# Education and Training – next stage

## A report from the NHS Future Forum

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# Introduction

Having been asked to undertake a second phase of the NHS Future Forum's work on education and training, we were once again struck by the willingness of individual patients, the public, staff and organisations to engage constructively with us.

On behalf of the NHS Future Forum and, in particular, the Education and Training group, I would like to thank all the people who took the time and effort to meet and speak with us and send us written submissions. All respondents were convinced that, to deliver our desired aim of high quality patient care and outcomes, the underpinning education and training also needed to be excellent. Only by developing a sustainable, high quality workforce can we achieve the desired outcomes for patients.

England's clinical workforce is widely considered a great asset for the population, but also for the reputation of the nation and the contribution it makes to the economic health of the country. Education finds a natural partner in clinical academia and the two should be considered together as the NHS frequently struggles with rapid dissemination of innovation. Education and training have a key role to play in ensuring all practitioners maintain up to date knowledge and skills and apply them in their practice, as well as producing the next generation of researchers.

This second phase of the NHS Future Forum's work has focused on maintaining high standards, seeking ways to improve even further and in striving to achieve excellence. Most of the Education and Training group are not educational experts, but in this short time we have attempted to distil the wide range of views from all perspectives, make recommendations and suggest some specific areas for further development.

What we want to see is increased consistency and quality in education and training and consequently in people's outcomes and experiences, a payment system which reflects good and excellent practice and a live conversation about the importance of education and training to all aspects of healthcare. With this report we aim to contribute to a real and enduring step change in improvement in quality and outcome of training and education across all healthcare staff.

Ultimately, however, it is not just about improving quality in the current system. What we need also is a much more nimble approach to workforce planning, education and training and a system which is able to respond more quickly to the challenges of changing patterns of care.

Such improvements will only be delivered through a partnership between patients and the public, the NHS, education and academia, underpinned by clear governance that will assure and incentivise a relentless rise in quality. Just as the White Paper '*Equity and excellence: Liberating the NHS'* focuses on patient-centred care, education and training should be based around patient needs. These should be embedded in every curriculum and based on the principles that guide the NHS and the values enshrined in the NHS Constitution.

**Julie Moore**

**Chair, Education and Training Group**
**Chief Executive**
**University Hospitals Birmingham NHS Foundation Trust**

# Summary

People have welcomed the second opportunity to contribute to the development of the NHS's education and training system. This summary sets out the main themes of the report and provides an overview of the recommendations we have made for a range of organisations.

Respondents have acknowledged that there have been some positive developments since our first report, including the moves to establish Health Education England (HEE) and the plans to further develop the role of the Centre for Workforce Intelligence (CfWI), though this is taking longer than expected. People were curious about how HEE would operate and the relationships it will develop, firstly with the NHS Commissioning Board, to ensure production of the appropriate health care workforce to meet planned health care provision; secondly with the CfWI, as accurate workforce data is essential to its planning; and thirdly with Public Health England to develop the public health workforce.

There has been great interest in the plans for local education and training boards (LETBs), in particular in their relationship to HEE and how to make the views of all stakeholder groups, irrespective of size or influence, integral to decision-making. Of the possible operational models, we have heard most support for direct accountability to HEE, a view we support. There was also recognition that the key to success will be through strong partnerships between service delivery and academia with LETBs focusing on delivery rather than just representing views.

The interest in local structures was matched by recognition that greater local responsibility is an opportunity to strengthen these partnerships between education, service and academia to deliver new practices and innovation. There was agreement that developing LETBs should align with the recent conclusions of the NHS Chief Executive's Review of Innovation. Therefore we recommend that:

1. **The Department of Health (DH) and HEE should assure themselves, through the authorisation criteria, that LETBs have robust and transparent governance in place to deliver strong partnerships across healthcare providers, academia, education and professions with the appropriate skills to serve the functions of the LETB.**

2. **LETBs must be able to demonstrate to HEE that they have the governance and partnership arrangements in place to deliver recommendation 1, including how the work and functions of the deaneries will be transitioned, working with the royal colleges and General Medical Council.**

3. **DH and HEE should ensure that the development of LETBs allows flexibility to evolve as the wider system matures, so that local organisations are able to take opportunities to work in new ways across service, education, research and innovation; for example in building closer ties with Academic Health Science Networks as they develop.**

Issues of quality and consistency of care have been at the heart of our engagement in this phase. The key role that patients and the public can play in education and training was highlighted along with the recognition that they need to be supported to do so.

There is support for the need to widen participation in healthcare careers by selecting for the required academic ability and also for values and beliefs and the wish to work in healthcare.

We found agreement for the principle that not all institutions should train and that those that do should be recognised at an organisational and personal level. This should include all organisations providing healthcare, including the NHS, independent and voluntary and community sectors. Quality assurance was also raised as an issue. To support these changes we recommend that:

4. **HEE should provide guidance for those who have a role in scrutinising local providers on how to challenge providers on the quality of their education and training provision.**
5. **Education and training organisations, including higher education institutions, NHS foundation trusts and GP practices, should be able to demonstrate that patients and the public have been engaged in their training programmes, for example in their annual report.**
6. **The NHS Commissioning Board should set out how it will work with the medical royal colleges and other professional bodies to promote an understanding and awareness of the central role of education and training in the delivery of high quality services for patients.**
7. **LETBs should only commission from institutions that select students and trainees in partnership with employers, ensuring wider participation through the use of processes such as value based recruitment based on the NHS Constitution.**
8. **DH, and in the future HEE, should develop a system which rewards high quality education and training at all levels and for all professions. This should include development of a quality premium for teaching which would be paid to organisations that demonstrate quality outcomes in learning.**
9. **DH, and in the future HEE, should ensure that LETBs can demonstrate their ongoing support for high standards of education and training and will properly address substandard clinical education.**
10. **LETBs must be able to provide assurance that they have sought proper evaluation of the local education and training provision, including:**
    - **ensuring the ongoing, necessary specialty based expertise has been obtained and considered**
    - **demonstrating that local providers have clear quality control mechanisms in place and offer value for money, and**
    - **putting systems in place to address any conflicts of interest that might arise.**

11. **Clinical commissioning groups (CCGs) must demonstrate a commitment to commissioning from service providers who are able to show evidence that high quality education and training is at the heart of their service.**

12. **The NHS Commissioning Board must assure itself that CCGs are delivering on Recommendation 11.**

13. **The Care Quality Commission (CQC) should agree a memorandum of understanding with professional regulators to set out the steps to take where CQC finds, or is alerted to, issues affecting quality of care which they believe are indicative of problems with the education and training of staff. This should include how they will inform LETBs and HEE.**

The critical role of ongoing development of staff was once again of particular importance and we were told of significant local variation in practice. With regard to continuing professional development, while there is good practice in places, this is not universal. Ongoing development needs to be recognised by staff and employers alike as necessary for the individual, and also critical for improving care. Equally, the value of interprofessional working needs to be more widely appreciated. Our recommendations are that:

