House of Commons
Health Committee

Education, training and workforce planning

First Report of Session 2012–13

Volume I

Volume I: Report, together with formal minutes

Volume II: Oral and written evidence

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/healthcom

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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Summary

The quality, safety, effectiveness and efficiency of healthcare services depend on the availability of sufficient numbers of well-trained and well-motivated staff. The NHS has, therefore, rightly attached a high priority to the education and training of staff. Despite this, however, there is now an urgent requirement for a whole-system review of the education and training of the health and care workforce.

This is made necessary by the consequences of the wider NHS reforms. More substantively, this situation presents a welcome opportunity to address some of the weaknesses of the current arrangements. These are complex, inflexible and unfair, and may be an obstacle to desirable changes in healthcare provision.

The challenge of workforce planning

Effective workforce planning in the NHS depends on the availability of up-to-date, high-quality data and intelligence. We welcome the remit that has been given to the Centre for Workforce Intelligence and commend its ambition to tackle deficiencies in workforce data. It is clearly not sufficient for the Centre simply to collate and interpret data. It should also challenge data from individual health economies against current clinical standards to ensure their workforce plans make adequate provision for the best skill mix.

However, we are concerned at some of what we have heard regarding the Centre’s capacity and capability. We are also concerned at the apparent lack of clarity about how it will fit into the new workforce planning system. The Department needs urgently to explain how it is ensuring that the Centre is adequately resourced to fulfil its remit, as well as clarify the Centre’s role in the new system. The Centre is substantially dependent for its success on data that is provided by employers. The Government must ensure that there are clear contractual obligations on all providers of NHS-funded services to provide full, timely and accurate workforce data; these obligations must be backed up by clear, strong and enforceable penalties.

Innovation in skill mix and clinical roles is crucial to achieving a more efficient and flexible workforce—but it is important for policy to be grounded on solid evidence.

We note that the Government has announced arrangements for the voluntary registration of healthcare assistants. However, the requirements of this key element of the workforce for training and professional development must be kept under review. In the longer run, only independent professional regulation will provide the best assurance to patients.

An acid test of the effectiveness of the new education and training arrangements will be their ability to deliver the more flexible medical training programmes which were described in the 2008 Tooke Report. We have received a broad basis of evidence which shows how it is possible to reconcile reasonable hours for junior doctors with high quality training and, most importantly, high standards of care for patients.

A clear mandate must be set for the new system to take account in workforce planning of the full range of evidence-based treatments—subject to the evaluations carried out by the
National Institute for Health and Clinical Excellence.

We believe that the openness of the UK to clinical staff trained overseas, and the ability of UK-trained staff to work overseas, is a continuing source of strength to UK healthcare, and that this openness should continue to be reflected in workforce planning. However, we also welcome the Government’s view that planning of the UK health and care workforce should not be dependent on significant future flows of trained staff from overseas.

Locum and agency staff provide a necessary element of flexibility in NHS staffing arrangements. However, they do not provide an optimum solution, either in terms of quality of care or value for money. We, therefore, urge the Government to proceed quickly with improved arrangements for workforce planning which should reduce the importance to the NHS of locum and agency staff.

Organisation of education, training and workforce planning

We welcome the inclusion in the Health and Social Care Act 2012 of an explicit duty on the Secretary of State to secure an effective system of education and training. However we are concerned that there continues to be insufficient clarity about how the Secretary of State intends to discharge this duty. The Department of Health must spell out how exactly Health Education England will be held to account—including the part that the planned Education Outcomes Framework will play.

We welcome the plan to set up Health Education England as an executive body with overall responsibility for education, training and workforce planning across the whole workforce. However, we are concerned that the Government has been slow in developing a coherent plan for the new organization. Greater clarity is particularly needed about how Health Education England plans to ensure that it develops a dynamic view of the changing education requirements of the whole health and care sector.

We also welcome the Government’s plan to create Local Education and Training Boards as provider-led bodies to take responsibility for education, training and workforce planning below the national level. We are concerned, however, at the Government’s protracted failure to produce concrete plans in respect of the Boards, which poses a significant risk to their successful establishment. It is unsatisfactory that so much about the Boards still remains vague and indeterminate.

The integration of the postgraduate deaneries into the new system will be crucial to its success. Although there is now greater clarity of intention, the period of uncertainty led to a regrettable loss of experienced staff. There continues to be an urgent need for more precision about how the deaneries will operate in future.

We welcome the Department’s intention to continue within the new system the work done to link innovation with education and training. We also welcome the intention to build on this through the creation of Academic Health Science Networks. However, there is a risk that the resulting arrangements could be incoherent and ineffective if they are too cluttered.
Funding education and training

The current arrangements under which providers are paid by the NHS for education and training are anachronistic and anomalous. Payment is only partially based on student or trainees numbers; it is not linked to quality; it is unjustifiably inconsistent between different professional groups, parts of the country and types of provider; and there is an almost total lack of transparency about how it is spent. Accordingly, we welcome the Government’s intention to move payment onto a tariff basis, including a quality premium. However, we note that there is so far slender evidence of progress in converting this desirable policy into a system that will work in practice. This work needs to attract a greater sense of urgency. At the same time, the Government needs to recognise that there are significant difficulties involved in constructing a workable tariff; the transition to any new system must not threaten the quality of clinical services.

We support the Government’s intention to introduce a levy on all healthcare providers (whether or not they supply services to the NHS) to provide a more transparent and accountable system of funding for education and training in the health and care sector. We are unconvinced by arguments from the independent sector representatives that this would put them at an unfair disadvantage. We recognise that there are particular concerns about the potential effect of a levy system on smaller voluntary-sector organisations, but workable exemption arrangements should be possible. Here again, there is slender evidence of progress in converting this policy into a system that will work in practice; this work needs to attract a greater sense of urgency.

The Department’s policy is currently to keep NHS funding for education and training broadly the same in cash terms from year to year. Against a background of inflation and major cost pressures, this is an extremely challenging financial settlement. We have heard evidence that education commissions are being significantly cut. Given the wider financial situation in the NHS, there is also the risk that SHAs will raid education and training budgets in 2012–13, as they have done before; the Government must act to safeguard funding during this period.
1 Introduction

1. The quality, safety, effectiveness and efficiency of healthcare services depend on the availability of sufficient numbers of well-trained and well-motivated staff. Throughout its existence, the NHS has, therefore, rightly attached a high priority to education and training of both new and current staff. In 2011–12 it spent £4.9 billion, around five per cent of its budget, on education and training.  

2. Despite this long-standing commitment, however, we believe there are two reasons why there is now an urgent requirement for a whole-system review of the education and training of the health and care workforce:

   - The first is the obvious point that the passage of the Health and Social Care Act 2012 means that various institutions and structures within the education and training system will no longer exist, or no longer exist in their previous form, which creates a practical requirement to make alternative arrangements.

   - More substantively, however, we believe that this practical requirement creates a welcome opportunity to address some of the weaknesses of the current arrangements and create new structures which will be better able to meet the needs of the health and care system of the future.

3. If we are to take advantage of this important opportunity to improve the effectiveness of our education and training structures, it is important to begin with an understanding of the weaknesses of the current system as it has developed. We believe these can be summarised as follows:

   - It is too complex, meaning that few people understand how it operates and that accountability is poor because of the lack of clarity.

   - It is inflexible and does not respond effectively to the changing demands of service delivery.

   - It is regularly accused of being unfair in the way in which it distributes the cost burden of training.

   - There is a danger that its inflexibility may itself prevent or delay desirable changes in provision.

4. That being so, it is possible to see what the criteria for an effective system of education, training and workforce planning are:

   - The system needs to be service-led.

   - It needs to be transparent and accountable—it has to be simpler than the current system.

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2 Department of Health, Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery, January 2012, para 124
• It needs to be responsive to demand.

• It needs to be dynamic, in the sense that it must be capable of understanding and reflecting the need for continuous change.

• As part of that process, it needs to maintain an up-to-date concept of what “good” looks like, and to be able to change accordingly.

• It must be apparent that the costs of the system are fairly borne by all service providers.

• The education, training and planning that the system provides need to be of high quality, and need to provide value for money.

It is against these criteria that we have set out to judge the Government’s proposals. (The terms of reference for our inquiry are set out in Annex A.)

5. During the course of the inquiry, 119 memoranda of written evidence were received and five evidence sessions were held. Oral evidence was taken from: Medical Education England, the Health Education England steering group, the Centre for Workforce Intelligence, a Strategic Health Authority cluster, the General Medical Council, the Conference of Postgraduate Medical Deans of the United Kingdom, the Higher Education Funding Council for England, the Health Professions Council, the Nursing and Midwifery Council, Skills for Health, million+, the NHS Future Forum Education and Training group, the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, a Health Innovation and Education Cluster, a Skills Academy, NHS Employers, the NHS Partners Network, Independent Healthcare Advisory Services, the Junior Doctors’ Committee of the British Medical Association, UNISON, the Royal College of Nursing, Unite / Community Practitioners’ and Health Visitors’ Association, Rt Hon Simon Burns MP, the Minister of State for Health, and officials from the Department of Health. We are grateful to our specialist adviser, James Buchan, Professor in Health Workforce Policy at Queen Margaret University, Edinburgh.³

³ Professor Buchan declared his interest as a columnist for the Nursing Standard and a Professional Adviser to the Centre for Workforce Intelligence.
2 The challenge of workforce planning

6. We believe that the new structures for education and training must be built around a stronger, more transparent and more accountable system of workforce planning. For too long our system has been characterised by “boom and bust”—alternating oversupply and undersupply of trained staff—with shortages eased by large-scale recruitment from overseas. This inability to identify and manage developments of the skill mix required in the health and care workforce has resulted in waste and inefficiency, as well as frustration and disappointment for individual trainees.

7. Effective workforce planning is not, of course, straightforward. It needs to take account of changes in technology and clinical practice as well as changing patterns of demand and expectations from patients and the wider community. Addressing all these issues effectively through workforce planning requires close alignment with service commissioning and funding, as well as linkages with employers, educators and trainers.

8. Furthermore, as we have noted in our previous reports, Sir David Nicholson (Chief Executive of the NHS) has highlighted the fact that the NHS now faces an unprecedented requirement to increase efficiency by four per cent a year over four years, and probably longer. This “Nicholson Challenge” arises because the NHS has to meet demand rising at its long-term trend rate of approximately four per cent a year out of marginal increases in real-terms funding. In our view this challenge can only be met through service redesign and reconfiguration (with many aspects of care moving from hospitals into primary-care and community settings); and integration of the NHS and social care services.

9. Workforce planning has a key part to play in achieving these objectives, allowing the NHS to enhance both the efficiency and quality of care delivery, at the same time as enabling flexibility in the face of rapid medical progress and varied other challenges.

The Centre for Workforce Intelligence

10. Sound, comprehensive and up-to-date data and intelligence are crucial to the success of workforce planning. In 2010 Mouchel Management Consulting Limited\(^4\) was contracted by the Department of Health (DH) to set up and run the Centre for Workforce Intelligence (CfWI)\(^5\).\(^6\) The Centre told us that it acts as “the national authority on workforce planning and development and the primary source of workforce intelligence for health and social care”, working with academic and other partners.\(^6\) Peter Sharp, the Chief Executive of the CfWI, explained to us that the Centre was addressing longstanding issues around

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\(^4\) The core business of the Mouchel parent company is road-building (it began as a manufacturer of reinforced concrete in 1907). It was reported in late 2011 that Mouchel had recorded major losses as a result of cuts in public spending and the discovery of an actuarial error in calculating its pension liabilities. It remained solvent by borrowing £180 million but its share price dropped dramatically as a result of continued uncertainty about the company’s future – “Mouchel ‘disappointed’ after losses treble”, BBC News website, 30 November 2011.

\(^5\) Q 79

\(^6\) Ev 111
workforce data (concerning completeness and quality) and working towards “the construction of a core national minimum data set for health and social care.” He told us:

We have an expansive stakeholder map of people who hold that data. We have tried to do the equivalent of “Trip Advisor” on it as to its relevance, value and whether or not you would want to use it and so on.

The Centre aimed:

to get from national down to regional […] and then local and hyper local. We have a project where we will have GPS [Global Positioning System] plotting right down to a hospital level where we will say where there are shortages. We will have a “red, amber, green” of any of the professions, whether doctors, nurses or midwives.

11. Mr Sharp emphasised that “We are not a data warehouse. Our job is not to house data. It is to use data and turn it into intelligence.” (This distinguishes the role of the CfWI from that of the NHS Information Centre, which does effectively act as a data warehouse in relation to NHS providers.) It also aimed “to work closely with the stakeholders to make sure the advice and guidance we produce is tailored to their needs.”

12. In *Developing the Healthcare Workforce* (December 2010) the work of the CfWI thus far was stated by the DH to be one of the achievements of the existing system that must be built upon. Data from providers would need to be collected locally, aggregated and made available to the CfWI. The Centre would “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”.

13. In evidence to us in November 2011 Jamie Rentoul, the DH’s Director of Workforce Development, explained something of the CfWI’s intended role in the system. The Centre would enable “challenge [to workforce plans] at a sufficiently granular level that people are able to do something with it”:

part of the purpose in having the Centre for Workforce Intelligence contracted but out of the system is that they are doing the analysis. It is their analysis for the colleges, professional bodies, patient groups, commissioners and employers to have a go at, to get it as good as it can be, and give that challenge.
14. We heard in evidence that there is general support in principle for the role of the CfWI. However, we also heard that, as a relatively new organisation, the CfWI was still only just beginning to establish its position within the NHS workforce system (“it is early days”, we more than once heard). At that time it was also seen as concentrating on issues at the national level and particularly around medical staff. Questions were also raised concerning the way that “the function of the organisation currently has focused on profession specific information and has had little engagement at organisational level”.

15. There was some criticism, too, of the quality of the CfWI’s output. Public health experts in the north west told us that “Recent statistics published by the CfWI regarding public health posts were seriously flawed” and that “Currently the Centre for Workforce Intelligence is not able to collate sound, up to date and accessible data on the public health workforce.”

16. It was queried in several submissions whether the CfWI had the necessary resources for the task it had been given—and this was linked by some to the perceived quality of its work. The Chartered Society of Physiotherapy told us:

recently we have been concerned about the quality of reports from the CfWI, because of a reduction in the CfWI staff resources available to produce them. We have been unable to support their conclusions based on inadequate time and professional resources. It is essential that the CfWI is properly resourced by the Department of Health.

17. Conversely, the Society and College of Radiographers argued that, “despite considerable investment in the Centre for Workforce Intelligence”, it had:

not delivered the new/better approach that is needed. In particular, it has not sought to derive workforce need from service delivery and healthcare need (which seem to us to be the right starting points), but has used current workforce numbers and affordability as the main influences. This perpetuates the short-term approach to workforce planning which drives a boom/bust (or glut/famine) cycle in relation to workforce supply, and fails to help deliver long-term skills-mix based solutions to cost and quality effective health care delivery.

18. Mr Sharp told us that the CfWI was working with the medical Royal Colleges on medical workforce issues—and written evidence from the Academy of Medical Royal Colleges seemed to support this, stating that Colleges were feeding their data sets on specialty workforce numbers into the Centre. (Other evidence emphasised the Royal
Colleges’ possession of quality data which the CfWI must use, rather than duplicating it unnecessarily.)

19. The Royal College of Pathologists said it had “previously had great concerns over the viability and fitness for purpose” of the CfWI, given its use of data that were “flawed and outdated”. However, subsequently the Centre had “engaged more comprehensively with the Royal Colleges”, recognising the data that the Royal College of Pathologists held. Dr Peter Nightingale, President of the Royal College of Anaesthetists, told us:

There is no doubt that the Centre for Workforce Intelligence has had a fairly sticky start inasmuch as it did not have good quality data on which to begin making its projections. It is improving, but it can only do a very good job if it gets very good data.

20. Another area of concern has been the extent to which the CfWI will be supplied with an adequate quantity and quality of data in the new NHS, where providers—whether NHS Foundation Trusts (FTs) or independent sector bodies—will be autonomous organisations. The Director of NHS Employers, Dean Royles, sought to reassure us that FTs would happily provide data if they were certain that it was not merely a bureaucratic chore but would help improve patient care. However, there have been failures by some FTs to supply the NHS Information Centre with data that clearly does relate to improving care (in relation to patient complaints), as we have noted in a previous report.

