

# A High Quality Workforce

NHS Next Stage Review

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# A High Quality Workforce

NHS Next Stage Review

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# Foreword

Staff involved in NHS services want to provide high quality care for patients. Over the past decade, significant improvements in both access and quality have been accomplished. These were enabled by investment and reform but they were delivered by staff working at the frontline.

Healthcare is delivered by a team. Every member of the team is valuable and has an important contribution to make to the success of care. These teams work increasingly with others, particularly social care workers, sometimes in integrated or co-located teams. It is for this reason that this document addresses needs across the whole NHS workforce and links to social care.

The NHS Next Stage Review describes a vision for the NHS that delivers high quality for all and gives staff the freedom to focus on quality. Achieving this vision requires us to provide the best possible education and training for future generations and to ensure that our existing staff get the support they need to continuously improve their skills.

The NHS workforce is most effective when it reflects the needs of patients. Accordingly, workforce planning should reflect service

planning, be based on pathways of care and reflect complex co-morbidities. This report outlines how we will achieve that by working bottom-up from the plans of service providers for the care they will be delivering for patients, as well as creating solutions at a national level to support these plans by improving the way the system works.

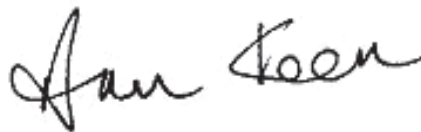
Working in partnership with staff is essential for this system to succeed. For all professions, we are introducing a stronger professional voice and scrutiny in the system. For individuals, money will follow the student or trainee with the introduction of tariffs that will ensure that the money dedicated to education and training is spent appropriately and to the best effect.

We will improve the quality of education and training by bringing together both the primary and secondary providers of NHS care, the higher education sector and industry. This will ensure that students and trainees get the breadth and depth of experience that they need. Commissioners will be supported by new flexibilities to recognise and reward high quality education and training outcomes.

This document describes a system for workforce planning, education and training that will be sustainable for the long term. It will put the workforce system on a firm foundation that will ensure the NHS continues to have the most talented staff, fully supported to deliver high quality care for patients.



Professor the Lord Darzi  
Parliamentary Under  
Secretary of State



Ann Keen MP  
Parliamentary Under  
Secretary of State for Health



David Nicholson  
NHS Chief Executive

# Response from Professor Sir John Tooke

Since the Interim report of my Inquiry into Modernising Medical Careers was published last autumn (2007), discussions between the Government and the medical profession have been ongoing. I am pleased that this report shows the Government's commitment to ensuring that medical education and training is on the right footing for the future and acknowledges the crucial part the profession of medicine has to play in securing that future.

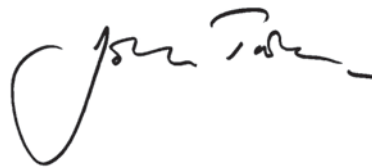
The proposals in this document address many of the challenges I set out in my Inquiry report.

In this regard, I am particularly pleased to see the creation of Medical Education England which will give the profession the strong voice and the scrutiny function that it needs. In addition, the move to a transparent tariff-based payments system provides a mechanism to incentivise educational activity and to protect this investment which is so vital to patient care quality. It is to be hoped that the proposals will create a system that will endure because there will be the checks and balances that were previously absent.

During the turbulence of the last two years, trust was lost between the profession and the Government. The strategic review offers a clear vision for the future of education and training of

the whole workforce, and offers a strong foundation for rebuilding that vital trust.

I entitled my report *Aspiring to Excellence*. That ambition was right. Good progress has been made to get these proposals this far; the challenge for us all is to secure their successful implementation for the benefit of patients, now and in the future.



Professor Sir John Tooke  
Dean of the Peninsula Medical School,  
Chairman, MMC Inquiry

# Introduction

1. As part of the NHS Next Stage Review, the future of the workforce has been considered. The main findings are in the final report, *High Quality Care For All*, which has been published today. This document explains in more detail how each of them will be taken forward.
2. This document responds to the challenges set out by the clinical visions produced in each region. These local visions show the level of ambition the NHS has for changing services for patients and the public for the better. Success requires not only the right vision, but also the right workforce.
3. The proposals in this document were developed over many months and with the involvement of more than a hundred people through four working groups. These groups brought together staff representatives and representatives from professional bodies, trades unions and higher education and acknowledged experts.
4. The working groups were asked to consider the following questions:
  - a. How will the roles played by healthcare professionals change and what will be the implications for career frameworks?
  - b. How should workforce planning be done to secure the workforce of the future?
  - c. How should education be commissioned and funded to ensure trainees and the NHS benefit from the highest quality education and training?
  - d. How should the infrastructure and the content of education change so that they enable the highest quality care for patients?
5. This work was underpinned by broader engagement with NHS staff. We captured the thinking of many professional leaders and frontline staff. We met with trainees to hear their perspectives, to understand the immediate issues for improvement and to harness their creativity in finding solutions. We acknowledge and appreciate the contribution that all these groups have made to these conclusions.
6. This report sets out the expectations of tomorrow's clinicians, future roles and training pathways and reforms to the system to ensure that it is fit to deliver. Together, these will ensure that the NHS continues to have a workforce that is able to deliver high quality care for patients.



# 1 Tomorrow's clinicians

7. Our vision is of an NHS that delivers high quality care for patients and the public. It puts quality at the heart of the Service and gives staff the freedom to focus on quality. This will enable the NHS to provide high quality care for patients in all aspects, not just some. Achieving this requires an effective team of professionals, across clinical<sup>1</sup>, managerial and supporting roles. To do their job well, they have to work closely with others, particularly social care workers, who are often part of the same team. Staff and patients alike value every member of the team.
8. It is this vision for the NHS that underpins all of our proposed changes to workforce planning, education and training.
9. Each region of the NHS has recently published its strategic vision for the future of health and health services. These visions were created by 2,000 frontline clinicians and staff working in health and social care organisations, who met in eight clinical pathway groups in each region. These visions are bold and ambitious in their proposals to improve quality of care for

patients. They demonstrate what can be accomplished when frontline staff are empowered.

## What tomorrow's clinicians can expect

10. The core principles that inform all the planned changes outlined in the document are the following:
  - > **focused on quality**
  - > **patient centred**
  - > **clinically driven**
  - > **flexible**
  - > **valuing people**
  - > **promoting life-long learning**
11. Our proposals are also underpinned by an explicit commitment to ensure that all models of care, the related service planning and consequent workforce planning link directly to the eight pathways of care – from maternity and newborn care through to end of life care. They must relate to the needs and aspirations of patients and the public and support a comprehensive and coherent vision for local health services.

<sup>1</sup> For the purposes of our strategy, the terms 'clinicians', 'clinical professions' and 'clinical professionals' cover all those groups of staff who provide clinical care for patients and the public. Whilst it sets out specific changes for doctors, dentists, nurses, midwives, healthcare scientists, pharmacists and allied health professionals, and to some extent, clinical support workers, the strategic principles apply to all clinical staff, including paramedics.

12. Clinical professionals have a legitimate expectation to be able to access the information they need to plan their careers; to access effective careers guidance; and to form realistic expectations about their own career opportunities.
13. Clinicians want well-defined career frameworks that provide the flexibility to change roles and settings, develop new capabilities and alter their professional focus in response to the changing healthcare environment, the needs of patients and their own aspirations. They must be positioned for success in leadership, management, research and educational roles. Critical to this is that education curricula and training programmes need to be integrally linked into current and emerging models of care and into scientific and technological advances. In this way, clinicians will be able to acquire the new capabilities and skills they need to respond to patient expectations.



we stand for today, the relationships with and between patients and staff, together in times of joy and sorrow, success and frustration.

15. Every member of the team must be pulling in the same direction. Without the surgery receptionist, no patients would have appointments. Without the hospital porter, there would be no patient on the operating table. For patients, the team must go beyond individual organisations – they expect everyone in the NHS (and beyond into other public services such as social care, housing, education and employment) to work together, to give them the high quality, integrated care that they need and want.

### **What is expected of tomorrow's clinicians**

14. Healthcare is delivered by a team. The team includes clinicians, managerial staff and those in supporting roles. All members of the team are valued. The sense of a shared endeavour – that all of us matter and stand together – was crucial in the inception of the NHS. It characterises what

#### *Practitioner, partner and leader*

16. In the past, the clinician's role within the team has often been confined to a practitioner, an expert in their clinical discipline. Yet frontline staff have the talent to look beyond their individual

clinical practice and act as partners and leaders. In future, every clinician has the opportunity to be a:

- > **Practitioner:** Clinicians' first and primary duty will always be their clinical practice or service, delivering high quality care for patients based on patients' individual needs. This means working with patients, families and carers in providing high quality, personal care, the most effective treatments and seeking to keep people healthy, as well as treating them when they are sick. It is an agenda that reinforces the importance of professional judgement, creativity and innovation.
- > **Partner:** Clinicians must be partners in care delivery, with individual and collective accountability for the performance of health services and for the appropriate use of resources in the delivery of care. Partnership requires clinicians to take responsibility for the appropriate stewardship and management of finite healthcare resources. Partners will be expected to work closely with others in the health service and beyond, such as colleagues in social care, children's centres and schools, to manage the balancing of individual and collective needs, integrating care around patients.
- > **Leader:** Clinicians are expected to offer leadership and, where they have appropriate skills, take senior leadership and management posts in research, education and service delivery. Formal

leadership positions will be at a variety of levels from within the clinical team, to service lines, to departments, to organisations and ultimately the whole NHS. It requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where this would benefit patients.

17. These three ways in which clinicians can use their talents are already in evidence in parts of the NHS and internationally<sup>2</sup>. The best work on professionalism is also acknowledging clinicians' wider roles in the NHS<sup>3</sup>.
18. The exact balance between practitioner, partner and leader will be different, depending on the professional role undertaken. For those in formal leadership roles, such as clinical directors, the majority of their time is spent as leaders. For many, clinical practice will continue to dominate – though they will still need to work with others as partners and show the necessary leadership to keep practice up-to-date and deliver the best possible care for patients.
19. What is clear is that this new professionalism, acknowledging clinicians' roles as partners and leaders, gives them the opportunity to focus on improving not just the quality of care they provide as individuals but also within their organisation and the whole NHS.
20. We will work with the NHS, the professions, the professional regulators and other key interested parties to support

<sup>2</sup> The formulation 'practitioner, partner, leader' builds upon international experience best exemplified by Kaiser Permanente's approach to clinical leadership in the United States.

