Education and Training

A report from the NHS Future Forum

Members

- **Julie Moore – Chair, Education and Training group**
  Chief Executive, University Hospitals Birmingham NHS FT
- **Dr Simon Brown**
  Huntington GP Consortia pathfinder lead
- **Professor Hilary Chapman**
  Chief Nurse, Sheffield Teaching Hospitals
- **Clare Leon-Villapalos**
  Intensive Care Nurse, Imperial College Healthcare NHS Trust
- **Dr Peter Nightingale**
  President, Royal College of Anaesthetists
- **Duncan Selbie**
  Chief Executive, Brighton & Sussex University Hospitals Trust
- **Mr Matthew Shaw**
  Orthopaedic surgeon and Co-founder, Remedy UK
- **Professor Sir John Tooke**
  Vice-Provost, University College London

Introduction

The NHS Constitution[1] states that the NHS "aspires to the highest standards of excellence and professionalism" and the White Paper "Equity and Excellence: liberating the NHS" sets out an "ambition for world-class healthcare outcomes".

To deliver high quality care, clinical staff must possess a high level of knowledge combined with excellence in practical skills, but they must also show kindness and compassion and respect for patients. If any one of these elements is missing, then significant problems in healthcare may occur and, indeed, have occurred.[2] Education and training are essential to ensure all staff are fully equipped to deliver world class healthcare.

Investing in education is not just about investing in the health of the population and in the individual, it also contributes to the economic health of the nation. The UK continues to be regarded as having some of the best healthcare education in the world and remains a major player in healthcare research. Healthcare education and training must deliver excellence in practice but must also strive to ensure that a world-class healthcare education system is developed and maintained.

Education and training are regarded as an essential part of the NHS not only to deliver excellence but to ensure that the NHS is responsive to changes in patient needs and in healthcare. It is too important to rush. Much further work is required, involving all stakeholders, to ensure that any changes will deliver the healthcare workforce for the current and future NHS.

Throughout the listening exercise, we were struck by the willingness and helpfulness of all we listened to and how positive and constructive their contributions were. The right people and organisations must be involved in helping to shape this agenda for the future.

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

[1] The NHS Constitution for England 2009
[2] Independent inquiry into care provided by Mid-Staffordshire NHS Foundation Trust January 2005 – March 2009 chaired by Robert Francis QC

Executive Summary

The general direction proposed in the White Paper "Liberating the NHS: *Developing the healthcare workforce*" is welcomed. However, it was published after the Heath and Social Care Bill, with the result that many people did not have time to give the proposals the due consideration needed.

The proposed abolition of the Strategic Health Authorities (SHAs) means there is an urgent requirement to put in place alternative arrangements to ensure that essential functions are maintained and for the workforce and postgraduate medical deanery staff who undertake these functions. Where new arrangements are not ready to be implemented, then an interim measure must be found.

All respondents wished to see England and the UK develop and maintain a world class healthcare educational system. This is essential, alongside excellent research and development, to provide world class healthcare.

There was agreement with many of the principles described in the White Paper and it was believed there were benefits in moving to a system that was more sensitive to the needs of the service and employers, whilst being professionally informed and underpinned by strong academic links. Many acknowledged that progress had been made whilst recognising there were still failings in the current system for workforce planning and the commissioning of education and training.

Respondents believed that the Centre for Workforce Intelligence (CfWI) had a vital role to play in the commissioning of education and training both nationally and locally and supported its establishment and development. The future shape of the workforce is linked intimately with the provision of education and training. Until the CfWI makes firm recommendations, and these are accepted, it will be difficult to plan in detail what provisions should be made for education and training in the future.

There was strong agreement that education and training needed to change and become more flexible and responsive to reflect changing health demands and new patterns of healthcare. This would mean a renewed and strengthened focus on continuing education and development.

There was also strong approval for a more collaborative multi-professional and multi-disciplinary approach to workforce planning and all education, including continuing professional development, because it was believed this would enhance flexibility of the workforce and encourage strengthened teamwork. The Government's consultation on *Developing the Healthcare Workforce* closed at the end of March 2011. The NHS Listening Exercise was therefore able to draw on the wide range of responses to that consultation and to test issues and ideas emerging

from it. In this report following the listening exercise, we have reflected the concerns we heard and identified actions that need to be taken in the short term to ensure essential services are maintained. We have not undertaken the detailed work now that needs to be carried out by the NHS and the Department of Health (DH) following the consultation.

