NATIONAL AUDIT OFFICE

Educating and training the future health professional workforce for England

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 277 Session 2000-2001: 1 March 2001

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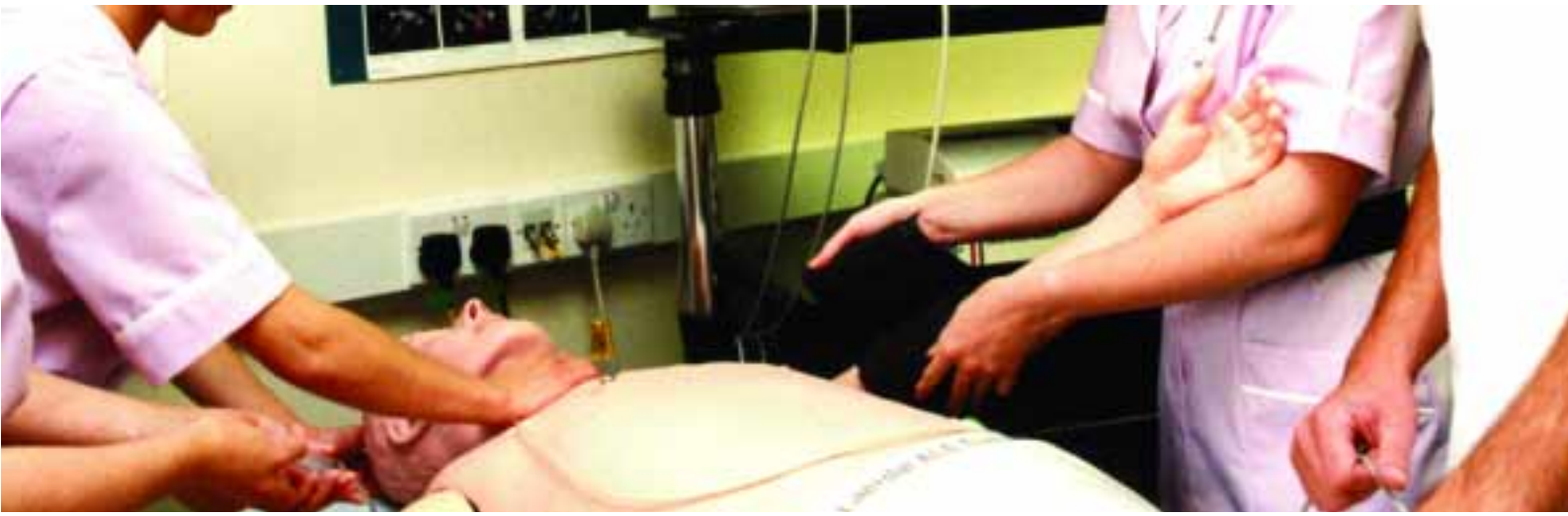

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John Bourn **National Audit Office**
Comptroller and Auditor General **23 February 2001**

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Contents

Part 2

Part 3

Part 4

Appendices

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summary & recommendations

1 The NHS faces significant shortages of nurses, midwives and other healthcare staff such as physiotherapists and radiographers, referred to for the purposes of this Report as the health professional workforce. There are a number of measures that can be taken to overcome these shortages of which a key one is through educating and training new staff. The NHS also has to continue to train and develop existing staff if it is to meet the Government's objective that healthcare services should be of a consistently high quality and that the way that these services are delivered should be modernised.

2 Together, we and the Audit Commission have taken stock of the education and training provision available to new and existing health professional staff. The Audit Commission's report[1], also published today, examines the planning and provision of education, training and development to existing healthcare staff in NHS Trusts in England and Wales. Our report looks at the effectiveness of the current arrangements for educating and training new staff (pre-registration education and training) in England. It is published simultaneously with the Auditor General for Wales' report on pre-registration education and training in Wales[2]. Taken together, the three reports provide a comprehensive picture of education, training and staff development and make significant practical recommendations for improvement.

3 Ensuring that the NHS trains the right numbers and types of health professions and that these staff are fit for practice is extremely complex (see Box A). It requires good workforce planning, a more strategic approach to the development of the entire NHS workforce and effective commissioning and delivery systems. It also depends on close co-operation between NHS organisations, separately and as part of Education and Training Consortia (and their successors, the Workforce Development Confederations which will be operating from April 2001), higher education institutions, and the statutory and professional bodies.

Box A: Key Facts

Since 1994-95 there have been annual increases in the number of health professional students on NHS funded pre-registration education and training programmes. For example, in England, the numbers of new nursing and midwifery student entrants each year has grown by 50 per cent (from 12,480 in 1994-95 to 18,707 in 1999-2000) and are set to grow still further under the NHS Plan.

In 1999-2000, the NHS spent £705 million on pre-registration training places and student bursaries for some 50,000 nursing and midwifery students and 14,000 health professional students. This training is provided under some 100 or so NHS pre-registration contracts, by 73 higher education institutions and leads to degree and, in the case of nursing and midwifery students, degree or diploma level professional qualifications.

Thirty-nine NHS Education and Training Consortia determine the number of places to be commissioned, based on workforce development plans from NHS Trusts, health authorities, social services and other employers of healthcare staff. From April 2001 Consortia will be replaced by 24 Workforce Development Confederations which will take on a wider role for developing the existing and future NHS workforce.

The availability of practice placements is one of the key factors in determining the number of students that can be trained and influences the quality of outcomes.