<sup>3</sup> For examples of where this is already taking place, see *Doctors in Society* (Royal College of Physicians 2005) and *Understanding Doctors: Harnessing Professionalism* (King's Fund and Royal College of Physicians 2008).

clinicians in developing the three core roles of practitioner, partner and leader as the essential components of their clinical practice. We will ask the appropriate professional regulators to lead this work, in partnership with patients, the public, employers, educators and professional bodies.

21. Only through embracing these higher expectations can we achieve the vision of an NHS that consistently delivers high quality care for patients.



## 2 Roles and education and training pathways

22. In this chapter, we outline the key changes to roles, education and career pathways. The local clinical visions in every region show the changes the NHS needs to make to improve the quality of care for patients; consequently, professionals will need to adapt too. This means the career pathways and education that underpin their skills will also need to change. Our starting point has been to understand the workforce implications of the emerging models of care and, from them, derive the roles, education and career pathways that will deliver these models to the highest quality and to meet staff needs.
23. The principles set out in Chapter 1 lead us to the following conclusions about our approach to roles, education and career pathways:
- > **Focused on quality:** Education and training pathways must reflect both what clinicians expect and what is expected from them across the range of different providers. Quality-focused means being clear about the roles of professionals and then ensuring structured training and career pathways that offer the appropriate breadth and depth of knowledge and experience. Furthermore, they must support working with partners, such as social care.
  - > **Patient centred:** The skills for listening, understanding and responding to the needs of individual patients and supporting them to manage their health in a manner that is respectful of diversity and difference must, wherever possible, be incorporated into education and training programmes and clinical practice.
  - > **Clinically driven:** The active engagement of clinicians in the development and delivery of workforce planning, education and training is essential in shaping the workforce that will deliver high quality care and improve patient pathways. The visions in each region show the level of ambition the NHS has for changing services for the better. Success requires not only the right vision, but also the right workforce.
  - > **Flexible:** Healthcare is constantly in a state of development and change with increasing emphasis on health promotion, well-being and disease

prevention and shifting patterns of care. Consequently, our approach both recognises the need to build in flexibility and reflects the importance we attach to continuous professional development (CPD) and life-long learning.

> **Valuing people:** This means designing education, training and career pathways that are sensitive to trainees' personal needs, and that acknowledge and appreciate the dedication and passion of those entering healthcare professions. The delivery of high quality education and training is an essential part of delivering high quality patient care.

> **Promoting life-long learning:** Staff in all roles and settings need opportunities to continuously update the skills and techniques that are relevant to delivering high quality care through, for example, work-based learning, distance and e-learning, and further education.

24. This document now applies these principles to the profession-specific changes for clinicians. It builds on the work undertaken as part of the 'Modernising Careers' projects in the Department of Health and the broader consultation that has accompanied these.

## The role of the doctor

25. In his Inquiry report into Modernising Medical Careers (MMC) *Aspiring to Excellence*, Professor Sir John Tooke highlighted the importance of reaching a consensus on the role of the doctor. This

challenge has already been taken up by the medical profession itself, with the Medical Schools Council, Royal Colleges, NHS Employers and the BMA working together to address this issue. This is something that the Department of Health supports.

26. As described in *High Quality Care For All*, there are significant changes underway in all advanced healthcare systems. Together, these changes mean that quality is a moving target – to stand still is to fall back. It is for these reasons that expectations of the role of the doctor are changing too.

27. Recent debate within the medical profession has already identified a number of distinctive features relevant to trained doctors as expert medical practitioners. NHS patients and the public expect their doctors to:

- > achieve accurate and timely diagnoses
- > ensure the safety of patients
- > help patients navigate through the healthcare pathway(s)
- > contribute appropriately as a leader of or partner in the clinical team
- > contribute to healthcare research, development and innovation
- > train future generations of healthcare professionals

28. They recognise that doctors are vitally important because of their core skills in:
- > leadership
  - > dealing with complexity and managing uncertainty
  - > effective and efficient problem solving
  - > working with patients to take legitimate risks and effectively managing risk by providing information alongside professional judgment to maximise patient independence and choice
  - > grasping clinical situations intuitively based on a deep, tacit understanding of their area of practice
29. Within the medical profession, plans are already in place to take these ideas forward. This work will take account of perspectives of patients and employers as well as other healthcare professional groups. We will work with leaders of the profession to ensure that medical education and training supports the development of the identified characteristics in tomorrow's expert medical practitioners.

### **Training and career pathway for doctors**

30. Over the next three years, in close engagement with the Royal Colleges, the professional regulators, the wider medical profession, universities, commissioners and employers, we will want to see the development of a reformed postgraduate training pathway for doctors. We will ask

Medical Education England (MEE) (see Chapter 3) to do this taking forward the recommendations of Professor Sir John Tooke in his Inquiry report.

31. The key elements of this training pathway will be as follows:
- > pre-registration
  - > specialty training
  - > modular credentialing
  - > partner, leadership and educational roles
  - > academia and research

#### **Pre-registration**

32. Current arrangements for recruitment to Foundation Programme training are perceived by many in the profession as not robust enough. New work needs to be undertaken to develop more reliable and valid selection methods for recruitment to these programmes. We will ask MEE (see Chapter 3) to consider this issue and make recommendations. We will also ask MEE to commission a formal evaluation of the two-year Foundation Programme, and a decision will then be made as to whether to continue with this or to move to an alternative model linked to a wider reform of postgraduate medical education structures.
33. We will seek to ensure that all successful UK medical graduates have access to Foundation Programme Year 1 placements to complete their GMC registration.

## Specialty training

34. After completing the Foundation Programme, trainees will enter specialty training, which includes training for general practice. Discussion will be needed to ascertain the balance between generalist/core training and specialty training in the earliest phase of that training. We will ask MEE (see Chapter 3) to undertake this work. At the end of this period, all doctors in training who have achieved the required curricula and assessment standards will be awarded a Certificate of Completion of Training (CCT). A CCT will allow the holder to apply for consultant posts or to become a general practitioner (GP), though they may then choose to complete fellowships, to specialise further or to explore areas of practice not covered by specialty or GP training.
35. In the light of the well-known difficulties with the implementation of the MMC programme, it is premature at this juncture to commit to an explicit and detailed postgraduate medical education and training structure. It is intended that a consensus on this will be achieved in time for implementation from August 2010. In the interim, the structure of training will remain on the current model<sup>4</sup>. This approach was supported in the recent Health Select Committee report on MMC. We will ask MEE (see Chapter 3) to continue discussions with Royal Colleges, deaneries, junior doctors, patients, employers, trades unions, Strategic Health



- Authorities (SHAs) and other stakeholders to advise on how best to take this key issue forward but we expect that the key principles that Professor Sir John Tooke articulated in his MMC Inquiry report will be upheld.
36. In the light of the increasing demand for primary and community care services, SHAs will be expected to expand GP training programmes in 2009 based on existing resource allocation. Further expansion of training programmes in England by up to 800 places is also being planned so that in future at least half of doctors going into specialty training will be training as GPs. The expansion of general practice underlines our commitment to supporting and improving primary care.
37. At the same time, historical patterns of GP training will be reviewed, in partnership with the profession, to examine whether they meet the demands of modern general practice. We commit to a thorough review of the lengthening of the period of

<sup>4</sup> That is, some specialties offer run-through training and others offer core training followed by competitive selection into higher specialty training.



training for GPs and we will ask MEE (see Chapter 3) to work with the Royal College of General Practitioners to review the evidence for the detailed nature of that change and to develop cost effective proposals for consideration and implementation.

38. In public health, there has been an unprecedented rise in expectations in what can be achieved. Obesity, drug and alcohol misuse, health inequalities and prevention of cancer and heart disease have the highest priority. We will address this by seeking to strengthen the numbers and skills of the public health workforce. We will also seek to encourage dual accreditation in public health and clinical specialties. This will enable doctors in clinical specialties, such as cardiology and diabetology, to become expert in prevention and health promotion.

### **Modular credentialing**

39. In partnership with the medical profession, in particular the Royal Colleges and the professional regulators, we will develop plans to introduce modular credentialing for the medical workforce over the coming decade. This means the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience. International experience<sup>5</sup> suggests that such an approach gives

assurance to patients and employers that professionals have the right skills to deliver high quality care, whilst giving recognition and acknowledgement to professionals themselves. It will help to facilitate movement in and out of training programmes at the appropriate level, and give greater flexibility to professionals to move between specialty training programmes or employers whilst having their capabilities and learning properly recognised.

40. We believe that this approach strikes the best possible balance between being varied and flexible, quality-focused and structured, recognising skill and capability and being sensitive to the needs of the Service and of doctors and their desire for professional development.
41. This approach will also support effective workforce planning, both through improved knowledge of the skill sets available and through a more flexible workforce that can develop approved and recognised skills more rapidly to meet changing service needs.
42. There are similar issues for dentists. The numbers of dental graduates is set to increase by 25% from 2010, and the provision of vocational training places is being expanded to reflect this. We are also exploring the scope to increase the vocational period to two years.

<sup>5</sup> Schemes for modular credentialing have had the greatest impact in Canada and the United States.

43. We will look to expand the concept of modular credentialing across other professions where and when this is appropriate. For example, the proposals for healthcare scientist training include the acquisition of 'accredited specialist expertise'.

### **Partner, leadership and educational roles**

44. In Chapter 1, we described our expectations for tomorrow's clinicians to be practitioners, partners and leaders in the NHS. The Tooke report emphasised the need to build on the expertise of senior doctors by encouraging them to take on partner, leadership and educational roles. We agree and intend to meet this need in a number of ways:
- > exploring changes to the undergraduate curricula for all medical students so that they reflect the skills and demands of leadership and working in the NHS
  - > integrating training in leadership, management and teaching for all junior doctors into postgraduate medical curricula
  - > introducing new standards in leadership to ensure that development programmes for clinicians and managers alike deliver to an assured quality
  - > ensuring that educational supervisors in secondary care undergo mandatory training and review of their performance for this role (as currently exists in primary care)

### **Academia and research**

45. A clear and integrated pathway through which junior doctors and dentists can combine research and education with a clinical career was the subject of the Walport report<sup>6</sup>. The report's recommendations have now been implemented, with training schemes launched for the Academic Clinical Fellowship and Clinical Lectureship phase of the training pathway, as well as a scheme for Clinical Senior Lectureships.
46. The focus on this important area will continue, building on the Walport report, so as to provide clear, flexible and integrated training to encourage more doctors and dentists to pursue a career in clinical research. This will also preserve a critical workforce that facilitates and delivers undergraduate medical and dental education.

