Agenda Item 7

Enclosure 4

Paper ETC53/02

Education and Training Committee

" FUNDING LEARNING AND DEVELOPMENT FOR THE HEALTHCARE WORKFORCE – DoH CONSULTATION PAPER " – PROPOSED RESPONSE

From the Executive

FOR DISCUSSION AND RESPONSE

Draft

Draft Response to the DoH Paper, " Funding Learning and Development for the Healthcare Workforce "

1. General Comments

1.1 This paper relates only to England, but nowhere is this made explicit. Geographical contextualisation is essential. Reference must be made to any cross-border implications (eg. for clinical placements).

1.2 Not one single HPC (or then CPSM) registrant seems to have been involved in the preparation of this paper. This is at the least an oversight. DoH needs to reassure HPC and the Allied Health Professions Forum as to where it obtained the necessary expertise on AHPs.

1.3 It is not clear exactly what role Workforce Development Confederations would be playing if the proposals are implemented. Clarification here would be appreciated.

1.4 In the same vein, the paper does not take account fully of the new opportunities for delivering placement education opened up by the new HEI/NHS Trust partnerships.

1.5 It is not explicit that non-NHS institutions are also involved in the provision of education and training and could make useful comment and contribution. If the non-NHS sector does not appreciate this and respond, might DoH perhaps follow up with bodies such as BUPA and the Association of Directors of Social Services to acquire this in-put?

2. Comments on the Text unrelated to specific Questions

2.1 Executive summary :

- the phrase " new types of worker " needs to be defined. Opening a new Part of HPC's Register is a lengthy task reserved to the Westminster Parliament while extending scope of practice of existing professions may have minimal regulatory implications.

- in the past it was DoH / NHS which blocked cross / multi-sectoral working. The exhortations here are very welcome, but the initiative can only come from DoH / NHS.

- at present HPC has no relationship with Further Education (FE) outside some approved courses being delivered collaboratively in FEIs. If DoH has some specific proposals for how to involve FE in HPC approval pre- and post-registration education and training more widely (eg. via umbrella bodies), it would be useful to know what is intended.

2.2 Paras 1.3 – 1.5 may relate to nursing but are largely irrelevant to AHPs. A perverse outcome would be to invest public resources in raising the number of good quality candidates for each physiotherapy place from 10 to 15.

2.3 Linked to para. 1.7 the paper does not make it as explicit as it might that retraining an existing professional does not create any additional staff, whilst still depleting the MPET budget.

2.4 On para 1.9 we await with interest the development of concrete proposals from NHSU.

2.5 Para 1.10 is the key linkage between QAA's Qualifications Framework (with its descriptors) and registration at HPC. It should stand us in good stead.

2.6 The statements about funding in para 1.13 are very welcome.

2.7 It should be noted that CPSM historically shared all the concerns set out in Chapter 2 (" Areas of Difficulty ").

2.8 Is the section on R & D (2.25 – 2.28) still up-to-date ? Events have moved very fast here recently.

2.9 On 3.9 some assurance needs to be given that resources would not be withdrawn from existing courses. Here, and in 3.10, the paper should acknowledge that HPC has the power (and duty) to refuse or withdraw approval from provision it considers under-funded. This links with concerns that the financial penalties against attrition could operate adversely either to tempt HEIs to lower standards or to prejudice the viability of courses. HPC would be grateful for assurances that definitions of attrition will be designed carefully and not penalise HEIs for matters outside their control, and, that when penalties are considered, they be realistic.

2.10 In 3.4 and 3.17 the paper allows the inference that HPC approval (and continued approval) can be assumed simply because a change in contracting adheres to a new DoH policy. This wording could be emended to avoid the inference.

3. Draft Responses to Specific Questions

3.29

- First, although the primary onus lies with HE and the NHS, this is also a responsibility and legitimate area of concern for HPC and for the Allied Health Professions Forum (AHPF) and its constituent members. Relevant teaching staff should be State Registered and in professional body (PB) membership. Second, the Institute for Learning and Teaching should play a role here as part of HE. Third, WDCs and other funding bodies should make effective professional development a condition of awarding contracts and HPC and PBs should make it a condition of initial and continued approval of courses. Fourth, HE and health and social care delivery bodies should consider making each other's provision open on a reciprocal basis. Lastly, the issue of CPD for clinical teachers is a matter of focused and specific concern for HPC in its own consultation process.

- Not for HPC.

- Not for HPC.

3.33 Neither of the first two bullet points are for HPC.

- Whilst HPC will wish to use its powers to promote good practice and beneficial change, those commissioning and delivering pre- (and, in due course, post-) registration education and training will need to understand that HPC's paramount duty of care is to users and potential users of registrants' services to ensure that practitioners are safe, effective and competent. HPC cannot approve, or continue to approve, provision which it judges not to meet these criteria or whose integrity has been compromised by over-hasty or mismanaged change. HPC has no direct duty of care to students on provision it deems to be failing and this consideration cannot affect its decisions. There is no reason to suppose that HPC would not follow the precedents set at CPSM of moving to withdraw approval from courses which – for whatever reason – found themselves with an inadequate number of inappropriately qualified staff to deliver the curriculum. The same considerations would apply to premises which must, in general terms, be appropriate and adequate to the provision being taught and, in some professions, must comply with very strict and specific legal requirements.

- There is no specific question to attach to this comment, but the contracts must be aligned with the relevant subject benchmark and then the eventual course programme specification must reflect the contract.

- While HPC itself could not end a contract, its power to withdraw approval from a course might have an even more drastic effect. HPC would move to withdraw approval in terms stated above.

3.35 (all three questions)

- This is an open-ended question where expert Council members should be invited to comment. The views of the professional bodies should also be very informative.

3.38

- The detail of delivery of common learning is not for HPC, but HPC must be satisfied that any redesigned or new delivery of teaching and learning meets the standards it will set.

- HPC has identified its stakeholders in terms of compliance with Part II of the HPO. This information is available on HPC's web-site. Additional stakeholders can be added.

3.39

- For HPC, only the risk of prejudice to the quality of resources if that might be an outcome.

- Not for HPC.

- While not directly for HPC, HPC would observe that successful innovation not shared would be a poor return on investment.

- Not for HPC.

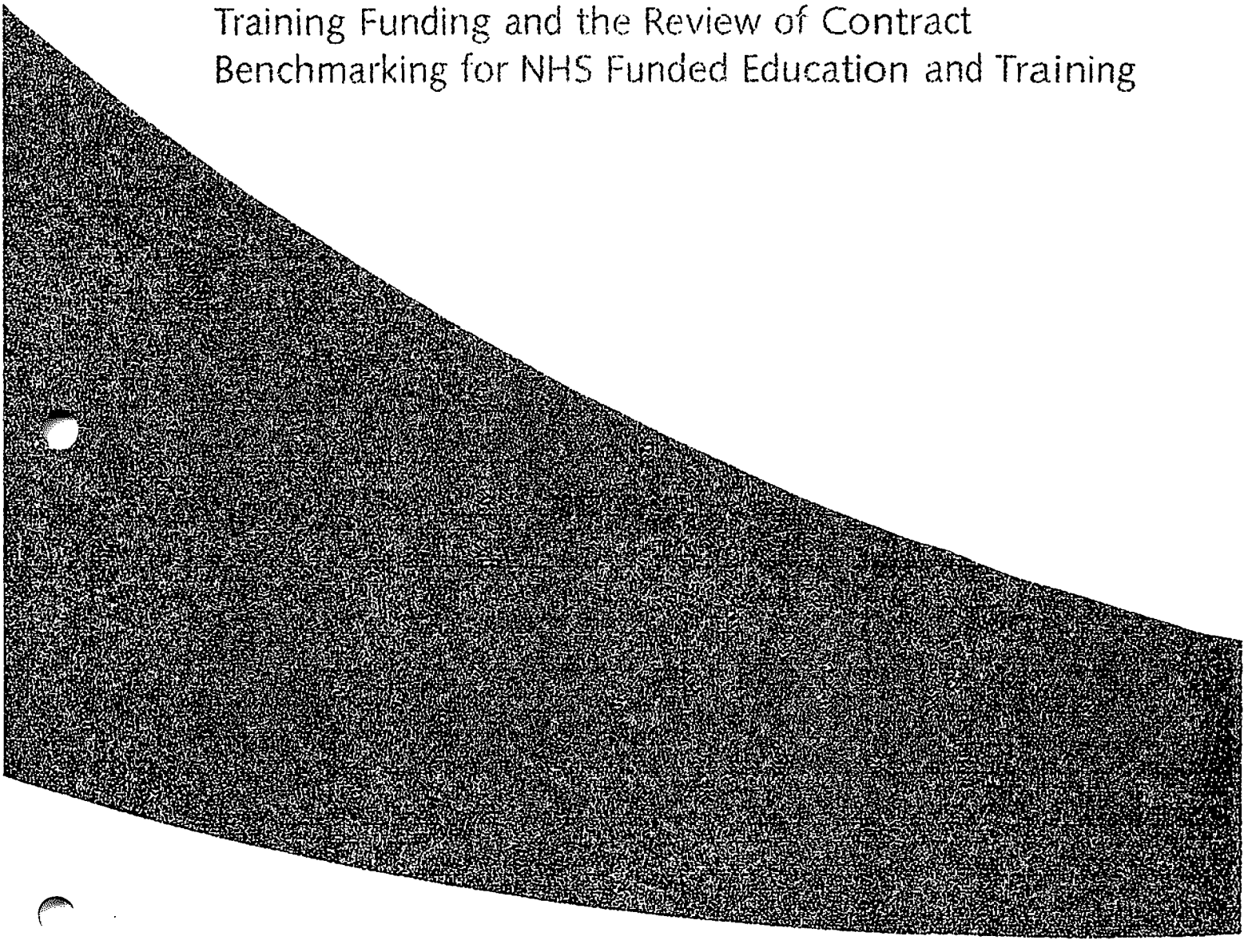
- Securing the appropriate resources.