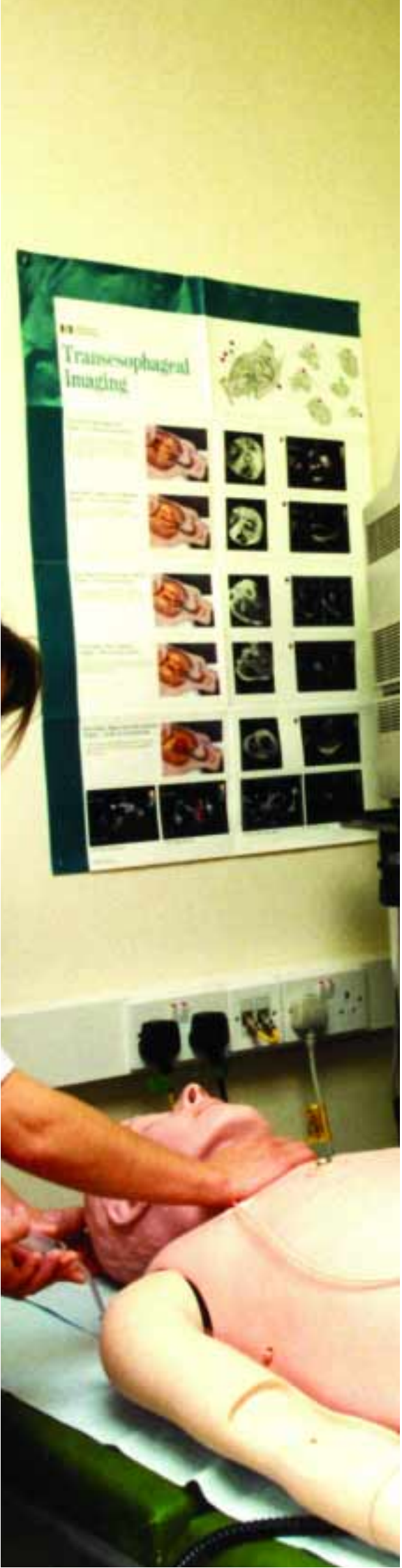
Not everyone who starts the training programme will complete it and some will choose not to work in the NHS.

A number of stakeholders are involved in assuring the quality of NHS funded health professional education leading to registration: the statutory and professional bodies, the Quality Assurance Agency, the Higher Education sector and NHS employers. Existing processes for quality assurance in England are being developed with a view to closer integration.

4 During 2000, in its consultation paper "A Health Service of all the talents: Developing the NHS workforce"[3] the Department of Health (Department) acknowledged problems with its current system of workforce development and planning. In July 2000, the NHS Plan[4] acknowledged that the biggest constraint the NHS faces today is staff shortages. The Plan proposed a number of staffing initiatives to increase the supply of qualified staff to the NHS. In particular, the Plan proposed an increase in the numbers of new health professional staff being trained. At the time of the Plan there were 50,000 nurses and midwives and 14,000 therapists and scientists on NHS funded pre-registration education and training programmes in England. The Plan stated that by 2004 there will be a further 5,500 nurses and midwives and 4,450 therapists and other health professional staff entering training programmes each year to help, over time, address the staff shortages and raise the quality of NHS services.

5 In the last two years the Department has put in place a package of measures to meet increasing demand for staff, including 'Return to Practice' programmes, increased recruitment from overseas and a range of recruitment and retention initiatives aimed at improving the working lives of staff. However, educating and training new health professions is the core way of meeting demand in the longer term, and the one over which the NHS has the closest control in relation to numbers and quality. As part of the overall package to meet demand, the Department will need to ensure that the increased numbers of commissions are delivered and also work with the NHS and higher education institutions to reduce the numbers of students who do not complete their studies.

6 The Department has now set the NHS a number of challenging objectives, including significant changes to workforce planning and development, increased targets for the number of pre-registration education and training places commissioned from universities and the introduction of a new model for nursing and midwifery allied health professional education. In this report we examine the effectiveness of the current arrangements for educating and training the future NHS health professional workforce and identify a number of issues that need to be addressed if the NHS is to achieve the challenges it has been set by the Department.



7 Our main findings are in Box B and our conclusions and recommendations for improving the education and training of the future health professional workforce follow.

Box B: Key Findings

On meeting demand:

In the past, underestimates by NHS Trusts have led to insufficient numbers of training places being commissioned which has contributed to staff shortages.

Since 1994-95 the commissioning levels have increased annually. However, prior to the NHS Plan, many Consortia were concerned that their current level of commissioning was unlikely to meet demand.

Following the NHS Plan, Consortia have been given additional resources and are working with higher education institutions to increase commissioning levels.

To date the higher education institutions have provided the education and training places to meet the NHS's increase in commissions while maintaining the overall quality of training provision.

Many higher education institutions believe that, if they are to continue to expand student numbers, there will need to be investment in the capital infrastructure.

The 1999 and 2000 NHS recruitment campaigns have increased applications for NHS funded programmes, although some places for nurse training remain unfilled.

There are wide variations in student attrition between institutions and limited understanding as to the reasons for variation. On average, our survey found that 20 per cent of nursing students (against 17 per cent found by the English National Board for Nursing, Midwifery and Health Visiting) and between 7 and 18 per cent of allied health professional students fail to complete the programme. Whilst these average attrition rates are comparable to attrition from other higher education programmes they represent wasted resources. The Department has set attrition targets of 13 per cent for nursing and midwifery students and 10 per cent for allied health professional students starting with the September 2000 intake. These present a challenging target for many institutions.

On costs and price:

The NHS does not have the information to understand or compare institutions' costing policies because some contracts between higher education institutions and Consortia have clauses that maintain commercial confidentiality.

There are wide variations in the price per student for the same qualification. The NHS has reduced its costs through reductions in average price paid per student in real terms. However, the scope for further gains needs to be offset against the fact that the contribution to overheads in NHS funded contracts is much less than for non-NHS funded contracts. Variations in the relationship between price and cost may not have led to the best allocations of resources.

There are no common contract and standard benchmark prices and a lack of consistent application of benchmark standards in assuring quality.

On developing more effective partnerships:

There is wide variation in the size and capabilities of Consortia and their management teams with scope for efficiency improvements, which are being addressed as part of the guidance on setting up Confederations.

There are many examples of improved partnership working but there is scope for more widespread improvements, identification of good practice and acknowledgement that education and training is a shared responsibility, particularly in relation to recruitment, retention and practice placements.

On better planning, commissioning and delivery of health professional education and training

8 During the early 1990s, when responsibility for nursing and midwifery education and training was transferring from the NHS to the higher education sector, the number of training places commissioned, for these and other health professionals, was reduced. Since 1994-95 the Department has increased significantly the numbers of student places year on year. Until now, these increases have been accommodated effectively by the higher education institutions concerned. However, there are indications that many of the institutions are beginning to reach full capacity. Investment in teaching and placement staff and in teaching accommodation, and more innovative approaches to identifying and using practice placements and other resources, are necessary if the expansion in numbers proposed in the NHS Plan are to be met.