21. As regards independent-sector providers, Mr Sharp told us that the CfWI had “started to negotiate points of entry for collecting data” from the private sector. Sally Taber, the Director of Independent Healthcare Advisory Services, told us that her organisation already provided data to the devolved administrations in Wales and Scotland. The

26 Ev w108, w260
27 Ev w101
28 Q 229
29 Ev w96
30 Ev w67–8
31 Centre for Workforce Intelligence, Shape of the Medical Workforce: starting the debate on the future consultant workforce – a discussion document for leaders, February 2012
32 www.cfwi.org.uk/publications
33 Q 319
34 Health Committee, Sixth Report of 2010–12, Complaints and Litigation, HC 786-I
35 Q 81
independent sector would happily do the same in England if there were a clear mechanism for doing so. Nevertheless, past experience (for instance, the poor track record of Independent Sector Treatment Centres in furnishing data) does throw doubt on the extent to which private providers can be relied on in this regard.

22. Local Education and Training Boards (LETBs) will clearly have a key role in ensuring data are collected from all providers at the local level—but the question does arise of what obligations providers will be under to supply data and what sanctions can be used against them if they fail to do so. Developing the Healthcare Workforce (December 2010) proposed a duty on all providers of NHS-funded care to provide data about their current workforces and future workforce needs; and this was supported in the subsequent consultation.

23. From Design to Delivery (published by the DH in January 2012) envisaged that the existing Electronic Staff Record (which provides information on directly-employed NHS staff) would continue to be the main source of workforce data. However, it noted that “with an increasingly diverse range of healthcare and public health providers there is no guarantee that all providers will use [the Electronic Staff Record] in the future.” Accordingly, arrangements would be made for the provision of data by providers that did not use the Electronic Staff Record. This would include developing a minimum data set. In addition, the Health and Social Care Bill allowed the Secretary of State to direct the Information Centre “to collect information that is necessary or expedient to have in the interests of the health service”. This would be “sufficient to enable directions to be given to require the provision of workforce data” from all providers of NHS-funded services. At the same time:

The provisions set out in the current Health and Social Care Bill for the provision of relevant data and information will include a requirement on providers to make available workforce and workforce planning data so that LETBs, the Information Centre and the Centre for Workforce Intelligence have access to the data and information needed for effective workforce planning.

In this regard, David Worskett, Director of the NHS Partners Network (which represents independent-sector healthcare providers in the NHS), anticipated, based on discussions with Monitor (the planned NHS economic regulator), “some very tight licence conditions about provision of information and data”. Nevertheless, it still remains unknown what the specification will be for the minimum data set, what the exact compliance mechanisms will be and what the penalty will be for non-compliance.

36 Q 319
37 Healthcare Commission, Independent sector treatment centres: the evidence so far, July 2008
38 Department of Health, Developing the Healthcare Workforce – A consultation on proposals, December 2010, paras 5.12–4
39 Department of Health, Liberating the NHS: Developing the Healthcare Workforce – A summary of consultation responses, August 2011, paras 4.12–4
40 Department of Health, From Design to Delivery, January 2012, para 150
41 Ibid., para 151
42 Ibid., para 149
43 Ibid., para 85
44 Q 319
Conclusions and recommendations

24. Effective workforce planning in the NHS depends on the availability of up-to-date, high-quality data and intelligence, yet only in recent years have steps been taken to ensure that this is fully and comprehensively available. We welcome the remit that has been given to the Centre for Workforce Intelligence; we also commend its ambition to tackle deficiencies in workforce data and to establish a core national minimum data set.

25. It is clearly not sufficient for the Centre simply to collate and interpret data. It should also challenge data from individual health economies against current clinical standards to ensure their workforce plans make adequate provision for the best skill mix.

26. We appreciate that the Centre is still a relatively new body and that its establishment pre-dates the full implementation of the new workforce planning system. However, we are concerned at some of what we have heard regarding its capacity and capability, in particular its capacity to test workforce plans against the requirement to match the best clinical standards. We are also concerned at the apparent lack of clarity about how it will fit into the new workforce planning system. The Department needs urgently to explain how it is ensuring that the Centre is adequately resourced to fulfil its remit, as well as to clarify the Centre’s role in the new system, particularly its working relationships with Health Education England and the Local Education and Training Boards. It must also set out how the Centre will be effectively performance-managed in the new system and held to account.

27. The Centre is substantially dependent for its success on data that are provided by employers. In future those employers will be autonomous organizations and Local Education and Training Boards will be responsible for gathering data from them. The Government must ensure that there are clear contractual obligations on all providers of NHS-funded services to provide full, timely and accurate workforce data; these obligations must be backed up by clear, strong and enforceable penalties. At the same time, there must be a clear complementary requirement on the local Boards in respect of gathering and passing on data—with a definite remit for Health Education England rigorously to performance manage the Boards in this respect.

Changing skill mix

28. In Developing the Healthcare Workforce (December 2010) the Government recognised that there had been “real strides in implementing skill mix changes to support more productive care, modelled around quality and the needs of patients”.45 However, it identified as a key deficiency in the current system that it “is too top-down, such that employers do not have the incentives and levers to innovate and secure the skill-mix that they want”. It argued that “supply-and-demand factors [are looked at] in single
professional silos [so that] […] potential for improving quality and productivity through skill mix change and developing the wider healthcare team […] is underdeveloped”.

29. Skill mix is far from being a new issue in healthcare. There has been a long-term trend towards the extension of non-medical clinical (and other healthcare) roles. These developments have been notable within nursing and the Allied Health Professions (AHPs), where recent years have seen the creation of enhanced and advanced roles, such as those of Nurse Consultant, AHP Consultant and Nurse Practitioner, with additional qualifications, skills and responsibilities—even including the authority to prescribe drugs. At the same time, unregistered healthcare assistants (HCAs)—sometimes referred to as clinical support staff, healthcare support workers, nursing auxiliaries or auxiliary nurses—have become a much more important and numerous part of the workforce. More highly trained staff of this type are also now being introduced, known as Assistant Practitioners. The Nursing and Midwifery Council (NMC) has estimated that there are as many as 300,000 HCAs (not including Assistant Practitioners)—about a quarter of the NHS workforce. The Royal College of Nursing (RCN) told us that there were as many HCAs again outside the NHS in settings such as care homes; and we heard about increasing numbers of HCAs working in the community, providing care in people’s homes. HCAs can perform a range of duties, from personal care (e.g. helping patients with washing and dressing) through to simple medical tasks, such as taking blood, and taking and recording vital signs. Under NMC guidance, a nurse who delegates a task to an HCA is professionally accountable for ensuring that the HCA is competent to carry out that task.

30. The creation of new roles and role substitution are widely seen as having the potential to enhance significantly the productivity and effectiveness of the healthcare workforce (allowing the more qualified members of teams to concentrate on the most challenging clinical tasks). In a memorandum that we received from Professor Alan Maynard, a longstanding advocate of changes in skill mix, he said that evidence indicated nurses in general practice, “particularly the 30,000 who have full prescribing rights, have the potential to replace GPs in the delivery of much of primary care”. However, there was a lack of good quality studies on this subject. Similarly, in secondary care, there was a “paucity of good evaluative studies of effectiveness and cost effectiveness” in relation to substituting nurses for doctors.

31. We heard from the Society and College of Radiographers about the adverse effects of failing to make full use of Assistant Practitioners: “These staff are essential to enable the skills of radiographers to be utilised more effectively such that radiographers are able to support medical staff to spend proportionally more of their time with patients with complex radiotherapy and clinical imaging or intervention needs.” At the same time, there had been a “failure to invest in developing advanced and consultant practitioners to deliver...
both ‘routine’ service needs [...], and to deliver service innovations that have been shown to improve quality and effectiveness”. There were “some very good examples in individual NHS Trusts of innovations that deliver the highest quality of care through excellent development of its whole radiographic workforce”, but these innovations were not widespread.\textsuperscript{52}

32. On the other hand, however, fears were expressed about the possible dangers of inappropriate changes in skill mix. Sara Gorton, Senior National Officer for Health at UNISON, told us:

we are hearing that role substitution is simply taking place, with sometimes registered staff being taken out of the system and replaced by assistant-practitioner level staff without a clear understanding of where the layers of accountability and supervision sit within those structures. We would like to see a consistent approach and a recommendation that we look at this issue from a whole-system perspective.\textsuperscript{53}

33. We also heard of concern about the perceived failure to recognise the importance of training and development for unregistered staff in general (NHS Pay Bands 1–4). John Rogers, the Chief Executive of Skills for Health (the Sector Skills Council for Health), emphasised to us that more needed to be done to “upskill” this group, so that skill mix could be changed, and productivity and quality improved.\textsuperscript{54} While Skills for Health is doing much good work in this respect,\textsuperscript{55} Mr Rogers told us that only three per cent of the NHS training budget was being spent on the 40 per cent of the workforce who are not healthcare professionals.\textsuperscript{56} We also heard from UNISON (the main union representing unregistered staff) and others about the failure to provide these staff with adequate appraisal, training and Continuing Professional Development (CPD), as well as proper career paths.\textsuperscript{57}

34. Concern about the level of professional training and development for HCAs raises the issue of their unregistered status. In July 2011, following our annual accountability hearing with the NMC, we endorsed the idea of statutory registration for HCAs.\textsuperscript{58} In November 2011 the Government announced that from 2013 there would be a voluntary register for HCAs, accredited by the Council for Healthcare Regulatory Excellence. This would be underpinned by a common code of conduct and basic training standards, to be developed by Skills for Health and its social-care counterpart (Skills for Care).\textsuperscript{59} However, there is controversy as to whether these measures are sufficient.

35. Professor Ieuan Ellis, Chair of the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, told us that he opposed statutory regulation:

\begin{flushright}
\textsuperscript{52} Ev w134–5  
\textsuperscript{53} Q 372  
\textsuperscript{54} Qq 169–70  
\textsuperscript{55} Qq 165, 170, 172 [Mr Rogers], 178, 179, 180 [Mr Rogers], 183 [Mr Rogers], 280–5  
\textsuperscript{56} Q 169  
\textsuperscript{57} Ev 140, w134–5, w215; Q 169–70, 174, 333  
\textsuperscript{58} Health Committee, Seventh Report of Session 2010–12, Annual accountability hearing with the Nursing and Midwifery Council, HC 1428, para 64  
\end{flushright}
Support workers should be working under the supervision of a registered practitioner. It is ensuring the appropriate supervisory arrangements and also ensuring that there is the appropriate education and training. That in itself does not mean that they need to be statutorily regulated [...] The education, training and supervisory arrangements for support workers are crucial, but that in itself does not lead me to conclude that there needs to be statutory regulation.60

36. We heard the same view from Mr Royles, of NHS Employers. He argued that there was:

a variety of other things that you can do in terms of standards, right from how we recruit people, the values they have, the training they are given, the qualifications they have, the supervision they receive on the ground and the ongoing training and development.

It was “offensive” to call HCAs “untrained”, when they had National Vocational Qualifications and apprenticeships; and statutory regulation would “reduce flexibility”.61 A “culture or an environment where people can raise appropriate concerns” was needed; regulation would not guarantee this.62

37. Dr Peter Carter, Chief Executive of the RCN, told us that HCAs were an essential part of the workforce, but “while some employers at one end of the spectrum educate and train them to a very high degree and some do it okay, there are copious examples of employers giving them next to nothing.” It was “wholly unacceptable” to put someone in a tunic, place them on a ward and expect them to “pick it up as they go along.”63 The Queen’s Nursing Institute told us: “There is a danger that our current approach to HCAs is recreating all the problems and risks of Victorian nurse training, which led to the registration of nursing being set up to protect the public nearly 100 years ago.”64

38. The subsequent Delivering Dignity report stated that the Commission on Dignity in Care for Older People had heard “a compelling case” that “all staff who provide care on our wards should be suitably qualified and have the appropriate regulatory mechanism in place”. It concluded that:

The Department of Health should consider setting minimum training and qualification standards for healthcare assistants in the NHS. If this recommendation is accepted, the Department of Health will need to resolve how healthcare assistants are registered and regulated.65

39. When we raised this issue with the Minister of State for Health, Rt Hon Simon Burns MP, he insisted the Government’s approach was “proportionate” and said it would wait to see how voluntary regulation worked rather than rushing into statutory regulation.66

60 Q 297
61 Q 342
62 Q 343
63 Q 385; cf. Ev 137
64 Ev w17
65 Commission on Dignity in Care for Older People, Delivering Dignity, February 2012, Recommendation 47 (p 34)
66 Qq 500–7
Conclusions and recommendations

40. Innovation in skill mix and clinical roles is crucial to achieving a more efficient and flexible workforce. However, it is important for policy to be grounded on solid evidence—both to overcome restrictive practices in support of sectional vested interests and to prevent inappropriate de-skilling in pursuit of mere cost-cutting.

41. Effective workforce planning requires effective training and professional development. Given the increasingly important role of healthcare assistants, it is essential that the Department of Health develop proper guidelines for the training requirements of this group of staff; and commissioners should take these requirements into account when commissioning care from healthcare providers.

42. We note that the Government has announced arrangements for the voluntary registration of healthcare assistants. However, in the absence of a professional regulator, we urge the Government to keep under review the requirements of this key element of the workforce for training and professional development. In the longer run, we reiterate our view that independent professional regulation of this group of staff provides the best assurance to patients.

Changing medical specialism

43. In its January 2012 report, the NHS Future Forum called attention to the fact that there was unfinished business from Professor Sir John Tooke’s report, Aspiring to Excellence (2008), in three important respects. Firstly, the Forum believed that the lack of flexibility in medical career pathways needed to be addressed. Secondly, it noted the major concern of employers that “the current system has resulted in too few generalists”.67 Thirdly, it reported “there was an almost unanimous view that the length of postgraduate GP training should be extended”.68

44. The DH gave its response to the Forum in From Design to Delivery (January 2012). The Department emphasised that “evidence of improvement in this area will be a critical part of HEE [Health Education England] and LETB quality assessments”.69 Medical Education England (MEE) was “working with the GMC, Wales, Scotland and Northern Ireland to establish an independent review of the shape of medical education and training”, and HEE would take this forward.70 On extending GP training, the DH was working on this with the Royal College of GPs, bearing in mind the need for changes to be “affordable and sustainable financially, as well as the right thing to do educationally and in the interests of patients”. Proposals were promised in spring 2012.71

45. When members of the Future Forum gave evidence to us in January 2012, Dame Julie Moore (Chair of the Forum’s education and training group) explained that greater flexibility in medical career pathways would have benefits in terms of workforce planning:

68 Ibid., para 84
69 Department of Health, From Design to Delivery, January 2012, para 18
70 Ibid., para 19
71 Ibid., para 20
The problem with workforce planning is I can say next year that I need more [Ear, Nose and Throat] surgeons, but it takes 10 or 12 years to make one and by the time you make one somebody might have invented a cure […] We believe there should be more flexibility in training so that, if somebody did invent a cure that meant you did not need a certain specialist, or you needed far fewer, then it would not take forever to retrain somebody.  

46. Professor Tooke, who sat on the Forum—and is now the Head of the School of Life and Medical Sciences at University College London (UCL)—explained the need to move away from the current inflexible system of career pathways. This was a “snakes and ladders” arrangement, whereby a doctor would ascend the ladder of “one of the myriad specialties” and could only switch to another specialty by sliding back down to retrain from the beginning again. We also heard from Dame Julie that the Forum thought “there should be more stop off points […] in a career for somebody who does not want to undertake the full range of consultant responsibilities.”

47. Professor Tooke echoed Dame Julie’s argument that creating more flexible career pathways could go hand-in-hand with fostering greater generalism—which was necessitated by an ageing population in which “co-morbidity is an increasing feature”. Trainees needed to be given “a grounding in generalism”. With this “profound foundation” under their belts, they would then be able to switch more easily between specialties during the course of their careers. Professor Tooke said that Aspiring to Excellence had proposed “some ways of converting foundation year 2 and the early part of core training into, say, four broad based generalist starts to specialist training”, yet this approach had not been widely adopted.

48. Dame Julie pointed out that there would also need to be a reversal of the attitude that generalists were of lower status than specialists. She pointed out that “In actual fact, you need a wider range of skills to be a generalist”, and referred to the situation in the United States, where generalist “diagnosticians” had “a very high status”.

49. In emphasising to us the case for longer GP training, Professor Tooke explained how this too was about achieving a broader generalist grounding:

we are fairly unique in Europe in assuming we can train a generalist—a general practitioner—in three years. We know, for example, that only half of GPs will have had relevant paediatric experience and probably the same proportion of relevant psychiatric experience. Yet those two disciplines account for a huge amount of the workload in the primary care setting.