What we heard

a. Scale and pace of change

A major concern was the sheer number of changes occurring at the same time and that there had not been the time to consider adequately the proposals for education and training or to put any alternative arrangements in place.

The White Paper recognised that time would be needed to change the system for planning and developing the healthcare workforce and that managing the transition would need careful consideration and timetabling. The importance of a safe and phased transition was emphasised again and again during the listening exercise.

Alongside the number of changes were anxieties over the speed of the process. Workforce staff and the postgraduate medical Deaneries are located within Strategic Health Authorities (SHAs) and therefore there were calls to find a new home for these as a matter of urgency before the proposed abolition of SHAs. Some respondents considered the proposed model of Provider Skills Networks was a potentially workable model, but it was felt there was insufficient time to establish these in most areas.

The effects of changes in education and training are not immediate. Most graduate courses are of three years duration and for doctors in excess of seven years. Mistakes may be costly and the impact of mistakes on both the health service and the public will be long lasting. Changes to the education of the healthcare work force need to be extremely well thought through and grounded in sound principles. It is essential that these are not rushed.

Recommendation

Interim arrangements must be put in place to allow an ordered and managed transition to the new arrangements with time taken to thoroughly review and plan for comprehensive multi-professional education and training.

b. Workforce Directorates and Postgraduate Medical Deaneries and loss of essential staff

There is widespread recognition that the postgraduate medical deaneries (PG Deaneries) must evolve to reflect the new NHS, but a precipitate change is considered to be very risky. PG Deaneries are complex organisations and are not uniform across the country: in some places they are concerned solely with medical trainees and in others they have a much wider remit that in some cases extends across the whole healthcare workforce. PG Deans have a unique role in regard to all trainee doctors as the legally designated Responsible Officer for medical revalidation, as required by the GMC. Because of the legal nature of this role, if this

post did not exist it would be necessary to recreate it. PG Deans also fulfil a number of national roles with respect to medical workforce planning and development that could not easily be replicated.

There was significant concern that, due to uncertainty over their future, many staff from the workforce directorates and PG Deaneries had left or planned to leave causing actual and potential problems with essential functions such as recruitment of medical trainees, oversight of training rotations and supervision of trainees' performance. The difficulties following the Medical Training Application System (MTAS) in 2007 are still fresh in minds and there is a concern that such difficulties may occur again unless urgent action is taken to secure an interim solution.

The move to the proposed Provider Skills Networks is viewed positively as is the intent to allow organisations to develop and implement local arrangements best suited to local circumstances. However, time is needed to establish these properly. In some parts of the country, a solution is in place or will be ready before the proposed abolition of the SHAs. In these cases, they should continue or proceed as planned.

Where plans for these new organisations are not yet in place, interim arrangements must be established to continue vital functions and ensure a smooth transition to the new bodies. The SHA workforce functions related to educational commissioning and workforce planning and the PG Deanery should be transferred to a host organisation until the new organisation is functioning. As newer organisations (such as Health Education England) are not yet established, the most obvious choice for hosting this function is a large teaching NHS trust (whether NHS foundation trust or not). This is most in keeping with the spirit of the education and training proposals.

Doubts have been expressed as to whether an NHS foundation trust could undertake such hosting. If the hosting were undertaken as a management arrangement (i.e. risks and liabilities transferred to the Secretary of State with the NHS foundation trust taking on the management of education and training in exchange for a management fee) then the only relevant transaction is the size of the fee which is unlikely to affect an NHS foundation trust's financial risk rating with Monitor. There are parallels with the National Institute for Health Research (NIHR) funding which is allocated to organisations via a network hosted by acute teaching NHS trusts.

Current SHA staff employed in the workforce directorates and the PG Deaneries need to be informed as soon as possible of interim arrangements to avoid further resignations.

Recommendation

An interim solution to hosting these functions must be urgently implemented and communicated to workforce and PG Deanery staff.

Where substantive arrangements are already in place, or will be in place in time for the proposed abolition of the SHA, these should be allowed to continue as planned.

c. Education is a core element of the NHS

High quality education and training are considered to be essential to delivering excellence in healthcare and necessary to underpin any changes to the way healthcare is delivered. It is a core part of NHS business. The NHS Listening Exercise has shown that it is a strongly held view that any successor organisations must remain part of the NHS underpinned by NHS values.

