Title: A NEW SYSTEM FOR WORKFORCE PLANNING EDUCATION AND TRAINING **IA No:** 8008 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 30/04/2012 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Other

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£120.7m	£0	£0	No	NA

What is the problem under consideration? Why is government intervention necessary?

The government is responsible for planning and developing the NHS and associated healthcare workforce. The current arrangements need to be developed to respond to and support the reforms set out in Equity and Excellence: Liberating the NHS. The current arrangements are not adequate to do so as they do not provide healthcare providers with the right incentives and levers to develop their workforce, and improve quality and resilience. The present system focuses often on the needs of professional groups in silos and is underpinned by funding arrangements based on historical flows, not the costs of providing education and training.

What are the policy objectives and the intended effects?

The policy objective is to improve care and quality outcomes for patients. The new system for planning and commissioning education and training is built on design principles (see paragraph 46) that have been developed through wide ranging consultation and the advice of the Future Forum. It will be more responsive to patient and public needs and changing service models, ensuring that investment in the capacity and skills of current and future staff reflects the needs of patients, carers and local communities. The intended policy effects will provide sustainable solutions that will lead to improved planning and education commissioning, resulting in improved patient care and value for money.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 0: Do minimum. Retain the structure as it is currently configured. Under this option, the existing staff and infrastructure of the workforce planning and education and training divisions of the SHAs would be retained with a new name. National functions would remain in DH as they are now.

Option 1. Develop a new system for education and training. Health Education England (HEE) a new national body, set up as Special Health Authority, will provide national leadership and oversight on strategic planning and development of the health and public health workforce . It will also allocate education and training and resources. Local Education Training Boards (LETBs), who will be committees of HEE, will provide the vehicle for providers and professions to work with HEE to improve the quality of education and training outcomes so they meet the needs of service providers, patients and the public.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 04/2017

Does implementation go beyond minimum EU requirements?			N/A			
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No	
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:** 0		

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible SELECT SIGNATORY: [signature] Date: 2.5.2012

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £105.7m	**High:** £135.6m	**Best Estimate:** £120.7m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£14m	4	Optional	**£14m**
High	£22.3m		Optional	**£22.3m**
Best Estimate	£18.2m			**£18.2m**

Description and scale of key monetised costs by 'main affected groups'

The cost above shows the transition costs for the new education and training system. There will be a reduction in running costs for the new system. Savings are shown in the benefits box.
We expect some redundancy costs. The figures above incorporate our current best estimates.

Other key non-monetised costs by 'main affected groups'

We have not identified any non-monetised cost associated with this option.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		£20.7m	**£128m**
High	Optional		£24.2m	**£149.7m**
Best Estimate			£22.4m	**£138.8m**

Description and scale of key monetised benefits by 'main affected groups'

The benefit above shows the reduction in running costs for the new education and training system.

Other key non-monetised benefits by 'main affected groups'

We expect the new education and training system to provide better integration of workforce planning with service and financial planning and the wider healthcare system, education, research and innovation. It will provide better value for money by improving capability and linking investment to clear education outcomes. The system will deliver a more sustainable and transparent investment in education and training and HEE will be responsible for developing a more transparent allocations policy.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5%

Key assumptions to achieving benefits are ensuring that robust governance structures and checks and balances are in place to avoid market failures. A risk is that the reduction in resources available to run the system could lead to a reduction in quality in education and training and the security of supply of future healthcare professionals and skills. However, budget reductions will not affect the education provision budget. The assurance process designed by HEE is intended to protect quality.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Evidence Base (for summary sheets)

A. Scope

1. The Government is creating a more autonomous and accountable NHS – with greater clarity about the roles and responsibilities of different organisations for provision and commissioning. The role of the Department of Health is fundamentally changing. The Health and Social Care Act 2012 formalises the relationship between the Department and the NHS, to improve transparency and increase stability while maintaining appropriate accountability.

2. This directly impacts on the way in which the NHS workforce is educated and trained and in the future, the Department will have progressively less direct involvement in planning and development of the healthcare workforce and Health Education England (HEE), a Special Health Authority, will have powers, directed by the Secretary of State, to plan and commission education and training.

3. Over the next few years, the wider health economy and the public sector generally face significant challenges: an ageing and growing population, new technology and higher public expectations and continuing growth in demand. Through developing their Quality, Innovation, Productivity and Prevention (QIPP) plans, the NHS has been planning for some time for a tighter financial environment, with the ambition of achieving efficiency savings of up to £20 billion for reinvestment in front line care. Healthcare staff account for the majority of NHS spending, so having the right mix of skills and empowered professionals will be essential in meeting these challenges.

4. The driving principle for reforming the education and training system is to improve care and outcomes for patients. Excellent health and healthcare depends on a highly skilled and educated workforce. The new system aims to be responsive to patient and public needs and changing service models, such that our investment in the capacity and skills of current and future staff reflects the needs of patients, carers and local communities.

5. The education and training system consists of:

    - workforce planning, including the quality assurance of local development plans and strategies;
    - commissioning education and training for the professional workforce;
    - contracting with education and training providers to manage the delivery of education and training;
    - quality assuring the delivery of education programmes; and
    - the management and delivery of medical education and training programmes (carried out by postgraduate deaneries)

Problem under consideration

6. Currently, Secretary of State has powers to make provision for the education and training of healthcare workers, which are delegated to the Strategic Health Authorities (SHAs).

7. The Health and Social Care Act 2012 makes provision for the abolition of SHAs in March 2013. The Secretary of State's education and training functions will need to continue to be exercised by a different body in the absence of SHAs. These functions include assuring the quality of workforce development plans and strategies, commissioning education and training, contracting with education and training providers to manage the

delivery of education and training, and quality assuring the management and delivery of postgraduate medical and dental education programmes. The SHAs host the postgraduate deaneries, who are responsible for the management and delivery of postgraduate medical education and training. A full list of SHA's roles and functions are set out at Annex A.

Consultation

8. To address this problem, in December 2010, the Department consulted on proposals for a new system for workforce planning, education and training through the publication of *Liberating the NHS: Developing the Healthcare Workforce – A consultation on proposals*. The consultation set out:

   - the overall vision for workforce planning, education and training
   - the context and case for change
   - the key functions that need to be delivered in a new system
   - the basis for transferring greater responsibility for planning and developing the workforce to healthcare providers
   - arrangements for sector wide oversight and support in developing the future workforce
   - proposals for the new public health workforce
   - proposals for reforming funding flows to be more transparent
   - transitional arrangements
   - the need for fairness, equality and diversity across the healthcare workforce

9. The consultation closed on the 31st March 2011 and over 500 responses were received from a wide range of individuals and organisations across the health and education sectors. The consultation process reaffirmed the critical role that education and training has to play in the continued improvement of NHS and public health services in England. These views were taken account of when designing the new system to ensure a safe and stable transition to the new system. The findings from the consultation were carefully considered in designing the new system and aided understanding in ensuring a safe and stable transition. The department published *Liberating the NHS: Developing the Healthcare Workforce – a summary of consultation responses* in August 2011.

