17. The last Government implemented some but not all of the recommendations Professor Sir John Tooke's report *Aspiring to Excellence.* Setting up Medical Education England (MEE) was a part of that response which we are now completing through the establishment of HEE. We made clear in *Liberating the NHS: Developing the Healthcare Workforce - From Design to Delivery* that the effectiveness of the new education and training system will be its ability to deliver more flexible medical training. A review is now underway that is being led through an independent, UK-wide review of the shape of training, led by an independent chair, Professor David Greenaway, Vice-Chancellor of Nottingham University.

18. This work is jointly sponsored by the Academy of Medical Royal Colleges (AoMRC), the General Medical Council (GMC), MEE, the Medical Schools Council (MSC), NHS Scotland, NHS Wales and the Northern Ireland Department of Health, Social Services and Public Safety. This Sponsoring Board has a UK-wide oversight of the review and sets out its strategic direction of travel. HEE will take over the sponsorship role for England from October 2012.

19. The aim of the review is to make sure we continue to train effective doctors who are fit to practise in the UK, provide high quality and safe care and meet the needs of patients and service now and in the future. It will look at potential reforms to the structure of postgraduate medical education and training across the UK. It will reflect on whether the current approach develops doctors who are capable of delivering high quality and safe care for patients, able to work effectively within the UK healthcare systems and are able to respond to the rapidly changing health needs of the UK population. It will consider issues such as the proper balance between specialism and generalism in medicine, the implications for education and training of more healthcare being delivered in the community, how to balance better the workforce demands of health services with the learning needs of trainees, and how to create flexible models of training which can respond to changing requirements of both patients and healthcare service.

20. The Chair intends to submit a report along with recommendations to the Sponsoring Board by summer 2013. The report will set out proposals for the structure of postgraduate medical education and training over the next ten years. It will consider

issues of flexibility, quality of education and training including outcomes, value for money and the responsiveness of training to the needs of patients, the wider population, the service and trainees.

Junior doctor training

While we recognise that introduction of the European Working Time Directive has had a significant impact on working and training practices, we do not feel any rosetinted nostalgia for a system which used to rely on over-tired and under-trained junior doctors. We have received a broad basis of evidence which shows how it is possible to reconcile reasonable hours for junior doctors with high quality training and, most importantly, high standards of care for patients.
(HC 6-I, Paragraph 66)

21. We fully understand that whilst it is possible to reconcile reasonable hours for junior doctors and high quality training, with high standards of care for patients, there are some areas where securing practical experience is more difficult within the Working Time Regulations. The *Better Training Better Care* initiative was established to ensure that the best possible use of training time is made available to all trainees.

22. HEE will continue to take forward the *Better Training Better Care* programme developed by MEE. The programme for *Better Training Better Care* seeks to spread good practice in planning training for junior doctors and includes two overlapping components:
    - The identification, piloting, evaluation and dissemination of good education and training practice; and
    - Improvements to curricula and the underpinning education and training frameworks to ensure training is fit for the purpose of providing safe, effective and improving patient care.

23. *Better Training Better Care* aims to improve the quality of training and learning for the benefit of patient care by enabling the delivery of the key recommendations from Professor Sir John Temple's report '*Time for Training'* and Professor John Temple's report '*Foundation for Excellence'.*

24. 16 NHS Trusts have been awarded funding to deliver pilots that deliver one or more of the three key objectives as sited in the report of Professor Sir John Temple *Time for Training*:
    - Appropriate supervision, and/or implementing a consultant present service
    - Service delivery must explicitly support training
    - Make every moment count

25. The next phase of the work will see the learning from these pilots shared across the service so that their good practice can be transferred and embedded in the training arrangements for junior doctors.

Different approaches to treatment

A clear mandate must be set for the new system to take account in workforce planning of the full range of evidence-based treatments—subject to the evaluations carried out by the National Institute for Health and Clinical Excellence.
(HC 6-I, Paragraph 69)

26. The new system for education and training will take account in workforce planning of the full range of evidence-based treatments, subject to the evaluations carried out by the National Institute for Health and Clinical Excellence (NICE). Employers will play a central role in the reformed education and training system, given greater accountability to plan and develop the workforce, whilst being professionally informed and underpinned by strong academic links.