Universities UK

Department of Health

Funding Learning and Development for the Healthcare Workforce

Consultation on the Review of NHS Education and Training Funding and the Review of Contract Benchmarking for NHS Funded Education and Training



Executive Summary – Main Issues

This consultation document considers how the NHS should use its £3 billion annual funding for learning and personal development better to support the development of staff, and to deliver the necessary skills to support patient centred services and public health strategies.

It proposes that funding should be reorganised on an interdisciplinary basis, ending the present rigid demarcations in the support given to different professions and occupational groups and should be underpinned by the key values of:-

- *Transparency* – education commissioners should be able to account fully for their use of funding;
- *Equity* – The main driver should be the need to deliver particular healthcare skills to patients rather than the delivery of particular types of professional. Distinctions that may introduce bias against certain types of training–for example through more comprehensive support for one group of staff than another should be avoided;
- *Comprehensiveness* – support should be available to all health service staff, with or without existing professional qualifications;
- *Responsiveness* – learning and development must be able to adapt quickly to support the delivery of new skills and new types of worker as requirements change and the workforce develops;
- *Integration* – healthcare staff of different disciplines should learn together as a precursor to, and continuing dimension of, working together;
- *Partnership* – the health and education sectors, social care, and private and voluntary sectors should work together to deliver training. There should be continuing support for learning and development from the wider NHS, and more recognition of the increasing role of further education in the development of the NHS workforce;
- *Flexibility* – people should be able to step on and off learning, accumulating credits.

The report recommends:-

- The abolition of the present distinctions between the former SIFT, MADEL and NMET budgets, which have perpetuated historical distinctions in professional education;
- That they all be replaced by a single integrated budget designed to support learning across the board;
- The closer integration of funding for Continuing Professional Development, NHS Learning Accounts and National Vocational Qualifications into the integrated budget to recognise the importance of supporting the development of all staff.

It also recommends:-

- *Standardised prices* for NHS funded learning and development;
- A *standard contract* for NHS funded learning and development – allowing for longer term, but more flexible and responsive contracts that will provide much more certainty to underpin investment in academic staff and capital;
- A rebasing of *placement funding* to support all disciplines;
- The development of *partnership* fora to ensure much greater coherence in the use of development funding, including that of the Higher Education Funding Council for England;

- The renaming of the Multi Professional Education and Training budget as the *Health Workforce Learning and Development Budget* to emphasise its inclusive nature;
- A looser designation of the budget into different elements supporting *innovation, placements, pre registration tuition, bursaries, continuing development of NHS workforce, development of staff without a professional qualification, and capital in support of education in the NHS.*

This consultation document seeks the comments of the health and education sectors on the future development of NHS learning and development funding. Final recommendations will be published following the consultation period.

Foreword – The NHS Workforce Development Budget

Until their formal merger in April 2001, the NHS supported the education and training of its professionals through three separate budgets:-

- The Non Medical Education and Training Budget (NMET), directly supported the education and training of nurses, midwives, allied health professionals and a number of other staff groups;
- The Medical and Dental Education Levy (MADEL) supported salary costs of doctors and dentists undertaking their postgraduate professional training, the costs of postgraduate deaneries, and continuing professional development for dentists; and
- The Service Increment for Teaching (SIFT) supported the additional costs to patient service providers of hosting placements for medical students, and Dental SIFT supported the actual cost of patient care in dental hospitals to support teaching. Medical for Dental SIFT supported costs associated with human disease teaching to dental students.

The budgets served quite different functions for their distinct professional client groups, and were separately managed at local, regional, and national levels. As now, the tuition costs of medical and dental undergraduate education were separately funded through the Higher Education Funding Council for England. In addition NHS service providers have always supported the development of their staff from their general funding, albeit to different extents.

These arrangements reflected long established divisions in workforce planning, learning and development for the different healthcare professions. The lack of commonality made it difficult to develop integrated approaches to learning and development across professional staff groups and the professional focus of the major budgets excluded other staff groups from access to these funds.

The NHS Workforce Planning Review, *A Health Service of all the talents*[1], published for consultation in April 2000, recommended major changes in the way that the Health Service planned its workforce. Central to these was the need for an integrated approach to planning, educating and developing the healthcare workforce, locally and nationally to support the development of a skilled workforce able to respond flexibly to patient needs and local communities. The Workforce Development Confederations (WDCs), established from April 2001 in response to these recommendations, replaced the former education consortia and Local Medical Workforce Advisory Groups. They brought together employers from within and outside the NHS to plan the whole healthcare workforce across wider communities including local authorities, the private and voluntary sectors, the prison service and other care providers. Higher Education Institutions became full members of the WDCs, which were also tasked to work closely with Learning and Skills Councils and postgraduate deaneries. With the further devolution of roles and responsibilities from the Department of Health arising from the *Shifting the Balance of Power* strategy, WDCs have taken on a wider range of functions set out in *Workforce Development Confederations – Functions, Accountabilities and Working Relationships*[2].

1 *A Health Service of all the talents: Developing the NHS workforce.* Consultation Document on the Review of Workforce Planning. Department of Health April 2000.

2 *Workforce Development Confederations – Functions, Accountabilities and Working Relationships.* Department of Health, April 2002.

A Health Service of all the talents recommended the merger of the three major NHS Education and Training Budgets to support more flexible and integrated training and education, and to support the development of new types of worker. The creation of the Multi Professional Education and Training budget (MPET) by the merger of the three NHS budgets in April 2001 was a first step in this process and allowed some virement between them. But the three elements have continued to serve the professional groups in different ways and the health and education sectors recognised that a unified approach to learning and development across the workforce could only be achieved by a fundamental reappraisal of its funding base.

There were other drivers for the development of a new approach to funding learning and development including:-

- The establishment of the *Changing Workforce Programme* to develop new and more flexible professional roles, which needed to be underpinned by learning programmes;
- The commitments in the *NHS Plan*: to increase staff numbers while changing the ways in which they work, to develop common learning programmes, to drive forward the development of staff without existing professional qualifications through investment in National Vocational Qualifications (NVQs) and NHS Learning Accounts, and to continue to widen access to professional training;
- The NHS Lifelong Learning Framework – *Working Together-Learning Together*[3], published in November 2001, with its emphasis on developing the whole NHS workforce and its introduction of the Skills Escalator concept whereby staff are trained and skilled to the maximum of their ability irrespective of where they start in the workforce (please see Annex C).

Separately, the National Audit Office (NAO) report, *Educating and training the future health professional workforce for England*[4], considered specific issues around funding for Non Medical Education and Training and attrition from courses and found that:-

- Many higher education institutions believed that, if they were to continue to expand student numbers, there would need to be investment in the capital infrastructure;
- The NHS did not have the information to understand or compare institutions' costing policies because some contracts between higher education institutions and consortia had clauses maintaining commercial confidentiality;
- There were wide variations in the price per student for the same qualification. The NHS had reduced its costs through reductions in the average price paid per student in real terms. However the scope for further gains needed to be offset against the fact that the contribution to overheads in NHS funded contracts was much less than for non NHS funded contracts. Variations in the relationship between price and cost might not have led to the best allocations of resources;
- There were no common contract and standard benchmark prices and a lack of consistent benchmark standards in assuring quality.

A parallel study by the Audit Commission[5], which considered education, training and development for healthcare staff in NHS trusts, looked at the way that trusts used their own resources and demonstrated wide variation in the management of training of staff. It found major variations – up to five fold in spending levels between trusts, and a failure in many cases to take account in training of such developments as health improvement programmes.

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3 *Working Together- Learning Together* – A Framework for Lifelong Learning for the NHS. Department of Health. London November 2001.

4 *Educating and training the future health professional workforce for England;* Report by the Comptroller and Auditor General; HC 277 Session 2000-2001: 1 March 2001.

5 *Hidden Talents – Education, Training and Development for Healthcare Staff in NHS Trusts*

These separate developments led to the establishment of two major reviews of education and training funding in the NHS. The first was a Review of the MPET Budget chaired by Professor Charles Easmon, then Regional Director of Workforce Development for the Department of Health London Region, which was asked to consider the better use of the MPET Budget. The second was a joint Health and Education group chaired by Martin Staniforth, Deputy Director of Human Resources in the NHS, and Professor Janet Finch, Vice Chancellor of Keele University, for Universities UK, to consider contract price benchmarking of, and attrition from, NHS funded courses. Their terms of reference and membership are at Annex A. The two groups have been privileged to draw upon a wide range of expertise from across the health and education sectors and have shared significantly overlapping membership and a single secretariat. Because of the interlinked nature of their work the two groups have liaised closely and have produced this joint consultation report on the major funding issues. Conclusions arising from consideration of the distinct issue of attrition from NHS Funded courses will be published separately.

The Wanless Report[6] which considered the wider issue of the future resourcing of the NHS, was undertaken contemporaneously with this work. Although it was not possible to take full account of the issues raised by Wanless in the main discussions of the MPET and Contract Benchmarking Groups, the two MPET groups were able to consider the main issues raised by Wanless and have noted the overall consistency of his conclusions with theirs.

6 *Securing our Future Health: Taking a Long-Term View*, Derek Wanless, HM Treasury, April 2002.

1 – What The Learning and Development Budget Should Do

1.1 This consultation document considers how the NHS learning and development budgets may be better used in the future. The structure of NHS funding for education and training reflects the divisions of the past under which different professions trained separately. Although the present budgetary arrangements have developed for sound reasons, they do not effectively support the more flexible approaches to learning and development which are now required.

1.2 The two Review Groups set out to identify how the funding might be used most effectively. They recognise that many of the proposals that follow have significant implications for the use of existing funding. They also recognise the importance of maintaining the stability of current arrangements as changes are introduced. It will therefore be important that changes are paced realistically.

Introduction

1.3 Every aspect of healthcare delivery and strategies for health depends on the education and skills of individual staff. Investment in their learning and personal development is, in a real sense, spending on patients and is essential to the future quality of the health service. The NHS in England will spend almost £3 billion centrally on education and training in the 2002/2003 financial year. Individual employers also invest in the training and development of their own staff and the Higher Education Funding Council for England in training for other disciplines including undergraduate medicine and dentistry. Funding also comes from the Learning and Skills Council for National Vocational Qualification (NVQ) type training, and for adult literacy and numeracy skills training. It is important that this funding is used in an integrated and flexible way, both to support the current and longer term supply of the skilled and qualified staff needed to deliver health care, and to ensure the continuing development of all NHS staff.