The Listening Exercise

10. In April 2011, the Government announced the 'Listening Exercise', led by the NHS Future Forum, set up as an independent group, to pause, listen and reflect on the content of the current Health and Social Care Bill and wider reforms. The NHS Future Forum consisted of a group of health experts to provide independent advice on four themes, one of which was education and training.

11. In June 2011, the Future Forum published its report and key recommendations of the Government's modernisation programme, this included *Education and Training – A report from the NHS Future Forum,* which endorsed the Government's proposal to set up a new body, Health Education England (HEE) to provide oversight and national leadership for

education and training. The Government's response to the NHS Future Forum, accepted all of the NHS Future Forum's recommendations, and for education and training signalled further engagement with stakeholders on the new system proposals, expediting HEE, and a commitment to publish more detailed policy proposals.

2nd Phase Future Forum

12. In August 2011, the government announced a second phase NHS Future Forum to continue its conversations on the proposals to modernise the NHS including to provide future advice about developing an education and training system that would deliver within the reformed system.

13. In January 2012, the NHS Future Forum second phase report was published, this included *Education and Training – next stage, A report from the NHS Future Forum,* setting out its key recommendations for education and training, which were accepted by the Government.

Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery

14. In January 2012, *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery* was published setting out the department's policy for a new education and training system. The policy builds on the public consultation carried out, and the further engagement following the Listening Exercise, and addresses the recommendations set out in the NHS Future Forum reports.

15. The consultation Impact Assessment (IA No: 8008) sets out the underlying problems that the new system for education and training will address. Professionals and healthcare providers will be able to secure the quality, innovation and productivity needed to improve healthcare outcomes in their localities. The way we plan and develop the healthcare workforce will respond to and support the wider NHS modernisation agenda reforms, and align with new ways of commissioning and providing services.

16. The system will need to evolve as the rest of the NHS and public health system matures. The new system needs to have the flexibility to respond and adapt to future challenges and seize opportunities to work in new ways across the NHS, the public health system and with education, innovation and research partners. The partnerships between employers, professions and with the education and research sectors, locally and nationally, will be critically important to this.

17. New capabilities and relationships will be required as we look to plan for the whole workforce. It is equally important that we build on the skills and knowledge we already have. A safe transition is needed to secure business continuity and maintain current training programmes. It is also important that we minimise the financial risks to the system so changes to the way we fund education and training will be done carefully and at the right pace.

Rationale for intervention

18. The rationale for intervention is that the Department needs to put in place a system that enables SofS to direct his powers to make provision for the education and training of healthcare workers. This rationale has been strengthened by the Health and Social Care

Act 2012, which now places a duty on the Secretary of State to exercise his functions to secure an effective system for education and training for persons who are employed (or considering becoming employed) in an activity which involves the provision of health services.

19. The wider reforms to the NHS provide an opportunity to strengthen the arrangements for education and training. The current education and training system has grown over time in a piecemeal way. Changes have been driven in response to structural reorganisations as well as educational priorities. Led by SHAs, it lacks the right incentives and levers for healthcare providers to be fully involved in workforce development. Instead, because of how it is structured, it focuses often on the needs of professional groups in silos and is underpinned by funding arrangements that are based on historical flows and not the actual costs of providing education and training

20. The preferred option is to put in place a provider-led system where healthcare employers and professionals can shape their future workforce and skills to meet the challenge of operating more cost effectively and improving patient outcomes. Greater responsibility and accountability for decision making will be delegated to employers who are best placed to understand the communities they serve and the needs of their own workforce.

21. In terms of timescale, we need the new system to be ready to take on the statutory functions for workforce planning, education and training when SHAs are abolished in March 2013.

22. The new system will have two central planks Health Education England (HEE) and the Local Education and Training Boards (LETBs).

<u>Health Education England</u>

23. HEE will be established initially as a Special Health Authority (SpHA) to provide national leadership and oversight on strategic planning and development of the health and public health workforce. It's purpose will be 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.

24. HEE will have five key national functions:

- providing national leadership on planning and developing the healthcare and public health workforce;

- authorising and supporting the development of LETBs;

- promoting high quality education and training responsive to the changing needs of patients and local communities. This includes responsibility for ensuring the effective delivery of important national functions such as medical trainee recruitment;

- allocating and accounting for NHS education and training resources and the outcomes achieved;

- ensuring the security of supply of the professionally qualified clinical workforce.

25. HEE will also enable local healthcare providers and professionals to take responsibility for planning and commissioning education and training by establishing and supporting the development of Local Education and Training Boards (LETBs), which will be committees of HEE.

Local Education and Training Boards

26. LETBs will be set up so that local partnerships, with healthcare and public health providers at their centre, can take on the functions of SHAs, including the postgraduate deaneries. They will shape the education and development of the people they employ, working together with those who provide education and invest in research.

27. The purpose of LETBs is to:

- identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public services;
- plan and commission education and training on behalf of the local health community in the interests of sustainable, high quality service provision and health improvement;
- be a forum for developing the whole health and public health workforce.

28. The core functions of a LETB are set out in Annex B.

29. Each LETB will bring together local providers and professionals to identify and agree local priorities for education and training, and plan and commission education and training on behalf of their health community.

30. HEE will allocate a proportion of the education and training budget to each LETB for commissioning purposes and will hold them to account for delivery against national education outcomes goals and priorities.

31. Each LETB will be part of HEE, taking the legally recognised form of a committee of HEE. The chair and the executive board of each of the LETBs will, however, operate under formal schemes of delegation from the national HEE body. The executive board of each LETB will represent the interests of **all** the healthcare providers, not just their own organisation, within the geographical area covered by the LETB. This reflects the policy intention of giving local healthcare providers and their healthcare professionals autonomy for planning and commissioning education and training, whilst ensuring robust governance. If there are potential conflicts anonymised data can be presented to the board.

32. Each LETB will have an independent Chair who is not a provider of NHS funded services in the LETB's geographical area. The Chair will be appointed by the Chair of HEE. LETBs are expected to meet a rigorous authorisation criteria to demonstrate they are acting on behalf of all of the members of the LETB and demonstrate clear and transparent governance.

33. Each LETB will have a number of operational staff who will plan, commission and assure the quality of education and training on behalf of the executive board. These operational staff will be employed by HEE, but will be accountable to the LETB executive board.