14. **The DH, and in the future HEE, should set out how it will embed training for team working, leadership development and the principles and values of the NHS Constitution at every level of the training and educational process.**

15. **The DH, and in the future HEE, should work with regulators to develop guidance to support programmes of appraisal and continuing development for healthcare workers. This should include a systematic approach to appraisal and personal development plans with an expectation that a minimum percentage of staff have plans.**

16. **LETBs should agree and allocate a minimum percentage of funding for continuing professional development. Employers will need to demonstrate how that money has been spent. This would need to be supported by local challenge mechanisms and publication of the information in their annual report.**

17. **LETBs should take account of the available evidence and tools to build a greater appreciation of interprofessional training approaches and take advantage of shared learning opportunities including common modules.**

There was strong agreement that medical education and training has become too rigid and inflexible. Many felt that there needed to be consideration given to developing alternative career pathways as well as a refocusing on developing generalists, in all care environments. Many respondents pointed out that much of what is needed was covered in the Tooke Report in 2007, including the case for extending GP training. One other theme was national consistency, with polarised views on the value of a national exam for medicine. This needs further consideration. Recommendations are:

18. **The DH, and in the future HEE, should set out how it will review the principles and aims of the Tooke Report, considering which aspects and outcomes remain relevant for implementation in the new system; in particular the extension of GP training, the development of a more flexible career pathway and the means to foster generalism in medicine both in the community and the hospital.**

19. **The General Medical Council should lead discussions on the desirability of implementing a national exam in medicine that would support alignment of registration and qualification.**

Quality and consistency were also major themes for nursing and midwifery, and particularly for support workers. There was support for a more rigorous selection process for nursing school places and a strong belief that employers need to take responsibility for the quality of those trained in their locality. Many respondents raised concerns regarding the lack of structure in nurse and midwife post-qualification careers, particularly in developing their leadership skills.

The recent announcements on developing codes of practice for support workers are welcome, but concerns remain about how robust a voluntary system will be. This is also the case for the new and developing professions in healthcare more generally, and in particular we have heard significant concerns about the lack of regulation for non-medical public health practitioners.

20. **The Nursing and Midwifery Council should work with the Royal College of Nursing, Royal College of Midwives, HEE, higher education institutions and providers to develop properly structured processes to support individual nurse and midwife development in post-qualification career pathways, ensuring support for clinical, managerial and specialist development. Other professional groups should consider developing post-qualification career pathways where they do not exist.**

21. **LETBs should lead work with local partners, including professional representatives, to develop the quality of nurse and midwife training locally. This should be replicated for all clinical training programmes.**

22. **CCGs must work with LETBs to develop their community services to deliver the movement of care to the community including increasing the provision of community placements for trainee nurses, midwives, allied health professionals and other appropriate professionals.**

23. **The DH should ensure that all public health specialists are regulated.**

Respondents told us that they believe that the current funding system has largely been effective in delivering the required levels of education and training, but care needs to be taken that this is not reduced during the transition to HEE. There was universal support for a transparent approach to funding flows with widespread agreement of the idea that funding should follow the trainees and that only high quality education and training should be commissioned. Our recommendations are:

**24. The DH should establish a transparent approach to funding flows for education and training monies, with a clear implementation plan for HEE, once established. In doing this, as part of the Multi-Professional Education and Training (MPET) review; the DH should:**

- **consider how to take forward the principle of having a fair tariff for trainees, money following the trainee and how to take account of outcomes not just volumes; and**
- **provide clarity for the future direction on fair funding to all training providers; it should also**
- **include clarification of the funding for professional development (CPD) and expectations on employers to resource professional development.**

**25. Establish transparent systems with robust accountability to make sure that organisations in receipt of education and training money are held to account for using it for the education and training of the NHS workforce.**

**26. LETBs must ensure there is transparent and unambiguous accountability to HEE for all MPET funding it receives for education and training.**

Finally, though the majority of discussions and responses have focused on how to improve quality in the current system, there has been recognition that we need to develop a much more flexible and responsive approach to planning for the future. We need a system that is able to respond to the changes in patterns of care and engages commissioners, employers and professionals in anticipating what will be needed in the future. To ensure this happens we recommend that:

**27. HEE and LETBs should work with the range of stakeholders, including the CfWI, to set out the strategic direction for the development of the workforce to more effectively meet the changing needs of patients and communities.**

# Context

1. In this second phase of the Forum's work on education and training, we have heard from many people with an interest in the topic. Some have been expressing their own personal views as patients or professionals and others represented their organisations.

2. This report attempts to convey the range of issues that we have heard about from patients, clinicians, professionals and providers. It covers what they believe are the key issues and opportunities and how, in some cases, they feel these could be addressed to improve the standards of education and training in this country. Some of the published evidence that supported the views of stakeholders is set out in the Evidence section, on page 34 of this report.

3. In the first phase, we were asked to provide advice on the Department of Health's education and training consultation (*Liberating the NHS: Developing the Healthcare Workforce*[1]). In doing so, we identified some immediate issues associated with the Health and Social Care Bill, in particular the abolition of the strategic health authorities. There is now work underway which reflects, in part, the NHS Future Forum's phase 1 recommendations to develop:

    - effective national planning and commissioning – supported by robust and accurate data
    - local level partnerships between employers, academia and education with clear governance and multi-professional engagement
    - clear accountabilities – national and strategic for workforce planning but with local flexibilities to develop the workforce to meet local needs and innovate, and
    - a flexible, responsive education and training system supported by an effective appraisal system and environment of learning development across all employers.

4. However, the overriding message of the NHS Future Forum's phase 1 report was that more time was needed to get it right and this second phase has given us the opportunity to do just that. In this phase, we have focused more on the quality of education and training and specifically, how best to ensure we develop a sustainable, high quality workforce with the capacity and capability to embrace changes and innovation in practice. We believe the NHS in England should be, as one participant suggested, 'aspiring to excellence rather than settling for mediocrity'.

5. It is the intention of this report to provide a number of recommendations for all the players in the system including Health Education England, the local training and education boards, employers, the regulators and others. However, it will also be relevant for those people either working in education and training or

[1] *Liberating the NHS: Developing the Healthcare Workforce,* Department of Health, (December 2010) http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122590

being educated or trained. Though there is clearly a need for a national strategic approach to some aspects, reform on this scale cannot and should not be driven from the centre alone. Success is dependent on all interested parties playing an active role.

6. What has also become clear, as the work of the second phase of the NHS Future Forum has progressed, is that there are fundamental links across all four workstreams; education and training, integration, information and the NHS's role in the public's health. Education and training underpins them all, with cultural change required in approach and attitude, from leadership to seeking feedback and challenging poor training.

7. We have tried to ensure that we have heard from the spectrum of patients, the public, staff and providers of healthcare and health education to cover aspects of education and training that will be of interest and concern to all. While medical education has dominated some of the discussions, in our second phase it was balanced by the attention nurse education received and wider concerns about continuing professional development in other groups.