1.4 Properly structured funding can support an environment in which effective learning can take place. Conversely, badly structured funding arrangements can create barriers and perverse incentives that will make modern approaches to learning much more difficult to deliver. The current compartmentalisation of funding around professions impedes the development of a modern, flexible healthcare workforce which can best benefit patients and local communities by working together, and be able to respond to the changes needed in the delivery of care.

1.5 The existing funding arrangements do not offer comprehensive support. As well as professionals including doctors, dentists, pharmacists, nurses and midwives, physiotherapists, occupational and other therapists, and healthcare scientists and technicians, the health service workforce comprises a wide range of other staff supporting the delivery of healthcare within NHS organisations. While much effort and resource has, properly, been expended in supporting the development of professional staff and those studying for professional qualifications, much less has been done for the many other staff on whom the professions, and patients and their carers depend. It is important that these staff have properly funded opportunities to develop and extend their skills and to acquire relevant, vocational and professional qualifications if they wish.

1.6 As services are increasingly delivered through primary and community care, it will be important that all trainees learn in these sectors. The delivery of an expanded service to patients in more locations

and nearer to home, will require the NHS to use its existing staff more effectively outside their traditional roles so that they can deliver care which may in the past have been provided by others. For example nurses and other professional staff will increasingly be the first point of contact in General Practice, and education too will increasingly need to be delivered in such settings.

1.7 It takes time for increased intakes to traditional healthcare programmes to deliver increased numbers of staff. Medical and dental students generally require at least five years, and most other professionals three years, to obtain their initial qualifications. Subsequent specialist training can take still longer. Furthermore changing demography limits the extent to which the NHS can expect to recruit trainees from the traditional school leaver pool. To tackle this, and to ensure that the NHS recruits a workforce which better reflects the local populations which it serves, it is important to widen access and entry by developing more flexible approaches to learning and development which will recognise and accredit prior experience, and to provide more flexible arrangements for supporting learners, enabling them to step on and off learning programmes with accumulated and transferable credits.

1.8 Traditional patterns of training where professionals learn separately have reinforced demarcations which can impede the scope for joint working in teams after qualification. The modernisation of NHS services requires an approach to learning and development which offers much wider opportunities to all staff before and after qualification to learn together and subsequently to work differently. The Changing Workforce Programme is already helping organisations to consider how they can make better use of the skills of their staff, by developing new or redesigned roles that improve patient care, and ensuring that staff can use their existing skills, and are helped to develop and acquire new ones.

1.9 In future it will be essential to offer all staff learning and development throughout their careers, so that they will learn and develop new skills and roles and be able to work across traditional professional and other boundaries. Through the development of the skills escalator, funding will need to support learning and development opportunities which embrace the whole of the actual and potential workforce, from those who may be socially excluded but who could, given the right support and opportunities, join the NHS workforce, up to senior specialist and consultant levels. The redesign of learning opportunities to enable all NHS staff to obtain additional skills throughout their careers will benefit both the individuals and the delivery of patient services. Roles and tasks can then be performed by the most suitable people, defined by their competencies to deliver particular aspects of care, rather than by their individual professional titles. Increasingly the proposed NHS University (NHSU) will enable staff to access Lifelong Learning.

1.10 The quality of teaching and education staff is crucial to the development and delivery of high quality learning opportunities for NHS staff and pre-registration students. To enable learners to acquire the skills to deliver evidence-based services, they need to learn how to seek out and appraise evidence when they need it. They also need an appreciation of research and its importance in the development of high quality services. Even if they do not want to develop as researchers themselves, learners need an appropriate understanding of research methods, so that they can support research being undertaken in the services in which they may work in future. It is therefore important that the education staff leading and delivering learning programmes have, and continually develop, the requisite research, education and clinical skills needed to provide high quality academic environment for learning, and to develop the evidence base for practice and the development of health services.

What the learning and development budget should pay for

1.11 NHS learning and development funds must support:-

- Higher education tuition costs for all students not yet in salaried employment studying for healthcare professional qualifications other than for courses funded through the Higher Education Funding Council for England;
- Bursary costs for degree and diploma students undertaking healthcare courses in higher and further education.

1.12 The NHS learning and development funds should contribute consistently and significantly to:-

- Educational innovation and developments linked to the NHS Plan, service modernisation and the NHS lifelong learning agenda;
- The costs to NHS organisations of practice placements.

1.13 In partnership with the individual and their employing organisation, the learning and development funds must support:-

- Tuition costs for people working in NHS organisations undertaking continuing personal and professional development;
- The costs of developing staff without a recognised professional qualification through further and higher education within the skills escalator approach;
- Salary costs of doctors and dentists undertaking postgraduate training;
- Salary costs of NHS employees undertaking continuing personal and professional development.

1.14 Consideration should also be given to funding:

- Support for capital costs of the educational infrastructure within NHS organisations, in partnership with the organisation concerned;
- Supporting capital developments in HE underpinning healthcare education and development.

1.15 To make a difference, it is essential for the new funding framework to provide enabling mechanisms for change and innovation in educational commissioning, while recognising and supporting the existing commitments it will inherit from the former MADEL, NMET and SIFT funding streams. Partnership working must be a key principle in the future application of the learning and development budget so that all stakeholders share in investment in, and development of, the workforce. The new budget will need to dovetail effectively with HEFCE and Learning and Skills Council funding and with the funding provided locally by NHS organisations. The principle should be that whatever their source, funds should support common aims. In time, although it has not been possible to consider this in depth as part of this Review, links should also be considered with the funding of education and training for social services staff.

1.16 Key values that should underpin the use of Workforce Development Funding in supporting the delivery of high quality services to patients include:-

- **Transparency** – education commissioners and providers should be able to account fully for their use of funding. Not all education and training funding can be readily tracked - SIFT for example in large measure supports service provision in teaching hospitals rather than education and training direct. Rebasing should be considered to distinguish clearly between education and training, and service funding;
- **Equity of treatment** – the main driver should be the need to deliver particular healthcare skills. Distinctions between groups that may introduce bias against certain types of training, for example in the way placements are funded, or in different arrangements for student support for degree and diploma courses, should be avoided;
- **Comprehensiveness** – learning and development support for the delivery of necessary skills should be available for all staff with or without professional qualifications, in the full range of health service settings. The proposed NHS University (NHSU) should play a major role in Partnership with others to support this;
- **Responsiveness to new demands** – learning and development should be able to support the delivery of new skills quickly as requirements change, so that developing clinical and care approaches may be readily delivered by the workforce;
- **Integration** – effective service delivery requires that staff should operate together in teams, and learning together is an important precursor to working together;
- **Partnership Working** – the Health and Education Sectors, social care, and the private and voluntary healthcare sectors, should work together to secure the effective delivery of learning and development. There should be continuing support for learning and development through other development funding in the NHS and an increasing recognition of the role of the further education sector in supporting NHS workforce priorities;
- **Flexibility** - the pattern of delivery of learning and development increasingly includes the option to step on and off training, with the student accumulating credits. Systems of support should reflect this.

1.17 The way these values might be addressed in the Review is summarised at Annex E attached.

2 – Current Arrangements

2.1 The existing Multi Professional Education and Training Budget (MPET) was created in April 2001 by the merger of the Non Medical Education and Training Budget, the Medical and Dental Education Levy, and the Service Increment for Teaching - all of which continue as separate elements. There remain important differences between the three component streams.

2.2 MPET – Non Medical Education and Training (NMET) supports:-

- Tuition fees for those training to be nurses and midwives, allied health professionals and for a range of other professions;
- Student support costs – bursaries, and salary replacement for all professionals;
- Post registration and second registration training for NMET professions;
- Learning programmes to support access to pre registration training, including the development of adult skills, Learning Accounts and National Vocational Qualifications;
- Development and innovation in education and training.

2.3 For pre registration training MPET (NMET) is allocated from the central Department of Health MPET budget, via NHS Strategic Health Authorities to the WDCs. The WDCs have to contribute to national targets for training. National allocation arrangements reflect detailed information gathered on current and potential training activity across the country and nationally agreed targets.

2.4 WDCs contract directly with Higher Education Institutions (HEIs) for pre and post registration education and training of healthcare staff, other than doctors, dentists and some other cognate disciplines. They also contract with Further Education Colleges for NVQs and learning programmes supported by NHS Learning Accounts. There are no standard unit prices for education. There is a bidding or negotiation process in which the WDC seeks the best price for education and training and in which true costs of the different education providers are obscured by commercial confidentiality. Contracts are commonly negotiated for 5 years in the case of pre registration courses, and three years for post registration, with a further "run out" period where courses last for more than one year. In practice both WDCs and HEIs are constrained by existing training commitments – the rollover student numbers and prices agreed in previous years for students still in the system. Expansion of education and training in a locality will be very conditional upon local capacity as well as the funding available to the WDC.

2.5 These arrangements may encourage HEIs and WDCs to negotiate prices below cost in parts of the country where there is ample education and training capacity, with education providers relying on cross subsidies to break even. Conversely where there is a shortage of capacity, prices may be agreed substantially above the true cost. In all cases, both parties can spend disproportionate amounts of time on the negotiation and operation of contracts. Although anonymised data shows that the majority of contract prices do cluster around a national average, the system permits very wide variations in the unit price of education and training, which frequently cannot be explained in terms of cost.

