Developing the Healthcare Workforce – Response from the Medical Schools Council

Executive Summary

1 Medicine is a national resource with educational requirements that must meet national and international standards and which, for all doctors, must be rooted in a deep understanding of science. Funding must be ring fenced and allocated transparently and in sufficient volume to meet the requirements of the numbers commissioned centrally - decisions cannot be left to local Skills Networks. High quality medical education requires national coordination and regulation.

2 Medical Education is a continuum from Medical School to retirement, overseen by the GMC, and so Medical Schools need to be true partners of NHS colleagues in primary and secondary care - designing new systems together - and preparing doctors for the myriad, ever-changing roles required of them – *see* the Consensus Statement on the Role of the Doctor. All Trusts must teach to a high standard as a requirement, otherwise short-term targets could decimate training opportunities at all levels.

3 Skills networks as proposed are too large to be effective – they could be useful advisory bodies providing intelligence on workforce needs, but contracting must be done in a profession-specific way. Employers cannot quality assure the posts that they themselves provide to train the staff whom they also employ. Ring fenced budgets for quality control, quality management and quality enhancement in medicine should sit with the post-graduate deans and the universities, and be accountable to the regulator. The HR function could sit with employers.

4 Post-graduate deans should have Honorary contracts with Medical Schools and should be physically located in Medical Schools to facilitate the continuum of education, improve the transition process from student to employee and engage with evolving scholarship & innovation. The Deanery function must be preserved despite the abolition of the SHAs as must existing contracts to support clinical academics.

5 There is little evidence that the current system for medical training is in need of major reform, although the work undertaken by MEE is of value in improving standards. Nor is there good evidence that a multi-professional approach is required to train medical students optimally. Inter-professional education to enhance team working once students have confidence in the unique requirements of their own profession is the way forward.

6 Clinical academic medicine is of vital importance to UK plc and is threatened by current proposals - higher fees will discourage intercalation; reduced NHS bursaries will limit widening access; the NHS Outcomes Framework requires no commitment to research and education; a focus on local issues will endanger the bigger picture - particularly with regard to smaller specialties; there is a risk of creating chasms between training in the different nations. Without clinical academics innovation, efficiency and productivity will stall.

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The Medical Schools Council is the authoritative voice of all the UK's Medical Schools.

Medical Schools acknowledge their responsibility to develop the clinical leaders for the future. The current leaders welcome this opportunity to transform a good system of medical education into a truly excellent one in which effective academic alliances with service providers will offer consistently high quality centres of excellence. Doctors make significant contributions to the UK's economy, and their education must prepare them for multi-faceted approaches to a wide range of career pathways. It is essential that HEIs be given a strong, and equal voice in the developing partnerships.

Recommendation 2 of the Tooke Report stated:

> *'Policy development should be evidence led where such evidence exists and evidence must be sought where it does not.'*

The Secretary of State for Health accepted this recommendation.

Developing the Healthcare Workforce provides little evidence with regard to the medical workforce that the current system is in need of major change, although of course there is always the opportunity to improve. The UK produces high quality doctors sensitive to patients' needs and it is essential that this internationally highly regarded system is improved rather than destabilised. Security of supply is indeed a national requirement and if a system not dissimilar to the proposed framework is put in place, it will be essential for HEE to ring fence the funds for the clinical training of both pre- and post-registration doctors and to allocate them centrally to the appropriate geographical locations to support the numbers that have been nationally commissioned. In concentrating on short term, local requirements, ill-defined skills networks must not be permitted to disrupt the UK's future supply of specialists nor inadvertently destroy the many examples of good practice. There has been a burgeoning of effective local partnerships between health care providers and academia over the last few years – AHSCs, BRCs and BRUs, HIECs and CLAHRCs – such partnerships have promoted translational research and the implementation of innovations across the academic: NHS interface and have permitted the integration of research with clinical training. The pace of change must allow sufficient time for effective piloting and evaluation.

