

Title: Health Education England IA No: 8040 Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	Date: 03/07/2012
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Primary legislation
Contact for enquiries:	

Summary: Intervention and Options	RPC Opinion: GREEN
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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, Measure qualifies as One-Out?
£0m	£0m	£0m	No
			In/Out/zero net cost

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

The education and training of the NHS workforce is crucial to the continuing delivery of high quality services. Health Education England, as the body responsible for providing national leadership for education and training, and with a budget to invest of around £5 billion, needs to be able to operate with independence and autonomy. Health Education England was established in the first instance as a Special Health Authority in June 2012, however, a more sustainable and appropriate statutory basis for a body of this type is to establish it as an Executive Non Departmental Public Body that will be at arms length from the Department of Health, whilst remaining accountable to the Secretary of State.

What are the policy objectives and the intended effects?

The policy objective is to ensure that the education and training system can operate safely and effectively as part of a stable health and social care system. Health Education England will continue to drive quality and value for money in the investment in education and training. As a Non Departmental Public Body, it will give the public and stakeholders across the NHS greater confidence that their needs and expectations will be addressed and that investment in education and training will be directed by service and clinical priorities.

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

Two options are considered.

Option 0 - Do nothing. This would leave Health Education England in place as a Special Health Authority. Whilst it would be able to carry out its education and training functions, this will not allow for the type of independent, permanent and stable system that will be crucial if it is to gain the full confidence of the range of partners involved in the planning, commissioning and delivery of education and training that will be required if it is to succeed in the long term.

Option 1 - Establish Health Education England as an Executive Non Departmental Public Body. This is the preferred option. It would see the roles and responsibilities of Health Education England and the wider education and training system enshrined in primary legislation. There are no cost implications associated with this option as the functions and budget for Health Education England will not change.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: Month/Year					
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 Minister:  Date: 3/7/12

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year n/a	PV Base Year n/a	Time Period Years n/a	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

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

There are no expected costs associated with this policy.

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

There are no expected costs associated with this policy.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

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

We are not able to monetise the benefits associated with the policy.

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

We expect the legislation on education and training to provide for a more transparent and sustainable system with improved clarity on roles, responsibilities and accountabilities. The non-monetised benefits are discussed in the evidence base and summarised at paragraph 67.

Key assumptions/sensitivities/risks

We assume Health Education England will remain the same size, retain the same structure and have the same skill mix.

Discount rate (%)

3.5

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	Zero net cost

Evidence Base (for summary sheets)

Scope

1. This Impact Assessment focuses solely on the impact of the draft clauses addressing the establishment of HEE as an Executive NDPB that have been developed as part of the draft Care and Support Bill.

Assessing the impact of the education and training reforms

2. A separate Impact Assessment has being developed to address the associated costs and benefits associated with the policy decision to establish HEE as a Special Health Authority. This was published in May 2012, and builds on an earlier consultation stage Impact Assessment published in December 2010. It assesses the impact of the introduction of the new system for education and training, including:
 - the establishment of Health Education England (HEE) as a Special Health Authority;
 - the establishment of Local Education and Training Boards (LETBs) as committees of the HEE Special Health Authority;
 - the introduction of an Education Outcomes Framework; and
 - planned reforms to the funding of education and training via the Multi-Professional Education and Training budget.