9 The Department's recommendations in their wide ranging workforce development review, and the subsequent publication[5] which sets out plans for taking forward the review's recommendations (Appendix 1 refers), are a good foundation on which to base revised workforce development, education and training arrangements. However, if the new systems are to be effective:

The Department, in particular, needs to:

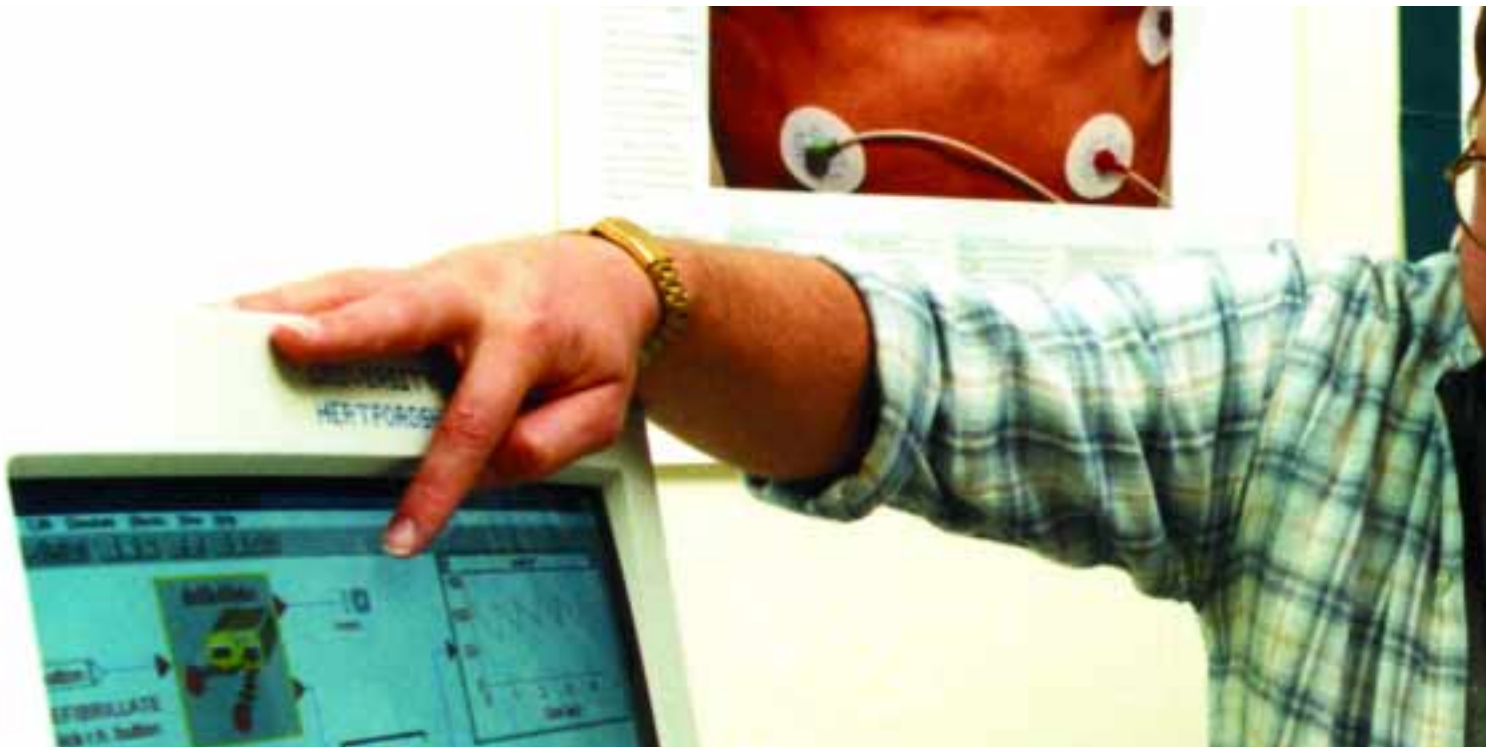
- standardise the guidance on workforce development information requirements in order to improve forecasting of education needs; and
- work with the Workforce Development Confederations, which will replace Consortia, to promote integration between top down strategic NHS developments and local workforce development planning. This means developing clearly defined roles and responsibilities for the Department's Regional Offices, Confederation management teams and their constituent members. It also requires skilled personnel, common data and planning systems to be put in place.

The NHS and higher education institutions need to:

- agree a set of guidance to facilitate the collection of consistent information on attrition, including a definition of attrition that recognises the scope for stepping on and off programmes; and
- improve attrition rates through evaluating and disseminating the lessons from national research on the reasons why NHS students join, drop out or transfer from programmes, adopting good practice developments from this and from the work being done in individual Consortia and higher education institutions.

Workforce Development Confederations need to ensure, in particular, that they:

- work with health authorities and employers to ensure that the staffing requirements of Health Improvement Programmes and other service development strategies such as National Service Frameworks are taken fully into account in determining the Confederations' commissioning plans;
- involve higher education institutions at all levels in planning education and training, both strategic and operational, and adopt a joint approach including shared responsibility for recruitment, selection and retention;



- liaise with higher education institutions to ensure that planned expansion in education and training places is achieved without diluting quality and standards of achievement. This includes the NHS working with institutions to provide support for students to ensure they meet quality standards, agreeing differential targets for attrition for higher education institutions where necessary and ensuring that information is collected in a way which is consistent with the national definition; and
- work with higher education institutions to develop and implement joint strategies to address the problems in arranging good quality practice placements, identifying alternative suitable placements in the NHS and the wider health economy but taking care to ensure that students obtain sufficient experience of working in an acute environment, the first destination of many students.

On the value for money obtained from health professional education and training

10 The current system of contracting is not as effective as it could be, although the Department's 1999 Good Contracting Guidelines[6] have helped introduce a more standardised approach. Many contracts fail to specify outcomes and there is scope to improve contract monitoring. There are variations in the price per student for NHS funded programmes which provide education and training for entry to the same health profession and, as a result of competition, the sharing of information on costs is very limited. We have identified significant benefits in moving towards longer term contracts between the NHS and higher education institutions and in developing benchmark prices in an open and transparent manner. There should be no surprises on either side, and an efficient monitoring system is needed to ensure that both parties obtain good value for money from the relationship. The work being done across the higher education sector on better accountability[7] should help in this respect.