### **The role of the nurse**

47. Nurses play a vital role in the NHS: they will always be at the heart of shaping patient experience and delivering care. Our ambition is to ensure that the NHS delivers high quality care in all aspects – an ambition that is impossible to achieve without high quality nursing. Our aspiration, therefore, is for the quality of nursing care in England to be recognised as excellent, to continue to attract highly motivated and talented individuals and to support nurses in leadership roles at all levels in the NHS.

<sup>6</sup> Medically- and dentally-qualified academic staff: recommendations for training the researchers and educators of the future, The Academy of Medical Sciences, 2005.

48. To begin realising our ambitious agenda, we have identified four steps:
- > building consensus about the role of the nurse
  - > finding meaningful ways to improve the quality of nursing care and identifying those accountable for improving it
  - > modernising nursing educational and career pathways
  - > recruiting and retaining the best candidates to nursing

### Reaffirming the role of the nurse

49. The National Nursing Research Unit at King's College London are leading work with the Department of Health, partners and employers to reaffirm the role of the nurse. This will set out a compelling and



inspiring portrait of the modern nurse, rooted in the values of the nursing profession and the NHS. We are refreshing the definitions of care and caring to meet the modern requirements of personalisation and choice, delivered by practitioners who plan and provide care, are advocates and guardians of the quality of care and promoters of good health for people and communities.

### Improving and measuring the quality of nursing care

50. We will work with professional leaders to support clear accountabilities for the quality of nursing care from point-of-care to the boardroom and to develop an indicative set of metrics to define and measure the quality of nursing care, as part of the quality metrics to be developed for the whole clinical team. The metrics will reflect issues of safety, effectiveness and compassion.
51. We will make available a set of metrics that clinical teams may choose to include as they develop their own clinical dashboards<sup>7</sup>. The Chief Nursing Officer will be a member of the new National Quality Standards Board that is being established to provide strategic oversight, leadership and advice on clinical priority setting and approve a new quality measurement framework.

<sup>7</sup> Dashboards help organisations manage and monitor performance against key areas of activities.

52. We will also put enablers in place to ensure we achieve this, including:
- > **Skills and capabilities:** comprehensive, continuing development programmes to equip nurses with the clinical and managerial skills they need to measure, understand and improve the quality of care
  - > **Role modelling:** nurse leaders to demonstrate this within organisations using metrics, accepting accountability, and taking on authority to drive the quality agenda
  - > **Support systems:** IT systems that deliver necessary information in timely fashion

## Modernising career and educational pathways for nurses

53. A national and co-ordinated approach to nursing careers will provide the enabling infrastructure for local organisations and individual practitioners to achieve much greater gains in healthcare quality. The Modernising Nursing Careers<sup>8</sup> programme is working to equip nurses with the skills and capabilities for their roles by:
- > creating a more flexible and competent workforce
  - > updating career pathways and choices for nurses
  - > better preparing nurses to lead in a changed system

- > updating the image of 'the nurse'
54. Our approach includes the following:
- > **Threefold increase in investment in foundation periods.** A foundation period of preceptorship for nurses at the start of their careers will help them begin the journey from novice to expert. This will enable them to apply knowledge, skills and competences acquired as students, into their area of practice, laying a solid foundation for life-long learning. As a first step, we will increase threefold the amount currently invested to provide newly qualified staff with protected time and other support as they move into practice for the first time.
  - > **Shift to a graduate registered nursing workforce.** Nursing must attract the best quality recruits in an increasingly competitive labour market. Evidence suggests that a graduate registered workforce may help achieve these objectives. We will explore the opportunity and impact of a graduate workforce with key stakeholders, while we await the outcome of the Nursing and Midwifery Council's recent consultation on pre-registration education.
  - > **Stronger clinical academic careers** that combine research and education with clinical careers to improve the translation of research into clinical practice. We will continue the work we have begun to

<sup>8</sup> Modernising nursing careers: setting the direction, Department of Health, 2006.

implement the recommendations of the UK Clinical Research Collaboration<sup>9</sup> so that we integrate clinical and academic nursing careers. We will undertake further work focusing on nurse educators.

- > **Taking a pathway approach** to nursing careers will better align careers with the full range of the needs of patients and the public, in health and in ill health. This will be supported by an educational framework and will provide a recognised career structure, better flexibility and career mobility. We will consider the best schemes to support nurses' time for, and funding of, education and promote equality of access to education.
- > **Support for careers in health promotion** to enable nurses to play a full role in health promotion and in maximising health potential for people, families and communities. In particular, there will be new education and development opportunities for specialist community public health nurses, including for health visitors, to enable them to play a central role in child and family health.
- > **New national standards for advanced and autonomous roles.** In order to assure the quality of outcomes and to protect the public appropriately, clear nationally agreed standards for advanced level practice are required for nurses working in extended, advanced and autonomous roles, both in the NHS

and in the independent and other sectors. We will work with the Council for Healthcare Regulatory Excellence and the professional regulators to ensure a consistent definition of advanced practice across the health professions.

55. The future framework for nursing careers will promote a greater diversity of careers, in different settings, across traditional boundaries. The proposals for pre-registration education and post-registration nursing careers have been subject to public consultations by the Nursing and Midwifery Council and Department of Health respectively, and these are due to report this summer (2008).

#### **Recruiting and retaining the best candidates into nursing**

56. In order to continue to recruit the best available candidates into nursing, the Department of Health will work with key partners and employers to ensure that nursing careers are as attractive as possible by developing career packages that attract people with strong values and attributes, and marketing those careers packages appropriately and effectively. We will build on the success we have had in attracting suitable candidates into careers in nursing.
57. Key to delivering this overall programme are clinical support roles, for example, healthcare assistants. We will work with partners and the profession to ensure that employees in these types of roles are appropriately trained.

<sup>9</sup> Developing the best research professionals. Qualified graduate nurses: recommendations for preparing and supporting clinical academic nurses of the future. Report of the UKCRC Subcommittee for Nurses in Clinical Research (Workforce), UK Clinical Research Collaboration, 2007.

58. This is an ambitious programme for nursing. We will undertake further detailed planning in partnership with professional representatives and nurses across the country on how best to deliver it.

## The role of the midwife

59. As part of the Next Stage Review, every NHS region established a clinical pathway group on maternity and newborn care. The message that we consistently heard was that women want greater choice and a more personal experience, with care provided by a named midwife. The quality of midwifery care in the NHS must reach the standards of excellence to which the profession aspires and which women and their families expect.

60. The midwifery profession rightly has high ambitions. It is already set to increase the number of midwives by up to 4,000, unless the birth rate falls, so that it can provide better care for women and their families. It expects its practitioners to be knowledgeable, skilled advocates for the women in their care, and accountable for the quality of the care they give and the services they manage. As with other professions, midwives need to be able to measure and articulate the quality of their care and to exercise a high degree of influence within organisations that provide maternity services.

61. We will work with the profession to plan improvements in frontline midwifery care,

develop leadership capacity and enhance quality.

62. Midwives are clear that they see a strong role where they:

- > are the clinician that pregnant women are more likely to contact once they access maternity services
- > broaden their responsibilities to support pregnant women in accessing a range of services to meet all their needs (for example, physical, mental and social care services) regardless of complexity
- > position themselves to be able to lead the transformation of services
- > become more likely to take on leadership roles at a variety of organisational levels
- > increase their influence on Boards by strengthening the role of the Head of Midwifery and using metrics to measure the quality of care

63. Achieving these goals requires the profession to recognise the challenges of attracting and retaining the next generation of midwives and equipping them with the skills to deliver high quality care. The education provided needs to be dynamic so that midwives in the future can be flexible and deal expertly with a range of situations, in a variety of settings, from the normal to more uncertain and complex clinical situations.

## Training and career pathway for midwives

64. In order to deliver this vision for midwifery and maternity care, several specific actions are required.
65. Education providers need to be responsive to the future direction by addressing the content of undergraduate and postgraduate curricula and supporting the availability of suitable clinical placements across a variety of settings. Providers need to be agile so that the current workforce develops to be more flexible and deliver reformed services. Future midwives must be educated to position themselves as expert and advanced practitioners who act as partners with women and families to navigate them around services and act as leaders across integrated pathways of care. Focusing educational and development opportunities on the maternity care pathway is of overarching importance. This will keep the needs of women and their families at the centre of educational provision and service design.
66. Midwifery aspires to become an all graduate profession and subsequent postgraduate midwifery career pathways need to be fit for purpose. Urgent consideration needs to be given to postgraduate education to ensure that

skills acquisition matches the reforms in service delivery. Similarly, the confidence of midwives to practise competently on qualification will need to be built up during a foundation year. Opportunities will also be taken to construct clinical academic midwifery careers with the implementation of the UK Clinical Research Collaboration<sup>10</sup> recommendations.

67. The development of midwifery careers and the roles of maternity support workers will be closely aligned to the *Maternity Matters*<sup>11</sup> care pathway.

## The role of allied health professionals

68. The allied health professionals<sup>12</sup> are a diverse group of practitioners who deliver high quality care to patients across a wide range of care pathways and in a variety of different settings. They normally begin their career as graduates of their chosen profession rather than sharing a generic entry point and branching off into specialisms as their careers progress. From day one, they are skilled practitioners in their profession of choice.
69. Nonetheless, all allied health professionals have four common attributes:
  - > they are, in the main, first contact practitioners

<sup>10</sup> Developing the best research professionals. Qualified graduate nurses: recommendations for preparing and supporting clinical academic nurses of the future. Report of the UKCRC Subcommittee for Nurses in Clinical Research (Workforce), UK Clinical Research Collaboration, 2007.