The consultation also proposes a multi-professional approach to education and training. The disparity in numbers of trainees militates against such an approach. Indeed we do not believe that there is evidence to support the emphasis on a much greater multi-professional approach in designing the new system, especially at the undergraduate level, when students are undertaking the complex education necessary to become professionals in whatever branch of clinical practice they will follow. There appears to be confusion between the undoubted benefits of inter-professional education, which should start at an undergraduate level and increase as clinical teams work together in practice, and a multi-professional approach to education and training for which the apparent benefits in terms of economy have not been clarified. All students need time to understand the unique demands and requirements of their own profession in order for them to contribute effectively to integrated team work for optimal patient care.

The founders of the NHS recognised the centrality of research and education to improved patient care. This must be preserved. Doctors employed by universities to pursue research and to educate the next generation of

healthcare workers, also spend half their time in the NHS caring for patients. They are thus in the ideal position to identify problems, devise effective solutions and bring evidence based innovations to their full time NHS colleagues.

The framework as presented appears to require less than optimal involvement of this valuable resource in the development of the new system. Universities need to be true partners of service providers and, as in other countries, should be closely integrated with the healthcare system. Recent experience has demonstrated that Trust Boards and SHAs have seen education as an easy target when financial cuts are required. The new system must ensure that the education levy on all providers (which we welcome) is sufficient to ensure high quality sustainable outcomes and is ring-fenced for the purpose of education and quality enhancement. (*cf* the success of ring fenced NIHR funding for research). Indeed the provision of high quality education must become an integrated and mandatory function for all providers,

The MSC welcomes the consultation's reference to '*Aspiring to Excellence'*. Unfortunately however the consultation does not fully reflect what that document actually recommended, which was:

> Final Recommendation 5
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> There needs to be a common shared understanding of the roles of all doctors in the contemporary healthcare team that takes due account of public expectations. Given the interdependency of professional constituents of the contemporary multi-professional healthcare team we suggest a similar analysis extends to other healthcare professional groupings. Clarity of the doctor's role must extend to the service contribution of the doctor in training, doctors currently contributing as locums, staff grades and associated specialists, the CCT holder, the GP and the consultant. Such issues need to be urgently considered by key stakeholders. Notwithstanding the need to keep such a key issue under constant review, stakeholders should seek to reach public consensus before the end of 2008, so important is the issue for current NHS reform.
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> Education and training need to support the development of the redefined roles for each professional grouping and provide the necessary educational foundations to enable them to practise safely and effectively and to aspire to enhanced roles.

The medical profession accepted this challenge and through a process of public engagement reached consensus on the role of the doctor (attached).

Our YouGov surveys (July and September 2008) demonstrated that patients wish to consult and be treated by doctors because they know that doctors' profound scientific education offers the best chance of an accurate diagnosis and effective treatment. This must not be forgotten in the design of the new system. The rush to invent new, cheaper, roles could well be counter-productive in the long term and the move away from recent aspirations to achieve a consultant-delivered service, which is implied but not explicitly stated in the consultation, requires much greater analysis at a national level . In stating that providers are '*best placed to commission the education and training that will achieve the right workforce',* the essential role of educational experts and professional colleagues is overlooked. Professions by their very nature encompass a body of knowledge

unreachable to those outside the profession and so managers alone will never be in a position to define education and training required to deliver effective, safe patient care for the duration of a healthcare professional's career.

The scientific basis of medicine and the cost in both time and money of acquiring proficiency were the two main reasons why '*Aspiring to Excellence'* proposed the creation of Medical Education England. The addition of Dentistry, Pharmacy and Healthcare Science to the original proposal was rational given the common scientific basis of the disciplines. The development of Programme Boards by MEE works well and their maintenance is the best way to avoid potential problems with the addition of the other professions. HEE must have a strong, functional Board rather than a representative panel. It must be given power over Skills networks to enforce effective governance arrangements and quality outcomes congruent with national as well as local interests.