11 A great deal of effort has been put into improving the quality of education and training and the work being done by the Department, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the Quality Assurance Agency[8,9] should inform improvements in the efficiency and effectiveness of quality assurance. Overall, however, we have identified a number of issues that need to be addressed in taking forward the cost and quality agenda:

The Department needs to:

- examine the current policy framework governing contracts with the Higher Education Funding Council for England and Universities UK (formerly the Committee of Vice Chancellors and Principals) especially on the treatment of capital development and research in contracts and consider the need to develop and issue new guidance;
- adopt nationally a consistent approach to setting contracts so that they include a proper consideration of outputs as well as costs. This would also facilitate benchmarking and better performance management of contracts. The NHS may be able to draw useful lessons from developments in this area from both higher and further education and the work being done by the Quality Assurance Agency;
- with the advent of Confederations, reconsider the guidance on contracting and the extent to which the move towards better partnership working will need to be reflected;
- for the longer term, consider whether a common generic pricing approach for core elements with some flexibility for elements such as geographical location, accommodation and staffing differentials should be applied as part of work to secure better value for money;
- agree a standard benchmark pricing formula for NHS funded programmes, similar to that operating for Higher Education Funding Council for England funded programmes; and
- work with the regulatory bodies, the new Confederations, the Quality Assurance Agency and other stakeholders to implement new integrated arrangements for the quality assurance of NHS funded health professional education.

The NHS and higher education institutions need to:

- identify the reasons for the significant variations in price per student undergoing the same professional training;
- introduce more collaboration into the contracting process, based on longer term contracts with clearly defined responsibilities for issues such as capital development;
- build on the work of the Department and Higher Education Funding Council for England Task Group on Research in Nursing and Allied Health Professionals in developing strategies for attracting sufficient and appropriate research funding to the higher education institutions which provide health professional education and training; and
- address shared concerns, as a matter of urgency, about the availability and quality of practice placements and teaching staff.

On developing more effective partnerships

12 There are many examples of the NHS and the higher education sector beginning to develop better partnership working. The NHS Executive and Committee of Vice Chancellors and Principals "A joint declaration of principles" (1998)[10] and the emphasis given in the Department's recent workforce planning review to developing partnerships are welcome initiatives. Both the NHS and the higher education institutions have agreed that there is scope for a more collaborative partnership approach involving all parties and in particular non-NHS employers and higher education institutions and, where relevant, the appropriate statutory and professional bodies, in determining issues around education and training. There is also a need for the NHS and other healthcare employers to acknowledge that they have a joint responsibility for many of the issues, such as practice placements and student attrition. Our findings and identified good practice point to specific lessons that the Department should take on board in developing the new Confederations:

The Department needs to:

- ensure that its new criteria for determining the membership, resources and technical skill base of the new Workforce Development Confederations (Appendix 1) is applied consistently and monitored fully;
- ensure that its new criteria and job descriptions for Chief Executives and Chairs (Appendix 1) are applied consistently and facilitate effective partnership working (as well as efficient management);
- develop effective arrangements for identifying and sharing good practice across and within the NHS and higher education institutions to avoid re-inventing the wheel and to maximise the effectiveness of education and training; and
- ensure that Confederations are monitored on a consistent basis in order to provide a common national approach to the delivery of outcomes.

Confederations will need to extend their partnership working to:

- work with member organisations to increase the profile and priority given to workforce development, including improving visibility and accessibility of Board members;
- implement and build on the new joint guidance which sets out clearly defined responsibilities for identifying, providing and managing practice placements[11]; and
- actively seek to spread good practice, for example on practice placements and joint appointments.

Part 1

Introduction

1.1 Nurses, midwives and health visitors; Allied Health Professionals such as physiotherapists and radiographers; and scientists account for two thirds of the staff who are responsible for direct patient care. For the purposes of this report, they are referred to as the health professional workforce. In September 1999, some 310,000 nurses, midwives and health visitors and 102,000 Allied Health Professionals and scientists were working in NHS hospital and community health services.

1.2 Ensuring a sufficient supply of adequately trained staff to maintain the NHS health professional workforce is essential to the operation of the NHS. In September 2000, in England, there were around 50,000 nursing and midwifery students and 14,000 student therapists and scientists on NHS funded pre-registration training programmes for the above health professions. This report focuses on the effectiveness of the current arrangements for their education and training.

1.3 Good education and training is essential if staff are to be able to deliver high quality health care services, while good planning is needed to ensure that the right numbers of each staff group are trained. This requires effective workforce planning and development systems and close co-operation between NHS organisations and other employers of health care staff, the relevant statutory and professional bodies and the 73 higher education institutions which provide pre-registration education and training for the health professions.

1.4 In April 2000, the Department of Health (Department) published a consultation paper "A Health Service of all the talents: Developing the NHS workforce"[3]. It identified, among other things, the need to develop a multi-professional approach to education and training, provide greater scope to switch training paths, widen entry routes and develop new types of healthcare worker. At the heart of the proposals was the recognition of the need to build on, and develop, partnership working with those providing education and training for the NHS workforce and with the relevant regulatory bodies. Following consultation the Department set out its plans in February 2001 for taking forward recommendations from the workforce planning review[5]. Appendix 1 sets out key elements relevant to this report.

1.5 During the last five years the NHS has increased significantly the numbers of students on health professional education and training programmes. For example, the number of entrants to nursing and midwifery pre-registration education and training programmes increased from 12,480 in 1994-95 to 18,707 in 1999-2000, an increase of 50 per cent. However, in July 2000, the NHS Plan[4] concluded that the biggest constraint the NHS faces today is shortage of staff. The Plan proposed to address these staff shortages, meet longer-term demand and raise the quality of service through a number of initiatives. In particular, the Plan states that by 2004 there will be 5,500 more nurses, midwives and health visitors and 4,450 other health professional students being trained each year. The Plan also provides for improved access to post-registration education and training and continuing professional development for health professionals already in service, both to maintain and enhance their levels of professional competence and to support the Department's commitment to lifelong learning.

There have been significant changes in the commissioning and delivery of education and training to improve quality

1.6 Until the late 1980s, NHS run Colleges of Nursing, Midwifery and Health Studies, provided the training for the majority of nurses, and midwives (health visiting education and training was already located in higher education). Nursing and midwifery students were NHS employees, providing a direct contribution to patient care on hospital wards. Since then, there have been a number of significant changes in the delivery of education and training for nurses, midwives and health visitors, with more changes in progress (**Figure 1**).

