NHS

Liberating the NHS:

Developing the Healthcare Workforce

A consultation on proposals

DH Department of Health

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Foreword

More than 1.4 million people work for the NHS in England and they are supported by many more people working in community care, in social care, and in public health services. They are the heart of healthcare in this country. Their skills, commitment, professionalism and dedication are key to improving the health outcomes of the nation.

The government is committed to delivering high quality care to the patients and public who depend on the NHS during periods of their lives. To fulfil this commitment, it is vital that every member of the healthcare workforce is supported by the highest possible standard of education and training.

Our investment in education and training is an investment in patient safety and improving healthcare outcomes.

Education and training are integral in ensuring the values and calibre of staff. They are also central to achieving the continuing development of the workforce, which is required as technology advances and opportunities for further improvement of the nation's health develop.

It is central to our vision that the healthcare professions provide leadership in ensuring the quality of education and training – so that locally and nationally we can all be confident about the standards being achieved.

We must also ensure that healthcare providers have the right number of staff with the right skills to provide excellent standards of care both now – and for the future.

Following the reforms outlined in the White Paper *Equity and Excellence: Liberating the NHS*, we want to empower healthcare providers, with clinical and professional leadership, to plan and develop their own workforce. They know what services their patients and local communities require – and they know what staff they need to deliver excellent, responsive healthcare. Therefore they are best placed to commission the education and training that will achieve the right workforce. To do this they will need to work closely with education providers.

This consultation seeks your views on the changes needed to support the development of the healthcare workforce to enable equity and excellence in healthcare. We look forward to your responses.

Andrew Lansley

Secretary of State for Health

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Executive Summary

Chapter 1 – Purpose & Scope

1. The vision set out in the white paper *Equity and Excellence: Liberating the NHS* can only be achieved if healthcare providers employ staff with the skill mix appropriate to deliver a high quality service to patients in every circumstance. That blend of skills will change repeatedly to satisfy the evolving healthcare needs of local communities.

2. Public investment is central to securing high quality services and training. However, we cannot continue to expect top-down workforce planning to respond to the bottom-up changes in patterns of service that will be required by GP consortia. In future the DH will have progressively less direct involvement in planning and development of the healthcare workforce, except for the public health services.

3. So, it is time to give employers greater responsibility for planning and developing the healthcare workforce. Local 'skills networks' of employers will take on many of the workforce functions currently discharged by Strategic Health Authorities, while the quality of education and training will remain under the stewardship of the healthcare professions, working in partnership with universities, colleges and other education and training providers.

4. This consultation document sets out proposals to establish a new framework for developing the healthcare workforce and seeks views on the systems and processes that will be needed to support it. The **final date for responses is 31st March 2011**, but earlier expressions of view would be helpful.

Chapter 2 – Vision

5. The current system of workforce planning has grown in a piecemeal way. There is an opportunity now to fundamentally reshape it.

6. This chapter sets out five objectives the new framework will need to deliver:

    - security of supply, having people with the right skills in the right place at the right time;

    - responsiveness to patient needs and changing service models;

    - high quality education and training that supports safe, high quality care and greater flexibility;

- value for money;
- widening participation.

7. This chapter also proposes 12 principles that should shape the design of the new system. They include:

- doing at national level only what is best done at national level – leaving maximum opportunities for flexible, local implementation and innovation;
- security of supply, having people with the right skills in the right place at the right time;
- ensuring effective professional engagement at local and national levels, with the professions having a leading role on safety and quality issues;
- ensuring strong partnerships with universities and education providers, to make the most effective use of the skills of educators;
- sustainable and transparent investment in education and training.

Chapter 3 – Context

8. About 1.4 million people in over 300 different roles make up the NHS workforce. More than half of them are healthcare professionals, including doctors, nurses, midwives, healthcare scientists, pharmacists and a wide range of Allied Health Professionals.

9. Currently Strategic Health Authorities (SHAs) determine where to invest the £5bn central budget for education and training. Most of the money is spent on developing the skills of the next generation of professionals, including clinical placements and other work-based learning through healthcare providers. The Department of Health will continue to ensure this core investment is available to make the sector more self-sufficient and less reliant on international recruitment.

10. Led by SHAs, the current system has made significant progress, notably in improving security of supply of healthcare professionals. However, there are deficiencies:

- the current system is too top-down;
- service development planning is often poorly integrated with financial and workforce planning;
- medical workforce planning and education is managed by postgraduate deaneries within SHAs, largely in isolation from the planning and commissioning of education for other healthcare professionals;

- there are persistent shortages of particular skills, including insufficient specialist skills in theatre, renal and intensive care nurses, which causes over-reliance on expensive agency staff and recruitment overseas. The agency bill for healthcare staff is more than £1.9bn;

- ways of working often follow a traditional pattern of looking at supply and demand within single professional silos;

- the costs of running the current system are high and vary greatly among SHAs.

11. There is scope to design a more streamlined system that contributes more to delivering better productivity and improved healthcare outcomes.

Chapter 4 – Developing a new system

12. This chapter sets out the core functions of workforce planning and development. It introduces the proposed roles and responsibilities that different organisations will undertake.

Chapter 5 – Increased autonomy & accountability for healthcare providers

13. This chapter makes clear that the responsibilities of planning and developing the workforce will apply to all providers of NHS-funded care, including providers in the independent and voluntary sectors. The consultation asks for views about duties that might be placed on providers, including a duty to consult on workforce plans and a duty to provide data about their future workforce needs. This information would be used to shape decisions about investment in education and training.

14. More than half the NHS's central funding for education and training goes directly to healthcare providers to support clinical placements. This chapter argues these placements are best managed multi-professionally across a network of healthcare providers. It asks for views on whether the providers should have a duty to consult widely and cooperate on education and training.

15. The chapter also asks for views on the workforce planning and management functions that would be undertaken by the local provider networks, including holding and allocating funding for education and training and taking on the deanery functions. The skills networks would include GPs in their role as providers of healthcare, and work in partnership with representatives of local authorities as providers of social care and commissioners of public health, and education providers.

Chapter 6 – Sector-wide oversight and support

16. This chapter explains why the Government intends to create an autonomous statutory board to support healthcare providers in their workforce planning, education and training. Health Education England (HEE) will be a lean and expert organisation, free from day-to-day political interference. It will focus on workforce issues that need to be managed nationally. It will bring together the interests of healthcare providers, the professions, patients and staff. HEE will take on the advisory role of Medical Education England and the professional advisory boards for education and training. Its functions will include championing the greater involvement of patients and local communities in planning and developing the workforce.

17. The chapter discusses how to get the right balance between strategic national oversight and greater freedom for local education commissioning. It looks at the analytical capability that will be needed for longer-term workforce planning in health and asks how the Centre for Workforce Intelligence can develop to make the most effective contribution. The role of the NHS Commissioning Board and healthcare regulators is also considered.

18. The Government intends to reduce significantly the level of central funding for Skills for Health. It supports moves towards a business model in which employers decide how much they need to invest in the services that Skills for Health can provide. The Government supports a much closer working partnership between Skills for Health and Skills for Care.

19. The professions and medical Royal Colleges have an important role to play in devising and delivering education in their specialties. Clinicians should be involved in the skills networks. The new framework provides an opportunity for the Academy of Medical Royal Colleges to give clinical and professional leadership in working across specialty boundaries. Similar support may be forthcoming from the professional bodies and representatives of other healthcare professions and from the education sector.

Chapter 7 – The public health workforce

20. The Government will consult during 2011 on a workforce strategy for public health. This chapter outlines how Public Health England (PHE) will need to work in close partnership with healthcare providers and local authorities. It asks for views about whether PHE and its partners in public health delivery should be represented on the HEE board. Another question is whether local authorities should become members of the NHS healthcare provider skills networks.

Chapter 8 – Funding and incentives

21. This chapter explains why relying solely on market levers to secure sufficient investment in healthcare skills is an unacceptable risk. It would also be unfair if some healthcare providers bore the costs of providing skills to the local labour market while others did not.

22. Current funding of training and development comes from top-slicing the NHS budget. Over time the Government intends to move to a levy on providers to raise the money needed to train the next generation of healthcare professionals. However, it would not be appropriate to apply a national levy to fund local investment to develop the skills of the existing healthcare workforce. HEE will take a strategic overview of the funding priorities and allocate money to different areas as appropriate. It needs an effective strategic relationship with the funding bodies for higher education, taking account of changes to the funding regime following Lord Browne's Review.

23. The chapter discusses how the flow of funding for education and training can be made fairer and more transparent. It notes that the DH has previously negotiated a benchmark price as a national tariff paid to higher education for the tuition costs of most NHS-funded pre-registration education programmes. Tariffs for medical and other clinical placements and tariffs covering other programmes and placements are to be considered as a way to provide a level playing field. Providers should be allowed time to adjust to these arrangements before further changes are made.

24. The Government asks for views on how quickly tariffs and a levy should be introduced and which healthcare providers should pay. Should it apply to healthcare providers who do not treat NHS patients, but do deliver services using staff trained by the public purse?

Chapter 9 – Transitional arrangements

25. There is a challenging timescale to put in place new systems and processes by 2012 to take on functions of Strategic Health Authorities before they are abolished. Providing stability and continuity will be important.

26. SHAs will hold and allocate the Multi-Professional Education and Training Budget for 2011/12. They will work with local health and social care economies to develop coherent plans for the new local framework. Providers are encouraged to take on SHA staff with appropriate knowledge and expertise.

27. Subject to Parliamentary approval, Health Education England will be established in shadow form in 2011 and as a special health authority to go live in April 2012. The chapter discusses how local healthcare provider skills networks will become legally established, and other transitional arrangements.

Chapter 10 – Equality and diversity

28. The DH will conduct an equality impact assessment on these proposals. The initial screening suggests the policy may provide opportunities to make a positive impact on equality and to tackle current inequalities. The consultation seeks to establish if any individuals or groups might be disadvantaged by the proposals.

1. Purpose & Scope – what is this consultation about?

Equity and Excellence: Liberating the NHS

1.1 The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS where:

- patients and the public are at the heart of everything the NHS does;
- health outcomes are among the best in the world;
- there is increased autonomy and clear accountability at every level, with healthcare professionals empowered to deliver results.

Responses to the White Paper consultation showed support for these principles. On 15th December 2010, we published the Government's response to the consultation, *Liberating the NHS: Legislative framework and next steps*, which sets out key themes from the consultation responses and more detail about the Government's plans going forward.

The White Paper said: 'Each year several billion pounds are spent on central funding of education and training for NHS staff through the Multi-Profession Education and Training levy, in addition to investment by NHS organisations in their own staff. A top-down management approach led by the Department of Health does not allow accountability for decisions affecting workforce supply and demand to sit in the right place. It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training.'

A healthcare workforce reflecting the needs of patients and communities

1.2 The vision set out in the White Paper can only be achieved if healthcare providers employ staff with the skill mix appropriate to deliver a high quality service to patients in every circumstance. The blend of skills that is appropriate will change repeatedly as clinicians strive to use the most effective and up-to-date techniques and technologies to satisfy the evolving healthcare needs of local communities. Successful patient care depends on the whole healthcare workforce working effectively together, in conjunction with social care and public health staff where appropriate. Through their creativity and commitment, the people who work in health and social care will realise improved healthcare outcomes for patients and local communities. There is strong evidence that staff who are empowered, engaged and well supported provide better

patient care. Employers must create an environment where talent flourishes and where everyone is able to realise their potential.

1.3 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.

1.4 There are in practice no market mechanisms capable of delivering the prospective supply of skills for healthcare. Although there may be signals covering need for skills, they are often very short-term in relation to the supply response required through training. There is therefore an unacceptable risk of undersupply of healthcare professionals, which would be unsafe, or oversupply, which would be wasteful and demoralising. Nor can we continue to expect top-down workforce planning to respond to the bottom-up changes in patterns of service that will be required by GP consortia. In future the DH will have progressively less direct involvement in planning and development of the healthcare workforce, except for the public health services.

1.5 The key lesson from recent NHS history and international experience is that the effective alignment of service development with financial and workforce planning enables high quality care with greater productivity. Critical to this is excellent education and training that is integrally linked into scientific and technological advances and enables everyone in the healthcare team to acquire capabilities and skills to provide new models of personalised care.

Purpose of this consultation

1.6 Our aim is to make sustainable changes that will support the reforms set out in the White Paper. We want to make the NHS more responsive to patients' changing needs while being more resilient to future funding pressures. Healthcare employers have an interest in securing the supply of skills they need. Insofar as they are increasingly responsible for determining and funding their needs, they will have an interest in avoiding either chronic shortages or over-supply. So, it is time to give employers greater responsibility for planning and developing the healthcare workforce, alongside greater professional ownership of education and training quality standards and content. This consultation therefore seeks views on the framework for planning and developing the healthcare workforce and commissioning multi-professional education. A new framework that will be driven by diverse patient needs, based on healthcare provider decisions and underpinned by strong clinical leadership; with the quality of education

and training remaining under the stewardship of the healthcare professions, working in partnership with universities, colleges and other education and training providers.

Scope and nature of this consultation

1.7 In designing the new framework the overriding test will be what provides the best health and well-being outcomes for patients and communities and the wider health and social care sector. As we develop and implement the new framework, we need to be mindful that NHS funding is fixed up to 2014-15. This makes it critical to consider issues of cost effectiveness and affordability at all stages of the design and implementation.