50. Another Forum member, Dr Nightingale, of the Royal College of Anaesthetists, told us that having more generalists in the acute sector meant:

72 Q 218
73 Q 239
74 Q 235
75 Q 237
76 Loc. cit.
a reduction in the availability of specialist consultants’ advice. The only way to get round that is either to expand that section of the medical workforce or to reorganise services […] There is a need to put more of the specialised services in fewer numbers of larger hospitals if we are not going to expand the consultant workforce to work in more hospitals […] There is no doubt that quite a lot of the service and training tension that is in there, where trainees are not adequately supervised, is due to there being too many hospitals trying to teach those specialty areas.\textsuperscript{77}

Dr Nightingale related this to the Forum’s view that “perhaps not every hospital should be having trainees”\textsuperscript{78}—or, as Dame Julie added, “Not every department within a [training] hospital” should have them.\textsuperscript{79}

51. In February 2012, subsequent to our taking evidence from the Future Forum members, the CfWI published a study on the medical workforce. This suggested that, if medical services continue to be delivered as they are at present, by 2020 the NHS will have 2,800 more consultants than it needs (given the numbers currently in the training pipeline). This could be addressed by the proposed shift to more consultant-present services, but other measures would be needed too—such as having different levels of consultant, introducing a “consolidation” year into the career pathway and training more junior doctors as GPs.\textsuperscript{80}

52. When we heard evidence in February 2012 from Mr Royles, of NHS Employers, he told us that moving towards less reliance on trainees for service delivery would be “a fundamental shift for us”. He favoured the idea of patients being seen by “an appropriately qualified doctor”, but it was necessary to make optimum use of the “entire medical workforce”, including Non-Consultant Career Grades, as well as how members of the non-medical workforce were deployed.\textsuperscript{81}

53. The Chair of the Junior Doctors’ Committee of the British Medical Association (BMA), Dr Tom Dolphin, spoke in a similar vein:

The model we are proposing is not so much consultant-present as trained-doctor service. A trained doctor, of course, can include not just consultants, GPs and clinical academics but also staff and associate specialist doctors \textit{[i.e. Non-Consultant Career Grades]} who are trained for the role that they are performing […] While training occurs through exposure to patients and delivering patient care, our view is that junior doctors ought to be viewed as being employed primarily to train. There will be service provision arising from that, but their primary focus should be training. It is the current arrangement they have for GP trainees and we think that ought to be the same in hospitals.\textsuperscript{82}

\textsuperscript{77} Loc. cit.
\textsuperscript{78} Q 239
\textsuperscript{79} Q 240
\textsuperscript{80} Centre for Workforce Intelligence, \textit{Shape of the Medical Workforce}, February 2012
\textsuperscript{81} Q 333
\textsuperscript{82} Q 378, cf. Q 380
Dr Dolphin rejected the idea that there was a risk of trainees being “over-supervised”; he was more concerned that they should not be “under-supervised” and thought that “the days of ‘do not hesitate to cope’ have to come to an end.”

54. On the length of GP training, Dr Dolphin thought there needed to be “a good educational case made for it”; this had almost been made “but not quite yet”, and there were concerns about the impact on training places in hospitals. He expressed concern at the possibility of more “break points” in training (for people to consolidate their learning by focusing on service provision at a junior level). There was a danger that people could find themselves “stuck”, without a way back into training, as had happened with such arrangements in the past.

55. When witnesses from the DH gave evidence to us in March 2012, Dr Patricia Hamilton CBE, the Director of Medical Education, told us the Department recognised that Non-Consultant Career Grades had not been sufficiently recognised and that greater use could be made of them within the medical workforce. On the issue of career pathways, she reiterated that these were under review and that a more broad-based approach to post-Foundation training had been developed, to allow doctors to “go into the specialty of their choice without having to go—snakes and ladders—right to the beginning of training”. Dr Hamilton also restated the Department’s commitment to change working patterns to reduce dependence on trainees for the delivery of services through having more consultant-present services.

56. Regarding the CfWI’s forecast of an oversupply of consultants, the Minister told us that it would be addressed by more services being delivered outside hospitals—but he did not explain how. Dr Hamilton mentioned that it was hoped to “direct more trainees into general practice”; more consultant-present services would require more consultants; more consultants could work shorter hours (over longer careers); and the development of “the seven-day week hospital” would require more consultants (in fewer hospitals).

Conclusions and recommendations

57. Four years ago Professor Tooke set down a clear agenda on the future of the medical workforce which was widely accepted. An acid test of the effectiveness of the new education and training arrangements will be their ability to deliver the more flexible medical training programmes which were described by Professor Tooke and endorsed by the NHS Future Forum.
Junior doctor training

58. It has been argued that changes to junior doctors’ working hours have had the effect of undermining generalist training by limiting the range of clinical experience of newly qualified doctors.

59. From 2004 the European Working Time Directive (EWTD) was partially applied to doctors in training, limiting them to working no more than 58 hours per week. The Tooke Report recognised that this was having a very significant impact, leading in many cases to the introduction of multidisciplinary teams to deal with clinical problems outside normal working hours (under the “Hospital at Night Team” initiative). The EWTD’s impact has been all the greater since 2009, when the Directive’s full limit of 48 hours per week was extended to trainees—a limit which is widely seen as excessively restrictive.

60. The outcome of a review by Professor Sir John Temple of the impact of the EWTD on medical training (Time for Training) was published in 2010.92 This confirmed that, in the context of traditional models of training and service delivery, learning opportunities for trainees were being lost. Professor Temple concluded that service delivery and training models both needed to be reconfigured and redesigned. This meant particularly that there would have to be more “consultant-delivered” services around the clock, with less reliance on trainees to provide out-of-hours services.

61. A review of another aspect of postgraduate training, the Foundation Programme, was undertaken by Professor John Collins, resulting in the publication of his report Foundation for Excellence (2010). This recommended that supervision for trainees should be strengthened, as many were being required to act beyond their level of competency.93

62. When we took evidence from officials of the DH in November 2011, Dr Hamilton assured us that work was underway in response to the Temple and Collins reviews through a programme called “Better Training Better Care”. The intention was to avoid “service issues trumping training”94 and to move away from a situation of “our most junior doctors providing most of the service”, which meant they could not be trained within the constraints of the 48-hour EWTD limit. This entailed moving to “a more consultant-present service and different ways of working across and within the professions”.95

63. Christine Outram, the Chief Executive of MEE, explained that the need for junior doctors to be on out-of-hours rotas had led to their missing training opportunities in-hours. Some hospitals had already addressed this by structuring their hours differently “so there is greater availability of senior doctors to oversee the work of juniors and be available when juniors need particular guidance or advice”,96 the intention was to spread this good practice.97

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93 Professor John Collins, Foundation for Excellence: An Evaluation of the Foundation Programme, October 2010
94 Q 11
95 Q 12
96 Q 13
97 Q 17
64. Another witness from MEE, Professor Sir Christopher Edwards (the Chairman), reiterated the point that some hospitals had shown it was possible to change working patterns to accommodate the EWTD and allow junior doctors to access training opportunities.98

65. Professor Sir Peter Rubin, Chair of the General Medical Council (GMC), emphasised the need to distinguish training from mere experience—the two were “completely different”, and training required time to be set aside by both trainees and trainers for that purpose.99 Professor David Sowden, Chair of the Conference of Postgraduate Medical Deans of the UK (COPMeD), denied that there was a risk of de-skilling junior doctors by increasing the level of consultant supervision: “good supervision does not mean the consultant doing the job”.100 He also told us that there was a case for a new “modularised” approach to training, based on “credentialing”. This would involve “saying you have reached a certain level which allows you to do a certain range of activities within the system”, allowing trainees to step “on and off an education and training escalator”—in contrast to the current “relatively inflexible system”.101 Sir Alan Langlands, Chief Executive of the Higher Education Funding Council for England (HEFCE), drew attention to the importance of maintaining the “hugely significant progress” that had been made in rebuilding the clinical academic workforce.

Conclusions and recommendations

66. While we recognise that introduction of the European Working Time Directive has had a significant impact on working and training practices, we do not feel any rose-tinted nostalgia for a system which used to rely on over-tired and under-trained junior doctors. We have received a broad basis of evidence which shows how it is possible to reconcile reasonable hours for junior doctors with high quality training and, most importantly, high standards of care for patients.

Different approaches to treatment

67. We asked Dr Hamilton, the Director of Medical Education at the DH, about the need to take account in workforce planning of different types of treatment (including Complementary and Alternative Medicine). This is relevant both to patient choice and to the role of the National Institute for Health and Clinical Excellence in evaluating the effectiveness and cost effectiveness of interventions. Dr Hamilton told us:

We certainly need to be aware of the different therapies and ways in which patients would choose to be treated, and the place in which they need to be treated. For example, we have asked the Centre for Workforce Intelligence to look at patient pathways: to look at the various ways in which patients present to the Health Service
and the various options they might have for meeting different sorts of therapists in different ways. We can then help plan and train the workforce we think they need.\textsuperscript{102}

Her DH colleague Mr Rentoul added that employers needed to work together to see what training was needed (considering “what services we want to offer, the mix of skills and therapies to do it”); and there might also need to be national input too.\textsuperscript{103}

68. When Dr Hamilton again gave evidence to us in March 2012 she told us that “our curricula are being increasingly driven by service need and employers”. Complementary and Alternative Medicine, though, “work on a slightly different framework than the more scientific, evidence based framework from which we compose the rest of the curriculum.”\textsuperscript{104}

Conclusion and recommendation

69. A clear mandate must be set for the new system to take account in workforce planning of the full range of evidence-based treatments—subject to the evaluations carried out by the National Institute for Health and Clinical Excellence.

Overseas-educated staff

70. The NHS, like most healthcare systems in developed countries, has a long tradition of being open to staff trained outside the home country. Originally, such NHS staff came predominantly from former British colonies and Dominions, and from the Republic of Ireland. More recently, substantial numbers have come from other countries in the European Economic Area (EEA),\textsuperscript{105} as well as from a wide range of non-EEA countries. This migration has been, and is, driven by both “pull” factors in the UK (including active recruitment by the NHS) and “push” factors in migrants’ countries of origin.

71. These employment patterns have both positive and negative implications. It is important that the UK healthcare system is open to new ideas, and the diverse backgrounds of members of staff are an important source of new perspectives. Overseas recruitment of staff can, however, also be a symptom of failure of local workforce planning; and significant employment of overseas-trained staff can raise other concerns, particularly about language competence as well as the ethical implications of attracting staff from poorer countries which have their own needs for well-trained clinical staff.

72. The GMC states that—as at April 2012—91,262 of its registrants (37 per cent of the total) held a primary medical qualification obtained outside the UK, with the largest single overseas-qualified group (10 per cent of all registrants) being from India.\textsuperscript{106}

73. NMC data show that in 2010–11 it registered 3,858 people from outside the UK. Of these, 2,715 came from the EEA and Switzerland (the single biggest group being from the

\textsuperscript{102} Q 30
\textsuperscript{103} Q 31
\textsuperscript{104} Q 490
\textsuperscript{105} The EEA countries are the 27 members of the EU, plus Iceland, Liechtenstein and Norway.
\textsuperscript{106} www.gmc-uk.org/doctors/register/search_stats.asp
Republic of Ireland); and 1,143 from the rest of the world (the single biggest group being from the Philippines).\textsuperscript{107} According to recent press reports, 3,197 nurses from the EU registered in the UK between November 2010 and November 2011, compared to 2,256 in the previous 12 months.\textsuperscript{108} It has been reported that London hospitals are recruiting as many as a third of their nurses from abroad.\textsuperscript{109}

74. We heard in evidence that the contribution of overseas-trained staff to the NHS was widely valued. Mr Royles, of NHS Employers, told us:

overseas staff have made a fantastic contribution to the NHS, from those who came over in 1948 on MV Empire Windrush and started working in our hospitals to those who are coming from Europe now, or doctors who have come over and transformed things like general practice or care of the elderly […]

He noted that there was now an international labour market in healthcare staff, with many British-trained workers wishing to pursue their careers abroad. It was necessary to recognise that “that the world is much smaller now”. It was possible within that global labour market to recruit staff from developing countries who could “get learning, education and training” in the UK and then “take something back to their countries”.\textsuperscript{110}

75. Ms Taber, of Independent Healthcare Advisory Services, told us that her organisation had experienced problems convincing the UK Border Agency’s Migration Advisory Committee that operating theatre staff should not have been removed from the Committee’s list of shortage occupations. While it was accepted that more had to be done to “grow our own theatre staff”, while vacancies existed they needed to be filled by overseas staff.\textsuperscript{111}

76. We heard from the development organisation VSO and also from the Wellcome Trust about the Medical Training Initiative, which allows overseas medical graduates from developing countries to undertake short periods of training (up to two years) in the UK, filling locum posts. However, the success of this scheme was under threat from a possible reduction in the maximum length of stay allowed by the UK Border Agency under a Tier 5 visa from 24 months to 12.\textsuperscript{112}

77. Professor Tooke, of UCL, thought that “if we had the most accurate workforce planning that we could” the NHS could be less dependent on overseas staff. However, given that “we are not always going to get it right”:

it would be far more preferable to find a way of increasing the number of overseas medical students that we could accommodate, who would go back to their own country once they were trained. They would be a very significant export for us,

\begin{flushleft}
\textsuperscript{107} Unpublished data provided by the Nursing and Midwifery Council  
\textsuperscript{108} “Overseas nurse numbers rise by 40%”, Nursing Times website, 9 January 2012  
\textsuperscript{109} Michael Howie, “Third of hospital nurses in London are foreign as training is cut”, London Evening Standard website, 27 February 2012  
\textsuperscript{110} Q 326; cf. Q 327  
\textsuperscript{111} Q 323; cf. Q 326, Ev 166  
\textsuperscript{112} Ev w49–50, w152–3
\end{flushleft}
would be good for global health, good for future relationships between our country and theirs and yet provide a reservoir of talent were we to get the numbers wrong and under-pitch in our own estimates. That is far more ethical than under providing and then taking away people from whence they have been trained.\textsuperscript{113}

\textbf{Conclusions and recommendations}

78. The NHS has historically welcomed large numbers of staff from overseas, including healthcare professionals who have been educated and trained in other countries. Their contribution to the success of the NHS has been rightly acknowledged and celebrated.

79. We believe that the openness of the UK to clinical staff trained overseas, and the ability of UK-trained staff to work overseas, is a continuing source of strength to UK healthcare, and that this openness should continue to be reflected in workforce planning.

80. However, we also welcome the Government’s view that planning of the UK health and care workforce should not be dependent on significant future flows of trained staff from overseas, both in order to improve “security of supply” and in order to avoid “poaching” skilled staff from developing countries. This approach should apply to public and private healthcare employers.

\textbf{Locum and agency staff}

81. The NHS makes substantial use of locum and agency staff to deal with staff shortages. Concerns at the high cost of this approach led to the development of in-house “banks” of temporary staff and in 2001 NHS Professionals was set up to run a national in-house NHS bank organisation on a non-profit basis. Since 2004 NHS Professionals has been constituted as a Special Health Authority. It has over 50,000 staff available to it, including doctors, nurses and other healthcare professionals, as well as administrative and clerical workers.\textsuperscript{114}

82. However, \textit{Developing the Healthcare Workforce} (December 2010) argued that the cost of locum and agency cover was still too high (at over £1.9 billion a year).\textsuperscript{115} As recent publicity has shown, there is a widespread perception that the NHS wastes money through such spending.\textsuperscript{116} Mr Rentoul, of the DH, told us:

\begin{quote}
the NHS is spending too much on agency staff at the moment […] we have seen significant growth in terms of the number of people in different professions coming through training such that you would expect us to be making progress in reducing agency usage, though not seeking to eliminate it.\textsuperscript{117}
\end{quote}

\textsuperscript{113} Q 234

\textsuperscript{114} www.nhsprofessionals.nhs.uk

\textsuperscript{115} Department of Health, \textit{Developing the Healthcare Workforce – A consultation on proposals}, December 2010, para 3.19

\textsuperscript{116} Laura Donnelly and Melanie Mulhern, “NHS pays £20,000 a week for a doctor”, \textit{Daily Telegraph} website, 17 March 2012

\textsuperscript{117} Q 37
83. Professor Edwards, of MEE, told us that the use of agency staff was “a complicated issue”. It was an expensive way to employ staff and “they do not have the same allegiance, attitudes and local knowledge”, so the percentage of such staff did need to be restricted, although “You are going to need some”. Professor Sowden, of COPMeD, added that use of locums was an inevitable consequence of the current system of postgraduate medical training and the gaps it created. With a different approach to workforce planning, the use of locums could be reduced—although not eliminated.\textsuperscript{118}

84. Mr Royles, of NHS Employers, told us:

agency and locum staff play an important part in having a flexible workforce. Therefore, occasionally, we need to bring in staff temporarily for short term increases in activity or to cover unexpected or more long term sickness absence. All those things are a legitimate use of agency and locum spend.