1 **There have been a number of changes to the education and training of health professionals since 1989 and a number of current initiatives which will bring about changes over the next few years**

This figure shows the key initiatives which have affected the commissioning and purchasing of health professional pre-registration education and training since 1989. The last four years have seen an increase in the number of initiatives, reflecting the increased priority and prominence given by the Department to securing a sufficient and adequately trained NHS workforce.

1989
- Start of Project 2000 for nursing diploma students in England
- White Paper "Working for Patients" published
- Start of transfer of NHS Schools of Nursing to higher education institutions

1990
- Working Paper 10 - devolved responsibility for education commissioning to employers

1996
- Completion of transfer of NHS Schools of nursing to higher education institutions.
- NHS Education and Training Consortia were established,comprising all local employers (NHS, social services, private, voluntary and independent sector employers) to undertake local workforce planning and commissioning of health professional education and training
- Regional Health Authorities replaced by Regional Offices

1998
- Nursing degree students were included in the Consortia remit
- Full purchasing responsibility was devolved to Consortia from Regional Offices
- NHS Executive and Committee of Vice Chancellors and Principals issue a joint partnership statement " A joint declaration of principles"
- The Departments proposals "Working Together" were issued

1999
- The NHS Executive issued "Non-medical education and training (NMET) Good Contracting Guidelines"
- The NHS Executive and Committee of Vice Chancellors and Principals -issued guidance on good practice in recruitment and retention of nurses in higher education
- The Department published "Modernising health and social services - developing the NHS workforce"
- The Department published "Making a difference", the Government's strategic intentions for nurses, midwives and health visitors
- The Health Committee issued a report and recommendations following their investigation of the "Future NHS staffing requirements Session 1998-99)"
- The Government responded to the Health Committee report acknowledging the need for a number of changes.
- The UKCC Education Commission published its report "Fitness for Practice" following a detailed review of nursing midwifery and health visiting

2000
- The Department published a workforce planning consultation paper "A Health Service of all the talents: Developing the NHS Workforce"
- The Government published the "NHS Plan" with proposals to address staffing shortages, meet long term demand and raise the quality of service
- The Department published the "Human Resources Performance Framework" which sets the overall direction and priorities for the NHS over the next four years
- The Department published "Meeting the Challenge; A strategy for the Allied Health Professions"
- The Department published a consultation paper "Modernising Regulation - the new Nursing and Midwifery Council"
- The Department published a consultation paper 11 Modernising Regulation -the new Health Professional Council"

2001
- The NHS Executive and the Quality Assurance Agency for Higher Education published a consultation paper: "Benchmarking academic and practitioner standards in health care subjects/professions"
- The ENB and Department published guidance: "Placements in Focus - Guidance for education in practice for healthcare professions"
- The ENB and Department published guidance: "Preparation of mentors and teachers - A new framework guidance"

1.7 The introduction of Project 2000[12] in 1989 was radical, as it changed the status of student nurses and midwives. They were no longer regarded as NHS employees, but were supernumerary to the nursing complement, and responsibility for providing their training was transferred to the higher education sector. The aim was to improve the quality of healthcare by producing qualified nurses and midwives (at diploma) level to meet the future needs of the NHS and assist recruitment and retention at a time when demographic trends were expected to reduce the supply of potential recruits.

1.8 A new model for nurse education and training was launched in 1999 following the Department's Nursing Strategy "Making a Difference"[13] and the report by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting Commission for Education on "Fitness for Practice"[14]. The emphasis is on more flexible career pathways into and through nursing and midwifery education; an increased emphasis on practice; and an education system that is more responsive to the needs of the NHS. This model was implemented by a number of higher education institutions working in partnership with their local Consortia in September 2000. The new model will be rolled out across all higher education institutions in England by Autumn 2002. Pilot schemes, using similar educational principles, will be developed for a number of Allied Health Professional programmes from 2001.

1.9 The last ten years have also seen changes to the arrangements for training other health professions, aimed at giving the Department greater responsibility and authority over the numbers, quality and suitability of its healthcare workforce. Incremental changes occurred to training for the Allied Health Professions that brought the majority of their education into the higher education sector at degree level, with the funding being split between the Department and the Higher Education Funding Council For England. In 1998, following the publication of the findings from the Dearing Inquiry into Higher Education[15], the responsibility for commissioning and funding of education and training places for all Allied Health Professions transferred to the Department.[16]

The NHS, higher education institutions and the various statutory and professional bodies all play a role in providing education and training

1.10 Current arrangements for planning and providing education and training are complex (**Figure 2**). It is a tripartite arrangement between:

i) the Department and NHS organisations, which determine needs for qualified health professionals, including NHS Trusts who provide the majority of practical experience during training;

ii) higher education institutions, which provide the academic content of training programmes. They are subject to external quality assurance and review by the Quality Assurance Agency for Higher Education; and

iii) statutory and professional bodies, which have a duty to establish the standards students are required to meet for admission to the Register. They are also responsible for approving and validating institutions and programmes and dealing with serious complaints about registrants.