<sup>11</sup> Maternity matters: choice, access and continuity of care in a safe service, Department of Health, 2007.

<sup>12</sup> Art therapists, dramatherapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, orthoptists, orthotists, prosthetists, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists, and operating department practitioners – who, whilst not strictly classed as allied health professionals, have been included within this work. Paramedics have not been included as they are covered by the work on emergency care practitioners.

- > they perform essential diagnostic and therapeutic roles
- > they work across a wide range of locations and sectors within acute, primary and community care
- > they perform the functions of assessment, diagnosis, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management and rehabilitation

70. These characteristics are essential to transforming health and social care. The knowledge, skills and experience that allied health professionals bring will be crucial if we are to continue to provide a sustainable service that not only ‘adds years to life’, but also ‘adds life to years’.
71. These are clinicians who can and should be able to lead the health promotion agenda, the shift of care closer to home, the management of long-term conditions and the return to work. But the range of knowledge, skills and competences that allied health professionals have to offer is not widely or fully understood. This means that their potential to be responsive, to ensure flexible, patient-centred care and to take on new and varied roles is not always maximised.

## **Training and career pathway for allied health professionals**

### **The Modernising Allied Health Professions Careers project**

72. The UK-wide Modernising Allied Health Professions Careers project started in 2005. It responds to the need for a flexible and responsive approach to allied health professional careers that reflects the diversity of the professions and the locations and sectors in which they work. At the same time, it seeks to maximise their potential to contribute to transforming patient care and promoting health and well-being through highlighting the competences (generic, common, shared and specific) that allied health professionals have in order to deliver the functions that patients and the public require.
73. The project has delivered a set of web-based tools that we will launch this summer (2008). The tools will be useful to clinicians in planning more flexible career pathways and ensuring future employment. The tools will also support them in planning their continuing development.
74. The tools are:
- > a web-based framework of competences that can be used in a number of ways, for example, for personal development planning by clinicians
  - > a web-based resource of allied health professional and support worker roles



already mapped to the career framework for use in workforce planning and service redesign

> learning design principles that can be applied to pre-registration and post-registration training to promote flexible learning

75. The tools will be useful to commissioners and service managers in designing services to meet public and patient needs, rather than starting with the assumption that particular professions are required. These tools will maximise the potential of allied health professionals to play a greater part in transforming care. The tools will also recognise that allied health professionals increasingly work across organisational boundaries and as part of integrated teams.



## **Future work to modernise allied health professions' careers**

76. For the most part, the allied health professions' clinical career pathway is well established, from graduate or postgraduate registration through to an extended scope, advanced practitioner or consultant role. Allied health professionals may also choose an academic, research or management route. The limited flexibility that exists in and between these career pathways should be overcome through use of the tools described above, and we will ensure that best practice is shared, though further work is required.
77. We will be focusing our attention, with key stakeholders, on pre- and post-registration education to ensure it supports a flexible and responsive approach to allied health professional careers that takes account of the need for care that is respectful of diversity and difference. We will also consider how we might better secure the quality of practice placements across a variety of clinical settings to ensure allied health professionals are not only fit for practice, but also fit for purpose.
78. We will be taking forward the UK Clinical Research Collaboration recommendations<sup>13</sup> to develop academic careers for allied health professionals in order to continue to ensure that the evidence of the interventions and service models that work well are translated into practice.

<sup>13</sup> Developing the best research professionals. Qualified graduate nurses: recommendations for preparing and supporting clinical academic nurses of the future. Report of the UKCRC Subcommittee for Nurses in Clinical Research (Workforce), UK Clinical Research Collaboration, 2007.

79. We will consider the benefits of preceptorship for newly qualified staff, recognising that whilst all new staff should expect proper induction and supervision at the outset of their career, allied health professionals are ready to practice from the day of registration.
80. We will also be paying particular attention to the leadership capacity and capability of the allied health professions to ensure that the NHS can benefit from the wide diversity of clinical leaders available.



### The role of the healthcare scientist

81. The healthcare scientist workforce in the NHS, including the Health Protection Agency and the National Blood and Tissue Authority, represent the largest group of scientists in a single employment sector in the UK. They are recognised for their

highly specialised skills, expertise and knowledge. Their vast scientific knowledge and skill base stretches across some 50 scientific disciplines encompassing biology, genetics, physiology, physics and engineering. This knowledge lies at the foundation of the profession's crucial and often unique roles in:

- > providing complex and specialist diagnostic services, analysis and clinical interpretation, including international and national reference or investigative services
- > offering direct therapeutic service provision and support, including specialised support and the development of specialist and highly complex treatment plans
- > introducing and disseminating technological and scientific advances into healthcare, and undertaking research, development and innovation
- > providing performance and quality assurance, risk management and clinical safety design and management in complex environments with sophisticated equipment in both public health and across all health sectors
- > teaching, training and providing a specialist consultancy and clinical advice service to other clinicians with respect to all of the key functions above

82. As a result, the healthcare scientist workforce makes a critical contribution to delivering healthcare. More than 80% of clinical decisions<sup>14</sup>, spanning all stages of clinical pathways from prevention and well-being through to end of life care, involve the work of healthcare scientists. This contribution is vital to safe and effective care, to achieving an accurate and timely diagnosis and to monitoring the response to a range of therapeutic interventions.
83. In the future, the unique skills of the scientific workforce need to be harnessed to ensure that the NHS remains at the forefront of research and development, that complex technological advances are adopted and introduced effectively and that science and evidence sit at the core of healthcare. At the same time, as science and technology advance and greater clinical scientific expertise is required, they will take on broader roles, including in leadership, management and education.
84. We will support healthcare scientists in meeting these challenges and safeguarding and enhancing the sustainability of this workforce by changing existing training and career arrangements to meet today's and tomorrow's needs. In doing so, the NHS will be able to continue to attract the very best of the UK's science students and graduates and they will maintain their excellent contribution for the benefit of patients and the public.

## Training and career pathway for healthcare scientists

85. Building upon recent publications<sup>15,16,17,18</sup> work is underway to develop a new training and career pathway for the scientific workforce through the Modernising Scientific Careers programme. This will create a flexible, responsive, sustainable scientific and technical workforce by:
- > establishing a common, modular and explicit career framework which supports the development of the scientific and technical workforce across some 50 healthcare science disciplines grouped into the three divisions of Life Sciences, Physiological Sciences and Physical Sciences and Engineering
  - > underpinning healthcare scientist training and career pathways on clearly defined standards, outcomes and an enhanced regulatory framework, bringing them into line with other healthcare professions and supporting, for example, life-long learning and revalidation requirements
  - > supporting the development of the scientific workforce in becoming practitioners, partners and leaders
  - > enabling more flexible, timely and focused workforce planning

<sup>14</sup> Report of the review of NHS pathology services in England, Department of Health, 2006.

<sup>15</sup> A career framework for healthcare scientists in the NHS, Department of Health/Skills for Health, 2005.

<sup>16</sup> National Occupational Standards in Healthcare Science, Skills for Health, 2005.

<sup>17</sup> Pathology: towards a competence-based workforce, Department of Health/Skills for Health, 2008.

<sup>18</sup> Health Science Career Programme: Skills for Health, 2008.

- > creating a broad-based core foundation programme to enable flexibility in career development and in service delivery
  - > integrating academic training with clinical training opportunities to foster translational research and innovation
  - > enhancing the capabilities and capacity of the scientific workforce to ensure that they respond to advances in science, changes to the technological landscape and developments in care pathways
  - > recognising and valuing the role of trainers in workplace training and assessment
86. The Modernising Scientific Careers model is a robust framework for delivering these aims. The key features are expected to be:
- > a learning and development programme for technical and support grades responsive to the evolving regulatory environment and which will potentially enable those who wish to develop into registered scientists to do so
  - > a competitive common entry into registration training for scientists based on graduate entry
  - > a three-year rotational Registration Training Programme (RTP) in each of the three divisions of the scientific workforce
  - > regulation for healthcare scientists to common and consistent standards
  - > on successful completion of the RTP, competitive entry into either:
    - Higher Speciality Scientific Training (HSST), or
    - employment underpinned by employer-based professional development programmes
- > regulation for healthcare scientists to common and consistent standards
  - > opportunities to develop 'accredited specialist expertise' to national standards in roles which employers have agreed to be needed for the delivery of local services
  - > a higher specialist register which will define eligibility to compete for consultant and senior healthcare scientist appointments
87. The next phase of the work will be to develop these elements of the programme in more detail. This will be done in close consultation with the scientific profession, MEE (see Chapter 3), medical Royal Colleges, trades unions, service providers, education and training commissioners and the other UK health departments.
- ### Training for dentists
88. In dentistry, expectations are also changing. Forty years ago, 40% of adults had no teeth<sup>19</sup>. Today the figure is below 10%. Nonetheless, every day some 250,000 people see an NHS dentist for check-ups and treatment. As more people retain more healthy teeth for longer, dentistry needs to focus increasingly on maintaining good oral health in adults and

<sup>19</sup> Choosing better oral health: An oral health plan, Department of Health, 2005.

preventing tooth decay in children and young people. Dentists also have an important role to play in reinforcing messages about healthy lifestyles, diet and smoking. Dentists are often in the best position to spot the first signs of oral cancer and other illnesses and refer accordingly.

89. We are already working with dental schools to ensure that these changing needs are reflected in undergraduate education and we will reflect them in our plans for postgraduate foundation training. We will also ask MEE (see Chapter 3) for advice on the implications this has for dental training and career pathways.

### **Transforming pharmacy**

90. Pharmacists, whether working in the heart of our communities, GP practices or hospitals, are the clinical professionals with specific expertise in the use of medicines, on which, as the most frequent healthcare intervention, the NHS spends over £10 billion a year. As well as ensuring the high quality, safe and effective use of medicines, pharmacists and their teams have an important role in promoting health and well-being, providing health checks, lifestyle advice and support for self-care. This will grow as the NHS focuses more on prevention as well as cure, exploiting pharmacy's ready accessibility to people who regularly use the NHS and those who do not.

91. Pharmacy practice has extended significantly recently with pharmacist prescribers, accredited community pharmacists with special interests and consultant pharmacists in hospitals and primary care, underpinned by the developing roles of pharmacy technicians and other pharmacy support staff. We have already published our plans for modernising pharmacy education, training, regulation and career pathways in the recent pharmacy White Paper<sup>20</sup>. These plans will be taken forward as part of the developments set out here.