2.6 Particular criticisms of MPET (NMET) include that :-

- Current market led contracting arrangements lead to major variations in unit education and training price which are not tied to cost or the quality and effectiveness of education;

- Some WDCs may find themselves in difficulty with their targets simply because local unit prices are high;
- Although national targets may be delivered, the system can give rise to wide variations in the delivery of trained staff around the country which will often not reflect local requirements;
- The meeting of pre registration education and training targets can be at the expense of other forms of learning crucial to delivery of the NHS Plan. These include post registration training, continuing professional development, and life long learning – a key issue with the development of innovative ways of delivering education in the workplace;
- It does not fund practice placements;
- The finance and workforce information data on which it is based is over complicated and liable to bias due to different understandings and interpretations by WDC data providers;
- The uncertainties created by periodic retendering and contract length have entailed a risk element for HEIs, which has in many cases been reflected in higher prices.

2.7 MPET Service Increment for Teaching (SIFT) mainly supports the additional costs incurred by NHS organisations in hosting medical and dental student placements. Medical SIFT includes:-

- Mmedical practice placements – directly linked to clinical student numbers;
- Facilities – fixed and semi fixed infrastructure costs (about 70% of the total).

Medical for Dental SIFT supports:-

- Costs associated with human disease teaching to dental students.

Dental SIFT supports:-

- Costs to the NHS of supporting clinical teaching of undergraduate dental students.

2.8 Much of the medical SIFT facilities funding is allocated on a historic basis with a high proportion going to teaching hospitals, especially in London. Except for the additional funding associated with the increases in the medical student intake of recent years, the facilities element remains based on the 1996 distribution, perpetuating historical inequity. In 2002/03 Medical SIFT has been allocated through the lead WDCs covering individual medical schools which are expected to consult with all WDCs where local providers host, or are affected by, placements associated with that medical school.

2.9 Medical for dental SIFT is allocated through WDCs to support human disease teaching to dentistry students.

2.10 Dental SIFT is allocated through a single National Dental Development Unit, now hosted by the South Yorkshire WDC, which is contracted to allocate funds to the 10 Dental Schools in England. It is the single most important source of income for the Dental Hospitals linked to the Dental Schools.

2.11 Common criticisms of MPET (SIFT) are that:-

- It supports undergraduate medicine and dentistry placements, while other healthcare professions are not supported by earmarked central funding;

- Medical SIFT in particular lacks transparency. The facilities element supports the provision of NHS service in medical undergraduate teaching hospitals, and is not clearly linked to the additional service costs of student teaching;
- Dental SIFT carries a disproportionately high level of central performance management compared to medical SIFT;
- Because medical SIFT is geared to the traditional clinical years of medical education, it does not reflect the trend to much earlier clinical exposure of medical students;
- Medical for dental funding is not always used fairly at field level for the teaching of dental undergraduates;
- It is disproportionately allocated to older teaching hospitals, particularly in London;
- Within the existing budget envelopes, it is hard to redistribute facilities funding into new teaching settings, particularly in the community, without financially destabilising existing centres;
- It is difficult to manage the impact of large sudden changes in the distribution of placements with changes in curricula.

2.12 The Medical and Dental Education Levy MPET (MADEL) supports:-

- Salary and support costs of doctors in postgraduate training (including GP Registrars);
- Salary and support costs of doctors and of some other staff training for public health;
- Support and development of CPD and vocational training for medical and dental practitioners;
- Development and innovation in education and training;
- Development and innovation in the education and training of trainers;
- Infrastructure (including contributions to facilities) for postgraduate medical and dental education in NHS Trusts;
- Management of doctors in training, and career doctors and dentists, referred by the GMC and GDC;
- Management of trainees with particular requirements eg flexible (part-time), academic, overseas, including refugee doctors (in line with Improving Working Lives);
- Involvement in change management and service reconfigurations as this relates to the use of, and distribution of, the medical workforce at regional level.

2.13 MPET (MADEL) is disbursed through Health Authorities to specific WDCs linked to post graduate Deaneries. Separate administrative arrangements have grown up around the deaneries. The funding can be moved around readily to follow trainees and its use is reasonably transparent. It is sufficiently flexible to support innovative developments in the education and training of junior doctors. Dental MPET(MADEL) is mainly disbursed through the National Centre for Continuing Professional Education of Dentists (NCCPED) to Postgraduate Dental Deaneries. Vocational training funds are allocated in response to bid to NCCPED.

2.14 Particular criticisms of MADEL include that:-

- Because of the link between medical and dental postgraduate education and service provision, funds are disbursed through distinct arrangements from other parts of MPET which has made it difficult to use such funds flexibly;
- It funds only the direct costs of postgraduate medical and dental education;
- It does not properly support the more structured training programmes introduced under the Calman reforms of specialist training which require senior doctors to give up service time that would otherwise support patient care.

Areas of Difficulty in Current Arrangements

2.15 This section considers how far the present arrangements currently underpin the key values set out at 1.16 above.

Transparency

2.16 As discussed above the current contracts for non-medical education are often subject to commercial confidentiality, making the establishment of effective working relationships and the assurance of value for money in the use of public funds difficult. And the situation where SIFT has been very unevenly distributed on historic principles as a service supplement to teaching hospitals, notably in London, has become harder to justify with the ending of the former internal market, and the increasing need to relocate education and training in primary and community care.

Equity of Treatment

2.17 There are very different approaches to the funding of student placements under current budgets. In particular while SIFT provides support for medical and dental placements – and arguably MADEL is almost entirely devoted to such support - no earmarked support exists for placements for nurses, midwives, the allied health professions, professions complementary to dentistry, and other groups including those undertaking NVQs, and cadets. With placements increasingly based in smaller primary care units the current discrepancies in funding are likely to become increasingly detrimental to the provision of high quality education in clinical settings. Furthermore, high quality placements require a substantial supporting infrastructure that will include suitable accommodation and catering facilities, as well as IT support and also proper personal support in the form of facilitators, mentors and supervisors.

Comprehensiveness

2.18 The unevenness with which the current arrangements support the different professions and occupational groups is compounded by their failure to make specific provision for existing staff (including support staff) without existing professional qualifications to develop new skills. Wider access to learning could provide opportunities for currently excluded groups.

Responsiveness to new demands

2.19 The emphasis on pre registration training for new entrants to healthcare, while necessary, has often meant that other forms of continuing education and training have had a lower profile. Present funding arrangements would inhibit the development of new training programmes to deliver new skills quickly. Additional NHS plan funding for NVQs and NHS learning accounts, has already benefited thousands of staff without professional qualifications and there is a need to support new and innovative programmes which prepare students to undertake a shorter pre-registration programme, such as those which provide a bridge between NVQ3 and pre-registration programmes. Integration of these and other opportunities for such staff groups will be vital to support the skills escalator strategy, the retention and development of staff, and the development of new ways of delivering care.

Integration

2.20 The continuing separation and distinct purposes of the different funding elements already described, have led to different structures that get in the way of different groups learning together. Common learning does not coexist easily with differences in:-

- The providers of funding;
- The levels at which funding is provided;
- The purposes and requirements of funding.

Partnership working

2.21 Close partnership working between the NHS, HEIs and other key stakeholders has been inhibited by the current contractual arrangements for non-medical education and training. While the development of Workforce Development Confederations is helping to bring key players together, it is important that funding arrangements support this. The WDCs, and the new national structures for workforce planning, do provide fora for much closer working, but they are essentially working with the legacy of uni professional arrangements. Building new liaison arrangements on, for example, the new strategic alliance between HEFCE and the Department of Health, and, more locally, through Health and Education Sector Partnerships, there is scope to bring much greater coherence to the use of funding, even where funding streams are not modified. In the future, this must also acknowledge the work of the NHSU in supporting Lifelong Learning for NHS staff.

2.22 Social Care education and training is currently funded separately from healthcare but the closer integration of health and social services is a Government priority. The organisational separation of health and social care services has meant that much of the contact has occurred locally where services for patients and social care service users meet. While this separation of responsibilities makes a single integrated approach to education and training funding complex, in the longer term careful consideration will need to be given to bringing these sectors much closer together.

Flexibility

2.23 Budget managers have commented on the major problems that arise from their inability to use the different parts of the current MPET funding flexibly. The limited virement arrangements introduced in 2001 with the creation of MPET has assisted to some extent, but the main flexibility available locally has been the scope to pool different sub elements of the MPET Budget, rather than to use it to best effect to deliver local targets within the national setting.

Specific Issues to be Considered

2.24 This section considers particular areas that the Reviews have identified as needing attention.

Research and Development support

2.25 The relationship between education and training, research, clinical skills and the development of academic staff is complex, as teaching is spread across both HE and NHS sites and staff. The funding base is also complicated by the presence at local level of different funding streams from HEFCE, the Learning and Skills Council as well as the different components of NHS MPET, and NHS service funding streams.

2.26 For the NHS the first priority is the delivery of a properly trained workforce in the right numbers, at the right time and in the right place, but the research and staff development environments are key to this, as the best qualified academic staff will be attracted to institutions with a strong research base and which invest in their teaching staff. Furthermore, students will be best able to develop critical appraisal skills and an appreciation of research and the importance of robust evidence for practice in a research active environment.

2.27 The research quality of academic departments involved in teaching pre-registration health students has increased over the last few years, as reflected in the increase in grades in the last HEFCE Research Assessment Exercise. But there is a need for further development, as highlighted in the report of the joint DH/HEFCE Task Group 3, chaired by Professor Janet Finch, which explored the problems of research capacity in the fields of Nursing and Allied Health Professions. Following from this, DH and HEFCE will be establishing two new award schemes to enable individuals to develop their research skills, and a strategic funding committee to advise DH and HEFCE on what else should be funded to ensure progress towards a mature and dynamic research base. Consideration will need to be given to whether any other specific initiatives or investments will be required for NHS-funded teaching staff in academic departments.

2.28 In addition to the need to develop the research base of learning environments by investment in the development of their research capability, teaching staff also need to maintain and develop their clinical and education skills. Not all staff need to develop in each of these areas, but a vibrant learning environment would see some staff developing in each domain. Particular issues are the availability of sabbaticals to allow teaching staff to maintain and develop their knowledge and skills, and the lack of explicit development funding for NHS funded academics, who do not receive the support available to their HEFCE funded colleagues.

Capital and Accommodation

2.29 Capital investment in infrastructure and accommodation is very important to the quality of both education and the student experience. It includes major items of equipment, new buildings and major refurbishment.