1.8 The role of the Department of Health is changing fundamentally. The forthcoming Health Bill will formalise the relationship between the Department and the NHS, to improve transparency and increase stability while maintaining appropriate accountability. In future it will have progressively less direct involvement in planning and development of the healthcare workforce, except for the public health services. The change in responsibilities has implications for the interactions on workforce matters with the Devolved Administrations. The Department will consult with the Devolved Administrations to ensure a UK-wide approach to education and workforce strategy within the new framework, where this is relevant.

1.9 A central feature of the proposed new framework is the commitment for healthcare providers to drive planning and development of the healthcare workforce. In partnership with staff and patients, they will take on many of the workforce functions currently discharged by Strategic Health Authorities (SHAs). The consultation addresses the specific roles and responsibilities of providers of NHS-funded healthcare and public health services. It considers where sector-wide oversight is required whilst recognising the need to empower local employers and clinicians. Accountability and responsibilities will be linked and transparent, in line with the design principles for developing the wider changes for service commissioning and provision of services.

1.10 The new framework will take account of how workforce needs are addressed across the wider healthcare sector, in the delivery of public health services and to reflect the common interests with social care where there are shared care pathways and cross-boundary flows of staff and skills. It will also recognise that much health education is developed with and delivered by universities and other education providers. Partnerships with the public and patients, staff, students, the professions, commissioners of care, regulators and academic partners are all required to achieve equity and excellence.[i]

1.11 This document sets out for consideration proposals for the new framework and the systems and processes to support it, and seeks views on their potential impact and efficacy, associated risks and opportunities. This consultation reflects the policy direction set out in *Liberating the NHS: Legislative framework and next steps*,

recognising that many changes are subject to Parliamentary approval. A number of questions are set out for response throughout the document. These are summarised in the final chapter, which provides information about how to respond to this consultation. **The timescale is for responses to be received by 31 March**. It would be helpful to receive responses in advance.

The White Paper *Equity and Excellence: Liberating the NHS* set out the following principles for workforce planning, education and training:

- Healthcare employers and their staff will agree plans and funding for workforce development and training; their decisions will determine education commissioning plans.
- Education commissioning will be led locally and nationally by the healthcare professions, through Medical Education England for doctors, dentists, healthcare scientists and pharmacists. Similar mechanisms will be put in place for nurses and midwives and the allied health professions. They will work with employers to ensure a multi-disciplinary approach that meets their local needs.
- The professions will have a leading role in deciding the structure and content of training, and quality standards.
- All providers of healthcare services will pay to meet the costs of education and training. Transparent funding flows for education and training will support the level playing field between providers.
- The NHS Commissioning Board will provide national patient and public oversight of healthcare providers' funding plans for training and education, checking that these reflect its strategic commissioning intentions. GP consortia will provide this oversight at local level.
- The Centre for Workforce Intelligence will act as a consistent source of information and analysis, informing and informed by all levels of the system.

Structure of this consultation document

1.12 The rest of this consultation document sets out:

- **the overall vision for workforce planning, education and training (Chapter 2):** the objectives for the system and the principles that should shape new arrangements;

- **the context and case for change (Chapter 3):** the range of workforce issues, looking across the whole NHS workforce, the particular issues for the clinical workforce, and the linkages with public health and adult social care;

- **proposals for developing a new framework (Chapter 4):** the key functions that need to be delivered in the system, and their interconnections;

- **increased autonomy and accountability for healthcare providers (Chapter 5):** the basis for the transfer of greater responsibility for planning and developing the workforce to healthcare providers, the obligations this transfer carries with it and the framework required for assurance that all providers will exercise these responsibilities in a sustainable way;

- **arrangements for sector-wide oversight and support in developing the future workforce (Chapter 6):** including a national executive body to provide leadership and assurance, and effective professional and system regulation of safety and quality;

- **proposals for the new public health workforce, arrangements for Public Health England (Chapter 7):** demonstrating the alignment between the planning and development of the public health workforce with the wider framework for workforce planning, education and training;

- **funding flows and incentives which support equity and excellence (Chapter 8):** fair and transparent funding such that money follows the student or trainee, with information available on the quality of education and training to inform student or trainee choice and the commissioning of education;

- **transitional arrangements (Chapter 9):** the practical steps that need to be taken so that there is a smooth transition to the new system;

- **equality and diversity (Chapter 10):** recognises that patients and staff are diverse and there is a need to ensure particular groups are not unjustifiably impacted by this policy.

2. Vision – what are we trying to achieve?

2.1 The White Paper reforms are bold. They will liberate professionals and healthcare providers to secure the quality, innovation and productivity needed to improve healthcare outcomes in their localities. The reform of the system for planning and commissioning education and training must also be bold. It will need to align with new ways of commissioning and providing services.

2.2 The current system has grown over time in a piecemeal way. Changes have been driven in response to structural reorganisations as well as educational priorities. We need to learn the lessons from past failures. The Health Select Committee[ii] inquiry into workforce planning and the crisis in medical recruitment and training in 2007 exposed deep flaws in the arrangements for workforce planning and education and training. There is an opportunity now to review and fundamentally reshape the whole system architecture for planning and developing the workforce. In the words of Sir John Tooke,[iii] 'in the interests of the health and well being of the nation, we should aspire to excellence'. This chapter therefore sets out for consultation:

- the objectives for workforce planning, education and design;
- the principles that should shape the design of the new system.

Objectives for workforce planning, education and design

2.3 In building a new framework we need to start with the objectives. What does the new framework need to achieve?

- ***Security of supply –*** ensuring sufficient numbers of appropriately skilled healthcare staff, with the right skills in the right place at the right time, able to achieve health and well-being outcomes that are amongst the best in the world.
- ***Responsiveness to patient needs and changing service models –*** better integration and alignment of workforce planning and development for the whole workforce with service provision and financial planning, such that the capacity and skills of current and future staff are developed to provide services that are built around the needs of patients and local communities.
- ***High quality education and training that supports safe, high quality care and greater flexibility –*** aspiring for excellence and innovation in all education and development activity, to build confident and competent healthcare staff able to deliver safe and high quality care, adapt quickly to changing models of service,

work in multi-professional teams and drive knowledge creation and new service models through evidence-based research and innovation.

- ***Value for money*** – ensuring transparent funding flows to support a level playing field across providers, with the right accountabilities and incentives at local and national level to support continuous improvement and a system able to demonstrate the value of the investment in education and training.

- ***Widening participation –*** supporting diversity and equitable access to services and education, training and development opportunities and a system where talent flourishes free from discrimination with everyone having fair opportunities to progress.

Question 1: Are these the right high-level objectives? If not, why not?

Design principles

2.4 In developing a new approach to workforce planning, education and training, it is also essential that there is agreement about the underpinning principles, which will inform the design. These include:

- alignment with the wider system design for the commissioning and provision of services;

- ensuring that fairness and transparency is at the heart of the new framework and in decision-making;

- ensuring the capability to plan effectively for both current and future workforce requirements;

- taking an integrated and multi-professional approach to workforce planning and to education and training where possible, with stronger whole workforce approaches;

- doing at a national level only what is best done at a national level – leaving maximum opportunities for flexible, local implementation and innovation;

- ensuring effective professional engagement at local and national levels, with the professions having a leading role on safety and quality issues;

- ensuring that arrangements for planning and developing the healthcare workforce have appropriate integration with the approaches to planning and developing the public health and social care workforce;

- ensuring strong partnerships with universities and education providers, to make the most effective use of the skills of educators;

- making sure there is sustainable and transparent investment in education, training and development to provide the skills needed so that funding allocated for the purposes of education and training is spent only on those activities;

- streamlining processes and structures ensuring that they are simple, cost-effective and efficient;

- providing clarity of roles, responsibilities and accountabilities;

- reinforcing values and behaviours which recognise the wider benefit to society of developing the health workforce and skills, and the need for cooperation and collaboration in doing so.

Question 2: Are these the right design principles? If not, why not?

3. Context – where we are now in planning and developing the workforce and the case for change

3.1 Over 1.4 million people in hundreds of different roles make up the current workforce delivering NHS services. There are significant linkages with the social care sector and with the proposed public health service. This chapter :

- highlights the importance of considering the whole workforce;
- sets out the particular issues in planning and developing the clinical workforce;
- summarises the current systems for planning and developing the workforce and the case for change.

Planning and Developing the Whole Workforce

3.2 The scale and range of the NHS workforce is highlighted in the table below.[iv] NHS careers[v] describes the full range of professions, careers and skills to be found within the healthcare workforce.

Staff Group	**2009**
All Staff	**1,432,000**
Qualified Nursing, Midwifery & Health Visiting staff	**417,000**
of which:	
Midwives	26,000
Practice Nurses	14,000
Support to Clinical Staff	**378,000**
Infrastructure Support	**236,000**
Total qualified scientific, therapeutic & technical staff	**150,000**
of which:	
Allied Health Professionals	74,000
Qualified Healthcare Scientists	32,000
Other qualified scientific, therapeutic & technical staff	43,000
of which Pharmacists [vi]	15,000
Doctors	**141,000**
of which:	
General Practitioners	40,000
Other GP practice staff	**92,000**
Qualified Ambulance staff	**18,000**
of which:	
Paramedics	10,000

3.3 The public health workforce is large and diverse – made up of a wide range of specialist and professional groups. This includes individuals working in and across all three facets of public health activity: health improvement, health protection and

healthcare public health. Members of the workforce range from, but are not limited to, Consultants in Public Health/Directors of Public Health (with roles in specialised commissioning, health improvement and health protection) to microbiologists, epidemiologists, health protection officers/nurses, health visitors and public health practioners. These professionals work closely and often within the NHS, so it is critical that their workforce planning, education and training is considered alongside the healthcare workforce.

3.4 At about 1.6m people the adult social care workforce is even larger than that of the NHS and works for a much greater number of employers, with the majority of providers being in the independent sector employing ten or fewer people. There are now more people working as personal assistants directly or indirectly employed by people who use services in a variety of care and support roles than people employed by local councils, although Directors of Adult Social Services continue to have an important role in workforce commissioning. Overall fewer than one in ten people in the workforce hold a professional qualification such as a degree in social work. Some professions such as nurses and occupational therapists work in either sector. A new Qualifications and Credit Framework is being developed by Skills for Care, the English partner of the Sector Skills Council, to help improve the skills of care workers in home, day, and residential care. *A Vision for Adult Social Care: Capable Communities and Active Citizens* recently set out the Government's plans for the sector, including for the people in the workforce.

3.5 In addition many more people are involved in wider primary care services including community pharmacy teams, opticians and the dental workforce. There are also a large number of carers, helpers and volunteers who support people receiving hospital and community services.

Developing the whole workforce

3.6 The ambition set out in the White Paper is to achieve healthcare outcomes that are amongst the best in the world. As the White Paper recognises, the people who work in the NHS are among the most skilled in the world and they are some of the most dedicated public servants in the country. It is their skills, training and purposeful dedication that lie at the heart of improving outcomes and quality of care. It is the individual interactions between staff, public and patients that turn personalised care from strategy to reality. Securing and nurturing their talent in the service of public and patients is the responsibility of everyone who works within the healthcare sector or supports healthcare delivery – from managers, healthcare professionals, team-leaders and educators through to the regulators and national professional bodies and NHS Employers.

3.7 Much of this consultation inevitably focuses upon professional education and training. This is, of course, vital but it is also important to invest in training and developing the wider healthcare workforce. Their support for front-line care is essential. To survive, thrive and become more productive, employers in every industry invest in the talent of **all** their workforce.

3.8 This is why the Coalition Government invests in skills development and apprenticeships and why the Department of Health supports Skills for Health and Skills for Care, with their strong focus on the skills and development of the wider health and social care team. We believe there should be a better balance of investment in healthcare across clinical, vocational and support skills. The Department supports the recommendations of the National Apprenticeship Advisory Committee chaired by Ron Kerr, Chief Executive of Guys and St Thomas's Foundation Trust. Its recent report urges healthcare providers to invest in apprenticeships, not only to bring new talent into the NHS but also to realise the potential of existing staff. A further £10m has been made available this year to support this ambition and help employers fund thousands more apprenticeships across the NHS.

Planning and Developing the Clinical Workforce

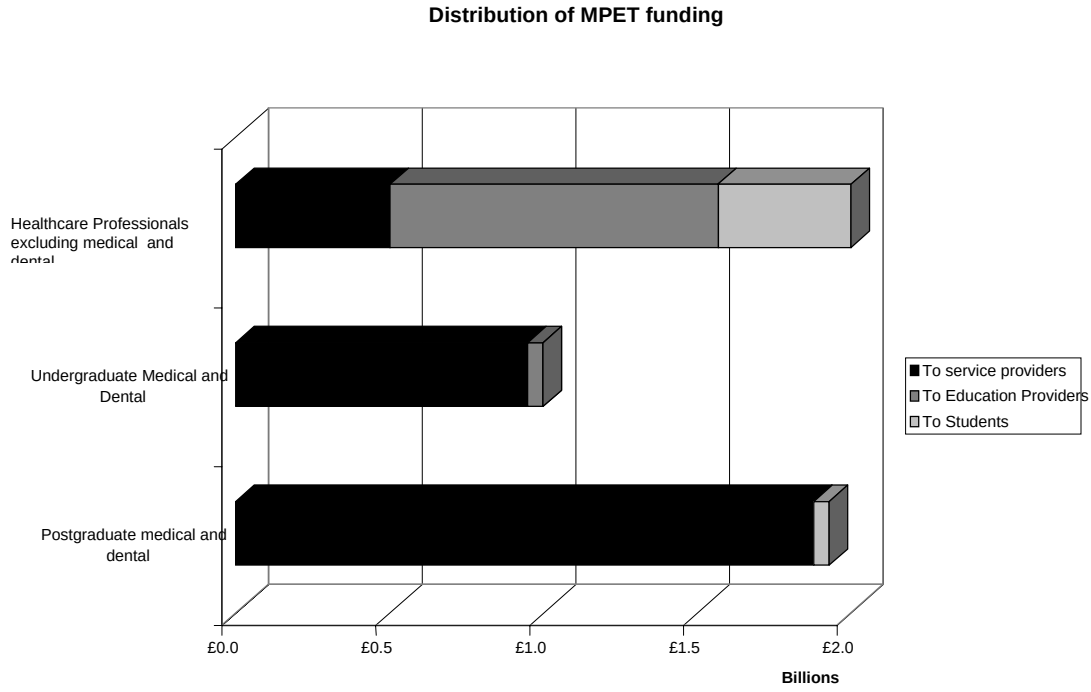
3.9 Healthcare professionals[vii] make up over half of the healthcare workforce. Their education and development is a central feature of every healthcare system. Most developed countries are increasing their investment in workforce planning and analysis to align service planning with development of multi-professional workforce models to improve healthcare outcomes. The absence of planning in the United States is often seen as a major constraint.[viii]

3.10 In this country, the Government invests heavily in educating and training new healthcare professionals in order to secure the skills needed to provide healthcare services. Healthcare employers invest in the continuing professional and personal development of their staff. We believe that such investment is in the public interest and in the interests of healthcare providers. It needs to be underpinned by effective workforce planning to avoid the risks to services that arise when there are insufficient clinical skills.