### **The wider healthcare team**

92. A key priority for the Next Stage Review is the development of the workforce, including those in clinical support roles, to deliver high quality and safe care. The wider healthcare team is essential both to the modernisation of professional career frameworks and to the quality of patient experience. They have continual and regular contact with patients and provide essential support to multi-disciplinary teams in the delivery of care. We need to engage these staff and demonstrate more clearly that we value their contribution to the multi-disciplinary team and to patient care and experience. The four pledges for NHS staff which are being made in the NHS Constitution reaffirm the commitment that good workplaces should exist for all NHS staff – they should not just be the preserve of high performing organisations.

<sup>20</sup> *Pharmacy in England: Building on strengths – delivering the future* (Cm 7341), 2008.

93. Some of the modernising career programmes, for example, healthcare scientists, will specifically address the needs of the wider healthcare team and introduce appropriate education and training frameworks to support their progression into professional careers. Changing roles and service reconfigurations will mean that education, training and appropriate regulation of these groups will be increasingly important if we are to continue to deliver and build on the high quality care that patients expect and deserve.
94. Within the ambulance service, significant progress has been made in recent years to ensure the workforce is fit for the future. New roles of emergency care assistant and emergency care practitioner have been put in place, and higher education for paramedics is being rolled out. The ambulance service is moving towards providing wider roles both within the ambulance service and in closer partnership with NHS services. Today, ambulance staff not only provide an emergency response but also increasingly offer urgent care services and act as a link to other urgent care services. Key challenges for the future will therefore be to strengthen workforce planning in urgent care and support leadership development as the Service continues to transform.



### **Investing in apprenticeships**

95. We will double our investment in apprenticeships by 2012/13. This is because we recognise the significant benefits that can be obtained from apprenticeships, particularly in preparing staff for key support roles and for entry to professional training. The NHS already uses apprenticeships extensively in support of dental nursing, pharmacy services and in general healthcare. However, we believe we can do more in this area. We will therefore continue to work with employers, trades unions and Skills for Health (the Sector Skills Council for the health sector) to identify the appropriate use of apprenticeships to support the new clinical career framework and in non-clinical roles. We will encourage awareness of the value of these important training programmes and will increase the number and the range of apprenticeships through new investment.

## Investing in education

96. As part of the national drive to achieve a first class skills base in the UK by 2020, we are working with Skills for Health to support employers to invest in education and training, particularly for staff in career framework stages 1–4. To support this, Skills for Health facilitated an agreement between the SHAs and the Learning and Skills Council earlier this year to establish a Joint Investment Framework which will provide matched funding of up to £100 million per year to tackle skills gaps and shortages. This partnership approach to supporting the development of NHS staff appears to be working well and supports the Government's wider Skills Pledge<sup>21</sup>.

## Educational pathways

97. We also recognise the need for clear educational pathways from schools and colleges into the NHS, especially for those who wish to undertake support roles. We will ask Skills for Health to continue to develop these pathways through their Sector Qualification Strategy for stages 1–4 and to incorporate the new mainstream Society Health and Development (SHD) diploma for 14–19 year olds.
98. We will also ask Skills for Health and Skills for Care (the Sector Skills Council for the social care sector) to build links in supporting the development of integrated teams.

## Regulation

99. A number of professions and healthcare workers are currently not regulated by statutory professional regulators, for example, clinical psychologists. Ensuring public safety is an essential part of our healthcare system and so an assessment of the risk to patients and the public is needed for current and new roles, not currently regulated. We are committed to ensuring that workforce standards are maintained to ensure public safety. Accordingly, those workers whose role involves sufficient risk should have proportionate assurance arrangements to ensure safe and high quality care for patients. This could be achieved through appropriate local supervision, employer-based regulation or through statutory professional regulation.
100. We will ask the Extending Regulation Working Group to investigate the regulation of staff in the wider healthcare team and provide us with advice about:
- > which occupational groups should be regulated
  - > which method of safeguarding the public is the preferred route
  - > a framework to support prioritising and taking forward regulation of new groups
  - > if a statutory regulator is the preferred option, which professional regulator(s) should take on the responsibility

<sup>21</sup> [www.dius.gov.uk/press/skills-pledge.html](http://www.dius.gov.uk/press/skills-pledge.html)

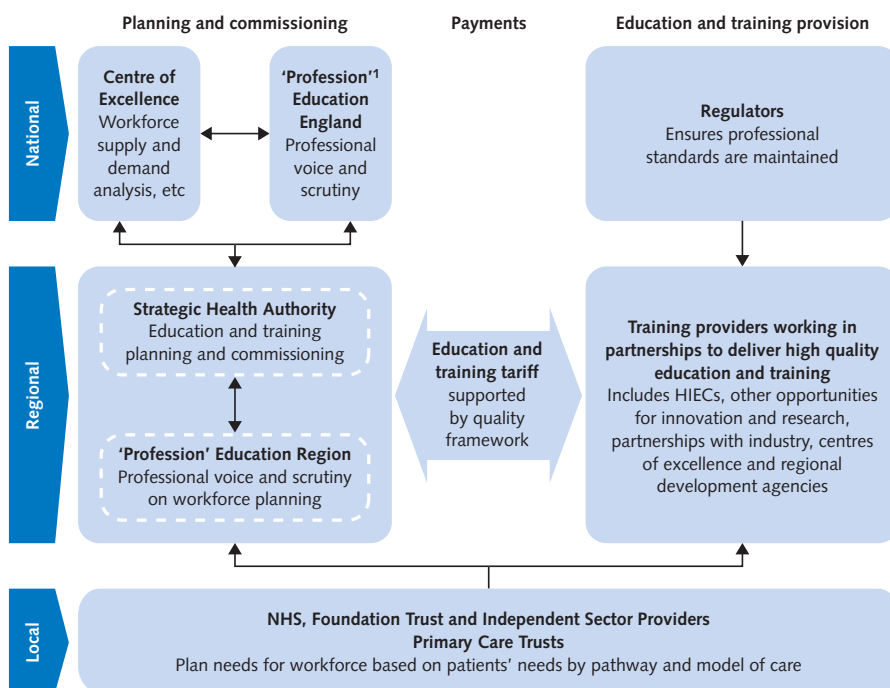
## 3 A system fit to deliver

### Improvements to workforce planning, education and training

101. Our approach to reforming the workforce planning, education and training system mirrors the approach for the NHS itself – a belief that quality is best served by devolving decision making as close as possible to the frontline in an environment of transparency and clear accountabilities. Providers of education and training must be held to account for their quality by strong commissioners. We have developed a vision for workforce planning, education and training based on the principles that any system should be:
- > **focused on quality** – high quality care requires the provision of high quality education and training. We must ensure that public resources secure the best possible quality and value for money
  - > **patient centred** – our workforce should reflect the needs of patients. Therefore, workforce planning should be based on service planning and should reflect how health and social care will jointly meet the needs of the local population
  - > **clinically driven** – this means workforce plans that reflect service plans, but also that professionals are meaningfully engaged and involved in the development of plans and the assurance of quality
  - > **flexible** – provision of education and training must be sufficiently flexible to give professionals both the breadth and depth of expertise that they need to deliver the high quality care to which they aspire
  - > **locally led** – we recognise that different populations have different needs. In a devolved NHS, to be successful, workforce planning must be devolved locally and assured nationally
  - > **clear about roles** – we intend to define system roles, ensuring a clear distinction between the roles and responsibilities of those who commission education and training and those who provide it
102. Our proposals, summarised below, are explored in more detail in the remainder of this chapter.



## Workforce planning, education and training architecture



<sup>1</sup> There will be professional advisory boards for each of the professional groups (see paragraphs 107–116 for further information).

<sup>2</sup> HIECs are Health Innovation and Education Clusters (see paragraphs 128–131 for further information).

## How this system will work

### Workforce planning

103. Greater clarity of accountability, roles and responsibilities at all levels will lead to better workforce planning and education commissioning. It must be based on a clear clinical vision and on clinical pathways (reflecting complex co-morbidities), which are determined locally to ensure that people can access the best possible care tailored to their personal needs.
104. Employers, as providers of the services that people need, will then be responsible for determining plans to develop the right workforce to provide safe, high quality patient services in the future. Most workforce planning will therefore be

carried out at a local provider level and will involve social care. Providers will find it helpful to work with other providers, Primary Care Trusts (PCTs) and other relevant health/care organisations, such as specialist care networks and GP collaboratives, to undertake workforce planning together and make best use of professional skills.

### Workforce planning capacity and capability

105. The new system will require active leadership and management of workforce planning and education commissioning throughout. The SHAs will therefore continue to be responsible for ensuring effective systems for workforce planning, education commissioning and quality assurance of health education in their regions. As education commissioners, they

will be able to recognise and reward quality, while professional regulators will ensure that education providers adhere to the standards they have set.

106. We must build both the capacity and capability across the whole range of commissioning organisations (such as SHAs, PCTs and local councils), and provider organisations (such as GP practices, specialist care networks, Foundation and NHS Trusts, and education providers) so that they have the leadership and the skills to plan beyond the short term. These organisations must be able to engage their clinical staff and communities in workforce planning and education commissioning and link the workforce plans to their service plans. They also need to be able to respond quickly to deal with changing Service requirements. At a national level, we will therefore create a Centre of Excellence (see paragraphs 117–121).

#### **National and local professional voice**

107. The professions must be able to contribute to strategic workforce development at all levels and must have clear mechanisms to enable this at national and regional level. At a national level, we will create professional advisory boards to provide an overview and assurance of workforce proposals for each of the professional groups.
108. We will improve key aspects of workforce planning at national level by establishing



an independent advisory non-departmental body, Medical Education England (MEE), for doctors and dentists and relevant low volume specialties that need to be planned nationally. It will also give advice on integrating and supporting the workforce planning of the healthcare scientist profession. This is a critical but vulnerable professional group whose roles and responsibilities complement or overlap with the medical profession in many areas of practice. Similarly, pharmacy workforce planning will form part of these arrangements as signalled in the recent pharmacy White Paper<sup>22</sup>.