His understanding was that the Government did not wish to eliminate the use of such staff completely, only to ensure that it was done “in the most strategically efficient way that you can.”\textsuperscript{119}

\textit{Conclusion and recommendation}

85. \textit{We accept that locum and agency staff provide a necessary element of flexibility in NHS staffing arrangements. We do not believe, however, that they provide an optimum solution, either in terms of quality of care or value for money. We, therefore, urge the Government to proceed quickly with improved arrangements for workforce planning, which should reduce the importance to the NHS of locum and agency staff.}
3 Organisation of education, training and workforce planning

The Secretary of State

86. The Government made clear in *Equity and Excellence* (July 2010) that “In future, the Department will have a progressively reducing role in overseeing education and training.”120 This was elaborated on as follows in *Developing the Healthcare Workforce* (December 2010):

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.121

At the same time, the consultation document also envisaged that the Secretary of State would have a role in holding to account HEE as regards “mid- to long-term system viability”, and meeting national workforce needs and strategic commissioning intentions.122

87. In its response to the Future Forum in June 2011, the Government promised that “To reinforce its importance, we will introduce an explicit duty for the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service.”123 The Health and Social Care Bill was amended accordingly.124

88. The response to the Future Forum also announced that the DH would “develop a national education and training outcomes framework, setting out the outcomes that HEE would expect providers to meet”.125 In evidence to us, the Department indicated that this would provide “metrics and indicators” to allow HEE to hold providers to account;126 but it was not made clear or explicit what role the Outcomes Framework would play in the Secretary of State holding HEE to account. Ms Outram, the Senior Responsible Officer for HEE, told us that HEE would be “accountable to the Secretary of State” through “a mandate—an agreement—with the Department that will be reviewed, over time, to deliver certain things.”127

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120 Department of Health, *Equity and Excellence: Liberating the NHS*, Cm 7881, July 2010, para 4.33
121 Department of Health, *Developing the Healthcare Workforce – A consultation on proposals*, December 2010, para 1.8, cf. para 1.4
122 Ibid., para 6.8
124 Health and Social Care Act 2012, section 7
125 Department of Health, Cm 8113, June 2011, para. 6.18
126 Qq 457, 519
127 Q 59
89. The Department subsequently affirmed, in From Design to Delivery (January 2012), that “The education and training system will remain accountable to the Secretary of State.” He “already has broad powers for education and training” and his new statutory duty in this regard was “not to grant new powers to intervene.” Rather, the “aim is to ensure the new education and training system is set up to deliver a greater level of local accountability and responsibility for decision-making: a system that aspires to excellence and supports the values of the NHS.” HEE would be “accountable to the Secretary of State” from the outset and would remain so.

90. Regarding the Education Outcomes Framework, the Secretary of State’s own introduction to From Design to Delivery explained that this:

\[\text{will directly link education and learning to improvements in patient outcomes. By providing a clear line of sight and improvement to patient outcomes, it will help address variation in standards and ensure excellence in innovation through high quality education and training.}\]

The document itself further explained:

Working with employers, clinicians and education providers, the Department, LETBs and HEE will develop a suite of metrics so that the system can demonstrate at all levels education quality outcomes as they impact on patient experience, care and safety.

Outcomes would be organised into the five following “key domains”:

- Excellent education;
- Competent and capable staff;
- Adaptable and flexible workforce;
- NHS values and behaviours, and
- Widening participation.

Conclusions and recommendations

91. We welcome the inclusion in the Health and Social Care Act 2012 of an explicit duty on the Secretary of State to secure an effective system of education and training. However we are concerned that there continues to be insufficient clarity about how the Secretary of State intends to discharge this duty. In particular, we seek reassurance that the Secretary of State shares our view that the effectiveness of the new system will be fatally undermined if it is not built upon a more accountable and transparent system of workforce planning.

128 Department of Health, From Design to Delivery, January 2012, para 6
129 Ibid., paras 37, 47
130 Ibid., p 5
131 Ibid., para 14
132 Loc. cit.
92. We also welcome the fact that the Secretary of State will have a clear responsibility for holding to account Health Education England. The Department must, though, spell out how exactly this will be done—including the part that the planned Education Outcomes Framework will play.

Health Education England

93. In Professor Tooke’s 2008 report on postgraduate medical education and training, *Aspiring to Excellence*, he recommended the creation of a new national body, NHS Medical Education England (NHS:MEE). This was intended to act as a single overarching education, training and workforce planning body for this section of the workforce, with control of a ring-fenced budget and engagement from the medical profession. 133

94. Later the same year, in *A High Quality Workforce*, it was announced that an independent body, to be called just MEE, would be created—but it would only be advisory in nature, without control of budgets. In addition, its remit would extend beyond doctors to include dentists, healthcare scientists, pharmacists and low-volume specialties. 134 MEE was established on this basis in 2009 as an Advisory Non-Departmental Public Body (NDPDB), with engagement from the professions facilitated through four separate Programme Boards for doctors, dentists, healthcare scientists and pharmacists. Similar Professional Advisory Boards (PABs), sitting outside MEE, were subsequently set up: the Nursing and Midwifery PAB, and the National Allied Health Professional Advisory Board (AHP-PAB).

95. In its original “vision” for NHS education and training, in *Equity and Excellence* (July 2010), the Coalition Government envisaged that:

   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. 135

However, in *Developing the Healthcare Workforce* (December 2010) it was proposed to create a new body, with executive powers, which would supersede both MEE and the PABs—namely HEE. It was explained that HEE would be “a lean and expert organisation, free from day-to-day political interference” 136 and that its role would mirror that of the NHS Commissioning Board in relation to commissioning healthcare services, in that it would perform functions that could only be undertaken at the national level. It would “have national oversight of education and training, whilst leaving healthcare providers with

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133 Modernising Medical Careers Inquiry, *Aspiring to Excellence: Findings and final recommendations of the independent inquiry into Modernising Medical Careers led by Professor Sir John Tooke*, January 2008, Recommendation 47 (pp 137–8)


135 Department of Health, Cm 7881, July 2010, para 4.33

136 Department of Health, *Developing the Healthcare Workforce – A consultation on proposals*, December 2010, para 6.3
a high level of autonomy”; and it would “work with the Department of Health to address the planning and development of the public health workforce”.

96. The need, in HEE’s relationship with the skills networks (as LETBs were then being called), to achieve “the right balance of strategic oversight, whilst giving healthcare providers greater freedom for education commissioning” was noted. HEE might need to commission at the national level education “for smaller professional groups, for example for healthcare scientists”; and where national priorities might have to override the aggregate of local plans, this “would need to be an evidence-based, fair and transparent process”. In discharging these responsibilities, HEE would 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.[137]

97. The timetable set out by the Government at this stage envisaged HEE becoming “established in shadow form in 2011 and as a special health authority to go live in April 2012, with the issue of its longer-term form being “revisited after April 2012”. As it turned out, however, matters proved rather more long drawn-out than this.

98. In June 2011 the DH put back to April 2013 the date at which HEE would become operational—in line with the decision to delay the abolition of Strategic Health Authorities (SHAs) to that date. At the same time, it promised to “ensure that HEE is in place quickly”, as a Special Health Authority “in shadow form, without full functions”, during 2012.

99. In July 2011 Sir David Nicholson announced that a Senior Responsible Officer for HEE would be appointed, to accelerate the process for setting up the new body. In October 2011 the appointment of Ms Outram to this post (in combination with her existing post of Chief Executive of MEE) was announced.

100. In autumn 2011 the Government promised that draft primary legislation “to support the continuing development of the education and training system, including establishing Health Education England as a non-departmental public body” would be brought forward for pre-legislative scrutiny in the new Parliamentary session, beginning in 2012.

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137 ibid., para 6.4
138 ibid., para 6.7
139 ibid., para 6.8
140 loc. cit.
141 ibid., para 9.6
142 Department of Health, Cm 8113, June 2011, para 6.8
143 ibid., p 60
101. When we took evidence from the DH in November 2011, Mr Rentoul explained that HEE would establish “national leadership and focus […] rather than having a set of functions sitting betwixt the Department of Health and strategic health authorities”\(^{146}\). By encompassing all healthcare professions and controlling funding (unlike MEE), HEE would provide “grit in the system in terms of outcomes achieved”.\(^{147}\)

102. We heard in addition from Ms Outram, as the person “leading on the set-up of [HEE]”\(^{148}\). She explained the sort of functions that would have to be undertaken by HEE at the national level. These included commissioning for “very small specialties, for example, where branches of some of the professions need very few people—types of medicine where you might need about 10 people across the country”. Another example was “the recruitment of junior doctors for the different specialty training paths”, where “There is an understanding that, to get that planning right, you need to take a national view”.\(^{149}\) HEE’s relationships with the NHS Commissioning Board and Public Health England (the planned new dedicated national public health service) would be “particularly important”.\(^{150}\)

103. Ms Outram also told us about her intention “to ensure a smooth transition” of the functions of the Programme Boards and PABs into HEE.\(^{151}\) We further heard about transitional arrangements from Kate Lampard, the Chair of the HEE Steering Group, which she explained was designed to “get the involvement and the perspective of a wide group of stakeholders” as early as possible. The group would:

> be providing the leadership to ensure that we set up the new system, the new architecture, appropriately, so that it takes account of the views of the stakeholders, and to offer support, encouragement and challenge to the staff as they set up Health Education England. In due course, we will hand over, to a formal board, Health Education England.\(^{152}\)

104. Subsequently, in \textit{From Design to Delivery} (January 2012), the Department stated that HEE would now “be established as a Special Health Authority (SpHA) in June 2012, taking on some functions in October 2012 and ready to take on full operational functions from April 2013.”\(^{153}\) It confirmed that establishment as an NDPB would happen after pre-legislative scrutiny in the coming Parliamentary session (2012–13) and legislation “as soon as Parliamentary time allows”.\(^{154}\) (The website for HEE now states that it will be established in July 2012.)\(^{155}\)

105. The key national functions for HEE were recast as follows:

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146 Q 23; cf. Q 442  
147 Q 24  
148 Q 1  
149 Q 41  
150 Q 56  
151 Q 39  
152 Q 38  
153 Department of Health, \textit{From Design to Delivery}, January 2012, para 36  
154 Ibid., para 37  
155 healtheducationengland.dh.gov.uk/about/timeline
• providing national leadership on planning and developing the healthcare and public health workforce;

• authorising and supporting the development of LETBs;

• promoting high quality education and training responsive to the changing needs of patients and local communities […]);

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

• ensuring the security of supply of the professionally qualified clinical workforce.156

An annually updated Strategic Education Operating Framework for HEE would “set out the medium and long-term context for the development of the health and public health workforce”.157

106. We heard in evidence from NHS Employers the view that “HEE must be employer led and patient focused.”158 Mr Royles, of NHS Employers, explained to us that, since HEE was being set up over employer-led LETBs:

we need employer representation, employer led, with Health Education England so that if there are disputes, conflicts or issues people have trust in that system. That might be about bringing people into Health Education England who have particular expertise in this area and who also happen to be employers and, maybe, medical directors, nursing directors, HR directors and chief executives.159

However, the Minister did not recognise this conception of HEE when we asked him about it.160 Mr Rentoul of the DH explained to us that HEE needed to carry not just the confidence of employers but also of “the education sector, professionals, patients, the commissioning system and, indeed, regulators […] This is about bringing together a range of different perspectives and making the system work effectively.”161

107. Evidence that we received from COPMeD in February 2012 raised the concern that there would not be sufficient time in the new Parliamentary session to legislate in relation to HEE, as the Government intends. COPMeD proposed that clauses be added to the Health and Social Care Bill, setting out principles to which HEE must be obliged to adhere in relation to: national workforce planning; ring-fenced funding of education and training; independent quality management and assurance of education and training; and national standards for delivery and outcome, particularly in respect of medical education.162

156 Department of Health, From Design to Delivery, January 2012, para 40
157 Ibid., para 55
158 Ev 159
159 Q 306
160 Q 443
161 Q 444
162 Ev 164
108. The Government’s reform proposals entail shifting at the national level from a body oriented towards certain professional groups (MEE) to one whose remit covers the entire healthcare workforce (HEE). This will bring the NHS in England into line with a number of other developed countries where a multi-professional approach to healthcare education, training and workforce planning is already well established. One such country is Scotland, where an equivalent body to HEE, NHS Education for Scotland, was established as long ago as 2002. We heard several times in evidence positive comments about the role of NHS Education for Scotland and its potential to serve as a model for HEE.\(^{163}\)

109. In *Developing the Healthcare Workforce* (December 2010) the DH promised to consult with the devolved administrations “to ensure a UK-wide approach to […] workforce strategy within the new framework, where this is relevant”.\(^{164}\) We heard in written evidence from the Royal College of Surgeons of Edinburgh about the extent to which the wider workforce “moves freely from country to country within the United Kingdom”.\(^{165}\) When we took oral evidence from Ms Outram, the Senior Responsible Officer for HEE, in November 2011 she explained the UK aspect of HEE’s role as it affected workforce planning:

> I do not think HEE has to take a UK view, but it has to bear in mind that the labour force it is working with—the market it is operating in—is UK wide. For example, if it was to cut the number of healthcare scientists it was training, in my opinion, it should not do that without discussing it with the devolved Administrations.\(^{166}\)

Mr Rentoul, of the DH, added that diminishing numbers of doctors trained in Scotland would have “a potential impact on England” and noted the need for an “exchange of information so that we each understand what is going on”.\(^{167}\) This point was elaborated for us by Professor Edwards, of MEE, who told us that “a UK wide perspective” was “absolutely vital”.\(^{168}\)

110. When we heard evidence from Professor Tooke, of UCL, he stressed the importance of “a central view and central intelligence […] to ensure that, for certain specialties, a national UK wide provision is protected.”\(^{169}\)

111. In *From Design to Delivery* (January 2012) the DH cited one of the underlying “design principles” for the new system as “supporting the development of the whole workforce, within a […] UK-wide context”.\(^{170}\) It reiterated that “HEE will work with the professional
regulators and the authorities in other parts of the UK to ensure a UK wide approach to […] workforce strategy.\textsuperscript{171}

Conclusions and recommendations

112. We welcome the plan to set up Health Education England as an executive body with overall responsibility for education, training and workforce planning, drawing input from all healthcare professions and other stakeholders. The creation of such a body is long overdue and has the potential to be a significant step forward.

113. However, we are concerned, given the centrality of this body to the Government’s plans, that the Government has been slow in developing a coherent plan for the new organization. It is being set up in shadow form in July 2012 and will be fully operational in April 2013. There is an urgent requirement for the Government to publish a clear and detailed execution timetable.

114. In the absence of this timetable there continues to be a lack of clarity about the role, responsibilities, powers and structure of Health Education England. Fears have been expressed to us that Health Education England, growing out of Medical Education England, could be predominantly focused on the medical workforce, despite its multi-professional remit. The Government must show that it is addressing and allaying these fears.

115. Greater clarity is particularly needed about how Health Education England plans to ensure that it develops a dynamic view of the changing education requirements of the whole health and care sector.

116. Greater clarity is also needed regarding the role of Health Education England in relation to the professional regulators and to its counterpart organisations in other UK countries.

117. The Government has acknowledged the need to take account of the UK-wide dimension of education, training and workforce-planning policy. However, in that context we are concerned that there must be adequate emphasis on workforce planning in particular.

Local Education and Training Boards

Status, composition, governance and size

118. The Government’s view of the status, composition and size of LETBs changed significantly between July 2010 and January 2012. In July 2010 the Government indicated that, in future, “healthcare employers and their staff” would be responsible for deciding on plans and funding for education and training.\textsuperscript{172}

\textsuperscript{171} Ibid., para 61
\textsuperscript{172} Department of Health, Cm 7881, July 2010, para 4.33
119. In *From Design to Delivery* (January 2012), the DH was more prescriptive; it defined LETBs’ purpose as being to:

- Identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public health services;
- Plan and commission education and training on behalf of the local health community in the interests of sustainable, high quality service provision and health improvement;
- Be a forum for developing the whole health and public health workforce.173

On this basis, a series of “core functions” for LETBs was set out.