3.11 Currently SHAs have a central role in workforce planning, and they determine where to invest the £5bn central budget for education and training. Most of this funding supports education and training for the next generation of healthcare professionals. Over half is directed to healthcare providers for the provision of clinical placements and other work-based learning activity (see graph below). The Department of Health will continue to ensure this core investment for training new healthcare professionals is available, so that the healthcare sector can become more self-sufficient and less reliant on international recruitment.

3.12 Effective planning to secure the next generation of healthcare professionals is challenging in a complex and dynamic environment like healthcare and against the long time horizons that professional training requires. All countries experience either skills shortages or over-supply from time to time, and these have implications for service delivery and pay costs. No system will achieve a perfect balance of skills and patients' needs at all times, but a systematic approach to planning rooted in the service plans of healthcare providers and responsive to change, and an education that provides the foundation for future adaptability, will mitigate the risks for patients, for services and for staff.

The distribution of multi-professional education and training funding (MPET) is outlined in the graph below:



Continuing professional and personal development

3.13 Securing the next generation of new professionals is vital but it is only the starting point for a continuum of learning and skills development. Around 60 percent of the staff currently working in the NHS will probably still be delivering healthcare in ten years. In its report *NHS Workforce Planning: Limitations and Possibilities* the King's Fund recommended a shift from the current emphasis on 'new recruits' to the development of skills for those who are already employed in delivering services. It concluded that the focus should be on creating a flexible approach to planning and developing the workforce that does not seek long-term precision but enables '*the*

current workforce to evolve and adapt to the inherently unpredictable healthcare environment'.

3.14 We agree with this analysis and the White Paper reforms will provide incentives for employers to invest in their workforce in order to compete effectively. The current system lacks clarity about the responsibility for continuing professional development and this leads to underinvestment and wasted opportunities for staff to develop to respond to change. In most areas SHAs currently provide some investment to support ongoing professional development. In the new NHS the responsibility for investing in the existing workforce and ensuring sustainability of specialist skills will sit where it should – with employers.

Clinical Leadership

3.15 The professions have a leading role at both a local and national level in ensuring investment in skills through continuing professional and personal development and maintaining the structure and content of education programmes, maximising every learning opportunity. Their clinical leadership will help raise the standards of education and training at every level, securing safe and high quality care.

The relationship between healthcare providers and education providers

3.16 The effective education and training of healthcare professionals depends on the health service having an effective partnership with universities, colleges and other education providers. Strong engagement with the education sector is necessary to ensure that training is educationally sound, with the right foundations and flexibility to accommodate changing roles and service models in the future. Support for innovation and research opportunities should be preserved and developed across disciplines and across specialties. Students need to be encouraged to learn the importance of research so they go on to use these skills in the improvement of services and health outcomes.

Current systems for planning and developing the workforce and for commissioning education and training

3.17 The current systems for planning and developing the workforce and for commissioning education and training are complex and involve many partners. **Annex A** sets out current roles and responsibilities.

3.18 Led by the SHAs and with increasing professional engagement, there has been significant progress in improving the approach to workforce planning, education and training in recent years. In particular:

- there is now much **greater security of supply**. There has been significant investment in education and training so that there are now more healthcare professionals and a better balance between aggregate supply and demand;

- the focus on quality in clinical care and the introduction of new metrics to support education commissioning has **increased the focus on the quality of education**;

- the **new professional advisory boards set up to review the interests of specific professional groups have also made good progress**:

    - Medical Education England – the advisory body that oversees the Medical Programme Board, the Healthcare Science Programme Board, the Dental Programme Board and Pharmacy Programme Board – has been able to give those professions a stronger voice on national workforce issues. In healthcare science, for example, the whole education and training pathway has been redesigned with greater patient focus and greater consistency; and in pharmacy, the profession is working together with public and private sector employers to improve planning and the education base;

    - The Nursing and Midwifery Professional Advisory Board and the National Allied Health Professional Advisory Board have driven forward the development of advanced practice, changing roles and a research culture;

    - The leadership of the Health and Education National Strategic Exchange[ix] and the development of Academic Health Science Centres and Health Innovation and Education Clusters have **brought together partners in health, education and research to drive innovation, knowledge creation and education and training**;

- In some areas there have been **real strides in implementing skill mix changes** to support more productive care, modelled around quality and the needs of patients;

- The **Centre for Workforce Intelligence was established earlier this year to provide leadership and expert authoritative advice** on workforce planning to the whole healthcare sector. It is increasingly able to provide intelligence and objective, evidence-based analysis to inform workforce planning, and advise on risks, opportunities and value for money.

It is important that the new framework builds on these achievements.

3.19 Equally, there are a range of issues which highlight the need for change:

- the **current system is too top-down**, such that employers do not have the incentives and levers to innovate and secure the skill-mix that they want to deliver better outcomes and productivity;

- **service development is often poorly integrated with financial and workforce planning**, reflecting a lack of alignment of accountabilities and incentives;

- **medical workforce planning and development is done largely in isolation,** currently postgraduate medical and dental deaneries within SHAs plan, commission, coordinate and quality-manage postgraduate medical and dental training. This is often done with limited systematic consideration of the wider workforce and limited involvement of healthcare professionals outside the medical profession;

- there is a **need for longer-term, strategic service commissioning** to give clearer signals to inform decisions on the longer-term investment needed in developing the workforce;

- there are **continued problems with the availability of particular skills** due to the lack of clear roles, accountabilities and incentives at different levels. For example, **shortages of specialist skills in theatre, renal and intensive care nursing persist** and they cause excessive **reliance on expensive agency staff and recruitment of overseas nurses**. The annual agency bill for healthcare staff is now over £1.9bn. Although international recruitment numbers have fallen, 3,100 nurses and 5,200 doctors from outside the UK registered to practice in the UK in the last 12 months.[x]

- there are **issues about the quality of medical training** that need to be addressed in the new system[xi] with greater local and national accountability for action being taken to ensure patient safety and adequate supervision of trainees.

- there is a **need for more consistent, high quality workforce information** to provide the foundation for local and national workforce planning;

- many of the **existing processes and ways of working have developed over time and follow traditional patterns by looking at supply-and-demand factors in single professional silos**. The potential for improving quality and productivity through skill mix change and developing the wider healthcare team including those in career framework levels 1-4 is underdeveloped.

- the **costs of running the current system are high**. In addition to the workforce planning undertaken by healthcare providers, SHAs spend significant and widely varying sums on planning and commissioning education. There is an opportunity to streamline processes and increase the emphasis on value for money in the future system.

3.20 The expansion of the NHS workforce over the last ten years has enabled services to expand but it has not achieved better productivity and while it has made great strides in the standards of patient care, there is still more work to do. Investment in the NHS has been protected with a relatively better settlement for healthcare than other public sector services. The future financial environment will, nevertheless, be challenging as healthcare providers seek to cut waste, constantly improve quality and become more productive. Employers need greater autonomy as they face up to difficult decisions and determine how to improve their services. There is scope now to design a more streamlined whole-system approach that shifts the balance to local planning and development for the whole workforce with clear accountability for performance.

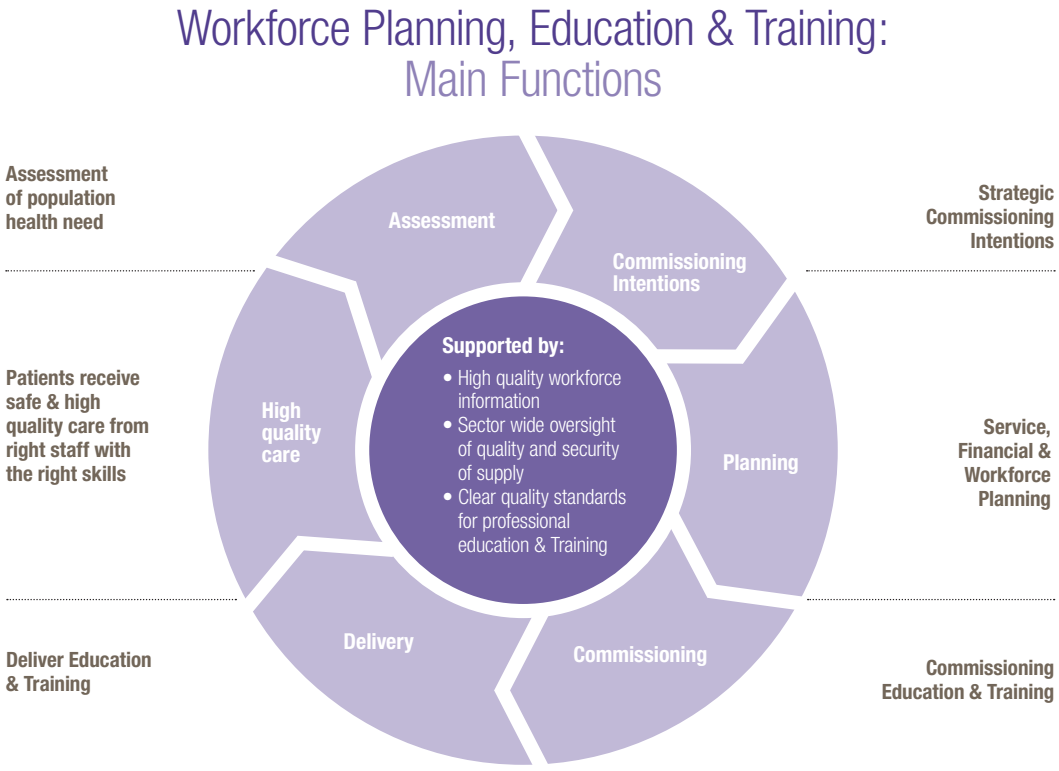
Question 3: In developing the new system, what are the key strengths of the existing arrangements that we need to build on?
Question 4: What are the key opportunities in developing a new approach?

4. Developing a new framework

4.1 The White Paper sets out to create an environment where staff and organisations enjoy greater freedoms and clearer incentives to flourish, but also know the consequences of failing the patients they serve and the taxpayers who fund them. This should apply equally to the approach to planning and developing the workforce.

4.2 In developing a workforce which is responsive to patient needs and changing service models, it is important that the core functions of workforce planning and development are integrated and aligned with the commissioning of service provision and financial planning. The simplified diagram below sets out the high-level functions and processes which need to be carried out:

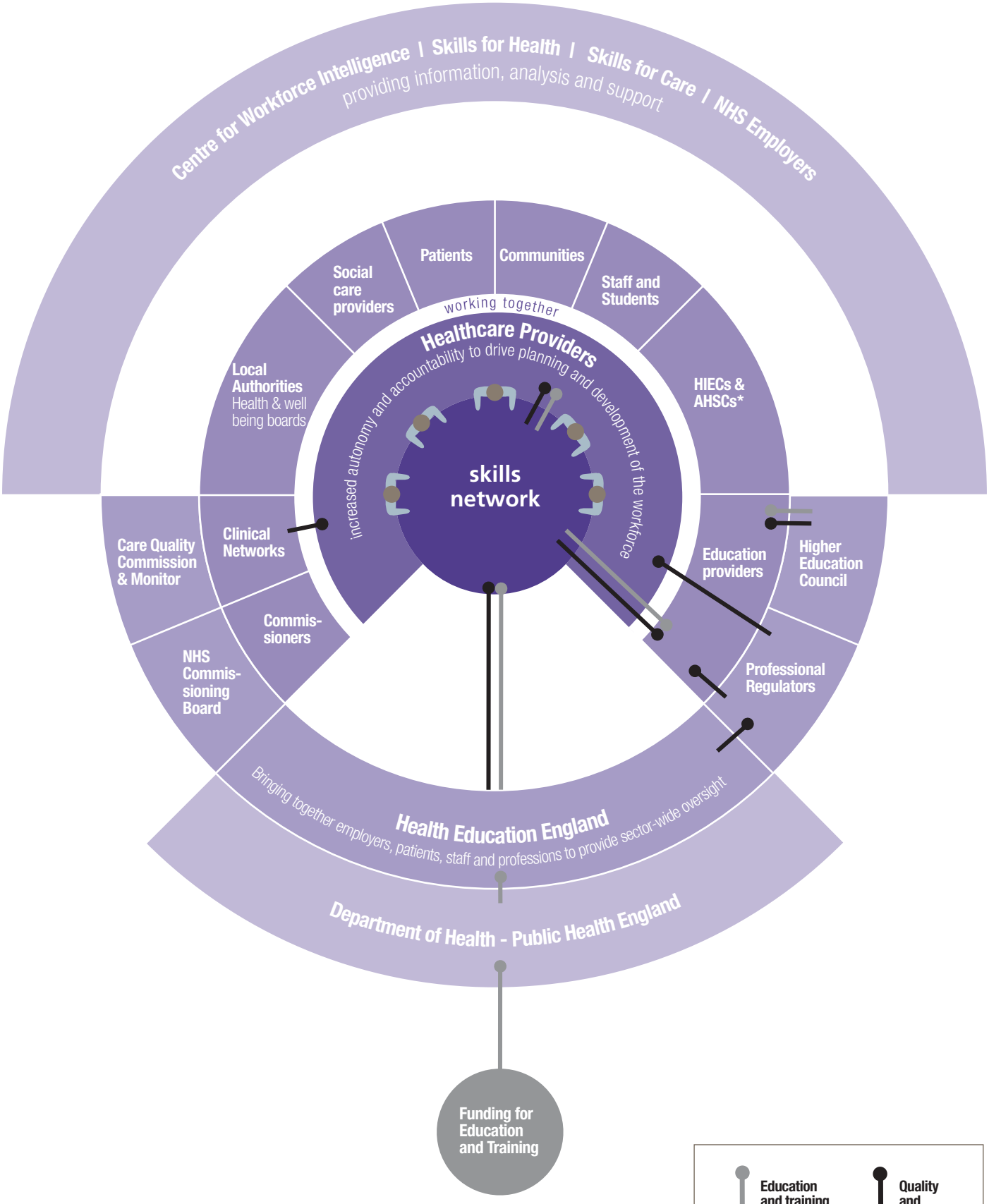
Integrating workforce planning, education and training with service and financial planning:



4.3 The following chapters set out the proposed roles and responsibilities of different organisations in taking forward the workforce planning, education and training functions, and proposals for a new framework to put in place the right incentives and accountabilities capable of achieving the high-level objectives set out in Chapter 2.

4.4 It is important that in designing the framework there is clarity on the duties and accountabilities of the different players – and as a result clarity on who is accountable for driving excellence and innovation, for ensuring value from the investment of public funds, and also for managing risks and taking action. This includes healthcare providers, the national body, the professional and system regulators, commissioners of services and education providers.

A new framework for planning and developing the workforce



* HIECs - Health Innovation and Education Cluster
AHSCs - Academic Health Science Centre

4.5 We recognise that this is a complex area, in which there are currently different arrangements for different parts of the workforce at different stages of their careers. This document sets out at a high level the proposed duties and accountabilities of different players, summarised above – recognising that much of the detail will need to be worked through when moving to implementation.

5. Increased autonomy and accountability for healthcare providers

5.1 The new framework for planning and developing the healthcare workforce rests on the transfer of greater responsibility to healthcare providers in line with the other reforms in the White Paper. This chapter:

- makes clear that the responsibilities for planning and developing the workforce apply to all providers of NHS-funded care, and builds on the pledges set out in the NHS Constitution;
- recognises that in exercising these responsibilities healthcare providers have an obligation to plan thoughtfully for the whole workforce and take commissioning decisions on a sustainable basis; and
- recognises that in taking the opportunities for a more provider-led system, there is also a need for clear duties for providers and appropriate 'checks and balances' to provide accountability.

NHS Constitution pledges

5.2 The framework for planning and developing the healthcare workforce has a firm foundation in the commitments that all healthcare providers have to ensure high quality working environments for their staff, as set out in the NHS Constitution. The NHS Constitution applies to all NHS bodies and private and third sector providers supplying NHS-funded services. It covers all staff wherever they are working, whether in the public, private or third sector healthcare providers. It sets out the rights and duties of employers and staff within the context of the enduring NHS values.

5.3 All providers of NHS-funded services have pledged to provide all their staff with personal development and access to appropriate training for their jobs, together with line management support to succeed. Staff are expected to take up training and development opportunities provided and to play their part in improving services by working in partnership with patients, the public and communities. These responsibilities provide the foundation for planning and developing a workforce able to meet future healthcare needs.

Planning and developing the healthcare workforce

5.4 With appropriate professional input and leadership, individual employers are best able to plan and develop their own workforce. In many areas, local employers working with their staff and clinicians are transforming services and we need to give them the

freedom to develop their workforce to support this. They should be the 'engine' of the system, and their assessment of what workforce and skills are needed to provide affordable, safe and high quality care should drive investment in education and training. Healthcare providers should identify their workforce needs and make sure that the approach to education and training is responsive to the needs of the service.

5.5 The new approach should provide real opportunities so that healthcare providers:

- have the right incentives to secure skills, invest in training and innovate to improve the quality of services they provide;
- have the capability and incentives to align service and financial planning and workforce planning; and
- have greater flexibility to respond to the strategic commissioning intentions of the NHS Commissioning Board and GP consortia.

5.6 To provide sustainable and improving services, healthcare providers need to operate within a functional local and national healthcare labour market and not in isolation. Creating functional labour markets for healthcare systems is not within the gift of any single healthcare provider, however big or however specialist. It is a strength of the current system that NHS healthcare providers are empowered to cooperate in planning and developing the workforce. Most now work together successfully in local networks so that they can plan for and secure the skills needed across their local health economy, and work together to tackle local skills gaps where they emerge.

5.7 Healthcare providers should have the right incentives to welcome and make use of the opportunities of a more provider-led approach to the development of the workforce. Past experience in England and lessons from other countries suggest that there are potential risks in a wholly devolved system:

- providers may take more short-term decisions in response to current pressures,[xii] with insufficient attention to the longer-term investment in the development of the future workforce;
- the length of time it can take to correct an undersupply of key healthcare professionals, due to the length of training;
- providers securing the skills they need by buying them in;
- individual providers not being able to offer the appropriate range of training opportunities and breadth of training required to train a complex workforce;

- challenges where the labour market for particular professional groups (particularly smaller groups) needs to be considered across a larger area;

- focusing on the current service that relies, for example, on doctors in training for delivery, can limit medium- to long-term planning of the workforce.

5.8 Healthcare providers should be motivated to address such challenges in developing their workforces to deliver safe and high quality care. To support healthcare providers in working together to develop strong and effective local arrangements, this consultation proposes a number of duties on any provider of NHS-funded care:

- a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop their workforce;

- a duty to provide data about their current workforce and future workforce needs;

- a duty to cooperate in planning the healthcare workforce and in the planning and provision of professional education and training.

Duty to consult on workforce plans

5.9 Understanding the patient perspective and public expectations of the services they access is an essential starting point in planning all aspects of healthcare. This applies particularly to planning and developing the workforce because the outcomes patients experience reflect the quality of their interaction with the people who make up the healthcare workforce and the quality of care they deliver. It is the skills and attitudes of staff that turn personalised care and shared decision-making from a policy objective into a reality.

5.10 Alongside this, it is fundamental that front-line staff are consulted about their education, training and skills, and about decisions on the shape and development of the workforce so that those plans reflect the knowledge and experience of staff. Buy-in to change from those at the front line not only makes for better decisions, it is also key to successful organisation and system development.

5.11 Workforce plans also need to reflect the strategic commissioning intentions for healthcare services. Chapter 6 refers to the role of the NHS Commissioning Board in providing oversight of the national picture. At a local level, GP consortia need to be consulted on workforce plans and check that they reflect their commissioning intentions.

Question 5: Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce?

Duty to provide data about the current workforce and future workforce needs

5.12 For effective workforce planning, healthcare providers will need to have a skills and development strategy that identifies their skills gaps based on workforce data about the workforce they currently employ and the workforce they plan to employ. This strategy should then inform the investment needed in education and training.

5.13 For this planning and commissioning cycle to work locally and nationally, there is a need for a national collection of workforce data. Information from individual healthcare providers needs to be aggregated locally, to enable employers to understand the dynamics and needs of their local labour market, and nationally, for the Centre for Workforce Intelligence to provide local and sector-wide advice on workforce planning and education and training commissioning.

5.14 A key aspect of workforce planning and commissioning in the new system would be dependent upon appropriate aggregation of workforce plans. Any mechanisms for sharing the data locally and nationally would need to be in line with competition rules and meet the requirements set by Monitor as the economic regulator. The NHS Information Centre has an overall remit to collect healthcare data, including workforce data and they would need to work with healthcare providers and the Centre for Workforce Intelligence to understand the range of workforce data required and the most cost-effective mechanisms to ensure synergies are in place for the collection of data from different sources. We would also consult further with Monitor to understand their role in overseeing these mechanisms.

Question 6: Should healthcare providers have a duty to provide data about their current workforce?
Question 7: Should healthcare providers have a duty to provide data on their future workforce needs?

Duty to cooperate in planning the healthcare workforce and in the planning and provision of professional education and training

Cooperation in planning the workforce

5.15 We believe that a measure of cooperation and joint planning for the development of the workforce is required in healthcare, building on the effective partnership-working that providers are already leading. The assessment by healthcare providers of the

future shape of the workforce and the future skills needed, is the basis for investment in education and training at:

- local level – to develop the local workforce and provide qualified professionals with new and specialist skills in a continuum of learning; and at

- national level – to inform the total level of investment needed to secure the next generation of healthcare professionals.

5.16 It is by coming together to understand local labour market dynamics that healthcare providers will be able to assess the investment in skills and development required. Their aggregate plans for the future shape of the workforce will be the basis for investment in educating and training the next generation of healthcare professionals.

Cooperation in planning and providing professional education and training

5.17 The structured education and training programmes that provide the next generation of healthcare professionals cannot be completed without undertaking clinical placements with healthcare providers. For medical, dental and healthcare science programmes these clinical placements often involve many years of 'on the job' training whilst in the employ of different healthcare providers. Over half of central funding for education and training goes directly to healthcare providers to support the clinical placements that are an integral part of professional training. The education programmes for healthcare professionals are mostly developed against nationally agreed criteria to meet the national standards set out by the professional regulators and other professional bodies. In many cases a clinical placement with one healthcare provider is only one part of a wider programme of clinical education and training with a range of healthcare providers inputting.

5.18 Providing, managing and quality assuring high quality clinical placements to train new healthcare professionals generally needs to operate at a larger scale than a single healthcare provider. For example, individual employers would struggle to provide the full range of postgraduate medical and dental training experience required. For smaller professions, it is important to recognise that this will require some national coordination. Individual employers will also lack the concentration of expertise needed to provide specialist training for smaller medical specialities and professions.[xiii] We believe that clinical placements for training the next generation of healthcare professionals, including their postgraduate training, are best managed multi-professionally across a network of healthcare providers.

Question 8: Should healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?

Healthcare provider 'skills networks'

5.19 In keeping with the commitment to put healthcare providers in the driving seat, it will be for healthcare providers to decide how they will work together. We do not plan to legislate to create local statutory bodies to undertake education and training responsibilities on behalf of healthcare providers. Healthcare providers will determine how they network to exercise their responsibilities in respect of planning and developing the healthcare workforce.

5.20 Healthcare providers will need to create a legal entity – an organisation permitted to enter into contracts and act on their behalf and under their direction, to carry out the range of functions currently undertaken by SHAs that are necessary to ensure effective planning and development of the local workforce.

5.21 The functions undertaken by a healthcare provider skills network might include:

- Managing and coordinating workforce data and workforce plans for the local health economy that respond to GP consortia strategic commissioning plans
- Developing on behalf of healthcare providers a local skills and development strategy
- Consultation with patients, local communities, staff and service commissioners to ensure that their views are reflected in the local skills and development strategy
- Improving the quality of local workforce data, and providing the Centre for Workforce Intelligence with that data
- Holding and allocating funding for the provision of education and training and accountability for education and training funding from the national education and training levy
- Contracting for the provision of education and training with education providers and healthcare providers
- Responsibility for ensuring value for money throughout the commissioning of education and training
- Taking a multi-professional approach to managing the provision of clinical placements and post-registration and postgraduate education and training programmes and continuing professional development, including the current deanery functions described in **Annex B**, against quality and cost metrics

- Partnership working with Universities and other education providers

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

- Ensuring continuous quality improvement and assurance of educator standards (in particular relating to postgraduate education)

- Contributing, as appropriate, to the development of national policies and issues

Question 9: Are there other or different functions that healthcare providers working together would need to provide?
Question 10: Should all healthcare providers be expected to work within a local networking arrangement?

Setting up local 'skills networks'

5.22 The size and governance structure of local networking arrangements would be determined locally in response to local need. In order to manage transition effectively there may be some general criteria for setting up 'skills networks' that it would be helpful to describe. For example:

- The skills network would need to create a legal entity able to undertake identified functions that would be owned and funded by all providers of NHS-funded healthcare within an agreed locality.

- The skills network would need to include GPs in their role as providers of healthcare and have appropriate governance.

- The skills network would include all NHS-funded healthcare providers within the agreed locality, with proportionate arrangements for very small providers.

- The skills network should include educational expertise familiar with the demands of health and social education and education provider capacity.

- The agreed locality may be regional or sub-regional. The arrangements would need to be big enough to manage post-graduate education programmes and the current deanery functions. Smaller 'skills networks' could achieve this by working collaboratively together to provide scale and diversity.

- There would be Local Authority representation from social care and public health commissioners and providers in the locality and other health-related services including community dental and pharmacy services.