109. MEE, supported by the Centre of Excellence, will have the following core functions for doctors, dentists, healthcare scientists, pharmacists and low volume specialties:
  - > bringing a coherent professional voice on matters relating to education and training and advising the Department of Health on policy

<sup>22</sup> *Pharmacy in England: Building on strengths – delivering the future* (Cm 7341), 2008.

- > professional high level scrutiny of and advice on the quality of workforce planning at national level
  - > professional scrutiny of and advice on the education and training commissioning plans developed at SHA level
  - > co-ordination of changes to postgraduate training pathways at a national level
  - > integration of service and professional perspectives in curricula development
  - > liaison with other healthcare professional education national oversight bodies and relevant bodies in the Devolved Administrations
110. MEE will be chaired by an independent doctor appointed by the Appointments Commission and will be accountable to the NHS Medical Director. It will bring together representatives of professional bodies, employers and trades unions and senior representatives of the Department of Health and NHS leadership. The membership of MEE will have a non-departmental majority. Other professional advisory bodies that are set up will be accountable to the relevant national chief professional officers.
111. MEE will also need to liaise with the other professional boards and national chief professional officers over the development of new roles and introduction of skill mix and new career pathway programmes.
112. The Modernising Medical Careers (MMC) (England) Programme Board, which will become the MMC (England) Implementation Committee, will continue to ensure the effective implementation of medical education policy. The current Programme Board's role in providing policy advice to ministers and the Department of Health will transfer to MEE, once it is established. The MMC Implementation Committee will be co-chaired by the Director of Medical Education for England, who will be a member of MEE. The Director of Medical Education will report on the MMC Implementation Committee's activity to MEE, and will be accountable to the NHS Medical Director to whom MEE itself also reports.
113. The Department of Health has created the post of Director of Medical Education to be the Senior Responsible Owner for the MMC Programme. This post has a remit that covers the full continuum of medical training: from undergraduate, through pre-registration and Foundation Programme training and specialty and GP training, up to the award of the CCT and certain aspects of CPD. The post holder will work with the professional regulators, Royal Colleges, deaneries, employers, trades unions, universities and others. The post holder will report directly to the NHS Medical Director who has operational responsibility for delivering quality and safety in the NHS, a key component of which is overseeing postgraduate medical education and training and ensuring the workforce is fit for purpose.

114. The Chief Medical Officer, as the Government's chief medical adviser, has a strategic leadership role within the Department of Health which includes medical education and training. As a Permanent Secretary, he sits on the NHS Management Board which oversees programmes of work in this area and has a UK-wide role on the UK Co-ordinating Group ensuring the consistency of approach between the four countries, as well as sitting on the MMC England Programme Board. He will work closely with the NHS Medical Director and with the Director of Medical Education in this regard.
115. Workforce planning for the other professions is and will continue to be carried out primarily at SHA and local level. Work will be taken forward with these professions to decide what other national professional advisory boards are required, recognising the contribution of the diversity of professional roles within multi-disciplinary teams to deliver effective evidence-based care.
116. There will also be regional advisory machinery to provide multi-professional and clinical pathway advice on workforce planning at SHA level. While this will be developed to suit local need, it will have the following functions:
- > bringing a coherent professional perspective to advise SHAs on education and training pathways to develop the workforce models that service providers need, for example, community-based cardiology services
  - > engaging with higher education institutions to translate workforce models, based on clinical pathways, into training pathways
  - > professional high level overview and assurance of the quality of the workforce plans created at SHA level, testing and challenging the plans developed in PCTs
  - > connecting with the other professional leaders at regional level and bringing a multi-disciplinary and regional perspective in advising the national MEE on the regional plans for medical, dental, healthcare scientists and pharmacists and low volume specialties
- Centre of Excellence**
117. We will establish the Centre of Excellence as a major objective resource for the health and social care systems. It will be hosted by one or more universities, with long-term horizon scanning, capability and capacity development for workforce planning functions, and the development of technical planning assumptions.
118. The Centre of Excellence will support the national and local professional advisory bodies. It will also enable the capacity and capabilities to make the SHA wide workforce planning, education and

training system more effective. It will be accountable to the Department of Health's Director General for Workforce.

119. We will set up the Centre of Excellence in a way that enables the system to have access to leading thinkers who will provide objective and credible analysis and information to form a shared evidence base for workforce strategy. We will work with partners and stakeholders to ensure that it gets the best data and informatics available and operates in a way that builds the trust and confidence of all. The Centre of Excellence will:

- > collate, synthesise and analyse SHA plans in light of clinical pathways and the implications for diagnostic services, which cut across all the clinical pathways, and present the professional advisory boards with appropriate advice for consideration
- > scan the horizon and gather intelligence for workforce planning through effective networks and act as an arena for new ideas, gathering and exploiting new information and best practice drawn from national and international experience
- > provide an evidence-based analytical function for workforce supply and demand modelling and provide a single evidence base for the health and social care systems
- > analyse labour market dynamics

- > develop a capacity and capability building function with tools and resources to support local implementation and multi-agency and social care workforce planning

120. The Centre of Excellence will collect local workforce data through the SHAs. In return, the Centre of Excellence will provide health communities – SHAs, PCT commissioning organisations and service providers, and in time, social care – with support such as:

- > workforce supply and demand analysis and forecasting intelligence
- > notification of anticipated changes, for example, in technologies/scientific advances and care delivery models which may impact on the workforce

121. Whilst MEE and the other professional advisory boards will be profession-specific, the Centre of Excellence will ensure that review arrangements for other staff groups are taken into account where appropriate. This will be done on a risk and proportionate basis, so that there is oversight and resources are focused where they can be most effective.

### **The workforce planning cycle**

122. The workforce planning cycle begins with PCTs and local councils commissioning services to meet the health needs of their local populations. PCTs and local councils will need to be confident that service providers have workforce strategies in

place that can deliver these services. Work is under way to understand how the commissioning assurance system can be used to support this.

123. In responding to PCTs' commissioning requirements, service providers will have to demonstrate how they will ensure the workforce they need with the right skills to deliver the services they are offering. They will need to develop integrated service and workforce plans that include proposals for training and development for their whole workforce, and for strategic workforce change. From these plans, PCTs will produce combined service and workforce plans for their local health economy, which they will send to their SHAs.
124. SHAs will then combine PCT plans into a single regional plan and will develop integrated service and workforce plans for their region. These will provide the basis for commissioning education and training for their local health economies from education providers. The regional plans will have a longer-term perspective and will be reviewed and assessed from a professional and clinical pathway and diagnostic services perspective. The plans, which will cover all staff groups, will be sent via the Centre of Excellence for synthesis and analysis to the relevant national and regional professional advisory boards for scrutiny and advice.

125. The Department of Health (and the Department for Innovation, Universities and Skills) will commission medical and dental undergraduates and low volume specialty professions nationally. This activity will be scrutinised by the appropriate national professional advisory bodies. The Department of Health will also perform its own assurance of SHA workforce plans through its normal SHA annual reviews. In addition, it will:
  - > secure and allocate funding for workforce development, education and training against quality assured SHA plans
  - > manage identified national risks through a strengthened, well informed bilateral process which will take place with the SHAs
  - > undertake long-term strategic workforce planning and policy development (taking account of the UK and global context) and develop the legal and regulatory framework needed to support the NHS

## **Education commissioning and provision**

126. SHAs will continue to be accountable for education commissioning and quality assurance. These responsibilities go beyond those of the professional regulators: they are not confined to ensuring satisfactory delivery of a defined standard, but are also responsible for ensuring that education commissioning

provides equality of access, value for money, continuous improvement in quality and fitness for purpose for local employers, taking appropriate account of the views of staff, patients and the public. To achieve this, SHAs (as education commissioners) will need to engage service providers and local health communities in education commissioning, ensuring strong coherence between workforce plans, service plans and financial plans. Education commissioners will also need to identify and respond quickly and effectively to changing service requirements, for example, further work is necessary to explore how SHAs and local councils might work together through Joint Improvement Partnerships to take forward areas of common interest.

127. We want trainees to enjoy high quality education and training that meets their professional and personal needs. We will explore options to further empower trainees by giving them greater voice and choice over where their training takes place. We recognise the huge personal dedication to becoming a healthcare professional and are absolutely committed to make sure the system recognises this.

#### **Health Innovation and Education Clusters**

128. One of the key partnerships in the health sector has been that between the NHS and universities. A number of recent factors, including the development of Academic Health Science Centres and the rapid development of the research and development programme, have prompted

universities and the NHS to look more closely at this relationship. We intend to enable providers of NHS services – in both primary and secondary care – to come together with partners in the higher education sector and industry to form Health Innovation and Education Clusters (HIECs). International experience in the United States, Canada and elsewhere has demonstrated that clusters can bring real advantages to the institutions involved, including the ability to attract more research funding and world-class researchers. They can drive innovation and improvements in patient care based on evidence and research. They can also raise the quality and pace of development of healthcare professional education and training.

129. Over time, in keeping with their aspirations and abilities, these HIECs will be able to be commissioned to provide healthcare professional education and training. This will ensure that trainees get the breadth, depth and quality of training and teaching to provide the high quality of care to which the NHS aspires.
130. The Department of Health will invite bids for approval of HIECs, and will provide financial support, probably on the basis of matched funding. The bids will be managed within the Department of Health and will be judged by an external panel of experts. Detailed criteria and rules will be announced in due course. The criteria will be permissive rather than prescriptive and will focus very particularly on added value

in innovation in care provision and/or high quality education at a local level. SHAs will remain responsible for commissioning and quality assuring the training that HIECs provide. We will therefore expect successful proposals to have demonstrated that they have SHA support.

131. HIECs will build upon and reinforce successful models of collaboration that are already found in the NHS. They will be an opportunity and not obligatory. The precise interpretation, focus and accountability model should be determined locally and designed to reflect the distinctiveness of their participating organisations and the needs of the local health economy and patients.