120. Membership arrangements for LETBs “should provide fair representation across the range of healthcare and public health employers, including acute, mental health and community services, primary care and local government.”174 There would be a requirement to have “a formal, decision-making Board accountable to HEE that derives its membership from the full range of healthcare and public health providers so that all types of healthcare provider are fairly and proportionately represented.”175

121. The size of LETBs was “a matter for local decision”, but the DH suggested “a scale of enterprise not too dissimilar to the range of current [postgraduate medical] deaneries [which are organised at regional level]”.176 The Department would “establish the legal form for LETBs when we set up HEE”.177 LETBs would be established in the first instance, by April 2012, as Education and Training Sub-Committees within SHAs (now gathered together into supra-regional clusters, ahead of their planned abolition in April 2013). These would then become “precursor LETBs” (subject to authorisation by HEE) in April 2013.178 It was further stated that “While the new NHS and public health system is taking shape and maturing the LETBs will be hosted by HEE from April 2013.”179

122. Broad authorisation criteria were set out. LETBs would have to show “Proper constitutional and governance arrangements to manage competing interests, and allow secure exchange of commercially sensitive workforce information”, but no indication was given of what these should be. LETBs would have to make provision for “Fair representation of local healthcare and public health employers, across sectors and including community and primary care employers, and private, voluntary and independent sector employers”. As regards “the education sector and local government”, they would only be required to have “Meaningful partnerships and engagement”.180
123. Although the Government’s views about LETBs have developed, their status and role continues to be the subject of considerable uncertainty. According to the DH, “Determining the detailed authorisation criteria, the accountability framework for allocating […] funding and establishing the authorisation process” for LETBs would all be “critical actions for HEE in its first year.”181

124. When we took evidence from members of the Future Forum shortly after the publication of From Design to Delivery, they informed us that each LETB was now to have the status of “an outpost of HEE”.182 In the Forum’s January 2012 report it noted there was “major support for common terms of reference and a single model for LETBs to promote consistency across the country”.183

125. When we took further evidence from Mr Rentoul, of the DH, in March 2012, he developed this thought as follows:

   The Local Education and Training Boards will be committees of Health Education England. Health Education England, subject to parliamentary approval, will be set up as a special health authority. The Local Education and Training Boards will be sub committees of that special health authority with formal schemes of delegation for what they are being asked to do.184

He explained that, in the DH’s original plans, LETBs had been envisaged as “being autonomous bodies, whether statutory or hosted by another NHS body”; on that basis, a contractual relationship between HEE and the LETBs had been considered. However, now it was intended that LETB staff would be directly employed by HEE; and LETBs’ relationship with HEE would be “more of a service level agreement and a formal scheme of delegation.”185 LETBs would be “formal sub committees of HEE with the level of delegation reflecting the authorisation process, again, with the intention of more delegated, devolved decision making.”186

126. On the number of LETBs, Mr Rentoul reiterated the estimate he had previously given us ("something like 10 to 15 as a kind of estimate").187 When this was qualified by the Minister ("The estimate is 12 to 16"), Mr Rentoul added: “There is quite a lot of active discussion locally on what they see as the right footprint, relationships, scale and leadership capability for them, and so on.”188

127. The emergence of LETBs at the regional level has led to talk of the possibility of more localised “sub-LETBs”.189 Mr Royles, of NHS Employers, emphasised the need for local
discretion for LETBs to “configure themselves to deliver for their local organisations and the patients in those areas”. He explained that:

With the idea of a labour market in somewhere like South Yorkshire, for example, or places in the north west around Greater Manchester, where they share a variety of different higher education institutions, it makes perfect sense that that is where that relationship is carried out.190

128. As regards the membership of LETBs, the Minister told us:

They will derive their board membership from a range of healthcare and public health providers, so that all types of healthcare are included and their views can be considered. What the board will also have is representation from local education providers who will agree in the developing of local public health workforce and research, as well as local government […] They will set up advisory arrangements to reflect the breadth of local interest and ensure that the decisions that are taken are reflective of the needs of local communities.191

Mr Rentoul added that:

A number of them—[…] in their current development stage—have a board, which may be 12 to 15, but also a wider partnership council that involves the wider range of stakeholders, to make sure the range of interests is represented.192

129. The level of detail that is starting to emerge about the composition of LETBs does appear to be assuaging some concerns which had previously been expressed. This was apparent from evidence that we took from Dr Dolphin, of the BMA, in February 2012:

One of the concerns we had originally was that the LETBs looked like they were going to be too employer-dominated—too heavy on the employer side. The proposition that is currently on the table is a lot better in the balance that it achieves.193

130. However, significant unease continues to be expressed by higher-education bodies about the role that they will play in LETBs. Supplementary evidence that we received from million+ (a university think tank) in March 2012 reiterates the fear that “LETBs may include a majority—and possibly a monopoly of healthcare providers.” On this basis, the organisation fears that there will be an overriding concern with “immediate or short-term workforce requirements” to the exclusion of considerations such as clinical academic workforce needs. Furthermore, there is a fear that “the LETBs will be dominated by the needs of acute providers” in particular. million+ also draws attention to what it sees as the potential for conflicts of interest to occur, with, for instance, “NHS providers in receipt of CPD funding […] able to award CPD training contracts to themselves”.194
131. There are also still issues concerning the involvement in, and representation on, LETBs of non-NHS providers, non-acute NHS providers (including GPs), and social-care commissioners and providers. We heard from Ms Taber, of Independent Healthcare Advisory Services, that involvement of the independent sector in a LETB was being piloted with the Midlands and East SHA cluster. Ms Taber felt “There must be, almost, a mandate for all the LETBs to have an independent sector representative on them.” She also told us that “The management of [the Midlands and East] LETB is going through Skills for Care to involve the social care side. There is a huge workforce out there that is not involved.” Mr Worskett, of the NHS Partners Network, noted the lack of any guarantee as regards LETBs engaging with the independent sector. He feared a replication of the current situation in respect of postgraduate medical deaneries, where independent-sector involvement had been “patchy.”

132. In written evidence in December 2011 the Royal College of General Practitioners told us it was “concerned that the new system may be dominated by secondary care providers such as Foundation Trusts”. It contended that “Whilst GP-employed staff only account for 10% of the NHS workforce […] the College believes that as a minimum GP provider representation on LETBs should be in excess of 10%”. This was because of: the complexity of general practice (with large numbers of heterogeneous providers); the fact that GP provision accounted for a disproportionate number of patient contacts in the NHS (90 per cent); and the fact that GPs were almost as numerous as hospital consultants. However, the DH still has yet to set out what the arrangements will be for the representation of GPs on LETBs—beyond saying that primary care providers will (like all others) be “fairly and proportionately represented”.

Conclusions and recommendations

133. We welcome the Government’s plan to create Local Education and Training Boards as provider-led bodies to take responsibility for education, training and workforce planning below the national level. We are concerned, however, at the Government’s protracted failure to produce concrete plans in respect of the Boards, which poses a significant risk to their successful establishment.

134. Between July 2010 and January 2012 the Boards were conceived of as loosely defined non-statutory “legal entities”, to be developed at local level. The Government has now concluded that they should be “outposts” of Health Education England. There is, however, still little central guidance about the requirements for authorization, despite the recommendation of the NHS Future Forum that there should be “common terms of reference and a single model […] to promote consistency across the country”.

135. It is unsatisfactory that so much about the Boards still remains vague and indeterminate. Crucially, the precise extent of their autonomy, and the means by which
they will be authorised and held accountable, are still worryingly opaque. This must be spelled out as a matter of urgency.

136. We welcome the Government’s guidance that Local Education and Training Boards should be comprehensive bodies, not restricted to healthcare providers. However, concerns remain among higher-education institutions that their viewpoint will not be adequately heard. The Government should provide a definitive list of stakeholders which should be represented, as well as providing greater clarity on other aspects of governance—not least how potential conflicts of interest are to be addressed.

137. We are also concerned that the geographical basis of Local Education and Training Boards remains obscure. Evidence submitted to us that there will be “10 to 15” (or alternatively “12 to 16”) calls into question their ability to reflect local conditions. There is a definite need for structures at the level of local health economies and the Department must make clear how these are to be facilitated.

Postgraduate deaneries

138. Postgraduate medical deaneries, which are currently incorporated into the SHAs, have a crucial set of responsibilities. They oversee the quality of postgraduate medical education for all those who have completed their first year of (post-qualification) vocational training. They commission and manage the delivery of postgraduate education for all doctors in training, across all grades, specialties and modes of training. They ensure the availability of sufficient training places to meet the NHS’s future needs and that recruitment to training places is rigorous and fair. Lastly, they advise SHAs on the distribution of funding for postgraduate training to providers (NHS Trusts, FTs and training GP practices) under Learning Development Agreements.

139. Deaneries liaise with the medical Royal Colleges and their Faculties. They also liaise with, and are accountable to, the GMC. At the national level, deaneries work together through COPMeD to ensure high standards and their consistent application throughout the UK. The Director of Medical Education for England at the DH (who reports to the NHS Medical Director) provides national professional leadership for the deans.

140. In Developing the Healthcare Workforce (2010) the DH indicated that the planned skills networks (i.e. LETBs) would take on the “functions” of the deaneries, as part of a multi-professional approach to postgraduate education and training. However, nothing more was said about what the fate of the deaneries would be, leading to considerable anxiety on this score.

141. In November 2011, when we took evidence from the current Director of Medical Education at the DH, Dr Hamilton, we asked her about the future of the deaneries. She told us:

They are very important and their function is essential. We have done a lot to assure their continuation during transition and the intention is that they continue beyond

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200 Department of Health, Developing the Healthcare Workforce – A consultation on proposals, December 2010, paras 5.21, 5.22, 5.26, Annex B (pp 73–4)
transition with, probably, many of the same staff. We have to talk about functions rather than individuals, but those functions will continue into the new system architecture.\textsuperscript{201}

142. She also said that “Deans and deaneries […] have an important role to play” and would be accountable to HEE in the new system.\textsuperscript{202} Deaneries would “move out of the SHA aegis at the end of March 2013 and into the new system architecture”, at that time becoming “truly multi-professional”. There would also be “obvious economies of scale and economies to be made in back office functions being shared and so on” when the deaneries became part of the LETBs.\textsuperscript{203} Within the LETBs, “The dean should be part of the board, because it is crucial that they represent the quality of education and training”.\textsuperscript{204}

143. Other evidence that we took in the autumn of 2011 reflected continuing anxiety about the future of the deaneries. Professor Sowden, of COPMeD, told us that the deaneries had to continue:

because they fulfil such an essential function at the moment. If they were not there, you would only have to reinvent them. Some countries around the world are in the process of inventing postgraduate deaneries by another name because they have had problems with systems that do not have postgraduate deaneries in them.\textsuperscript{205}

He indicated that haemorrhaging of experienced staff was continuing. There was a:

huge gap with people thinking, “What are we going to do?” These people are a scarce resource. Other people want them. Some of them are going off into the private sector and elsewhere. It will be almost impossible to get their like again for several years because we have struggled with that skill set over the last decade or two.\textsuperscript{206}

144. Sir Peter Rubin, of the GMC, explained why the specific role of postgraduate dean needed to continue:

The key thing is holding somebody, not a nebulous committee but a named person—nailing a named person—to account for the quality of postgraduate medical education in their area. That needs to be the postgraduate dean. The postgraduate dean needs to have the levers necessary to produce change when change is needed and those levers will usually be financial levers.\textsuperscript{207}

145. In *From Design to Delivery* the DH stated that LETBs would need to “operate on sufficient scale to offer a safe transition for the enduring workforce functions of SHAs, including the deaneries”. It was in consequence of this that “a scale of enterprise not too dissimilar to the range of current deaneries” was suggested for LETBs.\textsuperscript{208} Their “executive
structure and operational arrangements” would need to “ensure enduring deanery functions”.209 It was reaffirmed that deans and deaneries would provide “operational management” and “continuity” in their areas of responsibility during the transition period (up to April 2013).210 The “principles of the Human Resources Transition Framework agreed to underpin the wider [NHS] system reforms” would apply to education and training staff in SHA clusters, which would support LETBs in retaining the skills of current staff, including those in deaneries.211

146. The Department also stated that LETBs would:

need to appoint a Director of Education and Quality, or equivalent position, to be accountable to the Board for the effective quality management of education and training programmes commissioned or provided by the LETB. The Director of Education and Quality may also be the Postgraduate Medical Dean.212

The “function” of postgraduate dean was described as “key” and “essential”; and it was stated that “There must be a Senior Responsible Officer (SRO) role for junior doctors”213— which position could be held by the Director of Education and Quality. Occupants of these roles must be accountable to HEE for “professional education leadership”.214

147. When we took evidence from members of the NHS Future Forum in January 2012, Dame Julie Moore emphasised “the importance of not losing expertise and experience”. She argued that “If the [Director of Education and Quality] is not the postgraduate dean, then there must be medical representation on that [LETB] board.”215

148. Another Forum member, Professor Tooke, thought it was important to ensure “that the postgraduate deanery function is informed by educational expertise that resides within our universities”.216 He thought the new system would help address the fact that the deanery function had become “divorced from higher education”. We were “the only system in the developed world that has done that and, I would suggest, at a cost, so that we are not linking in educational expertise with the training of that important professional group [i.e. doctors]”.217

149. Professor Tooke’s Future Forum colleague Dr Nightingale, of the Royal College of Anaesthetists, wanted the Royal Colleges to be more involved in controlling the quality of training, “as opposed to the GMC working with the old deanery function”.218 (This appears, however, to run counter to the second Future Forum report, which seemed to

209 Ibid., para 83
210 Ibid., para 90
211 Ibid., para 89
212 Ibid., para 96
213 Ibid., para 98
214 Ibid., para 99
215 Q 224
216 Q 267
217 Q 209; cf. Q 212
218 Q 265
suggest that the extent of the Royal Colleges’ role was a factor in the system being overly complex.\textsuperscript{219} 

150. The issue of how consistent national (\textit{i.e.} UK) standards will be maintained across deaneries seems still to be contentious. Written evidence that we received from COPMeD in February 2012 argued that \textit{From Design to Delivery} “does not provide sufficient assurance on this topic”. There seemed to COPMeD to be “a genuine risk that local variation could be permitted at a level which might undermine national standards, and it is unclear to COPMeD as to how Colleges and Faculties will input into either national or local arrangements”. Also, the interface between HEE and the GMC in this regard seemed uncertain.\textsuperscript{220} 

151. COPMeD had additional concerns about “the necessary independence of quality management and assurance functions, particularly at the level of the LETBs with regard to PG [postgraduate] Deans and Deaneries”. It suggested “that more work needs to be done on this aspect of the proposed arrangements, ensuring that there is greater independent professional input from both PG Deans and specialties”.\textsuperscript{221} 

152. When we took evidence in February 2012 from Dr Dolphin, of the BMA, he told us that the Association would prefer deans to be employed by HEE and seconded to LETBs, as that would allow the deans:

> to remain independent with regard to enforcing the quality of training. They would be able to act without fear or favour when they go to the different employers, without having to worry that their employment status might affect their judgment.\textsuperscript{222} 

It actually appears from what we later heard from the Department that this will be the case, as all LETB staff are to be employed by HEE.\textsuperscript{223} Moreover, in the same evidence session, Dr Hamilton told us that the need for an independent challenge to the quality of medical training made it “very important to preserve the function of the deans”:

> We would expect the LETBs to be able to demonstrate that the dean can act independently of the conflicts of interest that may arise, particularly with service and training, in making sure the quality of training is preserved and not sacrificed to service and yet not compromising service either so we get that balance right.\textsuperscript{224} 

She reiterated several times the important role that the deans and deaneries were envisaged as playing in the new system within LETBs, both in respect of medical training and in their intended new multi-disciplinary role.\textsuperscript{225}

\begin{flushleft}
\textsuperscript{219} NHS Future Forum, \textit{Education and Training – next stage}, January 2012, para 60
\textsuperscript{220} Ev 162
\textsuperscript{221} Ev 163
\textsuperscript{222} Q 371
\textsuperscript{223} Q 446
\textsuperscript{224} Q 455
\textsuperscript{225} Qq 454, 460, 494, 544; cf. Q 429
\end{flushleft}
The Government’s intention that all the deaneries will become “truly multi-professional” within the new system is a significant policy innovation. Professor Sowden, of COPMeD, was confident that this could be achieved—provided that existing expertise could be retained:

The multi-professional bit is not difficult. It requires a different mindset and approach, but it is perfectly possible to achieve. We need to ensure that we secure the expertise we have within the system at the moment. Within a multi-professional deanery setting, that will be the existing postgraduate deanery staff together with those people in strategic health authorities who run education commissioning—so they are commissioning for the other healthcare professional groups—and workforce planning and development. Without those two bits together, you cannot create a multi-professional deanery.