B. Policy objective

34. The policy objective is to design and implement a new system for planning and commissioning education and training that is multi-professional and driven by patient needs. The system will put employers and professionals in the driving seat working in partnership with education and research and innovation sectors. They will have national support through HEE, to identify and anticipate key workforce challenges and be much more flexible and responsive in planning their workforce and developing the skills needed and supported by a fairer and more responsive funding system. The LETBs will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public. Through HEE, health and public health providers will have strong input into the development of national strategies and priorities so education and training can adapt quickly to new ways of working and new models of service.

Why do we need a national system?

35. Effective planning and commissioning for the healthcare workforce requires national co-ordination and assurance. HEE will provide this leadership and oversight.

36. Previous Health Select Committee inquiries have signalled the importance of having a focused national voice on education and training matters for the NHS. Medical Education England (MEE) was established as an Advisory NDPB on the back of a 2007 inquiry into failures on medical education reforms, and HEE is seen as a natural and multi-professional evolution of that decision.

37. As previously discussed, the Health and Social Care Act 2012 places a duty on the Secretary of State to exercise his functions to secure that there is an effective system in place for the education and training of the health and public health workforce. The Secretary of State will continue to exercise some functions to meet the duty and will remain ultimately accountable for meeting this duty and the investment of NHS funds. It would be impossible for the Secretary of State to delegate this duty to a third or private sector body. Neither the third sector nor the private sector are directly accountable to Parliament and Ministers and, particularly in the case of the private sector, there would be risk of conflicts of interest as private healthcare providers may also be providers of NHS services. It is the intention to allocate these functions to HEE.

38. In addition, it would be incoherent to place these functions together with the current £4.9bn budget (upon which the success of the NHS is dependant) outside the scope of the NHS, and would also risk the loss of staff (and expertise) who want to remain within the NHS.

Why do we need a local tier?

39. Workforce planning is currently carried out locally by the 10 SHAs because the planning, commissioning and quality assurance of education and training needs to be undertaken by people who understand the needs of healthcare employers and the specific learning and development requirements for health professionals.

40. When SHAs are abolished, local healthcare organisations, with their knowledge of the patients that they serve, are best placed to take on these functions and make decisions on the workforce needs for their community, according to local circumstances and priorities, with assurance and challenge regionally and nationally. Where changes are

planned to the size and shape of the workforce, healthcare organisations must provide assurance that the safety and quality of patient care is maintained or improved. The process should include clinical involvement, leadership and sign off.

41. The wider system reforms will liberate providers and clinicians to secure the quality and innovation needed to improve health outcomes. We have listened to those who responded to the consultation and to the advice of the NHS Future Forum in developing provider-led education and training arrangements. The outcome is that LETBs will be established so that healthcare and public health providers can shape the education and development of the people they employ, working together with those who provide education and invest in research.

42. Through the LETB, healthcare and public health providers will be able to give a clear articulation of the impact of future service needs on the workforce: what new skills need to be developed and how the shape of the workforce should change. This in turn will drive the education and training they commission for both the current and future workforce. Through the LETB, providers can ensure service planning; financial planning and workforce planning will be better integrated. Starting with a clear understanding of the service models best able to improve health outcomes, healthcare providers will be able to identify the specific competencies and skills needed at each stage of the patient journey and develop people they employ to provide these.

43. The LETBs will be the vehicle for providers, educators and clinicians to work with HEE to improve the quality of education and training outcomes across the system. Through HEE, healthcare and public health providers will have a strong and immediate input into the development of national strategies and priorities so that education and training is more responsive and can adapt more quickly to new ways of working and new models of service. Equally HEE will be in a position to support local initiatives undertaken by LETBs.

44. In addition, the new arrangements give healthcare and public health providers the opportunity to work together to undertake a range of workforce development activities that may be more cost effective than being undertaken by each provider independently.

<u>Design principles</u>

45. The system's design principles that were developed through consultation, are set out below:

- greater accountability for all providers to plan and develop their workforce, whilst being professionally informed and underpinned by strong academic links;
- aspiring to excellence in training and a better experience for patients, students and trainees;
- supporting NHS values and behaviours to provide person-centred care
- supporting the development of the whole workforce, within a multi-professional and UK-wide context;
- providing greater transparency, fairness and efficiency to the investment made in education and training
- reflecting the proposed, explicit duty on the Secretary of State to secure and effective system for education and training

46. Developing the education and training system will take time, and the system will need to evolve as the rest of the NHS and public health system matures. The new system needs to have the flexibility to respond and adapt to future challenges and seize opportunities to work in new ways across the NHS, the public health system and with education, innovation and research partners. The partnerships between employers, professions and with the education and research sectors, locally and nationally, will be critically important to this.

Secondary legislation

47. HEE is to be established as a new national body responsible for workforce planning and education and training in the NHS and public health system. Subject to parliamentary approval, HEE will be established as a Special Health Authority in June 2012. LETBs will be committees of HEE.

48. HEE will take on some functions from October 2012 and be fully operational by April 2013 when it take on responsibility for the education and training functions of the SHAs. A Chair, Non Executive Board members and the Chief Executive will be appointed between March and June 2012.

49. Within the context of the changes described above and the move to create a more autonomous and accountable NHS, the long-term plan is to place HEE on a permanent statutory footing by establishing it, in primary legislation, as an executive non-departmental body. We intend to legislate for this as soon as Parliamentary time allows. As a first step, the Government intends to publish draft clauses on education and training for pre-legislative scrutiny later in 2012.

Transition

50. Given the importance of education and training and the competing pressures across the wider system, it is vital that we ensure a safe and stable transition and a pace of change that is led by local priorities and capacity. We are taking a deliberate and cautious approach so that we can secure continuity and a safe transfer of essential skills and staff from SHAs and protect individuals currently undertaking training.

C. Description of options considered

51. There needs to be a workforce planning and education and training system in place to exercise Secretary of State's duty to secure an effective system for education and training for the NHS.

52. The SHAs and postgraduate deaneries currently employ around 2,000 FTE in workforce planning and education and training functions. Around 700 FTE deliver frontline education and training functions, working closely with providers such as Higher Education Institutes (HEIs), NHS Trusts and GP practices. The remaining 1,300 staff provide support to these functions to ensure robust governance, quality assurance, financial management and accountability of the current £4.9 billion MPET budget.

53. Exercising this system involves:

- Planning the workforce needed for the local health economy. This includes working with local NHS Trusts and GPs on the development of workforce strategies and planning pathways, system assurance and workforce capability and development.

- Leading on workforce modernisation and ensuring the appropriate skill mix in local NHS organisations is available to deliver services.

- Leading on health and wellbeing for the NHS in the local health economy.