Care must also be taken to ensure that devolution to local decision making does not jeopardise the UK-wide approach to the consistency of medical education and training: we believe this is a very significant risk which does not figure in the consultation. MEE has been successful in commissioning reports which build on the work identified in the Tooke Report. We should build on evidence (such as exposed by Collins and Temple) to bring about the changes that are truly necessary. We should strengthen rather than destabilise the system to address the challenges of an ageing population so clearly articulated in *Aspiring to Excellence.*

The impact of these changes plus others such as graduate repayments, the potential loss of clinical excellence awards, and differences across the four nations could have a significant adverse effect on academic medicine and it is essential that all is done to prevent this and to protect the nation from damaging consequences. Strengthening, rather than weakening academic medicine is vital to improve the efficiency and productivity of the NHS and to generate wealth for the UK through innovation and collaborative work with industry.

The consultation is unclear on governance arrangements, especially those that involve HEIs, and is also unclear on how levers will be introduced and managed to permit quality assurance and quality enhancement. One mechanism could be for Medical School involvement in determining allocations of the proposed 5% SIFT retention for quality enhancement.

The consultation makes little mention of educational regulators, in medicine's case, the GMC. Undergraduate medical education is the responsibility of medical schools which must be supported to deliver curricula which meet national and international standards. Curricula cannot be adapted piecemeal to meet local demands. We seek reassurance that the funding will continue to be made available to deliver high quality education in the full range of clinical settings. The rise in tuition fees is likely to have an adverse effect on widening participation. Clarity about the future provision of NHS bursaries is required urgently.

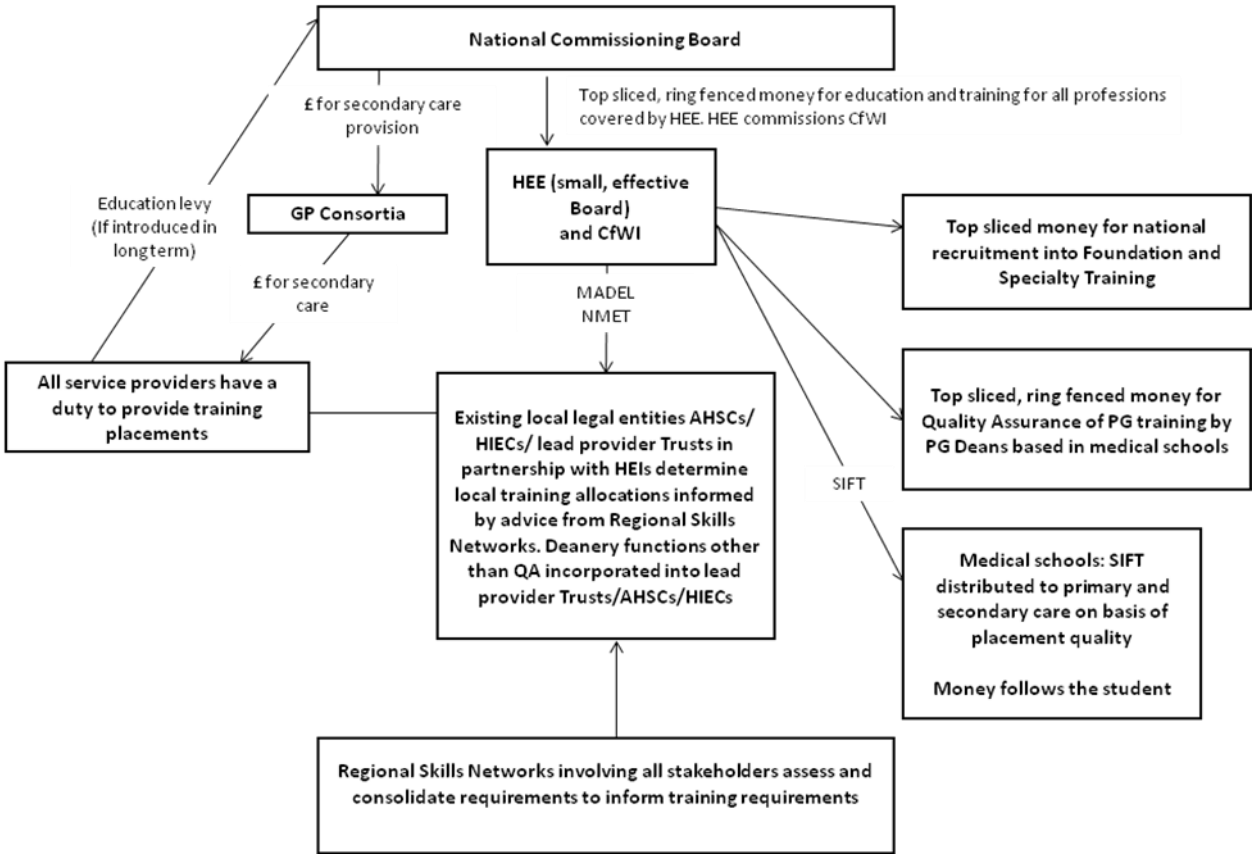
Service providers cannot be both gamekeeper and poacher and the MSC would like to see the quality assurance function for medical education more closely associated with the HEIs in partnership with postgraduate deaneries, and provided with levers to ensure that providers offer truly high quality placements. The fragmentation of undergraduate and post-graduate medical education must be avoided. Medicine must remain scientifically-based and the best way to ensure this is to base post-graduate medical education firmly in the