- There would be mechanisms for ensuring that the whole workforce is considered and for ensuring effective clinical engagement. There would need to be specific arrangements for planning and developing small staff group skills and professions alongside arrangements that are big enough to manage both pre- and postgraduate education programmes, for example in healthcare science programmes.

- The governance structure should provide robust accountability, finance and audit arrangements to member healthcare providers. Contracts for the provision of education and training by healthcare providers should be let with transparent rules and published output metrics to ensure contestability and value for money.

5.23 We will work with the SHAs, NHS Employers and healthcare providers to understand whether describing an outline for a healthcare provider 'skills network' to inform their establishment would help towards a smooth transition. Further work is also needed with SHAs and healthcare providers to look at areas where it may be cost-effective for 'skills networks' to work together, for example in providing support for the commissioning of education.

The relationship between healthcare provider 'skills networks' and education providers

5.24 Healthcare provider 'skills networks' will need to manage effective and mutually beneficial partnerships with universities, colleges and other education providers. These relationships need to aspire to and achieve excellence in the quality of education and training. Effective commissioning of health education should provide competitive incentives for education providers to be responsive to healthcare service needs, provide high quality education and value for money. At the same time, healthcare provider skills networks will want to build mature relationships, which leverage the skills of the education sector. Roles and responsibilities for commissioning and delivery of education and training will need to be clearly defined to reduce duplication and bureaucracy, and to minimise transaction costs.

5.25 Local networking arrangements would be able to build on the partnerships already established through Academic Health Science Centres and Health Innovation and Education Clusters. These offer a vehicle to bring together partners in education, healthcare and research to contribute to the rapid transfer of innovation and new technologies into practice.

5.26 The healthcare provider skills networks will have an opportunity when they take on the current deanery functions to adopt a stronger multi-professional approach to postgraduate education and training. They will be able to strengthen links with the education providers and those providing clinical placements to support this.

The healthcare provider framework for autonomy and accountability

5.27 We set out above three duties on healthcare providers to underpin a new framework where healthcare providers have much greater autonomy and are accountable for planning and developing the workforce.

5.28 What are these duties intended to achieve?

- coherent workforce plans which provide a sound and robust basis to develop local and national education and training plans;
- assurance that sufficient investment is made locally and nationally to maintain functional local and national healthcare labour markets;
- assurance that healthcare providers are not making decisions on workforce planning and education training in isolation;
- robust workforce planning leading to the commissioning and provision of education and training that is fit for purpose and meets the needs of patients;
- and ultimately, better quality of care and value for money.

5.29 Achieving these objectives will reduce potential in the system for market failure caused by shortages of healthcare professionals and specialist skills and improve the capability of the system to respond flexibly and quickly to the needs of patients and service innovation.

5.30 This consultation enables this position to be tested. NHS healthcare providers already have duties to cooperate in the provision of education and training. The Health Bill will introduce new general powers in respect of consultation and the provision of information and data. We will review the extent to which these powers are sufficient in relation to workforce planning, education and training and how to extend them, if necessary, to other healthcare providers.

5.31 New funding mechanisms will be needed to support this transfer of responsibilities and obligations to healthcare providers. Establishing a clear link between the funding invested in education and training with the decisions of healthcare providers affecting supply will provide the incentive to get better alignment between the investment in education and training and securing a stable supply. Proposals for moving towards a levy that aligns employer-derived funding with decisions about supply are set out in Chapter 8.

Question 11: Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?
Question 12: Are there other incentives and ways in which we could ensure that there is an appropriate degree of cooperation, coherence and consultation in the system?

6. Sector-wide oversight and support in developing the future workforce

6.1 The previous chapter emphasises greater autonomy and accountability for healthcare providers in the new system. However in delivering the objectives for the system and in managing risks, we also recognise the need for sector-wide oversight of key aspects of workforce planning, education and training.

6.2 This chapter therefore covers proposals for:

- a national executive body to provide sector-wide leadership and oversight of workforce planning, education and training, including effective accountability and scrutiny for public expenditure;
- strengthening the evidence base for workforce planning;
- ensuring that the NHS Commissioning Board is able to provide oversight in checking the fit between its strategic commissioning intentions and the national picture for investment in professional education and training;
- the remit of professional and system regulators in this area;
- the role of Sector Skills Councils and the professions;
- leadership development.

An autonomous Health Education England Board

6.3 To support healthcare providers in their workforce planning, education and training activity locally, we will create a statutory Health Education England (HEE) Board. This will be a lean and expert organisation, free from day-to-day political interference. HEE will provide leadership for effective workforce planning and the provision of high quality education and training that supports innovation, value for money, better skills development and security of supply. It will focus on workforce issues that need to be managed nationally and cannot be delivered by local provider skills networks. It will bring together the interests of healthcare providers, the professions, patients and staff. It will involve patients in the way it does business. It will promote equality in line with the Equality Act 2010 and the public sector Equality Duty requirements that come into force in April 2011.

6.4 In the same way that the NHS Commissioning Board will have responsibility for the national functions required for commissioning of services, HEE will only undertake education and training functions that need to be addressed at national level. HEE will have national oversight of education and training, whilst leaving healthcare providers with a high level of autonomy. It will have governance arrangements to ensure a balance of interests across the whole of the healthcare sector. It will take account of

the interests of social care providers, particularly where these are shared with healthcare providers. It will work with the Department of Health to address the planning and development of the public health workforce.

6.5 HEE will be a new organisation with new executive powers which reflect the principles of the White Paper. It will reflect the interests of employers and professions and draw on educational skills. It will bring together the voices of patients, staff, employers and professionals on planning and developing the whole healthcare workforce. It will take on the advisory role of Medical Education England (MEE) and the professional advisory boards for education and training, and will want to build on the work of MEE in nurturing strong clinical leadership. It will need to combine profession-specific insights and interests with an overarching, multi-professional approach. It will also focus on representing the needs of employers in developing their workforce multi-professionally.

The role of the Health Education England Board

6.6 HEE will have four main functions:

1. **Providing national leadership on planning and developing the healthcare workforce**

    - Bringing together the interests of healthcare providers, staff, patients and the professions
    - Providing a coherent professional voice and promoting strong clinical leadership nationally and locally relating to education and training, and the planning and development of the professional workforce
    - Providing sector-wide oversight for planning and commissioning education and training for the next generation of healthcare professionals
    - Securing effective commissioning of education and training, particularly for smaller professions and specialist skills
    - Liaising with equivalent bodies in the devolved administrations to assure a UK-wide approach where this is relevant

2. **Ensuring the development of healthcare provider skills networks**

    - Supporting an effective and comprehensive system of healthcare provider skills networks that are responsive to the needs of patients and local communities, and possess the necessary educational expertise and interface
    - Holding healthcare provider skills networks to account for effective commissioning and delivery of education and training

- Scrutiny of overall education and training plans of provider skills networks against strategic commissioning intentions of the NHS Commissioning Board, alongside current service needs
- Development of healthcare provider skills networks for small professional groups

3. Promoting high quality education and training that is responsive to the changing needs of patients and local communities

- Championing the greater involvement of patients and local communities in planning and developing a diverse workforce
- Promoting strong clinical leadership nationally and locally and embedding in training programmes
- Setting the framework for continuous quality improvement, assurance of the quality outcomes of education and training, and reviewing curricula to make sure they meet the needs of patients and the public
- Engaging with the professional regulators on the alignment and development of standards and training to meet the changing needs of services
- Engaging with national education bodies including higher education and further education to represent the interests of the healthcare sector and to drive a strategic approach for smaller professions
- Engaging with Monitor and the Care Quality Commission (CQC) on the planning and development of the healthcare workforce

4. Allocating and accounting for NHS education and training resources

- Allocating NHS resources to healthcare provider skills networks for the management and provision of education and training, funded by the national education and training levy, in a transparent and fair manner
- Promoting cost-effective workforce planning and value for money in the provision of education and training, and improving the evidence base on cost-effectiveness
- Taking a strategic overview of all aspects of financial support for the education and training of healthcare professionals, across different funding streams and across all professional groups and stages of training, such that the overall approach to funding and support is informed by provider skills network plans and workforce analysis
- Strategic planning with the Higher Education Funding Council for England on joint investment plans and the needs of the healthcare sector

Question 13: Are these the right functions that should be assigned to the Health Education England Board?

The relationship between local healthcare provider skills networks and Health Education England

6.7 The critical issue in the delivery of a successful education and training system will be to get the right balance of strategic oversight, whilst giving healthcare providers greater freedom for education commissioning. It is time to give employers greater responsibility for planning and developing the healthcare workforce, while giving the healthcare professions greater ownership of education and training quality standards and content. Getting the right blend of local decision-making with clinical leadership will deliver a framework that is:

- Driven by healthcare provider decisions;
- Underpinned by strong clinical leadership; and
- Set within the context of delivering sufficient investment in workforce education and training, whilst ensuring better outcomes for patients and value for money.

6.8 The guiding principle should be that healthcare providers have the right accountabilities and incentives to plan their workforce and invest in education and training. The aggregate picture will need national oversight and decisions on the appropriate overall level of investment. Some issues may also need to be taken forward nationally, such as commissioning education for smaller professional groups, for example for healthcare scientists. There may be occasions when HEE would want to commission more or fewer education and training posts than the aggregate of local plans. This would need to be an evidence-based, fair and transparent process, which carries the confidence of employers and professional bodies. In this framework:

- HEE will be accountable to the Secretary of State for mid- to long-term system viability and ensuring that at a national level there are sufficient future healthcare professionals with the right skills and training to meet future healthcare needs and respond to national strategic commissioning intentions;

- Healthcare providers will be responsible for working together to manage local workforce plans, and local provision of education and training, which respond to strategic commissioning intentions and enable providers now and in future to ensure that in their locality they have access to staff with the rights skills and training to deliver safe and high quality care.

Question 14: How should the accountability framework between healthcare provider skills networks and HEE be developed?
Question 15: How do we ensure the right checks and balances throughout all levels of the system?
Question 16: How should the governance of HEE be established so that it has the

confidence of the public, professions, healthcare providers, commissioners of services and higher education institutions?

Improving workforce information and the evidence base for workforce planning

6.8 The NHS requires a world-class workforce information system. Quality information, combined with the right support, will be key to delivering better care, better outcomes and reduced costs. High quality workforce information will support the effective alignment of service, financial and workforce plans, which should in turn inform appropriate commissioning of education and training.

6.9 Longer-term workforce planning in health requires a significant level of modelling and analytical capability that can translate local plans for the future shape and scale of the workforce into viable education commissioning plans. This requires an understanding of cross-boundary flows and of national and international labour market dynamics. Some healthcare providers may wish to develop such expertise, others will look for external support for such specialist analytical resource.

6.10 The Centre for Workforce Intelligence has been created to develop deep expertise about the health and social care labour market and workforce models, and to undertake horizon scanning so that future risks and opportunities for the health and social care workforce at a local, national and international level are identified. On the health side, they are well positioned to be able to aggregate healthcare provider workforce intentions and to advise the healthcare sector, at a local level and at a national level, on the scale and specificity of education and training that needs to be commissioned to secure sufficient supply of future healthcare professionals. Working in partnership with NHS Employers they will also be in a position to advise healthcare providers on future skills needs and to share the latest thinking about the different workforce models able to support improved services and new care pathways. The Centre will need to work closely with healthcare providers to support them in assessing the requirement for local investment in skills. In order to carry out their role effectively the Centre for Workforce Intelligence will need access to data from healthcare providers about the current and future healthcare workforce.

Question 17: How do we ensure that the Centre for Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?

The role of the NHS Commissioning Board

6.11 The NHS Commissioning Board will be independent, accountable and focused on promoting equality. It will lead on the achievement of health outcomes, allocate and

account for NHS resources, lead on quality improvement and promoting patient involvement and choice.

6.12 The NHS Commissioning Board will have a role in developing, supporting and holding GP consortia to account, including authorisation of consortia; holding consortia to account for delivering improvements in outcomes and against their financial performance; and intervening where there is failure or the risk of failure.

6.13 It will be important for national and local education and training plans to respond to the strategic commissioning intentions set out by the NHS Commissioning Board and GP consortia. At a national level, there will need to be mechanisms that allow the NHS Commissioning Board to have strategic influence on the national picture for education and training. To achieve this, one option would be for the NHS Commissioning Board to be represented on the board of HEE. HEE might also have a requirement to publish an assessment of how workforce planning and the investment in education and training is responding to the outcomes being sought by the NHS Commissioning Board.

Question 18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?

The role of Professional and System Regulators

6.14 There is a need for robust processes so that if education and training does not meet designated standards, then action is taken. Instances of such failure might include providers who are not cooperating on workforce planning and education and training – for example, in taking action to address local skills shortages – or not ensuring the suitability of staff who are providing care. The regulators have important roles to play in ensuring effective accountability.

Healthcare Professional Regulators

6.15 Healthcare Professional Regulators set standards of professional practice and standards of education and training for professionals. Their purpose is to protect patients and the public by ensuring the healthcare professionals are properly trained and observe appropriate standards of professional competence, conduct and ethics. Their statutory functions include:

- establishing minimum standards for admission to the register and use of a protected professional title, for example, registered nurse;
- approving and quality-assuring the provision of education and training to ensure it meets these standards;

- establishing and maintaining a register of professionals able to practice and use a professional title;
- setting standards of professional competence, conduct and ethics;
- operating systems to take appropriate action where a professional fails to observe or maintain the standards.

6.16 HEE will engage with the professional regulators on developing and aligning professional standards and standards of education and training to meet the changing needs of services, patients and local communities.

