Education Commissioning for Quality

Click here
This document outlines an enhanced, comprehensive education commissioning system for non-medical and medical staff, sets principles for managing relationships between health and education more effectively and provides guidance to build education commissioning capacity and capability in SHAs.

Cross reference

Links to the National Contract Standard Framework

Superseded documents

N/A

Action required

SHA Education Commissioners to reflect the minimum Contract Performance Indicators

Timing

Effective from April 2010

Contact details

Julie Badon
Education Policy Branch
Workforce Directorate
Room 2N14
Quarry House
Quarry Hill
Leeds LS2 7UE

For recipient use
The NHS Next Stage Review set out the ambition of the NHS to put quality at the heart of services. NHS staff are key to delivering this ambition. We need to make sure that they are recruited, trained, developed and retained to enable them to provide high quality care across the NHS.

This guidance sets out a complete education commissioning system, which seeks to re-focus education commissioning on quality. All this guidance relates to the Multi-Professional Education and Training levy funded expenditure managed by Strategic Health Authorities (SHAs). We consider that education commissioning embraces the following elements:

- investment and commissioning planning
- market management, through procurement and contracting
- education delivery by supporting and incentivising placements, user involvement and promoting innovation
- performance management.

In addition our system includes the Education Commissioning Assurance framework (DH, 2009), which can be used to support the development of education commissioning teams in relation to each of the elements of education commissioning.

The system is represented at a high level as a value chain (see Figure 1 on page 4).

How to use this guidance

This guidance has been developed for online use. Use the page buttons to work through the guidance or explore the information using the right hand side menu to access information for each element of the value chain. Throughout the document links have been added to help you navigate within this document or to reference external links providing supporting information. The guidance includes national policy as well as good practice guidance.
Figure 1: Education commissioning value chain

The education commissioning assurance framework is based on World Class Commissioning competencies and supports capability across the system.

**Inputs**
- Strategic Health Authority vision and priorities
- Students
- Financial resource
- Workforce plans
- Workforce information
- Market intelligence

**Planning**
- Investment plan
- Commissioning plan

**Procurement**
- Tendering
- Negotiating and letting contracts

**Contracting**
- Contract framework
- Quality assurance
- Performance management
- Financial management

**Education delivery**
- Academic education
- Practice education

**Performance management**
- Performance assurance
- Performance review
- Action planning

**Output**
- Qualified workforce in right numbers and with right competences

**Activities that add value**
- Managing knowledge and assessing needs
- Prioritising investment
- Stimulating the market
- Making sound financial investments
- Promoting improvement and innovation
- Leadership
- Working with partners
- Engagement with learners and service users
- Collaborate with service commissioners and providers

**Review by advisory machinery**
- Academic and placement capacity
- Quality outcomes

**Market management**
- Health/education relationship
- Strategic Health Authority procurement processes

**Contract framework**
- including learning and development agreement (LDA) benchmark price
- Quality assurance and performance management systems
- Information management systems

**Placement management and support**
- Curriculum design/innovation
- Student, employer and patient involvement
- Health/education relationship

**Performance management system**
- including performance indicators
- Risk based intervention
- Action planning
- Performance bonuses/penalties

**Introduction**

World Class Education Commissioning

Planning

Procurement/Contracting

Education delivery

Performance management

Print
‘Great commissioning’ has been described as:

“Intimately understanding end consumer needs and being accountable for meeting them with high quality, sustainable value for money outcomes using market making approaches to select the best service providers.” (Ernst and Young 2007)

Strategic Health Authorities (SHAs) have primary accountability for managing and developing the education market through engagement with primary care trust (PCT) service commissioners, providers of NHS commissioned services and education providers. Strategic management of the healthcare education market is a powerful tool in education commissioning for driving innovation, quality improvement and value for money as well as for making strong links between service needs and education delivery. In this way, effective market management provides strong evidence for all the World Class Education Commissioning competencies shown in Table 1.
### Table 1: World Class Education Commissioning competencies

(Refer to the *Education Commissioning Assurance Framework* (DH, 2009))

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Leadership</strong></td>
<td>Be recognised as leaders of education commissioning within the NHS.</td>
</tr>
<tr>
<td><strong>2. Working with partners</strong></td>
<td>Work collaboratively with partners to commission education that optimises health gains and reductions in health inequalities.</td>
</tr>
<tr>
<td><strong>3. Engagement with learners and service users</strong></td>
<td>Proactively seek and build continuous and meaningful engagement with learners and service users to shape and improve education.</td>
</tr>
<tr>
<td><strong>4. Collaborate with service commissioners and providers</strong></td>
<td>Lead continuous and meaningful engagement with service commissioners and providers to inform strategy and drive quality, education and curriculum design and resource utilisation.</td>
</tr>
<tr>
<td><strong>5. Manage knowledge and assess needs</strong></td>
<td>Manage knowledge and undertake robust and regular learning needs assessments that establish a full understanding of current and future education and training requirements.</td>
</tr>
<tr>
<td><strong>6. Prioritise investment</strong></td>
<td>Prioritise investment according to local needs, service requirements and the values of the NHS.</td>
</tr>
<tr>
<td><strong>7. Stimulate the market</strong></td>
<td>Effectively stimulate the education market to meet demand and secure required learning, skills and competency outcomes.</td>
</tr>
<tr>
<td><strong>8. Promote improvement and innovation</strong></td>
<td>Promote and specify continuous improvements in quality and outcomes from education in academic and practice settings through education provider innovation and configuration.</td>
</tr>
<tr>
<td><strong>9. Procurement</strong></td>
<td>Secure procurement skills that ensure robust and viable contracts.</td>
</tr>
<tr>
<td><strong>10. Manage the system</strong></td>
<td>Effectively manage the education commissioning system and work in partnership with academic and placement providers to ensure contract compliance and continuous improvements in quality and outcomes.</td>
</tr>
<tr>
<td><strong>11. Make sound financial investments</strong></td>
<td>Make sound financial investments to ensure sustainable development and value for money.</td>
</tr>
</tbody>
</table>
1.1 Planning
Overview of planning systems

Investment and commissioning planning

Strategic Health Authorities (SHAs) are accountable to the Department of Health (DH) for the use of the Multi-Professional Education and Training (MPET) levy. SHAs plan how they are going to invest MPET funds and commission education from a variety of education providers. This guidance has been designed to help SHAs maximise the benefits from the investment and commissioning planning processes. It is recognised that SHAs already have established processes in place for investment and commissioning planning; therefore this guidance does not provide a step-by-step guide to planning but rather brings together information on related processes, recommendations in relation to the content of plans and examples of existing good practice.

The guidance here includes:
- an overview of the commissioning cycle for health services (see Figure 2)
- an overview of the integrated workforce planning and education commissioning system (see Figure 3)
- the development of investment and commissioning plans (see 1.2)
- an overview of the national commissioning process (see 1.3)
- the review and advisory processes for investment and commissioning plans (see 1.4)
- a summary of roles and responsibilities in investment and commissioning planning (see Tables 2 and 3).
Commissioning cycle for health services

Figure 2: Phases of the commissioning cycle for health services

Needs assessment and strategic planning
Shaping and managing the market
Performance monitoring and evaluation

Overview of planning systems
The development of investment and commissioning plans
National commissioning
Review and advisory processes
Tables 2 and 3
Annex A
Annex B

Procurement/Contracting
Education delivery
Performance management

Print
The integrated workforce planning and education commissioning system

The majority of workforce planning is locally owned and led. Organisations which provide NHS services, such as foundation trusts and care trusts, plan for the workforce they need to deliver high quality services. At a local level, workforce plans will be driven by local needs and care pathways. Organisations which commission NHS and social care services, such as primary care trusts (PCTs) and local authorities, act on behalf of the health and care system to identify the workforce implications and risks of the commissioning decisions they make.

Locally, Health Innovation and Education Clusters (HIECs) are being established to help facilitate high quality training that is more responsive to local service needs. HIECs will bring together the NHS, universities, industry and other organisations and will work in partnership with commissioners to align training and education with the local vision for improved services. They will be supported by and, in turn, support informed local workforce planning.

At a regional level, SHAs have a key role in strategic workforce leadership. They develop, in partnership with commissioners and providers, an area strategic workforce development plan to support the regional clinical vision. They are accountable for investing in education and training to meet the local workforce needs of the NHS system and for securing high quality training and best value for money.

At a national level, the Centre for Workforce Intelligence will source, synthesise, critique and disseminate the best available analysis, evidence and intelligence to support the whole system in effective workforce planning.

Medical Education England (MEE) and the other national professional advisory boards for nursing, midwifery and allied health professions provide co-ordinated clinical input into workforce planning, education and training. These national boards link with the regional professional advisory mechanisms which will provide similar support to SHAs.

The role of DH at national level is to support change. It will do this by creating the right conditions and incentives, setting standards and advocating improvements with a strong national voice.

Stage 1 SHA operating plans – including initial workforce plans January

Stage 2 SHA operating plans – including final workforce plans March

DH/SHA detailed workforce planning conversations

Centre for Workforce Intelligence intelligence gathering

SHAs, providers and commissioners work together on plans

Centre for Workforce Intelligence stakeholder engagement

DH/SHA high level bilaterals

MPET service level agreement

STAs/deaneries provide initial medical foundation programme numbers – May

January–March

April–June

July–September

October–December

Centre for Workforce Intelligence provides advice to SHAs on workforce together on workforce plans – September/October

Initial medical specialty training numbers – October

World Class Commissioning strategic plans

Operating Framework

Professional advisory boards provide advice on SHA workforce plans – dates and process to be agreed

SHAs produce initial non-medical education and training commissioning plans

Final medical foundation programme numbers – September

Centre for Workforce Intelligence intelligence gathering

SHAs, providers and commissioners work together on workforce plans – September/October

World Class Commissioning strategic plans

Operating Framework

Professional advisory boards provide advice on SHA workforce plans – dates and process to be agreed

SHAs produce initial non-medical education and training commissioning plans

Final medical foundation programme numbers – September

Figure 3: Integrated workforce planning system

Introduction

World Class Education Commissioning

Planning

Overview of planning systems
The development of investment and commissioning plans

National commissioning
Review and advisory processes
Tables 2 and 3
Annex A
Annex B

Procurement/Contracting

Education delivery

Performance management

Print
1.2 Planning

The development of investment and commissioning plans

**Investment planning** is the allocation of MPET funds to different areas of education based on workforce strategy and plans, and the number of new commissions required for different professional groups.

**Commissioning planning** is the allocation of commissions to specific education providers.

The planning process will include both planning the investment of MPET funds in different education areas and planning how commissions will be allocated. These two processes may be carried out separately or together depending on local arrangements in relation to specific responsibilities. Similarly, the investment plan and commissioning plan may be separate documents or combined into one plan.

DH has provided guidance on the information required within SHA investment plans in order to meet the requirements of the MPET service level agreement (SLA). This guidance has been included as Annex A and will be revised annually.

During the development of the MPET investment plan the following factors should be taken into consideration:

- alignment to the SHA's business planning process
- strategic priorities identified through:
  - national priorities identified in the NHS Operating Framework
  - the SHA's workforce strategy
  - medium- and long-term service commissioning plans
  - local clinical visions
- national planning assumptions and advice provided by:
  - the Centre for Workforce Intelligence in relation to horizon scanning, new care pathways, annual assessment of priorities and workforce intelligence (from 2010/11)
  - MEE and other national professional advisory boards as appropriate
- advice from the regional professional advisory functions
- needs assessment for the region from the aggregated workforce plans
• local labour market supply and other sources of supply, such as overseas recruitment, return to practice and the development of existing staff
• level of uplift required as a result of expected attrition from training and the proportion of newly qualified professionals who may choose not to work in the NHS
• financial modelling based on robust scenarios, including sense checking with service providers.

The education commissioning plan is likely to be a three- to five-year plan reviewed annually. In addition to the above, the following factors should be taken into consideration during the development of the plan:
• outputs from education in terms of numbers
• feedback from quality assurance and contract performance management processes
• modelling of proposed commissioning numbers based on robust scenarios and using a modelling tool where possible, for example NHS South Central’s commissioning and supply tool (CAST); the modelling should include allocation to specific education providers and sense checking with service providers
• review of academic and placement capacity.

As well as specific requirements for the MPET SLA, the investment and commissioning plan(s) would be expected to include:
• strategic priorities
• financial forecasts
• governance arrangements
• commissioning arrangements, including:
  – education to be commissioned at a number of National Qualifications Framework levels defined, as far as possible, in terms of national competence frameworks
  – education and training for non-professionally registered staff, for example assistant practitioners (where MPET-funded)
  – education and training jointly funded with the Learning and Skills Council via the Joint Investment Framework (JIF)
– pre-registration nursing, midwifery, allied health profession (AHP) and healthcare scientist programmes (where MPET funded)
– post-registration programmes leading to second registration, for example community specialist
– continuing professional development (CPD) programmes and modules where it has been agreed these should be centrally funded and commissioned
– plans for postgraduate medical and dental education
– other plans for developing workforce capacity, for example overseas recruitment, return to practice and the development of new roles and ways of working
– regionally funded innovation, for example e-learning
– arrangements for delegated education commissioning responsibilities where relevant
– arrangements for national commissioning of small number specialties.

In addition there are a number of broader issues that education commissioners will need to consider when developing their investment and commissioning plans:

• the need to manage the tension between commissioning health professionals for the future and planning for the needs of today
• the need for a clear direction to ensure a balance between undersupply and oversupply, tempered by modelling scenarios that take account of risks and allow adjustments
• education follows changes to service as an enabler rather than a driver of change. Consequently, there has to be a recognition that trainees cannot be trained in an environment until that environment actually exists
• the fact that all providers of service, including the independent sector, need to be providers of education and that this must be taken into account when planning physical premises. Education requirements must be actively managed as part of service change
• the need to commission by looking at the whole career pathway as a continuum so that the whole system, including outcomes, is controlled.
• the need to commission for the local health economy so that the future workforce is protected, by balancing the needs of the profession or specialty against the needs of the locality.

Tables 2 and 3 describe the roles and responsibilities in investment and commissioning planning.
1.3 Planning

National commissioning

There are some healthcare professions, for which year-on-year commissioning numbers are small, that are commissioned nationally by a lead SHA acting on behalf of all SHAs. MEE and the other national professional advisory boards are likely to have a role in national workforce planning for small volume professions. Suggested criteria and a process for establishing national commissioning arrangements are described below.

Criteria for national commissioning

The following recommended criteria could aid decision making in relation to national commissioning:

- volume or number of commissions
- financial value (related to number of commissions and level of specialism)
- level of specialism of programme
- viability of multiple providers
- SHA location in relation to providers of small numbers specialties
- pre-existing commissioning of specialties
- advice on nationally planned specialties and professions.

Suggested process for establishing national commissioning arrangements

A sub-group or working party of the SHA education commissioners’ network, with clearly defined accountability, could decide what professions/specialisms should be commissioned nationally by a lead commissioner and makes recommendations for approval to the national SHA education commissioners’ network. The sub-group should include a DH representative to address principles of subsidiarity.

National commissioning arrangements should be included in all SHA investment plans so that SHAs taking on national commissioning are assured of funding. The MPET SLA will reflect national commissioning arrangements in its key performance indicators (KPIs).
Levers that may be used to derive greater value from investment and commissioning planning

Education commissioners have a number of levers at their disposal which they can use to encourage the planning system to develop new ways of delivering education, including:

- identification and evidence of the discontinuous changes that will affect the way service is delivered
- use of the Centre for Workforce Intelligence as it develops its focus on new care pathways and the horizon scanning function
- outcomes research to identify factors that affect return on investment
- identification and adoption of successful innovation.

Next stage in the education commissioning system

On the basis of the investment and commissioning plans, the SHA will:

- commission places on programmes from education providers using standard contract frameworks and benchmark price (BMP) where relevant, and ensure compliance with European regulations on procurement
- work in partnership with education providers to ensure there are sufficient high quality clinical placements for health students, including medical and dental undergraduates
- work in partnership with education providers, regulatory bodies and employers to develop programmes that are responsive to changes in healthcare
- work in partnership with education providers to express programmes in terms of national competence frameworks and explicitly linked to the NHS Knowledge and Skills Framework to ensure that students and staff have transferable qualifications.
1.4 Planning
Review and advisory processes

There are a number of review and advisory processes which are likely to impact on the development of MPET investment and commissioning plans.

**Multi-Professional Education and Training service level agreement**

DH has an SLA with SHAs, which is reviewed annually, concerning the utilisation of the MPET budget. SHAs are accountable for the use of the MPET budget and are responsible for feeding back to DH on performance against plans via quarterly monitoring processes. As part of the performance management process SHAs will be expected to provide their investment plan to DH by 31 May each year. Guidance on the information to be provided within SHA investment plans to meet the requirements of the MPET SLA can be found in Annex A.

**Strategic Health Authority assurance and annual bilateral process**

DH is responsible for ensuring that SHAs have in place robust commissioning regimes and that education commissioning plans are service-based. DH manages national risks through a two-day annual bilateral process with SHAs. The process, of which one day is focused on workforce issues, is part of the SHA assurance framework, which has three components:

- statutory obligations
- performance
- organisation and system health.

**National professional advisory boards**

The remit of the national professional advisory boards is to provide advice on workforce planning, education and training, not to implement policy.

**Medical Education England** has a remit covering medicine, dentistry, pharmacy and healthcare science. Separate programme boards advise on healthcare science, pharmacy and dentistry. MEE provides a professional ‘voice’ and national co-ordinated clinical advice on workforce planning, education and training. It is an advisory non-departmental public body, has an independent Chair and is accountable to the NHS Medical Director and ultimately the Secretary of State. MEE may be asked to advise on SHA plans.

The **Nursing and Midwifery Advisory Board** provides a professional ‘voice’ and national co-ordinated clinical input on workforce planning,
education and training for nursing and midwifery. It may be asked to advise on SHA plans.

The Allied Health Professions Advisory Board provides a professional ‘voice’ and national co-ordinated clinical input on workforce planning, education and training for the allied health professions. It may be asked to advise on SHA plans.

Regional professional advisory functions

The regional professional advisory functions are expected to provide an interprofessional, service-based review of SHA workforce and education commissioning plans. Annex B details the principles for the establishment of regional professional advisory functions.

Centre for Workforce Intelligence

The new Centre for Workforce Intelligence will provide an objective, trusted, credible source of workforce intelligence, analysis and evidence for the health and social care system, delivering strategic oversight and leadership on the quality of workforce planning. It will achieve this by exercising its responsibilities across three functions:

• aligning the whole system around a shared endeavour to improve and use high quality data, analysis and modelling
• horizon scanning for innovation and future service, workforce and labour market issues that are likely to have an impact on the health and social care workforce and new pathways
• providing leadership for capability building by supporting local organisations to use workforce information and tools effectively, promoting best practice in workforce planning, challenging the NHS and social care services to improve performance, and setting standards for resources and tools.

The Centre will also support the professional advisory boards and help inform their thinking and the advice they put forward on education and training issues. This in turn will influence national decision making on workforce policy and strategy.

The Centre will not be responsible for undertaking workforce planning for health and social care organisations as there are already clear roles, responsibilities and accountabilities for this across the system.
### Planning: Tables

#### Table 2: Roles and responsibilities – investment planning

<table>
<thead>
<tr>
<th>Activity that improves quality and adds value</th>
<th>Elements of the activity</th>
<th>Strategic Health Authority</th>
<th>Primary Care Trust</th>
<th>NHS service providers</th>
<th>Education providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of investment plan ensuring integration with local planning</td>
<td>Review of collated workforce plans</td>
<td>Responsible for activity</td>
<td>Submit workforce plans to SHA</td>
<td>Provide workforce plans (via PCTs)</td>
<td></td>
</tr>
<tr>
<td>Review of workforce strategy</td>
<td>Responsible for activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of NHS Operating Framework and local clinical visions to identify priorities</td>
<td>Responsible for ensuring integration with SHA planning</td>
<td>Engaged in identifying priorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of plan for use of MPET based on above</td>
<td>Accountable for MPET Planning for designated element of MPET could be carried out by locality groups or clusters</td>
<td>May plan for designated element of MPET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity that improves quality and adds value</td>
<td>Elements of the activity</td>
<td>Strategic Health Authority</td>
<td>Primary Care Trust</td>
<td>NHS service providers</td>
<td>Education providers</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Engagement with care pathway networks, service providers and PCT commissioners to validate plan</td>
<td>Accountable for MPET Planning for designated element of MPET could be carried out by locality groups or clusters</td>
<td>Work in partnership to validate plan</td>
<td>Work in partnership to validate plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement with education providers</td>
<td>Confirmation of cost of proposed programmes</td>
<td>Accountable for MPET Financial modelling could be delegated</td>
<td></td>
<td>Engaged in activity</td>
<td></td>
</tr>
<tr>
<td>Financial modelling for each element of plan</td>
<td>Accountable for MPET Financial modelling could be delegated</td>
<td></td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
<td></td>
</tr>
<tr>
<td>Review of investment plan</td>
<td>Sense check with service providers re financial issues</td>
<td>Accountable for MPET Financial modelling could be delegated</td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
<td></td>
</tr>
<tr>
<td>Review by regional professional advisory function</td>
<td>Responsible for activity</td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
<td></td>
</tr>
<tr>
<td>Review by MEE/national professional advisory boards</td>
<td>Responsible for activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes research</td>
<td>Longitudinal research to identify the factors that affect return on investment</td>
<td>Responsible for activity Research could be delegated/commissioned</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3: Roles and responsibilities – commissioning planning

<table>
<thead>
<tr>
<th>Activity that improves quality and adds value</th>
<th>Elements of the activity</th>
<th>Strategic Health Authority</th>
<th>Primary Care Trust</th>
<th>NHS service providers</th>
<th>Education providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of commissioning plan ensuring integration with investment plan</td>
<td>Development of plan</td>
<td>Responsible for ensuring integration between investment and commissioning plans</td>
<td>May plan for designated element of MPET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of quality outcomes</td>
<td>Review of annual reports from performance management of education contracts</td>
<td>Responsible for ensuring it happens</td>
<td>Review could be delegated</td>
<td></td>
<td>Engaged in activity</td>
</tr>
<tr>
<td>Review of capacity</td>
<td>Updates on placement and academic learning capacity</td>
<td>Responsible for ensuring it happens</td>
<td>Review could be delegated</td>
<td></td>
<td>Engaged in activity</td>
</tr>
<tr>
<td>Modelling of proposed commissioning numbers</td>
<td>Responsible for ensuring it happens</td>
<td>Modelling could be delegated</td>
<td></td>
<td></td>
<td>Engaged in activity</td>
</tr>
</tbody>
</table>
### Activity that improves quality and adds value

<table>
<thead>
<tr>
<th>Activity</th>
<th>Elements of the activity</th>
<th>Strategic Health Authority</th>
<th>Primary Care Trust</th>
<th>NHS service providers</th>
<th>Education providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of commissioning plan</td>
<td>Sense check with service providers re financial issues</td>
<td>Accountable for MPET</td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial modelling could be delegated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review by regional professional advisory function</td>
<td></td>
<td>Responsible for activity</td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
<td>Engaged in activity</td>
</tr>
<tr>
<td>Review by MEE/national professional advisory boards</td>
<td></td>
<td>Responsible for activity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Introduction

**World Class Education Commissioning**

### Planning

- Overview of planning systems
- The development of investment and commissioning plans
- National commissioning
- Review and advisory processes
- Tables 2 and 3
- Annex A
- Annex B

### Procurement/Contracting

### Education delivery

### Performance management

### Print
Planning: Annex A
Multi-Professional Education and Training budget: Strategic Health Authority investment plan guidance note 2009/10

Introduction

The MPET service level agreement (SLA) sets out the Department of Health’s main expectations for the utilisation of the MPET budget for 2009/10.