Strategic context

3. To meet the challenge of sustaining high quality services and improving health outcomes in the face of demographic and technological change, the Government intends to create a more autonomous and accountable NHS; with greater clarity about the roles and responsibilities of different organisations for provision and commissioning.
4. This need for change also extends to the way in which the NHS workforce is educated and trained. There are currently 1.3 million people employed in the NHS and there is significant public investment in England in educating and training new health and public health professionals. In 2011/12, the central investment in education and training (the Multi-Professional Education and Training budget – MPET) was £4.9 billion. There are serious consequences for the sustainable delivery of NHS services in the event of any workforce undersupply or if the quality of education and training does not meet the required standards.
5. Currently, Secretary of State has powers to make provision for the education and training of healthcare workers. These powers are delegated to the Strategic Health Authorities (SHAs).
6. The Health and Social Care Act 2012 makes provision for the abolition of SHAs. This is due to take place in March 2013, but the Secretary of State's education and training functions will need to continue to be exercised by somebody when the SHAs are abolished.
7. 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.
8. Medical Education England (MEE) is an Advisory NDPB that currently provides advice to Ministers on the education and training of doctors, dentists, pharmacists and healthcare scientists. The Department of Health has similar advisory boards that provide advice on the education and training of nurses, midwives, health visitors and the allied health professions.

9. MEE, and these other professional advisory boards, will cease to operate from the end of September 2012. HEE will take on board the enduring functions currently undertaken by MEE and the other professional advisory boards.

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

10. The Government set out its policy framework for the new education and training system when it published *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery* on 10 January 2012.
11. This document sets out the Government's vision for the education and training system and builds on an earlier public consultation that closed in March 2011, and addresses recommendations made by the NHS Future Forum in their reports of June 2011 and January 2012.
12. The Health and Social Care Act 2012 places a duty on the Secretary of State to exercise his functions under prescribed enactments to secure an effective system for education and training for persons who are employed (or considering becoming employed) in an activity which involves or is connected with the provision of services as part of the health service in England.
13. The wider reforms to the NHS provide an opportunity to strengthen the arrangements for education and training. The current education and training system does not offer healthcare providers the right incentives and levers to be involved in the development their workforce. 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 costs of providing education and training.
14. In response, the intention is to establish a new education and training system that can produce a more flexible workforce that responds to the changing needs of the new healthcare system. In establishing this new system, the key ambition is to give local healthcare providers and healthcare professionals the lead role in the planning and development of their workforce.
15. At the centre of this new system will be a new body with responsibility for providing national leadership for education and training for the NHS and public health system; Health Education England. Taking on the education functions of the SHAs, HEE will, at a national level, ensure that the 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.
16. 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 governing bodies of Local Education and Training Boards (LETBs), which will be committees of HEE.
17. Each governing body of a 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 the health community.
18. HEE will allocate a proportion of the education and training budget for commissioning purposes to each governing body of a LETB and will hold them to account for their investment in education and training and for delivery against national education outcomes goals and priorities.
19. From a statutory perspective, each governing body of a LETB will be part of HEE, taking the legal form of a committee of HEE. The governing body of a LETB will operate under formal schemes of delegation from the national HEE body. The governing body of a LETB will represent all the healthcare providers within the geographical area covered by that governing body. 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.
20. Each governing body of a LETB will have access to a number of operational staff who will plan, commission and assure the quality of education and training on its behalf. These operational staff will be employed by HEE, but will be accountable to the governing body of the LETB they are working for.

21. With SHAs due to be abolished in March 2013 and given the importance of education and training, a planned and stable transition is crucial to ensure continuity and safe transfer of essential skills and staff. With that in mind, HEE was established as a Special Health Authority in the first instance (in June 2012 with a view to commencing operations from October 2012 and taking on full functionality when the SHAs are abolished in 2013).