- Leading on postgraduate medical and dental education for the region, This includes:

    - co-ordinating and quality assuring recruitment of post graduate medical trainees to 45,000 places on Foundation, Specialty and GP training programmes;
    - setting standards, developing and delivering the requirements for trainee revalidation (the postgraduate dean is the Responsible Officer for trainee revalidation); and
    - continued professional development (eg for specialty doctors)

- Commissioning, contracting and quality assuring education for more than 80,000 undergraduate non-medical students on courses such as nursing, midwifery, allied health professions and healthcare science from over one hundred HEIs.

- Commissioning, contracting and quality assuring placements for more than 80,000 undergraduate health professional students and around 30,000 undergraduate medical and dental students through contracts or learning and development agreements from thousands of GP surgeries, and hundreds of NHS Trusts and other secondary care providers.

- Commissioning, contracting and quality assuring post registration training programmes including key government priorities such as health visitors and investing in strategic and continuing professional development initiatives to support the local NHS organisations in developing innovative approaches to the delivery of services

- Commissioning, contracting and quality assuring training programmes for 45,000 postgraduate medical and dental students through contracts or learning and development agreements from thousands of GP surgeries, and hundreds of NHS Trusts.

54. A detailed list of all SHA education and training functions can be found at Annex A.

55. Many of these functions require local knowledge and links with HEIs and NHS organisations, therefore it is not possible to plan, commissioning, quality assure and financially manage this scale of complex activity at a national level. A national body would need to work with local delivery arms to deliver these functions effectively. The local tier model is best placed to ensure that Secretary of State's functions are delivered effectively and efficiently.

56. Responses to the public consultation were considered when developing the options for the new education and training system. A large number of respondents highlighted the importance of retaining expertise and the need to protect and build on what works in the current system such as existing local partnerships between the education and health sectors. Many respondents highlighted examples of local best practice and pre-existing local innovation and flexibilities being developed. Proposals to include Local Authorities in the local arrangements were also supported. There were no responses suggesting locally based arrangements were not required. Concerns were that geographical areas covered should not be too large. Even organisations whose responses supported more national control supported the need for locally based functions. A main area of concern in the consultation was safe transition and the need to maintain stability and support for

students in the system.

57. There was also widespread support for the new body proposed, Health Education England (HEE), to provide, leadership and national oversight of the whole system. This was also supported by the NHS Future Forum who advised that the establishment of HEE should be expedited. They advised that HEE should be operational as soon as possible to provide focus and leadership while the rest of the education and training architecture is being put into place.

Option 0 Do Minimum

58. SHAs are currently directed by the Secretary of State to exercise statutory functions, therefore it is not possible to abolish SHAs without introducing replacement organisations to take on these roles and functions. As described above, the scale and complexity of the education and training system requires a local tier to deliver these functions.

59. The do minimum option would be to retain the structure as it is currently configured. Under this option, the existing staff and infrastructure of the workforce planning and education and training divisions of the SHAs would be retained with a new name. National functions would remain in DH as they are now.

60. As has already been noted, the SHAs play a key role in leading the current system. Currently they determine where to invest the budget for education and training at a local level. As set out in the Health and Social Care Act 2012, the SHAs will cease to exist in April 2013. In order to deliver the do minimum we would need to establish replacement bodies to host the existing functions and staff when SHAs are abolished.

61. We expect that the costs and benefits of the do minimum option would be similar to the costs and benefits of the current system, therefore we have taken the costs of the system in 2010/11 as our baseline against which we compare the preferred option.

62. In summary, the do minimum option will involve setting up the same structure as is currently in place, i.e. establishing replacement organisations that have the same functions as SHA, to deliver SofS duty to provide an effective system for education and training. However, the preferred option, set out below, provides improvements to the system over the do minimum and aligns the education and training system with the wider health reforms.

<u>Option 1 - Develop a new system for education and training that will have a national body Health Education England (HEE), set up as Special Health Authority</u>

63. The preferred option is to develop a new system for education and training that will have a national body HEE, set up as Special Health Authority, to provide national leadership and oversight on strategic planning and development of the health and public health workforce and allocate education and training and resources. LETBs will be committees of HEE. They will be the vehicle for providers and professions to work with HEE to improve the quality of education and training outcomes so they meet the needs of service providers, patients and the public.

64. The Department will set the education and training outcomes for the system as a whole, securing the resources necessary and continuing to set the regulatory, policy and legal

framework. It will hold the HEE Board to account for delivery of its strategic objectives.

65. The LETBs will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public. Through HEE, health and public health providers will have strong input into the development of national strategies and priorities so education and training can adapt quickly to new ways of working and new models of service. LETBs may also take on specific leadership roles for particular professional groups, such as the smaller professions and commissioning specialist skills.

66. HEE's role will be to ensure greater transparency in the education and training investments employers make in their workforce. LETBs will be responsible for investing in education and training to develop their future workforce and will have some flexibility to invest in education, training and ongoing professional development to support innovation and development of the wider health team. LETBs will also be able to ensure that funding in the new system follows the student/trainee on the basis of quality education and training outcomes.

67. Proposals to raise the education and training budget through a levy on providers will be developed for consultation.

68. Local education providers, universities, colleges and employers, will remain directly responsible for the provision and quality control of education at a local level. This framework will be maintained in the new system, with the LETBs assuming responsibility for the quality management role at local level and for meeting standards required by national frameworks and the regulators.