Included within the Department’s requirements is that SHAs provide an investment plan detailing how investment decisions have been made. Specifically:

“SHA investment decisions should be based on long-term (3–5 year) workforce plans using local and national data sources including Workforce Review Team (WRT) analysis and the Electronic Staff Record (ESR) Data Warehouse. They should take full account of the national policy priorities in this SLA and other developments including the findings of the Next Stage Review – A High Quality Workforce. SHAs should work with their local NHS organisations to ensure the data upon which they base their plans is timely, complete and of good quality.”

2009/10 MPET SLA – General requirements para 1

This document highlights the information required within SHA investment plans and suggests a structure for their layout. This structure is not mandatory and SHAs may wish to provide investment plans in a format more suitable to their individual requirements. However, SHAs should ensure that the content requirements set out below are clearly included within their plans.

2009/10 SHA investment plan suggested format

To allow for ease of reference between the two documents, it is suggested that SHAs base their investment plans on the sections of the MPET SLA, namely:

- introduction and general requirements
- undergraduate medical and dental education placement funding
- postgraduate medical and dental education funding
- nursing, midwifery and AHP education funding
- healthcare scientists
- wider workforce
- nationally hosted activities.

The minimum requirements for each of these sections are set out below.
Section 1 – Introduction and general requirements

This section of the SHA investment plan should provide general information on SHA investment planning, including the basis on which investment decisions are made, the links to the workforce planning process and the data sources utilised in this planning. Where appropriate, SHAs may wish to detail in this section any key assumptions, risks or issues relevant to the investment plan.

In particular, this section should provide assurance from SHAs on the following areas:

- Learning and development agreements (LDAs) are in place with all clinical training providers.
- Arrangements are in place (either directly or via higher education partners and others) to monitor the quality of training, including:
  - the satisfaction of students and trainees with their training (including through the Higher Education Funding Council for England (HEFCE) National Student Survey)
  - the satisfaction of employers with outputs from training.
- A director-level post for overseeing education and development is identified for all NHS organisations from which the SHA commissions training.

Section 2 – Undergraduate medical and dental education placement funding

This section of the SHA investment plan should detail the key investment plans and decisions for the utilisation of MPET funding in the delivery of undergraduate medical and dental education.

In particular, this section should provide assurance from SHAs on the following areas:

- Sufficient medical and dental placements are available for local medical and dental students.
- All LDAs and contracts specify the support required by students on clinical placements and include provisions for dispute resolution.
- All dental placements are funded in line with the nationally agreed dental placement rate.
• Arrangements are in place with medical and dental schools to monitor the quality of training against Quality Assurance Agency and General Medical Council/General Dental Council standards.

Section 3 – Postgraduate medical and dental education funding

This section of the SHA investment plan should detail the key investment plans and decisions for the utilisation of MPET funding in the delivery of:

• the Medical Foundation Programme
• medical specialty training
• dental specialty training and CPD.

In particular, this section should provide assurance from SHAs on the following areas:

• All staff involved in supervision of trainees have received the appropriate trainer training with plans in place to identify the proportion of trainers who have not received the necessary training, and proposals to resolve this.

Additionally, SHAs should provide in this section details of how they plan to meet, or contribute to meeting, the following KPI:

“Additional GP training programmes created to enable 2,700 doctors to enter year 1 of a GP training programme, reflecting national and local workforce planning predictions.”

2009/10 MPET SLA – Key Performance Indicator 2.1

Section 4 – Nursing, midwifery and allied health professions education funding

This section of the SHA investment plan should detail the key investment plan and decisions for the utilisation of MPET funding in the delivery of both pre- and post-registration training for nursing, midwifery and AHPs.

In particular, this section should provide assurance from SHAs on the following areas:
• Long-term commissioning plans for nursing, midwifery and AHPs have been agreed with higher education institution partners and are in place.

• Year-on-year variations in commissions are justified against long-term national and local workforce needs, including:
  – increasing the numbers of health visitors
  – providing significant increases in numbers of neo-natal nurses
  – developing school health teams.

• Arrangements are in place to monitor student and employer satisfaction with NHS commissioned programmes.

• All relevant contracts comply with the national BMP as at 31 March 2009.

• Funding for student grants is passed to Student Bursary Unit (SBU) on the first working day of each month on the basis of the appropriate share of national costs.

• Investment of funding has been provided for preceptorship for nurses.

• Plans are in place to take account of the move to registration at graduate level for nursing.

Additionally, SHAs should provide in this section details of how they plan to meet, or contribute to meeting, the following KPIs:

“Attrition rates for pre-registration professions show significant reductions to contribute to the achievement of the national average of 13%, as required under the national benchmark price agreement.”

2009/10 MPET SLA – Key Performance Indicator 3.1

“Sufficient numbers of non-medical prescribers are available to deliver improved NHS services and better access to medicines, in line with commissioning plans, and … those trained are able to use their qualification.”

2009/10 MPET SLA – Key Performance Indicator 3.2

“SHA commissions provide for the delivery of 4,000 more midwives nationally by 2012 (based on headcount).”

2009/10 MPET SLA – Key Performance Indicator 3.3

Section 5 – Healthcare scientists

This section of the SHA investment plan should detail the key investment plans and decisions for
the utilisation of MPET funding in the delivery of education and training for healthcare scientists.

In particular, this section should provide assurance from SHAs on the following areas:

- Investment plans show evidence of sufficient commissions for healthcare scientists.
- Workforce plans contain development of commissioning arrangements and infrastructure planning to deliver the Modernising Scientific Careers agenda, subject to consultation.

Section 6 – Wider workforce

This section of the SHA investment plan should detail the key investment plans and decisions for the utilisation of MPET funding in the delivery of wider workforce initiatives, including:

- paramedic pre-registration training
- end-of-life care.

In particular, this section should provide assurance from SHAs on the following areas:

- The SHA plan for development of the wider workforce has been updated and a report on progress published by 30 June 2009, including:
  - a review of investment through the JIF
  - progress on implementing the skills pledge in the SHA area.
- Joint plans are in place with ambulance services for the transition of paramedic pre-registration education to higher education, with supporting funding.
- Plans are in place by 30 June 2009 to ensure that appropriate education and training relating to end-of-life care are available, taking account of the needs of staff working in hospitals, the community, care homes, hospices and any other setting where people may die.
- Staff survey results on staff receiving job-relevant training and development show a year-on-year increase.

Additionally, SHAs should provide in this section details of how they plan to meet, or contribute to meeting, the following KPI:

“SHAs will support implementation of the Government aim of 5,000 additional apprenticeship starts in 2009/10.”

2009/10 MPET SLA – Key Performance Indicator 4.1
Section 7 – Nationally hosted activities

This section of the SHA investment plan should detail the key investment plans and decisions for the utilisation of national hosted activity budgets held within SHAs.

In particular, SHAs should provide in this section details of how they plan to meet the following KPI:

“SHAs provide assurances and accountability to other SHAs and DH for the use of allocated nationally hosted budgets.”

2009/10 MPET SLA – Key Performance Indicator 5.1
1. **Clarity of role:** SHAs must explicitly recognise the role and importance of these functions. It must be clear how the functions fit into the SHA structure and that their primary function is to help deliver successful workforce planning for the region.

2. **Flexibility:** The regional professional advisory function should be established to suit local need while remaining coherent with the national workforce planning system. SHAs should decide how the functions work with SHA education and training commissioners.

3. **Link to national professional advisory boards and Centre for Workforce Intelligence:** The regional professional advisory function must ensure that effective links with national boards and the Centre for Workforce Intelligence are developed. There must be a reflection of the national boards’ work programme and key themes and actions in the regional boards’ work programme and vice versa. The process for ensuring these common key elements should be agreed by national boards and regional functions from the outset.

4. **Review of SHA plans:** The regional professional advisory function should provide an interprofessional, service-based review of SHA workforce and education and training plans.

5. **Impact on education and training:** The regional professional advisory function should consider how local workforce plans and developments, such as modernising career programmes, feed through to education and training issues. The functions, or SHA commissioners, will need to link with the higher and further education sectors.

6. **Respected membership:** Regional professional advisory members should be sufficiently experienced and well respected for their advice to be considered representative of local employers and clinical professionals, and have the vision to deliver the broader Next Stage Review agenda.

7. **Clinical pathways based:** The regional professional advisory function should ensure that their advice is based upon patients’ clinical pathways.
8. **Interprofessional:** The regional professional advisory function should ensure that advice considers different staff groups together, not in isolation. The functions should consider all levels of clinical staff.

9. **Timescales:** The regional professional advisory functions should be able to contribute to the workforce planning cycle.

10. **Involvement of social partnership forums:** The regional social partnership forums should be involved in the design of the regional professional advisory functions.
2.1 Procurement/Contracting

Education market management

Introduction

In order to ensure that commissions can be placed with high quality education providers Strategic Health Authorities (SHAs) must manage the education market.

The healthcare education market in the different SHA areas varies significantly in terms of both size and nature. For this reason, different SHAs will approach management of the education market in different ways.

However, all SHAs should follow the principles of good market management practice outlined below (adapted from *Principles and Rules for Cooperation and Competition*, DH, 2007):

- Commissioners should commission education services from the providers who are best placed to meet the needs of employers, employees and future employees seeking to deliver high quality NHS care.
- Commissioning and procurement should be transparent and non-discriminatory.
- Payment regimes must be transparent and fair.
- Financial intervention in the system must be transparent and fair.
- Providers of NHS commissioned services, commissioners and education providers must work in partnership to ensure a sustainable, high quality workforce supply for NHS services. A set of values and principles have been agreed between the NHS and higher education (refer to Annex C).
- Commissioners and education providers should facilitate choice for employers and students by ensuring access to accurate and reliable information about the education services on offer and by supporting contestability.
- Commissioners should ensure that education providers’ promotional and marketing activity is consistent with employers’ and students’ best interests and the brand and reputation of the NHS.
- Education providers must not discriminate against employers or students and must promote equality.
- Joint ventures must be in students’, employers’ and taxpayers’ best interests and there should remain sufficient choice and competition to ensure high quality standards and value for money.
2.2 Procurement/Contracting

The healthcare education market

Supply and demand is one of the fundamental concepts of economics and is the backbone of a market economy. ‘Demand’ refers to how much (quantity) of a product or service is desired by buyers. ‘Supply’ represents how much the market can offer. The relationship between demand and supply underlies the forces behind the allocation of resources in a market.

Markets consist of a supply side and a demand side. The healthcare education market could be described as a quasi-market, as the commissioners purchasing the education are not the end users. However, for the purposes of this guidance the healthcare education market will be referred to on the basis that the nature of the demand side is understood.

High-level overview of the healthcare education market

Supply side

The supply side consists of higher education institutions (HEIs), further education (FE) colleges, other training providers, providers of NHS commissioned services delivering education services, newly established Health Innovation and Education Clusters (HIECs) and Academic Health Science Centres (AHSCs), individual subject matter experts, specialist postgraduate medical schools and medical schools.

Demand side – end users and commissioners

The demand side consists of SHAs, Higher Education Funding Council for England (HEFCE) acute trusts, foundation trusts, primary care trust (PCT) commissioning arms, PCT provider arms, social enterprises, local authorities, schools, the social care sector, independent healthcare providers, voluntary organisations providing health and social care, non-governmental organisations providing health and social care, students, patients and members of the public interested in health and social care.

The healthcare education market can be considered as comprising five major sectors, each of which can be further segmented into professions, occupations, levels of education and specialties, including placements. The five sectors are:

1. pre-registration non-medical education – nursing, midwifery, allied health professions (AHPs) and dental care professions funded via the Department of Health (DH) Multi-Professional Education and Training
(MPET) levy; healthcare science (HCS), paramedics and pharmacy funded via HEFCE

2. post-registration non-medical education – funded via MPET

3. lifelong learning – funded via MPET, the Learning and Skills Council (LSC) and providers of NHS commissioned services

4. undergraduate medical/dental education – funded via HEFCE with placement funding coming via MPET

5. postgraduate medical/dental education – funded via MPET.

Where funding stems from HEFCE the NHS has less direct control to manage and stimulate the market. However, some influence over the market can still be exerted via HEFCE and the professional bodies. The nature of the market varies significantly across the sectors as follows.

1. Pre-registration non-medical education

Nursing, midwifery and allied health professions

Supply side

Programmes in this section of the market are largely provided by long-term higher education partners. Some new providers have entered the market over the past ten years, although this has been limited. Where new providers have entered the market they have commonly used experience in related professional areas to evolve their portfolio to include new professions. For example, the University of Hertfordshire has been a provider of nursing and midwifery, paramedical, physiotherapy and radiography programmes for many years and in 2006 added dietetics to its portfolio. Canterbury Christ Church University has traditionally been a provider of nursing and midwifery, occupational therapy, diagnostic radiography, operating department practice and clinical psychology programmes, and in 2007 added a postgraduate diploma in speech and language therapy working in collaboration with the University of Greenwich.

Demand side

In March 2001, a report by the National Audit Office, Educating and Training the Future Health Professional Workforce for England, found that there were wide variations in the prices paid by the NHS in England for the education and training of nursing and allied health professional students, even when the qualifications were the same.
The MPET Benchmarking and Attrition Review Group was established following this report, with terms of reference that included the development of a standard benchmark pricing formula for NHS-funded non-medical pre-registration courses. Benchmark prices (BMPs) offer HEIs more stability and enable commissioners to focus on quality and innovation. Commissioners allocate business to well-performing organisations locally and potential students select from the available pool. For some professions there is little or no choice within a geographical area; consequently it is important to ensure that contract performance is rigorously monitored and the market stimulated. In future HIECs may be able to offer pre-registration education programmes. The first wave of successful HIECs will be announced in December 2009. HIECs will be partnerships between NHS organisations, the higher education sector, industry and other public and private sector organisations. Their purpose is to support high quality patient care by:

- facilitating the transfer of research and innovation from academic organisations and industry into healthcare practice
- strengthening the co-ordination of education and training to give greater continuity between undergraduate and postgraduate education and greater local responsiveness.

**Dental care professions**

**Supply side**

Dental care professions are commissioned from dental schools using MPET. This is a fairly specialist area and in most regions there is just one provider. It is therefore important to implement rigorous contract performance management in order to ensure maximum value for money. These professions do not currently have a BMP.

**Demand side**

Commissions are based on service provider workforce plans.

**Healthcare science (HCS)**

**Supply side**

HCS education and training are funded jointly by SHAs (using the MPET levy), HEFCE and employers. HEFCE-funded HCS training supplies recruits for the whole HCS workforce, not just the NHS. The commissioning arrangements in
individual SHAs are largely historical and differ from region to region.

Demand side
The SHAs’ commissioning is based on service provider workforce plans.

Future developments
The Modernising Scientific Careers programme aims to overcome the current challenges in planning and commissioning education for the HCS workforce by providing new, flexible training models, which will provide equity of access to training, career pathways and funding.

Paramedics
Supply side
Historically paramedic pre-registration training has been delivered in-house, using the Institute of Health and Care Development (IHCD) programme. Some HEIs have also provided Foundation Degree (FD) and BSc programmes in paramedic science. Paramedic pre-registration education and training are moving into higher education with the result that there is currently a mixed economy, including:

- in-house programmes (there will be no new registrations for the IHCD programme after March 2011)
- HEFCE-funded FDs and BScs
- MPET-funded FDs and BScs commissioned by SHAs.

Demand side
SHA commissions are based on ambulance service workforce plans.

Pharmacy
Supply side
Undergraduate pharmacy training is funded by HEFCE, and as a result there can be any number of schools, subject to student demand. Only a small proportion of this demand relates to the NHS workforce, the remainder relating to industry and the private sector.

Demand side
Training schools must have approval from the Royal Pharmaceutical Society and commissioners can influence the market indirectly by working with the Society.
2. Post-registration non-medical education

Supply side
This section of the market involves a broader range of providers. Established university partners provide programmes that are validated by the professional regulatory bodies, but a variety of courses may be provided by a range of universities, colleges, other education providers and individual or organisational subject matter experts, e.g. professionals or trusts/other service providers acting as education providers. In future AHSCs and HIECs will also have a role to play. AHSCs bring together healthcare, teaching and research to improve the quality of life of patients and local populations by taking research findings and translating them into healthcare practice.

Demand side
In this sector, commissioners may negotiate contracts with universities or other education providers for programmes and courses for which there is a high volume of demand. In some geographical areas, this may leave employers and students with little choice; however, in other areas there may be more providers, and commissioners may proceed through open tender. For more specialist education, employers or staff themselves may procure directly from education providers. All those involved in procurement should use robust market intelligence (see page 46) when making choices about providers.

3. Lifelong learning

Supply side
Training and education in this sector are provided via formal academic learning in FE colleges, study days run by FE and other education organisations, or apprenticeships; or as work-based learning which may or may not be accredited, for example as a National Vocational Qualification (NVQ) or Open College Network award.

Demand side
This training and education tends to be procured directly by employers and again robust and accessible information to inform choice is important.
4. Undergraduate medical/dental education

The NHS does not commission undergraduate medical and dental education; consequently NHS commissioners cannot directly influence this sector of the market. However, SHAs can lobby the Joint Investment Group that makes decisions about medical/dental education funding where there are concerns related to workforce need or the quality of medical/dental education.

5. Postgraduate medical/dental education

Supply side

SHAs must draw a clear distinction between the functions of commissioning and provision, and describe how the separation will be effected at a local level. The provider function will be achieved through a separate organisation, e.g. a HIEC where one exists.

Demand side

SHAs will have responsibility for commissioning postgraduate medical and dental education on the basis of medical workforce plans from providers of NHS commissioned services and information from the Centre for Workforce Intelligence, tested nationally by Medical Education England (MEE) and locally by professional advisory functions.

While recognising many examples of existing good practice, an England-wide focus on the commissioning function is intended to:

- continuously ensure that the quality of provision of postgraduate medical and dental education and training (PGMDET) is consistently high
- drive up quality and innovation in PGMDET through improved clarity of commissioning objectives by:
  - aligning quality management of PGMDET with commissioning
  - encouraging plurality of provision (enhancing contestability)
  - introducing the scope to reject poorer provision (via enhanced quality management processes)
- ensure the separation of provision from quality control and commissioning
- deliver best and, by implication, better value for money within a secure legal framework for provision
• ensure equality of access
• enhance the confidence of local employers in educational and financial processes by establishing explicit commissioning and contracting arrangements and performance management indicators
• ensure the doctors trained are fit for purpose as NHS employees, i.e. education and training are appropriate to meet future workforce, patient, population and service requirements to deliver high quality patient care.

Different models will operate in different SHA areas.
2.3 Procurement/Contracting
Good practice in healthcare education market management

Market management can be viewed as having three different but not mutually exclusive elements:

1. Contractual partnership working
2. facilitating contestability
3. facilitating competition.

1. Contractual partnership working

Contractual partnership working is key to managing the healthcare education market. All contractual relationships are partnerships where the contract clearly sets out the expectations of the partnership, including processes for dispute resolution, so making the partnership more robust. Given an ongoing workforce need for the product, well-performing organisations can expect significant stability. Contractual partnerships only break down where the expectations of either or both parties are unmet or where, in terms of demand, there is no ongoing need for the partnership.

In order to support a healthy education market in the context of contractual partnership working, the demand side and the supply side need to ask some key questions (see Table 4) and all parties need to discuss the answers and develop a plan for the contract going forward.
### Table 4: Supply- and demand-side market questions

<table>
<thead>
<tr>
<th>Supply-side questions</th>
<th>Demand-side questions – providers of NHS commissioned services</th>
<th>Demand-side questions – commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has our performance over the last year met the standards set out in the contract? Are there any factors that might affect our ability to meet the standards in future?</td>
<td>Has the workforce delivered by the education provider been successful in meeting our recruitment and selection standards and workforce needs?</td>
<td>What was the red, amber, green (RAG) rating of the provider for all relevant programmes and how did performance compare with other providers? Are we satisfied with the provider’s performance action plan?</td>
</tr>
<tr>
<td>What are the evolving workforce and education needs of healthcare service providers and does this indicate an ongoing need for the product? Is there alignment between evolving workforce and education needs and the strategic objectives of our organisation?</td>
<td>What does our workforce planning tell us about our future needs in relation to the outputs of the contract?</td>
<td>What do collated workforce and training plans tell us about the region’s future needs in relation to the output of the contract? How long does the contract have to run and do we need to plan a strategic review/benchmarking?</td>
</tr>
<tr>
<td>Do we have access to an adequate volume of quality placements to deliver the contract? Have we met our obligations to placement providers?</td>
<td>Are we satisfied that the education provider has met their obligations in relation to placement learning and did we meet our obligations as a placement provider?</td>
<td>Does the HEI have access to adequate placement and academic learning capacity to support proposed future commissions?</td>
</tr>
<tr>
<td></td>
<td>Does the volume of placements we offer tally with our current and future workforce need for the product?</td>
<td>Are we assured that money has followed the student into the placement environment in line with the national rates?</td>
</tr>
<tr>
<td>Could the staff and resources in our organisation be used differently if educational needs changed?</td>
<td>Do we have new workforce and education needs that could be met in future by the provider?</td>
<td>Do collated regional workforce and training plans indicate a need for new services that could potentially be offered by this provider?</td>
</tr>
</tbody>
</table>
The National Standard Framework Contract for non-medical, pre-registration education

In England, most nursing, midwifery and AHP pre-registration education is covered by the National Standard Framework Contract (NSFC). It is DH policy that SHAs should use the NSFC for these areas of the education market.