8. Finally, it has concerned us that some people have seen the NHS Future Forum as a means to resolve current local issues as well as wider workforce concerns. This leads the group to suggest that Health Education England and, in the future, local education and training boards will need to consider how to communicate more effectively the roles and functions of the new bodies across the country, to all organisations, the NHS, patients and the public.

# What we have heard and recommendations

## Structures and governance in the new system

### *National*

9. We have continued to hear strong support for the establishment of Health Education England (HEE) and the development of the Centre for Workforce Intelligence (CfWI), though this has not been without challenge.

10. The establishment of HEE needs to be undertaken as soon as possible to enable more detailed work developing the new systems and processes to commence. In doing so, it needs to be mindful of the balance between national and local requirements. While local flexibility is essential to enable areas to develop their own solutions and innovative practice, it is vital that there is sufficient national oversight to ensure security of supply as well as maintaining high quality and consistent standards across the country and the UK as a whole.

11. Concerns have principally been around the governance of HEE and the local education and training boards (LETBs); in particular, how HEE will take account of the various professional views and stakeholders, but be sufficiently agile to deliver what is required for all professional groups. The smaller professions, and indeed some larger ones, remain concerned about dominance by any one sector and that the multi-professional approach advocated by the Government and the earlier NHS Future Forum report may not be reflected in the final organisational structure of HEE. However, we heard nothing in the proposed approach by the Department of Health (DH) to substantiate these concerns.

12. We believe that in setting up HEE, the DH should be mindful of these concerns. However, this must not be at the expense of developing a high quality board, focused on delivery. Membership of the Board should be appropriate to that delivery, but with evidence of proper partnership working and wider input into decision-making. To enable healthcare workers to contribute to effective partnership working, HEE will need to play a key role in supporting leadership development and team working across all professions and at all grades.

13. HEE's relationship with the NHS Commissioning Board (NHS CB) is also critical. Service delivery and education and training are fundamentally interlinked. While HEE needs to be responsive to the changing needs of the NHS and to the NHSCB's commissioning priorities. It must be an interdependent partnership.

14. There is also considerable support for developing the work of the CfWI to ensure the system has good, robust and timely data to facilitate planning, across the whole of the UK. While the CfWI is relatively new, it needs to make rapid

progress in improving the evidence-base for workforce planning and providing intelligence, which supports those making decisions on education and training. The DH will need to ensure that, in the new system, HEE and the new LETBs have the appropriate levers to shape CfWI's health work programme.

15. Equally, it will be incumbent on LETBs to inform CfWI of their perceived workforce needs at a local level. Employers will need to engage more proactively, setting out clearly the impact of changing service models of health care provision on the skills needed in the future workforce. This will be particularly important with the increase in plurality of providers and the need to analyse in more detail the wider education and training landscape, including the independent sector.

16. We recognise that, because CfWI covers both health and social care, the DH seemed the right organisation to manage it. However, its functions in relation to healthcare are more naturally aligned to those of HEE. It would seem appropriate to consider how HEE might be able to manage the healthcare aspects of the contract on behalf of the DH in the near future, without losing any potential synergies between health and social care.

### *Local*

17. The area that has generated the most discussion and views has been the structure, accountabilities and form that the LETBs might take.

18. Every group we have spoken to wanted to ensure their seat at the table. However, the evidence on high performing boards is that they need to be established on the basis of their ability to deliver, not on their 'representational' make up of all stakeholders. This is not to suggest that the views of such stakeholders are not central to decision-making, but that this should be done through a transparent, systematic process, open to challenge by stakeholders, all LETB members and HEE.

19. A number of people expressed specific concerns to us about current activity to establish LETBs. In some areas key stakeholders and, in particular, higher education institutions (HEIs) have been excluded. In our view, this limited participation will mean that the LETBs will not have access to valuable expertise. It is vital to bring partners from across health and social care with HEIs into the process.

20. We heard major support for common terms of reference and a single model for LETBs to promote consistency across the country. They also need to be sufficiently large geographically, and in population and organisational terms, to ensure no monopoly interest dominates decisions and to provide a wide enough base of placements for trainees to develop skills. There was also widespread recognition that this should be balanced with sufficient flexibility to ensure local decision-making. Whatever the structure, transparency will be crucial in ensuring a strong partnership between academia and service provision.

21. Establishing the LETBs is also seen as an ideal opportunity to develop closer relationships across research, academia, education and service delivery, with closer partnerships delivering new practices and innovation rapidly from research to the bedside and broader community.

22. We are glad to see that the Government and the DH have taken on board our earlier recommendations on provider involvement and that work is underway to develop the LETBs. Two broad models have been discussed, the social enterprise model and some form of NHS arrangement including hosting by an existing NHS body. There is clear support for the latter with LETBs taking on the delegated decision-making powers as they demonstrate their capability to HEE.

23. LETBs will need to have clear educational, operational and financial governance and accountabilities and it is not for the Forum to get into the fine detail of how this is determined locally. However, we believe that to avoid the risk of planning in a vacuum and to ensure rapid establishment of the LETBs, a degree of specificity is appropriate at this stage. We would urge HEE to set out the principles to which LETBs should adhere as soon as possible to ensure that local partners are able to plan effectively.

24. Good governance principles suggest that the LETB should have an independent chair appointed by the LETB, with non-executive expertise in the needs of patients, trainees, service providers, and employers, able to provide effective challenge and hold the Board to account. In terms of appointed officers, the expectation would be that there should be a chief executive officer, who would be accountable to the LETB Board, which in turn should be accountable to HEE. In addition, the Board would need to include a finance director and appropriate senior clinical and academic staff. It will also be important to clarify the professional accountabilities of the postgraduate dean.

25. Whatever their exact configuration, LETBs will need to ensure they have effective arrangements for professional leadership and accountability for all health professions including medicine, nursing, pharmacy, healthcare science and allied health professions. In addition, they will need to have an established relationship with Public Health England and the local public health services, for public health clinicians. Strong links to academia, in common with all other developed healthcare systems, are to be encouraged.

26. We recognise that postgraduate deaneries play a key role in managing the relationship between training and service in ensuring high quality training and improving patient care. It is clear the crucial work and functions of the postgraduate deaneries will need a careful transition to the new arrangements, which also include close working with the medical royal colleges and the General Medical Council (GMC). For example, the responsible officer in postgraduate deaneries which are designated bodies under the Responsible Officer Regulations

2010[2] will have a key role in the revalidation of trainees by the GMC. The LETB will then need to be accountable for the local delivery.

27. Engaging commissioners, providers and employers more fully and consistently in educating and developing the workforce is a highly desirable outcome from these changes. Employers, in particular need to take greater responsibility for shaping their future workforce. LETB membership should reflect the future NHS, including mental health, integrated care and other services. This should be complementary to strong partnerships with higher education institutions.

## A recommendation for the DH, and in the future HEE, is that they:

1. Should assure themselves, through the authorisation criteria, that LETBs have robust and transparent governance in place to deliver strong partnerships across healthcare providers, academia, education and professions with the appropriate skills to serve the functions of the LETB.