university medical schools. This would have the advantage of addressing the current conflict of interest wherein healthcare providers supply post-graduate medical education, pay for it and employ the future workforce. Universities are integral to medical workforce development in all other developed countries and the UK risks ignoring this successful model at its peril. Strong partnerships between HEIs and Trusts facilitate the development of evidence-based, innovative curricula. Further work will be necessary to define the appropriate distribution of responsibilities for HR issues between Trusts, who rely on doctors in training for some service provision, and Universities who will be overseeing quality matters with Postgraduate Deans. Post-graduate deans, could, for example, be employed by local lead provider Trusts/AHSCs or HIECs but have honorary contracts with the universities and be physically based in Medical Schools, supported by ring-fenced funds for quality control, management and enhancement. Such a model would address Vice Chancellors' concerns around clinical liability and litigious trainees and should be explored. MSC strongly recommends making use of existing legal entities rather than creating new ones from scratch.

Transparency of funding for education must be brought about. The salary element of postgraduate doctors in training should be separated from the costs of providing, administering and quality assuring that education and training. Labelling the current MPET budget as predominantly training is mis-leading as it appears that an unfair proportion of training funds are allocated to PG medical trainees – when in fact they deliver a great deal of service (for which their salaries need to be paid) whilst also acquiring ever-increasing specialty expertise. Indeed many of the true costs of education lie hidden in the system and depend on good will. Going forward it will be important to argue forcibly that at least the current quantum of funding is required to deliver the required quality educational outcomes.

Provision needs to be made for the central processes involved in selecting trainees for posts. The recent MPET Review demonstrated that funding for pre-registration nursing and post-registration medicine is embedded in service, as both groups form an integral part of service delivery. Data are available to support a fair price for undergraduate medical placements without the need for any further review. However, in moving to transparent funding of education, great care must be taken not to destabilise tertiary centres. Either, an accurate system of calculating the true cost of specialist services must be created, or the approach commonly adopted internationally must be taken, with premia paid to reflect the higher cost base of university hospitals.

We have previously suggested and still endorse a model along the following lines:



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

We support the objectives outlined as long as equity of access to high quality care is maintained for patients across the UK. There is a very significant danger that GP consortia will not appreciate the complexity of educational requirements and the need for long term commitments. Indeed there is already evidence that GPs are loath to support the investment in academic posts and the additional costs of research. Doctors are a national resource and there is a requirement for consistent national standards across the UK.

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

The evidence for benefit from greatly enhancing multi-professional education and training is not presented in the consultation; in our view this evidence is at best mixed. The benefits of inter-professional education, which should start at an undergraduate level and increase as clinical teams work together in practice, are more obvious and such an approach can be further developed. However, undergraduates especially need to develop confidence in their unique uni-professional attributes before they can contribute effectively to integrated team-working. The other professions should follow the lead of medical doctors in developing consensus statements on their roles.