In the original proposals, the Provider Skills Networks, set up as separate legal entities, would not be part of NHS. All respondents felt that education is core NHS business and it was essential that these new organisations remained in the NHS.

Recommendation

Any successor organisation to the workforce and education and training arm of the Strategic Health Authorities, including the postgraduate medical Deaneries, must remain part of the NHS and have regard to the NHS Constitution and NHS values.

d. Name

There was widespread dislike of the name "Provider Skills Network" as this was considered to be ambiguous and did not reflect the fact that healthcare education embraces knowledge, professional attitudes and behaviours as well as skills. The use of "education and training" was universally preferred to "skills". Likewise "provider" was considered to be ambiguous, - provider of education or clinical care? It was considered essential to include "NHS" in the title. "Local" could be "regional" or the name of the area (e.g. North East or London), but it was recognised that the name "region" might be considered unhelpful.

Recommendation

A name for the new organisations could be, for example, "Local NHS Education and Training Board".

e. Governance arrangements

Without PG Deaneries, some form of Local NHS Education and Training Board (LETB) would be needed to disburse monies for education and training. It was accepted that there had to be robust accountability of the local education commissioning organisations for spending of almost £5 billion. The proposal that these organisations were led by providers was welcomed, but also that there had to be some executive officers, responsible to the providers and accountable to HEE. It is suggested that consideration is given to having an independent chair and independent members of these LETBs to ensure any potential or perceived conflicts of interest are addressed.

The establishment of Health Education England (HEE) is considered to be a positive development and respondents supported it being an independent body with real control over funding flows. The establishment of HEE is essential in getting the new local arrangements working and in providing clarity over governance. Until this is established, lines of accountability are unclear. If substantive appointments cannot be made, then it is suggested that interim arrangements for HEE are put in place to allow progress to be made.

A high level concern was also raised about the LETBs having a commissioning role and being made up of providers engaged in providing placements for training. The concern arose because there could be a conflict of interest if a provider was at risk of losing trainees due to poor quality placements. If an LETB was alone to judge quality there might be a risk that an NHS trust (also, of course, an LETB member) could be treated leniently. This could be avoided if external quality assurance was provided.

The form that LETBs may take will vary throughout the country as there are different structures which could be used as models, such as Academic Health Science Centres (AHSCs), and Health Innovation and Education Clusters (HIECs) in place in some areas but not others. This is to be welcomed, but the principles of accountability and governance will need to be consistent to all organisations.

There are issues that were raised with the forum that need to be addressed, but were beyond the scope of this exercise. These are actions for HEE to undertake when established, and are described here.

Firstly, a concern was raised that postgraduate medical trainees and funding were distributed historically. Funding is planned to flow from Health Education England but the CfWI should work with HEE to achieve national equity in workforce funding rather than some form of capitation basis.

Secondly, there were concerns that some key workers, such as health care assistants, who had a great deal of direct patient contact, were not registered or regulated other than through their contract of employment and there was no minimum standard of education and training for the role. There are other occupational groups that are also not regulated. It is suggested that HEE, in conjunction with employers

and the national regulators, undertake a review of roles and regulation and recommends the way forward.

Recommendation

The establishment of HEE should be expedited. It needs to be operational as soon as possible to provide focus and leadership while the rest of the education and training architecture is put into place.

f. Professional accountability

Postgraduate medical deans are accountable to the SHAs. Professional leadership is provided by the Director of Medical Education for England in the Department of Health who in turn reports to the NHS Medical Director. For any interim arrangements, it is proposed that professional leadership remains with the Director of Medical Education in the Department of Health. HEE should establish clear and robust arrangements to provide professional leadership for education for all healthcare professions, including post-graduate medical and dental education managed by the post-graduate medical and dental Deans.

Recommendation

Interim governance and reporting arrangements should be introduced until such time as the new arrangements are operational

g. Quality

Quality governance, the need for excellent quality assurance and management of education and training was considered essential. There is a perceived lack of consistency of outcomes from different institutions.

Quality governance needs to operate at three levels. Firstly, national standards which are set by professional regulators and, where they do not exist, HEE has a responsibility to set these. Secondly, LETBs need to manage the quality of delivery of education and training, both in Higher Education Institutions (HEIs) and placements. Thirdly, there needs to be a level of independent assurance brought in to assess and report on quality.