2.30 The balance between the use of NHS and Higher Education facilities in the teaching of healthcare disciplines is complex, with much variation between institutions and different capital funding

streams. Capital provision in Higher Education for the support of NHS funded education and training is funded indirectly through revenue prices. Maintenance and running costs of new or existing accommodation and facilities affect revenue prices significantly. HEI charges to WDCs reflect the risk factor for the Higher Education Institution of being left with a redundant and high cost investment in the event that the contract is not renewed. The condition of the higher education estate for the teaching of healthcare staff is very variable. In some areas, for example, a multiplicity of sites will add to costs and the satellite sites might have inadequate access to important facilities such as skills laboratories. The estate quality inherited from the former funding regime is likely to be a significant factor in the price variations noted above.

2.31 There is no separate capital provision for education in NHS premises which is funded from general NHS capital funding or, for example, through the Private Finance Initiative. There is no single assessment of the NHS teaching estate, or its fitness for purpose, and the picture is often complicated by local arrangements that reflect historical patterns of training delivery – for example HEI leasing of NHS premises.

Conclusion on Current Arrangements

2.32 It is clear that the current funding arrangements do not fit the needs of the new century. In particular they do not fully support delivery of the key values for funding set out in Section 1. Furthermore because funds are allocated by different routes with separate conditions and performance and quality requirements, it has been very difficult to stimulate integration in learning and its support services within either Higher Education or the NHS. Even such fundamentals as IT and library support have often been funded and operated separately and this is compounded by problems of communication between NHS and HE IT systems. In addition there has been a lack of recognition of the role of the wider education sector, particularly Further Education, in supporting workforce priorities in the health sector and the need for this to link with HE programmes. This will be a key issue to address as the realities of applying the skills escalator in practice begin to evolve, and the HEFCE Partnerships for Progression initiative provides important context for this. More specifically:-

- Prices negotiated between HEIs and WDCs reflect neither the true costs, nor the quality of the education and training offered;
- Uneven availability of earmarked central support for placements has led to two tier provision;
- Separation of funding, has led to a mismatch between allocations made for different purposes, local clinical services, and the populations served, and does not deliver best value for money;
- Distribution of funding has often been driven more by the potential availability of places than by need in a locality;
- MPET (MADEL) funding does not reflect the true costs of postgraduate medical and dental education including the infrastructure of supporting training and additional supervisory duties;
- The funding of capital in the higher education estate is likely to have continuing implications for price in the negotiation of contracts;
- The quite proper emphasis on pre registration training may be pursued in ways that limit the flexibility to support innovative education and training arrangements;
- Responsibility for funding research and staff development in NHS funded academic departments needs to be further considered and clarified.

3 – The Future Funding of Healthcare Learning and Development

3.1 This Chapter considers the options for change, makes preliminary recommendations, and invites comments from stakeholders.

3.2 In a rapidly developing and modernising service, it is essential that funding for learning and development should act as an enabler for change, quickly providing and developing the workforce to support new and reconfigured services that best reflect patient need.

3.3 The need for the service to respond quickly to developing health needs requires the NHS to use its workforce flexibly, giving new skills to existing staff whatever their present roles, as well as increasing the training numbers of new entrants for particular professions. Technical advance will catalyse this trend with learning increasingly being delivered through new technology, often at a distance.

3.4 It follows that fundamental restructuring of funding arrangements will be necessary to support NHS Modernisation, although the Groups recognise that change will need to be paced over time to:-

- Ensure that it is manageable for higher education and the health service organisations alike;
- Reflect the resources available, based on a realistic and agreed assessment of costs;
- Protect existing commitments;
- Ensure the short term financial stability of WDCs, HEIs and health service bodies.

Transparency

3.5 There are potentially three broad models for learning and development contracting funded through the former NMET stream:-

- The status quo under which WDCs negotiate a contract price with HEIs and Further Education Colleges for the provision of education;
- A model based on actual costs of individual institutions openly negotiated against national costing protocols;
- A system based on the HEFCE model under which a standard national price is set for a particular type of course, with additional standardised non core items to reflect special features of the course or HEI (for example London, or non London). The core price in the longer term would include all capital and accommodation costs for the HEIs but some transitional arrangements would be likely to be necessary while the existing commitments for repayment of capital costs and additional costs incurred in bringing the HE estate up to standard remained a burden on institutions.

3.6 The current market led arrangements for NHS funded learning and development have served both the NHS and Higher Education unevenly, with no clear relationship between costs and the prices paid, and little transparency or co-operation in the development of courses. Commercial considerations have engendered protective attitudes inimical to innovation, effective sharing of information, and to discussion of quality between Higher Education Institutions and the NHS. The possibility of losing a contract in retendering has meant that HEI investment in infrastructure has carried a redundancy and capital risk which has tended to force up prices. Against this background,

the NHS has had only limited information on the costs underlying the prices it pays for learning and development.

3.7 A model based upon the actual costs of individual institutions would have advantages over current arrangements. It would be possible to make open assessments of the comparative costs of different institutions. This approach would however share a disadvantage of present arrangements in that significant resources would be diverted into the assessment of cost, while inevitably, any guidance on costing would leave considerable latitude for local interpretation.

3.8 The National Audit Office study *Educating and training the future health professional workforce for England* recommended that the Department of Health should consider a common generic pricing approach for core elements with some flexibility for elements such as geographical location, accommodation and staffing differentials. It also recommended a standard benchmark pricing formula for NHS funded programmes similar to that operating for Higher Education Funding Council for England programmes.

3.9 The Review Groups endorse this approach, and believe that a uniform pricing approach offers the best option for both HEIs and the NHS. They believe that the possible disadvantages of a one size fits all approach for the core elements are outweighed by the removal of uncertainty and the greater transparency of the process. They also believe that broadly equivalent activity should be funded at broadly equivalent rates and that standard rate, non core, additions should be considered for specific factors that might affect some HEIs only – for example split campuses, or geographical location. Judgements about the commissioning of courses would then be based on educational quality, assessed through QAA and other agreed arrangements, rather than price.

3.10 Under this approach, the standard core price would be based on a study of the core costs of a representative sample of institutions, and would be applicable to all education of a particular type. Core prices would for example be separately assessed for pre entry, post registration, or second registration training for the range of profession specific courses. Costs would be adjusted to take account of factors including course length and whether training was delivered on a full or part time basis. The major elements constituting non core prices would be identified and assessed across a wide range of different institutions, and would be reflected in prices at standardised rates. The non-core costs to be included in contracts should be specified and agreed between the partners.

3.11 The Department of Health has commissioned work to determine an indicative common price for pre registration nurse and midwifery training to include recommendations on the items to be included as core and non core costs. Further and more detailed work will be necessary to identify the core and non core costs across all NHS funded courses and course types. With a standardised pricing system in place, national core and non core cost assessment cost assessment reviews should be undertaken on a cyclical basis, with active participation from the higher education and health sectors, taking account of empirical evidence across a wide range of institutions. This approach should be applied to both traditional and new innovative courses.

Equity of treatment

3.12 The Groups consider that the present arrangements for the support of placements and practice learning, which are limited to medicine and dentistry, do not sufficiently support the modernisation agenda, including the development of integrated learning. They recognise the dependence of all

undergraduate medical and dental teaching hospitals on SIFT funding, and the impracticality of wholly phasing out funding notionally earmarked for placement support especially at a time when the increasing use of placements in primary care settings will put an additional burden on relatively small organisations. They also recognise the need for the maintenance of existing commitments, especially those relating to the current expansion of medical schools.

3.13 But consideration should be given to a fundamental rebasing, so that funding for placements is clearly identified on a banded basis to reflect the support requirements of all the different types of learner, whether or not they are currently covered by SIFT, balanced against their service contribution. They believe that consideration should be given, at a minimum, to the phased extension of earmarked placement support to all students who are not already in paid health service employment in line with the resources available.

Comprehensiveness, Responsiveness to new demands, Integration

3.14 The devolution of responsibility to local level also requires that WDCs and employers have the maximum freedom to respond to local circumstances subject to meeting national workforce requirements. The flexibility of WDC funding proposed at paragraph 3.39 below will allow greater freedom for them to meet their national targets in new and innovative ways suited to their local health and education environments. This will allow them to develop, in particular, step on and off training quickly to deliver new skills learning through existing staff, to direct resources into new areas, including support for learning in Primary care, and to support new and developing professional roles.

Partnership working

3.15 The delivery of learning and development involves many different stakeholders. The nature of partnerships will vary according to the role of the bodies concerned. In general however, partnerships will share the following features:-

- A high level of mutual trust;
- Extensive information sharing;
- Joint problem solving;
- A strong motivation to achieve mutual gain for all partners;
- A long term relationship – based on joint principles and goals.

3.16 The key aspect of the partnership arrangements will be the opportunity for the NHS Higher Education and, increasingly, Further Education, to work together through standardised, and more flexible contracts that would in general roll forward indefinitely, subject to much more limited and specific rules on termination. Although in practice the non-renewal of contracts has been unusual, the greater certainty of longer term funding will facilitate cooperation over time in the development of HE provision, reducing the risk factor for Higher and Further Education in investing in staff and buildings to support healthcare education. Contracts should allow incremental change in the nature of educational provision so that changing NHS learning needs continue to be met, while Educational Institutions have greater certainty about the long term commitment of WDCs to them.

3.17 The ending of the market arrangements with the move to uniform prices will permit closer, and more constructive, relationships to be established based on information sharing. This would have its

most immediate impact at local level where realistic dialogue on inter linked learning, and wider and more effective use of placements, could be taken forward between Strategic Health Authorities as the parent bodies for the Health and Education Sector Partnerships, and WDCs, HEIs. Further Education Colleges will also be partners here, as the increasing inclusion of non professional staff in the remit of the budget will require strong local links to be built. Different education institutions would also be much better placed to work together directly in the provision of learning.

3.18 The development of partnership working will also provide the opportunity to extend the involvement of different groups including the private healthcare and voluntary sectors. Equally, new partnerships will be developed with and through the NHSU.