69. The new system will have the following structure:

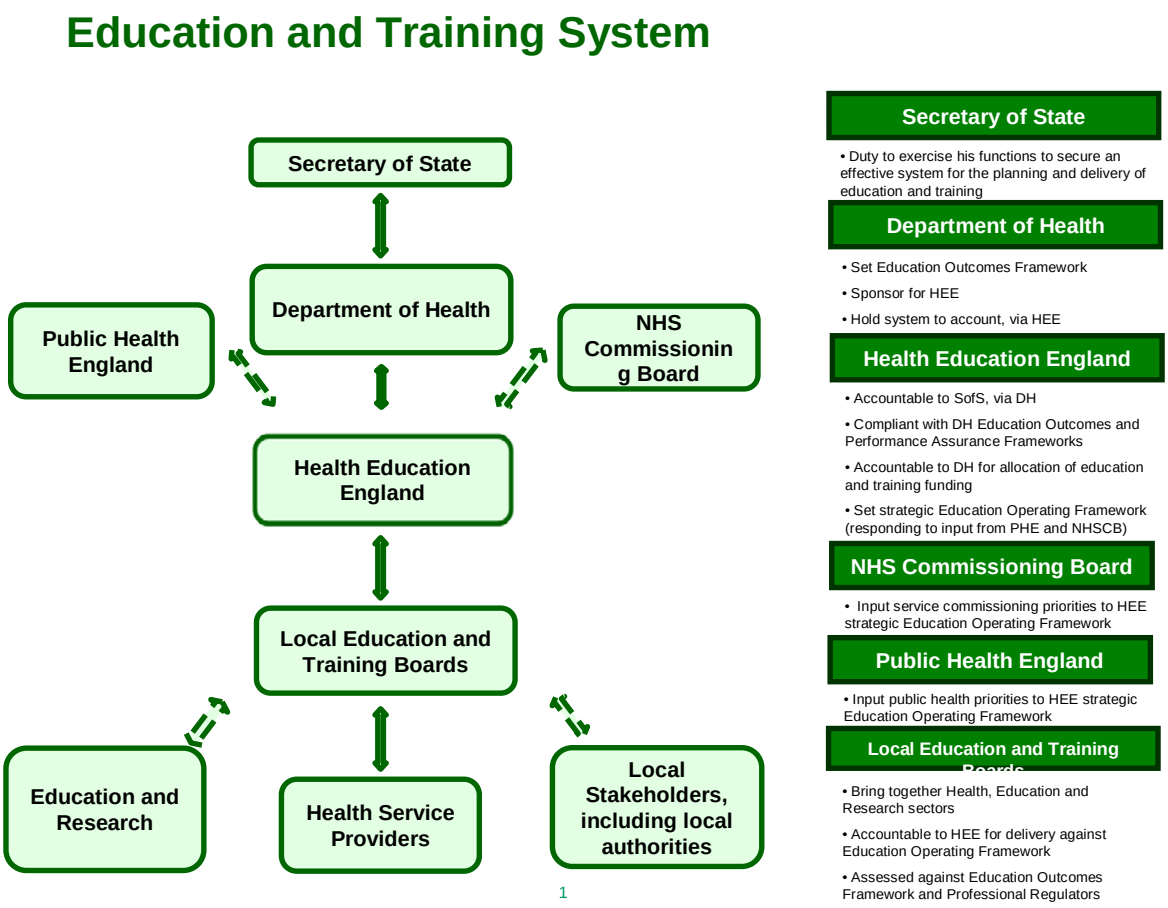
- The Health and Social Care Act 2012, places a duty on **the Secretary of State** to exercise his functions to secure and effective system for planning and delivering education and training for healthcare workers. HEE will be responsible for carrying out that duty. The Secretary of State will have powers to direct Health Education England, but will not intervene in the day to day running of the organisation. The aim of the new system is for power to be devolved to employers and clinicians.

- The **Department** will set the education and training outcomes for the system as a whole, securing the resources necessary and continuing to set the regulatory, policy and legal framework **.**

- **Health Education England** is to be established as a new national body responsible for workforce planning and education and training in the NHS and public health system. The key purpose of Health Education England is to ensure that the healthcare workforce has the right skills, behaviours and training, and is available in the right numbers to support the delivery of healthcare and health improvement.

- **Local Education and Training Boards** are being established to take on many of the workforce planning and education commissioning functions currently led by the SHAs and postgraduate deaneries. Led by local employers, they will identify and agree local priorities for education and training, and plan and commission education and training on behalf of their local health community.

70. A diagram of the new system is set out below:



The Operating Framework

71. The Operating Framework for the health and social care system requires an administration cost reduction of one third by 2014/15 from a baseline in 2010/11. Some of the administration cost reduction has already been realised in the Department and the SHAs as preparatory work has been taking pace for the introduction of the new education and training system. The cost base used in this IA is 2010/11, which reflects the fact that this is the baseline year for the policy changes.

The Education Outcomes Framework

72. An Education Outcomes Framework is being developed to set the high level objectives and quality outcomes for the education system. It will address variations in education standards and support innovation through high quality education and training. Indicators will be piloted in 2012/13, with a view to launching the framework in 2013/14.

73. Although the total amount of funding to run the system will reduce, the development of the Education Outcomes Framework will ensure that the quality of education and training across the system is maintained.

Moving to a tariff-based system

74. Current funding for clinical education and training is based on local agreements between SHAs and providers. This results in inequities in the funding of similar placements across the country. In particular, the distribution of funding for clinical placements varies widely across clinical placement providers, is not related to volume or quality of training provided, and does not cover all clinical professions.

75. Moving to a tariff-based system would enable a national approach to the funding of all clinical placements (both medical and non-medical) and postgraduate medical programmes to support a level playing field between providers.

76. The consultation response provided support for the introduction of such a system and particularly welcomed the introduction of a clinical placement rate for non-medical trainees to support the delivery of quality placements. The NHS Future Forum welcomed the proposal for transparent funding mechanisms.

77. We already have a benchmark price as a national tariff paid to higher education for the tuition costs of most NHS-funded pre-registration education programmes. This approach has been effective in delivering high quality, value-for-money programmes. In the future, HEE will be responsible for negotiating the national benchmark price with education representatives.

78. We have been working with stakeholders, including some of those who are likely to be most affected by the introduction of tariffs, to develop proposals for tariffs for non-medical education and training and undergraduate clinical placements for medical students in secondary care, and to consider the safest way to implement them without causing unnecessary destabilisation.

79. The Government is committed to the principle of tariffs for education and training as the foundation to a transparent funding regime. We will introduce the tariffs for non-medical education and training and undergraduate clinical placements for medical students in the hospital sector from April 2013, phased over a number of years. The Department will work with SHAs and service providers during 2012-13 to develop transition plans. Moving to a tariff base system is outside this Impact Assessment. A separate Impact Assessment will be developed.

Monetised and non-monetised costs and benefits of each option.

80. The original figure presented for SHAs administration costs, for education and training functions, in the annual accounts for 2010/11 was £130m. However, SHAs have been identifying efficiencies and working towards reducing their budgets since 2010/11. We have worked closely with SHAs to identify savings as part of developing their QIPP plans and through clustering of SHAs. We have also reviewed the categorisation of costs to ensure consistency across the country. A revised figure of £100m has been identified as the baseline before the changes covered by this Impact Assessment

81. Detailed work on the design of the new system and the numbers and structure of LETBs has not yet been completed so it not possible to give a final figure for administration costs. However, in implementing the new system and designing HEE and LETBs, we will take every opportunity to further reduce costs.

82. In addition to the efficiency savings already made by SHAs, it is expected that the system will gain further efficiencies by centralising the management of some SHA functions

within HEE. Furthermore, LETBs will be committees of HEE and their operational staff will be employees of HEE so HR and other key operational functions will be shared. Through standardisation of systems processes and contracts, to reduce duplication and increase efficiency, we anticipate the SHA element of the administration costs of the new system to further reduce to about £78m by 2014/15. This represents 1.6% of the money invested in the MPET levy, compared to the original figure of 2.7% in the 2010/11 accounts.

83. In addition to the £100m SHA costs, there are £6m of central costs, including £3m DH costs, which will form part of the HEE central budget. These costs are set out in the table below. However, we do expect additional costs of between £4m and £7.5m in running HEE central functions.