Overseas-educated staff

The NHS has historically welcomed large numbers of staff from overseas, including healthcare professionals who have been educated and trained in other countries. Their contribution to the success of the NHS has been rightly acknowledged and celebrated.
(HC 6-I, Paragraph 78)

We believe that the openness of the UK to clinical staff trained overseas, and the ability of UK-trained staff to work overseas, is a continuing source of strength to UK healthcare, and that this openness should continue to be reflected in workforce planning.
(HC 6-I, Paragraph 79)

However, we also welcome the Government's view that planning of the UK health and care workforce should not be dependent on significant future flows of trained staff from overseas, both in order to improve "security of supply" and in order to avoid "poaching" skilled staff from developing countries. This approach should apply to public and private healthcare employers.
(HC 6-I, Paragraph 80)

27. There is a great deal of learning to be shared through the international interchange of skills and experience and this will continue in the new system. The UK has prudently been moving towards greater self sufficiency in the supply of healthcare professionals for a number of years. There has been a decline in the numbers of healthworkers coming to work in the NHS in England. In 2009, thirty-seven health specific roles were included on the Shortage Occupation List and this had fallen to twenty-four in 2011. A key outcome for the new system will be to address skills gaps and continue to reduce reliance on staff that train in other countries.

28. Where overseas-educated staff are being recruited, the UK is committed to an ethical approach to recruiting healthcare professionals from overseas. The International

Recruitment Code of Practice governs international recruitment of healthcare professionals by the NHS and also allows the private sector to sign up to the principles contained within the Code of Practice. Among its underlying principles are that developing nations who are experiencing shortages of healthcare staff should not be targeted for active recruitment, unless there is an agreement with their government allowing recruitment.

Locum and agency staff

We accept that locum and agency staff provide a necessary element of flexibility in NHS staffing arrangements. We do not believe, however, that they provide an optimum solution, either in terms of quality of care or value for money. We, therefore, urge the Government to proceed quickly with improved arrangements for workforce planning, which should reduce the importance to the NHS of locum and agency staff.
(HC 6-I, Paragraph 85)

29. Whilst agency and locum staff do not provide an 'optimum solution,' they form a valid part of workforce plans and we cannot and indeed should not eliminate their use entirely, as they provide the flexibility required for a robust and responsive workforce. However, healthcare employers need to make more efficient usage of both their substantive and temporary workforces. So far employers have delivered £128 million of savings from plans to reduce annual agency spend by £300 million.

30. NHS Employers are currently undertaking work to assist with the reduction of agency expenditure in NHS trusts. The programme of work helps address demand and supply issues in the use temporary staff by NHS trusts, by offering a suite of case studies, guidance, tools and resources to enable them to minimise agency expenditure.

The Secretary of State

We welcome the inclusion in the Health and Social Care Act 2012 of an explicit duty on the Secretary of State to secure an effective system of education and training. However we are concerned that there continues to be insufficient clarity about how the Secretary of State intends to discharge this duty. In particular, we seek reassurance that the Secretary of State shares our view that the effectiveness of the new system will be fatally undermined if it is not built upon a more accountable and transparent system of workforce planning.
(HC 6-I, Paragraph 91)

We also welcome the fact that the Secretary of State will have a clear responsibility for holding to account Health Education England. The Department must, though, spell out how exactly this will be done—including the part that the planned Education Outcomes Framework will play.
(HC 6-I, Paragraph 92)

31. The Department will hold HEE to account on behalf of the Secretary of State through a framework agreement which will be published. The Education Outcomes Framework (EOF) is under development and will set expectations across the whole education and training system so that investment in developing the health and public health workforce supports the delivery of excellent healthcare and health improvement. The EOF will be the mechanism for holding HEE to account for the delivery of education improvements.

32. The publication *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery* set out the high level domains for the EOF. A series of co-production events involving all key stakeholders are identifying "ideal" outcomes across these domains. Further work will then be carried out to develop end state indicators and agree a programme of work to develop education outcomes so that the system can demonstrate how education and training impacts on patient experience, care and safety.