3.19 It is likely that some existing local structures including WDC Boards, and the Health and Education Sector partnerships would provide a forum for local partnership discussions. At national level there will be a particular need to build close links between DH, HEFCE and the regulatory bodies to ensure the compatibility of rules on funding and curriculum for the development of inter linked education between the NHS and HE funded groups. DH and HEFCE funding streams will need to be managed more closely and co-operatively together nationally and locally so that mutually compatible goals and approaches can be established at HEI level.

3.20 Social care presents particular issues due to the diffuse nature of provision across different sectors including local authorities and the voluntary and private sectors, and widely varying funding levels and sources. The Wanless Report, in considering the future funding of the NHS overall, recognised that it had neither the information nor resources to develop a whole systems model for health and social care, nor indeed to build up detailed projections for social care. It recommended that future reviews should fully integrate modelling and analysis of health and social care. The review groups also recognise the interdependence of the health and social care sectors and the need to establish close partnerships between them to deliver a holistic approach to service provision and education. But they believe that more detailed work should be undertaken on this aspect to work to an integrated partnership model outside the current MPET Review process.

Flexibility

3.21 Subject to the meeting of national requirements and existing contractual commitments, it is important that WDCs have freedom to use their funds as flexibly as possible in support of learning and development across the spectrum, to make best use locally of funding to support both traditional and innovative training arrangements. This will require the ending of the current demarcations between sub-budgets, with a strong focus on outcomes. Longer term rolling contracts will need to build in the facility to change the nature of provision over time and to respond to new needs.

Research and Staff Development

3.22 The Benchmark Group recognised the importance of a strong research base and academic staff development in delivering high quality education and training which will result in a future NHS workforce with well developed critical appraisal skills and research awareness.

3.23 The Group also believed that there should be clear links here with the local and national policy agendas for the NHS and the requirements of the NHS Plan, National Service Frameworks and Health Improvement Programmes.

3.24 In general, NHS learning and development funding should continue to support teaching staff development in research up to taught Masters level through WDC/HEI contracts. Funding should also be sufficient to support the continuing professional development of academic staff, whether in education or clinical practice. Funding for the development of research active departments needs further consideration by DH and HEFCE, in the context of the new strategic funding committee which will advise DH and HEFCE on measures required to implement the Task Group 3 recommendation that a fund should be established to support the development of research capacity in nursing and allied health professions. There will be implications for NHS R&D and HEFCE funding to support the development of research leadership, rather than research appreciation and utilisation skills.

Capital and Accommodation

3.25 The development of longer term, rolling contracts between NHS Workforce Development Confederations and HEIs will give greater certainty of commitment, removing some of the risk element that currently exists in terms of capital investment to support NHS funded education. Against this background the reviews have concluded that in the longer term capital reinvestment costs should form a part of the core price. However, the currently variable quality of the teaching estate suggests that consideration should be given to an independent expert audit of it, and that in the medium term some HEI contracts may need to include revenue provision to cover the cost of reinvestment. Issues will also arise with some inherent aspects of accommodation, including for example the age of the estate, or the funding of major capital projects in the future. There will also be a need to handle the financial legacy of past investments.

Recommendations and Questions

A standard price – recommendations

3.26 The current system for negotiating contracts between WDCs and Higher Education Institutions should be replaced by a system of standardised prices based on a periodic assessment of core costs applicable to all HEIs, and non core costs that might vary between HEIs. The prices would vary according to the subject, and also the nature of the course (for example part time or full time). Consideration may need to be given to the adoption of a similar approach to contracts with FE Colleges as their role in NHS funded learning increases.

3.27 Consideration should be given to how far NHS contracts already cover the development of HE staff as a core cost, and how far this should be covered in the standard unit price to support a consistent approach to the professional and academic development of all HEI academic staff.

3.28 In the longer term, the core price should include all capital and accommodation costs associated with provision of courses. In the shorter term the teaching estate should be audited, to inform adjusting revenue payments for the medium term only to reflect the additional costs of reinvestment.

3.29 In the shorter term there will need to be a transitional period while existing contracts run out and HEI costs are adjusted to reflect the income from new, fixed, prices.

Questions for consultation

- **What would be the respective responsibilities of the NHS and HE in ensuring effective professional development of Higher Education staff supporting healthcare learning?**
- **What timescale should apply in the transition to a new pricing system? Should all existing contracts run to their agreed expiry, or should there be a different transitional model?**
- **What issues will arise in the interim funding of major capital developments, especially if an audit of the HE estate reveals a significant backlog of repairs?**

A standard contract – recommendations

3.30 There should be a standard national contract for NHS funded learning and development up to and including Masters level (beyond in the case of taught doctorates for Clinical Psychologists), specifying in particular the outcomes to be achieved from courses, quality assurance arrangements and performance monitoring arrangements.

3.31 The model contract should support integration between the teaching of different healthcare disciplines including HEFCE funded courses such as medicine, dentistry and pharmacy. It should ensure a focus on innovation and modernisation, and in particular support the development of the skills escalator through encouraging step on and off learning, the transferability of accredited learning between programmes, and the development of research awareness.

3.32 Unless there are exceptional circumstances, contracts should roll forward indefinitely to allow for reasonable levels of certainty to support investment in HE staff and capital, and to allow for the development of longer term co-operative links between partners. However, because by comparison with some HEFCE funding, NHS funding is geared to the delivery of particular skills which may be

specified on a local and national basis, contracts should be flexible enough to maximise the scope for the greatest local freedom within national objectives. Flexibility in contracts will also allow the nature of the educational provision to be varied over time to reflect developing local and national NHS requirements.

3.33 Subject to the adoption of standardised prices, contracts should not be terminated prematurely on grounds of cost. There should however be an agreed and transparent process for the winding up of contracts. Circumstances where termination could be appropriate might include:-

- An inability to adapt to changing requirements, for example where there was an end to the need for the type of education and adaptation was impractical;
- An inability to recruit or retain sufficient students;
- Where independent Quality Assurance had identified shortcomings and remedial measures were not effective.

Questions for consultation

- **How can the contracting process support appropriate integration between HEFCE and NHS funded courses locally?**
- **Would rolling contracts represent a fair balance between the needs of HEIs to minimise risk in investing in staff and capital, and the changing needs of the NHS?**
- **How feasible would it be to move between different learning and development models in the course of a contract – for example if changes required a significantly different configuration of staff and premises?**
- **In what circumstances might contracts need to be ended?**

Placement support – recommendation

3.34 The Department of Health should undertake a fundamental reappraisal of the current support for all practice placements, and work to rebase existing funding clearly to distinguish resources supporting education and development from those supporting, service, or other activities. This applies particularly to the current SIFT arrangements. SIFT facilities funding should be separately reviewed to identify how:-

- Far it supports service, rather than teaching activity;
- Placement funds can better support common learning during clinical placements;
- It can support more multidisciplinary use of clinical teaching facilities.

3.35 Over time, placement support should be redirected to support all healthcare training in the NHS, while maintaining the financial stability of healthcare providers. Support should continue to be distributed through WDCs and should be banded to reflect the level of support needed by the different healthcare disciplines. It should be used, as far as possible, to encourage the interdisciplinary use of facilities.

Questions for consultation

- **Medical placement support is currently divided between placement funding linked to student numbers, and facilities funding supporting institutions hosting placements more generally. Assuming wider earmarking of funding for different groups, how should placement support be allocated in future?**

- What are the implications of change, especially where NHS hosts have been awarded additional SIFT to support NHS placements under the more transparent arrangements that have governed the new medical student allocations? Do particular issues arise for the allocation of Dental SIFT?
- What are the practical difficulties of rebasing funding from general Trust funding into a non medical placements fund?

Partnership structures – recommendations

3.36 National liaison arrangements between the health and education sectors are already under review, to ensure that they are effective and include the range of partners involved in the learning and development of the whole NHS workforce.

3.37 The Health and Education Sector Partnerships should form the main fora for liaison at local level. They should include further education providers to support the development of staff without existing qualifications and to support their progression to pre registration programmes if they wish.

3.38 The links between health and social care workforce development require particular consideration, but because of the complexity of this area, and the number of different stakeholders involved, this work should be undertaken outside the current work.

Questions for consultation

- What structures are necessary to co-ordinate the provision of common learning at local and national level?
- Which major stakeholders should be represented?

Future structure of the budget – recommendation

3.39 To support the development of the budget, the existing rigid distinctions between NMET, MADEL and SIFT be ended, and that new and more flexible sub designations should be established – these are set out in more detail in Annex D. WDCs would be able to use the funds allocated to them flexibly subject to the meeting of national priorities. The key elements would comprise:-

Innovation and development – *A single, innovation fund to drive change, to support service needs transparently, and which will be disbursed in the most effective way having regard to value for money, need and impact.*

Practice placements and learning and educational infrastructure – *Support for practice placements that encourages the creation of a high quality, multi-professional education infrastructure within health service organisations. Resources to be provided via a transparent mechanism which reflects the differential needs, and costs, of supporting different groups of students.*

Tuition costs for students training for the healthcare professions – *A standard core national rate for agreed outputs to be paid to Higher Education establishments providing NHS commissioned learning and development for entry to healthcare professions. Non core additions, at standard rates, would support pressures that did not apply uniformly to all HEIs, including geographical factors, and the nature of the teaching estate.*

Support for bursary costs – *All students undertaking relevant healthcare courses, commissioned via the NHS, to have access to bursaries, the level of which is determined, and the amount of which is paid, via a transparent national mechanism.*

Partnership support of tuition and salary costs for employees of NHS organisations undertaking continuing personal and professional development – *A transparent framework to be established within which NHS organisations have access to partnership funds in support of all employees undertaking continuing personal and professional development up to Masters level, and within which such funds are disbursed in the most effective way having regard to value for money, need and impact.*

Partnership support costs for the development of staff without a recognised professional qualification – *A framework which brings staff without existing professional qualifications into the skills escalator, encourages recruitment from local communities and reflects close working with further education, learning and skills councils, and trades unions.*

Support for capital costs of NHS infrastructure – *A framework within which capital bids for educational infrastructure within NHS organisations have fair access to the various mechanisms via which capital schemes can be resourced.*

Questions for consultation

- What risks and benefits would be associated with the adoption of a looser budget framework?
- Should the principle that only direct costs of postgraduate medical and dental education are funded through MPET be maintained?
- What should be the balance between supporting creativity and innovation at local level and spreading good practice more broadly across the country?
- What should be the approach to the issue of management costs?
- What should be the priorities for early implementation?

