

Health Committee inquiry into Education, Training and Workforce Planning

Medical Schools Council response

19 December 2011

1. Background and summary

1.1 Medical schools are the UK's centres of excellence in medical education and training and should be the first port of call for any inquiry into education, training and workforce planning. Medical schools are clear that only through the alignment of academic endeavour with patient care can service transformation and improved quality be brought about in the NHS.

1.2 The Medical Schools Council represents the interests and ambitions of UK medical schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine. The membership of the Medical Schools Council is made up of the Heads or Deans of the 31 UK undergraduate medical schools, plus the postgraduate London School of Hygiene and Tropical Medicine.

1.3 Key issues for the Medical Schools Council relevant to the themes of the inquiry are listed below. However we suggest keeping the Inquiry open until after the DH has published its recommendations for Education and Training, in order that the Committee might receive views on actual rather than speculative plans. While many issues raised in our response refer to the context in England specifically, many challenges and solutions we identify are applicable across the UK. Addressing these common challenges will only be possible through sharing information and good practice across the UK, the Medical Schools Council is committed to this.

1.4 Summary:

- Health Education England (HEE) should be established as a matter of urgency to avoid damage to local relationships through the establishment of 'shadow' Local Education and Training Boards (LETBs).
- HEE must relate to, and learn from, the Devolved Administrations.
- LETBs must include Higher Education Institutions (HEIs) as full partners with the providers of healthcare in order to achieve excellent and innovative education and training and thus improved patient care.
- Postgraduate deaneries and HEIs must be closely aligned, through honorary contracts and joint NHS/university appraisals.
- The transformative potential of Academic Health Science Networks, and the equivalent in the Devolved Administrations, should be harnessed for education, training and research as well as service delivery.

- The role of the GMC in curriculum development should be maintained. Curricula cannot be adapted piecemeal to meet local demands and the national regulator's role in quality is vital.
- Clarity is needed on the relationship between 'outcomes' and 'domains' in the *NHS Education Outcomes Framework* and effective metrics must be developed if it is to be of practical use.
- Educational funding must be ring-fenced, must not be further diluted and should transparently follow the student.
- There must be a reasoned approach to workforce planning which ensures flexibility, especially in higher training.
- A properly resourced Centre for Workforce Intelligence (CfWI) (or equivalent body), working on behalf of HEE, should seek to develop long term plans based on realistic estimates.
- Changes to the immigration system should not remove the attractiveness of working and studying in the UK due to the importance of: diversity of our medical students, the overseas educated workforce to the NHS and the need to retain global competitiveness.
- The public health workforce needs clarity, stability and leadership to ensure it meets the challenges of health inequalities and an ageing society.

2. Stable transition

2.1 LETBs must include universities as full partners with the providers of healthcare. This is necessary because:

- Medical education is a continuum from medical school to retirement, and medical schools need to be true partners of NHS colleagues in primary and secondary care - designing new systems together - and preparing doctors for the myriad, ever-changing roles required of them.
- Employers cannot quality assure the posts that they themselves provide to train the staff whom they also employ. Conflicts of interest are present for all involved in education and training, and partnership is the only way to overcome this.
- Medical schools are responsible for managing quality issues arising from GMC feedback on placements. Without high level input into LETBs, medical schools will not be able to discharge this function.
- Academic expertise is needed to both inform and transform education and training.

2.2 We are concerned that piecemeal establishment of 'shadow LETBs' is taking place in the absence of national guidance. Medical school experiences have included:

- Active exclusion from discussions about the development of LETBs
- Absence of consideration of quality assurance in LETBs' design
- Inconsistent communication between Strategic Health Authorities (SHAs) taking forward plans for LETBs, and HEIs

While we recognise that HEE will be authorising LETBs to national standards, 'shadow LETBs' pose a real threat to damaging local relationships.

2.3 HEE should be established as a matter of urgency, with close links with the Devolved Administrations to ensure a UK wide oversight is maintained.

- National quality requirements must be imposed on every LETB to ensure high and consistent standards.
- Good practice should be identified and adopted from NHS Education for Scotland and the nascent Welsh Board for Academic Medicine.