The NSFC was reviewed in the spring/summer of 2009 to support quality enhancement, and the following is a summary of the changes:

- addition of a clause linking payment with performance
- update to Schedule 3 ‘Contract Performance Management’ (formerly Quality Assurance) to link with core national contract performance indicators (CPIs), and a contract performance management system (see page 107)
- development of a new optional model partnership agreement between HEIs and their placement providers for use at Schedule 2. SHAs may use either the new model partnership agreement or the original partnership agreement, or ask HEIs to work with placement providers locally to develop a regional version. The model partnership agreement includes the following additions:
  - placement provider responsibilities as described in the core minimum placement provider indicators shown in Annex D (these should also be referenced in learning and development agreements (LDAs) between SHAs and organisations in receipt of MPET funding)
  - HEI responsibilities in relation to placements as described in the placement development and support section of this guidance
  - a robust dispute resolution clause
  - a requirement for the agreement to be formally signed
  - a requirement for the agreement to be formally monitored as outlined in performance indicator P1 on page 116 and action plans developed and implemented to address any weaknesses
  - a requirement for the HEI to inform the SHA of the findings of placement audits.

Given the large number of placements we suggest that there should be a generic agreement signed once by all placement providers linked with any of the local HEI contracts. In other words, each placement
provider’s signature will cover that organisation’s responsibilities in relation to all the HEIs they work with and all the professions for which they provide placements. Other arrangements are permissible where these are practical locally. We also suggest that signatures could be obtained gradually as placements are audited in the routine cycle although, again, other approaches are permissible where SHAs judge that a different approach is required to support value for money and quality enhancement.

2. Facilitating contestability

Contestability is about creating the conditions required to allow new providers to enter the market. Contestability can prevent stagnation by providing a challenge to the existing market. During 2009/10, £20 million of government funding will be made available to support SHAs to set up regional commercial support units (CSUs). These units are intended to provide commercial support to commissioners and providers to stimulate the market and manage contracts effectively. The ultimate aim of the work of these units is to ensure an appropriate balance between co-operation and competition. Regional CSUs could be an important resource for education commissioners seeking to develop appropriate contestability and it is recommended that SHA workforce and education teams make contact with their SHA CSU lead in order to discuss the possibilities.

In relation to non-medical pre-registration education where there is a BMP, contestability relates to quality and not price. However, where there is no BMP, e.g. for Foundation Degrees and continuing professional development (CPD), contestability links with both price and quality. When a well-performing contract of this type expires, commissioners could use a local benchmarking process to test price and quality. This would involve comparing data supplied against the performance indicators in the contract with data from potential competitors in order to test value for money. Where the exercise indicates that a better price is available for the same or better quality provision, this could be used either as a tool in negotiation with the provider or as a trigger for a competitive tendering exercise.

Contestability alone cannot drive up quality, particularly where demand is high. High demand increases the need for performance management on the part of the commissioner.
In order to facilitate contestability, commissioners need to be proactive in seeking the involvement of a broad range of education providers. Open days relating to educational needs emerging from workforce planning can provide an opportunity for potential providers to meet commissioners and end customers, and to explore the services required in more detail. Attracting potential providers to such events would involve advertising for interested parties in appropriate journals such as *Times Higher Education*, *Nursing Times* and other professional journals, and developing a section of the SHA website for evolving education requirements and professional networking.

It is also helpful to offer potential providers information about standard contracts used by commissioners locally and the performance indicators within those contracts, as well as information about the local health economy.

Providers may also benefit from support such as workshops, outside of any specific tender activity, to help them submit high quality responses to any future invitations to tender. Regional CSUs have a remit to support providers as well as commissioners, and SHA workforce and education leads could discuss with SHA CSU leads the possibility of regional CSUs providing workshops of this type.

Having made contact with potential new providers, it is important to start collecting market intelligence (see Market intelligence, page 46).

When looking to introduce new providers to the market it is important that commissioners consider the potential impact on the placement market, both within and outside the SHA region. New entrants to the market should be able to identify a placement pool that does not destabilise placement capacity for current well-performing providers.

Where there is little or no choice of providers available locally, SHAs should consider e-learning and other distance learning options where appropriate, e.g. for some lifelong learning and CPD courses.

3. Facilitating competition

Competition is often linked to the notion of compulsory competitive tendering; however, competition can be either ‘in the market’, i.e. education providers competing for students, or ‘for the market’, i.e. education providers competing to attract commissioners.
Competition in the market can occur in the non-medical post-registration and lifelong learning sectors where quality and price are levers. However, it is currently difficult to access reliable and comparable information about provision to support choice, and in some areas there are few providers available. One option for managing this would be for SHAs to collect and publish information on key characteristics of education services for core areas of strategic importance in a standardised way, in order to support end user choice. However the challenge with this is that courses, modules and programmes with the same title may actually be very different in terms of content, level of study and number of academic credits awarded, making comparison difficult. It is also important to note that the credit level descriptors are not standardised, although HEIs do follow guidelines.

Competition for the market may occur where an existing contract becomes non-viable or is terminated on grounds of poor quality, or where new education provision is required to meet evolving service needs. Education commissioning is exempt from the EU consolidated procurement directives (January 2006) and so it is not essential to put new contracts and those that have expired/been terminated out to tender. However, local SHA Standing Financial Instructions (SFIs) may require this.

Where there is no requirement under SHA SFIs to put a contract out to competitive tender, the decision should be driven by clear criteria, for example:

- the value of the contract
- existence of unique expertise in a current partner HEI
- fairness to all well-performing local partners
- value for money
- evidence of the fitness for purpose of qualifiers.

All public sector organisations are now required to produce an innovation procurement plan in order to drive innovation through procurement and to utilise innovative procurement mechanisms. There should be ongoing dialogue between service procurement and education procurement teams to ensure sharing of good practice.

The new Procurement, Investment and Commercial Division (PICD) of DH will have a key systems and professional leadership role, including oversight of the NHS commercial
landscape through a new National Procurement Council, which is currently in development.

Where competitive tendering is required the new regional CSUs may be able to offer practical guidance.

The NHS Purchasing and Supply Agency’s functions will be merged during 2009/10 into the Office of Government Commerce’s Buying Solutions Agency and the regional CSUs. The Buying Solutions Agency offers pre-tendered contracts with a range of suppliers under what are known as framework agreements. Public sector customers can purchase goods and services using these frameworks, enabling them to save time and resources. A small commission (averaging less than 1%) is collected from the suppliers for each sale they make under a framework. There is now a framework agreement for learning, development and e-learning, which covers a number of areas of lifelong learning including statutory and mandatory training, as follows:

- Skills for Life
- communications and marketing
- customer service
- diversity and equal opportunities
- e-learning (to be launched at a later date)
- working with ministers
- finance
- vocational training
- health and welfare
- human resources
- information and records management
- information technology
- social awareness
- languages
- legal
- management and leadership
- organisational development
- policy skills
- procurement
- programme and project management
- provision of specialist services
- security.

When putting a contract out to competitive tender it is important to provide early notice to the market and to publicise opportunities well. Employers should be involved in developing invitations to tender (ITTs) which should be unambiguous and concise. ITTs should include clear reference to shortlisting criteria and
scoring systems, and commissioners should always be prepared to offer feedback that will enable providers to improve future responses. Employers should also be involved in shortlisting and interviewing. Shortlisting criteria and interview questions could include:

- suitability of proposed timeframe for developing the education
- evidence of partnership working with an appropriate range of employers and potential students
- evidence of adequacy of academic and placement learning capacity
- extent to which the proposal answers all the specific requirements of the ITT
- value for money
- evidence of a record of accomplishment in innovation, including generation of improved ways of working, adoption of curriculum changes to embed new innovations in patient care and treatment, and dissemination of innovative practices.

Standard contract frameworks should be developed which can be tailored to include specific clauses relating to the agreed timeframes for development of the education.

Contracts should include clear performance indicators covering all elements of the student lifecycle. Sample indicators for guidance are shown in Performance Management, Table 8.

**Market intelligence**

Good market intelligence is key to market management and stimulation. Market intelligence includes exploring potential new providers and researching information on these as well as current providers.

The new DH Strategic Market Development Unit will provide leadership and support to service commissioners in relation to market analysis and market-making, and may in time be able to support the education market.

Universitiesnet (www.universitiesnet.com) provides a useful resource for exploring potential new providers, as it offers an online list of all universities and colleges in England. The website www.universities.co.uk provides a short summary of each education provider’s core business and links to the websites. Commissioners should also explore opportunities for education provision with local healthcare providers, and in particular HIECs and AHSCs.
Intelligence about current and potential new providers might include:

- financial information
- performance and quality information
- strategic plans.

Financial information
This is available from the education providers’ annual accounts. Key data to consider might include:

- auditors’ confidence in the financial management of the organisation and financial security going forward
- auditors’ confirmation that funds have been used to support the aspects of the business for which they were supplied
- proportion of income from current NHS contracts, if any.

Performance and quality information
There is a substantial amount of performance and quality information in the public domain from professional regulatory bodies, HEFCE, the National Student Survey and published league tables. Clearly, this information needs to be professionally interpreted by commissioners and consideration needs to be given to the review methodologies and the areas of performance that the different reviews focus on. The following web links may be useful:

www.nmc-uk.org/aArticle.aspx?ArticleID=1710: Nursing and Midwifery Council annual monitoring reports
www.qaa.ac.uk/reviews/reports/instIndex.asp: Quality Assurance Agency (QAA) reports
www.unistats.com: National Student Survey reports
www.hefce.ac.uk/Learning/PerfInd: HEFCE performance indicators
www.timesonline.co.uk/tol/life_and_style/education/good_university_guide: The Times league tables
www.guardian.co.uk/education/universityguide: The Guardian league tables

Strategic plans
Education providers’ strategic plans are available via the internet and give information about each organisation’s mission, vision and values.
By researching these plans commissioners will be able to map education providers’ aims and values against those of the NHS. In addition, the plans will give an insight into the organisation’s commitment to employer engagement and user involvement in course design and delivery.
Procurement/Contracting: Annex C

The NHS and higher education – a strategic partnership: vision, values and principles

Background

The work of the NHS and the higher education sector is inextricably linked: they share responsibility for teaching, research and service delivery. Higher education is integral to workforce planning and the production of a sustainable health service workforce. The NHS provides a unique environment for research that stretches across the range of disciplines that underpin healthcare, sustaining new treatments and improved patient care.

Following the NHS and higher education seminar held on 1 November 2007, it was agreed to produce an:

“ambitious vision of what the higher education sector and Strategic Health Authorities want to achieve through a collaborative, forward-looking national partnership, which complements locally shaped, regional relationships”.

Vision

That the NHS and the higher education sector work together as a strategic partnership which underpins the clear flow of communication on issues relating to the delivery of the future health workforce; the context of this delivery; challenges faced by each sector; and opportunities to be embraced.

That the NHS and the higher education sector collaborate effectively to understand the shape and characteristics of the future health workforce, including recognising the requirements in terms of quality and productivity.

Principles and values

1. The NHS and higher education have relationships currently defined by contractual obligations. We recognise the need to move beyond these obligations and to form a distinctive collaboration encompassing longer-term commitment and financial stability.

2. Recognising that the higher education sector has a key role in educating the future health workforce, the NHS at all levels should articulate its vision of the skill needs of the future health workforce. The NHS should aspire to working with the higher education sector.

*Within postgraduate medical education this should also include medical Royal Colleges, deans and deaneries; effective collaboration with regulators is a separate matter but an important aspect of the full picture of effective working relationships.
sector as a key partner in the delivery of the future health workforce.

3. The NHS is seeking to produce an integrated, multi-professional and patient-focused healthcare workforce, and the higher education sector will collaborate as necessary to support this aspiration, which will require flexibility and responsiveness.

4. SHAs and universities should seek to facilitate a strategic environment for productive research partnerships between universities and healthcare organisations in their regions, and explore new means of harnessing academia and the advantages of a research-orientated and evidence-based culture in the promotion of service quality.

5. SHAs and universities should facilitate a strategic environment to encourage knowledge transfer and knowledge exchange between the healthcare and higher education sectors, particularly in the field of the service applications of research findings.
These indicators have been designed to mirror the responsibilities of the HEI set out in the CPIs in Performance Management, Table 5. Placement provider indicators should also be included or referenced in LDAs. The model Partnership Agreement at Schedule 2 has been amended to include the placement indicators and reference to the placement-related indicators from the CPIs in Annex J.

The placement provider shall:

1. ensure that it makes senior staff available to be involved in the following as required:
   - reviewing the institution's recruitment and selection policies and criteria
   - reviewing course content and delivery
   - reviewing the Criminal Records Bureau (CRB), Independent Safeguarding Authority (ISA) and occupational health clearance processes that the institution has in place to screen students before they are admitted on a practice placement
   - reviewing contract performance returns to confirm veracity as appropriate

2. ensure that students receive an appropriate induction to all placement areas

3. ensure that it makes placement educators available annually for involvement in developing performance action plans

4. ensure that all relevant staff working in the placement area have education responsibilities included in their job descriptions and competencies defined in their job specifications. Ensure that all relevant staff employed in the placement area are either competent to support student learning and assessment or are required to commence a programme of CPD on recruitment, or on completion of any preceptorship period or equivalent, to achieve these competencies.

(Note: It is accepted that placements in very small organisations, including social enterprises and care homes, may require significant input from placement support staff employed by HEIs in order to deliver quality placements. In these circumstances, the professional staff member(s) in the placement area should still have relevant education responsibilities in their job descriptions and should have access to appropriate development. It is accepted that the education and assessment responsibilities...
of staff in these small organisations may be quite different from those of a nurse on an acute hospital ward. The metric should be interpreted flexibly by the HEI and SHA to take account of local circumstances.)

5. immediately notify the institution of any serious untoward incidents where the involvement of a student calls into question their fitness for training

6. accept as valid the CRB and occupational health checks carried out by the institution in accordance with mutually agreed criteria

7. immediately notify the institution of any service provision changes that might affect the students’ ability to meet the specified learning outcomes set by the institution

8. ensure that students receive feedback on their performance in a timeframe appropriate to the activity performed as agreed between the Institution and placement provider

9. ensure that student assessment is appropriately moderated as agreed between the institution and the placement provider

10. collect and collate feedback from all students and regularly agree action plans with the institution to address the issues raised.
3.1 Education delivery

Supporting and incentivising placements

Placement capacity and quality

Placements are important to education across all sectors of the healthcare education market. There are three key issues that may impact on placement capacity and quality over the next few years:

1. The Multi-Professional Education and Training (MPET) funding review is aiming to ensure that funding to support placement learning follows the student and this will replace historical arrangements.

2. Patient treatment and care will increasingly be provided closer to home as opposed to the hospital environment and this means that placement learning will need to shift from the acute setting out into the community.

3. Placements will increasingly take place in a greater plurality of providers from social enterprises to independent and voluntary sector organisations.

These changes present some benefits in relation to placement learning but also come with associated challenges that must be overcome in order to maximise the pool of quality placement learning opportunities.

1. MPET Funding Review

The Department of Health is developing proposals for a set of placement rates so that money will follow the students into the placement environment wherever that might be eg community hospitals, social enterprises, independent sector organisations, voluntary organisations, Foundation Trusts, schools, social services, Mental Health Trusts etc.

Subject to approval by the NHS Operations Board, placement rates would apply to all professional groups ie medical students, nurses, midwives and AHPs etc. This means that many organisations that previously received no funding at all for placement learning because they did not take medical students would get funding in line with the volume of placements support offered.

Challenges

- Because Service Increment for Teaching (SIFT) facilities funding will be subsumed into the new placement national rates, some NHS Trusts may have a reduced overall funding envelope for placements.
Some organisations may find that their placement funding fluctuates from year to year in line with the volume of students supported. This will make investment in initiatives to support student learning and assessment more challenging. Furthermore, smaller organisations may find that it is difficult to make use of the national rates to support student learning without the economies of scale enjoyed by larger organisations.

While there have not been any national placement rates for non-medical placements until now, Strategic Health Authorities (SHAs) have provided funding to some Trusts and this has largely been used to fund placement facilitators. Some higher education institutions (HEIs) have provided additional funding and supported joint posts. In future, employment models for placement facilitators will need to take account of shifts in placement volumes between organisations.

Developing a set of placement rates is complicated, so we are proceeding with extreme caution. The intention is to operate the placement rates in shadow form from April 2010. This will allow further refinement as we move forward through the next financial year.

2. Patient treatment and care will be provided closer to patients’ homes

The NHS Next Stage Review reinforced the messages in Our Health, Our Care, Our Say about the need to move services closer to, and in some cases into, people’s homes. Acute hospitals will focus on surgery, acute events and specialist care, while planned care and initiatives to support people of all ages to stay healthy and manage long-term conditions will become more community based. This will allow greater flexibility in sourcing suitable placement environments as a more diverse spectrum of organisations become involved in delivering NHS services.

Challenges

- Very small organisations may lack the staff to support both patient care and student learning, and arrangements will need to ensure that they can contribute to the placement pool. In addition, small independent and voluntary providers may have concerns about the adequacy of their insurance arrangements. HEIs will need to develop relationships with a wider range of organisations, most, and eventually all, of which will be outside direct SHA control, reducing SHA leverage.
• Service delivery changes will mean that staff already working in the community will need to engage in significant continuing professional development (CPD) to ensure that they have the full range of competencies required to function effectively in the context of new ways of working. Strategies will be needed to ensure that adequate numbers of staff remain able to support pre-registration students’ learning and assessment.

• There may be significant lead in times for new placement areas to come on-stream once they have been identified. Staff who are to be involved in supporting student learning and assessment will need to develop an understanding of the learning outcomes and assessment tools, and placement environments will need to be audited and approved.

• New placement providers will need to ensure that facilities are configured appropriately to support student learning and assessment. For example, surgeries, treatment bays and diagnostic areas will need to be large enough to support student observation as well as supervision and assessment.

• Service delivery changes will also mean that students will need to be placed in lower volumes with greater geographical spread and this will have practical implications for HEIs conducting placement quality audits and providing tutor support. In addition, students will need to cope with additional travel and possibly accommodation costs.

3. Placements will take place in a greater plurality of providers

System levers support placement capacity and quality, for example the placement national rates, links between workforce planning and commissioning planning, the SHA contract with the HEIs, and learning and development agreements (LDAs) between service providers in receipt of MPET funds and the SHAs.

Challenges

Smaller organisations with negligible requirements for new staff may consider that the national rates are not adequate compensation for the challenges associated with offering placements, such as the potential need to enhance insurance arrangements, re-configuring office, treatment and diagnostic space, releasing staff for development to ensure they can support students appropriately and managing challenging student behaviours.
Managing the challenges

Looking across the challenges associated with each, we can broadly divide them into six topic areas as follows:

1. funding
2. sourcing and geographical spread
3. staffing
4. insurance and indemnity
5. buildings and capital investment
6. leverage.

1. Funding

Subject to approval from the NHS Operations Board, DH intends to issue shadow placement rates for the different professional groups, which will operate in shadow form from April 2010 to March 2011. This will allow us to test the placement rates fully before making any decision to redistribute funding.

Once agreement is reached on when to implement the placement rates, the NHS Operations Board will also agree the model for transition and the degree to which SHAs may be given some additional flexibility for handling local circumstances.

LDAs between SHAs and providers of NHS commissioned services in receipt of MPET funding should drive strong educational governance, including cross-professional executive-level responsibility for education funding and delivery. LDAs should include or link to the non-medical placement performance indicators and any other indicators developed at a later date. Use of these indicators will enable SHAs to publish placement red, amber, green (RAG) ratings derived from review of performance against these indicators. Combining all the placement indicators with the CPD indicators, which are expected to be available sometime in 2010, will allow SHAs to publish RAG ratings indicating the learning and development performance of service providers in receipt of MPET funding. LDAs could also be used as a vehicle for linking allocation of CPD and Joint Investment Framework (JIF) funding to these RAG ratings.

Employment models for MPET funded placement support roles

Historically SHAs have allocated funds to some organisations, most often acute and foundation trusts, to support placement learning. These funds are most frequently used to employ additional staff. These staff have various titles...
e.g. placement facilitators, placement managers, education advisors, etc. The post-holders also have varying responsibilities from the purely administrative to a mixture of administration, practice, education, leadership and quality audit. Some post-holders are employed by HEIs on HEI pay scales but many are employed by providers of NHS commissioned services at anything from Agenda for Change band 5 to band 8b.

Given that we can expect placement education to shift out of the acute environment into a variety of community settings, placement support staff will need to have the flexibility to move to where the demand and the funding are, and employment models that tie these staff to providing services in just one organisation will not be suitable.

Where staff are co-funded by HEIs they will be able to deliver services in a variety of health and social care settings as required. Where this is not the case, placement support staff could be employed by a host provider of NHS commissioned services holding a service level agreement (SLA) with other local service providers or by an independent agency. A consortium of HEIs offering AHP programmes in London is currently conducting a scoping exercise, funded by NHS London, looking at the feasibility of an interprofessional placement agency. Agencies of this type could employ placement support staff who would work in a variety of settings.

*Managing economies of scale*

Where a diverse range of providers supports placements, as we would expect with the planned service delivery changes, many organisations will support a small but important volume of placements. These organisations may face challenges in making use of funding from the placement national rates owing to problems with economies of scale. Pooling funding with other organisations in the health economy may facilitate more innovative use of the funding.

2. **Sourcing and geographical spread**

The movement of services and hence placements into a more diverse range of providers will require HEIs to develop relationships with a wider range of health and social care delivery organisations and to develop innovative approaches to partnership working. There will also be a need for professionals to assess the suitability of new placement environments and for information sharing to build professional confidence in the quality
of learning and assessment in non-traditional settings. A project funded by DH from the North Western Deanery explored these issues and the report *Training in Alternate Learning Environments: Opportunities, Challenges and Strategies* (2008, available from Dr Mohan Kumar, North Western Deanery) includes some useful case studies.