## A recommendation for LETBs is that they:

2. Must be able to demonstrate to HEE that they have the governance and partnership arrangements in place to deliver recommendation 1, including how the work and functions of the deaneries will be transitioned, working with the royal colleges and GMC.

### *Future developments*

28. One area of particular interest to the Forum is the NHS Chief Executive's Review of Innovation, recently led by Sir Ian Carruthers[3]. This recognises the need to ensure the reputation and expertise of academia and the NHS, through embedded research and development together with excellent education, and the important role this plays in economic growth of the UK. The Education and Training group strongly supports this development.

29. The proposed development of Academic Health Science Networks (AHSNs) to stimulate innovation, research and growth in life sciences is welcome. We see innovation as an essential partner to excellent education and training and the commitment to 'hard-wire' innovation into educational curricula, training programmes and competency frameworks at every level is crucial. We believe the establishment of joint industry and NHS training and education programmes for senior managers will also provide an effective lever to drive this change.

30. The Innovation Review and the NHS Future Forum work have been undertaken concurrently, so neither has been able to draw in any detail on the conclusions and recommendations of the other. However, as education, training, research

[2] Medical Profession (Responsible Officers) Regulations 2010, http://www.dh.gov.uk/en/Managingyourorganisation/Responsibleofficers/index.htm

[3] *Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS,* Department of Health (December 2011) http://www.dh.gov.uk/health/2011/12/nhs-adopting-innovation/

and innovation are so closely linked, we believe that it will be vital to consider the recommendations of both reports together. This will ensure that the desired synergies are realised and the systems are coterminous, where possible.

31. It is therefore important that, where things are already developing and working well, this should be encouraged to continue. For example, some in London are already operating this sort of model and the participants tell us that it is effective. Where this is not already the case, and given the AHSNs are likely to include major teaching hospitals, it is essential that the process to establish LETBs be considered concurrently with the work to stimulate innovation.

**A recommendation for the DH, and in the future HEE, is that they:**

3. Should ensure that the development of LETBs allows flexibility to evolve as the wider system matures, so that local organisations are able to take opportunities to work in new ways across service, education, research and innovation; for example in building closer ties with Academic Health Science Networks as they develop.

## The quality and priority of education and training

32. The focus of the whole of this report is on developing the standards and quality of our education and training system. However, while some issues are specific to particular groups, others apply across all disciplines. This section covers these wider topics.

33. Quality, consistency, and the means to measure and benchmark standards of education and training in all groups have been the central themes of this period of engagement by the Forum. Whatever systems are put in place, it is clear that attitude is fundamental to how healthcare workers approach their jobs and the people they interact with and, as one participant said, the NHS should 'recruit for values, educate for knowledge and train for skills'.

34. This has been reinforced by the recent public expressions of concern about the quality of care sometimes received by patients in the NHS, attributed by many to poor education, insufficient leadership and a reluctance at all levels to accept responsibility for behaviours and actions. Whilst it is not our belief that education or training alone are responsible, it is clear that they do have a major role to play in addressing these concerns.

35. We heard repeatedly from patient groups, carers and professionals that care, compassion and the ability to treat people with dignity, together with communication skills, teamwork and leadership training, should be essential parts of every curriculum. Equally, there was support for some interprofessional education and training to ensure that different professionals are made aware of

the various skills and abilities of other professionals and a team based approach was embedded from the beginning.

36. The importance of patient and carer input to education and training was emphasised. There needs to be a more formal 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, compassion and to be treated with dignity.

37. Input from patients in both the curriculum planning and in the delivery of education and training was seen as immensely positive. The NHS must engage more constructively with patients and the public, 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 change how healthcare workers view their relationships with patients fundamentally.

38. As part of this, we need to ensure that patients and members of the public, including young people, are able to undertake these roles effectively. Just as we recognise the need for leadership training for those delivering NHS services, it is important that lay and patient leaders also have access and support to develop their skills and confidence. National Voices have identified this as an area in need of development and have invited the Government to work with them on an initiative to support patient leadership. We welcome this approach.

39. It is equally important that those who challenge organisations locally should be able to do so with the appropriate tools to support them. Local scrutineers have a key role to play here. Currently, Primary Care Trusts, LINks and Overview and Scrutiny Committees do this but in the future, it will be the responsibility of clinical commissioning groups (CCGs) and local HealthWatch. This would also help local health and wellbeing boards to know that their workforce is being trained to serve the needs of their whole population.

## A recommendation for HEE is that it:

4. Should provide guidance for those who have a role in scrutinising local providers on how to challenge providers on the quality of their education and training provision.

## A recommendation for education and training organisations, including higher education institutions, NHS foundation trusts and GP practices, is that they:

5. Should be able to demonstrate that patients and the public have been engaged in all aspects of their training programmes, for example in their annual report.

### *Education and training as a priority*

40. In this phase, with more opportunity to consider the issue of quality, it became clear to us that education and training is not a priority for every organisation. This can be manifested as a lack of engagement by employers, for example by not attending meetings to discuss changes to the education and training arrangements or in preventing staff from providing or attending training opportunities. HEE needs to have the authority to intervene if lack of interest and attendance means that essential functions are not carried out and prevent local arrangements falling into abeyance.

41. In our view, this underlines the need for the LETB to be a real partnership between the NHS, employers, educational bodies and academia to deliver optimal and flexible training, with clear outcome measures, governance and accountabilities, and with a shared goal of aspiring to excellence.

## A recommendation for the NHS CB is that it:

6. Should set out how it will work with the medical royal colleges and other professional bodies to actively promote an understanding and awareness of the central role of education and training in the delivery of high quality services for patients.

### *Widening participation and focusing on values*

42. We have heard strong views about how the NHS needs to be smarter about determining who enters our courses and training schemes. This is recognised to be complex, especially the effective selection of school leavers that will ensure they are likely to have the right values in the future, while maintaining the diversity essential for a wide variety of roles in the profession.

43. We have heard of some excellent schemes to widen participation, for example in dentistry and medicine. However, these sorts of initiatives are not sufficiently widespread. While we accept the need for intellectual ability, there is also a need to ensure that the individuals selected demonstrate an aptitude for the caring professions and have values that underpin their choice of career. It was felt by some that the emphasis on academic ability as the dominant selection criterion is a significant barrier to those from lower income groups applying for places on many of the healthcare courses and has contributed to a workforce which does not reflect the diversity of our population.

44. The NHS Constitution offers a tangible set of values against which to select students and we support this being used more broadly in a more values based approach to selection. There are also more specific, professionally tailored

examples of guidance, such as the Royal College of Nursing's '*Principles of Nursing Practice*'[4] which provide frameworks to support this.

45. It is important that selection and career development encourage wider participation. This widens the pool of potential trainees leading to an increase in quality and allows a workforce that is representative of its patients as well as having wider societal benefits in promoting fairness.

46. There are examples of policies to ensure wider participation in medical and non-medical training. These include the NHS Bursary, which provides means-tested support to healthcare students to assist with living costs while studying and includes extra support for disabled students or those with dependents. There is also a requirement in the national standard contract for non-medical student commissioning to widen participation.