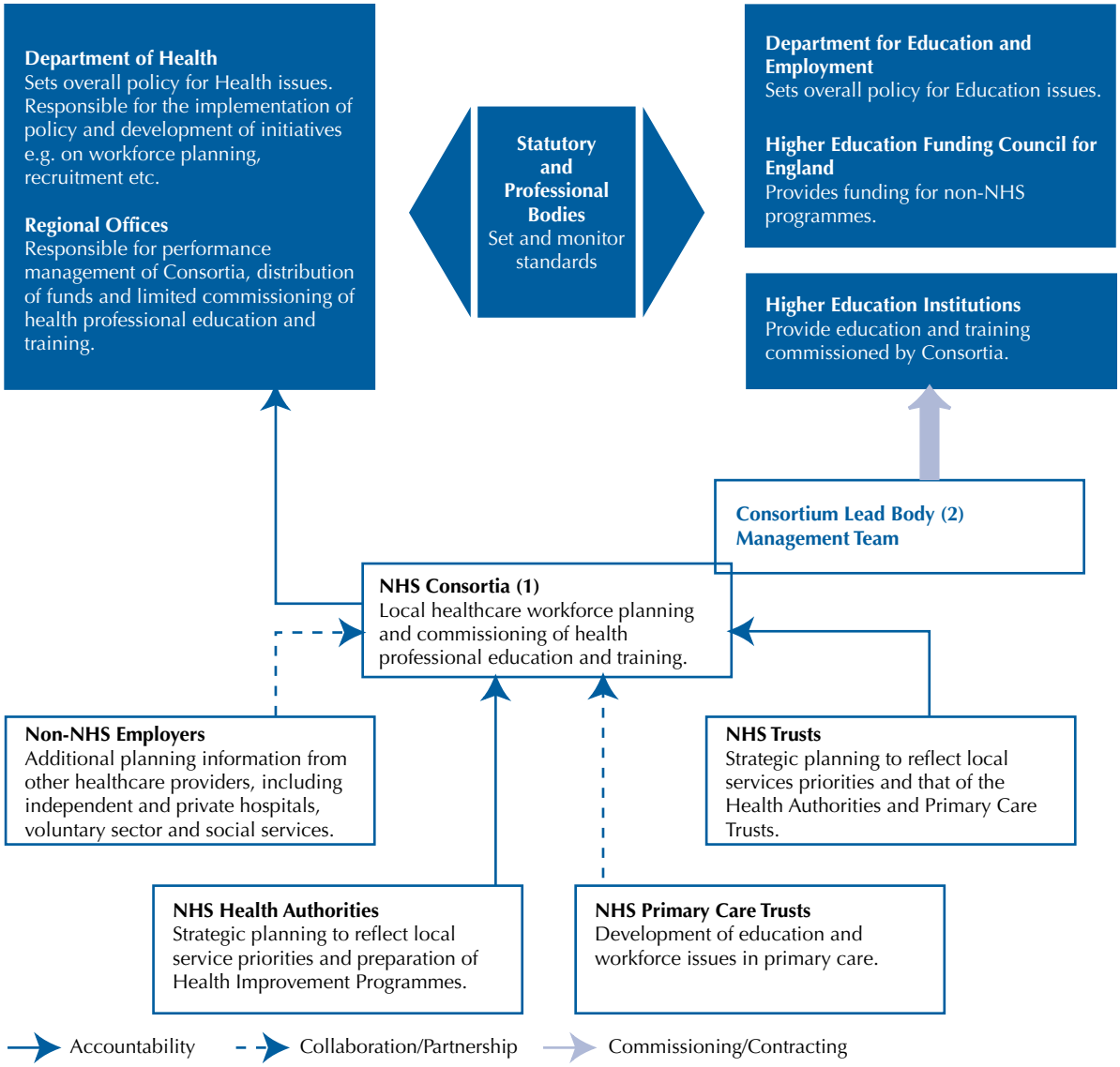
Consortia are responsible for planning and commissioning health professional education and training and vary in size, budget and number of contracts

1.11 Between 1996 and 1998, the Department devolved responsibility for planning and commissioning education and training of health professionals from its Regional Offices to local Education and Training Consortia[17]. Consortia are geographically based groups of NHS and other employers of healthcare staff. To obtain devolved status, Consortia had to meet a number of explicit criteria, which included ensuring that they had adequate workforce planning capacity, systems and people in place to administer budgets and contracting. During the process of devolution some of the original 44 Consortia merged. By April 1998, 34 Consortia had obtained full devolved responsibility and the remaining five achieved this during 2000-01.

1.12 Membership of a Consortium includes representatives from health authorities, NHS Trusts, Primary Care Trusts, social services and other employers of healthcare staff in the designated geographical area. Under the leadership of a Chair, each Consortium is responsible for:

- co-ordinating and collating employer led workforce planning data;
- commissioning education and training direct from higher education institutions;
- managing the contracts between the lead body and higher education institutions; and
- planning and developing an integrated education and development strategy.

2 **Education and training of health professionals - roles, responsibilities and accountabilities of the main stakeholders in England**



Notes:
1. Consortia are not legal entities, hence cannot contract directly with the higher education institutions, they are not allocated funds nor can they employ staff.
2. One of the NHS bodies within each Consortium, usually an NHS Trust (but can also be a health authority), is designated the "lead body" and carries out the contracting and financing functions through a management team acting on behalf of the Consortium.