2.4 Action must be taken to prevent loss of education and training expertise in SHAs and Deaneries.

3. National structures

3.1 We welcome the duty on the Secretary of State to maintain a system of education and training in the NHS.

3.2 HEE needs to link to DH directly, in the same way as the National Institute for Health Research (NIHR), rather than via the NHS Commissioning Board (NHSCB). This will ensure clear lines of accountability, reflecting the Secretary of State's responsibility to maintain the education and training system. Additionally, HEE must be given 'teeth' with the right to call on the NHSCB for support if local plans cannot be accommodated within national requirements.

3.3 HEE must have a defined relationship with the Health Education National Strategic Exchange (HENSE), with stronger links between both NIHR and HENSE and between HEE and the Office for Strategic Coordination of Health Research (OSCHR), to coordinate and maximise research outputs alongside consideration of education and training.

3.4 There must be strategic oversight looking at developments in all the Devolved Administrations to avoid opening any chasms between medical training systems in the UK, particularly if these might jeopardise free flow of graduates across borders. Such oversight is also necessary to inform possible changes in medical student numbers.

3.5 In terms of the role of Skills for Health and Skills for Care, we welcome the review of issues of the appropriate training, role and regulation of healthcare assistants being undertaken by these bodies.

4. Local structures

4.1 Key principles developed by the Medical Schools Council (MSC) and Conference of Postgraduate Medical Deans (COPMeD) on the future of postgraduate deaneries are appended. In summary, we believe that:

- All postgraduate deans should have an honorary contract with their local university and should have joint appraisal with the university and NHS along Follett principles. COPMeD/MSC should work to develop a model contract for use locally, to ensure that this link is strong.
- England should align itself with developments in the Devolved Administrations on working relationships between postgraduate deaneries, HEIs and the NHS. This will ensure coherence within and between countries in the UK.
- Postgraduate and undergraduate medical deans should jointly ensure that academic training programmes, with their key role in innovation and growth, are of the highest standard.

4.2 As outlined above, less than full academic partnership on LETBs would mean that they fail to flourish and provide the NHS with the innovation it needs. We acknowledge that concerns have been raised that HEI involvement on LETBs will produce conflicts of interest. We think it should be recognised that NHS providers commissioning placements from themselves also present potential conflicts of interest. Medical schools are required by the GMC to act as Quality Managers for clinical placements. Without executive membership of LETBs and the capacity to change the distribution of placements, medical schools will not be able to discharge this function.

4.3 An independent chair and partnership on LETBs between HEIs and healthcare providers will produce stable entities and address any conflicts of interest. This replicates a model which has been found to be successful in Academic Health Science Centres.

4.4 The transformative potential of Academic Health Science Systems/Networks should be harnessed for education, training and research. These partnerships between academia, the NHS, the third sector and local authorities are designed to provide innovative solutions for service, education and research delivery and are emerging as catalysts for change. Designation of 'Academic Health Science Networks' (AHSNs) (as proposed by DH (2011) *Innovation, Health and Wealth*¹) is a welcome step, particularly as "every local NHS organisation should aspire to be affiliated to its local AHSN". Criteria for AHSN designation must include the importance of education and training as well as research and service delivery and there must be sufficient funding to incentivise partnership. There will be variation across the UK in how AHSNs work, based on local factors, but all AHSNs must be integrated with LETBs.

4.5 Health Innovation and Education Clusters (HIECs) have delivered real benefits in transforming certain care pathways. We would argue that these initiatives and their funds should not be lost and that they should take their place as part of larger AHSNs.

¹ DH (2011) *Innovation, Health and Wealth*, p. 19

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131784.pdf

5. Regulation, quality assurance and outcomes

- 5.1 The role of the GMC in curriculum development (through setting standards in *Tomorrow's Doctors*) should be maintained. Curricula cannot be adapted piecemeal to meet local demands and the national regulator's role in quality is vital. There must also be respect for university processes, with acknowledgment that if something comes into the curriculum something has to come out.
- 5.2 We see AHSNs having a role in curricula development in partnership with the regulator. For example, one medical school is redesigning its medical undergraduate curriculum to align with the focus of the Academic Health Science Partnership to which it is attached. Building on practice such as this will help to develop training programmes that are increasingly sensitive to population healthcare needs. It is also the intention that AHSNs will share best practice.
- 5.3 Clarity is needed on the relationship between 'outcomes' and 'domains' in the *NHS Education Outcomes Framework* and effective metrics must be developed if the Framework is to be of practical use. The framework needs to recognise that without transparency in the detailed allocation of educational budgets, it will be impossible to raise the quality of education in Trusts and in primary care, meaning that desired educational outcomes will not be achieved. There must be the means to withdraw funding if independent quality assurance processes find that employers are failing to provide education of the required quality