47. More recently, the funding policy mandates approval by the Office for Fair Access for degree programmes that charge over £6,000pa. This is a new lever for widening participation and we suggest that HEE should consider how it could actively engage with Office for Fair Access on how to make best use of this tool for healthcare related courses.

48. In addition to issues relating to new entrants into the education and training system, we have also heard concerns about how individuals who may have taken a break from work are helped to return. Healthcare as a whole is female dominated, and even traditionally male professions such as medicine and dentistry have told us that their entrants are now approximately 50% female. This change requires very different approaches in terms of flexible working patterns and skill mix. It also means the system needs to have clear and recognised paths back into the workforce for those who wish to return. This is of particular importance to general practice where there are barriers enabling these highly skilled practitioners, who are needed to meet demand, to return to practice after a period out of service.

49. One further theme in the discussions was that the system, and the individuals within it, need to move to a culture that invites and welcomes feedback and is seen to act upon that feedback. Education and training is no different. There are examples where students and trainees do have the opportunity to feedback their experiences, but this needs to be done in a much more systematic and targeted fashion in an embedded system.

50. Finally, there is a strong sense from the people we have met that a high quality workforce takes a proactive role in determining its own future. In particular, students and trainees should be able to demonstrate how they are shaping their own education and development, including welcoming feedback from patients and showing evidence of where they have used it in their own development. We heard some excellent examples of this from allied health professionals but, disappointingly, this was often without the support of their employers.

[4] *Principles of Nursing Practice,* Royal College of Nursing (November 2010) http://www.rcn.org.uk/development/practice/principles/the_principles

## A recommendation for LETBs is that they:

7. Should only commission from institutions that select students and trainees in partnership with employers, ensuring wider participation through the use of processes such as value based recruitment based on the NHS Constitution.

### *Quality of education and training organisations*

51. It is widely believed that some training is of poor quality and not fit for purpose, either at the whole establishment, department, placement or trainer level. There is considerable cynicism about the processes intended to address this, across all groups, particularly as the final sanction to remove students and trainees is rarely employed because of the pressure to maintain the service. People reported that they see day-to-day service delivery taking precedence over quality of training or patient safety considerations.

52. Dentists, and other groups we spoke to, raised the issue of the low value that is placed on a career in clinical education. There is a lack of recognition for the time that is required to teach well and a perception that clinical education is less well regarded within the professional groups. This contributes significantly to the priority that education and training receives within organisations.

53. There is clearly a balance to be struck between the needs of the patients, the service and the provision of training. The system relies on trainees, in particular medical trainees, for a significant part of the care the NHS provides, and many have told us of the value of properly supervised on the job training. This is supported by the evidence[5], but only if the service time has high educational value.

54. Some participants have supported the view that any organisation in receipt of NHS funding, including the independent and voluntary and community sector, should be expected to have a duty to provide training. However, we believe a positive approach would be more effective. We have suggested, and received considerable support for our view, that individuals and areas should be accredited to provide education and supervision to a sufficient standard in order to accept trainees. This would mean that in the future:

    - not all organisations, employers or practices should train, and independent and charitable sector organisations across all care environments should be considered in those that may
    - not all parts of training institutions should automatically train and
    - not all clinicians within those training groups should be trainers, and those that do should want to and be given appropriate development and support including the time to do so.

[5] *Time for Training: a review of the impact of the working time directive on the quality of training*, Professor Sir John Temple, Medical Education England, Department of Health (May 2010) http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf

55. To provide the incentive we suggest that HEE look at developing a quality premium to reward excellence in training. This should build on the work the DH has done to date to develop an education Commissioning for Quality and Innovation payment (CQUIN) and be underpinned by a properly constructed academic base. Participants have suggested that this might be done through allowing LETBs to top-slice their training budgets and release this when organisations have demonstrated, through evidence outcomes based metrics, that they deliver high quality evidence. These should include trainee and patient reported experience measures, which can help ensure issues are identified and acted upon promptly.

56. A strong partnership between employers and HEIs in the new LETBs will offer an opportunity to move to this sort of approach. The combined knowledge of the local market and incentives to develop a high quality workforce should enable the board to identify providers who are not delivering to a high enough standard and put in effective mitigating strategies promptly, well before the sanction of removing training posts in most cases.

57. Some have suggested that the GMC extend the annual survey of medical trainees to undergraduate medical students. The GMC should research what this might realistically add to the annual Quality Assurance of Basic Medical Education (QABME) process.

## Recommendations for the DH, and in the future HEE, are that they:

8. Should develop a system which rewards high quality education and training at all levels, for all professions. This should include development of a quality premium for teaching which would be paid to organisations that demonstrate quality outcomes in learning.

9. Should ensure that LETBs can demonstrate their ongoing support for high standards of education and training and will properly address substandard clinical education.

## A recommendations for LETBs is that they:

10. Must be able to provide assurance that they have sought proper evaluation of the local education and training provision, including:
    - ensuring the ongoing, necessary specialty based expertise has been obtained and considered
    - demonstrating that local providers have clear quality control mechanisms in place and offer value for money, and
    - putting systems in place to address any conflicts of interest that might arise.

## A recommendation for CCGs is that they:

11. Must demonstrate a commitment to commissioning from service providers who are able to show evidence that high quality education and training is at the heart of their service.

## A recommendation for the NHS CB is that it:

12. Must assure itself that CCGs are delivering on Recommendation 11.

## A recommendation for CQC is that it:

13. Should agree a memorandum of understanding with professional regulators to set out the steps to take where CQC finds, or is alerted to, issues affecting quality of care which it believes are indicative of problems with the education and training of staff. This should include how it will inform LETBs and HEE.

### *Assuring quality*

58. The first education and training report from the NHS Future Forum made recommendations on the development of a comprehensive system of quality governance and explicit educational outcomes. Subsequently, the DH has begun to work with stakeholders to develop an evidenced based 'NHS Educational Outcomes Framework'. This is still in the early stages and is welcome, but it is important that the detail be developed as soon as possible and that it should be academically sound and reflect the ambitions of the new rather than the existing system.

59. Additionally, LETBs should be encouraged to own the quality agenda with delivery embedded at the operational level. One of the key success criteria for LETBs will be how they improve quality and value for money across education and training.

### *The number of players in the system*

60. A final point on quality. The issue of the number of organisations involved in medical and other clinical education, has been raised a number of times. Clarity is required, for example, with regard to the role of medical royal colleges and other professional bodies in the provision and oversight of curricula and ensuring the quality of their delivery by education providers. This will need to be done with deaneries, as part of the LETB, and other organisations.

61. The issue of externality in the scrutiny of training also requires consideration. The lines of responsibility may not be clear nor the nature of overlap or the interplay of roles. This contributes to the complexity of the environment of quality assurance. The burden of inspection and regulation must be kept proportionate to the benefits for trainees and this may vary between specialties. For medicine, the GMC must lead on this, working with the postgraduate deaneries and medical royal colleges.