Problem under consideration

22. HEE will be the body responsible for providing national leadership for education and training, with a budget of around £5 billion. It was established in the first instance as a Special Health Authority in June 2012.
23. A more sustainable and appropriate statutory basis for a body of this type is to establish it as an Executive Non Departmental Public Body (NDPB). The new education and training system is being reformed to enable it to be more responsive to the vision of service commissioners and the needs of local healthcare providers. It is important that HEE has the independence and autonomy to enable it balance national workforce priorities with the service needs of local healthcare providers and the quality and education requirements of specific professions.
24. The development of the new policy framework for education and training has taken place alongside the development of the Health and Social Care Act 2012, so it has not been possible to legislate for the new arrangements through that Act. There were, however, several Government amendments made at House of Lords Committee Stage and Report Stage. These amendments included:
 - placing a duty on the Secretary of State to exercise his functions under prescribed enactments to secure that there is an effective system for the planning and delivery of education and training;
 - placing duties on the NHS Commissioning Board and clinical commissioning groups, in exercising their function, to have regard to the need to promote education and training; and
 - ensuring arrangements for the provision of NHS services include arrangements for securing co-operation with the Secretary of State in the discharge of his education and training duty.
25. These amendments to the Act, alongside the establishment of HEE as a Special Health Authority in June 2012, will enable the new education and training system to become fully operational from April 2013.
26. Whilst HEE as a Special Health Authority will be able to carry out its education and training functions, including establishing governing bodies of LETBs, it will not allow for the type of independent, permanent and stable system that will be crucial if it is to gain the full confidence of the range of partners involved in the planning, commissioning and delivery of education and training that will be required if it is to succeed in the long-term.
27. Maintaining HEE as a Special Health Authority would mean the Secretary of State could instruct or direct HEE at any time. Directions could require HEE to carry out its functions in a particular way whenever the Secretary of State decided that was appropriate. The Secretary of State could also decide to abolish HEE at any time. This would undermine HEE's ability to plan on a long-term and strategic basis at a national level.
28. Maintaining HEE as a Special Health Authority would also go against the broader policy intention of giving providers of NHS healthcare greater operational freedom and independence as it would mean involving NHS providers within a body that was open to the direction of the Secretary of State. Further, the Secretary of State could direct LETBs about how to exercise their functions, given that they are part of HEE. This would mean that LETBs would not have the intended level of autonomy and freedom to commission and plan education and training locally.
29. Ministers have made a commitment to Parliament that they will legislate at the next possible opportunity to put the education and training system on a firmer footing. The draft Care and Support Bill provides the opportunity to consider this.

Rationale for intervention

30. The rationale for intervention is to ensure that the education and training system can operate with the necessary independence from the Department of Health with clearly defined duties and powers enshrined in primary legislation.
31. HEE's range of responsibilities and size of budget make it more appropriate for it to become an Executive NDPB, able to work independently of the Department of Health, but with clearly defined accountability to the Secretary of State and Parliament.
32. As an Executive NDPB, the public, health professions and stakeholders in the service will have greater confidence that their needs and expectations will be addressed by HEE, and that investment in education and training will be directed by service and clinical priorities.
33. Establishing HEE as an NDPB will mean it operates with clearly defined duties and powers enshrined in primary legislation. The primary legislation would give governing bodies of LETBs clearly defined functions in their own right. Further, their functions would be conferred directly by legislation rather than by way of delegation from HEE. Although the Secretary of State will have regulation making powers in respect of HEE's activities, the Secretary of State's exercise of these powers would be subject to parliamentary control, which would make the control measures more transparent.
34. As part of this legislative framework, we will be able to place clearer obligations on providers of NHS services. All contracts to provide NHS services will include arrangements to ensure that a NHS provider is a member of a LETB, co-operates with the governing body of a LETB and provides the governing body of a LETB with such information as it requests.
35. It is important to note that the Department is committed to establishing a stable system architecture whereby if Special Health Authorities are established for specific purposes, they are for a time limited period of three years. Although HEE will be established as a Special Health Authority before these powers come into force (and will therefore not be subject to the three-year review provisions), it shows that the clear policy intention is for Special Health Authorities to be time limited bodies rather than long-term bodies. This is because Special Health Authorities are intended to be preparatory vehicles to support a smooth and safe transition of functions to the new body which is to be established at arm's-length of Government. This is exactly what we intend to do by establishing HEE as a Special Health Authority in the first instance, and then as an NDPB.
36. Lastly, the intention when establishing HEE as a NDPB is to give the Secretary of State regulation making powers to require HEE to secure education and training for other workers eg social care workers. Although the intention is for HEE's remit to be limited to the NHS Act 2006, this permits flexibility for the future. As a Special Health Authority, HEE could not take on functions in respect of social care workers in the future.