Nor do we believe that employers alone are best placed to commission education and training. Educationalists, healthcare professionals and employers need to work together to create programmes that will be right for entire careers and which take account of patients' requirements. They need insight into developments in the pipeline.

Strong partnerships need to be created to co-develop curricula and embed evidence based, innovative approaches to education, training and patient care.

Medical undergraduate curricula are designed to meet the requirements of the modern day doctor working within a healthcare system that delivers patient centred care. These requirements are best served by a fully integrated approach to teaching which requires that students move across health care sectors in a way that reflects the care pathways model. In both secondary and primary care, students are learning about the whole range of medical problems in a variety of contexts including hospital and community settings. To facilitate this approach requires equity of funding for all teaching activity, regardless of the location of the placement.

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

HENSE, the Programme Boards within MEE and the overview provided by MEE itself. It is vital that there is the greatest clarity on the accountabilities between HEE and skills networks for managing the levy, and to ensure that HENSE is maintained and its role enhanced.

Consistent UK-wide approach to date and especially the overview provided by COPMeD for postgraduate medical training; oversight by the GMC of the continuum of medical education and training, since its merger with PMETB

National selection and allocation processes for Foundation and Specialty training (the funding stream for this must be secured through top slicing) building on recent work by the Academy of Medical Royal Colleges

National control of undergraduate medical student numbers with funding through HEFCE

National planning of specialty numbers

Widespread involvement in research and clinical trials; the success of NIHR in ring-fencing money to protect research is an especially useful model for any educational levy to adopt

Minimal transactional costs

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

The development of true partnerships between universities and healthcare providers – AHSCs, BRCs, BRUs etc

The opportunity to ring-fence the funds for education and to use them transparently to drive up quality

The opportunity to reach consensus on the roles of the different healthcare professions and to determine whether as a society we wish to have a consultant delivered service.

Greater involvement of medical schools in post-graduate medical education and training and vice versa, ensuring smoother transition from undergraduate to postgraduate training, and enhanced opportunities to quality assure placements and to optimise medical education generally

Re-structuring of medical training to provide more education in the community and in public health with moves away from sub-specialisation

The opportunity to increase and systematise quality management activities through collaboration between medical schools, post-graduate deaneries, medical Royal Colleges and the GMC.

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?

It is important to consult patients – but important too, to take action on the basis of their responses.

The YouGov survey conducted for the Role of the Doctor workstream revealed that patients *strongly agreed* that there should be no uncertainty about the outcome of their treatment. Healthcare professionals *strongly disagreed* with this statement, knowing that uncertainty is unavoidable. It is essential that patients understand this. When asked '*Which one of the following healthcare professionals would you choose to see first if you were worried about your health'* 91% of respondees chose the doctor. 94% also stated that their top priority was having confidence that the doctor would achieve an accurate diagnosis of what was wrong with them. Such unequivocal responses need to be taken into account in considering future developments.

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

Yes they should provide data – but they should be accurate with a clear indication whether they refer to headcounts or full time equivalents. The GMC could also usefully collect data on the numbers in each specialty and their employment status. The private sector must also be involved.

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

Yes. The Centre for Workforce Intelligence working on behalf of HEE should seek to develop long term plans based on realistic estimates.

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

Providers of both service and education should work together to draw up realistic workforce plans reflecting integrated care pathways for patients. However one should be realistic about the extent to which small providers need to be involved in the planning process.

All providers however, both public and private, must have a duty to provide high quality education and training and should be penalised if the quality falls below the required standard. To maintain the current high standards of medical education and training in the UK, it is vital that all publicly funded health care providers in England

deliver education at an appropriate standard. This has additional benefits to the service itself, by ensuring that the clinicians involved in healthcare are up to date in their own training as teachers.

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

Data reflecting the quality of placements need to be collected in order to enhance and assure quality. There should be an obligation on Trust Boards to spend funds designated for education and training on their intended purpose. Providers must meet agreed targets and respond promptly and effectively to rectify poor quality placements. Consultant job plans should include time for education and training and for contributions to national requirements in these areas.