The name of the new budget – recommendation

3.40 The interim name for the merged funding stream – the Multi Professional Education and Training budget (MPET) recognised the need to move to an inter professional model of education and training. The next stage will involve the inclusion of existing NHS staff without existing professional qualifications within its scope. For this reason the Groups recommend that the budget be entitled the Health Workforce Education and Development Budget.

Comments

3.41 We would welcome comments on the proposals and recommendations in this consultation document. These should be sent preferably by Email to:-

Helen Friedrichsen
Quarry House
Quarry Hill
Leeds LS2 7UE
By 25 October 2002
MPET@doh.gsi.gov.uk

3.42 Responses to this consultation document will normally be made available unless they are confidential. Please tell us if you want your responses to be confidential. The outcome of the consultation will be published and followed by an action plan.

Annex – A

Terms of reference of the two reviews

The Benchmarking and Attrition Group was established to consider pricing and attrition issues in non medical healthcare professional education following the publication of the National Audit Office Report *Educating and training the future health professional workforce in England* with Terms of Reference:-

- To consider and make recommendations on the development of a standard benchmark pricing formula for NHS funded courses at HEIs.
- To consider and make recommendations on the development of a consistent approach to setting NHS contracts to ensure they consider outputs as well as costs/inputs.
- To consider and review the overall policy framework for NHS contracts and make recommendations on the length of contracts, treatment of capital development and research and development under the Multi Professional Education and Training Levy (MPET).
- To consider and make recommendations on a single and consistent definition of attrition from NH funded courses at HEIs.

The MPET Review group was established to identify how the former NMET, MADEL and SIFT budgets should be developed to achieve a much higher degree of coherence in supporting the healthcare professions. A core issue was the lack of consistency in the way the different elements of MPET supported different professional groups – with only NMET directly funding workforce development, SIFT supporting service costs to NHS providers of undergraduate medical education and MADEL supporting the replacement salary costs of doctors in specialist training.

The Terms of Reference of the Review are:-

- To review the current use of the financial provision underpinning the Education and Training of Healthcare Professionals.
- To recommend the principles and scope of the single education levy, how it should support the NHS Modernisation Agenda and wider Government Plans, how it should interact with HEFCE funding and how it should be managed.
- To identify key problems and obstacles to achieving this and to recommend solutions.
- To propose an action programme and timetable for change.

Annex – B

Membership of the two review groups

Membership of the Contact Benchmark and Attrition Review Group

Names	Titles
Professor Janet Finch (Joint Chair)	Vice Chancellor, Keele University
Martin Staniforth (Joint Chair)	Deputy Director of Human Resources, Department of Health
Tony Burton	Economic Advisor, Department of Health
Barbara Butler (Secretariat)	Senior PA to Martin Staniforth
Maggie Deacon	Chief Executive, Kent, Surrey & Sussex WDC
Mariella Dexter	Chief Executive, Avon, Gloucestershire & Wiltshire WDC
Professor Charles Easmon	Director of Workforce Development, London Regional Office, Department of Health
Iain Graham	Head of Nursing and Health Visiting, IHCS, Bournemouth University
Eve Jagusiewicz	Policy Advisor, Universities UK
John Langford	Assistant Director of Public Health/Regional Dental Officer, West Midlands Regional Office, Department of Health
Colin McInnes	Director of Finance and Information, Avon, Gloucestershire & Wiltshire WDC
Professor Dame Jill Macleod Clark	Deputy Dean of the Faculty of Medicine, Health and Biological Sciences, University of Southampton
Eileen Martin	Chair of Council of Deans and Heads of UK Faculties for Nursing, Midwifery and Health Visiting
David Noyce	Higher Education Funding Council for England
Jan Parkin (secretariat)	Education and Training Funding Team, Department of Health
Maggie Pearson	Deputy Director of Human Resources, Department of Health
Edward Pope	BUFDG, University of Central Lancashire
John Rushforth	Higher Education Funding Council for England
John Sargent	Chief Executive, Greater Manchester WDC
Ros Slocombe	Director of Resource Management, East Midlands WDC
John Tarrant	Vice Chancellor, University of Huddersfield
Marc Taylor	Head of Research & Development Branch, Department of Health
Karen Teal	Section Head, Learning and Personal Development Division, Department of Health.
Simon Thompson	Director of Finance, Performance & Commissioning, Cheshire and Merseyside WDC
Paul Turner	Executive Officer, Council of Deans and Heads of UK Faculties for Nursing, Midwifery and Health Visiting
Bill Urry	Head of Education and Training Funding Team, Department of Health
Tim Wheeler	Principal, Chester College of Higher Education

Membership of the MPET Review Group

Names	Titles
Professor Charles Easmon (Chair)	Director of Workforce Development, London Regional Office, Department of Health
Professor Gifford Batstone	Director of Workforce Development, South West Regional Office, Department of Health
Mike Bewlock	Head of Finance and Commissioning, Kent, Surrey & Sussex WDC
Sue Brennan	Social Care Modernisation Branch, Department of Health
Sir Kenneth Calman	Vice Chancellor, Durham University
Helen Chalmers	Finance Director, UCL Hospital
John Downer	Financial Management Branch, Department of Health
Helen Fields	Branch Head, Learning and Professional Development Division, Department of Health
Helen Friedrichsen (Secretariat from March 2002)	Education and Training Funding Team, Department of Health
Nic Greenfield	Chief Executive North Central London WDC
Brendan Hicks	Dean Director, Postgraduate Deanery for Kent, Surrey and Sussex
Peter Hill	Chair COPMED, Dean's Rep on RDWDs
Hedley Hilton	Education and Training Funding Team, Department of Health
Debra Humphris	Director, New Generation Project, Faculty of Medicine, University of Southampton
Eve Jagusiewicz	Policy Avisor, Universities UK
Chris Jeffries	Finance Director, Greater Manchester WDC
Bryan Kessie	Business Manager, North West Deanery
Professor Dame Jill Macleod Clark	Deputy Dean of the Faculty of Medicine, Health and Biological Sciences, University of Southampton
Stuart Mallett	Senior Accountant South East Regional Office, Department of Health
Colin McInnes	Director of Finance & Information, Avon, Gloucestershire & Wiltshire WDC
Anne Mercer	Social Care Modernisation Branch, Department of Health
David Moss	Chairman, UK University Hospitals Forum
Mike Newett (Secretariat to February 2002)	Education and Training Funding Team, Department of Health
David Noyce	Higher Education Funding Council for England
Phyllida Parsloe	Chair, North Bristol NHS Trust
Claire Potter	Section Head, Learning and Personal Development Division, Department of Health.
Deepak Puri	National Dental Development Unit
Tim Sands	Head of Workforce Development Branch, Department of Health
John Sargent	Chief Executive, Greater Manchester WDC
John Scott	Chair of Council of Dental Deans
Liz Scott	Education and Training Funding Team, Department of Health
Chrys Short	Assistant Director of Nursing, Thames Gateway NHS Trust
Ros Slocombe	Director of Resource Management, East Midlands WDC
David Smith	Conference of Postgraduate Dental Deans and Directors (COPDEND)

Membership of the MPET Review Group

Names	Titles
Geoff Taylor	Conference of Postgraduate Dental Deans and Directors (COPDEND)
Simon Thompson	Director of Finance, Performance & Commissioning, Cheshire and Merseyside WDC
Rod Tooher	Head of Primary Care Workforce Development, Department of Health
Bill Urry	Head of Education and Training Funding Team, Department of Health
Tony Weetman	Dean of the Medical School, Sheffield (undergraduate interest)
Jonathan Wise	Acting Director of Finance, London Regional Office, Department of Health
Tim van Zwanenberg	Chair of COGPED

Annex – C

Note on the Skills Escalator

The NHS Plan sets out a vision of a modernised NHS with many more staff, working differently. It describes how services will be redesigned around the patient's journey and how this will radically improve the patient's experience. Our strategy to deliver the challenging objective of growing and changing the workforce is called the Skills Escalator. The essence of this approach is that staff are encouraged through a strategy of lifelong learning to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. Meanwhile efficiencies and skillmix benefits are generated by delegating roles and workload down the escalator.

The Skills Escalator is also about attracting a wider range of people to work within the NHS by offering a variety of step-on and step-off points. Traditional entry points such as registered professional staff will continue but they will be complemented by other entry routes such as cadet schemes and role conversion, attracting people in other careers who are seeking new challenges and drawing people back into the labour market. This offers the dual benefit of growing the NHS workforce whilst also tackling problems of longer-term unemployment and social exclusion, which have such a high correlation with poor health. It will enable people to start or further develop careers in the NHS, as young people starting out, in mid- or later-life or as a second career. Age, background and existing academic attainment will no longer be barriers to those with the potential and will to progress their careers. It will also enable the NHS to have a workforce that is more representative of local communities and to demonstrate the benefits of working in the NHS.

The Department of Health published the Lifelong Learning Framework for the NHS *Working Together – Learning Together* on 27th November 2001. The vision and strategy for lifelong learning is to develop and maintain a workforce fit for the future. The framework is intended for use by employers and Workforce Development Confederations to ensure staff are equipped with the skills and knowledge to work flexibly in support of patients and are supported to realise their potential. The Lifelong Learning Framework concept underpins the Skills Escalator.

The Skills Escalator operates at all levels of the workforce, thus offering the powerful recruitment message of endless opportunity. Its extreme expression is that in theory, staff can progress from cleaner to consultant. This is illustrated by showing the stages of development as seven basic categories, which are listed at Annex A.