Some deaneries are in fact already operating on a multi-professional basis. One example is the East of England Multi-Professional Deanery. Another was the former Trent Multiprofessional Deanery, which merged in 2007 with the Leicestershire, Northamptonshire and Rutland Healthcare Workforce Deanery to form the East Midlands Healthcare Workforce Deanery. The new East Midlands Deanery was initially constituted on a multi-professional basis too, but Professor Sowden, who was himself the Dean, told us that it had actually reverted to being only a medical deanery. He explained in subsequent written evidence that this had come about as a result of the requirement to effect a purchaser / provider split in respect of deaneries. The multi-professional education and training functions of his deanery were transferred to the SHA Workforce Directorate, as part of the commissioning role, leaving Professor Sowden with a postgraduate medical deanery constituted as a provider unit.

Conclusions and recommendations

The integration of the postgraduate deaneries into the new system will be crucial to its success. We regret the fact that the Government allowed uncertainty about the future position of the deaneries to persist for so long. Although there is now greater clarity of intention, the period of uncertainty led to a regrettable loss of experienced staff.

There continues to be an urgent need for more precision about how the deaneries will operate in future. The distinct position of postgraduate dean should continue to exist to provide an independent professional voice. There needs to be greater clarity about relationships with the General Medical Council, the Director of Medical Education and Health Education England. Finally, there must be a convincing plan to
realise the Government’s stated aspiration for deaneries to become “truly multi-professional” in their new role.

**Innovation bodies**

157. In *From Design to Delivery* (January 2012) the DH stated that LETBs would need to “build alliances with” Health Innovation and Education Clusters (HIECs), Academic Health Science Centres (AHSCs) and Academic Health Science Networks (AHSNs) “to promote research and innovation, benchmarking and co-ordinating approaches to improve workforce productivity”.\(^{232}\) LETB Boards would have to work with AHSNs in respect of the public health workforce; and “work with and be advised by academic health science systems so that local decisions are informed by the latest research and thinking about innovation and entrepreneurship”.\(^{233}\) Boards would also need to “take account of the developing AHSNs to ensure the synergies in embedding research and innovation can be realised”.\(^{234}\) LETBs would:

- be key partners in promoting and ensuring integration of innovation and leading practice in both training and service delivery in line with the precepts set out in the recent report *Innovation, Health and Wealth*. Further work is needed on the best alignment and mechanisms for collaboration with the Academic Health Science Networks as they evolve.

Existing structures that could “facilitate this interface during transition” included the National Institute for Health Research (NIHR), AHSCs / Academic Health Science Systems, Clinical Networks, Clinical Senates, Clinical Research Networks and HIECs.\(^{235}\)

158. When we questioned Professor Tooke about the relationship between the various bodies in the NHS “innovation landscape” he told us he saw it “quite simply”. The five existing AHSCs were “major centres of biomedical science expertise and have a diffusion mechanism to translate research into practice”. The AHSNs would take on the diffusion role, which needed to be undertaken throughout the country at regional level. At the same time, some AHSNs would be “doing substantive amounts of biomedical research and they may qualify for academic health science centre status in the future.” Overall, though, he envisaged “a model of a relatively small number of globally competitive AHSCs and then a regional panoply of networks that is a diffusion vehicle for the NHS.”\(^{236}\)

159. Dame Julie Moore emphasised to us the Future Forum’s view that there needed to be geographical coterminosity of education and academic research.\(^{237}\) (In its January 2012 report the Future Forum referred to the “number of players in the system” generally as a complicating factor.)\(^{238}\) We heard similarly in written evidence from Ed Macalister-Smith,

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\(^{232}\) Department of Health, *From Design to Delivery*, January 2012, para 78

\(^{233}\) *Ibid.*, para 82

\(^{234}\) *Ibid.*, para 83

\(^{235}\) *Ibid.*, para 103

\(^{236}\) Q 207

\(^{237}\) Q 208

\(^{238}\) NHS Future Forum, *Education and Training – next stage*, January 2012, paras 60–2
the Interim Independent Chair of the shadow LETB for NHS South Central (South of England). He saw the need for the roll-out of AHSNs:

...to be accompanied by a de-cluttering of related and overlapping organisational structures, in a process that needs to be led preferably at [Chief Executive Officer] (or Executive Director) level in every provider organisation. The geographic footprints of LETBs could usefully be co-terminous with AHSNs, and could incorporate HIECs and [Collaborations for Leadership in Applied Health Research and Care].

At the same time, there was a need to avoid rationalisation leading to the stifling of local initiatives, take-over by particular sectors (e.g. universities, FTs or particular professions) or bureaucratisation.

**Conclusions and recommendations**

160. We welcome the Department’s intention to continue within the new system the work done in recent years—through the Health Innovation and Education Clusters and Academic Health Science Centres—to link innovation with education and training. We also welcome the intention to build on this through the creation of Academic Health Science Networks. However, there is a risk, through creating a yet more complicated landscape of Boards, Clusters, Centres / Systems, Networks and Collaborations, that the resulting arrangements could be incoherent and ineffective. The Department must develop a plan to rationalise these bodies and structures, to bring about as much de-cluttering and geographical coterminosity as possible without limiting local initiative and creativity.

161. The same point applies to the planned new education, training and workforce planning system as a whole. The NHS Future Forum has rightly referred to the “number of players in the system” as a complicating factor. Nothing we have heard suggests that the new arrangements will be any less overpopulated with stakeholders, sometimes with overlapping or unclear responsibilities. If this is not addressed, it will be a serious shortcoming in the Government’s reforms.
4 Funding education and training

The proposed tariff

162. As we have already observed, the current arrangements for funding education and training in the NHS are widely seen as lacking in transparency and accountability—with unfairness in how funds are allocated and too little focus on quality and value for money. The proposed response to this is the development of a tariff system, whereby “the money follows the student”, instead of providers receiving a block grant; and a requirement on providers to account for the service they provide.

163. In Developing the Healthcare Workforce (December 2010) the Government stated its commitment “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”.240 Accordingly, HEE would be made responsible for benchmark pricing in respect of HEE-funded education;241 and a tariff-based approach would be adopted to funding for all clinical placements (medical and non-medical), as well as postgraduate medical education and training.242

164. Given the substantial financial impact that this would have for the funding of some providers, implementation of tariffs would take place over time to avoid destabilising any provider and allow adjustment to the new arrangements. Options for managing the transition from 2012–13 would be discussed with providers and SHAs.243 The proposed tariffs would be based on “a detailed costing exercise […] undertaken with a sample of providers”. In the longer term, the DH aspired to tariffs based on “the cost of education and training, net of any service contribution”, which would avoid cross-subsidisation of service provision from education and training funds, ensuring that the money followed the student more effectively.244

165. In evidence that we received in autumn 2011 we heard that there was widespread support for the principle of funding reform. Professor Sowden, of COPMeD, told us that the current arrangements were:

opaque and through a glass darkly for almost everyone in the system. You cannot properly explain to anybody exactly how money flows right to the end point, which is the delivery of education and training for the student or trainee. That is not an acceptable position. The aspiration to have a tariff based system is absolutely right and proper […] it will take some time to achieve, but it will be worth the effort.245

240 Department of Health, Developing the Healthcare Workforce – A consultation on proposals, December 2010, para 8.11
241 Ibid., para 8.12
242 Ibid., para 8.13
243 Ibid., para 8.14
244 Ibid., para 8.15
245 Q 146
Education, training and workforce planning

166. Other witnesses agreed that, while the challenges involved in constructing more transparent arrangements should not be underestimated, they were not insurmountable. Professor Edwards, of MEE, told us that there was a potential model in the work of the NIHR in unravelling a hitherto “totally opaque” system for funding research:

No one really knew where it was going or how it was being used. What they did on day one was to take the money away. They took it away, gave it back for a three year period and then produced a very clear plan. It is going to take quite a long time to work it out.

There was also the example of the work done by NHS Education for Scotland on the Additional Cost of Teaching fund (through which clinical placements for medical students are funded—equivalent to the Service Increment for Teaching in England):

They took four years to have a dialogue with people locally as to how the money was being used and how it could better be used, and so on. They have now come up with a really sensible way in which that money is being properly allocated. You cannot change things overnight. You will destabilise not only teaching and training but also the delivery of healthcare. We have to be very careful, but it is possible to do it if you have that sort of approach.246

167. We were told in some submissions that non-medical clinical placements were “currently reliant on good will, professional responsibility and subsidised funding from other areas within service provider organisations”.247 However, the introduction of a dedicated tariff for this purpose could have the perverse effect of causing providers to opt out of providing non-medical placements in favour of providing medical placements. This would be due to the tariff for the latter being so much greater than that in respect of the former.248

168. Other evidence we received raised concerns that the tariff would be based too narrowly on the cost of training and would not “take account of the wider potential costs to services of providing training”. This could leave some providers at a significant disadvantage, “especially in an environment where healthcare providers are competing with one another” (as the Government intends in the NHS).249 Birmingham Children’s Hospital FT was concerned about the potential impact of tariffs on specialist providers, given “the higher level of pay for medics that specialist Trusts have to fund to top up basic tariff funding”.250

169. There was strong independent-sector support for the principle of tariff funding, on the basis that it would allow such providers to make a full contribution to training and be appropriately remunerated. We heard from independent-sector healthcare providers that they were particularly keen to be more involved in postgraduate medical training but

246 Q 145; cf. Qq 117, 146
247 Ev w196
248 Loc. cit.; Ev w161
249 Ev w98; cf. Ev w33
250 Ev w87
found this difficult as they were largely excluded from the current system (financially and otherwise).  

170. The Priory Group, “the largest independent sector provider of mental health, specialist care and specialist education services by number of beds” (which provides a significant number of NHS-funded services), welcomed the commitment to “transparent funding flows for education and training”. It told us that, under the current system, “funding arrangements are not consistently applied between regions in England, and funding is often not made available to independent sector providers”. We were subsequently also told by Mr Worskett, of the NHS Partners Network, that his organisation liked:

the very sound principle that anybody who is appropriate to do training should be allowed and used to do it, that the money should follow the trainee […] I am sure the people who belong to the Partners Network would want to participate very fully in that and bear their full burden of the training responsibility.

171. The DH, for its part, was unable in autumn 2011 to give us any more information about its plans for tariff-funding, beyond explaining the principle and assuring us it would “move with care” to avoid destabilisation.

172. Dame Julie Moore, of the NHS Future Forum, told us as follows about the Forum’s proposal for a quality premium to reward excellence in training:

The quality premium you get now for clinical care [under Commissioning for Quality and Innovation (CQUIN)] is a bit of the budget that is held back. If you achieve it, you are given that extra and it is a low percentage, 1% rising to 2%. It could be done similarly to recognise high quality education. Of course very low quality education would be recognised by it being removed.

Her Forum colleague Dr Nightingale explained that a quality “metric” would have to be developed. Professor Tooke, also of the Forum, said this would start with “process measures and stakeholder feedback” but ultimately should be based on measurements of improvement in the quality of patient care. When we asked Professor Tooke whether the quality premium would apply to medical schools, he appeared to indicate to the contrary.

173. We later heard approval of the quality premium in principle from several quarters, including the independent sector, NHS Employers and two trade unions (the BMA and
the RCN). Dr Dolphin, representing the BMA, thought that “We should learn from the tariff for service and make sure that we do not end up with a tariff that simply rewards activity.” Although measuring quality in health training was difficult, he thought it could be done.260

174. In From Design to Delivery (January 2012) the DH reiterated its commitment to tariff-based funding for all clinical placements (medical and non-medical) and for postgraduate medical programmes. It noted that this had been supported in consultation responses and by the Future Forum. The Department confirmed that HEE would in future negotiate benchmark prices for non-medical education with higher-education providers.261

175. The DH had been working with stakeholders to develop tariffs for clinical placements and consider how best to implement them without causing unnecessary destabilisation. They would be implemented “in the hospital sector from April 2013, phased over a number of years”; and the Department would work with SHAs and providers on transition plans during 2012–13.262

176. At the same time, the DH was working with stakeholders on developing tariffs for postgraduate medical training (including GP training). This would continue and would include consideration of “an appropriate pace of transition, taking into account the financial impact of the other tariffs”.263

177. Lastly, in order to have a robust funding mechanism, “and to reduce the amount of cross subsidisation”, the Department planned “to set the education and training tariffs alongside the service tariffs in future.” This would take time to develop and embed. The Department would:

work with stakeholders to revise the reference costing methodology to identify the costs of delivering education and training alongside service costing. Until the tariffs can be based on the revised costings, we will seek to minimise the impact of the changes to education and training income to allow providers to plan accordingly.264

178. When Mr Rentoul, of the DH, appeared before us in March 2012 he told us that, in respect of the tariff for clinical placements, there would be “a complex transition” which was “going to take some time” and the DH “working with the strategic health authorities over the next few months to develop transition plans”.265 Regarding the Future Forum’s proposed quality premium, Mr Rentoul told us that “We are supportive of that”,266 but it was still “work in progress”.267 He indicated that this was linked to the proposed Outcomes Framework, which would provide “a better set of metrics and indicators that support being

260 Q 392
261 Department of Health, From Design to Delivery, January 2012, paras 131–4
262 Ibid., para 136
263 Ibid., para 137
264 Ibid., para 138
265 Q 516
266 Q 518
267 Q 519
able to benchmark performance” and that the premium would operate along the lines of CQUIN.268

Conclusions and recommendations

179. The current arrangements under which providers are paid by the NHS for education and training are anachronistic and anomalous. Payment is only partially based on student or trainees numbers; it is not linked to quality; it is unjustifiably inconsistent between different professional groups, parts of the country and types of provider; and there is an almost total lack of transparency about how it is spent.

180. Accordingly, we welcome the Government’s intention to move payment onto a tariff basis, including a quality premium, as recommended by the NHS Future Forum. However, we note that there is so far slender evidence of progress in converting this desirable policy into a system that will work in practice. Bearing in mind that implementation of the new system is supposed to begin in April 2013, we believe this work needs to attract a greater sense of urgency.

181. While taking this work forward the Government needs to recognise that there are significant difficulties involved in constructing a workable tariff. It is important that the transition to any new system avoids unnecessary turbulence, and—in particular—threats to the quality of clinical services.

The proposed levy

182. In Equity and Excellence (July 2010) the Government stated that:

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.269

In Developing the Healthcare Workforce (December 2010) it was reiterated that there should be “a level playing field in the investment and deployment of education and training funding”, enforced by Monitor.270

183. The Government further stated as follows:

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

268 Loc. cit.
269 Department of Health, Cm 7881, July 2010, para 4.33
270 Department of Health, Developing the Healthcare Workforce – A consultation on proposals, December 2010, para 6.21
providers and ensure that everyone invests in the totality of education and training required to train future healthcare professionals.  

184. The basis for the proposed levy was further elaborated as being to ensure “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.”  

This would help render transparent “the contribution and benefits for individual providers”.  

It would also “more closely align funding and incentives with the need to secure supply of skills without chronic shortages or oversupply.” It was acknowledged that such a significant change would take time to implement, in order to develop appropriate arrangements and avoid unnecessary disruption. Staged implementation was expected, with a notional levy preceding an actual one.  

A number of consultation questions were asked, including whether the levy should be paid by providers of non-NHS services who “deliver their services using staff trained by the public purse”.  

It was also asked whether public health education and training should be funded by an equivalent levy on public health providers or through central funding.  

185. In From Design to Delivery (January 2012) the DH noted that there were concerns about the practical implementation of the levy, with fears of “potential side effects”.  

The Department promised to “undertake further work and consult widely on how such a levy could be designed, and the possible impact it would have, before we produce firm proposals for formal consultation and possible legislation.”  

186. It has often been argued that, as Dr Dolphin of the BMA noted in evidence to us, the independent sector has not been prepared to match the training commitment of the NHS, treating training as “an externality that they can rely on others [i.e. NHS organisations] providing for them”.  