Health Education England

We welcome the plan to set up Health Education England as an executive body with overall responsibility for education, training and workforce planning, drawing input from all healthcare professions and other stakeholders. The creation of such a body is long overdue and has the potential to be a significant step forward.
(HC 6-I, Paragraph 112)

However, we are concerned, given the centrality of this body to the Government's plans, that the Government has been slow in developing a coherent plan for the new organization. It is being set up in shadow form in July 2012 and will be fully operational in April 2013. There is an urgent requirement for the Government to publish a clear and detailed execution timetable.
(HC 6-I, Paragraph 113)

In the absence of this timetable there continues to be a lack of clarity about the role, responsibilities, powers and structure of Health Education England. Fears have been expressed to us that Health Education England, growing out of Medical Education England, could be predominantly focused on the medical workforce, despite its multi-professional remit. The Government must show that it is addressing and allaying these fears.
(HC 6-I, Paragraph 114)

Greater clarity is particularly needed about how Health Education England plans to ensure that it develops a dynamic view of the changing education requirements of the whole health and care sector.
(HC 6-I, Paragraph 115)

Greater clarity is also needed regarding the role of Health Education England in relation to the professional regulators and to its counterpart organisations in other UK countries.
(HC 6-I, Paragraph 116)

The Government has acknowledged the need to take account of the UK-wide dimension of education, training and workforce-planning policy. However, in that context we are concerned that there must be adequate emphasis on workforce planning in particular.
(HC 6-I, Paragraph 117)

33. HEE was established as a Special Health Authority on 28 June 2012. HEE's Directions were published on the DH website on the 28th June. These directions allow HEE to put in place preparations to ensure that it will be fully operational to take on its full education and training functions when strategic health authorities are abolished on 1st April 2013. Specific functions include:
    - Building its capacity and capability, including appropriate governance and operational and financial systems;
    - Developing and publishing its HR policy, strategic education operating framework and criteria for establishing LETBs;
    - Putting in place its advisory structure;
    - Reviewing and approving strategic health authority education and training plans for 2013/14;
    - Considering how education and training can raise awareness of the NHS Constitution and promote its values; and
    - Establishing the appointment criteria and set up governing bodes for LETBs as committees of HEE.

34. The publication *Introducing HEE* was developed by the HEE Transition Team, working with stakeholders in preparation for HEEs establishment and was published on 22nd June. It provides an outline of the operating model for implementing the policy set out in *Liberating the NHS: Developing the Healthcare Workforce - From Design to Delivery*, including the commitment to a multi-professional approach and greater clarity about HEE's role in regard to the professional regulators and other stakeholders.

35. *Introducing HEE* sets the vision for a dynamic and professional organisation focused on a threefold mission:
    - To develop a world class workforce capable of supporting a world class health service – meeting the needs of patients and communities
    - To ensure excellence and continuous improvement in the education and training of the health workforce, so as to improve health service
    - To deliver HEE's objectives through a partnership approach that is underpinned by strong governance and accountability.

36. It is only through a wide partnership - with employers, higher education, the health professions, service commissioners, regulators, Local Authorities and patients – that HEE will ensure a strategic approach that meets changing needs.

37. The new Chair and Chief Executive of HEE, and in due course the full Board and executive team will take forward plans to explain the role and benefits of HEE and the accountabilities across the new system. The Secretary of State has set the objectives for HEE in 2012/13. These are published on the HEE website, www.hee.nhs.uk.

38. HEE and the LETBs will be closely involved in setting priorities and commissioning work under the current contract.

Local Education & Training Boards

We welcome the Government's plan to create Local Education and Training Boards as provider-led bodies to take responsibility for education, training and workforce planning below the national level. We are concerned, however, at the Government's protracted failure to produce concrete plans in respect of the Boards, which poses a significant risk to their successful establishment.
(HC 6-I, Paragraph 133)

Between July 2010 and January 2012 the Boards were conceived of as loosely defined non-statutory "legal entities", to be developed at local level. The Government has now concluded that they should be "outposts" of Health Education England. There is, however, still little central guidance about the requirements for authorization, despite the recommendation of the NHS Future Forum that there should be "common terms of reference and a single model […] to promote consistency across the country".
(HC 6-I, Paragraph 134)