As the NHS is seeking to focus more on clinical outcomes, likewise, in education and training, there should be a focus on outcomes. There is limited evidence available on educational outcomes and this should be an area that needs further development, led by HEE.

Recommendation

HEE must ensure that there is a comprehensive system of quality governance and explicit educational outcomes.

h. Links with Higher Education Institutions

There was a concern that there was no explicit mechanism for HEIs to be involved in the planning of education and training. HEIs are best equipped to develop curricula designed to meet desired learning outcomes and provide an educational foundation that equips trainees to adapt as service needs evolve. Medicine has the benefit of the medical Royal Colleges in planning education and setting curricula, approved by the General Medical Council, a mechanism that does not exist for other professions. This was endorsed by NHS providers who felt they themselves lacked the necessary knowledge about education. The potential for destabilising of HEIs was also concerning if numbers commissioned varied significantly from year to year.

It was accepted there could be a perceived conflict of interest if HEIs were represented on the Board, however a mechanism for consultation over planning was considered a good way forward. In addition, it may be helpful for postgraduate medical Deans, if they are not already employed by Universities, to hold honorary contracts with Universities to maintain their educational links

Recommendation

Each LETB should establish mechanisms for consulting HEIs over their future commissioning. HEE should ensure each LETB has a robust mechanism for joint planning and developing curricula.

i. Funding arrangements

The proposal for transparent funding mechanisms was welcomed, as was the removal of block allocations allowing continuation of good educational placements and the potential for removing trainees from poor training environments and placements.

There was concern expressed about how this might operate and the potential unanticipated consequences. The vast majority of funding devolved to post-graduate medical deaneries goes towards salaries for trainees. If funding is not ring-fenced any unplanned reduction in the Multi-Professional Education and Training (MPET) levy will mean a reduction in trainee numbers thus destabilising workforce plans.

It was recognised that in larger training organisations there were some infrastructure costs which needed to be funded. There were two possible mechanisms for funding students and trainees, either an allowance per trainee or a supplement to tariff for organisations with trainees.

National tariff is adjusted to take account of MPET funding. Given the proposal that Monitor takes the lead in setting the national tariffs in the future, it is suggested that they are also involved in setting educational tariffs as well.

There is a parallel with the changes to Research and Development funding from the National Institute for Health Research. The funding used to be provided through a block grant which, when the method of funding was changed, was re-allocated to those organisations undertaking research. These changes were phased-in over 3 years. The amounts of money for education and training are larger, so a longer time period of, say, 4 – 5 years might be appropriate.

Recommendation

Any changes to the funding mechanisms are phased-in over a period of time to reduce any destabilising effects on individual organisations.

The funding changes should be considered as part of the whole funding picture as education allocations are considered in setting the current tariff for clinical work.

j. Levy

The proposed education and training levy on all providers who employ staff trained by the NHS was considered to be a good idea, but one with potential side effects. For example, this would apply to the third sector and local authority employers as well as to private commercial organisations, which might be a deterrent to the stated aim of more voluntary organisation involvement in health. This may lead to such organisations seeking to recruit from outside the UK. We were informed by charities that if this levy were imposed they would reconsider their approach to NHS work, including employing staff from Europe, or no longer undertaking it.

Recommendation

The proposal for a levy on all employers of NHS trained staff should be modelled in detail following wide consultation with the third sector and commercial health care providers to ensure that whilst a level playing field is achieved, any unintended consequences do not occur.

k. Emphasis on Continuing Professional Development

It was emphasised that most of the future workforce of the NHS is the current workforce. To deliver the NHS of the future requires all staff, not just professional staff, to have access to continuing professional development (CPD). CPD is essential for building in flexibility to enable the staff of the NHS to respond to changing heath care needs, new technology and ways of delivering care. CPD needs to be regarded seriously, adequately resourced and prioritised and should be linked to staff appraisals. We heard of examples of where CPD was undertaken comprehensively

but we also heard from staff who had received no professional development since qualifying.

There was also a view that NHS CPD should be available to all staff who deliver NHS care including social care services.

Recommendation

Reflecting the importance placed on the provision of access to CPD by the NHS Constitution, employers should prioritise the provision of CPD. We support the NHS Future Forum's report on Clinical Advice and Leadership in relation to its recommendation on continuing professional development.

l. Smaller professions

There was a concern from those in smaller profession that their voice might not be heard and their profession overlooked. It is assumed that there is a parallel with education and training commissioning and clinical commissioning, in that smaller professions and specialties will be commissioned nationally. However, until HEE is established and is able to state how it will arrange for the appropriate commissioning of education for smaller professions, there is anxiety in these groups and specialties.