Some practice learning and assessment can also take place in simulation centres and this can provide a number of benefits in relation to both placement capacity and quality. For example, NHS North West has invested in the upgrade of clinical skills facilities in HEIs, aimed at fundamentally managing placement capacity for diagnostic radiography students. The provision of parallel facilities across HEIs also paves the way for a single model of clinical supervision and assessment. More broadly, the North West Simulation Strategy is focused on realising increased accessibility for healthcare learners at all levels, ensuring maximum efficiency through co-ordinated use of resources across a very large and disparate geographical area.

The University of Plymouth has for many years worked with the Casualty Union to simulate scenarios that will both challenge and formally assess learner responses to real-life situations. Students benefit from engagement with service users and the service environment from a very early stage in their courses, giving them an authentic insight into work life.

HEI helplines can provide an important link point with the HEI for practice educators and students who are spread across a wide geographical area. For example, the University of the West of England runs a phone and e-mail support service staffed from 09.30 to 17.00, Monday to Friday. The administrative staff on the helpdesk allocate cases to university employees who are known as ‘Academics in Practice’. These staff are based in the practice setting for at least 50% of their contracted hours.

HEIs may benefit from working in partnership with each other to support the development and maintenance of these relationships. There are already a number of examples of good practice in this area. For example:

- King’s College London and London Metropolitan University, which both provide pre-registration dietetic programmes in London, have been working in partnership to source, quality assure, approve and support placements. A shared database of
placements has been developed, hosted by King’s College. Both HEIs share the same set of placement learning outcomes, and student and practice educator post-placement feedback mechanisms have also been developed in partnership. A placement manager based in King’s College actively seeks potential new placements and the HEIs work in partnership to support new placements and to carry out approval and quality monitoring audits.

- In the south of England physiotherapy providers have worked in partnership using funding from four local SHAs to develop the Physiotherapy Placement Management System (PPIMS). This database facilitates allocation of placements and maximum utilisation of placements across SHA boundaries.

- In Yorkshire and the Humber the SHA has invested in a region-wide web-based placements evaluation, profiling and audit tool. This has been developed to share placement information and support the quality assurance and approval process across HEIs, disciplines and provider organisations. Allocation of placements and identification of interprofessional learning opportunities across the region can also be supported. Students can also access information about their future placements.

3. Staffing

**Small organisations**

In the future, many of the organisations providing NHS commissioned services will be small organisations with limited staff, e.g. care homes and social enterprises. Staff in these organisations may struggle to balance their responsibilities in relation to patient care and treatment with their responsibilities for supporting student learning and assessment. Under these circumstances, additional input from professional education support staff with a remit to work across placement provider organisations as required could help. An HEI, a regional Placement Agency or a host provider of NHS commissioned services holding an SLA with other local providers of NHS commissioned services could employ these staff. These arrangements would benefit from significant partnership working across HEIs to develop standard assessment documentation and other policies and procedures.

Yorkshire and the Humber SHA has invested in region-wide common assessment tools
for midwifery, radiography, nursing, dietetics and physiotherapy. Further developments are taking place through the Centre for Excellence in Teaching and Learning (CETL)-funded Assessment for Learning in Practice Settings (ALPS) project to develop common assessment ‘tools and processes’ across disciplines: [www.alps-cetl.ac.uk](http://www.alps-cetl.ac.uk).

**Staff undertaking CPD for advanced practice roles**

Service delivery reforms will require NHS staff to work in new ways and take on new responsibilities. These staff will need to undertake CPD to develop the competencies required for their new or enhanced roles. Engagement with CPD takes time and it will be difficult for staff undertaking CPD to support the learning and assessment of more junior staff at the same time. Organisations should plan staff CPD in a staggered way to ensure that adequate support remains available for pre-registration students and that innovative educational models for CPD are used to minimise the time staff spend off site in relation to their development. Organisations putting a significant proportion of their potential placement educator pool through CPD for advanced practice are considering using a proportion of national rates funds to pay for backfill.

Staff employed as backfill can only function effectively in the support of student learning and assessment if they have had access to placement education development opportunities. For this reason, HEIs should make training and development resources available to agency and bank staff as well as permanent staff. Once again, standardised assessment documentation across HEIs would support the use of agency and bank staff for student learning and assessment.

As an incentive, HEIs could consider making a broad range of CPD available at reduced cost to service staff involved with their students.

**The role of interprofessional learning**

Interprofessional learning (IPL) occurs where two or more professions learn from and about each other to improve collaboration and the quality of care (Centre for the Advancement of Interprofessional Education (CAIPE)). While interprofessional learning presents some organisational challenges it also offers students the opportunity to gain deeper insights into the roles of other professions in order to prepare themselves for effective joint
working in practice. Registered professionals seeking to support pre-registration students can pool resources and share responsibility for facilitating learning and assessment and this can open up new practice learning environments. Many learning outcomes still need to be addressed with a uniprofessional focus but a range of knowledge, skills and attitudes in practice can be explored and tested interprofessionally. For example, the North West Clinical Placement Strategy has seen the introduction of a comprehensive and dedicated resource, targeting both placement quality and interprofessional learning through Practice Education Facilitators (PEFs), and capacity and breadth through Placement Development Managers.

Using problem-based learning to tackle scenarios based on clinical pathways, PEFs act as organisational champions of IPL, facilitating and leading structured sessions across groups of students in practice.

Similarly at postgraduate level, NHS North West and North Western Deanery are looking to develop a service improvement model using IPL to support existing clinical teams to work together on areas for development. It is hoped that this will help make the service improvement work a meaningful learning experience across professional groups.

The University of Plymouth teaches the theoretical component of the first year of all its undergraduate programmes interprofessionally. Podiatry, physiotherapy, occupational therapy, dietetics, midwifery and nursing students then go into the same placement settings where they are overseen by a team of placement-based academics from all professions. These teams are led by an academic (0.5 whole-time equivalent in each trust) and a clinician. All professionally qualified university academics are required to be a member of a team to ensure a range of interprofessional support is available for the students and for the qualified staff supporting them in practice. Three universities, Plymouth (professions as listed above), Exeter (radiography) and University College St Mark and St John (speech and language therapy) support these teams, ensuring involvement from a range of professions.

**The role of peer assisted learning**

Peer assisted learning (PAL) has attracted international attention in a range of healthcare professions, both as a means of improving the
student learning experience and in terms of its potential for increasing the availability of clinical placements by placing several students under the supervision of one qualified practitioner. There are obvious risks associated with this approach which need to be rigorously managed but there are published reports of the benefits and these are explored in a useful literature review (Julie Baldry-Currens, The 2:1 clinical placement model: review, *Physiotherapy* 2003; 89(9):540–55).

Students on early observational placements can use PAL to reduce their dependence on qualified practitioners by discussing observations with each other, highlighting questions and investigating the answers as a team. The shared view of the group can be discussed with the supervisor for validation and correction where necessary.

Using PAL, experienced students can work together on a caseload delegated by a qualified practitioner. The qualified practitioner still needs to take the time to assess each patient in order to feel confident delegating elements of treatment; however, reviewing cases before and after any intervention with a group of students together saves time and allows more in-depth reflection on the practice experience. Sharing a caseload gives students access to a wider variety of experience.

### 4. Insurance and indemnity

Insurance cover held by providers of NHS commissioned services varies. Furthermore, HEIs may use organisations that are not providers of NHS commissioned services to supply placements, e.g. independent or voluntary sector organisations that do not have NHS service contracts, educational and social care organisations. Smaller organisations may not have the same level of insurance cover as large NHS/foundation trusts. It is therefore important to understand what insurance cover placement providers have and to take action to support potential placement providers blocked from entry to the market by difficulties associated with enhancing their insurance arrangements.

Insurance cover is needed for:

- injuries to students
- non-clinical (i.e. non practice related) harm to the public or property
- clinical (i.e. practice related) negligence.
Injuries to students

As a result of the Health and Safety (Training for Employment) Regulations 1990 the placement provider is responsible for the health and safety of the student while on placement as if the student were their employee. Most employers are required to hold Employers’ Liability (EL) insurance and there is an agreement in the UK insurance industry that people on work experience will be regarded as employees in respect of insurance by all UK insurers and hence they will be covered by EL policies. (See Health and Safety Executive: Employer’s Liability (Compulsory Insurance) Act 1969, A Guide for Employers.) Certain health service bodies and NHS trusts are exempt from the requirement to have EL insurance but most choose to have it. (See Employer’s Liability (Compulsory Insurance) Regulations 1998.) HEIs should check that placement providers and potential placement providers have EL insurance and that the policy wording is appropriate.

Harm to the public or property

Under the Health and Safety at Work etc. Act 1974 there is a general duty on students to take reasonable care for their personal health and safety and for that of others who may be affected by their acts or omissions. There is also a duty on students not to intentionally or recklessly interfere with or misuse anything provided by the organisation where they are working. If a student fails to comply with these duties they could be held personally liable. Students might be covered in relation to professional negligence via their student membership of professional associations where this is applicable.

Clinical negligence

There is a duty on placement providers to ensure that staff and students are only asked to do tasks that they have the competence to do and to ensure that staff and students are appropriately trained and supervised. Public Liability insurance may indemnify organisations should the organisation fail to comply with these duties. In addition the Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies. All NHS trusts (including foundation trusts) and primary care trusts (PCTs) in England currently belong to the scheme. Independent sector treatment centres are also part of the scheme but it has not yet been extended to other providers of NHS commissioned services such...
as care homes, social enterprises and voluntary sector organisations. Under the Health and Social Care Bill 2007 there was a Statement of Intent to extend the NHS Indemnity Scheme to “any body providing NHS services”. The National Standard Framework Contract between SHAs and HEIs states that placement providers should indemnify the HEI and the SHA against any claims made as the result of acts or omissions by students. Historically this has made some smaller providers of NHS commissioned services reluctant to offer placements because of the associated risk and the cost of extending their insurance cover. Extension of the CNST to all providers of NHS commissioned services would support sourcing of placements from the full range of providers of NHS commissioned services and so support placement capacity and quality.

There is also a duty on HEIs to ensure that students are properly prepared for placement and their competence appropriately tested to confirm their fitness for placement. HEIs should ensure that placement providers understand students’ competence and that they are appropriately informed of issues that might affect their fitness for placement that would need to be monitored. Again the HEIs’ Public Liability insurance may provide indemnity should an HEI fail to comply with these duties.

Health and safety is the responsibility of all parties and should be approached in the spirit of partnership where all parties take reasonable steps to ensure students’ fitness for placement, as well as providing appropriate support and supervision.

5. Buildings and capital investment

Much of the move of NHS services from acute hospitals into the community will involve the use of existing estate. However, buildings will need to be modified to deliver new patient pathways and some new buildings will be required. Our Health, Our Care, Our Community (DH, 2006) sets out design principles for capital investment to move care closer to home. These principles do not include consideration of the suitability of buildings for education and training but SHA Workforce Directorates should work closely with their SHA Strategic Estates Advisors (SEAs) who will in turn work with PCT commissioners to influence investment decisions in relation to workforce, education and training needs. Under the NHS Operating Framework PCTs must assure themselves that providers of NHS commissioned services have fully integrated
financial and workforce implications into their business and service plans.

6. Leverage
The responsibility for ensuring adequate placement volumes and quality must be seen as a shared responsibility across providers of NHS commissioned services, i.e. any organisation with a contract to deliver NHS services, HEIs and SHAs. However, it is important to be clear about the responsibilities of the different stakeholders and these should be defined contractually.

SHA responsibilities
Once shadow prices are announced SHAs should work with providers of NHS commissioned services to agree maintenance of overall placement volumes. However, SHAs cannot be held responsible for placement support made available to specific HEIs as these are dependent on the HEI/placement provider relationship. SHAs should manage any issues highlighted through routine contract performance review (see 4.1 Performance management). When national rate payments go live SHAs should have mechanisms in place to ensure that the funding passes to placement providers as appropriate. For larger SHAs these mechanisms are likely to involve passing money via HEIs or placement agencies. SHAs are also responsible for MPET investment and commissioning planning using workforce planning information supplied by providers of NHS commissioned services. SHAs should develop three- to five-year strategic commissioning plans to give the system time to respond to any increased placement requirements associated with increased commissions. SHA responsibilities should be managed by DH using the SHA performance management system.

HEI responsibilities
HEI responsibilities are set out in the placement indicators. These include ensuring that:

- students achieve agreed standards before being released to placements
- agreed Criminal Records Bureau (CRB) and occupational health procedures are followed and NHS representatives are involved in panel decisions relating to student fitness for placement
- placement educators are fully supported to develop placement learning and assessment competencies
• placement provider concerns relating to individual students are managed in a timely and supportive manner.

SHAs hold HEIs to account for meeting these standards via their contracts.

Providers of NHS commissioned services’ responsibilities

Providers of NHS commissioned services are responsible for producing fully integrated service delivery, finance and workforce plans. Where workforce plans indicate an increased requirement for newly qualified professional staff, service providers should consider any action they need to take to increase their placement capacity in line with this.

Placement providers are responsible for meeting the placement performance indicators. RAG ratings from review against these indicators could be shared with PCT commissioners to support service commissioning decisions. Red rated placement providers should be prevented from offering placements until quality improvements can be demonstrated.
3.2 Education delivery

User involvement

Good user involvement can take many forms. The Department of Health (DH) document *Real Involvement: working with people to improve services* (2008) describes an involvement continuum and states that good involvement should be:

- something that starts early and continues throughout the process
- inclusive
- informed
- fit for purpose
- transparent
- influential, i.e. it should make a difference
- reciprocal, i.e. it should include feedback
- proportionate to the issue.

The involvement continuum

Different elements of the continuum are shown below.

**Stages of the continuum**

- giving information
- getting information
- forums for debate
- participation
- partnership.

There should be feedback loops from each part of the continuum back to the different groups of users so that they can see the impact of their input. It is important that users understand the purpose of their involvement and the scope of their influence from the outset. Users need to understand what is set in stone and what can be responsive to input.
Involvement in education commissioning, procurement, design and delivery

**Students**

Students include both people seeking to join the NHS workforce and staff currently delivering NHS services.

*The NHS Constitution* (DH, 2009) includes pledges that commit the NHS to ensuring that staff are actively engaged in decisions that affect them and that they have access to training and development opportunities to support them in their jobs.

The NHS should ensure that current and potential future staff are systematically involved in designing and delivering healthcare education. This will become increasingly important as service delivery models change, with more care moving closer to patients’ homes, and as professional career pathways are implemented.

There should be support for staff and future staff in making choices about their education.

**Employers**

Providers of NHS commissioned services and higher education providers need to maintain and enhance partnership working at national and local levels. In addition national and local work should be systematically linked.

**Patients and carers**

*High Quality Care For All* (DH, 2008) emphasises the importance of empowering patients to make informed choices for themselves and their families. Empowered patients also have a role to play in the design and delivery of education supporting the healthcare workforce.

Having defined involvement and those who need to be involved, this guidance will consider relevant tools and techniques for each element of the involvement continuum in healthcare education.
Techniques and tools for involvement

The techniques and tools presented here are taken from evidence submitted by SHAs and HEIs and from the DH publication *Real Involvement: Working with people to improve health services* (2008). With regard to the latter the approaches have been adapted to fit the healthcare education sector. Case vignettes demonstrate how the techniques and tools have been used successfully in healthcare education.

Giving information

Modern media have opened up a range of options for conveying information. Students and health service users are increasingly using electronic media such as blogs on websites, and accessing Twitter and social networking sites such as Facebook and MySpace. Websites are already used to provide students with information from the results of student surveys. For example, the National Student Survey (NSS) results are published on the Unistats website. Until last year results for NHS funded courses were not published because response rates were too low for the information to be meaningful. However, following additional DH investment this year the response rate is now around 60% and so results have been available to students and potential students to view since September 2009 at: [www.unistats.com](http://www.unistats.com).

Methods used to give information should be appropriate to the group or groups linked with each involvement activity. In many cases, more traditional approaches such as open meetings, letters, posters and newsletter articles would be more appropriate.

Example from practice: NHS London’s contract performance management website

NHS London has a section of its website set aside to provide stakeholders with information about the quality of the education it commissions. The front page includes information about the purpose of NHS London’s reviews as compared to those carried out by the Professional Regulatory Bodies. Links are then provided to:

- results of reviews
- websites showing results of reviews carried out by other organisations
- resources to support the review process
- FAQs.

The website can be found at: [www.london.nhs.uk/what-we-do/developing-nhs-staff/education-and-training](http://www.london.nhs.uk/what-we-do/developing-nhs-staff/education-and-training)
Getting information

When seeking information about users’ views it is important to remember that there may be information already in the public domain that reports the views of the group or groups in question. The ‘Athens’ website, which is accessible to all academic staff and to NHS staff, offers useful links to NHS e-libraries and allows database searches. NHS staff wishing to use the site should contact their regional library lead (see Annex E). Further information about Athens and how to access the site can be found at this link: www.library.nhs.uk/forlibrarians/content/corecontent/athens/eligibility.

Surveys are useful where there is clarity about the questions to be asked, for example the Postgraduate Medical Education and Training Board (PMETB) survey, which looks at the experiences of postgraduate medical students and their clinical teachers. One-to-one semi-structured interviews and focus groups can be helpful where there is less clarity because participants have more freedom to talk about the things that are important to them.

The media can also be a useful source of information about service user views, student views and how the public might perceive different groups of service users. This information could be used to powerful effect in curriculum planning.

Example from practice: University of Chester Learning Disabilities Media Research Group

This initiative aims to engage in research, publications and campaigning on behalf of those with a learning disability. The main initial function will be to collect data on media representations of learning disabled people in films, TV soaps, documentaries, newspapers, magazines, photographs and paintings. The group comprises interested parties from both within the University as well as the local community. For further information please contact: Professor Tom Mason (t.mason@chester.ac.uk) or Dianne Phipps (d.phipps@chester.ac.uk).

Debating

Debating is important to help give exposure to different opinions, to challenge thinking, identify potential blockages to change and to find ways to overcome those blocks. Debates can be live in either a specially arranged meeting or as part of a routine meeting, or they can...
take place electronically via chat rooms, which allow participants to post their comments online for everyone who has access to the chat room to see. ‘Real-time’ webchats using instant messaging such as MSN or AIM allow electronic debate at a pre-determined time whereas chat rooms work better for stimulating debate over a longer period of time, allowing reflective people more time to consider their views.

Live debates can be stimulated using a variety of tools:

- **World café or station master** events allow stakeholders to circulate round different stalls or stations where information is presented and questions put forward for debate. Facilitators can either ask all groups the same questions and look for areas of consensus or use a ‘snowball’ approach where ideas from each group are tested with the next until the final group puts forward suggestions based on the ideas filtered through the other groups.

- **Forum or theatre roleplay** involves a group of actors depicting a scenario then pausing from time to time to ask participants what might happen next. Once the actors have ideas from the participants they improvise using the ideas put forward. At the end of each scene there is an opportunity for debate about the outcomes and how they might influence policy. For example, the actors might portray potential students trying to decide what to study and where. They might include school leavers interested in healthcare careers, a young mother who wants to become a nurse and qualified allied health professionals who want to advance their practice in particular fields. The roleplay might attempt to draw out the challenges the students would face in accessing information about potential providers, types of qualification and the quality of education provided by different providers. This might help participants to think about what needs to change to support student choice.

- **Simulations** set out scenarios for participants to help them relate the questions they are being asked to debate to the future landscape. For example, an SHA and local HEIs might work in partnership to explore the role of staff who support placement learning, looking particularly at potential roles, employment models for those roles and their scope. Facilitators could then present an imaginary practice
learning landscape set five years in the future to an invited audience of HEI, SHA and NHS service provider staff from all sectors, alongside students from a range of professions and HEIs and patients representing different care pathways. This imaginary landscape might be given in the form of a map or using pictures showing where services are being provided, and the characteristics of the service and hence learning environments. Information about the financial support available for placements might also be set out in a user-friendly format. Participants could be asked to represent the different players in this landscape during debates at facilitated tables. Feedback from these debates could be used to draw out issues and ideas for implementation. Findings could then be tested with a fresh group of stakeholders.

Example from practice: Staffscope: understanding the future needs for London’s health and social care workforce – a ‘soft’ futures approach: NHS London

This involvement exercise was a two-day behavioural simulation setting out a possible London healthcare landscape in 2014. The event involved 70 cross-sector NHS and non-NHS participants. It was followed by seven workshops that refined the results with approximately 130 further stakeholders. The work resulted in a report which outlines the key workforce challenges associated with the future healthcare landscape. The report is available at: www.london.nhs.uk/what-we-do/developing-nhs-staff/workforce-for-london/supporting-materials.

- **Storytelling or biographies** can help to make people’s experience more real and so stimulate debate with greater insight. For example, an HEI might ask a patient who had been in hospital with a respiratory condition to describe their experience of being treated by supervised student physiotherapists and then would ask the students and supervisors to describe
the same event. Participants could then consider what might be done to improve the experience for all parties.

- **Consensus methods** can be used to establish the extent of consensus or to develop consensus statements. The Delphi technique and nominal group process are examples. The Delphi technique is a postal questionnaire method using open-ended questions to obtain broad views from people, allowing them to maintain anonymity. Responses from a first round of questionnaires would be used to produce a set of statements that participants could be asked to respond to, to indicate their level of agreement. Rankings are collated and reflected in another set of statements and participants are then asked again to rank their level of agreement. These rankings are analysed to give an assessment of the degree of consensus. Nominal group process applies the same process but using a series of face-to-face meetings of stakeholders. This process could be experienced as quite threatening for participants and tends to work best with very senior experts.

**Participation and partnership working**

Users can be involved at a participatory level in the operational processes associated with education design and delivery. Where this involvement is systematised it becomes an ongoing partnership. At a strategic level, partnership working between higher education and the users of those education services in healthcare is facilitated nationally via the Health Education National Strategic Engagement (HENSE) group. The membership of HENSE is shown in Annex F. It is important that the links between local partnerships at SHA level and HENSE are strong and education service users should lobby the relevant HENSE representatives in order to influence the agenda. Equally HENSE representatives should feed key issues back to the SHAs via the meetings of National SHA Workforce planners, education commissioners and finance leads. Contact details for the chairs for each of these groups are given in Annex G.