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

Yes this must be a requirement as trainees require access to the different care environments. There need to be powerful penalties for non-cooperation. Local networks should work together to provide economies of scale and to reduce transactional costs. For medicine this will involve networks that cover a sufficiently large group of providers to deliver all aspects specialist training, with national supervision for smaller specialties.

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?

The duties listed above are insufficient to guarantee effective coordination and delivery of medical education and training. The funding of the quality management processes and the power to withdraw salary funding from poor quality placements needs to be held separately from the provider network. Quality assurance and enhancement functions as well as academic medical training currently undertaken by post-graduate Deaneries should be aligned with medical schools to benefit from educational best practice. Improved working between medical schools and postgraduate deaneries will streamline and improve medical training; this needs to be realised in a tripartite partnership with healthcare providers.

More generally, healthcare providers need to work in partnership with the HEIs to develop long term, sustainable plans. We note that there is little mention in the consultation of how such relationships with HEIs will be promoted and sustained, and indeed only one consultation question even mentions undergraduates. Universities should be seen as partners rather than merely providers of education and training (of course, Trusts themselves are also providers of education and training, questioning the reality of the commissioner-provider split that underlies much of the consultation)

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?

There must be a legal obligation on all providers both to pay the education levy and to engage actively in educating and training both the current and future workforce. There should be no option that allows payment of a levy without also participation in teaching. There need to be clear financial penalties for non-compliance. Further work needs to be undertaken to develop measures that accurately reflect the quality of a placement, although such work has already commenced for medical placements.

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

The four broad functions proposed are, in the main, appropriate. However in allocating the resources for NHS Education and Training, the Quality Assurance function and its linked funding stream must lie outside the provider networks, for example within post-graduate deanery functions attached to medical schools.

Funds will need to be retained centrally for those activities which still need to be undertaken nationally and levers must be developed to counter local plans which are not in the national interest.

HEE should hold the contract for the Centre for Workforce Intelligence.

HEE should recommend to HEFCE student numbers for medicine and dentistry working in concert with colleagues across the UK.

The GMC's role in the regulation of medical education is clear and works well. The HEE should work through Programme Boards to facilitate employer involvement in curriculum development and to ensure curricula are relevant and deliverable across the UK.

The Medicine Programme Board should therefore be retained and should carry out the functions originally described in the Tooke report, namely:

- Hold the ring-fenced budget for medical education and training for England
- Define the principles underpinning postgraduate medical education and training (PGMET)
- Act as the professional interface between policy development and implementation on matters relating to PGMET
- Develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery (now the CfWI)
- Ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the Regulator on the resultant synthesis
- Coordinate coherent advice to Government on matters relating to medical education
- Promote the national cohesion of Postgraduate Deanery activities
- Scrutinise medical education and training commissioning functions of the skills networks, facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained
- Commission certain subspecialty medical training
- Act as the governance body for future changes in PGMET
- Work with equivalent bodies in the Devolved Administrations thereby promoting UK wide cohesion of PGMET whilst facilitating local interpretation consistent with the underpinning principles'

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

An independent mechanism with the power to impose significant financial penalties must be created in order to protect the investment in education and training and to drive up standards. The organisation and planning skills currently sitting in post-graduate deaneries must not be lost, but could usefully sit within the HR and other departments of lead provider Trusts. The QA function should sit alongside similar functions within medical schools on the undergraduate side. An inventory of functions which must remain national should be created and funds set aside to permit their delivery.

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

The GMC as the regulator of medical education will continue to play a central role in quality assurance and curriculum development for the benefit of patients. Effective partnerships between education and service need to be fostered with external, independent quality assurance of activities. HEE must be given 'teeth' with the right to call on the NHS Commissioning Board for support if local plans cannot be accommodated within national requirements.

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?

HEE should have a small board which includes non-executive directors with a clinical academic background.

The Chair of HEE should be non-partisan and independent and must have experience of contemporary issues in health and education.

An Executive Director of Medical Education should chair the Medical Programme Board.

The CMO and the NHS Medical Director should sit on both HEE and the NHS Commissioning Board.

In creating the governance structures account should be taken of the systems in place in the other 3 nations.

There should be close links with NIHR for academic training

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?