	Estimated Running costs 2010/11
Department of Health	£3m
SHAs core	£100m
Medical Education England & Professional Advisory Boards	£1m
MPET "lead" budget	£2m
TOTAL	**£106m**

84. LETBs will take on the majority of the functions currently discharged by the SHAs with respect to education and training. This will include supporting 45,000 postgraduate medical and dental trainees, 23,000 undergraduate medical and dental students and about 90, 000 undergraduate non-medical students.

85. In addition, SHAs and deaneries spent £82m on education provision for these trainees, which is outside of the running cost allocation and not subject to the reductions in administrative funding. This includes SHA expenditure for knowledge management, quality control, leadership management/provision, SIFT coordinators, Skills for Health, Leadership Academy and payment from other SHAs or third parties. Postgraduate Deanery expenditure on provision and commissioning including heads of school, Associate Deans, training programme directors, quality control, support staff pay, Foundation Programme directors, Specialty Programmes, lead employer support, recruitment costs and payment from other SHAs or third parties.

86. It is expected that there will be between 12 to 16 LETBs. It will be for local determination to identify the numbers of staff LETB's employ but we do not expect them to be more than 1800 FTE staff in total. HEE will be based in Leeds, with a small representation in London. It is expected that it will employ from 120 to 150 FTE staff.

87. The new education and training system will have a reduction in annual administration costs, which will result in savings for running the system in the future. To achieve this it is necessary to incur some transition costs to move to the new system. Transition costs for the new organisations have been budgeted for two financial years. The forecast transition costs in 2011/12, excluding redundancies, is £1m and for 2012/13 is £5.1m.

88. The £5.1m includes, £1.6m for HEE start-up costs, and £3.5m for the Education and Training Reform Programme budget. The Education and Training Reform Programme budget includes the staff and non-staff costs of the six programme workstreams delivering the new education and training system. The workstreams include:

- Governance. including the Programme Board and its secretariat
- Policy, including establishing the legal framework
- Development of HEE and LETBs
- Funding Flows
- Higher Education Interface
- Workforce Information Architecture

89. SHAs are currently working with local providers to design the LETBs. The expectation is that LETBs will have minimal transition costs, since most of the staff will move directly from SHAs. We are not expecting dramatic changes to the geographical distribution because LETBs will be expected to manage their cost within allocated resources. We expect a small number of redundancies to occur. It is not yet clear how many redundancies there will be. If there were 100 to 200 redundancies, then we would expect the total cost to be between £9m and £18m based on an average staff cost of £60k and a redundancy multiplier of 1.5. This would be over 4 years from 2010/11 to 2014/15.

90. We expect the value of the contract with the Centre for Workforce Intelligence, to provide advice and information to the NHS and social care system on workforce planning and development at local and national levels, to remain unaltered at the current level of £5m per year.

91. Taking both running cost savings and transition costs into account, the assumption is that the total cost savings of the new education and training system would have a net present value of £120.7m over ten years.

92. Annual profile of monetised costs (these are provisional figures, subject to change) are set out in the table below:

	10-Nov	11-Dec	Dec-13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	Total
Administration costs	£106m	£101m	£95m	£89m	£84m	£84m	£84m	£84m	£84m	£84m	£894m
Education support	£82m	£82m	£82m	£82m	£82m	£82m	£82m	£82m	£82m	£82m	£820m
CfWI	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£50m
Transition costs	£0m	£4m	£8m	£3m	£3m	£0m	£0m	£0m	£0m	£0m	£20m
Total cost of the system	£193m	£192m	£190m	£180m	£174m	£171m	£171m	£171m	£171m	£171m	£1768m
Discount rate	*1*	*0.966*	*0.934*	*0.902*	*0.871*	*0.842*	*0.814*	*0.786*	*0.759*	*0.734*	
NPV	£193.2m	£185.5m	£177.8m	£162.1m	£151.7m	£143.8m	£138.9m	£134.2m	£129.7m	£125.3m	£1542m

93. Cost-savings per annum (these are provisional figures, subject to change) are set out in the table below:

	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	Total
Administration costs	£0m	£5.6m	£11.2m	£16.8m	£22.4m	£22.4m	£22.4m	£22.4m	£22.4m	£22.4m	£168.2m
Education support	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0.0m
CfWI	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0.0m

Transition costs	£0m	-£4.4m	-£8.5m	-£3.4m	-£3.4m	£0m	£0m	£0m	£0m	£0m	-£19.7m
Total cost of the system	£0m	£1.2m	£2.7m	£13.4m	£19.1m	£22.4m	£22.4m	£22.4m	£22.4m	£22.4m	£148.6m
Discount rate	*1*	*0.966*	*0.934*	*0.902*	*0.871*	*0.842*	*0.814*	*0.786*	*0.759*	*0.734*	
NPV	£0m	£1.1m	£2.6m	£12.1m	£16.6m	£18.9m	£18.2m	£17.6m	£17m	£16.5m	£120.7m

Non-monetised benefits

Better integration of workforce planning with service and financial planning

94. The new system puts employers and professionals in the driving seat because they are best placed to identify and anticipate local workforce challenges and be flexible and responsive to developing and planning their workforce. Through the LETB healthcare providers can ensure service planning, financial planning and workforce planning will be better integrated. They have a clear understanding of the service models best able to improve health outcomes. They will be able to identify the specific competencies and skills needed at each stage of the patient journey and develop the people they employ to provide these skills.

Better integration with the wider healthcare system and education, research and innovation.

95. In its national leadership role, HEE will work to form close partnerships with:

- the NHS Commissioning Board to ensure that the strategic framework for education, training and workforce planning reflects service commissioning priorities, and that workforce development implications of innovation and changes in the pattern and nature of services are identified and addressed in a timely and effective manner.

- the Health Research Authority to ensure that education and training plans are informed by future research, innovation and academic workforce needs and will support LETBs to ensure that local training programmes are positioned to deliver a rapid uptake of effective and evidence based innovation.

- Higher Education Funding Council for England (HEFCE) who, with HEE, will be responsible for national planning and funding all higher education for the health sector and the key health, public health and life science professions. An important aspect will joint support for widening access to health education under graduate programmes.

96. At a local level, LETBS will work in partnership with providers of education to jointly plan and deliver education programmes and placements. They will also be key partners in promoting and ensuring integration of innovation and leading practice in both training and service delivery. They will ensure alignment and development of mechanisms for collaboration with evolving Academic Health Science Networks.

Better Value for Money and Capability

97. Through the LETB, healthcare and public health providers will be able to give a clear articulation of the impact of future service needs on the workforce; what skills need to be developed and how the shape of the workforce could change. This in turn will drive the education and training they commission for both the current and future workforce. These new arrangements also give healthcare and public health providers the opportunity to work to together to undertake a range of workforce development activities that will be

more cost effective than being undertaken by each provider independently.