**Workforce planning**

Employers routinely have a key role to play in workforce planning through the production of integrated service, finance and workforce plans and the resultant training plans.
Training plans should be based on a comparison of the competencies needed by the planned workforce and those already demonstrated by staff in post. Patients, carers and NHS staff should have opportunities to contribute to the work of defining competency requirements for service delivery. The Skills for Health Competence Search Tool, Knowledge and Skills Framework (KSF) Competence Mapping Tool, Health Functional Map and Career Framework Tool may be useful resources to support this process. Further details can be found at [https://tools.skillsforhealth.org.uk](https://tools.skillsforhealth.org.uk).

Once identified, competencies can be mapped to existing educational pathways such as National Vocational Qualifications (NVQs), Open College Network awards, Apprenticeships, Skills for Life training and undergraduate and postgraduate professional qualifications, as well as being used to develop new educational pathways in partnership with education providers. As the Sector Skills Council (SSC) for health, Skills for Health is responsible for health related NVQs, although in some areas these qualifications are the joint responsibility of and are jointly owned by Skills for Health and Skills for Care and Development. Information about health and social care qualifications can be found on the Skills for Health website at: [www.skillsforhealth.org.uk/page/awards-and-qualifications/s-nvqs](http://www.skillsforhealth.org.uk/page/awards-and-qualifications/s-nvqs).

In addition the Qualifications and Curriculum Development Agency has a database of all accredited qualifications which can be found at: [www.accreditedqualifications.org.uk/index.aspx](http://www.accreditedqualifications.org.uk/index.aspx).

In relation to new education initiatives, potential students and employer representatives should be involved in development from the outset. Where a particular need is shared across a range of service providers in an SHA area, the SHA should co-ordinate the development work involving a range of potential education providers and employers.

Patient and carer input could come via Local Involvement Networks (LINks) (see Annex H) and other networks linked with specific conditions or care pathways. Network groups are registered with the NHS networks website, which can be viewed at: [www.networks.nhs.uk](http://www.networks.nhs.uk).

SHAs are responsible for turning collated workforce plans into investment and commissioning plans. Employers will have the opportunity to review and influence these
plans through the work of the Professional Advisory Boards and the Centre for Workforce Intelligence.

Procurement

All SHAs should have a local workforce and education market strategy. While the SHA will need to take the lead all stakeholders, including PCTs, providers of NHS commissioned services, education providers, students and service users, will have a role to play in development and ongoing review. Debate could be stimulated using any of the techniques and tools described earlier in this guidance.

Where employers procure education directly, they may wish to work with existing education partners. However, evidence should be available for the SHA showing the results of market testing, exploring whether the education being offered represents value for money.

Where the SHA is undertaking a more central procurement exercise, action should be taken to ensure adequate contestability.

Employers, students, patients and carers could be involved in pre-tender meetings, the development of specifications, short-listing and interviews.

This involvement could include participation in focus groups as part of the pre-tender meeting, review of specifications, contributions to short-listing panels, review of short-listing decisions and interviewing.

Ongoing education design and development

Mechanisms should be in place to ensure that students, employers and NHS service users can give input into the full development of new education initiatives and the review or formal re-validation of existing education. Students are routinely members of school and faculty boards and these are key routes for students to influence the development of new and existing education provision. Service users are also sometimes members of these boards. SHAs and HEIs should have user involvement strategies to underpin this work.
Example from practice: York St John University and the NHS Institute for Innovation and Improvement, Service Improvement Skills Project

York St John University has been working with the NHS Institute for Innovation and Improvement as part of a national initiative to develop packages of learning designed to incorporate service improvement skills into the undergraduate curriculum. This is now being rolled out across most HEIs in the Yorkshire and the Humber region and approximately 50 HEIs nationally.

Locally the learning is being applied to post-registration education, e.g. regional interprofessional mentorship training and work-based modules available at various academic levels, which focuses on improving patient safety in the student’s personal field of practice, i.e. reducing falls in elderly care, safeguarding vulnerable adults and improving hospital discharge.

Example from practice: University of Northumbria’s work with a LINk

The University of Northumbria’s School of Health, Community and Education Services has a vision for working with their LINk in Newcastle to develop and enhance curricula. The LINk in Newcastle has three working groups formed in response to priority issues raised by users and carers. These are:

- domestic violence
- social care for older people
- child and adolescent mental health.

There is a plan for a member of the academic staff from the University of Northumbria’s School of Health, Community and Education Services to sit on each group in order to feed in the university’s current work and take back ideas for enhancement. The university hopes to make this work high profile with students so that user involvement becomes second nature to them.

For further information please contact: Dr Anna Jones (anna.jones@northumbria.ac.uk).
Example from practice: Sheffield Hallam University’s Virtual Residents Project

Enabling student nurses to access experiences across the diversity of service delivery is a challenge, as placement opportunities are not always available. At Sheffield Hallam University a Service Users’ and Carers’ group is working with students and staff to create virtual residents that live in a town whose profile is based on the demographics of the South Yorkshire region. Service users and carers bring their unique perspective to create characters and experiences that ask the student to think differently about how to support their needs. Creative approaches are used, e.g. music, poetry, monologues and storytelling alongside virtual families and everyday situations. Students can experience service provision in community, home and hospital settings, in midwifery, child, mental health, adult and learning disability nursing.

Example from practice: University of Huddersfield, Sheffield Hallam University, University of Hull: Medicines with Respect Project (MwR).

This collaborative project, funded by Yorkshire and the Humber NHS, brought together universities and associated trusts to develop and evaluate a stepped approach to developing and assessing the medicines’ management competency of mental health nursing students and mental health nurses going through their preceptorship period. The project has initiated and will evaluate specific pharmacology and medicines management activities designed to facilitate the development of the knowledge and clinical skills required to administer oral and intramuscular injections safely and competently. Analysis of the outcomes of the MwR project is being undertaken by a service user employed as a research assistant, using statistical and qualitative data analysis, and it will inform ongoing educational developments. For further information please contact: Steve Hemingway, Project Co-ordinator (s.j.hemingway@hud.ac.uk).
Example from practice: Service User Involvement Strategy at the University of Chester

A Service User Involvement Special Interest Group meets on a regular basis to explore opportunities for user and carer involvement in teaching, attending meetings, curriculum planning, committee work, writing research grants, undertaking research and publishing. Presentations are made regularly at the faculty staff days by both service users and carers as well as by academic staff interested in the development of service user and carer involvement. There are also three PhD students who are actively engaged in projects related to service users and carers, and a series of publications is currently being constructed. For further information please contact: Dianne Phipps (d.phipps@chester.ac.uk) or Professor Tom Mason (t.mason@chester.ac.uk).

Example from practice: Kingston University Faculty of Health Service User Consultative Forum

Kingston University’s Service User Consultative Forum has developed detailed guidelines for academic staff on the involvement of service users in curriculum design, education delivery and research. An Honorary Fellow in Patient and Public Involvement has been appointed and is a member of the Faculty Learning and Teaching Committee. This committee has a central role in developing and reviewing policy across all programmes in order to enhance quality of the learning experience.

For further information please contact: Denise Forte (d.forte@sgul.kingston.ac.uk).

Education delivery

Users have a role to play in supporting education delivery at all stages of the student lifecycle, from recruitment through to academic and placement learning and assessment.

Service delivery staff can give valuable insights at recruitment, particularly in relation to applicants’ attitudes and perceptions of the realities of working in healthcare, and their
expectations. Users, carers and members of the public could also be involved in the student selection process.

**Example from practice: Keele University Training for Involvement in Student Selection**

This project piloted the inclusion of lay people, drawn from two NHS trust volunteer banks, in the selection of recruits to nursing programmes. The aim was to use lay perspectives of potential students’ suitability in relation to interpersonal skills and attitudes.

Service delivery staff have a critical role to play in supporting student learning and assessment during placements or work-based learning. Supporting the development of the staff of the future is a key requirement of service providers in receipt of MPET funding and is monitored and evaluated under the terms of SHA LDAs. Education providers have a duty to support placement staff in understanding the learning outcomes that students are seeking to achieve, and in ensuring that all those required to support students have access to courses and resources that will enable them to develop and maintain the necessary skills for supporting student learning and assessment in practice. Healthcare assistants and ward clerks in placement areas can also be involved in supporting student development.

**Example from practice: The University of Nottingham’s Befriender Scheme**

This scheme utilises the skills of healthcare assistants to support first-year student nurses on their first placements. Students reported the following benefits of the scheme:

- It enabled them to settle into the ward more quickly, as there was always someone to talk to who knew the ward routines.
- It allowed students to feel more comfortable, knowing that they had someone to work with.
- It helped ensure that students always had something relevant to do, such as giving a bed bath, doing observations and working on key skills.

The healthcare assistants commented that the scheme benefited them by giving them the opportunity to share their skills and to feel valued as part of the team.
In addition, service delivery staff can make key contributions to academic teaching, bringing valuable practical insights to lecture material. Many education providers make joint appointments with service providers to support this work.

The role of students themselves in education delivery should not be overlooked. More senior students can support the induction of new joiners and offer workshops giving more junior students insights into the realities of the placement experience. Peer-assisted Learning (PAL) is a core feature of placement learning in many professions where more than one student is allocated to each practice educator. Under these conditions students work together to assess patients and to develop care and treatment plans for educators to review before implementation. When properly planned and monitored, learning of this type helps to build student confidence and increases placement capacity.

PAL is also central to problem-based learning in the academic environment where students work in small self-directed teams to tackle a problem that is often practice based. A tutor acts as a facilitator and is available to answer questions and offer guidance as required. This helps students to practise thinking critically and working as a team, mirroring the real-life practice environment.

Users can offer feedback to students in the context of role play in simulation laboratories. This can be formalised and even used as part of the summative assessment where patients agree to play the role of ‘standardised patients’ in objective structured clinical examinations.
Example from practice: Use of role players in the clinical skills laboratory, Faculty of Health and Social Care Sciences, Kingston University and St George’s, University of London (KU/SGUL)

Simulation in the skills laboratory

The use of the simulated experience in the clinical skills laboratory allows students to explore, rehearse and consolidate areas of care delivery. It enables the development of core competencies and also addresses specific individual learning needs. It creates a safe and supportive practice setting which reflects ‘real’ practice environments.

The use of role players in simulation

The inclusion of users is crucial to the success and positive feedback received in the KU/SGUL simulation experience. Role players work across a wide range of simulated exercises. They are recruited from ex-nurses, ex-students, the Kingston University retirement scheme, local schools and colleges, and other user groups.

The inclusion of users as ‘patients’ enables students to develop specialist knowledge about patient care in a safe environment. They assist students to focus on the importance of communication, safety, dignity and comfort to patients. Comments from students include:

- “The patients were very realistic.”
- “It’s amazing how real it feels as well.”
- “It gave me more confidence in terms of how to deal with the patient, because we have a real patient.”
- “Having real people is brilliant. It taught me an awful lot.”

The role players value participation as they have the opportunity to contribute to improving healthcare – and they have fun during the experience!

For further information, please contact: Linda Burke (L.Burke@sgul.kingston.ac.uk).
Service users may also be able to contribute to academic education delivery. This approach is used most frequently in mental health and learning disabilities nursing.

Example from practice: User involvement in delivering mental health education, London South Bank University

An approach frequently used is to involve groups of service users in workshop style sessions with student mental health nurses, for example in discussing scenarios reflecting practice dilemmas. Evaluation of this approach suggests:

- It is an effective way of involving service users with a range of abilities and levels of confidence in professional education and training.
- It promotes opportunities for social interaction between students and service users outside the practice environment, characterised by open and engaging styles of communication.

This contributes to students re-conceptualising their perceptions of service users in more positive ways.

Quality assurance and contract performance management

Students, employers and patients/carers can all be involved in reviewing education services and developing action plans to promote improvement (see 4.1 Performance management).

Performance indicators and quality standards can be used to embed user involvement in the system. For example, the national pre-registration, non-medical contract performance indicators require user involvement in the following aspects of education planning and delivery:

- recruitment, selection and marketing
- the development of course content and the design of course delivery
- assessing the adequacy of the support available for staff involved with placement learning and assessment
- assessing the adequacy of student preparation for placements
- developing and monitoring CRB and occupational health processes
- developing and monitoring processes for assessing student fitness for placement
• collecting and acting on student feedback in a systematised way.

Users should be involved in evaluating performance against standards and also in developing action plans to tackle weaknesses and drive up quality. Students and employers could also get involved in annual review meetings, either through attendance or by recording information about their experiences. Service user networks and associations can give useful ideas for improving education services, and input from these sources should be proactively sought.

Formalised systems for collecting, collating and acting on student and employer feedback help to give education providers and commissioners insights into the extent to which the education being offered meets the needs of the NHS workforce.

Where results of reviews are published students and potential future students can access valuable information to enable them to make choices about their future development. Recent additional investment in the NSS resulted in a significant improvement in response rate, taking the rate for NHS funded courses above 60%. This means that results from the NSS this year will now be published on the Unistats website. Further work is needed to disaggregate the results so that students can look at an HEI’s performance in relation to the specific pre-registration programme that interests them rather than the broader subject area, as is the case at the moment.

Results of SHA reviews could be published alongside information about how the results should be interpreted and links to the results of other reviews. This gives students a wide-ranging understanding of quality and performance. For example, a student considering studying a pre-registration nursing degree in the South Central SHA area could look at the NSS results and the Guardian and The Times league tables. They would give information about the experiences of former students, the support with learning they feel they received and the fairness of their assessments. In addition the student could look at results for the Nursing and Midwifery Council (NMC) reviews which would indicate the NMC’s confidence that the product of the courses would be fit to practise as a nurse.
The SHAs’ league tables would show whether the university provides value for money for the taxpayer and would be an indicator of whether the university might be in a strong position to get future business from the SHA. Taken together, this information could be useful to students in supporting their decisions about what to study and where.
Overcoming potential barriers to user involvement

There are a number of potential barriers to effective user involvement, which can be summarised as follows:

- practical/organisational difficulties
- lack of financial resources
- unsupportive organisational culture
- variability in the competence of different sectors of the community to be involved.

A proactive approach is required to overcome these barriers and some good practice is described in the following sections.

**Practical/organisational difficulties**

It is often challenging for organisations to co-ordinate the involvement of their own staff in different elements of the education value chain. User involvement is therefore unlikely to be effective unless the systems and resources are in place to support it from the outset.

Organisations should ensure that someone has responsibility for keeping an up-to-date database of user contact details. It is important to have a wide range of potential contacts to prevent involvement fatigue in particular individuals or organisations. Several universities, including Nottingham and Leeds, employ a User and Carer Development Worker with the specific aim of co-ordinating and facilitating user and carer involvement in education design and delivery.

It is also important to ensure that those charged with promoting user involvement have access to relevant networks and support groups. LINks and other networks such as those registered with NHS networks are useful resources when sourcing users for involvement in particular projects or areas of work.

When recruiting users for a piece of work it is essential to inform them of the purpose of their involvement and ensure that no false expectations are set up. Users should be made aware that any future action would need to be affordable, safe, effective and aligned with policy commitments as well as being acceptable to users. It is also important to help people understand the range of views there might be even amongst people from the same user group, and that it is not always possible to achieve consensus.
Advance planning is essential for successful user involvement, as additional time will need to be built in for training before users can be involved effectively.

It is essential to be clear about the aims and objectives of the work and to be able to articulate them without the use of jargon and acronyms that prevent users getting involved on an equal footing with professionals. Teams should aim to discuss their work as a matter of routine in everyday language so that a big switch in approach is not required when seeking to bring in users. At the very least, an up-to-date glossary of terms should be available.

Thought should be given to different mechanisms for involvement, as face-to-face meetings may not always be practical. The previous section (Techniques and tools for involvement) gives some examples of techniques that can be used to achieve different types of involvement. Consideration will need to be given to the specific needs of the users for each piece of work. For example, special arrangements may be required to support users whose first language is not English, as well as those with mobility difficulties, visual impairment or special dietary needs.

Involvement might produce a strong psychological response. If this is a possibility advice should be sought to ensure that the benefits of involvement justify any possible side effects. This should be discussed fully with users who express an interest in being involved and advice from their doctors should be sought with their consent. The organisations’ counselling services should be available to anyone who might need them. In situations where there is risk of a significant psychological response it is often more appropriate to access information from patient organisations or other sources that are already in the public domain.

While tokenism must be avoided it is also important to remember that user involvement should be in proportion to the impact of the change on the users in question, and that it is not necessary to plan large-scale involvement activities for every piece of work.

It is also important to consider from the outset how feedback might be given. Where a large number of users have been involved it may not be possible to give individual feedback, and newsletters or web updates may be more appropriate.
Lack of financial resources

Involvement can take many different forms, not all of which require significant financial outlay. However, it is important to ensure that the cost of user involvement is built into any work or project plan from the outset so that it forms a clear part of the budget. The DH document *Reward and recognition: The principles and practice of service user payment and reimbursement in health and social care* (2006) provides guidance and can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126863.

Costs vary and might include recognition of the value of users’ time, travel both for the users and any carers who need to accompany them, signers to support users with impaired hearing, provision of information in Braille, translation and interpretation services for users whose first language is not English and childcare costs.

Clearly SHA and HEI funds to support involvement will be limited and it may be necessary to explore more cost-effective approaches. For example, where the involvement is to gain information it is important to remember that in some areas significant amounts of information are already available in the public domain, reducing or removing the need to collect fresh data. Electronic approaches to user involvement can save money on venues and travel and allow users to contribute in their own time without the pressure of trying to be assertive when under time pressure in meetings.

**Example from practice: Payment of carers and service-users, University of Leeds**

The University of Leeds has developed a policy for both the payment of carers and service users and the reimbursement of their expenses in relation to their involvement with the University’s Assessment and Learning in Practice Settings project. Further information can be obtained from Chris Essen, Service User and Carer Involvement Development Worker: C.S.Essen@leeds.ac.uk.

Organisational culture

User involvement requires strong leadership and should be embedded into policies and processes at all levels. Organisational values should reflect a commitment to user involvement, thereby making a very public statement about what users and commissioners can expect from the organisation.
Staff should have access to development opportunities specifically designed to help them understand and implement user involvement initiatives and relevant support networks.

**Example from practice: Involvement initiative**

The Professional Education Public Involvement Network (PEPIN, www.pepin-uk.net) is a community of practitioners who seek to share information and promote discussion relevant to the inclusion of patient, service user and carer voices in professional education. PEPIN runs an open forum where challenging issues are debated and manages an online discussion forum. For further information visit the website or contact Chris Essen: C.S.Essen@leeds.ac.uk.

**Example from practice: Support network**

DUCIE, the Developers of Users and Carers in Education network, is a support network for user and carer involvement development workers who are employed within UK HEIs. Meetings are held three times a year, with email and telephone contact maintained in between. For further information please contact Jill Anderson: j.anderson@lancaster.ac.uk or Chris Essen: C.S.Essen@leeds.ac.uk. DUCIE has developed guidelines for employing development workers, which may be useful to organisations considering these roles, and these are available at: www.mhhe.heacademy.ac.uk/themes/ducie-guidelines.
Skills for Health, Skills for Care and the NHS Centre For Involvement have produced a short guide and supporting DVD entitled Your Voice Counts: How patients and the public can influence education and training to improve health and healthcare (Skills for Health, 2008). The DVD includes personal involvement stories from different perspectives, covering all elements of education commissioning design and delivery. For further information, please contact: rachel.hawley@skillsforhealth.org.uk.

The need for training
Training should be tailored to the specific involvement activity but training resources for core elements of user involvement should be developed for ongoing use. Core elements of training might include:

- **clarifying expectations** – organisations cannot commit to implementing the ideas put forward by any individual user or group. However, users should expect to be treated with respect and to be able to understand the rationale behind any decisions made following their involvement.

- **rights and responsibilities** – users should know what the organisation expects of them and what they are entitled to by way of support for their involvement, e.g. expenses, counselling, etc.

- **the benefits of user involvement** – previous examples of effective involvement practice.

Training needs can be met in a variety of different ways, e.g. leaflets, web-based support materials, workshops and pre-meetings.

Further information
There is a significant amount of information in the published literature and the following recent literature reviews are a useful source of additional information for user involvement leads.

a) Perceptions of service user and carer involvement in healthcare education and impact on students’ knowledge and practice: a literature review

Authors:
Morgan, Angela and Jones, Diana
Summary

The Centre for Excellence in Teaching and Learning for Health (North East), regional healthcare education collaboration, undertook a literature review to inform involvement strategies. They found that both students and service users identified benefits from engagement and recommended further development of evaluation methodologies.

b) User and carer involvement in the training and education of health professionals: A review of the literature


Authors:
Repper, Julie and Breeze, Jayne

Summary

The authors sought to describe methods of involving users in healthcare education, to discuss ways in which initiatives had been evaluated, and to identify areas for development in education, practice and research. They carried out a literature review of 38 papers, most of which provided small-scale qualitative studies of mental health service users that focused on process rather than outcome. They found that service users consistently prioritised the need for training in interpersonal skills over ‘technical’ skills in order to support their involvement. The review showed that there was little research into organisational strategies for involvement and no studies investigating the effect of involvement on practice. Two studies indicated that students who are exposed to user involvement demonstrate more empathic understanding and better communication skills. The authors conclude that if user involvement in training and education is to facilitate services that reflect the priorities of the people using them, it must be developed in partnership with service providers. They recommend further research to explore the impact of involvement and to track the development of organisational involvement strategies. They also argue for the establishment of systems for supporting users, including training for both users and staff.
Creating a culture of innovation in education commissioning

High Quality Care For All (DH, 2008) puts quality at the heart of the NHS, providing an ambitious shared vision for the future of the NHS. It describes a reformed system that supports quality improvement. One of the key enablers for this is creating an environment within which innovation can flourish.

In order to respond quickly and effectively to changing service requirements and continuously improve quality, education commissioners will have to work with education providers to promote quality and innovation. A High Quality Workforce (DH, 2008) makes a commitment to improve education commissioning in order to drive quality and innovation – “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”.

Education commissioning needs to create the opportunities for innovation in education delivery to happen. Education commissioners achieve this by acting as enablers and making use of the levers that will promote innovation in education delivery. They also enable the diffusion and adoption of innovation through the education they commission by ensuring that successful innovations are part of curricula and become embedded in practice, and that commissioned education includes preparing students to be the innovators of the future. In order for this to be successful they need to exhibit key leadership behaviours and create an innovation culture.