Policy objective

37. The policy objective is to ensure that the education and training system can operate safely and effectively at arm's-length from the Secretary of State, with the necessary performance assurance systems in place and clear lines of accountability.
38. A summary of the proposed education and training draft clauses is set out below.

Health Education England

- i. HEE will be established as an Executive NDPB with an independently appointed Chair and Non Executive Directors.
- ii. Secretary of State's duty to exercise his functions to ensure there is an effective education and training system will be delegated to HEE (in respect of specified functions), with the Secretary of State retaining responsibility for ensuring HEE carries out this duty properly.

- iii. Secretary of State will publish the education outcomes expected of HEE and the system, and HEE will be required to have regard to these when carrying out particular functions.
- iv. HEE will publish a Strategic Education Operating Framework setting out priorities for the system, and will have a duty to exercise its functions with a view to ensuring that healthcare workers are available in sufficient numbers with the appropriate skills and training to deliver health services.
- v. HEE will have a duty to secure advice from organisations / set up appropriate advisory arrangements to secure the intelligence and expertise it needs to function effectively.
- vi. HEE will have a duty to co-operate with other NHS bodies.
- vii. HEE will be required to carry out its functions with a view to securing continuous improvement in the quality of education and training, it will be required to have regard to the NHS constitution and it will be required, in exercising its functions, to act with a view to securing that education and training provided to care workers is provided in a way which promotes the NHS constitution.

Local Education and Training Boards

- viii. Governing bodies of LETBs will continue to exist as committees of HEE, with an independent Chair.
- ix. HEE will publish criteria that governing bodies of LETBs must meet to be appointed as committees. Secretary of State will approve the criteria.
- x. Governing bodies of LETBs will be required to produce and publish education and training plans. These will specify how the governing body proposes to achieve the outcomes set by Secretary of State and HEE and will reflect local priorities agreed by the members of the LETB. These plans will be submitted to HEE for review or approval.
- xi. HEE will allocate funding to the governing bodies of LETBs to enable them to commission the education and training activities agreed in their plans.
- xii. Governing bodies of LETBs will be required to monitor the quality of education and training they commission and will have the power to report findings to the relevant professional regulator.

Intervention powers

- xiii. In the event that a governing body of a LETB is failing to carry out its functions or to meet the criteria set by HEE for it to operate, HEE will have the ability to intervene; HEE will have powers to appoint new members of the governing body, to undertake the functions itself or to arrange for another governing body to carry out the functions.
- xiv. Secretary of State will also have powers to intervene where HEE is failing or has failed to exercise any of its functions, and that failure is significant.

Staffing and costs

- 39. HEE will be based in Leeds, with a small representation in London. It is expected to employ from 120 to 150 staff. Staff will transfer to the Special Health Authority from the Department, SHAs and the existing Advisory NDPB, MEE. Staff will be employed on NHS terms and conditions and will have access to the NHS pension scheme.
- 40. It is anticipated that there will be between 12 to 16 governing bodies of LETBs employing approximately 1800 staff. These staff will lead locally on the planning, commissioning and quality assurance functions for each governing body of a LETB. Staff will transfer to the Special Health Authority from the SHAs and their postgraduate deaneries. Staff will be employed on NHS terms and conditions and will have access to the NHS pension scheme.
- 41. Some of the education planning and commissioning functions are part of the overall NHS management costs, and as such are subject to the same efficiency requirements as the rest of the system. The Operating Framework for the NHS in England 2012/13 set an expectation that running costs in 2014/15 will be, on average, one third lower than running costs in 2010/11.