The CfWI should take time to ensure that it has accurately determined the nature of the information it is seeking to collect from employers and must require that the data be presented to it in a consistent manner to facilitate accurate and effective analysis.

The GMC should also collect data on doctors by specialty and employment status.

Working with the Specialist Societies, the CfWI should attempt long term predictions of workforce requirements. The length, arduousness and consequent expense of medical training is obvious, as is the need to base any

decisions on medical workforce planning on the best possible predictions of patient demographics and needs. There is therefore an absolute need to avoid decisions based on short-term expediency; in particular there must be a binding decision on the extent of consultant –delivered service in the future that ensures the country has the best possible healthcare over a period which can be measured in decades rather than years, as recommended in the Temple Report to MEE.

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

The CMO should sit on both HEE and the NHS Commissioning Board. The Chair of HENSE should work closely with HEE.

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?

HEE - with financial penalties to enforce compliance. The GMC, CQC and Monitor must inform HEE of concerns they have picked up. Effective partnerships with HEIs must be created.

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

The suggestion that it supports smaller providers seems sensible.

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?

Doctors play key leadership roles both locally and nationally. The undergraduate curriculum already takes the first steps in preparing students for this role. Doctors are aware of their role in developing the health of the population as well as attending to the patient in front of them. The Medical Schools Council will continue to work to spread best practice in medical education and assessment, to innovate and to enhance quality. In particular it is working with the NHS and Academy of Medical Royal Colleges to ensure that the Medical Leadership Competency Framework is adopted by schools. This type of initiative should be developed and exploited further. In deciding the size of skills networks, careful consideration needs to be given both to the breadth of strategy and economies of scale offered by sub-national arrangements and to the ease of communication and speed of more local and familiar arrangements. Both might be achieved through a hub and spoke arrangement, i.e. a regional hub and two or three local spokes corresponding to health economy areas.

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?

Effective leadership and management are vital. The Medical Schools, working with the GMC, strive to ensure that the doctors of the future understand their personal responsibility for creating systems which function

optimally – and for addressing flaws in any system. Ensuring that the regulator is fully involved will be key to achieving such developments.

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

It is important for colleagues to understand the demands of others' activities and so it would be reasonable for HEE to be accountable for the framework of leadership development across all leaders in healthcare – if it is given the capacity and additional funding to undertake this.

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?

Multi-professional education at the undergraduate level, other than for groups requiring the same scientific basis to their studies or where there are certain shared needs, has not been demonstrated to have any real impact or saving. Undergraduate courses are intensive and in a changed University environment with much higher fees, students will be seeking to ensure that they are best equipped at undergraduate level to follow the course that they have chosen. Once students have acquired confidence in the unique contribution of their own profession they more readily appreciate the skills and talents of others and can come together to create effective, well functioning teams. Indeed all medical schools already make substantial efforts to ensure that there is awareness of what each profession does and employ trainers from a variety of different backgrounds. The larger numbers of nursing and AHP students compared with medicine, and the greater number of HEIs involved in educating the former, makes complete integration unworkable.

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On the other hand inter-professional learning for areas of the curriculum such as leadership and management and for team building is important and should be developed in an expanding continuum across the whole of healthcare education.

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?

Enhancing the contribution of public health to the UG medical curriculum will become increasingly important. The extensive structural reforms proposed for public healthcare are a possible distraction from the primary objective of implementing strategies that directly improve population health – through legislation as well as 'nudging people in the right direction'. The proposed move of Public Health to local authorities means that the latter will have to ensure that the next generation of public health professionals is trained and thus they will need to be key partners in, or at the least have some close interaction with healthcare provider skills networks. They must ensure that all public health professionals maintain consistent standards as defined by the Faculty of Public Health and are properly regulated – clinicians by the GMC and non-clinicians by the HPC.

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?

Regional skills networks will require an overview of the entirety of health related issues and would thus need to encompass social care and public health as well as direct clinical care. A mechanism must be developed which allows input from interested parties, without representation from every single interest group. Public Health England needs to be an independent Special Health Authority with the ability to challenge public bodies and vested interests with evidence. PHE requires ring fenced funding and must employ clinicians on NHS terms and conditions even if they are seconded to Local Authorities..Local Authorities must not be permitted access to monies designed for public health.