The NHS Constitution (DH, 2008) begins with seven key principles that guide the NHS. The third principle includes the NHS commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

“The NHS aspires to the highest standards of excellence and professionalism – in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.” (NHS Constitution, DH 2009, page 3)
SHAs have a new legal duty to promote innovation (www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm) and are responsible for leading and embedding innovation in the NHS at a local level. The Department of Health (DH) has produced a briefing pack for the NHS entitled *Innovation for a Healthier Future. Creating a Culture of Innovation in Education Commissioning* draws on the information within this briefing pack.

The innovation pathway

“Innovation results in significant change that makes a large difference in performance whether achieved by the creation of new ideas or the adaptation of proven ideas from elsewhere. It can take a variety of forms whether relating to improvement of services, new technology, new information systems or new workforce practices. It can be enacted through an incremental series of changes that builds over time or a step change that quickly transforms a process or system.” *Creating an innovative culture*, (DH, April 2009).

All innovation begins with creative ideas and while these are a necessary starting point for innovation they are not enough. Thorough testing and piloting, followed by successful implementation and wide adoption and diffusion, form the other important components of an innovation pathway.

Barriers to innovation in education commissioning and delivery

There is already evidence of successful innovation in the delivery of education. However, it is clear from discussions with education commissioners that there are a number of barriers which sometimes prevent the wider diffusion and adoption of innovation. These include:

- lack of definition of the benefits of innovations in education commissioning and delivery for:
  - service delivery
  - patient experience
  - learner experience
- difficulty in demonstrating the link between the education commissioning system and what happens in the delivery of education in terms of innovation
inability to identify the priorities for innovation in education commissioning and delivery
• inability to overcome the barriers to/inhibitors of innovation
• lack of structures and processes that will enable long-term commitment to innovation and provide economies of scale
• loss of organisational memory due to organisation restructuring and movement of key staff.

Roles and responsibilities in innovation

High Quality Care For All (DH, 2008) promises to strengthen leadership and raise the profile of innovation, inject new funding, provide improved access to evidence and information and support individuals and organisations to innovate. SHAs will play a central role in co-ordinating and leading delivery of the commitment.

The Strategic Health Authority (Promotion of Innovation) Directions (April 2008) state that:

“In performing its functions each strategic health authority must promote innovation for the purpose of securing continuous improvement in the commissioning and provision of health care.”

The new legal duty for SHAs to promote innovation means raising the profile of innovation and encouraging a more rapid adoption of innovation throughout the health service.

The role of DH is to create the conditions for innovation to flourish, to work with the NHS to ensure the system-wide levers of change support innovation and to selectively stimulate innovative activity.

The role of the SHA is to create the right context and reinforce the right leadership behaviours to stimulate innovation. In doing this the SHA will have to respond to local needs, where possible involving patients, carers and the public in co-designing innovative solutions. SHAs own the legal duty to promote innovation in partnership with local NHS organisations. They will determine the best way to discharge and implement this duty within their region and will be required to produce an Annual Innovation Report (AIR), setting out what progress has been made, what resource has been used and what the impact has been. All SHA board
members will be responsible for stimulating, supporting and promoting innovation within their region.

**What this means for education commissioning**

The SHA has primary responsibility for promoting innovation in healthcare education design and delivery by incentivising and promoting adoption and diffusion of innovation. The SHA will commission education that includes preparing learners to be the innovators of the future and will also be instrumental in enabling the adoption and diffusion of innovation by ensuring successful innovations are part of curricula and become embedded in practice. To do this they will need to work in partnership with education providers, NHS service providers and PCT commissioners.

Given the SHA’s key role in promoting innovation in education design and delivery, it would be expected that the AIR includes explicit reference to progress and impact in this area, in particular how innovative activity known to improve outcomes is integrated into learning.

SHAs will also need to consider how innovation in education commissioning:

- relates to the SHA’s research and development (R&D) strategy and the wider context for engagement with higher education
- aligns with the SHA’s quality and productivity strategy.

All innovation activity in the NHS should be underpinned by the four principles of change, which are:

- **co-production** – SHAs will need to work with a range of stakeholders to maximise the contribution to innovation
- **subsidarity** – while SHAs have the legal duty, their role is concerned with facilitating and ensuring that innovation takes place where it will have an impact
- **clinical leadership** – SHAs should help to create the right climate so clinicians can champion and drive innovation
- **system alignment** – SHAs are able to develop strong partnerships to tackle problems and innovate.
Benefits of innovation in education commissioning and delivery

There are benefits to patients, services and learners from innovation in education commissioning and delivery.

Patient experience
- Care delivered by well-informed staff with up-to-date knowledge and skills.
- Staff equipped with the knowledge and skills to deliver care along care pathways that reflect the most up-to-date evidence-based practice.

Service delivery
- A planning system which promotes the delivery of education in new ways to meet the needs of discontinuities in the way service is delivered.
- A service with built-in flexibility where staff are able to offer the latest and best treatment.
- A service delivered by staff with the capability to innovate and deliver continuous improvement.

Learner experience
- Adoption by education providers of best practice in education delivery.
- Access to education closely aligned to service and patient need.
- Education designed to provide future NHS staff with the skills to be innovative themselves and to deliver the best in patient care.
- Education that will enable the future healthcare workforce to contribute to the development of services and better patient care.

Successful innovation
Evidence from SHAs and discussions with education commissioners suggest there are some common principles that should underpin good practice in the creation of a culture of innovation in education commissioning.

- Establish education commissioning as an enabler by the creation of the right conditions and opportunities for innovation, for example by:
• collaborative working with service providers and education providers
• rewarding successful innovation.

Focus on overcoming the barriers to innovation, in particular by incentivising and rewarding successful innovation in education delivery and creating innovation champions.

Utilise partnerships and collaboration to encourage and support innovations:
• Health Innovation and Education Clusters (HIECs) are one example of local partnership but SHAs will also have other mechanisms for establishing partnerships with and between education providers and service providers. Further information on HIECs can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098887
• The establishment of Academic Health Science Centres (AHSCs) will foster world class partnerships between research, teaching and patient care organisations so that developments in research can be more rapidly translated into benefits to patient care in the NHS and across the world.

Leadership

Evidence suggests that successful leaders of innovative organisations:

• **lead continuous improvement and innovation** – ensure there is a clear vision and strategy for innovation and plan to measure performance against targets
• **encourage partnerships and collaboration** – stimulate collaboration and look for ideas and partnerships outside the organisation
• create space, time and resources for innovative activity – provide staff with resources to develop ideas and allow them the time and autonomy for creative thinking
• celebrate and reward innovative thinking – recognise and promote the success of adopters and diffusers of innovation
• use and share evidence – use the best available evidence to inform decisions and create forums for sharing ideas and experiences
• manage risk and tolerate failure – foster a culture which allows for managed risk taking and celebrates failure as an opportunity for learning and improvement
• promote learning and development – develop the capability of individuals to innovate and build this into training programmes and curricula.

Leading innovation in education commissioning
Successful innovation in education commissioning requires strong leadership that champions the importance of innovation and creates a culture that will support innovation. Education commissioners believe the key characteristics that will help create a culture of innovation in education commissioning are:

• strong SHA leadership in promoting innovation
• recognition and reward for individuals and organisations who successfully innovate
• partnership working with service providers and education providers
• access to best practice and evidence in relation to innovation in education commissioning and delivery.

Figure 4 shows how DH, SHAs, PCTs and trusts can provide leadership to promote innovation.
Figure 4: Leading innovation in education commissioning

Common behaviours
- Lead continuous innovation and improvement
- Encourage partnerships and collaboration
- Promote innovation by providing space and time
- Recognise and promote the success of adopters and diffusers of innovation
- Use and share knowledge
- Manage risk and tolerate failure
- Promote learning and development
- Continually seek out, adopt and spread best practice

Set direction
- Ensure system incentive and national policies encourage innovation
- Support and foster a leadership culture that rewards innovation

Promote innovation in partnership with local organisations
- Create the right culture and leadership behaviours for innovation to flourish

Form partnerships with local organisations to support innovation
- Encourage research and innovation to inform practice
Levers that promote innovation in education commissioning and delivery

Education commissioners have a number of levers they can use to improve the conditions for innovation. They can:

• provide local leadership in education commissioning
• proactively manage the local education market
• develop partnerships and collaborations between NHS organisations and universities
• use performance metrics to measure the quality of commissioned education
• use performance incentives to promote innovation in education delivery
• capture and disseminate evidence of best practice via a web-based portal
• use local and national networks to share information on innovation
• commission outcomes research to inform future investment in education.

Recognising and rewarding successful innovation

SHAs can reward innovation through the use of the new quality and innovation premium where there is evidence of innovation in education delivery, measured through the SHA’s performance management system.

To encourage the implementation of new ideas the NHS is also introducing a regional innovation fund to support faster innovation and more universal diffusion of best practice, together with a series of innovation ‘challenge’ prizes to reward those who have excelled in creating and diffusing innovative ideas and encourage others to do likewise.

Priorities for innovation in education delivery

Each SHA will need to identify priorities for its own local area but the following have been identified as priorities for innovation in education delivery by SHAs across England:

• developing learning that increases flexibility for learners
• developing programmes that cross sectors
• interprofessional learning and team-based learning in academic and practice settings
• personalisation of learning
• use of e-learning
• use of simulation in the learning of clinical skills
• mobile technology to support practice learning and assessment in practice
• investing in learning infrastructure that improves the efficiency and effectiveness of education delivery and patient safety.

Measuring innovation in education commissioning

Work is under way nationally and internationally to develop an innovation metrics index. In the short term DH is working with SHAs to develop a simple set of measures that can be used across the NHS. These measures will focus on whether the innovation offers value for money, value to patients and improved staff experience, and how long it takes from invention to adoption to diffusion of innovation.

In order to know if education commissioners are getting better at promoting innovation it is necessary to have some measures that can be used to assess progress and provide benchmark information. Discussions with education commissioners suggest measures in the areas shown below would be useful. It is recommended that SHAs further develop measures in the areas shown, either locally or nationally via the national SHA education commissioners’ network:

• learner satisfaction measured using the National Student Survey (NSS)
• improvement in education commissioning outcomes measured by reference to focused outcomes research, to establish benchmark information
• the number of innovations that target specific education challenges
• the number of innovations in education that target specific service/user needs
• the number of innovations in education commissioning and delivery that are scaleable to national roll-out
• the time taken from initial idea to adoption of the innovation by other SHAs or education providers
• value for money measured either by savings to the MPET levy achieved or additional revenue generated through the adoption of innovation
• how well innovative activity that is known to improve outcomes, both for learners and patients, is integrated into learning.

Example of innovation in education commissioning

In NHS South West there is no standard CPD funding model. Instead they have developed Strategic Service Improvement Funds (SSIF). NHS organisations are pooled into local healthcare SSIF communities that are served by one or more HEIs for CPD activity. There is a lead PCT in each SSIF pool and collectively they decide the local service development need. This translates into a joint CPD plan with each HEI (up to the agreed SHA contractual funding for that year) and will probably include some new activity. It is not about purchasing accredited modules, although they are available, but rather shaping the delivery to the community needs. The aim is that the demand from the HEI is driven by a shared need, not just individual or sole organisational demand. The SSIF communities have welcomed this as it has released them from traditional thinking and driven collective service delivery.

In addition, NHS South West is seeing the emergence of a Shell Framework model where CPD is driven by employers rather than what is available. The programmes include a work-based learning element and may include significant amounts of Accredited Prior Experiential Learning (APEL).
Education delivery: Annex E
Regional library leads, June 2009

NHS East Midlands: richard.marriott@eastmidlands.nhs.uk
NHS East of England: rachel.cooke1@nhs.net
NHS London: richard.osborn@londondeanery.ac.uk
NHS North East: david.peacock@northeast.nhs.uk
NHS North West: david.stewart@nhs.net
NHS South Central: helen.bingham@nesc.nhs.uk
NHS South East Coast: louise.goswami@nhs.net
NHS South West: tricia.ellis@southwest.nhs.uk
NHS West Midlands: claire.edwards@westmidlands.nhs.uk
NHS Yorkshire and the Humber: kim.montacute@yorksandhumber.nhs.uk

Introduction
World Class Education Commissioning
Planning
Procurement/Contracting
Education delivery
Supporting and incentivising placements
User involvement
Innovation
Annex E
Annex F
Annex G
Annex H
Annex I
Performance management
Print
Education delivery: Annex F

Membership of the Health Education National Strategic Engagement group, June 2009

From health:
The NHS CEO represented by the DG Workforce, Chair
Pat Hamilton
Clare Chapman
Director of Medical Education
David Foster
Alastair Henderson
Deputy Chief Nursing Officer
tbc
John Rogers
SHA Chief Executive
Moira Livingston
Russell Hamilton
SHA Director of Workforce
Skills for Health Chief Executive
NIHR representative
David Foster
SHAHQ representative
John Rogers
NIHSW representative

From higher education:
DIUS Senior Officer
Martin Williams
Sir Alan Langlands
CEO HEFCE
Andy Haynes
Sir John Tooke
UUK nominee
UKHEAC nominee
Tony Weetman
MSC nominee
Council of Deans nominee
Sue Bernhauser
DIUS Senior Supporting Officer
Owen Fernandez

Supporting and incentivising placements
User involvement
Innovation
Annex E
Annex F
Annex G
Annex H
Annex I

Performance management
Print
Education delivery: Annex G
Contact details for SHA groups, June 2009

Workforce commissioners  joe.mcardle@northwest.nhs.uk
Finance leads  chris.jeffries@northwest.nhs.uk
Workforce planners  ruth.monger@southcentral.nhs.uk

Introduction
World Class Education Commissioning
Planning
Procurement/Contracting
Education delivery
Supporting and incentivising placements
User involvement
Innovation
Annex E
Annex F
Annex G
Annex H
Annex I
Performance management
Print
Information adapted from *Real Involvement: Working with people to improve health services* (DH, 2008)

A LINk brings together local people, organisations and groups that want to improve health and social care services in their area. LINks’ members could include:

- carer networks
- patient transport groups
- older people’s forums
- local business groups
- support groups for specific service users
- faith groups
- patient groups
- minority ethnic groups
- tenants’ groups
- NHS foundation trust governors
- neighbourhood renewal networks
- youth councils
- student groups
- self-advocacy groups
- interested members of the public.

**What is the purpose of LINks?**

**Scope**

LINks consider health and social care services in their area across all sectors, i.e. the NHS, the local authority, voluntary organisations, private companies, social enterprises and education providers.

**Activities**

1. Promote and support the involvement of people in commissioning, providing and scrutinising health and social care services.
2. Monitor the way health and social care services are commissioned and provided, and gather the views and experiences of people using them within the local area.
3. Reach out to local communities and provide opportunities for them to have their say in the way local services are planned and commissioned.
4. Convey the views and experiences of people to the organisations responsible for commissioning, providing, managing and scrutinising the services, and make recommendations on how those services might be improved.
Education delivery: Annex I
Further information on innovation

Websites

Academic Health Science Centres
www.ahsc.org.uk

Department for Innovation, Universities and Skills
www.dius.gov.uk

Department of Health
www.dh.gov.uk

NHS Evidence (an online portal that will allow quick and easy access to authoritative and unbiased evidence to support clinical and non-clinical decision making)
www.evidence.nhs.uk

NHS Institute for Innovation and Improvement
www.institute.nhs.uk

Regional Innovation Hubs via NHS Innovation Hubs
www.innovations.nhs.uk

Documents

Breakthrough to real change in local healthcare: A guide for applications to create Health Innovation and Education Clusters (HIECs)
Department of Health (2009)

Creating an innovative culture. Guidance for strategic health authorities (SHAs): new duty to promote innovation, Department of Health
(2009)

Innovation for a healthier future, NHS briefing pack (2009)

Life Sciences Blueprint: A Statement from the Office for Life Sciences, HM Government
(2009)

Williams I, de Silva D, Ham C (2009) Promoting and embedding innovation: Learning from experience, Health Services Management Centre, University of Birmingham,
www.hsmc.bham.ac.uk/publications/pdfs/Promoting-and-embedding-innovation.pdf
4.1 Performance management

Contract performance management

All contracts should be performance-managed, but the system described below sets out Department of Health (DH) policy for nursing, midwifery and allied health professional (AHP) pre-registration contracts where there is a benchmark price (BMP). Elements of the system could be applied to any contract where this would support value for money and quality enhancement.

Contract performance management for nursing, midwifery and AHP pre-registration contracts where there is a BMP should be based on the following principles, which will allow Strategic Health Authorities (SHAs) to drive up value for money, promote innovation, link payment with performance and ensure that qualifiers are fit to deliver high quality care in a range of organisations providing NHS commissioned services.

Contract performance management should:

- be transparent
- be locally standardised and compliant with national policy where it exists
- actively assure quality and promote quality enhancement
- actively promote partnership working between higher education institutions (HEIs) and providers of NHS commissioned services
- assure and promote the quality of academic and placement learning in an appropriately balanced way
- place the minimum burden possible on HEIs and providers of NHS commissioned services while ensuring the five criteria above are met.

In order to achieve this, contract performance management should have the following components and characteristics:

- the core minimum national contract performance indicators (CPIs) compliant with national definitions for the quantitative indicators (see Table 5). SHAs should consider the need for additional local indicators in the light of local priorities and the need to minimise burden
- annual assessment of performance against defined targets and tolerances for each contract performance indicators. SHAs should define targets and tolerances for quantitative CPIs locally and review them annually, making revisions where necessary. Revisions should take account
of national guidance where available (this will be produced for 2010/11 in order to allow for collection of baseline data), profession-specific issues, the need for stretch to drive continuous improvement, and local workforce priorities. For qualitative indicators it is recommended that SHAs ask HEIs each question once for each profession or, for nursing, once for each branch. This is considered an appropriate way to reduce burden because activity to support quality in partnership with employers and placement providers tends to take place at profession rather than programme level.

- **specified evidence requirements** for each CPI (exemplars are given in Annex K, but SHAs should set evidence requirements locally). Evidence for quantitative CPIs should comply with national definitions for each element of the calculation.
- **use of the findings from other reviews** where these meet SHA information needs, in order to minimise burden.
- **use of supporting business intelligence** to give attention to the longitudinal outcomes of education and to provide information to support interpretation of the results of performance assessment. SHAs should define research relating to supporting business intelligence on the basis of local priorities; however, SHAs are required to report within the next three years on student and employer feedback in relation to the readiness for work of new registrants.
- **red, amber, green (RAG) ratings** for each performance indicator based on annual comparison of performance against defined standards set locally; and a system for aggregation, again defined locally, to give a RAG rating for each programme (see Annex M).
- **clear criteria for linking payment with performance**, based on an aggregate of CPI RAG ratings at programme level, including as a minimum those shown in Table 5.
- **payment in retrospect** of funds linked with performance.
- **requirement for action planning** to tackle all areas of weakness identified.
• **risk-based interventions**, including strong interventions in the event that data or information is withheld or misrepresented

• **publication of findings.** The format for publication may be decided locally, but as a minimum RAG ratings for each profession at each HEI should be shown. SHAs may also decide locally to publish results at programme level. Profession ratings should be based on an aggregate of programme ratings weighted for the number of commissions. Additionally, larger SHA areas may choose to publish league tables.

The above principles, components and characteristics are reflected in the revised version of Schedule 3 of the *National Standard Framework Contract* (NSFC).
4.2 Performance management

Core minimum national contract performance indicators for non-medical pre-registration education where there is a benchmark price

CPIs are qualitative or quantitative measures of performance that relate to defined goals for quality and innovation in the healthcare education system, which will be set locally. Assessing performance using CPIs and defined local goals allows fair comparison of education provision locally and transparency nationally.

A core minimum set of CPIs for nursing, midwifery and AHP pre-registration education where there is a BMP were developed in order to produce a suite that met the following criteria:

- focus on SHA and service commissioner priorities of value for money, development of a fit-for-purpose workforce and promotion of innovation
- ability to promote partnership working between HEIs and providers of NHS commissioned services
- avoidance of perverse incentives
- utilisation of relevant evidence from other reviews, e.g. those by the Nursing and Midwifery Council and the Health Professions Council (it is acknowledged that ongoing work is required to promote effective partnership working with review bodies to ensure that information is shared in a timely way)
- suitability for linking payment with performance
- consideration of all elements of the student lifecycle from marketing, selection and recruitment through to academic and placement learning and final results
- promotion of completion of the feedback loop from students and employers to enhance quality.

In addition to using the CPIs, SHAs should collect information on longitudinal outcomes; for example student feedback on the value of their programme of study in preparing them for work, patient/carer and employer feedback on the performance of new qualifiers, retention information, career progression information and serious untoward incidents involving NHS-funded qualifiers. However, it is recognised that there are a number of challenges associated with collection and interpretation of such data:
The Electronic Staff Record (ESR) would not currently support collection of this data, as there is no link between NHS staff numbers and organisations involved in pre-registration education.

For the information to be useful, contradictory factors would need to be identified and accounted for appropriately. This would require ‘research-style’ data collection and evaluation, which has significant resource implications.

Ethical issues associated with the collection and use of the information, for example data protection issues, would need to be considered.

With the above challenges in mind, SHAs should work in partnership with HEIs and employers to identify local priorities and explore opportunities for joint research projects. However, it is a requirement that all SHAs report on longitudinal outcome data relating to student and employer feedback within the next three years.

It is recommended that SHAs collect data to support the interpretation of the results of assessment against the CPIs.

For example, it may be helpful to know about the proportion of late completers who had academic difficulties as compared with those who simply took periods of leave due to uncontrollable circumstances such as pregnancy, sickness or carer’s leave.

Finally, SHAs should continue to work with Skills for Health to explore the enhancements that would be required to enable SHAs effectively to use information from the National Student Survey administered by Ipsos MORI. Enhancements could include:

- action to raise response rates above 75%
- disaggregation of the current subject clusters (Annex N) so that findings could be viewed at profession level
- disaggregation of information about students’ placement experiences to allow identification of the placements used.

DH has invested just over £80,000 in this survey for 2009 and this has increased student response rates to the same level as that for non-NHS-funded programmes. The full set of questions in the National Student Survey (NSS) is shown in Annex O and HEFCE publish annually the NSS digest on their website.
Sampling

In order to enhance credibility, transparency and fairness SHAs should sample the evidence submitted by HEIs and their placement partners. The following approach is given as guidance.

**Routine sampling**

SHAs should routinely sample a range of CPIs in each HEI/profession group every year. It is recommended that all CPIs are sampled every three years.