It is unsatisfactory that so much about the Boards still remains vague and indeterminate. Crucially, the precise extent of their autonomy, and the means by which they will be authorised and held accountable, are still worryingly opaque. This must be spelled out as a matter of urgency.
(HC 6-I, Paragraph 135)

We welcome the Government's guidance that Local Education and Training Boards should be comprehensive bodies, not restricted to healthcare providers. However, concerns remain among higher-education institutions that their viewpoint will not be adequately heard. The Government should provide a definitive list of stakeholders which should be represented, as well as providing greater clarity on other aspects of governance—not least how potential conflicts of interest are to be addressed.
(HC 6-I, Paragraph 136)

We are also concerned that the geographical basis of Local Education and Training Boards remains obscure. Evidence submitted to us that there will be "10 to 15" (or alternatively "12 to 16") calls into question their ability to reflect local conditions. There is a definite need for structures at the level of local health economies and the Department must make clear how these are to be facilitated.
(HC 6-I, Paragraph 137)

39. Rapid progress is being made in the development of shadow LETBs which are operating as sub-committees of the SHAs, building capacity and capability so that they will be ready to be authorised as LETBs accountable to HEE from April 2013. There is strong provider leadership for establishing new local arrangements and growing engagement with clinicians, the education sector and other stakeholders. It is expected that up to sixteen LETBs across England will apply for authorisation. The shadow LETBs are all developing supporting structures at a local level to reflect local conditions and ensure their priorities and concerns are captured and addressed.

40. The detailed LETB authorisation framework is currently in the process of being finalised, having been developed in co-production with the shadow LETBs and stakeholders. The authorisation criteria will ensure that there is a common core framework for LETBs whilst supporting the maximum level of local accountability and freedoms. It is anticipated that the final framework will be published by DH in September following its final approval by the Secretary of State. In the interim, LETBs are self-assessing their local arrangements and state of readiness against the draft authorisation criteria. The process of authorisation will take place between October 2012 and March 2013 with the expectation that LETBs have the support they need from HEE and SHAs to achieve authorisation by April 2013. The outcomes following the process of authorisation will be: 'authorised', 'authorised with conditions', or 'not authorised'.

41. There are six domains for the authorisation of the LETBs, which build on the expectations for good LETB practice set out in *Design to Delivery:*
    - Vision and leadership
    - Meaningful engagement with key partners
    - Good governance
    - Effective financial control
    - Organisational capability
    - Outcome-led improvement

Postgraduate deaneries

The integration of the postgraduate deaneries into the new system will be crucial to its success. We regret the fact that the Government allowed uncertainty about the future position of the deaneries to persist for so long. Although there is now greater clarity of intention, the period of uncertainty led to a regrettable loss of experienced staff.
(HC 6-I, Paragraph 155)

There continues to be an urgent need for more precision about how the deaneries will operate in future. The distinct position of postgraduate dean should continue to exist to provide an independent professional voice. There needs to be greater clarity about relationships with the General Medical Council, the Director of Medical Education and Health Education England. Finally, there must be a convincing plan to realise the

Government's stated aspiration for deaneries to become "truly multiprofessional" in their new role.
(HC 6-I, Paragraph 156)

42. We have always been clear that the important role that postgraduate deans carry out would continue in the new system. In our response to the Future Forum, we confirmed that post-graduate Deans and SHA staff involved in planning and developing the workforce will continue to manage and assure education and training, including the training and recruitment of junior doctors and dentists.

43. The role and functions of the Postgraduate Deaneries are a central component in the effective planning and provision of high quality medical and dental education. These functions will continue within the new system, with responsibility and accountability for these functions moving to LETBs. Each LETB must have a named responsible officer (RO) to lead medical education and to fulfil the formal requirements of the RO as it applies to the revalidation of doctors in training.

44. The role of the Postgraduate Medical Dean is fundamental to ensuring that coherent and comprehensive systems remain in place to oversee the provision and outcomes of postgraduate medical education and training at a local level, and that doctors in training gain the necessary understanding, skills and expertise to provide a safe and effective service whilst meeting the requirements of the nationally approved Foundation and Specialty training curricula. The Postgraduate Medical Dean will also continue to deliver quality management of postgraduate medical education within their Deanery area in accordance with the requirements of the GMC's Quality Improvement Framework.