62. We suggest that all health professional regulators should look at how they could work together and with other bodies, such as the royal colleges and professional organisations, HEE and the Higher Education Statistics Authority, to reduce the burden of inspection and regulation by coordinating and looking for areas of

duplication. This would also help address the points raised in counsel's closing submission to The Mid Staffordshire Public Inquiry[6], which highlighted the need for improved information sharing regarding the quality of services to include local HEIs, deaneries as well as the regulator and service providers.

## Developing and maintaining the workforce

63. There is widespread recognition that ongoing development enables staff and services to respond to the changing care needs of the population as well as innovation and developments in clinical practice. It offers an opportunity to embed the principles of team working and the need to work across organisational boundaries, including social care. It also links back to the earlier section in the report about the need to instil the values and behaviours in staff delivering NHS services, as set out in the NHS Constitution.

64. We must not lose sight of the fact that the current workforce in training is the workforce of the future and, without a systematic approach to developing their skills, attitudes and behaviours, the NHS will be unable to deliver high quality care in the future.

### *Continuing professional development*

65. For non-medical professionals, continuing professional development (CPD) remains an area of particular importance. Defining what is meant by CPD is not straightforward; it means different things to different people, ranging from building skills post-qualification to training in specialist areas of practice and team based training, such as resuscitation or interprofessional training, such as the Clinical Academic Training Pathway for nurses, midwives and allied health professionals.

66. There are examples of comprehensive CPD systems but this is by no means consistent. Many employers do not always see it as a priority, which has led to significant local and regional variation in access to funding and support for ongoing development. The problems of access seem to be most striking in the community but were also raised by pharmacists, dentists and several trainee doctors, who have experienced inequities in access to ongoing development. We believe this is short sighted, with all services facing longer-term challenges as a consequence of having inadequately trained staff.

67. There is also anxiety that there is a risk that access to CPD will be a casualty of the financial restrictions; in particular, that staff may only receive training in mandatory areas such as hygiene and fire training. This is of particular significance for the registered professions for whom the regulators set CPD requirements to maintain their registration. We are very clear that employers should see mandatory training as separate from investing in CPD. They should

[6] *Transcript of Inquiry counsel's closing submissions to The Mid Staffordshire NHS Foundation Trust Public Inquiry,* pp22-26 (December 2011)
http://www.midstaffspublicinquiry.com/hearings/s/498/week-thirty-seven-28-nov-1-dec-2011

recognise their obligations to staff in assessing their need and the service requirement for continuing training.

68. In the first Forum report on Education and Training we supported the recommendation made by the Clinical Advice and Leadership workstream, that the National Quality Board should review the provision of CPD across the NHS. This work has yet to be taken forward and we would urge that the National Quality Board do so as a matter of some urgency now that this second phase of our listening has been completed. The review should ensure it considers the needs of the total healthcare market, for example including what developmental training is available to newly qualified pharmacists in the community. It should also provide an overview of the experiences of the entire workforce at all grades, including Bands 1-4.

69. We believe CPD needs to be recognised by clinicians and employers alike as necessary (linked to appraisal) but also essential for maintaining high standards in clinical practice (developing the individuals and the service). All staff should participate in an appraisal system that is linked to their own personal development as well as meeting the needs of their employer. The formation of the LETBs offers an opportunity to acknowledge this and embed the principles set out in both the NHS Constitution and CQC's essential standards on CPD from the outset.

## Recommendations for the DH, and in the future HEE, are that they:

14. Should set out how they will embed training for team working, leadership development and the principles and values of the NHS Constitution at every level of the training and educational process.

15. Should work with regulators to develop guidance to support programmes of appraisal and continuing development for all healthcare workers. This should include a systematic approach to appraisal and development plans with an expectation that a minimum percentage of staff have plans.

## A recommendation to LETBs is that they:

16. Should agree and allocate a minimum percentage of funding for CPD. Employers will need to demonstrate how that money has been spent. This would need to be supported by local challenge mechanisms and publication of the information in their annual report.

### *Interprofessional education*

70. Interprofessional education has been raised a number of times in this second engagement process and it is clear that there is a great deal of anxiety and misunderstanding about training across professional boundaries. We believe this report should be used as an opportunity to dispel some of the myths associated with it.

71. Interprofessional education is defined as where 'two or more professions learn with, from and about each other to improve collaboration and the quality of care'[7]. It recognises the value in training along pathways and practising as a team but does not mean all training is undertaken together.

72. While it is obvious that individual disciplines need to acquire a great depth of knowledge before they can help transfer it to others, the Forum believes the evidence that the value of interprofessional education in consolidating skills in teams and developing an appreciation of others roles is significant. As one person described it, 'transforming teams of experts into expert teams'.

73. There is particular value in shared learning between clinicians and managers, ensuring they have a common understanding of the challenges and demands each face. A good example we heard about placed emerging medical leaders into mentoring relationships with senior managers to bridge the divide between medical staff and managers at an earlier stage.

74. To enhance the reputation and realise the benefits of interprofessional education, LETBs and higher education institutions will need to work together to consider what educational methods are most effective for their particular needs and undertake a thorough analysis of the outcomes. One way of moving interprofessional education at postgraduate level onto a higher plane is to assemble groups of representatives from two or more professions around patient-informed issues that require interpretation of evidence, quality improvement strategies and/ or primary research.

### A recommendation for LETBs is that they:

17. Should take account of the available evidence and tools to build a greater appreciation of interprofessional training approaches and take advantage of shared learning opportunities including common modules.

## Medical education and training

75. We have heard a wide spectrum of views expressed on the education and training of doctors. The selection of undergraduates continues to be a challenge. In particular, some argue that the current selection processes may be contributing to an imbalance in the career choices of medical graduates. Some suggested that medical students also need stronger career guidance throughout their training to ensure a better balance between the choices of individuals and available places on training schemes and subsequently jobs.

[7] *Creating an Interprofessional Workforce: an Education and Training Framework for Health and Social Care*, Department of Health (September 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078592

76. Tuition fees are also changing in England. This will potentially leave every graduate embarking on their career with significant debts. For a medical student these are likely to exceed £50,000. Although provisions have been made for students from low-income families, there is concern that this could deter applicants from poorer backgrounds from applying for long courses such as medicine and it is important that this risk is mitigated through appropriate support.

77. Professor Sir John Tooke addressed the issues around medical training in detail in his 2007 report '*Aspiring to Excellence*'[8]. Many of his recommendations have been taken forward, but some, set out below, have yet to be addressed. We recognise that with the passage of time there is a case for revisiting the principles and aims of the report in light of subsequent developments. However, in our view many are still valid and should be implemented without further delay.

## *The 'shape of training'*

78. In terms of postgraduate training, there is a widely expressed view that the system has, despite the intentions of '*Modernising Medical Careers'*, become too rigid and inflexible. Specialties are chosen early and training placements can be service driven rather than developmental. For example, many do not have experience in primary care and we were told of cases where foreign placements were blocked. It is also very difficult to reconsider choices at a later point without significant re-training. This has been a common theme from many sources.