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?

Ring fence the funds so that they are spent only on education, and ensure that quality measures are in place to deliver excellence in education and training.

Health care providers to work in partnership with HEIs to co-develop programmes, particularly in ways that emphasise the distinction for postgraduate doctors between training and the provision of care. The role of the professional regulators is also crucial in this.

Take forward new initiatives on the basis of evidence rather than dogma. In turn this means ensuring that where existing research is not sufficient to answer questions, appropriate measures are put in place to close the gap.

Ensure that there is expansion of education and training in the community and in public health at a time when both will be changing radically.

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

Ring fenced funds for the clinical education of the nationally determined numbers of medics and dentists

Structures to support recruitment to Foundation and Specialty training posts

Recruitment to and training in, very small specialties

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

Closer partnership working with universities will facilitate an evidence based approach and ensure that quality enhancement is delivered.

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?

Adopt the system used widely internationally and pay a premium to university hospitals that recognises the additional cost of specialist services and of providing the correct environment for research and education.

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?

It is unlikely that the price paid will reflect the actual cost – but it needs to be a fair and realistic sum that is reviewed regularly.

Despite the lack of transparency, high quality education is currently provided. If MPET accounts for 5% of current expenditure, a 5% levy could be raised against the expenditure of all providers.

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

The recent MPET review demonstrated that the actual cost of delivering education and training to the healthcare workforce was greater than the funds available and so the tariff would not be able to provide the average national cost unless the funding stream were increased – which we would welcome. However since this does not seem likely, there seems little point in conducting further analysis, given also that the most recent review had already been scheduled for implementation this year.

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

This would not be an effective use of resources, given the work which has already gone in to at least 3 reviews over the last decade

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

Perhaps penalties through a top slice on MPET (to go back into the skills network for redistribution) for those that fail to engage with education and training and fail to deliver high quality placements would be a better way to proceed initially.

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?

All providers – including the private sector.

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

See Q 35

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

Training outcomes should be published, using established quality indicators. There should be a greater duty on Trust Boards to monitor performance in this area. Universities will need to publish key information sets on their undergraduate courses and the regulator also publishes the outcomes of quality assurance visits.

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

By imposing minimum sizes (similar to those of current SHAs) on the networks commissioning services. As we have previously stated in our comments to the Department, we believe that remodelled HIECs offer the potential for a network below HEE to ensure the most appropriate distribution of funding, to monitor the introduction of educational innovations and to hold local skills networks accountable. If adopted, the role that HIECs and SHAs have in introducing research innovation should not be sidelined by the new need to deal with more operational educational issues.

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

Those currently used by NES. They should be introduced, evaluated and allowed to evolve with time.

Q41: What are the challenges of transition?

Undermining all the good work that has been undertaken since the inception of PMETB.

The transactional costs of multiple contracts making small courses unsustainable – HEIs withdrawing from healthcare provision due to uncertainty of future funding.

Loss of expertise from SHAs, PCTs and Deaneries

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

There is certainly the potential for disengagement and loss of expertise during the next few months of uncertainty. However the proposals offer the chance to re-invigorate health care professional training by establishing a true partnership between healthcare providers on the one hand and HEIs and postgraduate deaneries on the other. By ensuring that money follows students and trainees in a transparent way for educational purposes, unencumbered by service issues, real improvements in quality can be achieved, and health care providers will have a much greater stake in ensuring the success of this. As a result, graduates will be better prepared for practice.

Q43: What support systems might they need?

Adequate funding

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

As a nascent organisation it is not yet in a position to facilitate a smooth transition. We anticipate that much greater resource will be necessary to supply the information required by many new skills networks.

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

Universities are awaiting the announcement on this that follows the Browne review and will make appropriate changes.

The concomitant changes to the fee structure in universities have the potential to lessen rather than widen diversity, although universities are expected to address this in response to new guidance from OFFA.

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?

See Q 45