For qualitative CPIs, HEIs could simply submit a yes/no response indicating whether they have evidence. This evidence need not be routinely submitted with the Contract Performance Return. However, it should be reviewed as part of the routine sampling system both for validation of the existence of evidence and to confirm the quality of the evidence (for example copies of signed placement agreements or action plans relating to recruitment policies).

**Specific interest sampling**

Specific interest sampling should be used in situations where some aspects of an HEI’s Contract Performance Return are felt by the contract manager to warrant further examination, e.g. when levels of performance appear to be materially high, low, inconsistent or indicative of good practice.

**Transparency and credibility**

It is recognised that HEIs seek to work in effective partnerships with the local NHS and SHAs. It is therefore expected that relationships will be open and transparent, supporting credibility of the contract performance management system. In the unlikely event that it becomes known that an HEI has withheld information or has deliberately provided misleading information, the programme in question should be automatically red-rated.
4.3 Performance management

Risk rating principles

SHAs should apply a RAG rating to each quantitative CPI for each programme. Qualitative CPIs should be risk-rated either red or green.

Specific tolerances should be used to assign ratings to quantitative CPIs. It is expected that these will vary between SHA regions and between professions. Tolerances should be reviewed annually and amended where appropriate.

SHAs should take account of the following factors when setting tolerances:

- stretch to encourage continuous improvement
- local workforce priorities
- differences between professions and between levels of exit award associated with the same professional registration, e.g. nursing degrees and nursing diplomas
- local baseline and trend data as it becomes available.

Quantitative indicators may have either three tolerances – red, amber and green – or five tolerances where allowance needs to be made for concerns about high numbers as well as low numbers. For example, for actual recruitment against commissioned numbers, tolerances would need to be set as shown below, where the actual tolerances are simply examples.

**R2 tolerance example**
(see Annex M) (aggregating CPI RAG ratings)

<table>
<thead>
<tr>
<th>RED</th>
<th>AMBER</th>
<th>GREEN</th>
<th>AMBER</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;-15%</td>
<td>-15% to -5%</td>
<td>-5% to 5%</td>
<td>5% to 15%</td>
<td>&gt;15%</td>
</tr>
</tbody>
</table>

SHAs may wish to give CPIs a weighting to reflect local priorities.

Once risk ratings have been determined these should be used to produce a standardised core for all annual reports for each profession at each HEI. These should be discussed at an annual review meeting.

**Consequences of risk ratings**

**Linking payment with quality**

As a minimum, SHAs should RAG-rate performance against each CPI for a programme and use this to produce an aggregate rating for the programme (see Annex M) This rating should be used to make decisions about performance-related elements of funding.
From 2010/11, 5% should be made available as a performance premium. The full 5% should be paid for all green-rated programmes. Payment of part of this performance-related funding could be made where programmes demonstrate a significant improvement on performance in the previous contract year at local discretion, or where they meet targets for key indicators of local interest. Where a discretionary payment is made it should be linked to an action plan designed to drive up performance further.

In order to support transparency DH will request the following information each year from all SHAs:

- the full set of CPIs (i.e. the national CPIs and any local additions)
- aggregation methodologies
- tolerances
- performance-related elements of payments to HEIs and the associated rationales.

DH is proposing a bilateral process whereby DH may challenge local requirements and request a supporting rationale. Local indicators and processes for all SHAs will be published centrally; however, review results will be published locally as results are not intended for national comparison.

**Risk-based interventions**

Red, amber or green ratings should trigger different levels of intervention. The primary aim of these interventions should be to drive up quality to meet the required minimum standard. Red-rated programmes should be monitored frequently against an action plan that includes specific measurable success criteria, some of which should be achieved rapidly to support confidence that medium- and long-term goals, such as improvements relating to quantitative indicators, will be achieved. Guideline interventions for programmes showing different levels of risk are shown in Table 7.
Tables: Performance management

Table 5: Core minimum national contract performance indicators
non-medical pre-reg education

(See Annex K for evidence exemplars)

<table>
<thead>
<tr>
<th>Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECRUITMENT</strong></td>
</tr>
<tr>
<td><strong>R1:</strong> A representative sample of senior staff from providers of NHS commissioned services carry out a stock-take of recruitment and selection policy and processes and mutually agree any actions with the HEI annually.</td>
</tr>
<tr>
<td><strong>R2:</strong> Variance between commissioned numbers and actual students recruited per programme (%): [ \frac{(\text{number of students commissioned} - \text{number of starters})}{\text{number of students commissioned}} \times 100. ]</td>
</tr>
<tr>
<td><strong>LEARNING IN THE UNIVERSITY</strong></td>
</tr>
<tr>
<td><strong>A1:</strong> A representative sample of senior staff from providers of NHS commissioned services mutually take stock, review and agree with the HEI action required to ensure that course content is suitable for ensuring a workforce that is fit for purpose.</td>
</tr>
<tr>
<td><strong>A2:</strong> A representative sample of senior staff from providers of NHS commissioned services mutually reviews and agrees with the HEI action required to ensure that course delivery is suitable for ensuring a workforce that is fit for purpose.</td>
</tr>
</tbody>
</table>
LEARNING IN THE PRACTICE SETTING

P1: The core placement indicators (Annex J) are reviewed at a defined frequency and the review confirms that either there are no risks or that risks are being managed effectively. The frequency will be as set by professional regulatory body requirements or once every five years as a minimum, whichever is the more frequent with the following exceptions where annual review is required:

- placements providing more than 10% of the total placement volume for that programme in the contract year
- organisations where the HEI has raised formal concerns about placement performance with the SHA.

P2: A representative sample of senior staff from providers of NHS commissioned services, as agreed with placement providers, confirms that all staff involved in placement learning and assessment have access to educational resources, including, where relevant, formal training programmes to enable them to support student learning and assessment effectively.

P3: A representative sample of senior staff from providers of NHS commissioned services, as agreed with placement providers, confirms that any concerns about the fitness for placement of students are being responded to in line with processes and timeframes mutually agreed by the HEI and the placement provider and the NHS and HEIs work in partnership to resolve any issues.

P4: A representative sample of senior staff from providers of NHS commissioned services, as agreed with placement providers, confirms that Criminal Records Bureau (CRB)/Independent Safeguarding Authority (ISA) and occupational health checks, and any resultant actions, are carried out by the HEI in accordance with mutually agreed processes.
Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)

P5: A representative sample of senior staff from providers of NHS commissioned services as agreed with placement providers confirm that students starting placements demonstrate basic skills, knowledge and professional behaviours as mutually agreed with the HEI.

OUTPUTS

O1: Attrition as a % for the programme

Attrition % = \[
\frac{\text{Discontinuations + External Transfers Out + Internal Transfers Out} - (\text{Internal Transfers In + External Transfers In})}{\text{Starters}} \times 100
\]

Note: In relation to students transferring from nursing diploma to degree programmes – For the purposes of the attrition calculation HEIs should indicate the number of external transfers in and out that are transferring from diploma to degree so that a manual adjustment can be made to ensure that HEIs are not inappropriately penalised. However these numbers must be included in the initial external transfers in and out submitted to ensure that SHAs can check that all the numerical data submitted is accurate.

O2: Percentage of students commissioned who complete on time, i.e. within one month of the end of the programme (or locally agreed time dependent on the reassessment committee).

For each cohort:

\[
\frac{\text{(number of students commissioned – number of students that complete under the definition of standard progression) / number of students commissioned}}{100}.
\]
Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)

**COMMITMENT AND TRANSPARENCY**

<table>
<thead>
<tr>
<th>C1: HEI confirms over the course of the year it has reported any weaknesses identified by relevant reviews eg PRB, QAA or internal reviews within 2 weeks of verbal feedback or as soon as possible and in any case within 3 working days of receipt of the written report whichever is soonest. In addition, the HEI is able to confirm that an action plan has been or is being developed in partnership with placement providers. Or the HEI is able to confirm that no weaknesses were identified by any form of review over the previous year.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>C2: The HEI collects student feedback through the National Student Survey and other appropriate means such that an audit trail showing resultant action plans and service improvements can be demonstrated.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>C3: Contract performance returns and other routine data returns are produced on time and meet the criteria specified.</th>
</tr>
</thead>
</table>

**Notes**

* For quantitative indicators SHAs should devise an approach locally for managing small cohorts.

* All placement providers should be aware of the contact details of the mutually agreed subset of placement providers so that they can raise concerns relating to the indicators.
**Table 6: Supporting business intelligence**

<table>
<thead>
<tr>
<th>Required</th>
<th>Recommended supporting business intelligence (SHAs should decide what is useful/practical locally given resources available)</th>
</tr>
</thead>
</table>
| Student feedback on the extent to which their course prepared them for practice, by HEI by profession. | Patient/carer feedback on the performance of new qualifiers.  
(Report required from each SHA by April 2012.) |
| Employer feedback on the performance of new qualifiers by HEI by profession. | First destination of NHS-funded qualifiers by HEI by profession. (Note: the next ESR review will consider options for supporting this.)  
(Report required from each SHA by April 2012.) |
| Exits as a percentage for the programme for each cohort:  
Exits (%) = ((discontinuations + external transfers out + internal transfers out) / (starters + external transfers in)) x 100 | Longitudinal career progression/retention, e.g. at two, three and five years, of NHS-funded qualifiers, by HEI by profession.  
SHAs may wish to use this as a metric once trend data is available. Should be collected to support understanding of attrition. |
<table>
<thead>
<tr>
<th>Required</th>
<th>Recommended supporting business intelligence (SHAs should decide what is useful/practical locally given resources available)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entry level qualifications.</td>
</tr>
<tr>
<td></td>
<td>Demographic information.</td>
</tr>
<tr>
<td></td>
<td>Circumstances associated with late completion and percentage of students completing at 12 months and 24 months.</td>
</tr>
<tr>
<td></td>
<td>Serious untoward incidents (SUIs) involving NHS-funded qualifiers by HEI by profession in the first year post-qualification. (Note: the next ESR review will consider options for supporting this.)</td>
</tr>
</tbody>
</table>
The programme enters a formal period of turnaround where the SHA will require rapid evidence that success criteria set in the six-month action plan have been met.

The SHA should work in partnership with the HEI to support improvement. The aim of the turnaround period is to restore confidence in the performance of the HEI. The SHA should meet frequently with the HEI, for example at fortnightly reviews, and mutually agree actions going forward.

An extraordinary review meeting following the same format as the annual review meeting should be called by the SHA to coincide with the agreed deadline for achieving the success criteria. If the success criteria are not met within the specified time, the SHA should consider whether there has been a material breach of the contract; the SHA may act on that breach under the terms of the contract or reserve its right to act. In the event that the SHA reserves its right to act, a further action plan will need to be developed and the HEI will remain in ‘special measures’. The contract between the SHA and the HEI should be clear that where the SHA reserves its right to act, this should not be taken as a waiver of its right to act in future.

The SHA should liaise with the HEI to identify key actions and organise a programme of review meetings in proportion to the scale and scope of the risk.

The frequency of review should be determined locally, dependent on the value and strategic importance of the contract. Action plans relating to high value contracts of strategic importance should be reviewed at least quarterly. Action plans for all amber-rated programmes should be reviewed once between annual reviews.

The SHA should meet routinely with the HEI to discuss ongoing business and the HEI should use these meetings to report on evolving areas of potential concern. For any professions where new commissions become available or where existing commissions need to be reallocated, HEIs with a green rating for that profession should be considered first. This consideration must explore the potential for additional academic and placement learning capacity at the HEI.
Table 8: Sample performance indicators for lifelong learning and continuing professional development contracts, with evidence exemplars

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition and evidence exemplars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECRUITMENT</strong></td>
<td></td>
</tr>
<tr>
<td><strong>R1:</strong> The HEI monitors the suitability of candidates, to include as a minimum consideration of:</td>
<td>Acceptable evidence would be:</td>
</tr>
<tr>
<td>• previous academic qualifications</td>
<td>• anonymised records of shortlisting and, where relevant, interview paperwork.</td>
</tr>
<tr>
<td>• work experience, relevant baseline competencies</td>
<td></td>
</tr>
<tr>
<td>• fitness for practice, i.e. health and CRB/ISA status.</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Definition and evidence exemplars</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>LEARNING IN THE UNIVERSITY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A1:</strong> A representative sample of senior providers of NHS commissioned services staff, past and potential future students, service users and carers mutually review and agree with the HEI action required to ensure that course content and delivery is suitable for ensuring a workforce that is fit for purpose. This review must include as a minimum discussion relating to:</td>
<td>Acceptable evidence would be:</td>
</tr>
<tr>
<td>• linking the curriculum with the NHS aspiration for the professional workforce to be practitioners, partners and leaders</td>
<td>• minutes of meetings containing clear, unambiguous reference to the discussions, including the minimum requirements described opposite and action points agreed or</td>
</tr>
<tr>
<td>• supporting interprofessional learning</td>
<td>• a signed letter from the representative sample of senior NHS staff agreeing that the Contract Performance Management (CPM) is being met and setting out the specific issues discussed, including the minimum requirements described opposite and action points agreed.</td>
</tr>
<tr>
<td>• ensuring that teaching includes innovative approaches to patient care and treatment</td>
<td></td>
</tr>
<tr>
<td>• ensuring that delivery includes innovative approaches to teaching and assessment</td>
<td></td>
</tr>
<tr>
<td>• any concerns raised formally by students and/or the local NHS.</td>
<td></td>
</tr>
<tr>
<td><strong>A2:</strong> Percentage of students that evaluate the course, module or programme as highly relevant in enabling them to do their job better (when selecting from a four-point scale – highly relevant, relevant, limited relevance, not relevant); or similar local measure.</td>
<td>Annual reports showing the results of student surveys.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Definition and evidence exemplars</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>LEARNING IN THE PRACTICE SETTING</strong></td>
<td></td>
</tr>
<tr>
<td>P1: Where the course, module or programme requires workplace learning with a formal assessment component, either at the student’s usual place of work or elsewhere, the placement has been audited to ensure it meets the needs of the contract.</td>
<td>Annual reports showing the results of audits.</td>
</tr>
<tr>
<td><strong>OUTPUTS</strong></td>
<td></td>
</tr>
<tr>
<td>O1: Percentage of contract value used annually.</td>
<td>Annual report.</td>
</tr>
<tr>
<td><strong>COMMITMENT AND TRANSPARENCY</strong></td>
<td></td>
</tr>
<tr>
<td>C1: The HEI confirms that it has reported any weaknesses identified by PRB review, QAA or internal review within two weeks of verbal feedback or within 24 hours of receipt of the written report, whichever is soonest, and is able to confirm that an action plan has been or is being agreed in partnership with placement providers. Alternatively, the HEI is able to confirm that no weaknesses were identified by any form of review over the previous year.</td>
<td>Relates to contract year being reviewed.</td>
</tr>
</tbody>
</table>

*Introduction*

World Class Education Commissioning

Planning

Procurement/Contracting

Education delivery

Performance management

Contract performance management

Core minimum national contract performance indicators

Risk rating principles

Tables 5-8

Annex J

Annex K

Annex L

Annex M

Annex N

Annex O

Print
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition and evidence exemplars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C2:</strong> The HEI collects student feedback on course content and delivery, adequacy of preparation for placements and placement learning experiences, and can demonstrate an audit trail showing resultant action plans and service improvements.</td>
<td>Action plans and collated student feedback for each cohort must be available on request.</td>
</tr>
<tr>
<td><strong>C3:</strong> Contract performance returns and other data returns are produced on time and meet the criteria specified.</td>
<td>Returns requested by the SHA from HEIs are returned by the date specified. This CPM is confirmed by the SHA.</td>
</tr>
</tbody>
</table>
Performance management: Annex J

Core minimum placement provider indicators (for education covered by the National Standard Framework Contract)

These indicators have been designed to mirror the responsibilities of the HEI set out in the core minimum national contract performance indicators in Table 5. Placement provider indicators should also be included or referenced in learning and development agreements (LDAs). The model Partnership Agreement at Schedule 2 has been amended to include the placement indicators and reference to the placement-related indicators from the CPIs in Table 5.

The placement provider shall:

1. ensure that it makes senior staff available to be involved in the following as required:
   • reviewing the institution’s recruitment and selection policies and criteria
   • reviewing course content and delivery
   • reviewing the CRB, ISA and occupational health clearance processes that the institution has in place to screen students before they are admitted on a practice placement
   • reviewing contract performance returns to confirm veracity as appropriate

2. ensure that students receive an appropriate induction to all placement areas

3. ensure that it makes placement educators available annually for involvement in developing performance action plans

4. ensure that all relevant staff working in the placement area have education responsibilities included in their job descriptions and competencies defined in their job specifications. Ensure that all relevant staff employed in the placement area are either competent to support student learning and assessment or are required to commence a programme of continuing professional development (CPD) on recruitment, or on completion of any preceptorship period or equivalent, to achieve these competencies

(Note: It is accepted that placements in very small organisations, including social enterprises and care homes, may require significant input from placement support staff employed by HEIs in order to deliver quality placements. In these circumstances, the professional staff member(s) in the placement area should still have relevant education responsibilities in their job descriptions and should have access to appropriate development. It is accepted that...
the education and assessment responsibilities of staff in these small organisations may be quite different to those of a nurse on an acute hospital ward. The metric should be interpreted flexibly by the HEI and SHA to take account of local circumstances.

5. immediately notify the institution of any serious untoward incidents where the involvement of a student calls into question their fitness for training

6. accept as valid the CRB and occupational health checks carried out by the institution in accordance with mutually agreed criteria

7. immediately notify the institution of any service provision changes that might affect the students’ ability to meet the specified learning outcomes set by the institution

8. ensure that students receive feedback on their performance in a timeframe appropriate to the activity performed as agreed between the institution and placement provider

9. ensure that student assessment is appropriately moderated as agreed between the institution and the placement provider

10. collect and collate feedback from all students and regularly agree action plans with the institution to address the issues raised.
Performance management: Annex K
Evidence exemplars for contract performance indicators for non-medical pre-reg education

Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)

Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)

RECRUITMENT

R1: A representative sample of senior staff from providers of NHS commissioned services carry out a stock-take of recruitment and selection policy and processes and mutually agree any actions with the HEI annually.

Recruitment and selection plan showing actions and the outcomes of these actions. As a minimum this plan should include the following topics:

- support for widening access
- promotion of equality and diversity
- ensuring candidates’ compatibility with core NHS and professional values
- management of concerns raised formally by employers about the suitability of students recruited previously
- innovation in marketing, recruitment
<table>
<thead>
<tr>
<th>Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)</th>
<th>Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)</th>
</tr>
</thead>
</table>
| **R2**: Variance between commissioned numbers and actual students recruited per programme (percentage)  
Number of students commissioned – minus number of starters / number of students commissioned x 100 | Numerical targets for red, amber and green ratings setting tolerances for both under and over-recruitment. Targets to be set for each profession to take account of baseline assessment, local workforce priorities and the need for stretch. |
| **LEARNING IN THE UNIVERSITY** | |
| **A1**: A representative sample of senior staff from providers of NHS commissioned services mutually take stock, review and agree with the HEI action required to ensure that course content is suitable for ensuring a workforce that is fit for purpose. | Plan showing actions and the outcomes of these actions. As a minimum this plan should include the following topics:  
- linking the curriculum with the NHS aspiration for the professional workforce to be practitioners, partners and leaders  
- support for interprofessional learning  
- management of concerns about the curriculum raised formally by employers about the suitability of students recruited previously. |

**Introduction**

World Class Education Commissioning

Planning

Procurement/Contracting

Education delivery

Performance management

Contract performance management

Core minimum national contract performance indicators

Risk rating principles

Tables 5-8

Annex J

Annex K

Annex L

Annex M

Annex N

Annex O

Print
Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)

Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)

A2: A representative sample of staff from providers of NHS commissioned services mutually review and agree with the HEI action required to ensure that course delivery is suitable for ensuring a workforce that is fit for purpose.

Plan showing actions and the outcomes of these actions. As a minimum this plan should include the following topics:
- any updates required to include innovative approaches to patient care and treatment
- any updates required to include innovative approaches to teaching and assessment
- management of concerns raised formally by students and/or the local NHS.
**LEARNING IN THE PRACTICE SETTING**

<table>
<thead>
<tr>
<th>Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)</th>
<th>Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)</th>
</tr>
</thead>
</table>

**P1:** The core minimum placement provider indicators (Annex J) are reviewed at a defined frequency and the review confirms either that there are no risks or that risks are being managed effectively.

- The frequency will be as set by Professional Regulatory Body requirements or once every 5 years as a minimum, whichever is the more frequent with the following exceptions where annual review is required:
  - placements providing more than 10% of the total placement volume for that programme in the contract year
  - organisations where the HEI has raised formal concerns about placement performance with the SHA.

Evidence needs to be available on request of reviews at a defined frequency of compliance with the expectations set out in the placement agreement between the HEIs and placement providers.

Acceptable evidence would be:

- a record of the review showing the results for each indicator and the action plan for all indicators where weaknesses were identified.

Note: The core minimum set of indicators relating to the placement providers’ responsibilities must also be linked with the LDA.
Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)

Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)

**P2:** A representative sample of senior staff from providers of NHS commissioned services as agreed with placement providers confirm that staff involved in placement learning and assessment have access to educational resources, including where relevant formal training programmes, to enable them to support student learning and assessment effectively.

Evidence needs to be available on request of confirmation from the representative sample of senior staff from providers of NHS commissioned services.

Acceptable evidence would be:
- minutes of meetings containing clear, unambiguous reference to the confirmation or
- a signed letter from representative senior practice staff from the NHS in the region agreeing that the CPI is being met.

**P3:** A representative sample of senior staff from providers of NHS commissioned services as agreed with placement providers confirm that any concerns about the fitness for placement of students are being responded to in line with processes and timeframes mutually agreed by the HEI and the placement provider and the NHS and HEIs work in partnership to resolve any issues.

Evidence needs to be available on request of confirmation from the representative sample of senior staff from providers of NHS commissioned services.