79. The system needs to enable individuals to develop their skills by working in other disciplines, taking up academic fellowships or gaining international experience all of which can contribute to their portfolio of skills and benefit patients. Several people have told us that this lack of flexibility led to them leaving medicine altogether.

80. Service transformation, the innovation agenda and the importance of the life science industries to the national economy will place increasing reliance on clinical academics in view of their key roles as educators, researchers and service improvers. Education and training arrangements need to be sensitive to their needs, reinforcing the concept of an integrated academic pathway that gives those entertaining a clinical academic career a clear line of sight on senior positions, be they in primary or secondary care. Particular account needs to be taken of the need for flexibility with regard to out of programme activity and ways of assuring that gender is not a barrier to clinical academic career progression.

81. Many feel there are also insufficient alternative endpoints in terms of career grades other than consultant or GP. There need to be other properly constructed jobs with education opportunities for doctors other than consultant

[8] *Aspiring to Excellence: Final report of the independent inquiry into Modernising Medical Careers,* Professor Sir John Tooke (October 2007)
http://www.mmcinquiry.org.uk/MMC_FINAL_REPORT_REVD_4jan.pdf

or GP. Some doctors expressed their view that they would like to have the option to choose to continue in hospital medicine without having to assume the level of responsibility associated with being a consultant. It is important to recognise that these concerns have been acknowledged by Medical Education England and steps are being taken through the Shape of Training work to address these issues. This work should continue, alongside the assessment of the future shape of the medical workforce.

### *The lack of generalists*

82. One of the major concerns expressed by employers is that the current system has resulted in too few generalists. This is in part due to the need for trainees to specialise early but it has two particular consequences. The first is that increasing specialisation is having an impact on current hospital services, which can struggle to provide appropriate senior staff cover 24 hours a day and seven days a week. The second is that, as the population ages and more people are living with one or more complex long-term conditions, the need for doctors with a broader practice experience in community and acute care is increasing. These concerns have been acknowledged by the profession and we are aware that the Academy of Medical Royal Colleges is looking at developing a curriculum that will allow a breadth of experience and flexibility to decide a final career choice with the benefit of having experienced a range of specialties.

83. We heard a number of views that this trend is in part being driven by the perception that generalists are less well-trained and less able than specialists. These issues are discussed in detail in the recent report of the independent commission on generalism for the Royal College of General Practitioners and the Health Foundation[9]. While we endorse their recommendations on steps to upgrade the status of generalists and incentives to make it an attractive career option for high achieving doctors, this is not just a primary care issue but an important issue in the hospital environment.

### *Length of general practitioner training*

84. The move to shift more clinical care into the community means GPs will need to take on more complex care for their populations. To do this they need high quality training and experience and, while we heard that the length of training for consultants was widely felt to be about right, there was an almost unanimous view that the length of postgraduate GP training should be extended.

85. While GP trainees may be deemed to be 'clinically competent' after three years, their experience of some areas of clinical practice can be limited. For example, though a significant proportion of their caseload will involve treating children and families, we know that in many parts of the country up to 50% of GPs will have

[9] *Guiding patients through complexity: modern medical generalism*, Report of an independent commission for the Royal College of General Practitioners and The Health Foundation (October 2011) http://www.health.org.uk/publications/generalism-report/

had not formal paediatric or child health training. Additional training time would enable GPs to embed clinical competencies and develop team-working and leadership skills as well as areas of special clinical interest. They would still be able to meet the service commitment but would be able to take a much more considered approach and focus on effective case management and work with patients to optimise treatment in the community.

86. This is an important issue that needs a decision. Any decision should be based on good evidence and looking at costs and benefits, including consideration of the opportunity costs of investing in longer training rather than continuing professional development for the existing workforce. While we felt the arguments made to us were convincing, we recognise that there are operational and financial issues to be considered and recommend that discussions should be undertaken with the Royal College of General Practitioners as a matter of urgency.

### *National quality assurance in medicine*

87. We have heard, in some detail, the concerns of NHS organisations and others about the preparedness of some medical graduates to enter the workplace. The GMC has addressed this in part, but a case remains for greater consistency in the final undergraduate examination, with consideration of registration at the end of the undergraduate period. This will need to be balanced against the advantages of the current system, which many believe stimulates innovation and quality in graduates.

88. We were also told about work that is underway to consider restoring the opportunities for Foundation Year 1 doctors to spend a week shadowing their predecessors. Given the evidence of the benefits this provides, we believe this would be a straightforward way to start to address this issue.

## A recommendation for the DH, and HEE in the future, is that it:

18. Should set out how it will review the principles and aims of the Tooke Report, considering which aspects and outcomes remain relevant for implementation in the new system; in particular, the extension of GP training, the development of a more flexible career pathway and the means to foster generalism in medicine both in the community and the hospital.

## A recommendation for the GMC is that it:

19. Should lead discussions on the desirability of implementing a national exam in medicine that would support alignment of registration and qualification.

## Nurse and midwife education and training

### *Quality and consistency*

89. While there are clearly some excellent examples of nurse and midwife education and training, there is huge variation in quality across the country. This is one area where we found almost universal concern. We have heard about issues at all stages, in selecting candidates, in undergraduate education, post-registration and post-graduate training and examples of poor standards of care.

90. Selection in nursing was a particular issue, with a sense that the focus has moved away from selecting students on their ability, capacity for compassion and caring and desire to work in nursing. This has led, in some cases, to significant dropout rates and issues with basic skills such as numeracy. There are also concerns about inconsistency and responsiveness in undergraduate training with widespread support for the development of a mechanism to improve this. There is also a view that we need to be training nurses and midwives for the new health environment, and shifting the emphasis to the community.

91. In the immediate post-registration, preceptorship, period we heard from recently qualified nurses who had not been offered any further training or induction. This lack of initial investment means employers miss the opportunity to ensure that all of their staff understand the values of the organisation they should be espousing or to ensure they have the right basic skills.

92. There is evidence that access to post-graduate training for nurses, particularly in specialist areas such as intensive care and emergency medicine, learning disability and older people's nursing, is declining significantly. There is inconsistency in both the availability and quality of postgraduate training. This trend is in part because organisations are not releasing staff to provide the programmes but also because of the lack of quality assurance of some of the existing courses.

93. We heard that this is a particular issue in provision of community placements for nurses and midwives. Though the number of nurses and midwives has increased, the numbers with community skills is dropping. It is an overly complex system too. In nursing, there are eight pathways in different branches of community work but no requirement for a community qualification or assessment of competence. Where training is offered, the lack of community placements means providers are often relying on 'virtual' training experience. There is a clear mismatch between intention and the capability and capacity within the system.

94. We believe that at the heart of these issues is the need for focus and leadership from employers. They bear the consequences of the current system failures and are in the best position to determine what is required. Where it works, and there are some very good examples, high quality nurse and midwife training is the result of strong partnerships with employers, who can ensure valuing training is part of the organisation's culture.