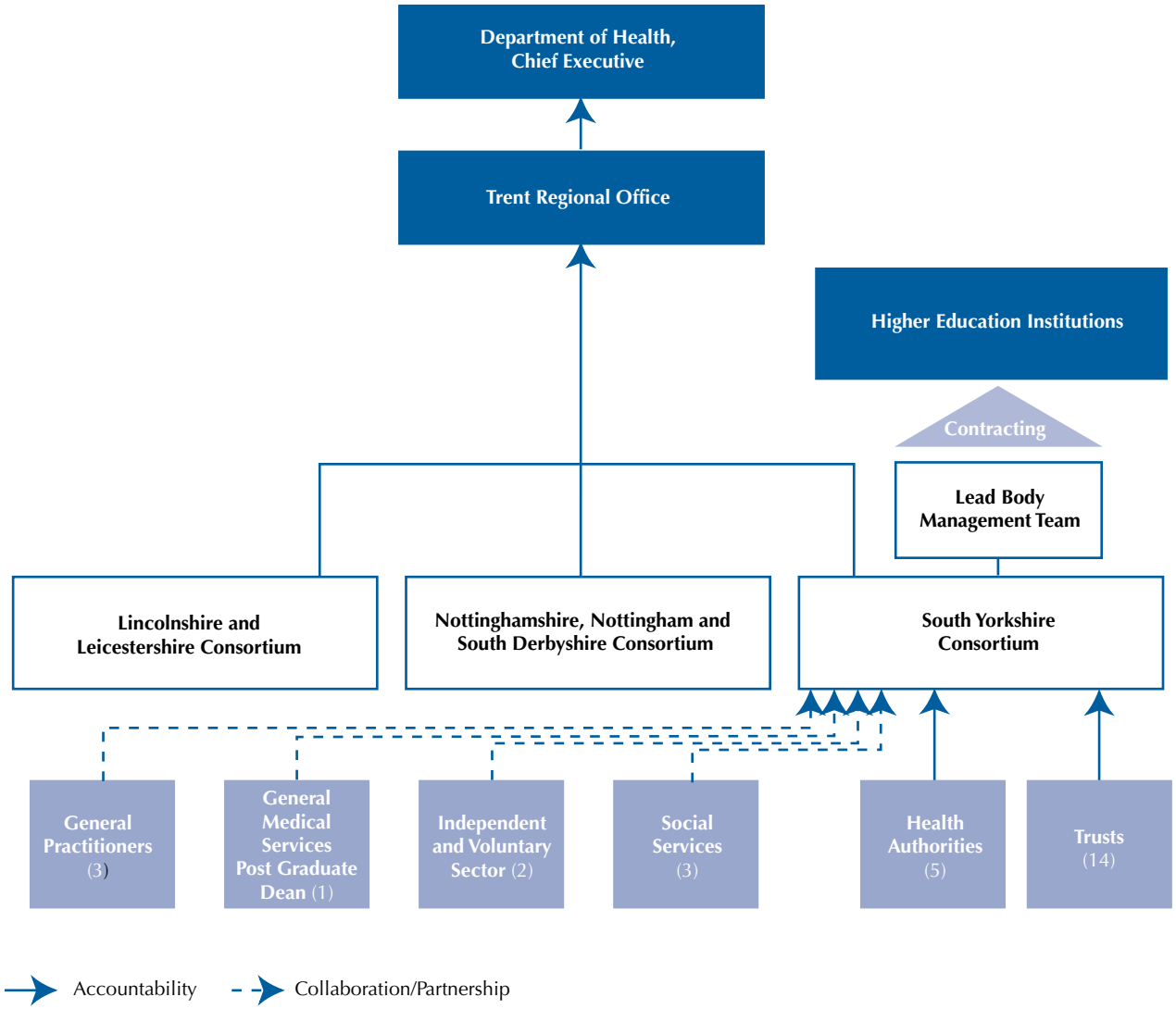
1.13 Consortia are not legal entities and therefore they cannot contract directly with higher education institutions nor can they employ staff. Instead, one NHS body within each Consortium is designated as the lead body and carries out these functions on behalf of the other members. A management team employed by the lead body handles the administrative work of the Consortium. However, NHS Trust and health authority members are jointly accountable to the Department of Health for the expenditure of NHS money, for the contracts they enter into with education providers and for the Consortium's overall performance. **Figure 3** illustrates the relationships within, and accountabilities of, Consortia.

The funding arrangements for the £1 billion or so spent on educating and training the health professional workforce are complex

1.14 The establishment of Consortia was linked with the changes that were made by the Department to the arrangements for NHS funding of education and training. For pre and post registration health professional education and training a new funding stream was introduced - Non Medical Education and Training (NMET)[18] levy - derived from a levy on all health authority budgets. In 1999-2000 the levy was £900m and was increased to £1 billion in 2000-01.

3 **Consortia Membership and Accountability- Using Trent Region and its South Yorkshire Consortium as an example**

Consortia are responsible for commissioning education and training from higher education institutions, but the actual contracting is done by the lead body of each consortium



Notes: 1. The number in brackets denotes the number of representatives on the Consortium Board

1.15 In 2000-01, 70 per cent of the NMET levy (£705 million) will be spent on pre-registration education and training of which around £300 million is to fund student bursaries through the Students Grants Unit and around £400 million funds contracts with higher education institutions. The remainder of the levy will be spent on post registration training and management and specialist development projects.

1.16 The average Consortium budget is around £22 million. This is used to fund pre and post registration training, student bursaries and specialist development projects. Our survey found that the average value of each NHS funded pre-registration contract with a higher education institution is £4 million with the range from £250,000 to £11.9 million per year. Also, that for many of the higher education institutions with NHS contracts, the NHS is their second largest source of funding (Higher Education Funding Council for England being by far the largest).

Helping to build the future NHS workforce

1.17 The workforce planning review "A Health Service of all the talents: Developing the NHS Workforce"[3], issued for consultation in April 2000, identified a number of areas in which workforce planning needed to be improved. It made a range of recommendations in four key areas:

- achieving greater integration and more flexibility in planning;
- gaining better management ownership with clearer roles and responsibilities;
- improving training, education and regulation; and
- increasing staff numbers and changing career pathways.

1.18 Central to the review's recommendations was the importance of better integration between workforce, service and financial planning. Since June 2000, the Department has been reviewing the responses to the consultation paper and, in February 2001, the Department set out its plans for taking forward the review's recommendations[5]. A summary of the key issues that are relevant to this report are detailed at Appendix 1. Given that our value for money audit investigation overlaps with a number of the issues in the consultation review we provided the review team with a response to the consultation paper based on our emerging findings. Where relevant we refer to the review at strategic points throughout this report.

1.19 The workforce planning review[3], like the NHS Plan's proposals[4] to increase the numbers of health professionals, go wider than the planning and delivery of health professional education and training. However, they are clearly an important input to our examination. As is the subsequent Human Resources Performance Framework in October 2000[19], which includes objectives and targets linked to previous initiatives such as: Improving Working Lives[20] Working Together[21] and Developing the NHS Workforce[3]. Together they set the overall direction and priorities for the NHS over the next four years. In conducting our examination we have assessed achievements and problems in the current system and what might be done to help ensure that these proposals for change are implemented successfully.

There are a number of initiatives involving the NHS, and higher education sectors and statutory and professional bodies aimed at improving the education and training environment

1.20 The Department has been working with the Quality Assurance Agency for Higher Education and other major stakeholders to streamline the higher education institution's quality assurance arrangements of health professional programmes in England[8]. As part of this work, the Departments of Health in England, Wales and Northern Ireland and the Scottish Higher Education Funding Council contracted with the Quality Assurance Agency to establish and facilitate the setting up of benchmarking sub-groups in the various healthcare subjects/professions[9]. The aim is to develop statements of the required academic and practitioner standards that will assist higher education institutions when they design and deliver programmes. They will provide points of reference for external review and promote public understanding of, and employer confidence in, higher education awards in healthcare subjects.

1.21 The Higher Education sector have commissioned PA Consulting to review the current accountability arrangements in higher education institutions, assess their cost effectiveness for institutions and stakeholders, and recommend ways in which the interests of both might be better served. The Better Accountability Programme[7], includes a number of developments that will impact on the NHS relationship with the higher education sector. These include: proposals for better sharing of information within the sector; the creation of a risk based framework of probity assurance; and an assessment of student centred outcomes to improve the processes for establishing and delivering shared objectives. PA Consulting have also developed a framework to assess the effectiveness of the relationship between stakeholders and institutions. The aim is to improve accountability through partnership and transparency. As part of this initiative, the Department is a member of a Higher Education Forum which provides a platform for discussing key issues relating to the proposed new accountability regime.