6. Protection and distribution of funding

- 6.1 Educational funding must be ring-fenced, must not be further diluted and should transparently follow the student. Trusts should provide detailed evidence of how SIFT² and MADEL³ are spent, this should also apply to equivalent arrangements in the Devolved Administrations.
- 6.2 SIFT payment rates for primary care clinical placements must be set at a level sufficient to allow medical schools to continue to move placements out of secondary care into primary care, to align with the move towards community care.
- 6.3 As envisaged on the last review of the Multi Professional Education and Training budget (MPET), a proportion of MPET should be reserved, and awarded after successful provision of education and training to ensure that high quality is delivered in placements. We envisage that this could be coordinated jointly by undergraduate and postgraduate deans reporting to LETBs.
- 6.4 The outcome of the MPET Review should be proportionate and based on MPET income rather than trust turnover. Transition is key and changes need to be phased in. A transparent process

² Medical Service Increment for Teaching

³ Medical and Dental Education Levy

for on-going review, allocation and determination of funding is essential to ensure protection of educational budgets in the context of a challenging financial environment.

7. Workforce planning

- 7.1 There must be a reasoned approach to workforce planning which ensures flexibility, especially in higher training. This should not be driven by unrealistic workforce models which ignore trends of early retirement and feminisation of the workforce. Work with medical royal colleges will be important to ensure flexible career pathways for the workforce which are aligned with undergraduate curricula and delivered to a high standard
- 7.2 CfWI (or an equivalent body) working on behalf of HEE, should seek to develop long term plans based on realistic estimates. We believe that greater resources will be needed to allow CfWI to provide LETBs and HEE with the information required. Workforce planning must take a UK wide approach.
- 7.3 The number of consultants taking voluntary early retirement has increased by 72% in one year⁴. We are concerned that this may destabilise the system and may be an unintended consequence of NHS reforms and changes to the NHS pension.
- 7.4 A decision is still pending regarding Clinical Excellence Awards and we are concerned that changes to the way that excellence is rewarded will have a detrimental effect on the incentives for the highly mobile clinical academic workforce to remain working in the NHS.
- 7.5 Overseas educated healthcare staff members in medical schools contribute directly to the delivery of high quality healthcare services by providing patient care at the highest of levels, as well as through contributions to education, training and research. A large proportion of non-EU academic staff members teaching clinical medicine have not previously been students in the UK. This suggests the importance overseas educated staff to delivering medical education. We would argue that changes to the immigration system should not remove the attractiveness of working and studying in the UK due to the importance of the overseas educated workforce to the NHS.
- 7.6 The public health workforce needs clarity, stability and leadership to ensure it meets the challenges of health inequalities and an ageing society. Guidance on transfer of contracts for public health academics is required to ensure the protection of this vital workforce. We note that the timeline for PCT clusters to produce their plans is by the end of January 2012 and that a consultation on the public health workforce strategy is expected by the end of December 2011. We feel that this is a challenging timeline for views to be fully considered before plans are made. Medical schools have experienced difficulties with securing appropriate honorary

⁴ HSJ (2011)'Number of consultants retiring early rises' <http://www.hsj.co.uk/news/workforce/number-of-consultants-retiring-early-rises/5038103.article>

contracts for academic GPs in the absence of national guidance and some PCTs have declined to offer these. It is essential that this is not also the experience of clinical academic members of the public health workforce.

7.7 The academic career structure for public health is lacking clarity and this may influence the sustainability of the academic public health workforce. Successes in the broader academic training pathway should be replicated. Medical Schools Council is seeking to work with the Faculty for Public Health and Academy of Medical Sciences on this issue.