Care Quality Commission

6.17 The White Paper proposed that CQC's remit as the quality inspectorate across health and social care for both publicly and privately funded care should be strengthened. It will also include Healthwatch England, a powerful new consumer champion promoting the voice of patients and the public.

6.18 CQC's central function is to ensure that care providers are meeting the essential standards of quality and safety set out in regulations and CQC guidance. These include key requirements on the suitability of staffing, which set out what providers should do to make sure that they have the right staff with the right skills, qualifications, experience and knowledge. The standards cover the training needs for staff and how they should be supported to carry out their role, and ensuring that trainees and students are only given tasks and provide care appropriate to their stage of training and competence.

6.19 We would expect CQC to identify and take appropriate and proportionate regulatory action with individual providers if these standards are not being met, and to highlight any systemic issues. Local provider skills networks, HEE and professional regulators will want to make use of information provided by CQC's actions.

Monitor

6.20 Monitor will be developed into the economic regulator for all of healthcare in England. The Department of Health, working with the Department for Communities and Local Government, will also consider the proposed role for Monitor in overseeing the market in adult social care, and ensure that such a role does not duplicate existing functions. Its principal duty will be to protect the interests of patients and the public by promoting competition where appropriate, and through regulation where necessary. It is proposed that Monitor will have regard to the following objectives:

- maintaining the safety of patients and individuals accessing services
- securing ongoing improvements in quality care

- providing equitable access to essential health and adult social care services
- supporting commissioners in maintaining continuity of essential services
- securing ongoing improvements in efficiency of services
- promoting appropriate investment and innovation
- making best use of limited public resources

6.21 If providers do not meet the duties set out in Chapter 5, for example in not cooperating on the provision of education and training, then this may raise competition issues. We will therefore discuss further with Monitor and others whether the enforcement powers for these duties should rest with Monitor. In pursuing their objectives Monitor will also have an interest in ensuring a level playing field in the investment and deployment of education and training funding.

Question 19: Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and cooperation in planning the workforce and in the planning and provision of professional education and training?

The role of Skills for Health and Skills for Care

6.22 Skills for Health is the sector skills council (SSC) for healthcare in the UK. The Government has made clear in the recent skills strategy[xiv] published by the Department for Business, Innovation and Skills (BIS), that for SSCs 'implementing innovative solutions to improve the commitment of employers to skills… will be their core role in future'.

6.23 In recent years, Skills for Health has received a small level of core funding from BIS for its sector skills council remit, together with funding from the Department of Health for programmes and projects to support the development of workforce skills.

6.24 In line with the intention to give providers greater autonomy and accountability for planning and developing the workforce, and the progressively reducing role for the Department of Health in overseeing education and training, the Government intends to reduce significantly the level of central funding for Skills for Health, and support moves to a business model where employers decide on their need to invest in the specialist advice and support that Skills for Health can provide.

6.25 The Department has reviewed the future role of Skills for Health and considers the best fit for Skills for Health in the new framework is a focus on the wider healthcare team and supporting smaller providers to improve the skills of their staff. There is synergy in this with the role of Skills for Care as the partner for adult social care in England of the SSC, Skills for Care and Development, and a joint focus on the skills pool that both health and social care providers draw from and development of more

integrated services in the future. The Government supports a closer working partnership between Skills for Health and Skills for Care and will consider in discussion with the organisations and with health and social care employers the scope for further simplifying the system and reducing costs.

Question 20: What support should Skills for Health offer healthcare providers during transition?

Question 21: What is the role for a sector skills council in the new framework?

The role of the Professions

6.26 The new framework for education and training reaffirms the central role of professionals in future arrangements. At a national level and through representation on HEE, the professions will have a pivotal role in promoting excellence and innovation in the development and delivery of education and training. At local level, professionals should take clinical ownership of education programmes and training practices to ensure they meet the needs of patients and the public, are adaptable to the changing needs of the service and are flexible for the needs of trainees and students.

6.27 Each of the independent professional regulatory bodies has a role for setting standards of education and training and quality assurance processes, and for ensuring that these are met. Professions and professionals are involved in different ways dependent on the regulatory body. Whilst some regulators, such as the GMC and NMC, focus on one or two professions others, such as the HPC, work across a number of professions.

6.28 The medical Royal Colleges have an important role to play in devising and delivering education in their specialties. They contribute individually and collectively through the Academy of Medical Royal Colleges to selection and recruitment, assessment and the development of curricula and educational policy development. They contribute to quality management within the General Medical Council quality assurance framework and can bring innovation and improvement to education and training. The new framework provides an opportunity for the Academy to provide clinical and professional leadership in working across specialty and professional boundaries and in embracing new ways of working for both consultants and medical trainees.

6.29 Other healthcare professions have a variety of professional bodies, Royal Colleges and societies that provide varying degrees of input and involvement in professional education and training, selection and recruitment and policy development. The new framework similarly provides these organisations with opportunities to work in new ways and collaboratively support innovation and improvement in education and training and working across traditional professional boundaries.

6.30 The Medical Schools Council, Council of Deans of Health, the Academy of Medical Educators, the Dental Schools Council, Council of University Heads of Pharmacy Schools and other strategic higher education fora, for example in healthcare science, also possess considerable expertise in the education and assessment of healthcare professional students and trainers. They provide advice and examples of best practice for academic partners and the professions. They too are a source of quality enhancement and educational innovation.

Question 22: How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?

Leadership Development

6.31 A consultation into the future design of the education and training system for undergraduate and postgraduate professionals in healthcare would not be complete without consideration of how leadership and management development will be commissioned. The White Paper *Equity and Excellence: Liberating the NHS* makes it clear that clinicians will be in the driving seat and this must be reflected in the education and training system so that current and future clinicians are equipped to be professionals, partners *and* leaders.

6.32 The National Leadership Council has led the drive over recent months to partner with professional bodies and higher education to ensure that leadership development in health is incorporated into undergraduate and postgraduate curricula. There has also been investment provided to broaden the experience of a whole new cadre of clinical leaders through the clinical fellowship programme. There is much still left to do, however, and it is proposed that HEE be accountable for the framework of leadership development across all leaders in healthcare, including those with clinical training and those without. HEE would thereby contribute to developing leadership capabilities that foster trust across clinicians and managers who have too often been developed within silos.

Question 23: In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?
Question 24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?
Question 25: What are the key opportunities for developing clinicians, managers and other professionals in an integrated way both across health and social care and across undergraduate and postgraduate programmes?

7. The Public Health Workforce

7.1 In 2011, we will develop and consult on a workforce strategy for public health, working with a wide range of employers and professional bodies covering those key workforces that will form part of the new Public Health England and those with whom it will have close associations. The strategy will ensure continuity of education and training provision and capacity within the arrangements to be established for the training and education of NHS professional staff. This will continue to be the foundation for many public health professionals and practitioners whether working in the NHS, Local Authorities or elsewhere.

Public Health England

7.2 Public Health England will need to work in close partnership with the healthcare providers and Local Authorities on the arrangements for planning and developing the public healthcare workforce and to avoid duplication of effort.

7.3 It will have the national leadership and policy role for several key public health workforces, for example public health specialists, the specialist healthcare science workforce and the training and education of doctors in public health and health visitors.

7.4 Through the ring-fenced grant relationship with Local Authorities and Directors of public health, for the local delivery of public health, it will have a close interest in those workforces directly employed by them but whose training and education mainly still lies with healthcare providers.

7.5 As a provider and employer in its own right, of health protection services, it will have a close interest in the training and development of key roles, for example Health Scientists (such as microbiologists) and Health Protection nurses, whose training and education lies in the NHS.

7.6 As a commissioner of public health services from NHS providers, whether directly or through Local Authorities, it has a continued interest in the standards and quality of training and education of specialist staff delivering those services and in curriculum development.

7.7 Public health is everyone’s business and preventative medicine/care will remain a key area of work for all NHS staff. With general responsibilities around health improvement and prevention of ill health, Public Health England will continue to have expertise in and a specific interest regarding the development of this area of healthcare training.

7.8 The Centre for Workforce Intelligence will support Public Health England and its partners, providing workforce data about their current workforce and future workforce needs.

7.9 The alignment with HEE will need to recognise the number of different roles that Public Health England has. Public Health England could be integrated with and form a part of the proposed HEE Board and fully participate in the processes that it will be responsible for, e.g. education and training tariffs and the application of MPET. Public Health England could be represented on the HEE Board and be involved in the commissioning of small specialist groups.

Question 26: How should Public Health England, and its partners in public health delivery, be integrated within the new framework for planning and developing the healthcare workforce?

7.10 Local Authorities could be part of the healthcare provider skills networks, perhaps as a discrete network, or connected with providers of the services they commission. Inclusion of Local Authorities would ensure that networks were reflective of the changing skills mix needed in the workforce to deliver care in multi-professional and multi-disciplinary settings across the NHS and public health service. There are a number of options for funding this, e.g. a levy, as for NHS providers, or via central funding.

7.11 The duty to cooperate proposed for healthcare providers might also need to apply in order to ensure that public health workforce numbers and needs are taken into account and appropriate placements are made available. This would also enable Local Authorities to represent their needs as commissioners of public health services from healthcare providers. Alternatively, HEE and Public Health England could enter into a national partnership arrangement with Local Authority associations such as the Local Government Association.

Question 27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities; and what funding mechanisms should be employed with regard to the public health workforce?

8. Funding and incentives to support equity and excellence

8.1 There is significant public investment in England in educating and training new public health and healthcare professionals in order to secure the skills needed to provide health and healthcare services. In 2010/11, the central investment in education and training was £4.8bn. There needs to be appropriate funding mechanisms which provide incentives and allow responsibility for education and training decisions to be in the right place, to be transparent, and to drive quality and value for money. This chapter therefore:

- emphasises the importance of appropriate investment in the education and training of the workforce;
- sets out proposals for the separate and transparent allocation of resources for professional education and training so that funding follows the student or trainee, is fair, responsive and supports a level playing field;
- sets out broad proposals for ensuring all providers contribute to the costs of education and training;
- supports the further development of quality metrics for education and training to better inform the students or trainees and the commissioners of education and training.

Investing in the Workforce

8.2 Relying solely on market levers to secure sufficient planning and investment in essential healthcare skills is an unacceptable risk for healthcare provision in this country. It would also be unfair if only some healthcare providers bore the costs of providing skills to the local labour market. Over time we intend to move to a levy on healthcare providers to provide the investment needed to train the next generation of healthcare professionals. This will provide a level playing field for healthcare providers and ensure that everyone invests in the totality of education and training required to train future healthcare professionals.

8.3 Training the next generation of healthcare professionals is only one aspect of developing the workforce. Healthcare providers also need to invest more widely in the skills of the whole workforce and to continue to invest in new and specialist skills for the healthcare professionals they employ. This local investment by all local individual healthcare providers is equally important if health services are to have the full range of skills they need. It would not be appropriate to apply a national levy to fund the local investment that is needed to train and develop the existing healthcare workforce.

Ensuring a strategic approach to funding

8.4 The current approach to funding the development of the future healthcare workforce has grown up piecemeal over time. There are different accountabilities for deciding on the appropriate level of investment, different funding streams, different ways of supporting the costs of training and different approaches to quality assurance for different professional groups at different stages of their education and training. It is important that in the new approach, the funding system is fair, transparent and more responsive to local decisions by provider skills networks on their priorities in developing their multi-professional workforces.

8.5 HEE needs to be able to take a strategic overview of the funding priorities, informed by the plans of healthcare provider skills networks and workforce analysis, and then allocate to different areas as appropriate. As part of this there needs to be an effective strategic relationship with the funding bodies for higher education, building on the work of the Health and Education National Strategic Exchange. Further work will also be needed, as part of this strategic relationship, to ensure that future funding arrangements take account of changes to the wider funding regime for Higher Education following Lord Browne's Review.[xv]

Question 28: What are the key issues that need to be addressed to enable a strategic, provider-led and multi-professional approach to funding education and training, which drives excellence, equity and value for money?

Moving to a fairer and more responsive funding system

8.6 The Multi-Professional Education and Training (MPET) budget funds central investment in the training and development of the healthcare workforce, including the costs of clinical placements for students and trainees, tuition fees and student support. Some MPET funding is also used to support the induction and development of existing staff – such as training on prescribing for non-medical staff and some CPD and training for staff in pay 1-4.

8.7 The current funding arrangements do not always support the principles that education and training investment decisions should be taken in the right place, be transparent and drive quality and value for money. Funding available to providers can be based on historical funding flows rather than the costs of providing education and training, and there is not always clarity around the training that will be funded locally and that which will be funded from the central MPET budget.

8.8 In the future, it is proposed that the MPET budget should be confined to funding education and training for the next generation of clinical staff only, and that healthcare providers should be clearly responsible for funding the development of their existing

workforce. Local skills networks may choose to collaborate on their investment in CPD and development of the existing workforce to maximise the value for money. Some flexibility to support the development of new roles and advanced practice may be required to ensure the right incentives are in place to encourage local investment in innovative solutions to deliver services through different approaches to skill mix.

Question 29: What should be the scope for central investment through the Multi-Professional Education and Training budget?
Question 30: How can we ensure that changes to funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?

8.9 To support the commissioning of high quality education and training it is important that the funding arrangements are transparent and facilitate the movement of training provision to where it is of the best quality and to address any imbalance between workforce supply and service demand.

8.10 In the future, it is proposed that HEE will be responsible for allocating NHS resources to healthcare provider skills networks for the management and provision of education and training funded by the national education and training budget as set out in paragraph 6:6.