## Education funding

132. We will improve transparency, promote fairness and reward quality in education funding. Current arrangements will be modernised. In particular, we will rebase the current historical funding arrangements for the Multi Professional Education and Training Budget (MPET) and replace them with a tariff-based system where the funding follows the student or trainee.
133. The detailed proposals will be developed over the coming months with key stakeholders and will seek to ensure fair funding to support each of the following five core activities:

- > **student support** – we will review the existing arrangements for student support, including the anomaly under which nursing degree students receive lower support than nursing diploma students
- > **placement support** – we will develop proposals to rebase the historical funding arrangements for clinical placements with a system of tariffs that provides more appropriate support for all clinical professions and enables education commissioners to secure the required number of high quality placements, including innovative placements in new settings
- > **tuition support** – the introduction of a benchmark price for selected non-medical education and training has already addressed many unjustifiable differences in the price of healthcare education across England. The benchmark price will be reviewed to ensure it remains fair to both education





commissioners and education providers. We will also consider extending it to cover more professions beginning with clinical psychology

- > **preceptorship** – we will triple the funding we provide to support preceptorship for newly qualified nurses and midwives. We will also consider whether similar support is required for other clinical staff such as allied health professionals
- > **workforce change** – we will continue to provide funds for strategic development to support workforce change taking account of advice on new roles from the national professional advisory boards and of rigorous evaluation

134. These proposals represent a significant shift from the current arrangements. We will therefore consult key stakeholders as we develop the proposals and will take care to develop effective transitional arrangements to ensure that those providers whose current income is significantly affected have time to adjust to the required changes.

### Focus on quality

135. We will refocus education commissioning on quality. In particular, we will support education commissioners to:
- > be clearer about the outputs they require
  - > work in strategic partnerships with higher education institutes and service

providers to promote quality and innovation

- > promote the use of feedback from trainees, employers, patients and the public in the design and delivery of education and training
  - > ensure effective quality assurance systems with minimum duplication and burden on the NHS or higher education sector
136. We will also encourage education commissioners to consider using their education funding creatively to encourage and reward high quality learning and innovation. This might include, for example, the introduction of premium placement rates to promote the development of placements in new settings.

### Regulation

137. The professional regulators will:
- > ensure the involvement of patients and the public in the development of professional standards
  - > approve curricula to educate the clinicians of tomorrow to meet patient, public and service needs (where it is within their role and responsibility)
  - > ensure concordance across professional groups when the same competence applies
  - > facilitate the development of proportionate revalidation arrangements

to provide assurance of quality and to support delivery of robust arrangements for CPD

138. Education and training provision will be regulated by the appropriate professional regulator to ensure professional standards are defined and delivered without unnecessary bureaucracy for the NHS or education providers. To support this, we will ask the Council for Healthcare Regulatory Excellence to commission research to identify and promote best practice in quality assurance of education and training.

### Developing existing staff

139. Sixty per cent of the staff that will deliver NHS services in ten years time are already working in healthcare. We have a responsibility to support their development so that they have the skills and knowledge to deliver high quality, safe care and are enabled to meet the changing needs of patients and local communities, including the ability to work in new clinical settings that provide care closer to home.
140. We are also keen to support them to increase their skills so that they may progress through the career framework to fulfil their individual potential. We believe that this continuing development offers significant benefits not only for staff, but also for employers and for patients. All NHS jobs therefore need to be supported by ongoing learning and CPD.

141. CPD for employed staff is rightly the responsibility of individual employers. Some do this well, but this is not always the case<sup>23</sup>. We therefore intend to strengthen the arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills. We will do this by:
- > improving transparency of investment in CPD by promoting the publication of key metrics on access, quality and expenditure, which over time will be reported, benchmarked and made available to employers, employees, patients and the public
  - > strengthening education governance through learning and development agreements
  - > supporting the Government Skills Pledge<sup>24</sup>, ensuring appropriate development for all staff
  - > promoting the equity of access to CPD
  - > ensuring CPD is linked to patient, service and staff needs
  - > promoting the nomination of a named member of the Board of each NHS provider with responsibility for overseeing education and development
142. These initiatives will build on and support our commitment to ensure that all staff have clear roles and objectives, annual appraisal and professional development

<sup>23</sup> Although standard, consistent information on training is very difficult to obtain due to the variety of approaches organisations take in budgeting for training

<sup>24</sup> [www.dius.gov.uk/press/skills-pledge.html](http://www.dius.gov.uk/press/skills-pledge.html).

plans (using the Knowledge and Skills Framework where appropriate).

## **Simulation, clinical skills and innovative approaches to education**

143. We need to use modern education techniques if we are to fulfil our ambition to widen participation in learning and to enhance the learning environment for both those in training and those undertaking CPD. We will therefore review the appropriate use of e-learning and other modern education techniques, such as high-fidelity simulation suites, to develop a strategy for the appropriate use of e-learning, simulation, clinical skills facilities and other innovative approaches to healthcare education.

## **Why this system will work**

144. **Getting it right.** This new approach is locally led, driven by service needs and integrated with service and financial planning, with strong national assurance and professional review. It will also be supported by analytical insight through the newly created Centre for Excellence.

145. **Driving quality.** There is a clear separation between the commissioning of education and training and its provision. This approach ensures a dispassionate performance challenge to education and training providers. The introduction of tariffs for education and training will bring greater transparency whilst ensuring that resources devoted to education and training are spent on education and training. Driving quality will be further supported by the creation of a quality framework, enabling commissioners to recognise and reward quality through additional payments.

146. **Delivering innovation.** The development of a collaborative education and training system based on strong local partnerships between health services, higher education and others will ensure that professionals get the quality, breadth and depth of education, training and experience that they need. The improved focus on the quality of education and innovation will maximise the benefits and ensure that professionals have the flexibility to meet the evolving needs of patients.

## Appendix

The following MMC Inquiry recommendations are covered in the *NHS Next Stage Review: A High Quality Workforce*

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
5	<p>There needs to be a shared understanding of the roles of all doctors in the contemporary healthcare team that takes due account of public expectations.</p> <p>Given the interdependency of professional constituents of the contemporary multi-professional healthcare team, we suggest a similar analysis extends to other healthcare professional groupings.</p> <p>Clarity of the doctor's role must extend to the service contribution of the doctor in training, doctors currently contributing as locums, staff grades and associated specialists, the CCT holder, the GP and the consultant. Such issues need to be urgently considered by key stakeholders.</p> <p>Notwithstanding the need to keep such a key issue under constant review, stakeholders should seek to reach public consensus before the end of 2008, so important is the issue for current NHS reform.</p> <p>Education and training need to support the development of the redefined roles for each professional grouping and provide the necessary educational foundations to enable them to practise safely and effectively, and to aspire to enhanced roles.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 12, 14–19, 20, 25, 27–29 and 34</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
6 (i)	<p>DH should strengthen policy development, implementation, and governance for medical education, training, and workforce issues and their interface with service, embracing strong project management principles and addressing specifically</p> <ul style="list-style-type: none"> <li>a) clearer roles and responsibilities for a single Senior Responsible Officer,</li> <li>b) clear roles and accountability for senior DH members,</li> <li>c) better documentation of key decisions on policy objectives and key policy choices,</li> <li>d) faster escalation and resolution of 'red risks'.</li> </ul> <p>The CMOs* should be the SROs** for medical education.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 107–114</p>
8	<ul style="list-style-type: none"> <li>i) Recognising the interdependency of education, clinical service and research DH should strengthen its links ... within the Department</li> <li>ii) Recognising the interdependency of education, clinical service and research DH should strengthen its with ... NHS providers ...</li> <li>iii) Recognising the interdependency of education, clinical service and research DH should strengthen its ... with other Government Departments</li> <li>iv) Recognising the interdependency of education, clinical service and research DH should strengthen its links ... with ... the Department for Innovation, Universities and Skills</li> <li>v) Recognising the interdependency of education, clinical service and research DH should strengthen its ... with ... the Department of Business, Enterprise and Regulatory Reform</li> <li>vi) Ministers should receive annual progress reports on the development and functioning of such links.</li> </ul>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 108–111, 113, 114 and 128–131</p> <p>v) Outside the remit of the <i>NHS Next Stage Review</i></p>

\* Chief Medical Officer

\*\* Senior Responsible Owner

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
9	<p>At a local level Trusts, Universities and the SHA (or equivalent) should forge functional links to optimise the health:education sector partnership.</p> <p>As key budget holders SHA Chief Executives should have the creation of collaborative links between local Health and Education providers as one of their key annual appraisal targets.</p> <p>Success should be measured against tangible outcomes</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 128–131</p>
10	<p>All four Departments of Health in the UK and the four Chief Medical Officers must be involved in any moves to change medical career structures. In many instances it seems likely that the Department of Health in England will continue to have a lead role but from time to time, collective agreement may determine that lead responsibility for specific issues passes to another Health Department and/or its Chief Medical Officer.</p> <p>Regardless of which Department leads, accountability should be explicit and every effort made to acknowledge the views of the four countries.</p> <p>DH should have a coherent model of medical workforce supply within which apparently conflicting policies on self-sufficiency and open-borders/overproduction should be publicly disclosed and reconciled.</p> <p>We recommend that overseas students graduating from UK medical schools should be eligible for postgraduate training as should refugee doctors with the right to remain in the UK.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 108–116 and 117–121</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
12 (i)	<p>DH Workforce should urgently review its medical workforce advisory machinery to ensure that it receives integrated and independent advice on medical workforce issues to inform/complement SHA and local deliberations. Both national and devolved workstreams must be adequately resourced.</p> <p>The medical workforce advisory machinery should also take account of national policies impacting on the workforce such as the shift of more care to the community.</p> <p>Revisions to the current arrangements need to reflect the following principles:</p> <p>Medical workforce planning needs to embrace the consensus view of the role of the doctor and roles of other healthcare professionals referred to in Recommendation 5.</p> <p>Plans should be based on robust information on available and projected medical specialist skills, requiring relevant databases.</p> <p>Whilst recognising that doctors are just one part of the workforce, sufficient attention and resource needs to be devoted to medical workforce planning reflecting doctors' crucial roles and the expense involved in their development.</p> <p>A national perspective needs to be integrated with regional requirements including the views of service, particularly with regard to the maintenance of sufficient subspecialty expertise to meet the needs of the nation, and the overall health of clinical academia.</p> <p>Consideration should be given to the creation of an arm's length body, a NHS Medical Education England, NHS:MEE, mirroring NIHR to undertake commissioning of higher specialist training that is not required in every locality.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 101–103, 105, 106 and 108–121</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
12 (i) (continued)	<p>The criteria for the award of such training positions should reflect the Trust's performance in relation to training, innovation and clinical outcomes.</p> <p>Professional advice to the medical workforce advisory machinery needs to include that from doctors at the cutting edge of their discipline with the foresight to project potential developments in healthcare.</p> <p>The Panel believes that this might best be accomplished through arrangements that mirror those in place for the previous Medical Workforce Standing Advisory Committee (MWSAC).</p> <p>Regional workforce plans should be subject to a national oversight and scrutiny advisory committee with service, professional and employer representation. Such oversight should encourage local responsiveness and acknowledge issues facing the Devolved Administrations whilst ensuring national consistency on roles and standards</p> <p>Modelling capacity should be enhanced by drawing on the expertise in the university sector, for example health economists, epidemiologists, modellers, etc.</p> <p>The assumptions underlying projections should be subject to professional scrutiny and regular review.</p>	
16	<p>DH should recognise the burgeoning supply of medical graduates it has commissioned and make explicit its plans for the optimal use of their skills for the benefit of patients.</p> <p>It is recommended that sufficient numbers of Core Specialty training posts (see Recommendation 33) should be made available to accommodate doctors successfully completing FY1 and the use of commissioning funds for this purpose should be monitored.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 32, 33, 108–116 and 132</p>