Improvements in Workforce Planning

98. The system provides an opportunity to improve the operation of the overall healthcare labour market through better matching of the supply of trained staff with the demand for trained staff, but it is not possible to quantify the benefits of this.

99. It will also provide an opportunity to make changes to the balance between clinical specialties trainees and different professions e.g. medics v AHPs v nurses to reflect local need.

Linking investment to outcomes

100. The Education Outcomes Framework will set clear outcomes for the education and training system that will enable the allocation of education and training resources to be linked to quantifiable, quality outcomes. These in turn will support delivery of the outcomes set for the NHS Commissioning Board and Public Health England.

101. It 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. LETBs and HEE will use the Education Outcomes Framework as the basis for developing the operating model and working arrangements with partners.

A more equitable and transparent investment in education and training

102. The new tariff based funding system will provide a more equitable and transparent methodology for funding investment in education and training. Tariffs will provide a system of funding where all clinical placement providers are paid the same for the same activity. The introduction of tariffs will ensure that all providers receive the same level of funding for the same output. This will deliver transparency to payments made and a level of equity. However, there may still be some level of inequity remaining dependent on how closely the tariff reflects the true cost of training.

103. To further strengthen the equity of payments to providers, and to ensure a level playing field, information will be collected on the costs of education and training alongside the service reference cost collection for activity. By introducing a robust costing mechanism, tariffs will be set to better reflect the true cost of training.

HEE will be responsible for developing a more transparent allocations policy.

104. HEE will be responsible for developing a more transparent allocations policy for distributing funding to LETBs. A number of principles have been identified which HEE will refine and use to underpin the allocations policy.

105. Future allocation methodology will:

- Recognise existing patterns of training;
- Not be unnecessarily disruptive;
- Be transparent and clearly based on rules;
- Be equitable in allowing access to a trained workforce in the NHS across England;

- Ensure economies of scale in commissioning where this is appropriate, for example for small specialist groups;
- Support high quality education and training;
- Support the education and research interface.

The proposed tariff based funding system will ensure that money follows the student and allows new providers to access funding as appropriate

Risks and assumptions

106. The key assumptions are:

- HEE is successfully established as a Special Health Authority by the end of June 2012.
- Shadow LETB boards established as Local Education and Training SHA sub-committees from April 2012.
- HEE is fully operational by April 2013.
- LETBs established as HEE committees or transitional arrangements in place by April 2013

107. Below are the key risks to the sector if there is not a national system in place to support healthcare providers in their role to lead on education and training:

- No national system in place to plan, commission and quality assure the education and training of the health and public health workforce in England;
- No system in place to commission trainee placements;
- No system in place to deliver important national functions such as medical trainee recruitment;
- Short-termism and failure to invest sufficiently in the next generation of healthcare professionals, and local failures to invest in specialist skills;
- Fragmentation/lack of appropriate scale – providing high quality education & training often needs to operate at a larger scale than a single provider;
- No alignment to ensure that decisions on workforce supply reflect service strategy and commissioning intensions. National and local failures to invest in small professions and specialist skills.

Direct costs and benefits to business calculations (following OIOO methodology

<u>Economical/Financial</u>

108. There are no impacts on the market, consumers, businesses or labour market because we expect the number of trainees in the system to remain unaltered.

109. One of the main benefits of the new education and training system will be to level the playing field so that all providers of NHS funded services will be involved in commissioning and planning decisions. Putting local providers in the driving seat might pose a risk on competition matters. However, as the requirements for access to the education provision market and LETBS (see para 32) are already clearly set, we do not anticipate the new structure to have a negative impact on the actual level of competition

in education and training.

110. There are no impacts on innovation e.g. new low carbon technologies.

111. We do not expect there to be any direct economical or financial impacts on other government departments. However, we expect HEE to work closely with the education and research sectors.

Social

112. The driving principle for reforming the education and training system is to improve care outcomes for patients. The new system will produce a flexible workforce that can cope with changing patient need and adapt to innovation in service models. The Education Outcomes Framework will directly link education and learning to improvements in patient outcomes, addressing inequalities in the provision of care and improving health and wellbeing.

113. Widening participation will be priority for the new system. This will be realised through a requirement on widening participation to be placed on LETBs through their arrangements with HEE.

Environmental

114. There are no environmental impacts.

Summary with description of implementation plan.

115. To summarise the new system will have two central planks, HEE and LETBs. HEE will provide national leadership and oversight on strategic planning and development of the health and public health workforce, and allocate education and training resources. LETBs will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public.

116. Although many of the functions carried out by Strategic Health Authorities are critical and will continue in the new arrangements, there are significant differences in the new system. These are:

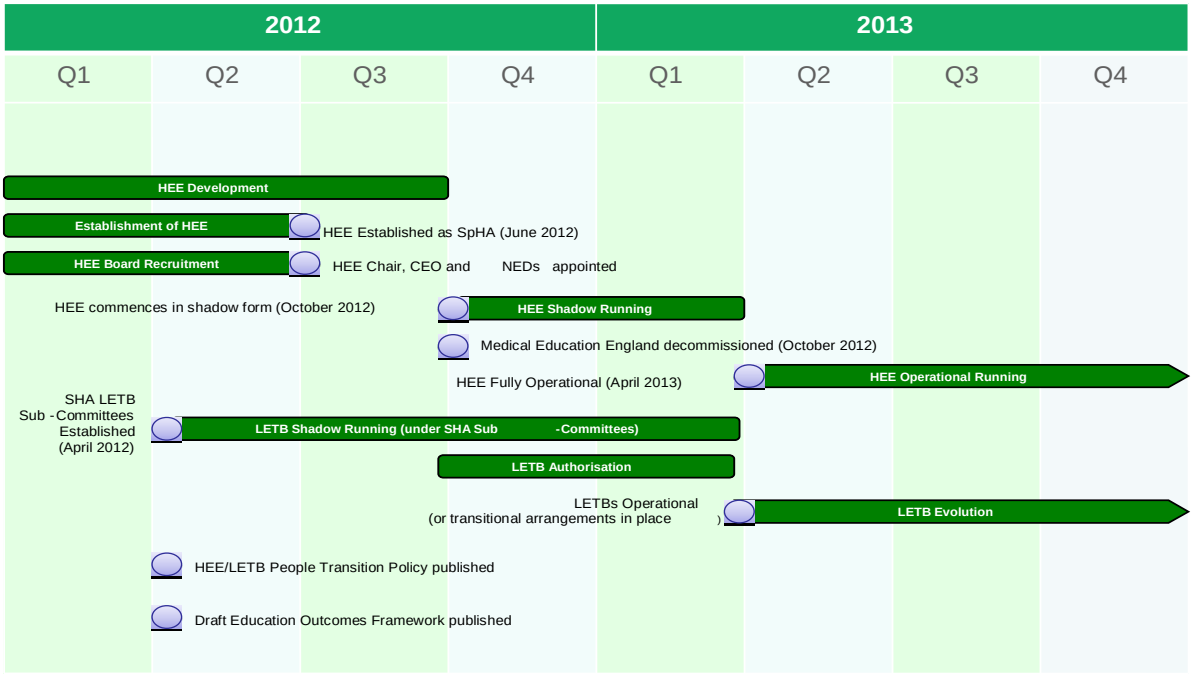
- LETBs will put providers and professionals in the driving seat. They understand the service priorities and how to be more responsive. It is employers and clinicians who know best the needs of patients and local populations and how they access and use the health and care system.
- HEE will provide national leadership and oversight on strategic planning. There will be a fairer and more responsive funding system
- There will be a clear focus on quality so that investment in education and training will support improvements in healthcare.