Employers will benefit because a structured programme of skills development and acquisition will help them to recruit and retain staff, developing them to fill posts which are traditionally hard to recruit to. Individuals will benefit in a range of ways. Those who are socially excluded, older people and the unemployed can be introduced or re-introduced to the working environment and developed so that they can subsequently be employed within the NHS. Those already within the NHS will benefit from the opportunity to develop and enhance their skills and take on new and more challenging roles.

Some staff may wish to develop their skills at a particular level of responsibility. Others may choose to develop the skills necessary for the next level of responsibility. This does not guarantee promotion or advancement but it puts them in a position to take advantage of openings that become available. In this way, people are enabled to have careers that are satisfying, whilst simultaneously filling skills gaps that develop because of staff turnover and new or increased demand for a service. This will help reduce the stagnation that can occur at all levels of the career ladder – and help to re-stimulate people with new challenges.

Communities will benefit from an active approach to employing and developing staff by major local employers.

There are clear links between learning and education developments in the NHS and the Skills Escalator. These range from work being carried out on improving adult literacy and numeracy skills through to the multi-professional director development programme.

There are also close links between the Skills Escalator and the work taking place to modernise pay and workforce planning. Under the Health Departments' proposals for pay modernisation ('Agenda for Change'), employers will be able to fit new jobs into a national pay framework using the new NHS job evaluation scheme currently under development. This will make it far easier for employers to introduce new roles and help prevent artificial career ceilings, whilst ensuring that there is a fair and consistent relationship between pay and job weight. Additionally there will be a consistent approach to applying standards to all jobs across the NHS and a common language for describing the knowledge and skills required. Work is also taking place to develop a career map for the NHS identifying different skill levels covering the range of career roles from new entrants to consultants and senior managers.

Seven categories within the Skills Escalator

A. Socially excluded individuals who can be placed on employment orientation programmes to develop an understanding of working life
B. The unemployed placed in starter jobs with structured training and development, in conjunction with job rotation, to provide a good mix of skills required within the workplace, enabling them to gain longer-term employment.
C. Less skilled or experienced people already working within the NHS can be developed by use of job rotation and training and development programmes, in conjunction with their appraisal and personal development plans. This is essential to providing appropriate qualifications for further advancement (e.g. NVQs), as well as developing and providing a greater mix of skills.
D. Semi-skilled workers can be developed through NVQs or equivalent vocational qualifications, to put them in a position where they can access education towards professional qualification.
E. Through the use of appraisal and development, qualified professionals can identify development needs and use training and job rotation opportunities to acquire a range of skills at staged intervals.
F. Staff in more demanding or complex posts will require support for continued learning and skills development. Staff will be encouraged in role development and flexible working in line with the service priorities and their own career choice.
G. The most advanced staff will continue to develop by means of flexible 'portfolio careers', planned in partnership with employers, informed by appraisal, career and development planning processes.

Annex – D

Future Structure of the Levy

This Annex considers the possible future structure of the NHS Workforce Development Budget. The MPET Group believed that the overall budget should be divided into a series of sub budgets covering healthcare professional training, and the development of existing NHS staff.

Support for innovation and developments

Key success criterion: *A single, innovation fund will be established, to drive change, to support service needs transparently, and which will be disbursed in the most effective way having regard to value for money, need and impact.*

Support for innovation and development will be a key component of the workforce development levy, which will enable change and make a real difference. It will need to balance "bottom up" creativity for meeting local innovation, against the development of schemes requiring a greater critical mass than can be achieved locally. Examples of its potential uses include:

- Funding to support educational developments such as inter-professional and common learning training and facilities to promote this;
- New ways of workforce planning and development;
- New types of healthcare worker.

Support for practice placements and the learning and educational infrastructure

Key success criterion: *Support for practice placements that encourages the creation of a high quality, multi-professional education infrastructure within health service organisations. Resources to be provided via a transparent mechanism which reflects the differential needs, and costs, of supporting different groups of students.*

A Health Service of all the Talents made clear the need for health service organisations to 'own' responsibility for securing and developing their workforces. It follows that workforce development funding must provide a means to encourage appropriate quality – reflecting technological advances in learning, and supporting infrastructure within healthcare service providers, without precisely determining the nature of the facilities to be provided.

To underpin the key success criteria, one methodology would be to provide support under a transparent system of bandings. The number of bandings should be kept to a minimum, and be based on the intensity of student support required, and the level of access to certain types of facilities necessary.

The funding methodology should also encourage the development of common learning by ensuring that facilities are not specifically provided to any one healthcare group.

Support for tuition costs of students learning for the healthcare professions

Key success criterion: *Establishment of a standard core national rate for agreed outputs to be paid to Higher Education establishments providing education and training for students training for the healthcare professions.*

Non core additions, at standard rates, would support pressures that did not apply uniformly to all HEIs including geographical factors, and the nature of the teaching estate.

The establishment of standard rates would enable a move away from the traditional contracting model to one of strategic partnership. Under the partnership model, relationships could be longer-term, and the NHS could build on its influence of curricula, and the nature of outcomes, for all healthcare professionals.

In a national rate it could also be possible to include a non core transparent element in support of the revenue consequences of capital developments in higher education, specific to healthcare courses, for example multi-professional clinical skills laboratories and the development needs of teachers in both academic and clinical settings.

Support for bursary costs

Key success criterion: *All students undertaking relevant healthcare courses, commissioned via the NHS, to have access to bursaries, the level of which is determined, and the amount of which is paid, via a transparent national mechanism.*

In principle the Students Grant Unit provides an effective model for the disbursement of bursary costs. The management arrangements for the SGU are being adapted to take account of Shifting the Balance of Power, and to strengthen the role which WDCs, as important customers of the SGU, play in its governance.

Partnership support of tuition and salary costs for employees of NHS organisations undertaking continuing personal and professional development

Key success criterion: *A transparent framework to be established within which NHS organisations have access to partnership funds in support of all employees undertaking continuing personal and professional development, and within which such funds are disbursed in the most effective way having regard to value for money, need and impact.*

The framework developed should allow for differential ratios in funding between the levy, the organisation and the individual. This would be necessary to cover the range of salary and salary support costs currently in the system.

Partnership support costs for the development of staff without a recognised professional qualification

Key success criterion: *A framework established which brings this group of staff into the skills escalator, encourages recruitment from local communities and reflects close working with further education, learning and skills councils, and trades unions.*

Providing development opportunities for existing skilled but not professionally qualified staff will bring a much wider range of staff, to contribute significantly to the direct care of patients. In future the NHS should ensure that all staff can develop their skills through a mixture of local and national funding, but this will be underpinned by new regulatory arrangements.

Support for capital costs of NHS infrastructure

Key success criterion: *A framework exists within which capital bids for educational infrastructure within NHS organisations have fair access to the various mechanisms via which capital schemes can be resourced.*

The workforce development budget levy is entirely comprised of revenue budget and includes no capital. It is therefore important that workforce development requirements be given equal consideration with healthcare service when capital allocations are made.

Annex – E

Proposed learning and development budget values

Key values	Objective	Current position	Way forward
Transparency	Education commissioners and providers to be able to account fully for their use of funding	Contracts for non medical education and training are subject to commercial confidentiality. This hinders effective working relationships and means it is difficult to assure whether value for money is being achieved	Review the way non medical education and training is commissioned.
			Devise a model where there is a clear relationship between cost and price and make the process transparent.
		SIFT unevenly distributed on historic principles – mainly as a support for service and weighted towards London teaching hospitals	Rebase placement support to identify clearly the elements that do and do not support education and training
Equity	Healthcare skills delivered to all NHS staff avoiding bias to one group over another	Different approaches to funding of student places For example, SIFT and MADEL support only medical and dental learning	Modernise current arrangements to to support all types of trainee.
			Consider rebasing all all placement support making allowance where appropriate for benefits to the host from service provision by students.
		Medical school placements and dental undergraduate schools are supported by SIFT. There is no equivalent budget for other healthcare professions including nurses, midwives, allied health professions and other key health professions.	Support the development of integrated learning.
			Maintain existing commitments eg support for current expansion of medical schools
Comprehensiveness	Education and training support to be available to all staff with or without professional qualifications	Support for different professions is disparate.	Provide wider access to learning opportunities for for currently excluded groups.
		There is no specific provision for staff without existing qualifications to develop new skills.	

Proposed learning and development budget values

Key values	Objective	Current position	Way forward
Responsiveness	Learning and Development which can support the delivery of new skills in response to developing clinical and care approaches	Education and training funding arrangements are focused on pre-registration training for new entrants. Other types of education and training have a lower profile. In some areas this has lead to a lack of flexibility to deliver new skills quickly	While maintaining increases in pre-registration learning, encourage flexibility at a local level to respond to local circumstances, subject to meeting national targets. Promote flexible ways of learning for all staff eg step on and off training and flexible ways of funding learning. Direct resources into new areas e.g. support for learning in primary care Encourage new ways of delivering care e.g. by developing new roles
Integration	Staff learning together as a precursor to working together	Different groups do not learn together. There are separate budgetary streams which provide differently for different staff groups. Funding is not used flexibly to best effect across professions.	Development of a more flexible budget which WDCs can allocate flexibly according to local need (within national priorities). Promote the idea of common learning.
Partnership working	Health and education sectors, social care, private and voluntary sectors working together to deliver training	Current contractual arrangements inhibit close partnership between the NHS, HEIs and other key stakeholders Current funding structures are based on a uni-professional approach Social care and healthcare learning and development is funded separately	Facilitate partnership working amongst many different stakeholders Engender open and constructive dialogue between HEIs and the NHS over contracts. Encourage involvement with wider stakeholders over wider education and training issues. Consider how to integrate education and training for social care and healthcare in the future.

Proposed learning and development budget values

Key values	Objective	Current position	Way forward
Flexibility	Increased provision of step on and step off training	Emphasis on traditional, uni-professional training routes Marginal use of funding to support step on and off training	Encourage flexibility in the use of budgets by WDCs to support traditional and innovative training routes. End current demarcations between sub budgets. Create longer term contracts with facility to change nature of provision over time e.g. to increase the provision of flexible training routes.