45. The new education and training system through HEE and LETBs will take a clear multi-professional approach. One of the three mandated posts in the LETB executive team is the Director of Education and Quality (DEQ). This role is responsible for education and quality across the whole workforce, and is expected to take a clear multi-professional approach.

Innovation bodies

We welcome the Department's intention to continue within the new system the work done in recent years—through the Health Innovation and Education Clusters and Academic Health Science Centres—to link innovation with education and training. We also welcome the intention to build on this through the creation of Academic Health Science Networks. However, there is a risk, through creating a yet more complicated landscape of Boards, Clusters, Centres / Systems, Networks and Collaborations, that the resulting arrangements could be incoherent and ineffective. The Department must develop a plan to rationalise these bodies and structures, to bring about as much de-cluttering and geographical coterminosity as possible without limiting local initiative and creativity.
(HC 6-I, Paragraph 160)

The same point applies to the planned new education, training and workforce planning system as a whole. The NHS Future Forum has rightly referred to the "number of players in the system" as a complicating factor. Nothing we have heard suggests that the new arrangements will be any less overpopulated with stakeholders, sometimes with overlapping or unclear responsibilities. If this is not addressed, it will be a serious shortcoming in the Government's reforms.
(HC 6-I, Paragraph 161)

46. Over the last decade many new organisations and programmes charged with improving innovation in the NHS have emerged. They have often been introduced as a result of new initiatives and policies, but few have ever been de-commissioned. Innovation Health and Wealth (IHW) is the NHS Chief Executive's report on the adoption and spread of innovation in the NHS. Launched by the Prime Minister in December 2011, it sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. It includes a number of recommendations designed as an integrated set of measures that together will support the NHS in achieving a lasting and profound change in the way the NHS operates, including a sunset review of all DH/NHS funded or sponsored innovation bodies and programmes. This review will complete by the end of 2012 which will inform the strategic approach to innovation in the modernised NHS.

47. Academic Health Science Networks (AHSNs) will bring together the local NHS, universities, public health, social care to work with industry to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems. They will be able to simplify the local organisational landscape and contribute to a national network of AHSNs that will support proven innovations to be adopted rapidly across the country. We have published the AHSN designation and establishment process and are currently seeking expressions of interest. We expect some AHSNs to be operational in 2012/13 and for all AHSNs to be established by 31 March 2014.

48. Planning a developing the healthcare workforce is inevitably complex and needs to engage a larger range of stakeholders to be effective. The new education and training system provides a consistent and stream-lined approach with clear accountabilities and a single body, HEE, to provide national leadership and oversight, and supporting a small number of locally grounded LETBs which will secure greater local ownership and autonomy. AHSNs will work closely with the LETBs to ensure that education and training supports a workforce receptive to research and innovation.

The proposed tariff

The current arrangements under which providers are paid by the NHS for education and training are anachronistic and anomalous. Payment is only partially based on student or trainees numbers; it is not linked to quality; it is unjustifiably inconsistent between different professional groups, parts of the country and types of provider; and there is an almost total lack of transparency about how it is spent.

(HC 6-I, Paragraph 179)

Accordingly, we welcome the Government's intention to move payment onto a tariff basis, including a quality premium, as recommended by the NHS Future Forum. However, we note that there is so far slender evidence of progress in converting this desirable policy into a system that will work in practice. Bearing in mind that implementation of the new system is supposed to begin in April 2013, we believe this work needs to attract a greater sense of urgency.
(HC 6-I, Paragraph 180)

While taking this work forward the Government needs to recognise that there are significant difficulties involved in constructing a workable tariff. It is important that the transition to any new system avoids unnecessary turbulence, and—in particular—threats to the quality of clinical services.
(HC 6-I, Paragraph 181)

49. We have confirmed that the first tariffs for education and training will be implemented from April 2013. The first stage will include tariffs for non-medical education and training and undergraduate medical placements in primary care.

50. In order to avoid destabilisation through the introduction of the tariffs, we have agreed to take a phased approach to implementation. Any provider that will lose funding when the tariffs are introduced will receive transition funding so that their losses in any year are capped. In order to provide this transition funding, increased payments to organisations gaining funding will be phased in over time.