117. HEE will be established as a Special Health Authority in June 2012, with a view to commencing operations from October 2012, taking on full functionality when the SHAs close in April 2013. Shadow LETB boards will be established as Local Education and Training SHA sub-committees by April 2012 and full LETBs established or transitional

arrangements in place by April 2013.

118. The timeline for transition is shown below:

Timeline for Transition



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SHA FUNCTIONS FOR WORKFORCE PLANNING AND EDUCATION AND TRAINING

This paper set out the detailed functions that SHAs carry out to support workforce planning and education and training. These functions are best on the N. West SHA model, but roles and functions are mainly generic across SHAs.

The functions cover five key areas:

- Workforce strategy and planning
- Postgraduate medical and dental education (the deaneries)
- Education commissioning
- Wider workforce
- HR Strategy

Workforce strategy and planning

These include three areas of work:

- Workforce planning
- Workforce modernisation
- Health and well being for NHS Staff

Workforce Planning involves:

- Planning the workforce needed for the local health economy
- Improving workforce planning, productivity and data integrity through better systems and processes across the SHA.
- Development of an SHA wide workforce strategy and detailed pathway plans.
- Assuring a system able to deliver a safe, affordable and sustainable workforce for the SHA through the provision of analytical reports and input into performance conversation.
- Improving workforce development and workforce decision making across the SHA through a programme of workforce capability and capacity building.

Workforce Modernisation

This involves leading of the promotion of skill mix, in particular through assistant and advanced practitioners, in local NHS Organisations is available to deliver services.

Health and Well Being for NHS staff

This work develops on from the Boorman report on health and well-being of NHS staff. It supports one of the QIPP workforce targets of reducing sickness and absence across the SHA NHS organisations:

Postgraduate medical and dental education

This is led by the SHA's deaneries, who directly manage the education and training of all the junior doctors in training. This encompasses:

- Recruitment
- Management of placements and rotations
- Formal appraisals(Annual Review of Competence Progressions)

- Quality assurance of training
- Training the trainers
- Quality assurance of learning environments in each trust education provider
- Liaison with GMC for approval of posts
- Setting standards, developing and delivering the requirements for trainee revalidation (the postgraduate dean is the Responsible Officer for trainee revalidation).

Education commissioning

Education commissioning covers three key areas:

- Commissioning of nursing, midwifery, allied health professions and healthcare scientists education from Universities.
- Management of learning and development agreements with trust education providers for placements and other workforce development activities
- Development of the wider workforce

Commissioning of nursing, midwifery, allied health professions and healthcare scientists education from Universities

This work comprises the development of an annual commissioning plan for the SHA based upon the workforce plans produced by the workforce strategy team.

These commissions are let through formal contracts with each University and include both pre registration and post registration (Continuing professional development). All activity with any of the Universities goes through the contracts. The contracts are managed through:

- Formal regular contract monitoring information analysis.
- Regular contract monitoring meetings.
- Involvement of trusts in partnership with each University for placements.
- Quality assurance of education provision within the contract.
- Strategic development of education capacity.
- Day to day management of the contracts.

Management of learning and development agreements with trust education providers for placements and other workforce development activities

This work involves the commissioning, contracting and quality assuring of placements for all healthcare professions across the SHA. This includes detailed liaison with the medical and dental schools for undergraduate medical and dental education placements. The Learning and development agreements cover all education and training financial flows to trusts and are legal contracts with Foundation Trusts and independent sector providers.

Wider workforce

This area of work covers provision of vocational qualifications and apprenticeships for the unregistered workforce. This is an important part of developing skill mix as well as ensuing a widening access route for people with lower levels of academic qualifications to pursue health careers. It also covers the cadet programme.

HR Strategy

The HR strategy supports the Human Resources function across the SHA, particularly capacity and capability building. This includes

- Work with the regional Social Partnership Forum to engage staff side partners in the delivery of the SHA's strategic objectives
- Manage the submission of the VSM remuneration and severance proposals to the Remuneration Committee seeking to protect the reputation of the NHS
- Ensure continued roll out of Electronic Staff Record across the region to maximise system efficiencies
- Delivery of regional and sub regional employment clearing house arrangements to minimise risk of redundancies within the SHA
- Provide support to NHS organisations on the development of "back office" shared service arrangements and health economy employment contracts where deemed appropriate
- Facilitate towards World Class Human Resource and Organisational Development Programme, which assesses organisational performance, benchmarks within the SHA and shares best HR practice.
- Evaluation of Seasonal Flu programme and development & delivery of current year programme
- Development of shared occupational health services across the region to provide better support
- Commissioning the regional leadership academy including contract management

LETB Functions

The core functions of a LETB are to:

- Bring together all healthcare and public health employers providing NHS funded services with education providers, the professional, local government and the research sector, to develop a skills and development strategy for the local health workforce that meets employer requirements and respond to the plans of commissioners;

- Consult with patients, local communities, and staff to ensure the local skills and development strategy is responsive to their views;

- Aggregate workforce data and plans for the local health economy and share with the CfWI to improve local workforce planning;

- Account for education and training funding allocated by HEE;

- Commission education and training to deliver the local skills and development strategy and national priorities set out in the Education Operating Framework;

- Ensure value for money throughout the commissioning of education and training and for running costs;

- Secure the quality of education and training programmes in accordance with the requirements of professional regulators and the Education Outcomes Framework;

- Take a multi-professional approach in planning and developing the healthcare and public health workforce and in commissioning education and training;

- Support access to continuing professional development and employer-led systems for the whole health and public health workforce;

- Work in partnership with universities, clinical academics, other education providers and those investing in research and innovation;

- Work with local authorities and health and well-being boards in taking a joined-up approach across the local health, public health and social care workforce;

- Work with HEE to develop national strategy and priorities