Acceptable evidence would be:
- minutes of meetings containing clear unambiguous reference to the confirmation or
- a signed letter from representative senior practice staff from the NHS in the region agreeing that the CPI is being met.
<table>
<thead>
<tr>
<th>Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)</th>
<th>Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)</th>
</tr>
</thead>
</table>
| **P4:** A representative sample of senior staff from providers of NHS commissioned services as agreed with placement providers confirm that CRB/ISA and occupational health checks and any resultant actions are carried out by the HEI in accordance with mutually agreed processes. Evidence needs to be available on request of confirmation from the representative sample of senior staff from providers of NHS commissioned services. Acceptable evidence would be:  
- minutes of meetings containing clear, unambiguous reference to the confirmation or  
- a signed letter from representative senior practice staff from the NHS in the region agreeing that the CPI is being met. |
| **P5:** A representative sample of senior staff from providers of NHS commissioned services as agreed with placement providers confirm that students starting placements demonstrate basic skills, knowledge and professional behaviours as mutually agreed with the HEI. Evidence needs to be available on request of confirmation from the representative sample of senior staff from providers of NHS commissioned services. Acceptable evidence would be:  
- minutes of meetings containing clear, unambiguous reference to the confirmation or  
- a signed letter from representative senior practice staff from the NHS in the region agreeing that the CPI is being met. |
<table>
<thead>
<tr>
<th>Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)</th>
<th>Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)</th>
</tr>
</thead>
</table>

**OUTPUTS**

**O1: Attrition as a % for the programme**

For each cohort:

Attrition % = \[
\frac{\text{Discontinuations} + \text{External Transfers Out} + \text{Internal Transfers Out} - (\text{Internal Transfers In} + \text{External Transfers In})}{\text{Starters}} \times 100
\]

Note: In relation to students transferring from nursing diploma to degree programmes - For the purposes of the attrition calculation HEIs should indicate the number of external transfers in and out that are transferring from diploma to degree so that a manual adjustment can be made to ensure that HEIs are not inappropriately penalised. However these numbers must be included in the initial external transfers in and out submitted to ensure that SHAs can check that all the numerical data submitted is accurate.

Numerical targets for red, amber and green ratings. Targets to be set for each profession to take account of baseline assessment, local workforce priorities and the need for stretch.
### Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)

<table>
<thead>
<tr>
<th><strong>O2:</strong> % of students commissioned who complete on time ie within 1 month (or a locally agreed time dependent on the re-assessment committee) of the end of the programme. For each cohort:</th>
</tr>
</thead>
</table>
| \[
\text{[(number of students commissioned – number of students that complete under the definition of standard progression)/ number of students commissioned]} \times 100
\] |

### Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)

Numerical targets for red, amber and green ratings. Targets to be set for each profession to take account of baseline assessment, local workforce priorities and the need for stretch.

### COMMITMENT AND TRANSPARENCY

<table>
<thead>
<tr>
<th><strong>C1:</strong> HEI confirms over the course of the year it has reported any weaknesses identified by relevant reviews eg PRB, QAA or internal reviews within 2 weeks of verbal feedback or as soon as possible and in any case within 3 working days of receipt of the written report whichever is soonest. In addition, the HEI is able to confirm that an action plan has been or is being developed in partnership with placement providers. Or the HEI is able to confirm that no weaknesses were identified by any form of review over the previous year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports from other reviewers and associated action plans should be available if requested.</td>
</tr>
</tbody>
</table>

---

**Introduction**

**World Class Education Commissioning**

**Planning**

**Procurement/Contracting**

**Education delivery**

**Performance management**

- Contract performance management
- Core minimum national contract performance indicators
- Risk rating principles
- Tables 5-8
- Annex J
- Annex K
- Annex L
- Annex M
- Annex N
- Annex O

---

**Print**

- Planning
- Procurement/Contracting
- Education delivery
- Performance management
<table>
<thead>
<tr>
<th>Indicator (see glossary at Annex L for detailed definitions of all the individual elements of the calculations required for the quantitative indicators)</th>
<th>Evidence exemplar (SHAs should set evidence requirements and numerical targets locally using the exemplars below for guidance. Evidence for all qualitative CPIs should demonstrate effective partnership working between SHAs and providers of NHS commissioned services and higher education.)</th>
</tr>
</thead>
</table>
| **C2:** The HEI collects student feedback through the National Student Survey and other appropriate means such that an audit trail showing resultant action plans and service improvements can be demonstrated. | Action plans and collated student feedback for each cohort must be available on request and should cover the following topics as a minimum:  
- course content and delivery  
- adequacy of preparation for placements  
Placement learning experiences  
National Student Survey data and/or any other relevant source may be used. |
| **C3:** Contract performance returns and other routine data returns are produced on time and meet the criteria specified. | CPI is confirmed by the SHA. |
## Performance management: Annex L

Contract performance indicator glossary for non-medical pre-reg education

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>APEL</td>
<td>Accreditation of Prior And Experiential Learning (APEL) is a process that enables people to receive formal recognition for skills and knowledge they already possess. This can include organised prior-learning where the learning has been assessed and where certificates are awarded on completion as well as earning gained through less structured general work and voluntary experiences and short courses</td>
</tr>
<tr>
<td>Commissions</td>
<td>Number of commissions per programme per intake as specified in the commissioning letter from the SHA to the HEI</td>
</tr>
</tbody>
</table>
Term | Definition
--- | ---
Discontinuations | Students that permanently leave the programme before the end date for any reason other than those that are external transfers out. Students who qualify with an exit award that does not allow them to practise in the profession to which they were originally recruited should be counted as discontinuations.

In terms of discontinuations it is useful to discuss this locally – but it would be useful to collect a breakdown of discontinuations for action planning purposes and for information the following are most likely to be useful categories and should be annually monitored:

- academic failure (02 definition in HESA terms)
- placement failure (02 definition in HESA terms)
- CRB failure (02 definition in HESA terms)
- personal circumstances (07 definition in HESA terms)
- financial circumstances (06 definition in HESA terms)
- took up employment (10 definition in HESA terms)
- wrong career choice (07/10 definition in HESA terms)
- ill health (04 definition in HESA terms)
- dissatisfaction with the course (07/03/11 definition in HESA terms)
- dissatisfaction with practice placement (07/03/11 definition in HESA terms)
- dismissed (academic misconduct, conduct disciplinary) (02 definition in HESA terms)
- deceased (05 definition in HESA terms)
- completed course but awarded a qualification that is not associated with eligibility to join the register (98 definition in HESA terms)
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>External transfers in</td>
<td>Students that join a programme other than at the start having come from a different NHS funded programme, pathway or institution or students that APEL in. External transfers in should be included as starters from the year in which they join. Note: In relation to students transferring from nursing diploma to degree programmes - For the purposes of the attrition calculation HEIs should indicate the number of external transfers in that are transferring from diploma to degree so that a manual adjustment can be made to ensure that HEIs are not inappropriately penalised. However, these numbers must be included in the initial external transfers in submitted to ensure that SHAs can check that all the numerical data submitted is accurate.</td>
</tr>
<tr>
<td>External transfers out</td>
<td>Students that leave the programme other than as a qualifier to join a different pathway programme or institution than that which they joined originally but which is still funded by the NHS. Note: In relation to students transferring from nursing diploma to degree programmes - For the purposes of the attrition calculation HEIs should indicate the number of external transfers out that are transferring from diploma to degree so that a manual adjustment can be made to ensure that HEIs are not inappropriately penalised. However these numbers must be included in the initial external transfers out submitted to ensure that SHAs can check that all the numerical data submitted is accurate.</td>
</tr>
<tr>
<td>Internal transfers in</td>
<td>Students that join a following cohort to repeat modules as an NHS funded student because they were not progressed to the next year or join a following cohort because they have repeated modules as a self funded student but are now returning as an NHS funded student to complete. For the avoidance of doubt only students with agreed SHA funding may be entered as Internal Transfers In. Students counted as Internal Transfers in MUST NOT also be counted as Starters. Internal transfers in should match internal transfers out of the same programme.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Internal transfers out</td>
<td>Students that are not progressed to the next stage of the programme and are allocated to join the following cohort to repeat modules, whether or not the repeat is being funded by the NHS. Students that repeat modules such that they cannot progress in the standard timeframe with funding other than that provided by the SHA are internal transfers out until they re-enter with SHA funding. Students that repeat modules in holidays or alongside modules they are taking on the standard progression route should be treated as though they are progressing in the standard way. Internal transfers out should match internal transfers in to the same programme.</td>
</tr>
<tr>
<td>Interrupts</td>
<td>Students who temporarily leave a programme for a short time. Interrupts SHOULD NOT appear in the calculation of attrition or exits so long as the student returns to the SAME COHORT.</td>
</tr>
<tr>
<td>Programme</td>
<td>The primary qualification aim for which the student enrolled eg BSc Physiotherapy, MSc Dietetics.</td>
</tr>
<tr>
<td>Providers of NHS commissioned services</td>
<td>Any organisation providing services under an NHS contract ie includes independent healthcare providers, the voluntary sector, social enterprises, community hospitals, polyclinics, GP practices etc.</td>
</tr>
</tbody>
</table>
| Senior staff from providers of NHS commissioned services | Suitable staff should be agreed locally but should be selected based on the following criteria:  
  • having the authority to act on behalf of their organisation  
  • having sufficient experience to understand strategic as well as operational issues for their organisation and more widely  
  • having specific discipline knowledge where deemed necessary. |
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard progression</td>
<td>Students who qualify from the programme of study for which they originally enrolled within the normal programme duration as specified in the prospectus and/or programme handbook, without re-sitting such that they would not complete within the normal timeframe. Only students qualifying with the award required to enable them to join the professional register relating to the original commission should be counted as students who qualify. Students who qualify with an exit award that does not make them eligible for the register as intended must be counted as discontinued.</td>
</tr>
<tr>
<td>Starters</td>
<td>For the purposes of the attrition calculation for programmes starters include first time entrants to year 1, first time entrants as external transfers in, including APEL (see definition.) Starters should be recorded 10 weeks after the official start date for the programme for the purposes of calculating attrition and exits. Internal transfers in (see definition) are NOT included.</td>
</tr>
</tbody>
</table>
Performance management: Annex M

Aggregating contract performance indicators for non-medical pre-reg education red, amber, green ratings to give programme ratings

SHAs may wish to give CPIs a weighting to reflect local priorities, and these weightings may also vary across professions, where appropriate. SHAs should design systems locally to aggregate results up to programme level. An example of how this could be done is shown below. Note that it is simply an example to illustrate the approach. SHAs must develop local weightings and scoring systems that set appropriate local stretch. National comparison of performance would still be possible if this was ever required, but it would need to use actual results against each of the national CPIs.

Step 1: Decide on weightings for each CPI

Qualitative indicators can only be red or green, i.e. HEIs and providers of NHS commissioned services must decide if the performance is adequate to warrant a green rating. The guidance is that where there are deficits, unless these are very minor, a red rating should be given.

The illustrative weightings in the table below give a 70% weighting to the combined quantitative CPIs and a 30% weighting to the combined qualitative CPIs. The illustrative rationale for this is that the SHA that set these weightings wants to drive improvements in recruitment to target and in outputs as a priority. This is just an example – another SHA may have different priorities, although it is important to bear in mind that there are far fewer quantitative CPIs.
Illustrative weightings for each contract performance indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 (Involving service providers in recruitment)</td>
<td>1</td>
</tr>
<tr>
<td>R2 (Actual vs commissioned)</td>
<td>5</td>
</tr>
<tr>
<td>A1 (Involving service providers in course design)</td>
<td>1</td>
</tr>
<tr>
<td>A2 (Involving service providers in course delivery)</td>
<td>1</td>
</tr>
<tr>
<td>P1 (Need for placement audit against core national indicators)</td>
<td>4</td>
</tr>
<tr>
<td>P2 (Placement provider access to development resources and courses)</td>
<td>1</td>
</tr>
<tr>
<td>P3 (Concerns about student fitness for purpose responded to)</td>
<td>1</td>
</tr>
<tr>
<td>P4 (Placement provider involvement in CRB/ISA and occupational health policy)</td>
<td>1</td>
</tr>
<tr>
<td>P5 (Feedback that students meet relevant standards before placements)</td>
<td>1</td>
</tr>
<tr>
<td>O1 (Attrition)</td>
<td>15</td>
</tr>
<tr>
<td>O2 (Completion on time)</td>
<td>15</td>
</tr>
</tbody>
</table>
### Indicator Weighting

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 (Third party review)</td>
<td>1</td>
</tr>
<tr>
<td>C2 (Ensuring the loop from student feedback to enhanced quality is closed)</td>
<td>2</td>
</tr>
<tr>
<td>C3 (Accuracy and timeliness of data returns)</td>
<td>2</td>
</tr>
</tbody>
</table>

### Step 2: Assign scores to each rating

In the example below minus scores have been used for both red and amber ratings so that the higher weightings bring down amber scores as well as red.

These scores give an equal three-point difference between each rating band.

#### Illustrative scores for each rating

<table>
<thead>
<tr>
<th>RED</th>
<th>AMBER</th>
<th>GREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minus 4</td>
<td>Minus 1</td>
<td>Plus 2</td>
</tr>
</tbody>
</table>
Step 3: Calculate scores for each contract performance indicator using the red, amber, green scores and weightings

Example showing results for a programme with some weaknesses

<table>
<thead>
<tr>
<th>Indicator and brief description</th>
<th>RAG</th>
<th>Score</th>
<th>Weighting</th>
<th>Weighted score (weighting x score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 (Involving service providers in recruitment)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>R2 (Actual vs commissioned)</td>
<td>A</td>
<td>–1</td>
<td>5</td>
<td>–5</td>
</tr>
<tr>
<td>A1 (Involving service providers in course design)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A2 (Involving service providers in course delivery)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>P1 (Placement audit)</td>
<td>G</td>
<td>2</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>P2 (Placement provider access to development resources and courses)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Indicator and brief description</td>
<td>RAG</td>
<td>Score</td>
<td>Weighting</td>
<td>Weighted score (weighting x score)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----</td>
<td>-------</td>
<td>-----------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>P3 (Concerns about student fitness for purpose responded to)</td>
<td>R</td>
<td>−4</td>
<td>1</td>
<td>−4</td>
</tr>
<tr>
<td>P4 (Placement provider involvement in CRB/ISA and occupational health policy)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>P5 (Feedback that students meet relevant standards before placements)</td>
<td>R</td>
<td>−4</td>
<td>1</td>
<td>−4</td>
</tr>
<tr>
<td>O1 (Attrition)</td>
<td>R</td>
<td>−4</td>
<td>15</td>
<td>−60</td>
</tr>
<tr>
<td>O2 (Completion on time)</td>
<td>A</td>
<td>−1</td>
<td>15</td>
<td>−15</td>
</tr>
<tr>
<td>C1 (Third party review)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>C2 (Ensuring the loop from student feedback to enhanced quality is closed)</td>
<td>G</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>C3 (Accuracy and timeliness of data returns)</td>
<td>R</td>
<td>−4</td>
<td>2</td>
<td>−8</td>
</tr>
<tr>
<td>Total score</td>
<td></td>
<td></td>
<td></td>
<td>−72</td>
</tr>
</tbody>
</table>

**Introduction**

**World Class Education Commissioning**

**Planning**

**Procurement/Contracting**

**Education delivery**

**Performance management**

Contract performance management

Core minimum national contract performance indicators

Risk rating principles

Tables 5-8

Annex J

Annex K

Annex L

Annex M

Annex N

Annex O

**Print**
Examples showing results for a programme with significant weaknesses

<table>
<thead>
<tr>
<th>Indicator and brief description</th>
<th>RAG</th>
<th>Score</th>
<th>Weighting</th>
<th>Weighted score (weighting x score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 (Involving service providers in recruitment)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>R2 (Actual vs commissioned)</td>
<td>R</td>
<td>–4</td>
<td>5</td>
<td>–20</td>
</tr>
<tr>
<td>A1 (Involving service providers in course design)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A2 (Involving service providers in course delivery)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>P1 (Placement audit)</td>
<td>G</td>
<td>2</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>P2 (Placement provider access to development resources and courses)</td>
<td>R</td>
<td>–4</td>
<td>1</td>
<td>–4</td>
</tr>
<tr>
<td>P3 (Concerns about student fitness for purpose responded to)</td>
<td>R</td>
<td>–4</td>
<td>1</td>
<td>–4</td>
</tr>
<tr>
<td>Indicator and brief description</td>
<td>RAG</td>
<td>Score</td>
<td>Weighting</td>
<td>Weighted score (weighting x score)</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>-------</td>
<td>-----------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>P4 (Placement provider involvement in CRB/ISA and occupational health policy)</td>
<td>R</td>
<td>-4</td>
<td>1</td>
<td>-4</td>
</tr>
<tr>
<td>P5 (Feedback that students meet relevant standards before placements)</td>
<td>R</td>
<td>-4</td>
<td>1</td>
<td>-4</td>
</tr>
<tr>
<td>O1 (Attrition)</td>
<td>R</td>
<td>-4</td>
<td>15</td>
<td>-60</td>
</tr>
<tr>
<td>O2 (Completion on time)</td>
<td>R</td>
<td>-4</td>
<td>15</td>
<td>-60</td>
</tr>
<tr>
<td>C1 (Third party review)</td>
<td>R</td>
<td>-4</td>
<td>1</td>
<td>-4</td>
</tr>
<tr>
<td>C2 (Ensuring the loop from student feedback to enhanced quality is closed)</td>
<td>R</td>
<td>-4</td>
<td>2</td>
<td>-8</td>
</tr>
<tr>
<td>C3 (Accuracy and timeliness of data returns)</td>
<td>R</td>
<td>-4</td>
<td>2</td>
<td>-8</td>
</tr>
<tr>
<td>Total score</td>
<td></td>
<td></td>
<td></td>
<td>-162</td>
</tr>
</tbody>
</table>
Example showing results for a programme with very few weaknesses

<table>
<thead>
<tr>
<th>Indicator and brief description</th>
<th>RAG</th>
<th>Score</th>
<th>Weighting</th>
<th>Weighted score (weighting x score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 (Involving service providers in recruitment)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>R2 (Actual vs commissioned)</td>
<td>G</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>A1 (Involving service providers in course design)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A2 (Involving service providers in course delivery)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>P1 (Placement audit)</td>
<td>G</td>
<td>2</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>P2 (Placement provider access to development resources and courses)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>P3 (Concerns about student fitness for purpose responded to)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Indicator and brief description</td>
<td>RAG</td>
<td>Score</td>
<td>Weighting</td>
<td>Weighted score (weighting x score)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>-------</td>
<td>-----------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>P4 (Placement provider involvement in CRB/ISA and occupational health policy)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>P5 (Feedback that students meet relevant standards before placements)</td>
<td>A</td>
<td>−1</td>
<td>1</td>
<td>−1</td>
</tr>
<tr>
<td>O1 (Attrition)</td>
<td>G</td>
<td>2</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>O2 (Completion on time)</td>
<td>A</td>
<td>−1</td>
<td>15</td>
<td>−15</td>
</tr>
<tr>
<td>C1 (Third party review)</td>
<td>G</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>C2 (Ensuring the loop from student feedback to enhanced quality is closed)</td>
<td>G</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>C3 (Accuracy and timeliness of data returns)</td>
<td>G</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total score</td>
<td></td>
<td></td>
<td></td>
<td>52</td>
</tr>
</tbody>
</table>

**Performance management**

Contract performance management
Core minimum national contract performance indicators
Risk rating principles
Tables 5-8
Annex J
Annex K
Annex L
Annex M
Annex N
Annex O

**Print**
Step 4: Set bandings for aggregated RAG ratings from the worst possible scores to the best

In the worked example, the best possible score would be 100. The worst possible score would be minus 228. SHAs should set bandings to ensure appropriate local stretch. In the example below the SHA has set the amber band as widest, followed by green and then red. This is just an example and should in no way be taken as guidance regarding the width of the bands, which must be decided locally.

Example of possible banding structure

<table>
<thead>
<tr>
<th>Green banding</th>
<th>Amber banding</th>
<th>Red banding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plus 100 – zero</td>
<td>Minus 1 – minus 150</td>
<td>Minus 150 – minus 228</td>
</tr>
</tbody>
</table>

RAG ratings should be discussed at an annual contract performance review meeting.

Note: SHAs will need to collect baseline data locally to inform the setting of weightings and bandings. The above is an illustrative example only and there is no expectation that the final local SHA decisions will follow this example.
Performance management: Annex N
National Student Survey subject clusters

<table>
<thead>
<tr>
<th>Cluster name</th>
<th>Professions included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Nursing and midwifery</td>
</tr>
<tr>
<td>Subjects allied to medicine</td>
<td>All AHPs except physiotherapy and radiography (diagnostic and therapeutic)</td>
</tr>
<tr>
<td>Anatomy, physiology and pathology</td>
<td>Physiotherapy and some health-funded bioscience subjects (plus numerous other non-health-funded programmes)</td>
</tr>
<tr>
<td>Medical technology</td>
<td>Diagnostic radiography and radiotherapy (plus numerous other non-health-funded programmes)</td>
</tr>
<tr>
<td>Biology</td>
<td>Some bioscience subjects (plus numerous other non-health-funded programmes)</td>
</tr>
<tr>
<td>Chemistry</td>
<td>Some bioscience subjects (plus numerous other non-health-funded programmes)</td>
</tr>
</tbody>
</table>

Performance management

Contract performance management
Core minimum national contract performance indicators
Risk rating principles
Tables 5-8
Annex J
Annex K
Annex L
Annex M
Annex N
Annex O
Performance management: Annex O

National Student Survey questions

Overall, I am satisfied with the quality of the course

The teaching on my course
Staff are good at explaining things.
Staff have made the subject interesting.
Staff are enthusiastic about what they are teaching.
The course is intellectually stimulating.

Assessment and feedback
The criteria used in marking have been clear in advance.
Assessment arrangements and marking have been fair.
Feedback on my work has been prompt.
I have received detailed comments on my work.
Feedback on my work has helped me clarify things I did not understand.

Academic support
I have received sufficient advice and support with my studies.
I have been able to contact staff when I needed to.
Good advice was available when I needed to make study choices.

Organisation and management
The timetable works efficiently as far as my activities are concerned.
Any changes in the course or teaching have been communicated effectively.
The course is well organised and is running smoothly.

Learning resources
The library resources and services are good enough for my needs.
I have been able to access general IT resources when I needed to.
I have been able to access specialised equipment, facilities or rooms when I needed to.
Personal development

The course has helped me present myself with confidence.

My communication skills have improved.

As a result of the course, I feel confident in tackling unfamiliar problems.

Practice placements

I received sufficient preparatory information prior to my placement(s).

I was allocated placement(s) suitable for my course.

I received appropriate supervision on placement(s).

I was given opportunities to meet my required practice learning outcomes competencies.

My contribution during placement(s) as part of the clinical team was valued.

My practice supervisor(s) understood how my placement(s) related to the broader requirements of my course.