7.8 A strong identity needs to be fostered for members of the public health workforce. Medical members of the public health workforce must feel that they have a unique and valued role in the public health team. This should be facilitated through ensuring NHS contracts for medical public health professionals.

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Appendix: COPMeD/MSC Joint working between Undergraduate and Postgraduate Deans- Agreed Principles

COPMeD and MSC members have agreed that the structures and guiding principles for the delivery of medical education and training must reflect a consistent, common approach across the UK. This will enhance the transition between the undergraduate and postgraduate arenas for the benefit of trainees and patient safety. In addition, it has the potential to allow the sharing and development of best practice which should allow for economies of scale and add value to the wider medical education continuum.

The fact that there is now a single regulator in the UK for medical education provides an opportunity to develop such a continuum. Indeed, the GMC has indicated that it wishes to see evidence of close collaborative working between medical schools and postgraduate deaneries. Joint working between medical schools and postgraduate deaneries would facilitate this broad aim.

We look to the Departments of Health UK Scrutiny Group, to the GMC and to the Academy of Medical Royal Colleges to support us in this. Benefits would accrue from greater commonality across the health educational and workforce development sector; the different health professions may wish to devise their own sets of similar overarching principles.

The Health Select Committee and Earl Howe in the House of Lords, have recognised the requirement for closer partnership and collaboration between Higher Education Institutions (HEIs) and the NHS. It is hoped that that the authorisation criteria for Local Education and Training Boards (LETBs) in England will reflect this.

Key principles

- Collaboration between undergraduate and postgraduate medical education and training (pgmet) should be enhanced and a continuum developed between undergraduate and postgraduate education and CPD, as expected by the GMC as regulator. Such a system would enhance patient safety and deliver excellence in education and training.
- All postgraduate deans should have an honorary contract with their local university(ies), with joint appraisal developed with the University(ies) and NHS along Follett principles. COPMeD and MSC will work to develop a model contract for use locally, to ensure that this link is strong and consistent. The processes employed must also be able to support the revalidation of PG Deans.
- Consideration should be given to extending such arrangements to other roles within pgmet. For example, senior postgraduate medical education roles such as deputy or associate postgraduate Deans and similar. Any such arrangements will need to take account of the variation in organisation, roles and responsibilities across the UK.
- MSC and COPMeD should work collaboratively to ensure the effective implementation of the GMC standards for the recognition and approval of trainers

- England should align itself with developments in the Devolved Administrations (DAs) on working relationships between postgraduate deaneries, higher education institutions and the NHS. This will ensure coherence within and between countries in the UK.
- The Quality Management (QM) and Quality Enhancement (as part of the GMC's *Quality Improvement Framework- QIF*) of undergraduate and postgraduate posts/ placements should be managed collaboratively, with funding following quality and hence to placements/posts that offer demonstrable value in achieving defined educational outcomes. Such QM processes should include resolution of the tension between education, training and service requirements with appropriate time for these activities being formally recognised in all job plans of those with defined educational responsibilities. They should also recognise and take advantage of opportunities to share and develop best practice.
- There should be transparency in the allocation of educational funds with trusts providing detailed evidence of how SIFT and MADEL are spent, or the equivalent arrangements in the DAs.
- COPMeD and MSC should share quality data across undergraduate and postgraduate placements to identify issues with placements quickly and to align with the GMC's move to single inspections for both undergraduate and postgraduate posts/placements. This will facilitate both QM (as part of GMC's QIF) and quality enhancement. Particular attention should be paid to the transition from UG to PG education and training, ensuring that there is consistency in relation to both the competences of graduating medical students and the expectations of the service of such newly qualified doctors. This work should build on existing work on postgraduate quality metrics already commenced in Scotland and England.
- Postgraduate and undergraduate medical deans should jointly ensure that academic training programmes are of the highest standard
- In order to facilitate the introduction of such improved working and enhanced collaboration, there should be regular meetings of the English UG and PG Deans similar to systems already in place in the DAs. MSC and COPMeD should meet on a regular basis to help ensure the continuing development of the partnership working envisaged in this paper.

We look to those designing the new structures in England to accept these guiding principles and to devise mechanisms to promote and facilitate their implementation within both the governance arrangements and the new systems' architecture.

MSC COPMeD, 14 December 2011