It is clearly right, particularly in view of the expanding role of the independent sector in care provision in recent years, that the independent sector (whether providing NHS-funded care or not) should contribute to the proposed new levy.  

187. The Priory Group accepted the principle of a levy—but was apprehensive about ensuring that it would be remunerated properly for the training it undertook itself. It told us that “Before [a levy] is implemented it is vital that clarity and equity of funding flows [i.e. the education and training tariff system] is established first in order that the levy can deliver maximum benefits.”  

The same view was expressed to us by the Foundation Trust Network.

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271 Ibid., para 8.2; cf. para 1.4  
272 Ibid., para 8.16  
273 Ibid., para 8.17  
274 Ibid., para 8.18  
275 Ibid., Question 36 (p 58)  
276 Ibid., para 7.10; Question 27 (p 53)  
277 Department of Health, From Design to Delivery, January 2012, para 140  
278 Ibid., para 141  
279 Q 377  
280 Ev w18  
281 Ev w74
188. The NHS Partners Network, however, was straightforwardly hostile to the whole idea of a levy. It argued that imposing a levy on the independent sector could end up being unfair to private providers, “distorting competition” and actually jeopardising existing training provision in the sector, which is often provided, free of charge, to the benefit of the NHS.\textsuperscript{282}

189. The organisation’s Director, Mr Worskett, elaborated on this in oral evidence. He told us that, while the existing system contained “a lot of distortions”, it was “not working that badly”.\textsuperscript{283} The danger of introducing a levy was that it could introduce “a different set of distortions”.\textsuperscript{284} There had long existed a “pluralist system”, in which “health professionals of all categories” moved back and forth between NHS and other providers, each undertaking different proportions of work in each sector.\textsuperscript{285} For a levy to be fair, the costs and benefits of training to the various players in this system would need to be apportioned precisely by “unravel[ing] this complex plural structure”.\textsuperscript{286} However, “Trying to unscramble all of that is a huge challenge.”\textsuperscript{287} Mr Worskett suggested that “we will get into a terrible morass of interlinked issues”—such as the additional costs incurred by private providers due to their inability to use medical trainees in carrying out surgery (in contrast to NHS hospitals).\textsuperscript{288}

190. He told us that the independent sector was already engaged in (largely unrecognised) training of various kinds at its own expense, from which the NHS benefited.\textsuperscript{289} Instead of paying a levy, he preferred to see the independent sector make its contribution to training “through doing more of the training ourselves and putting the training in”—although he also indicated that he expected the independent sector in future to be paid for this under the proposed tariff.\textsuperscript{289}

191. Ms Taber, the Director of Independent Healthcare Advisory Services, was also clearly hostile to the idea of a levy. When we asked her whether she wished to see a levy, she told us “No, not particularly. I do not.”\textsuperscript{290} She thought that it was necessary to dispel the “myth” that the independent sector undertook no training. She agreed with Mr Worskett that much training was currently undertaken in the private sector, free of charge, to the benefit of the NHS but that this was largely unacknowledged.\textsuperscript{291}

\begin{footnotes}
\textsuperscript{282} Ev 150; Charlotte Santry, “Private sector warns of training levy danger”, Health Service Journal, 10 November 2011, pp 10–11
\textsuperscript{283} Q 350; cf. Q 356
\textsuperscript{284} Q 350
\textsuperscript{285} Q 351
\textsuperscript{286} Q 355
\textsuperscript{287} Q 351
\textsuperscript{288} Q 356
\textsuperscript{289} Qq 305, 350, 355, 362–3, 366
\textsuperscript{290} Q 353
\textsuperscript{291} Q 350
\textsuperscript{292} Loc. cit.
\textsuperscript{293} Qq 335, 340–1, 354–5, 359–60, 363–6; cf. Ev 166
\end{footnotes}
192. Like Mr Worskett, she thought that, rather than paying a levy, the independent sector should “work with the LETBs to make sure there are training opportunities—so that we pay our way that way—that will be much better.” She added: “I see us being almost mandated or encouraged to provide training opportunities so that we contribute financially that way, in that we provide training in the areas the independent sector works in.”

193. When we heard evidence from healthcare trade unions on this issue they expressed support for a levy paid by all providers, including the independent sector. Dr Carter, of the RCN, pointed out that there were complications around, for instance, the ability to pay of a small residential home—but this could be addressed through taking a proportionate approach.

194. When the Minister and officials from the DH gave evidence to us in March 2012 they were only able to tell us that the Department was still considering whether to proceed with a levy and, if so, what form it would take. In this regard there was much work still to be done with stakeholders. The Minister told us that there would be some sort of contractual requirement on the independent sector to make a contribution to training—but it had yet to be decided whether this would take the form of paying a levy.

195. Dr Hamilton, the Director of Medical Education, drew attention to an issue that had been raised with the DH in consultation responses:

   an unintended consequence might be that [a levy] would be detrimental to the voluntary or third sector, such as Macmillan nurses, who also provide services. If the levy were to apply to them, that would seem to be unfortunate. That is one of the reasons why it has gone back to be thought about in more detail.

Conclusions and recommendations

196. We support the Government’s intention to introduce a levy on all healthcare providers (whether or not they supply services to the NHS) to provide a more transparent and accountable system of funding for education and training in the health and care sector.

197. We heard from some independent-sector representatives that they fear a levy would put them at an unfair disadvantage. However, we are unconvinced by these arguments. If there is to be a comprehensive tariff system for funding education and training, as the Government intends, it should be possible for independent-sector providers to be remunerated for training that they undertake on a fair and transparent basis, alongside NHS organisations.
198. We urge the Government to ensure that the levy system covers social care services, as well as healthcare, to ensure that the education and training system reflects the policy intention to deliver more integrated health and social care services.

199. We recognise that there are particular concerns about the potential effect of a levy system on smaller voluntary-sector organisations. However, we believe that it is possible to construct workable exemption arrangements to cover these cases and this issue cannot be used to justify the current opaque and unaccountable system.

200. Although, however, we support the Government’s policy objective in this area we note—once again—that there is slender evidence of progress in converting this desirable policy into a system that will work in practice. We believe this work needs to attract a greater sense of urgency.

**Funding in the transition period**

201. Although the Government has made clear its intention to fund education and training activity through a system of tariffs and levies, and we support this intention, there remains an urgent need to maintain the current commitment to education and training during the transition.

202. Although it had been reported that the Multi Professional Education and Training levy (MPET) budget would be cut by up to 15 per cent over three years, beginning in 2011–12, Mr Rentoul, of the Department, informed us that, while possible cuts had been discussed with SHAs, this had been before the overall NHS funding settlement was clear. MPET funding for 2011–12 was actually broadly remaining the same in cash terms.

203. However, another witness drew attention to the likely effect of inflation on net funding levels, and it has also been pointed out that the MPET budget is being required to meet significant new cost pressures including from health visitors and psychological therapies as well increased benchmark prices for courses funded from the Non-Medical Education and Training levy. In addition to these cost pressures, there is concern that “raiding” of funds by SHAs might take place in the transitional year. Dame Julie Moore, of the NHS Future Forum, told us in January 2012 that the Forum had recommended HEE be given control of “the full sum that was available this year”.

204. Sir Alan Langlands, of the HEFCE, told us that “We know, from our relationships with SHAs for nursing, midwifery and allied health professions, that over the next three years...
years we are going to see a cut of 14%.”306 million+ told us that “Universities in England have confirmed that the number of commissions is likely to decrease by around 10-15%.”307

205. The Nursing and Midwifery PAB told us it was concerned that SHAs were reducing numbers of student nurse commissions, regardless of workforce demand.308 Manchester University and AHSC referred to 10 per cent cuts in nursing commissions (in 2011–12),309 while UNISON gave us a figure of 20 per cent.310 According to million+, some universities were reportedly facing cuts of 50 per cent in midwifery courses.311

206. Mr Rentoul, of the DH, told us that he did not recognise these statistics and that midwifery commissions were actually “still at near record levels”. He did, however, acknowledge that there had been some reduction in the number of nursing commissions, reflecting the end of a period of significant growth in NHS funding.312 When we subsequently questioned the Minister on midwife numbers he told us this was certainly an area where more staff were needed, but he maintained that there were currently record numbers in training; and there had been significant growth in the workforce in recent years.313

207. The AHP-PAB drew attention to the fact that:

Significant reductions in education commissioning for pre-registration AHP student numbers are taking place led by the SHAs/SHA clusters. These reductions are set in the context of increasing demand on MPET and are being implemented without taking account of the advice of the AHP-PAB.314

This was reinforced by evidence from the Allied Health Professions Federation, according to which commissions had been cut by up to 30 per cent in recent years.315 Manchester University and AHSC told us of a 6.4 per cent cut in AHP commissions in 2011–12.316

“Budget raiding”

208. The current system is supposed to allocate specific funds to education and training through a complex series of block grants. It is widely believed that these funds voted are regularly “raided” for other purposes. Mr Gilpin told us that this had not occurred in his

306 Q 145
307 Ev 141
308 Ev 106
309 Ev w199
310 Q 387
311 Ev 141
312 Q 72
313 Q 495
314 Ev 109
315 Ev w240
316 Ev w199
region. A small proportion of funding had been held in reserve, but this had still been spent on education and training (either on capital projects or to cover contingencies).\(^{317}\)

209. Mr Royles, of NHS Employers, acknowledged in a later evidence session that there were allegations of raiding, but was sceptical as to whether it did actually occur: “What some people mean is that money that they think was ring-fenced to one particular profession is not spent in that profession but is spent somewhere else.” There was also a misapprehension that arose from the disjunction between the financial year (which ran from April to April) and the academic year (which ran from September to September).\(^ {318}\) Mr Royles did, though, endorse the principle of ring-fencing education and training funds at the national level.\(^ {319}\)

210. When we asked Mr Rentoul of the DH, in November 2011, whether raiding of education and training budgets was now going on, he told us “Not to a great extent”. He seemed to indicate that the case for giving HEE control of funding was predicated on considerations other than the need to prevent raiding of education and training budgets.\(^ {320}\) When Mr Rentoul again appeared before us in March 2012, alongside the Minister, both agreed that significant raiding of education and training budgets had occurred in the past—but insisted that “in recent years there has been less of it.”\(^ {321}\)

211. Other witnesses, however, insisted both that substantial raiding had occurred in the past and that it was continuing. Professor Sowden, of COPMeD, told us that raiding of budgets by SHAs:

> has reduced the investment in the education and training infrastructure for all professional groups. In some areas of the country, that has been much more of a problem than others. It has continued in the last couple of years, in some areas, to the detriment of the system. Those systems are likely to have to pay a price for it in due course.\(^ {322}\)

We also heard from Professor Les Ebdon, the Chair of million+, that:

> One practical proposal to safeguard education and training is to ring fence the education and training budget. It has been, in recent years, a soft target for savings and we have seen damage, particularly at the healthcare assistant, nursing and midwifery end of the spectrum.\(^ {323}\)

212. Dr Carter, of the RCN, specifically challenged the account given by Mr Royles:

> despite what people say, the sad fact is that when the health economy is in trouble it is the education and training budgets that are one of the first to be raided. We know,
because they tell us, that our members cannot get study leave and the whole continuing professional development is compromised.

He thought it was vital that in the new system LETBs were “set up as legal entities […] so that the money is ring-fenced, they produce budgets and we know that the money ends up where it is intended—that is, to develop and educate the workforce”.

213. Dame Julie Moore, of the NHS Future Forum, told us that the Forum wanted the new system:

   to be very transparent so that people knew where the money was going […] Once HEE gets the money, it will go down because it has nothing else to spend it on.

214. When officials from the Department gave evidence in March 2012, Dr Hamilton, the Director of Medical Education, assured us that HEE, by holding LETBs to account for their expenditure of education and training funds, would be able to make sure those funds were being used for their intended purpose. Regarding arrangements for the transition year of 2012–13, Mr Rentoul told us that:

   we have a service level agreement with each of the SHAs for their MPET money with some key performance indicators and what they have to deliver for it. We monitor and track progress. For the 2012–13 financial year, we will continue to do that to protect the money.

Conclusions and recommendations

215. We heard from the Department that its policy is currently to keep NHS funding for education and training broadly the same in cash terms from year to year. Against a background of inflation and major cost pressures, this is an extremely challenging financial settlement

216. We have heard evidence that education commissions are being significantly cut. Given the wider financial situation in the NHS, there is also the risk that SHAs will raid education and training budgets in 2012–13, as they have done before.

217. “Raiding” of education and training funds for other purposes has a long history. While we welcome the Government’s willingness to apply a “ring-fence” to the Multi Professional Education and Training levy, we are sceptical about its effectiveness. We believe the Government’s plans for more fundamental reform discussed earlier in this chapter represent a more realistic way of safeguarding education and training activity within the health and care system. In the meantime the Government must act to safeguard funding for education and training during 2012–13.
Conclusions and recommendations

The Centre for Workforce Intelligence

1. Effective workforce planning in the NHS depends on the availability of up-to-date, high-quality data and intelligence, yet only in recent years have steps been taken to ensure that this is fully and comprehensively available. We welcome the remit that has been given to the Centre for Workforce Intelligence; we also commend its ambition to tackle deficiencies in workforce data and to establish a core national minimum data set. (Paragraph 24)

2. It is clearly not sufficient for the Centre simply to collate and interpret data. It should also challenge data from individual health economies against current clinical standards to ensure their workforce plans make adequate provision for the best skill mix. (Paragraph 25)

3. We appreciate that the Centre is still a relatively new body and that its establishment pre-dates the full implementation of the new workforce planning system. However, we are concerned at some of what we have heard regarding its capacity and capability, in particular its capacity to test workforce plans against the requirement to match the best clinical standards. We are also concerned at the apparent lack of clarity about how it will fit into the new workforce planning system. The Department needs urgently to explain how it is ensuring that the Centre is adequately resourced to fulfil its remit, as well as to clarify the Centre’s role in the new system, particularly its working relationships with Health Education England and the Local Education and Training Boards. It must also set out how the Centre will be effectively performance-managed in the new system and held to account. (Paragraph 26)

4. The Centre is substantially dependent for its success on data that are provided by employers. In future those employers will be autonomous organizations and Local Education and Training Boards will be responsible for gathering data from them. The Government must ensure that there are clear contractual obligations on all providers of NHS-funded services to provide full, timely and accurate workforce data; these obligations must be backed up by clear, strong and enforceable penalties. At the same time, there must be a clear complementary requirement on the local Boards in respect of gathering and passing on data—with a definite remit for Health Education England rigorously to performance manage the Boards in this respect. (Paragraph 27)

Changing skill mix

5. Innovation in skill mix and clinical roles is crucial to achieving a more efficient and flexible workforce. However, it is important for policy to be grounded on solid evidence—both to overcome restrictive practices in support of sectional vested interests and to prevent inappropriate de-skilling in pursuit of mere cost-cutting. (Paragraph 40)
6. Effective workforce planning requires effective training and professional development. Given the increasingly important role of healthcare assistants, it is essential that the Department of Health develop proper guidelines for the training requirements of this group of staff; and commissioners should take these requirements into account when commissioning care from healthcare providers. (Paragraph 41)

7. We note that the Government has announced arrangements for the voluntary registration of healthcare assistants. However, in the absence of a professional regulator, we urge the Government to keep under review the requirements of this key element of the workforce for training and professional development. In the longer run, we reiterate our view that independent professional regulation of this group of staff provides the best assurance to patients. (Paragraph 42)

**Changing medical specialism**

8. Four years ago Professor Tooke set down a clear agenda on the future of the medical workforce which was widely accepted. An acid test of the effectiveness of the new education and training arrangements will be their ability to deliver the more flexible medical training programmes which were described by Professor Tooke and endorsed by the NHS Future Forum. (Paragraph 57)

**Junior doctor training**

9. While we recognise that introduction of the European Working Time Directive has had a significant impact on working and training practices, we do not feel any rose-tinted nostalgia for a system which used to rely on over-tired and under-trained junior doctors. We have received a broad basis of evidence which shows how it is possible to reconcile reasonable hours for junior doctors with high quality training and, most importantly, high standards of care for patients. (Paragraph 66)

**Different approaches to treatment**

10. A clear mandate must be set for the new system to take account in workforce planning of the full range of evidence-based treatments—subject to the evaluations carried out by the National Institute for Health and Clinical Excellence. (Paragraph 69)

**Overseas-educated staff**

11. The NHS has historically welcomed large numbers of staff from overseas, including healthcare professionals who have been educated and trained in other countries. Their contribution to the success of the NHS has been rightly acknowledged and celebrated. (Paragraph 78)