Tariffs

8.11 The Government is committed to the principle of tariffs for education and training as the foundation to a transparent funding regime that provides genuine incentives within the health sector and minimises transaction costs.

8.12 The Department of Health has previously negotiated 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. We therefore propose that HEE become responsible for negotiating the national benchmark price.

8.13 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. The Department of Health has been working with partners to develop proposals for a tariff-based approach to clinical education and training funding. Such tariffs would enable a national approach to funding of all undergraduate clinical placements (both medical and non-medical) and postgraduate medical programmes to support a level playing field between providers.

8.14 The variation in current funding arrangements means that the introduction of these tariffs would have a bigger impact on some providers than others. There are other

changes to the funding flows within the sector that will also impact on providers. We therefore recognise that we would need to take time to implement tariffs to avoid the risk of destabilisation of providers and allow time for providers to adjust to these changes in funding before we make further changes that would have a significant impact on the amount of funding provided to support education and training of the future workforce. The Department of Health will work with providers and SHAs during this consultation to build further understanding of the implications of the indicative tariffs that have been developed, and options for managing transition from 2012-13.

Question 31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?

8.15 The cost of providing education and training is not always clear. The proposed tariffs would be based on a detailed costing exercise that was undertaken with a sample of providers. Longer-term, the Department believes the most equitable and efficient basis for setting the education and training tariffs is on the basis of the cost of education and training, net of any service contribution. This should ensure that there is no cross-subsidisation and that funding will follow the student more effectively.

Question 32: If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?
Question 33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?
Question 34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

Moving to a levy to fund education and training

8.16 Clarifying what activity will be funded from a central budget, how the funding will flow, and the appropriate basis for funding will introduce transparency into the funding arrangements. However, we believe that we could go further in introducing transparency by ensuring that those who are chosen to train the future workforce are rewarded in doing so, and those that undertake less training than they receive the benefit from, contribute to the training provided by others.

8.17 Current funding arrangements are based on top-slicing the NHS budget to fund training and development. This is a simple and effective method of funding education and training, however, the contribution and benefits for individual providers are not transparent.

8.18 In the long term, transparency could be achieved by replacing the current MPET budget with a levy on providers. This would also more closely align funding and

incentives with the need to secure supply of skills without chronic shortages or over-supply. This is a significant change and it is sensible to take some time to develop the proposals to ensure that the appropriate legislation is in place, that the administrative arrangements are appropriate and proportionate and, most importantly, that the provision of education and training and the provision of services are not unnecessarily disrupted by the introduction of the levy. We would expect to take a staged approach to implementation, with a notional levy introduced in advance of a real levy being introduced at a later date. We will undertake further work on proposals for a levy in the light of responses to the consultation.

Question 35: What is the appropriate pace to progress a levy?
Question 36: Which organisations should be covered by the levy? Should it include healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse?
Question 37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?
Question 38: How can we introduce greater transparency in the short to medium term?
Question 39: How can transaction costs of the new system be minimised?

Developing quality metrics for education and training

8.19 To improve the information available on the quality and outcomes of care, the consultation document *Liberating the NHS: An Information Revolution* set out a series of proposals for action. The objective is to drive up quality by giving people better information on which to make decisions about their care. The same approach applies to education and training.

8.20 For education and training, we also want to see much better information on the quality of education and training and the outcomes being achieved. There has already been progress in developing quality indicators for commissioning non-medical education, and work is underway to develop indicators for medical education. The Education Commissioning Assurance Framework already piloted and tested by SHAs will be made available as a tool to support education commissioning by both national and local education commissioners in the new system architecture.

Question 40: What are the key quality metrics for education and training?

9. Transitional arrangements

9.1 Changing the system for planning and developing the whole healthcare workforce will take time. The current system is complex and is led by the SHAs. Putting in place new systems and processes by 2012 to take on their functions will be challenging. Some aspects of the new framework will take longer to achieve in full. Managing the transition will need careful thought and planning – and will be informed by the responses to this consultation. Providing stability and continuity for education programmes and service delivery will be important so that patients have confidence that services and skilled professionals will be available when and where they are needed and training programmes are not disrupted.

9.2 The approach to transition and implementation will depend on Parliamentary approval of the Health Bill and the responses to this consultation. In that context, this chapter sets out:

- the central role for SHAs in leading the transition to the new system up to April 2012;
- potential initial steps in establishing HEE and local provider skills networks;
- arrangements for funding education and training in transition;
- the approach to workforce planning information.

9.3 SHAs will lead the transition to the new system across their region and continue planning with healthcare providers and education providers to build up local processes and infrastructure to support a smooth migration of their functions to healthcare providers. SHAs will hold and allocate the MPET budget for 2011/12. They will continue to lead on workforce planning and the commissioning of education and training. SHAs will work with local health and social care economies to develop coherent plans for the new local framework, building where possible on existing arrangements. They will agree with their healthcare providers the leadership and accountability arrangements through the transition period and ensure that training programmes are not disrupted to the detriment of existing trainee students.

9.4 David Nicholson's letter of 10th September 2010 set out the Government's commitment to support current employees of SHAs and Primary Care Trusts through the change, to treat them well and, where it is the right thing to do, support them in moving into new roles, minimising the cost and complexity and ensuring we retain essential talent and capability through the transition. Healthcare providers setting up networking arrangements that will take on functions from SHAs will need to consider

the knowledge and expertise that staff currently managing those functions can offer. Those creating new organisations in the change process will need to be provided with developmental support to enable them to undertake their future roles, recognising the value of their skills and experience.

9.5 At a time of major change in the NHS, it is essential that fairness lies at the heart of decision-making. NHS organisations should ensure that all decisions are taken with due regard to public sector equality duties and are fair, transparent, accountable, evidence-based and consider the needs and rights of the workforce.

Establishing HEE and managing the transition

9.6 Subject to the responses to this consultation and Parliamentary approval, the Health Education England Board will be established in shadow form in 2011 and as a special health authority to go live in April 2012. It will develop its future business model, organisational structure and staffing in 2011, drawing from the lessons in establishing MEE and the other professional advisory boards. The longer-term form for the HEE will be revisited after April 2012.

Establishing local healthcare provider skills networks

9.7 Subject to the responses in this consultation and Parliamentary approval, healthcare providers will set up ‘skills networks’ that can legally enter into contracts on their behalf. They will be created, owned and funded by healthcare providers, with appropriate professional input, including GPs. They will have representation from social care and public health. Their governance and structure will be determined by healthcare providers. Models that are developed will be shared with SHAs and healthcare providers to assist their thinking about appropriate local models for their networks.

Funding in transition

9.8 Throughout the transition period, we will need to ensure that funding flows are robust and accountabilities clear. It is essential that the existing population of students is protected and that education programmes are not disrupted by these proposals.

9.9 If education and training tariffs are introduced, the Department of Health will work with SHAs to manage the implementation. SHAs will be responsible for agreeing transition plans with providers in their areas. These transition plans will determine whether providers will receive transitional funding to help them to implement the tariffs.

9.10 Once HEE is established, it will take responsibility for allocating funding including any transitional funding agreed with providers prior to the establishment of HEE.

9.11 In the short term, the Department of Health will retain responsibility for negotiating the benchmark price for non-medical pre-registration programmes and the tariffs for clinical education and training. Once HEE is established, it will be asked to contribute to this work, to ensure that the tariffs support the commissioning and quality assurance of education and training. This collaborative approach between the Department of Health and HEE will continue until the new costing and tariff arrangements are introduced.

Workforce planning information in transition

9.12 The Centre for Workforce Intelligence will continue to build its skills and expertise to fulfil its role in the new framework. In 2011/12 the Centre will work with SHAs, NHS employers and the professional advisory boards to advise on workforce and education and commissioning plans.

Question 41: What are the challenges of transition?
Question 42: What impact will the proposals have on staff who work in the current system?
Question 43: What support systems might they need?
Question 44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?

10. Equality and Diversity

Equality Impact Assessment

10.1 The NHS, as set out in the NHS Constitution, is about fairness for patients and the NHS workforce. The future of the NHS will depend on its workforce, its people and its diversity. Ensuring we have the right people, in the right places, with the right skills will mean that we are responding positively to the QIPP agenda and developing a leaner service, fit for the future.

10.2 Staff are our biggest asset and they will be the ones who, through their creativity and commitment, drive improvements delivering a personal, fair and diverse service for themselves and for patients. To support this, organisations must create an environment where talent flourishes and where everyone is able to realise their potential.

10.3 One of the purposes of the proposals described in the White Paper is to refocus the NHS on delivering excellence and promoting equality. This acts as a steer for ending discrimination and tackling inequalities in the outcomes of healthcare. By assessing the potential impact on equality of the policies set out in the White Paper and the policies it sets out, we aim to set a baseline against which we can measure progress in reducing inequalities over time, and to identify where most effective action needs to be taken.

10.4 By identifying the potential equality impact, the Department of Health can take steps to modify its policies and functions if necessary aiming to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- promote good relations between groups

10.5 The initial Equality Screening, published with this consultation, suggests the policy may provide opportunities to make a positive impact on equality and to tackle current inequalities. The consultation will help to identify risks and opportunities. The full Equality Impact Assessment process will identify how risks could be mitigated and how opportunities could be maximised, and will inform and shape the development of the policy.

10.6 We want our reforms to advance equality of opportunity for all staff and patients of different ages, ethnic groups, sexual orientation, gender; for transgender people, pregnant women, those who are married or in a civil partnership, people of different religions or belief, and people with different disabilities.

10.7 We want all students whatever their background to have better access to high quality health education and training, and be able to shape the education they, and future students, receive. We want everyone who works in the NHS to reach their full potential and achieve better health outcomes for their patients. Finally, we want patients to influence the education system through expressing their experience and views, so as to improve their experience of health and social care and how it is delivered.

Question 45: Will these proposals meet these aims and enable the development of a more diverse workforce?
Question 46: Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender, gender identity (including transgender people), religions or belief; pregnant women, people who are married or in a civil partnership, or disabled people) will be advantaged or disadvantaged by these proposals or have greater difficulties than others in taking part in them? If so, what should be done to address these difficulties to remove the disadvantage?

11. Summary of Consultation Questions

Consultation Questions – Chapter 2

Q1: Are these the right high-level objectives? If not, why not?

Q2: Are these the right design principles? If not, why not?

Consultation Questions – Chapter 3

Q3: In developing the new system, what are the key strengths of the existing arrangements that we need to build on?

Q4: What are the key opportunities in developing a new approach?

Consultation Questions – Chapter 5

Q5: Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce?

Q6: Should healthcare providers have a duty to provide data about their current workforce?

Q7: Should healthcare providers have a duty to provide data on their future workforce needs?

Q8: Should healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?

Q9: Are there other or different functions that healthcare providers working together would need to provide?

Q10: Should all healthcare providers be expected to work within a local networking arrangement?

Q11: Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?

Q12: Are there other incentives and ways in which we could ensure that there is an appropriate degree of cooperation, coherence and consultation in the system?

Consultation Questions – Chapter 6

Q13: Are these the right functions that should be assigned to the Health Education England Board?

Q14: How should the accountability framework between healthcare provider skills networks and HEE be developed?

Q15: How do we ensure the right checks and balances throughout all levels of the system?

Q16: How should the governance of HEE be established so that it has the confidence of the public, professions, healthcare providers, commissioners of services and higher education institutions?

Q17: How do we ensure that the Centre for Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?

Q18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?

Q19: Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and cooperation in planning the workforce and in the planning and provision of professional education and training?

Q20: What support should Skills for Health offer healthcare providers during transition?

Q21: What is the role for a sector skills council in the new framework?

Q22: How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?

Q23: In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?

Q24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?

Q25: What are the key opportunities for developing clinicians and managers in an integrated way both across health and social care and across undergraduate and postgraduate programmes?

Consultation Questions – Chapter 7

Q26: How should Public Health England, and its partners in public health delivery, be integrated within the new framework for planning and developing the healthcare workforce?

Q27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities; and what funding mechanisms should be employed with regard to the public health workforce?

Consultation Questions – Chapter 8

Q28: What are the key issues that need to be addressed to enable a strategic, provider-led and multi-professional approach to funding education and training, which drives excellence, equity and value for money?

Q29: What should be the scope for central investment through the Multi-Professional Education and Training budget?

Q30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?

Q31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?

Q32: If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?

Q33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?

Q34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

Q35: What is the appropriate pace to progress a levy?

Q36: Which organisations should be covered by the levy? Should it include healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse?

Q37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?

Q38: How can we introduce greater transparency in the short to medium term?

Q39: How can transaction costs of the new system be minimised?

Q40: What are the key quality metrics for education and training?

Consultation Questions – Chapter 9

Q41: What are the challenges of transition?

Q42: What impact will the proposals have on staff who work in the current system?

Q43: What support systems might they need?

Q44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?

Consultation Questions – Chapter 10

Q45: Will these proposals meet these aims and enable the development of a more diverse workforce?

Q46: Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender, gender identity (including transgender people), religions or belief; pregnant women, people who are married or in a civil partnership, or disabled people) will be advantaged or disadvantaged by these proposals or have greater difficulties than others in taking part in them? If so, what should be done to address these difficulties to remove the disadvantage?