51. SHAs have been asked to agree transition plans with their providers by 5 October. Once the Department has received and analysed all of the transition plans, the details and phasing of implementation plans will be confirmed. HEE and LETBs will be responsible for working with providers on the implementation of tariffs in line with the agreed transition plans.

52. Work to develop tariffs for postgraduate medical placements and placements in primary care will continue during 2012-13, with a view to implementing as soon as possible.

The proposed levy

We support the Government's intention to introduce a levy on all healthcare providers (whether or not they supply services to the NHS) to provide a more transparent and accountable system of funding for education and training in the health and care sector.
(HC 6-I, Paragraph 196)

We heard from some independent-sector representatives that they fear a levy would put them at an unfair disadvantage. However, we are unconvinced by these

arguments. If there is to be a comprehensive tariff system for funding education and training, as the Government intends, it should be possible for independent-sector providers to be remunerated for training that they undertake on a fair and transparent basis, alongside NHS organisations.
(HC 6-I, Paragraph 197)

We urge the Government to ensure that the levy system covers social care services, as well as healthcare, to ensure that the education and training system reflects the policy intention to deliver more integrated health and social care services.
(HC 6-I, Paragraph 198)

We recognise that there are particular concerns about the potential effect of a levy system on smaller voluntary-sector organisations. However, we believe that it is possible to construct workable exemption arrangements to cover these cases and this issue cannot be used to justify the current opaque and unaccountable system.
(HC 6-I, Paragraph 199)

Although, however, we support the Government's policy objective in this area we note—once again—that there is slender evidence of progress in converting this desirable policy into a system that will work in practice. We believe this work needs to attract a greater sense of urgency.
(HC 6-I, Paragraph 200)

53. The committee received a diverse range of views with regards to the proposal to raise the education and training budget through a levy on providers. This illustrates the complexity associated with the proposal and the need for detailed work before firm proposals can be brought forward for consultation.

54. We will also consider other measures that will increase transparency in the short and medium term.

Funding in the transition period

We heard from the Department that its policy is currently to keep NHS funding for education and training broadly the same in cash terms from year to year. Against a background of inflation and major cost pressures, this is an extremely challenging financial settlement
(HC 6-I, Paragraph 215)

We have heard evidence that education commissions are being significantly cut. Given the wider financial situation in the NHS, there is also the risk that SHAs will raid education and training budgets in 2012–13, as they have done before.
(HC 6-I, Paragraph 216)

"Raiding" of education and training funds for other purposes has a long history. While we welcome the Government's willingness to apply a "ring-fence" to the Multi

Professional Education and Training levy, we are sceptical about its effectiveness. We believe the Government's plans for more fundamental reform discussed earlier in this chapter represent a more realistic way of safeguarding education and training activity within the health and care system. In the meantime the Government must act to safeguard funding for education and training during 2012–13.
(HC 6-I, Paragraph 217)

55. The Department has a service level agreement (SLA) with SHAs that sets out the requirements on the SHA to invest MPET to meet future workforce needs. There is no evidence that SHAs plan to 'raid' education and training budgets in 2012-13. Each SHA has an agreed investment plan which sets out how they will meet the requirements of the SLA with the Department, and the needs of their local health economy, through utilisation of their education and training funds.

56. In the future, HEE will be responsible for managing the education and training budget to ensure that the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement. LETBs will be held to account for the education and training funding allocated by HEE and its disbursement in support of education and training.

ANNEX A:

Health Education England and Local Education & Training Board timetable

Introducing Health Education England published by HEE transition team	22 June 2012
Secretary of State sets out HEE priorities for 2012/13	28 June 2012
HEE established as Special Health Authority	28 June 2012
LETB Development Plans (to include geographies) submitted to HEE	31 July 2012
Guidance on authorisation criteria and process for LETBs published	September 2012
Initial LETB 13/14 Workforce and Investment Plans to be submitted to HEE	30 September 2012
MPET review transition plans submitted to DH	October 2012
LETB Independent Chairs appointed	1 October 2012
Authorisation process for LETBs	October 2012-March 2013
LETB Five Year Workforce Skills and Development Strategy to be submitted to HEE	31 March 2013
HEE takes on full responsibilities and LETBs established	1 April 2013