12. We believe that the openness of the UK to clinical staff trained overseas, and the ability of UK-trained staff to work overseas, is a continuing source of strength to UK healthcare, and that this openness should continue to be reflected in workforce planning. (Paragraph 79)
13. However, we also welcome the Government’s view that planning of the UK health and care workforce should not be dependent on significant future flows of trained staff from overseas, both in order to improve “security of supply” and in order to avoid “poaching” skilled staff from developing countries. This approach should apply to public and private healthcare employers. (Paragraph 80)

Locum and agency staff

14. We accept that locum and agency staff provide a necessary element of flexibility in NHS staffing arrangements. We do not believe, however, that they provide an optimum solution, either in terms of quality of care or value for money. We, therefore, urge the Government to proceed quickly with improved arrangements for workforce planning, which should reduce the importance to the NHS of locum and agency staff. (Paragraph 85)

The Secretary of State

15. We welcome the inclusion in the Health and Social Care Act 2012 of an explicit duty on the Secretary of State to secure an effective system of education and training. However we are concerned that there continues to be insufficient clarity about how the Secretary of State intends to discharge this duty. In particular, we seek reassurance that the Secretary of State shares our view that the effectiveness of the new system will be fatally undermined if it is not built upon a more accountable and transparent system of workforce planning. (Paragraph 91)

16. We also welcome the fact that the Secretary of State will have a clear responsibility for holding to account Health Education England. The Department must, though, spell out how exactly this will be done—including the part that the planned Education Outcomes Framework will play. (Paragraph 92)

Health Education England

17. We welcome the plan to set up Health Education England as an executive body with overall responsibility for education, training and workforce planning, drawing input from all healthcare professions and other stakeholders. The creation of such a body is long overdue and has the potential to be a significant step forward. (Paragraph 112)

18. However, we are concerned, given the centrality of this body to the Government’s plans, that the Government has been slow in developing a coherent plan for the new organization. It is being set up in shadow form in July 2012 and will be fully operational in April 2013. There is an urgent requirement for the Government to publish a clear and detailed execution timetable. (Paragraph 113)

19. In the absence of this timetable there continues to be a lack of clarity about the role, responsibilities, powers and structure of Health Education England. Fears have been expressed to us that Health Education England, growing out of Medical Education England, could be predominantly focused on the medical workforce, despite its multi-professional remit. The Government must show that it is addressing and allaying these fears. (Paragraph 114)
20. Greater clarity is particularly needed about how Health Education England plans to ensure that it develops a dynamic view of the changing education requirements of the whole health and care sector. (Paragraph 115)

21. Greater clarity is also needed regarding the role of Health Education England in relation to the professional regulators and to its counterpart organisations in other UK countries. (Paragraph 116)

22. The Government has acknowledged the need to take account of the UK-wide dimension of education, training and workforce-planning policy. However, in that context we are concerned that there must be adequate emphasis on workforce planning in particular. (Paragraph 117)

Local Education and Training Boards

23. We welcome the Government’s plan to create Local Education and Training Boards as provider-led bodies to take responsibility for education, training and workforce planning below the national level. We are concerned, however, at the Government’s protracted failure to produce concrete plans in respect of the Boards, which poses a significant risk to their successful establishment. (Paragraph 133)

24. Between July 2010 and January 2012 the Boards were conceived of as loosely defined non-statutory “legal entities”, to be developed at local level. The Government has now concluded that they should be “outposts” of Health Education England. There is, however, still little central guidance about the requirements for authorization, despite the recommendation of the NHS Future Forum that there should be “common terms of reference and a single model […] to promote consistency across the country”. (Paragraph 134)

25. It is unsatisfactory that so much about the Boards still remains vague and indeterminate. Crucially, the precise extent of their autonomy, and the means by which they will be authorised and held accountable, are still worryingly opaque. This must be spelled out as a matter of urgency. (Paragraph 135)

26. We welcome the Government’s guidance that Local Education and Training Boards should be comprehensive bodies, not restricted to healthcare providers. However, concerns remain among higher-education institutions that their viewpoint will not be adequately heard. The Government should provide a definitive list of stakeholders which should be represented, as well as providing greater clarity on other aspects of governance—not least how potential conflicts of interest are to be addressed. (Paragraph 136)

27. We are also concerned that the geographical basis of Local Education and Training Boards remains obscure. Evidence submitted to us that there will be “10 to 15” (or alternatively “12 to 16”) calls into question their ability to reflect local conditions. There is a definite need for structures at the level of local health economies and the Department must make clear how these are to be facilitated. (Paragraph 137)
Postgraduate deaneries

28. The integration of the postgraduate deaneries into the new system will be crucial to its success. We regret the fact that the Government allowed uncertainty about the future position of the deaneries to persist for so long. Although there is now greater clarity of intention, the period of uncertainty led to a regrettable loss of experienced staff. (Paragraph 155)

29. There continues to be an urgent need for more precision about how the deaneries will operate in future. The distinct position of postgraduate dean should continue to exist to provide an independent professional voice. There needs to be greater clarity about relationships with the General Medical Council, the Director of Medical Education and Health Education England. Finally, there must be a convincing plan to realise the Government’s stated aspiration for deaneries to become “truly multi-professional” in their new role. (Paragraph 156)

Innovation bodies

30. We welcome the Department’s intention to continue within the new system the work done in recent years—through the Health Innovation and Education Clusters and Academic Health Science Centres—to link innovation with education and training. We also welcome the intention to build on this through the creation of Academic Health Science Networks. However, there is a risk, through creating a yet more complicated landscape of Boards, Clusters, Centres / Systems, Networks and Collaborations, that the resulting arrangements could be incoherent and ineffective. The Department must develop a plan to rationalise these bodies and structures, to bring about as much de-cluttering and geographical coterminosity as possible without limiting local initiative and creativity. (Paragraph 160)

31. The same point applies to the planned new education, training and workforce planning system as a whole. The NHS Future Forum has rightly referred to the “number of players in the system” as a complicating factor. Nothing we have heard suggests that the new arrangements will be any less overpopulated with stakeholders, sometimes with overlapping or unclear responsibilities. If this is not addressed, it will be a serious shortcoming in the Government’s reforms. (Paragraph 161)

The proposed tariff

32. The current arrangements under which providers are paid by the NHS for education and training are anachronistic and anomalous. Payment is only partially based on student or trainees numbers; it is not linked to quality; it is unjustifiably inconsistent between different professional groups, parts of the country and types of provider; and there is an almost total lack of transparency about how it is spent. (Paragraph 179)

33. Accordingly, we welcome the Government’s intention to move payment onto a tariff basis, including a quality premium, as recommended by the NHS Future Forum. However, we note that there is so far slender evidence of progress in converting this desirable policy into a system that will work in practice. Bearing in mind that
implementation of the new system is supposed to begin in April 2013, we believe this work needs to attract a greater sense of urgency. (Paragraph 180)

34. While taking this work forward the Government needs to recognise that there are significant difficulties involved in constructing a workable tariff. It is important that the transition to any new system avoids unnecessary turbulence, and—in particular—threats to the quality of clinical services. (Paragraph 181)

The proposed levy

35. We support the Government’s intention to introduce a levy on all healthcare providers (whether or not they supply services to the NHS) to provide a more transparent and accountable system of funding for education and training in the health and care sector. (Paragraph 196)

36. We heard from some independent-sector representatives that they fear a levy would put them at an unfair disadvantage. However, we are unconvinced by these arguments. If there is to be a comprehensive tariff system for funding education and training, as the Government intends, it should be possible for independent-sector providers to be remunerated for training that they undertake on a fair and transparent basis, alongside NHS organisations. (Paragraph 197)

37. We urge the Government to ensure that the levy system covers social care services, as well as healthcare, to ensure that the education and training system reflects the policy intention to deliver more integrated health and social care services. (Paragraph 198)

38. We recognise that there are particular concerns about the potential effect of a levy system on smaller voluntary-sector organisations. However, we believe that it is possible to construct workable exemption arrangements to cover these cases and this issue cannot be used to justify the current opaque and unaccountable system. (Paragraph 199)

39. Although, however, we support the Government’s policy objective in this area we note—once again—that there is slender evidence of progress in converting this desirable policy into a system that will work in practice. We believe this work needs to attract a greater sense of urgency. (Paragraph 200)

Funding in the transition period

40. We heard from the Department that its policy is currently to keep NHS funding for education and training broadly the same in cash terms from year to year. Against a background of inflation and major cost pressures, this is an extremely challenging financial settlement (Paragraph 215)

41. We have heard evidence that education commissions are being significantly cut. Given the wider financial situation in the NHS, there is also the risk that SHAs will raid education and training budgets in 2012–13, as they have done before. (Paragraph 216)
42. “Raiding” of education and training funds for other purposes has a long history. While we welcome the Government’s willingness to apply a “ring-fence” to the Multi Professional Education and Training levy, we are sceptical about its effectiveness. We believe the Government’s plans for more fundamental reform discussed earlier in this chapter represent a more realistic way of safeguarding education and training activity within the health and care system. In the meantime the Government must act to safeguard funding for education and training during 2012–13. (Paragraph 217)
Annex A: Terms of reference

The following terms of reference were agreed by the Health Committee on 8 November 2011:

The Committee will examine the Government’s plans regarding healthcare education, training and workforce planning. Consideration will be given to whether, and how, the proposals will ensure:

- the right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels;
- that training curricula reflect the changing nature of healthcare delivery, including the medico-legal context;
- that all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce;
- multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels;
- high and consistent standards of education and training;
- that the existing workforce can be developed and reskilled for the future (through means including post-registration training and continuing professional development); and
- open and equitable access to all careers in healthcare for all sections of society (by means including flexible career paths).

With these key themes in mind, the Committee will look at:

- plans for the transition to the new system, up to April 2013;
- the future of postgraduate deaneries;
- the future of Health Innovation and Education Clusters;
- the role of the Secretary of State for Health in the new system;
- the proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to the other parts of the new NHS system architecture;
- the proposed role, structure, status, size and composition of local Provider Skills Networks / Local Education and Training Boards, including how plans for their authorisation by Health Education England will address issues relating to governance, accountability and potential or perceived conflicts of interest, and how
the Boards will relate to Clinical Commissioning Groups and the Commissioning Board;

- how professional regulators, healthcare providers and commissioners, universities and other education providers, and researchers will all participate in the formulation and development of curricula;

- the implications of a more diverse provider market within the NHS;

- how the workforce requirements of providers of NHS and non-NHS healthcare will be balanced;

- the role and content of the proposed National Education and Training Outcomes Framework;

- the role of the Centre for Workforce Intelligence;

- the roles of Skills for Health and Skills for Care;

- the role of NHS Employers;

- how funding will be protected and distributed in the new system;

- how future healthcare workforce needs are being forecast;

- the impact of people retiring from, or otherwise leaving, healthcare professions;

- the place of overseas educated healthcare staff within the workforce;

- how the new system will relate to healthcare, education, training and workforce planning in the other countries of the UK; and

- how the public health workforce will be affected by the proposals.
## Annex B: Glossary

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AHP</td>
<td>Allied Health Profession</td>
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<td>AHP-PAB</td>
<td>National Allied Health Professional Advisory Board</td>
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<td>AHSC</td>
<td>Academic Health Science Centre</td>
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<td>AHSN</td>
<td>Academic Health Science Network</td>
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<tr>
<td>CfWI</td>
<td>Centre for Workforce Intelligence</td>
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<tr>
<td>CLRN</td>
<td>Comprehensive Local Research Network</td>
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<tr>
<td>COPMeD</td>
<td>Conference of Postgraduate Medical Deans of the UK</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>EWTD</td>
<td>European Working Time Directive</td>
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<td>FT</td>
<td>Foundation Trust</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HEFCE</td>
<td>Higher Education Funding Council for England</td>
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<td>HEI</td>
<td>Higher Education Institution</td>
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<td>HIEC</td>
<td>Health Innovation and Education Cluster</td>
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<td>LETB</td>
<td>Local Education and Training Board</td>
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<td>MEE</td>
<td>Medical Education England</td>
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<td>MPET</td>
<td>Multi Professional Education and Training levy</td>
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<td>NDPB</td>
<td>Non-Departmental Public Body</td>
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<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
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<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<td>PAB</td>
<td>Professional Advisory Board</td>
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<td>PG</td>
<td>Postgraduate</td>
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<td>RCN</td>
<td>Royal College of Nursing</td>
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<td>SHA</td>
<td>Strategic Health Authority</td>
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<td>UCL</td>
<td>University College London</td>
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Formal Minutes

Tuesday 15 May 2012

Members present:

Mr Stephen Dorrell, in the Chair
Andrew George
Barbara Keeley
Grahame M. Morris
Dr Daniel Poulter
Mr Virendra Sharma
Valerie Vaz

Draft Report (Education, training and workforce planning), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 217 read and agreed to.

Annex and Summary agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

Written evidence was ordered to be reported to the House for publishing on the Internet.

[Adjourned till Tuesday 22 May at 9.30 am]
Witnesses

Tuesday 15 November 2011

Jamie Rentoul, Director of Workforce Development, and Dr Patricia Hamilton CBE, Director of Medical Education, Department of Health, Kate Lampard, Chair, Health Education England steering group, and Christine Outram, Senior Responsible Officer for Health Education England and Managing Director, Medical Education England.

Peter Sharp, Chief Executive, Centre for Workforce Intelligence, and Tim Gilpin, Director of Workforce and Education, NHS North of England Strategic Health Authorities Cluster.

Tuesday 29 November 2011

Professor Sir Christopher Edwards, Chairman, Medical Education England, Professor Sir Peter Rubin, Chair, General Medical Council, Professor David Sowden, Chair, Conference of Postgraduate Medical Deans of the United Kingdom, and Sir Alan Langlands, Chief Executive, Higher Education Funding Council for England.

Dr Anna van der Gaag, Chair, Health Professions Council, Professor Tony Hazell, Chair, Nursing and Midwifery Council, John Rogers, Chief Executive, Skills for Health, and Professor Les Ebdon CBE DL, Chair, million+.

Tuesday 24 January 2012

Dame Julie Moore DBE, Chair, NHS Future Forum Education and Training group, Professor Sir John Tooke, Head, School of Life and Medical Sciences, University College London, and Dr Peter Nightingale, President, Royal College of Anaesthetists.

Professor David Peters, Professor of Integrated Healthcare, University of Westminster, Professor Ieuan Ellis, Chair, Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, Professor Rajan Madhok, Chair, Greater Manchester Health Innovation and Education Cluster, and Dr Mike Farrell, Head of Educational Development, Skills Academy for Health North West.

Tuesday 21 February 2012

Dean Royle, Chartered FCIPD, Director, NHS Employers, David Worskett, Director, NHS Partners Network, and Sally Taber, Director, Independent Healthcare Advisory Services.

Dr Tom Dolphin, Chair, Junior Doctors’ Committee, British Medical Association, Sara Gorton, Senior National Officer, UNISON Health Service Group, Dr Peter Carter, OBE, MCIPD, General Secretary, Royal College of Nursing, and Obi Amadi, Lead Professional Officer, Unite / Community Practitioners’ and Health Visitors’ Association.

Tuesday 6 March 2012

Rt Hon Simon Burns MP, Minister of State for Health, Jamie Rentoul, Director of Workforce Development, and Dr Patricia Hamilton CBE, Director of Medical Education, Department of Health.
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52 Society and College of Radiographers
53 Chartered Institute of Housing
54 Heart of England NHS Foundation Trust
55 NHS South of England, Workforce Development Directorate
56 Fresenius Medical Care
57 University of Cumbria
58 General Osteopathic Council, the Council of Osteopathic Educational Institutions and the British Osteopathic Association
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61 Macmillan Cancer Support
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64 Lancashire Public Health Network
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72 Dr Judith Evans, Consultant Surgeon, Plymouth
73 Lincolnshire Health and Social Care Community
74 Sands
75 NHS North West
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77 Merseyside & Cheshire Health Innovation Education Cluster
78 Council of University Heads of Pharmacy Schools
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80 Faculty of Pharmaceutical Medicine
81 Cheshire & Merseyside Directors of Public Health and the North West School of Public Health
82 Current and former participants on the Postgraduate Certificate in Strategic Workforce planning
83 Academy of Medical Educators
84 NHS South of England
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List of Reports from the Committee during the current Parliament

The following reports have been produced by the Committee in this Parliament. The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

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