Recommendation

HEE should establish a framework for the commissioning of education for dealing with professions and specialties that have smaller numbers of practitioners.

m. Coverage of Local Education and Training Boards

There were concerns that there should not be too many LETBs. This is because of the risk that economies of scale would be lost in terms of being able to commission sufficient volumes and in terms of keeping overheads to a minimum.

Recommendation

HEE, as part of its oversight and governance responsibilities, should ensure local organisations are of sufficient size to commission effectively and efficiently.

n. UK issue - not just England

It was stressed that these changes applied to England only and yet for small volume, highly specialised services, liaison and transfer of staff across devolved administration boundaries is desirable.

Recommendation

Liaison between England and the devolved administrations should ensure that there is adequate UK provision for small volume specialties.

o. Transferability of qualifications

The issue of transferability of qualifications was raised with us although we have been assured this would not be an issue. However, for staff concerned it would be helpful for them to have information about this.

Recommendation

Information be made available to advise staff about transferability of educational qualifications throughout the UK.

p. Regulation

It was perceived there was a potential danger of over-regulation and too many regulatory bodies, requirements and inspections. In this regard, the damage done to the UK clinical research base by too much research bureaucracy should be an object lesson. Regulators appreciated the potential for duplication and the need to keep regulatory bureaucracy to a minimum. Some regulators had already started working more closely to seek to avoid this, which is welcomed. HEE have a key role to ensuring that regulation is proportionate and avoids becoming too burdensome

Recommendation

Education regulators to work together to ensure that the regulatory burden is kept to a minimum.

Context

The current system for workforce planning and the commissioning of education and training is complex and led by SHAs. Many existing processes and ways of working have developed over time and follow traditional patterns, looking at supply and demand factors in single professional silos. Medical workforce planning is done largely in isolation from other healthcare professions. The current funding arrangements are based on historical flows rather than the costs of providing education and training.

The reforms set out in the White Paper “Equity and Excellence, Liberating the NHS” require the system architecture for workforce planning, education and training

needs to be considered and aligned with the new system architecture for the NHS as set out in the White Paper.

The consultation paper proposed a new framework to support healthcare providers build systems and capability, underpinned by strong clinical leadership. It also proposed a more transparent, stream-lined, multi-professional system focusing on planning and development of the whole workforce and providing better outcomes for patients.

The proposed framework is described in the White Paper " Liberating the NHS: *Developing the healthcare workforce*" and was launched for consultation in December 2010.

The objectives of the new framework are:

- Security of healthcare staff supply
- Responsiveness to changing service models
- Continuous improvement in the quality of education & training
- Transparent Funding Flows

The intended effects are improved planning and education commissioning resulting in improved patient care and value for money.

Evidence

In its responses to the House of Commons Health Select Committee[3] and the Tooke Inquiry into Modernising Medical Careers[4], the previous Government accepted that the approach to workforce planning needed to be strengthened. The Health Select Committee identified insufficient focus on long term strategic planning and too few people with the ability and skill to plan effectively, that the system was poorly integrated and a lack of co-ordination between workforce activity and financial planning.

This led to the establishment of the Centre for Workforce Intelligence (CfWI) to provide strong system leadership for workforce planning, investment in capability and knowledge across health and social care and improve access to evidence, intelligence and analysis.[5]

[3] House of Commons Health Committee, Workforce Planning – Fourth Report of session 2006-07
[4] "Aspiring to Excellence" Final report of the Independent Inquiry into Modernising Medical Careers, Professor Sir John Tooke 2008
[5] Impact assessment for CfWI
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_114739

Lord Darzi's review of the NHS workforce[6], set out a new vision for the future of education and training that described a greater role for clinicians as practitioners, partners and leaders in the planning and provision of healthcare. His report recommended that the professions should be able to contribute to strategic workforce development at all levels. The new framework for planning and developing the workforce builds upon the professional advisory boards Lord Darzi established to bring a coherent professional voice on matters relating to education and training. The framework sets out ways in which the professional voice can be further strengthened, locally and at a national level.

[6] A High Quality Workforce: NHS Next Stage Review Professor Lord Darzi of Denham 2008