42. Any costs associated with establishing HEE are expected to be incurred when it is established as a Special Health Authority. There are no expected costs associated with establishing HEE as an Executive NDPB. It is assumed that HEE will remain the same size, will retain the same structure and will carry out the similar functions as it does as a special health authority.
43. The functions of HEE are not expected to attract VAT, although we will investigate this further with HMT colleagues, and if required seek exemptions as has been done for other NDPBs such as the NHS Commissioning Board and the clinical commissioning groups.
44. Given the policy ambition is to create independent and autonomous partnerships of healthcare providers with responsibility for commissioning education and training, establishing HEE as an NDPB is an efficient way of doing this. Because each LETB governing body will be a committee of HEE, the operational staff within each LETB will be employees of HEE so HR and other key functions can be shared.

Description of options considered (including do nothing)

Option 0 – Do nothing

45. As a Special Health Authority, HEE functions under direction from the Secretary of State and it will have the capability to carry out its range of responsibilities from April 2013.
46. This is not, however, the preferred long-term solution for the reasons discussed earlier. HEE will provide a service to the NHS in overseeing workforce planning and education commissioning, but it will need to work independently and directly with a wide range of other bodies and sectors to do this effectively including the NHS Commissioning Board, the higher and further education sector, research bodies and professional regulatory bodies.
47. It is the Department's view that this wide-ranging remit and the responsibilities associated with managing the investment of around £5 billion of public funding require the longer-term status of HEE to be an Executive NDPB. This will allow for the roles, responsibilities and accountabilities of HEE and the Local Education and Training Boards to be clearly set out in primary legislation so that there is clarity on accountability to the Secretary of State and to Parliament.

Option 1 – Establish HEE as an Executive NDPB

48. The preferred option is to establish HEE as an Executive NDPB.
49. Creating an NDPB is the strongest option as its form would fit the functions required. It would offer a greater level of independence, autonomy and certainty than that provided for by a Special Health Authority, enabling it to maximise its impact by taking a long-term and strategic approach to balancing national workforce priorities with the service needs of local healthcare providers and the quality and education requirements of specific professions. This would be accompanied by the introduction of specific duties to strengthen arrangements for NHS healthcare providers to participate in the new education and training system, something which couldn't be done if HEE wasn't being established as an NDPB.
50. It would mean the Government keeps its commitment of ensuring healthcare education and training functions remain part of the NHS. This would not be the case if the functions were brought within the Department either centrally or at arm's-length through the establishment of an Executive Agency.
51. It would be consistent with wider policy aim of putting distance between the Department and the NHS, and because the LETB operational staff will be part of HEE, is the most efficient way of achieving policy aims of securing local NHS leadership for planning and commissioning education and training.

52. Finally, its status as an NDPB would ensure its operational independence is consistent with other bodies performing key NHS functions, such as the NHS Commissioning Board, the Care Quality Commission and Monitor. Its range of responsibilities and size of budget make it more appropriate for it to become an Executive NDPB, able to work independently of the Department of Health, but with clearly defined accountability to the Secretary of State and Parliament. This is particularly important as Secretary of State will be delegating (and therefore retaining) the education and training duty to Health Education England.

Cabinet Office three tests for NDPBs

53. The chosen option is to establish Health Education England as an NDPB. In recognition of government policy that new NDPBs should only be created as a last resort, the Cabinet Office three tests have been applied in order to assess whether an NDPB is required.

Is this a technical function which needs external expertise to deliver?

54. Yes. 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. It is the view of this Government that local healthcare providers, working in partnership with education providers, the professions, local government and the research sector, are best placed to do this role. Given the broader policy intention is to give local providers of NHS services greater independence and autonomy, an NDPB is the appropriate vehicle for bringing together local partnerships of providers to plan and commission education and training.
55. The Secretary of State currently devolves his powers for education and training to the SHAs who plan, commission and quality assure education and training on behalf of their NHS providers. The SHAs will be abolished in March 2013 and their functions, and necessary expertise, will transfer to HEE.

Is this a function which needs to be, and be seen to be, delivered with absolute political impartiality?