Please respond online:
www.consultations.dh.gov.uk/workforce/education-and-training

Alternatively please send your responses via e-mail to:
educationandtrainingconsultation@dh.gsi.gov.uk

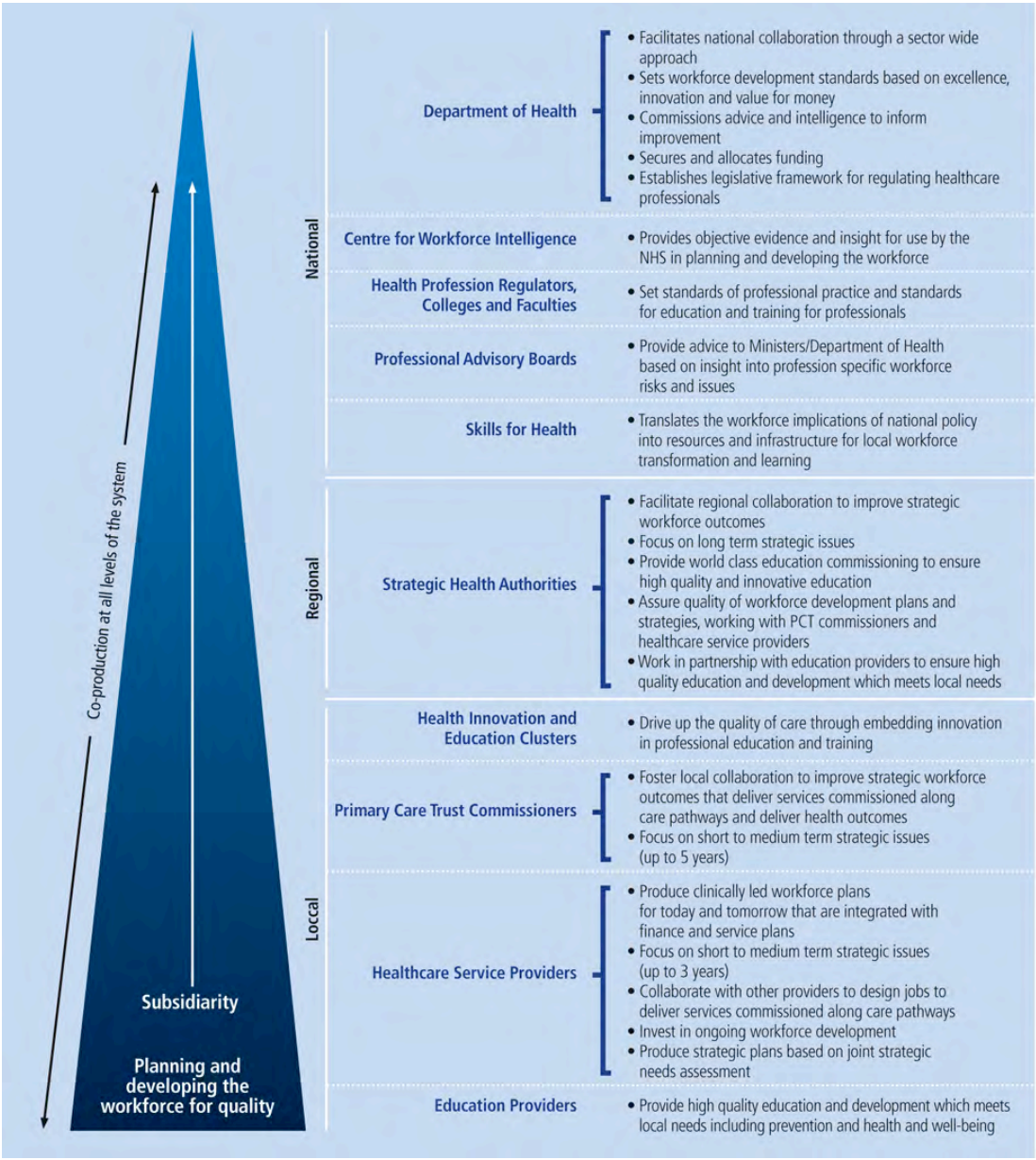
or via post to:
Consultation Responses
Workforce Education Policy Team
Department of Health
Room 2N12, Quarry House
Quarry Hill
Leeds
LS2 7UE

Comments should be received by **31st March 2011**.

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Department of Health consultations website at:

www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex A. Current system for planning and developing the NHS workforce



Annex B. Key stakeholders and organisations

Academic Health Science Centres	Academic Health Science Centres are partnerships whose core mission is to bring together world-class research, teaching and patient care in order to speed up the process of translating developments in research into benefits for patients, both in the NHS and across the world.
Association of Directors of Adult Social Services (ADASS)	ADASS represents all the directors of adult social services in England. It informs and briefs government ministers and civil servants about the impact of their policies and works with them on policy initiatives wherever appropriate, while engaging with opinion formers across the whole spectrum of current media outlets.
Care Quality Commission (CQC)	CQC is the independent regulator of health and adult social care services in England. It also protects people detained under the Mental Health Act. www.cqc.org.uk
Centre for Workforce Intelligence (CfWI)	The CfWI provides objective analysis and evidence for the planning and development of the workforce at both national and local levels. www.cfwi.org.uk
Council for Healthcare Regulatory Excellence (CHRE)	CHRE scrutinises and oversees the work of the healthcare regulatory bodies and sets standards for training and conduct of health professionals. www.chre.org.uk
Department of Business, Innovation and Skills (BIS)	The Department of Business, Innovation and Skills works to build a dynamic and competitive UK market through promoting business, innovation and enterprise and creating a highly skilled workforce. It promotes high quality universities and a free and open market. www.bis.gov.uk

Education Commissioning for Quality (ECQ)	ECQ is an enhanced, comprehensive education commissioning system for non-medical and medical staff to supports world-class education commissioning.
GP Consortia	Consortia of GP practices will work with other health and care professionals, in partnership with local communities and local authorities to commission local healthcare services.
Health and Education National Strategic Exchange (HENSE)	HENSE is where senior leaders in health and education including the Department of Health, Department of Business, Innovation and Skills (BIS), NHS Employers and HEFCE meet together.
Health Education England (HEE)	HEE will provide national leadership on planning and development of the healthcare workforce. It will act as a forum for the interests of healthcare providers, staff, professionals and patients. It will commission education and training in areas which can only be addressed at the national level such as smaller professions and specialist skills.
Health Innovation and Education Clusters (HIECs)	Formal partnerships between the NHS and the higher education sector, industry and other private and public sector organisations. They are responsible for driving up the quality of education and training and promoting innovation in healthcare.
Healthcare Professional Regulators	Healthcare Professional Regulators' purpose is to protect the public by keeping a register of health professionals who meet standards for their training, professional skills, behaviour and health: • General Chiropractic Council (GCC) www.gcc-uk.org • General Dental Council (GDC) www.gdc-uk.org • General Medical Council (GMC) www.gmc-uk.org • General Optical Council (GOC) www.optical.org • General Osteopathic Council (GOsC) www.osteopathy.org.uk • Health Professions Council (HPC) www.hpc-uk.org • Nursing and Midwifery Council (NMC) www.nmc-uk.org • General Pharmaceutical Council (GPhC) www.pharmacyregulation.org

Healthcare service providers	They are any organisation that provides healthcare services to the public and patients. The majority but not all are funded by the NHS. They include NHS providers, private and voluntary third sector providers which are wholly or partly funded by the NHS and independently funded private service providers. They are central to planning and developing the healthcare workforce. They are responsible for ensuring their workforce is equipped with the right skills in the long and short term. These decisions will inform education and training commissioning.
Higher Education Council (HEC)	The Browne Report (2010) proposes the creation of HEC to replace the Higher Education Funding Council for England, the Quality Assurance Agency, the Office For Fair Access and the Office of the Independent Adjudicator. HEC would be responsible for investing in priority courses; setting and enforcing baseline quality levels; delivering improvements on the access and completion rates of students from disadvantaged backgrounds; ensuring that students get the benefits of more competition in the sector; and resolving disputes between students and institutions.
Higher Education Institutions	Higher Education Institutions will work with education providers to tailor education and training programmes to ensure students have the appropriate competences required to receive academic awards and meet the requirements of their healthcare roles.
Local Government Group (LGG)	The LGG is made up of six organisations who work together to support, promote and improve local government: • **Local Government Association**; • **Local Government Improvement and Development;** • **Local Government Employers;** • **Local Government Regulation;** • **Local Government Leadership;** • **Local Partnerships.**
Local healthcare provider skills networks	These local ‘skills networks’ will be legal entities, created, owned and funded by the healthcare providers. They will be accountable for allocating training and funding received from the national body. They will coordinate workforce data

	and workforce plans for the local health economy in response to GP consortia strategic commissioning plans.
Medical Royal Colleges	Medical Royal Colleges develop curricula for postgraduate medical training and set assessments and examinations in line with the standards of the regulator to ensure fitness to practise. The Academy of Medical Royal Colleges brings together the medical Royal Colleges.
Monitor	Monitor is the independent economic regulator of healthcare. It will promote effective and efficient providers of healthcare, promote competition, regulate prices and safeguard continuity of services. www.monitor-nhsft.gov.uk
National Quality Board (NQB)	The NQB is a multi-stakeholder board established to strengthen leadership and ensure alignment on quality throughout the NHS. Its key aims are to deliver high quality care for patients through advising on quality improvements and overseeing the development tools and system leavers to support quality improvement. www.dh.gov.uk/ en/Healthcare/NationalQualityBoard/index.htm
NHS Commissioning Board	The NHS Commissioning board is independent and accountable focused on promoting equality. It will lead on the achievement of health outcomes, allocate and account for NHS resources, lead on quality improvement and promoting patient involvement and choice.
NHS Employers (NHSE)	NHS Employers represents trusts in England on workforce issues and ensures the NHS is a positive place to work, deals with pay and negotiations employment policy and practice recruitment. It represents the employers' perspective in policy discussions and supports workforce planning through advice and information. www.nhsemployers.org
Postgraduate medical and dental deaneries	The postgraduate medical and dental deaneries within the SHAs provide essential functions in devising and delivering training programmes to meet the needs of the service and trainees. They are responsible to the GMC and GDC for

	quality management of placements and programmes, ensuring proper supervision and assessments. Their functions will be taken on by healthcare provider skills networks with a much stronger multi-professional approach.
Professional Advisory Boards	The professional advisory boards provide a professional voice and strategic clinical input to the Department of Health on workforce development planning and education and training. The boards include: • Medical Education England: a multi-professional board covering medicine, dentistry, pharmacy and healthcare science. • Nursing and Midwifery Advisory Board • Allied Health Professions Advisory Board
Social Partnership Forum	The Social Partnership Forum brings together NHS Employers, trades unions and the Department of Health to discuss, debate and involve partners in the development and implementation of the workforce implications of policy. www.socialpartnershipforum.org
Skills for Care	Skills for Care, the SSC for social care, will work closely with Skills for Health. It is responsible for the strategic development of the adult social care workforce in England. It aims to support employers to improve standards of care provision through training and development, workforce development planning and workforce intelligence. www.skillsforcare.org.uk
Skills for Health	Skills for Health is the Sector Skills Council (SSC) for health care and is responsible for identifying and addressing skills gaps and shortages, developing and managing national workforce competencies and improving workforce skills. www.skillsforhealth.org.uk

Annex C. The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:
www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator Department of Health
3E48, Quarry House
Quarry Hill
Leeds
LS2 7UE

E-mail consultations.co-ordinator@dh.gsi.gov.uk **Please do not send consultation responses to this address.**

Confidentiality of information

1 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

2 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

3 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

4 The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at:

www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

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Department of Health (2010) *Equity and Excellence: Liberating the NHS*

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Temple (2010) *Time for Training: A review of the impact of the European Working Time Directive on the quality of training*

Tooke (2008) *Aspiring for Excellence: final report of the independent inquiry into Modernising Medical Careers*

Notes

[i] Engagement with Local Authorities, the future Public Health England and with education providers will all be critical. This consultation should be read in conjunction with *A Vision for Adult Social care: Capable Communities and Active Citizens* and *Healthy Lives, Healthy People: Our strategy for public health in England.*

[ii] House of Commons Health Committee (2007) *Workforce Planning – Fourth Report of Session 2006-7* London: SO.

[iii] Tooke (2008). Aspiring for Excellence: final report of the independent inquiry into Modernising Medical Careers..

[iv] NB: all numbers as of 30 September 2009, rounded to nearest 1,000. Data source: NHS Information Centre Workforce Census 2009.

[v] www.nhscareers.nhs.uk

[vi] The annual Workforce Census does not collect the number of registered pharmacists; it only collects the number working in the NHS so excludes high street and community pharmacists. There are currently 37,000 registered pharmacists in England.

[vii] Including doctors, dentists, nurses, midwives, healthcare scientists, pharmacists, allied health professionals (art therapists, drama therapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, orthotists, orthoptists, prosthetists, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists and paramedics). For a full list of professions visit NHS Careers at: www.nhscareers.nhs.uk

[viii] King's Fund (2009) *NHS Workforce Planning: Limitations and Possibilities*. London: King's Fund. OECD (2008) *The Looming Crisis in the Health Workforce: How can OECD Countries Respond*. Paris: OECD. www.cfwi.org.uk/cfwi-international

[ix] HENSE, AHSC and HIECs (see Annex B).

[x] Evidence from the NMC and GMC register.

[xi] Collins (2010) *Foundation for Excellence: An Evaluation of the Foundation Programme*.
Temple (2010) *Time for Training: A review of the impact of the European Working Time Directive on the quality of training*.

[xii] King's Fund (2009) *NHS Workforce Planning: Limitations and Possibilities*. London: King's Fund.

[xiii] For example, healthcare scientists – prosthetists, orthotists and orthoptists.

[xiv] www.bis.gov.uk/news/topstories/2010/Nov/Skills-for-sustainable-growth

[xv] Browne (2010) *Securing a Sustainable Future for Higher Education: An independent review of higher education funding and finance*.