MMC Inquiry Reference	MMC Inquiry Recommendation	Response
18	The medical profession should have an organisation/ mechanism that enables coherent advice to be offered on matters affecting the entire profession. In relation to postgraduate medical education and training we recommend that NHS:MEE assumes the co-ordinating role.	<i>NHS Next Stage Review: A High Quality Workforce</i> , paragraphs 108–116
19	There should be enhanced opportunities for training in medical management during postgraduate training years to fuel an increase in clinically qualified managers and an awareness of the interdependency of clinicians and managers in the pursuit of optimal healthcare.	<i>NHS Next Stage Review: A High Quality Workforce</i> , paragraphs 15, 16, 18–20, 29 and 44
20	Doctors in training should be better represented in the management structures of Trusts to ensure that they better understand service pressures and priorities and Trusts better appreciate their service role and training needs.	<i>NHS Next Stage Review: A High Quality Workforce</i> , paragraphs 19, 29 and 44
21	The CMOs as leads for Medical Education will interact with NHS:MEE and equivalent structures in the Devolved Administrations as the reference point for interactions with the medical profession over matters relating to PGMET.	<i>NHS Next Stage Review: A High Quality Workforce</i> , paragraphs 109 and 114
23	Funding flows for postgraduate medical education and training should accurately reflect training requirements and the contributions of service and academia. The current MPET Review should lead to a clearer contractual basis reflecting both agreed volumes and standards of activity and should recognise the service contribution of trainees and the resources required for training.	<i>NHS Next Stage Review: A High Quality Workforce</i> , paragraphs 132–134

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
24 / 25	<p>The Medical Postgraduate Deanery function in England should be formally reviewed with respect to whether:</p> <p>i) the relationships and accountabilities are currently optimal; ii) the present arrangements meet redefined policy objectives of optimal flexibility in postgraduate training and aspiration to excellence, and the NHS imperative of equity of access.</p> <p>Any new arrangements should conform to redefined principles, referred to in Recommendation 1, co-developed to govern postgraduate training.</p> <p>Postgraduate Medical Deans should have strong accountability links to medical schools as well as SHAs in line with Follett appraisal guidelines for clinicians with major academic responsibilities. Such arrangements will improve links with medical academic expertise and will facilitate the educational continuum from student to continuing professional development.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 128–131.</p> <p>Note: The establishment of HIECs offer a possible model for the provider element of postgraduate medical education.</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
26	<p>Reflecting the fact that Postgraduate Medical Education and Training involves service, academic and workforce dimensions, it is proposed that the Foundation School concept be developed further as Graduate Schools, on a trial basis initially, where supported locally. The characteristics of such Schools, the precise nature of which would depend upon local circumstances and relationships, need to reflect the crucial interface function played by the Medical Postgraduate Deanery between the service, the profession, academia and workforce planning/commissioning. Graduate Schools would involve Postgraduate Deans, Medical Schools, Clinical tutors, Royal College and Specialist Society representatives and would have strong links to employers/services and SHAs.</p> <p>The Graduate Schools could also oversee the integrated career development of the trainee clinical academic/ manager (see Recommendation 41), as well as NIHR faculty.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 128–131</p> <p>Note: SHAs will be required to describe how they intend to introduce a commissioner and quality assurance split from education provision</p>
33	<p>Foundation Year 2 should be incorporated as the first year of Core Specialty Training. This will require broad based 'theming' of the current FY2 provision.</p> <p>The acquisition of competences of the current Foundation Programme should continue across FY1 and first year of Core pending formal review of this curriculum and development of detailed Core curriculum objectives.</p> <p>The current commitment to FY2 GP placements should continue as part of Core Specialty Training and be developed further as resources permit.</p> <p>Doctors in Core Specialty Training should be called Registered Doctors.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 34 and 35</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
34	<p>At the end of FY1 doctors will be selected into one of a small (for example four) number of broad-based specialty stems: for example medical disciplines, surgical disciplines, family medicine, etc.</p> <p>During transition, 'run-through' training could be made available after the first year of Core, for certain specialties and/or geographies that are less popular than others. Core Specialty Training will typically take three years and will evolve with time typically to encompass six 6-month positions.</p> <p>Care will be taken during transition to ensure that the curricula already agreed with PMETB are delivered and the appropriate knowledge, skills, attitudes and behaviours are acquired in an appropriately supervised environment.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 32 and 33</p>
35	<p>For those who remain uncertain regarding career destination there will be opportunities for competitive transfer between the Core stems during years one and two. For a minority, therefore, Core training might thus extend to 3.5 to 4 years.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraph 35</p> <p>Note: MEE will begin work with Royal Colleges and the professional regulators to address this issue further</p>
37	<p>Satisfactory completion of assessments of knowledge, skills, attitudes and behaviours will allow eligibility for i. selection into Staff Grade positions in the relevant broad area or, ii. selection into Higher Specialist Training. Doctors in Higher Specialist Training, in all specialities including general practice, will be known as Specialist Registrars.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 45 and 46</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
39	<p>Doctors should be allowed to interrupt their training for one year or longer by agreement to seek alternative experience that enhances their career and contribution to the NHS, having regard to Service need.</p> <p>The Regulator in conjunction with the Royal Colleges will determine whether experiences should contribute to completion of training subject to appropriate competency assessment.</p> <p>Postgraduate Deaneries and the Regulator should positively facilitate such experiences.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 108 and 109</p> <p>Note: MEE will take these issues forward working with the MMC Implementation Committee. Further work will be undertaken to review the 'Reference Guide for Postgraduate Specialty Training in the UK'</p>
40	<p>Selection into Higher Specialist Training to the role of Specialist Registrar will be informed by the Royal Colleges working in partnership with the Regulator.</p> <p>The Panel proposes that in due course this will involve assessment of relevant knowledge, skills and aptitudes administered several times a year via National Assessment Centres introduced on a trial basis for highly competitive specialties in the first instance.</p> <p>A limited number of opportunities to repeat the National Assessment Centre tests following further experience will be determined.</p> <p>Candidates will apply via Postgraduate Deaneries or Graduate Schools.</p> <p>Application will take place three times a year on agreed dates ... This will avoid the once-a-year appointment system with its inherent risks to service delivery.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraph 112</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
40 (continued)	<p>Save in the most exceptional of circumstances, candidates will be restricted in the number of local programmes to which they may apply (and to the number of occasions on which they may apply). They will use a common national form with specialty-specific questions and will provide their standardised assessment score/ranking along with a structured CV. Graduate Schools linked to the 30 UK Medical Schools would reduce the size of Units of Application and address the family-unfriendly situations that arose therefrom. Shortlisted candidates will be subject to a structured interview for final selection.</p>	
43	<p>Successful completion of Higher Specialty Training as confirmed by assessments of knowledge, skills and behaviours will lead to a CCT, confirming readiness for independent practice in that specialty at consultant level. Higher specialist exams, where appropriate, administered by the Royal Colleges, may be used to test experience and broader knowledge of the specialty and allow for credentialing of subspecialty expertise. Recruitment to consultant positions may be informed by the extent of experience, by skills suited to enhanced roles, and by sub-specialty expertise</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 34 and 35</p>
45	<p>The length of training in General Practice should be extended to five years (three years in Core plus two years as a GP Specialist Registrar supervised by a Director of Postgraduate GP Education). Extension to five years would bring GP training in line with the other developed European countries. Opportunities should exist to accommodate late entrants to GP training with other specialist skills.</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraph 37</p>

MMC Inquiry Reference	MMC Inquiry Recommendation	Response
47	<p>The Panel recommends the formation of a new body, NHS Medical Education England (NHS:MEE). This body would fulfil the following functions:</p> <p>Hold the ring-fenced budget for medical education and training for England [Rec 23];</p> <p>Define the principles underpinning PGMET [Rec 1, 2];</p> <p>Act as the professional interface between policy development and implementation on matters relating to PGMET [Rec 3, 18];</p> <p>Develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery [Rec 12, 13, 17];</p> <p>Ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the Regulator on the resultant synthesis [Rec 14];</p> <p>Co-ordinate coherent advice to Government on matters relating to medical education [Rec 18];</p> <p>Promote the national cohesion of Postgraduate Deanery activities [Rec 24, 25];</p> <p>Scrutinise SHA medical education and training commissioning functions, facilitating demand-led solutions whilst ensuring maintenance of a national perspective is maintained [Rec 22];</p> <p>Commission certain sub-specialty medical training [Rec 12];</p> <p>Act as the governance body for MMC and future changes in PGMET [Rec 6];</p> <p>Work with equivalent bodies in the Devolved Administrations thereby promoting UK-wide cohesion of PGMET whilst facilitating local interpretation consistent with the underpinning principles;</p> <p>NHS:MEE would be accountable to the SRO for medical education [Rec 21] and be advised by an Advisory Board with professional, service, academic, employer, BMA and trainee representation [Rec 7].</p>	<p><i>NHS Next Stage Review: A High Quality Workforce</i>, paragraphs 108–116</p>