56. Yes. The continued delivery of healthcare services is dependent on the continuing security of supply of health professionals such as doctors, dentists and nurses. The education and training of health professionals can take a long time, for example, it can take 10 to 15 years to fully train doctors to be qualified consultants. It is therefore important that any decisions on the investment in the workforce are based on the best available evidence about future demand and supply, and are not driven by short-term priorities.

Is this a function which needs to be delivered independently of Ministers to establish facts and/or figures with integrity and credibility?

57. Partly. Whilst HEE will publish information concerning its performance against national outcome goals and priorities, the publication of facts and figures is not a reason in itself for establishing it as an NDPB. However, the functions of HEE and the governing bodies of LETBs will rely on the evidence base provided by local NHS healthcare providers. Stakeholders have also given a clear message through consultation that the independence of HEE is crucial if it is to operate with the full confidence of the range of partners involved in the planning, commissioning and delivery of education and training.

Monetised and non-monetised costs and benefits of each option (including administrative burden)

58. There are no anticipated costs associated with option 1. HEE will be expected to retain the same operational set up, and its remit and functions are not expected to change in any significant way.
59. There are no monetised benefits associated with option 1.

60. The non-monetised benefit is that stakeholders and the public will have increased confidence in HEE to address their needs and invest money in education and training to support service and clinical priorities. Parliament will have increased reassurance on the accountability of HEE and will support the fact that the Department of Health and Ministers are no longer able to interfere in the day to day operations of HEE.

Rationale and evidence that justify the level of analysis used in the IA (proportionality approach)

61. There is no evidence that the establishment of HEE as an NDPB will increase the costs of the system.
62. HEE's running costs and budget for investment in education and training nationally will be set by the Department of Health and HMT and will be subject to strict financial controls.

Risks and assumptions

63. Key assumptions are that:
- i. no further significant reforms are made to the education and training system that could impact on these proposals.
64. Risks include:
- i. following pre-legislative scrutiny of the draft clauses, amendments are required that might alter the remit of HEE and/or impose additional costs. If this happens the Impact Assessment and the cost/benefits will be reviewed to reflect this.

Direct costs and benefits to business calculations (following OIOO methodology)

65. There are no costs or benefits for businesses.

Equality Analysis

66. The Department will be publishing a separate Equality Analysis alongside the Impact Assessment.

Summary and preferred option

67. In summary, the preferred option is to establish HEE as an Executive NDPB (Option 1) for the following reasons.
- i. It offers sufficient levels of independence and political impartiality in terms of structures, reporting lines and decision making, allowing it to operate with the full confidence of the range of partners involved in the planning, commissioning and delivery of education and training.
 - ii. It would enable direct reporting to the Secretary of State and Parliament, but ensures no day to day interference in operational functions.
 - iii. It allows providers of NHS services and the healthcare professions to bring the necessary skills and expertise to support these functions, and integrates education and training with the funding and provision of services.
 - iv. It ensures the Government meets its commitment to the NHS Future Forum to keep the education and training functions part of the NHS

- v. It allows for the introduction of clear duties on HEE and on NHS healthcare providers to strengthen their participation in the new education and training system, something which couldn't be done if HEE wasn't being established as an NDPB.
- vi. It is the most efficient method of creating independent and autonomous partnerships of healthcare providers to lead on the commissioning and planning of education and training, and no additional costs are anticipated on top of those required to operate HEE as a Special Health Authority.

Annex A – Reports and further information

- *Liberating the NHS: Developing the Healthcare Workforce – A consultation on proposals*
- *Liberating the NHS: Developing the Healthcare Workforce – A summary of consultation responses*
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122590
- *Liberating the NHS: Developing the Healthcare Workforce - From Design to Delivery*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076
- *NHS Future Forum: Summary report on proposed changes to the NHS*
- *Education and Training: A report from the NHS Future Forum*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443
- *Government response to the NHS Future Forum report*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444