95. The development of LETBs, we believe, offers an opportunity for employers to lead the work to drive up the quality of nurse and midwife training, supervision of placements, induction and preceptorship. Nurses and midwives need to be empowered to develop their leadership skills though access to a leadership framework from undergraduate level throughout their careers.

96. We recognise that a lot of this evidence is anecdotal, but it does reflect a large number of discussions, not just with nurses, midwives and organisations representing them. We welcome the news that the Royal College of Nursing will be setting up a commission to look systematically at what constitutes good nurse training and to identify areas of good practice. This will help employers and the wider membership of the LETB benchmark and develop their own education and training programmes.

## A recommendation for the Nursing and Midwifery Council is that it:

20. Should work with the Royal College of Nursing, Royal College of Midwives, HEE, higher education institutions and providers to develop properly structured processes to support individual nurse and midwife development in post-qualification career pathways, including support for clinical, leadership, managerial and specialist development. Other professional groups should consider developing post-qualification career pathways where they do not exist.

## A recommendation for LETBs is that they:

21. Should lead work with local partners, including professional representatives, to develop the quality of nurse and midwife training locally. This should be replicated for all clinical training programmes.

## A recommendation for CCGs is that they:

22. Must work with LETBs to develop their community services to deliver the movement of care to the community, including increasing the provision of community placements for trainee nurses, midwives, allied health professionals and other appropriate professionals.

### *Regulation of health and social care support staff*

97. During the past months, we have heard the wide spectrum of views from many people on the regulation of support staff. This is an issue which garners strong views ranging from those calling for statutory regulation of health and care support staff to those who argue that there are already existing tiers of regulation protecting patients and service users and that it is the key role of employers to ensure safe, high quality care.

98. We believe that there are very real issues with the system at present, specifically around quality assurance of support workers who are now assuming a more pivotal role in patient care and how to ensure a greater degree of transferability.

These concerns have been highlighted in the evidence and the closing statement to the Mid Staffordshire Public Inquiry.

99. Consequently, we welcome the recent announcement that the DH has commissioned Skills for Health and Skills for Care to work with partners to take forward the development of a code of conduct, minimum recommended standards of training and core training standards for more advanced tasks for healthcare support workers and adult social care workers in England.

100. This will complement the proposed legislation for a system of assured voluntary registers in the current Health and Social Care Bill. However, we can see the need for further checks and balances with the onus on employers to instigate further checks on those who are not on the voluntary register and monitoring by CQC through its quality assurance process.

### *Registration and regulation of new types of worker*

101. The Forum has also heard wider concerns from a range of people about the development of new and existing practitioner roles, including critical care practitioners and physician's assistants. These roles are necessarily flexible and evolve as clinical practice moves on. However, this has led to issues with consistency and patient safety, which raise questions about the need for regulation and we believe warrants further consideration. This could also ensure that practitioners have skills that are transferable across providers of healthcare.

102. We have also heard that there is particular concern about non-medical public health specialists who are trained and work alongside public health doctors. However, unlike the doctors, who are regulated by the GMC, they are not subject to any compulsory regulation. Indeed, we have been told of a number of different voluntary regulatory systems for non-medical public health specialists.

**A recommendation for the DH is that it:**

23. Should ensure that all public health specialists are regulated.

## Funding

103. There have been several attempts to review education and training funding and we do not want to repeat these arguments. It is our view that, generally, the current funding has been effective in delivering the levels of education and training required in the system. The proposal for transparent funding mechanisms is universally welcomed, as is the drive to ensure that the funding follows the trainee and that only quality training environments should be funded. This will need to be supported by better information on the outcomes achieved to enable HEE and the LETBs to drive up quality and provide value for money on investment.

104. Whatever the process, any changes to funding are potentially destabilising at a time of financial constraint and, while we strongly support the need for an open and transparent review of the funding arrangements for training, this must be done in a systematic, phased and gradual manner.

105. Concerns were raised throughout the engagement process and in written responses to the Forum that in the past the education and training budget had been used for purposes other than education and training. There is particular anxiety about what might happen prior to HEE assuming its full responsibilities in 2013. We believe the new system will provide greater assurance that funding allocated to education and training is spent on education and training, however it will be important for the DH and the strategic health authorities to ensure that this is also the case in 2012/13 as the transitional year.

106. It is crucial, however, that transparency of funding occurs at all levels and that all elements of funding should be considered simultaneously, not piecemeal, as this risks allowing attrition of the different funding streams.

## Recommendations for the DH are that it:

24. Should establish a transparent approach to funding flows for education and training monies, with a clear implementation plan for HEE, once established. In doing this, as part of the Multi Professional Education and Training (MPET review); the DH should:
    - consider how to take forward the principle of having a fair tariff for trainees, money following the trainee and how to take account of outcomes not just volumes
    - provide clarity for the future direction on fair funding to all training providers, and
    - include clarification of the funding for professional development (CPD) and expectations on employers to resource professional development.

25. Should establish transparent systems with robust accountability to make sure that organisations in receipt of education and training money are held to account for using it for the education and training of the NHS workforce.

## A recommendation for the LETBs is that they:

26. Ensure there is transparent and unambiguous accountability to HEE for all of MPET funding it receives for education and training.

## The Future

107. The majority of respondents have focused in their discussions on the current system and what needs to be done to improve the quality now, but there has been a recognition that we need to do so in the context of future needs. The

time lag in workforce development, particularly in healthcare, has major implications for what we do now and how we design our education and training systems for the future.

108. There is support for the need to develop a much more flexible and responsive approach to workforce planning, education and training. We need to enable the system to respond more quickly to the challenges of changing patterns of care. In the future we will need to be providing better support to people with long-term conditions and people in later life, better integrated services and more services in community settings and our workforce needs to be educated and trained appropriately.

109. This offers a significant challenge for service commissioners, employers and professionals to articulate clearly the future service need, the workforce change required to deliver that and therefore better medium term workforce planning and development.

## A recommendation for HEE and the LETBs is that they:

27. Should work with the range of stakeholders, including the CfWI, to set out the strategic direction for the development of the workforce to more effectively meet the changing needs of patients and communities.

# Evidence


- *Creating an Interprofessional Workforce: an Education and Training Framework for Health and Social Care*, Department of Health (September 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078592
- *Aspiring to Excellence: Final report of the independent inquiry into Modernising Medical Careers*, Professor Sir John Tooke (October 2007) http://www.mmcinquiry.org.uk/MMC_FINAL_REPORT_REVD_4jan.pdf
- *Evidence to Alan Milburn's panel on fair access to the professions*, The Medical Schools Council (April 2009) http://www.medschools.ac.uk/News/Consultations/2009/Pages/Panel-on-Fair-Access-to-the-Profession.aspx
- *Tomorrow's Doctors 2009*, General Medical Council (September 2009) http://www.gmc-uk.org/TomorrowsDoctors_2009.pdf_39260971.pdf
- *Education Commissioning for Quality*, Department of Health (January 2010) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110774
- *NHS Constitution: The NHS belongs to us all*, Department of Health (March 2010) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613
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