Working jointly with the Audit Commission

1.22 Given the wide scope of the subject and the implications for all levels of management in the NHS, we worked jointly with the Audit Commission to evaluate the NHS arrangements for educating and training NHS health professionals and other healthcare staff.

1.23 The Audit Commission[1] focused on how NHS Trusts in England and Wales identify and meet the training and development needs of their existing healthcare staff. We looked primarily at the systems underlying the planning and supply of newly qualified health professionals in both England and Wales. In doing so, we took into account the perspectives of both the NHS and higher education institutions. Taken together the Audit Commission's report, the Auditor General for Wales's separate report on the Welsh system of pre-registration education and training[2] and this report provide a comprehensive picture of pre and post registration education and training for NHS healthcare staff in England and Wales.

Scope and methodology of our study

1.24 We examined:

- how effective current education and training arrangements are in meeting the demand for new health professionals, what problems stand in the way of the new proposals to increase the number of training places and what needs to be done to help successful implementation of the workforce development review (Part 2);
- the value for money obtained from the £705 million per year that the NHS currently allocates to the provision of pre-registration, health professional education and training programmes (Part 3); and
- the scope for improved partnerships between the NHS and other employers and the higher education institutions and regulators of education and training (Part 4).

1.25 Our detailed methodology and a list of site visits are at Appendix 2. A key source of evidence for our report is our comprehensive surveys of Consortia and the higher education institutions who contract with them, focussing on nurse and midwife diploma and degree programmes and radiotherapy, physiotherapy, occupational therapy and clinical psychology degree programmes. We obtained a 100 per cent response rate from the two sectors.

1.26 We established a joint advisory group with the Audit Commission to provide advice and guidance on the scope and methodology for the study and on the study's emerging findings (Appendix 2 details the membership).

1.27 We also consulted widely, including: the United Kingdom Central Council for Nursing, Midwifery and Health Visiting; the English National Board for Nursing Midwifery and Health Visiting; the Royal College of Nursing; the Royal College of Midwives; the Colleges of Radiographers, Occupational Therapists; the Chartered Society of Physiotherapists; the Institute of Biomedical Science; the Health Care National Training Organisation; the Quality Assurance Agency for Higher Education; the Council of Deans of Nursing; the Committee of Vice Chancellors and Principals (now Universities UK); the Council for Professions Supplementary to Medicine; the Higher Education Funding Council for England; and BUPA.

Part 2

Planning, commissioning and delivering health professional education and training

2.1 The Department, through the NHS, commissions education and training on behalf of the whole health economy in England. Its workforce planning arrangements are the main approach for determining the number of new health professional staff needed and consequently the number of training places the NHS needs to commission from the higher education sector. This part of our report examines the effectiveness of NHS workforce planning in this respect, the adequacy of the arrangements for commissioning the required numbers of training places, and the success of higher education institutions in meeting this demand.

The NHS has acknowledged that there are problems with the system of workforce planning, and is introducing changes from April 2001

2.2 The Department of Health launched a review of NHS workforce planning in early 1999, and consulted widely on its conclusions. The consultation document[3] acknowledged a number of problems with the current system of workforce planning for health professionals, in particular the need for better links with NHS service developments. A number of the review's proposals were developed in the NHS Plan and in February 2001, the Department set out plans for taking forward the review's recommendations (Appendix 1 refers). A number of the recommendations which will fully involve all employers and higher education institutions, including the establishment of Workforce Development Confederations, are to be implemented from 1 April 2001.

2.3 In the light of our survey work and discussions, we identified a number of factors that will determine the success of the Department's new approach:

(a) improved workforce planning skills at employer level, to achieve better estimates of future demand for the education and training of health professionals;

(b) linking of workforce development more closely to Health Improvement Programmes, National Service Frameworks and better integration of NHS strategic and local employer planning;

(c) ensuring that commissioning of education and training will meet demand; and

(d) further improving the performance of the higher education institutions and the NHS in filling commissioned places, retaining students and supplying sufficient newly qualified staff to the NHS.

a) Improvements in workforce planning skills and better estimates of future demand for education and training are possible

2.4 In assessing the demand for education and training places for health professionals, Consortia take account of the future workforce needs of healthcare employers, both public and private sector, to:

- replace existing staff who will retire;
- replace those who leave the NHS for other reasons;
- fill current vacancies and adjust to planned changes in staffing levels; and
- facilitate the introduction of new approaches to the delivery of healthcare.

2.5 The Audit Commission's findings at NHS Trusts suggests that their workforce planning processes are impeded because managers' understanding of the process and commitment to it are limited and that the input of business managers and senior professionals is a weak point in many NHS Trusts.

2.6 We found that for many NHS employers there are weaknesses in the information base used and differences in the level and expertise of input to plans. For example:

- while two-thirds of Consortia NHS members had nominated an individual to lead on workforce planning issues, around half of these did not have staff with the necessary experience or training;
- the profile given to workforce planning varied. For example, Chief Executives or Board level equivalents in NHS Trusts and health authorities approved workforce plans in two-thirds of Consortia, but in one-third approval was below that level;
- two-thirds of Consortia management teams were provided with workforce plans from their non-NHS members, the remainder made a best estimate;
- one-third of Consortia management teams included someone who was very experienced in workforce planning. However in seven of the 39 Consortia, staff had limited experience including two Consortia whose staff have had no workforce planning training;
- Consortia management teams used a total of 14 different workforce planning tools. In half of the Consortia, the same model was used by all of their members, whereas in others a variety of models and methods were used; and
- all but one of the Consortia management teams had issued workforce planning guidance to employers, and most had held at least one seminar or workshop during 2000 to help standardise workforce planning and the forecasting of demand for health professional education and training. Consortia also monitor compliance with their guidance, mainly by using deadlines and milestones, with one third using peer or independent review.

2.7 Overall, most Consortia saw weaknesses in the quality, accuracy and timeliness of information used for forecasting education and training needs at employer level. They felt that workforce planning and development did not always have the profile it needed to have within the employer organisation and that more involvement of the Chief Executive or Boards in approving plans was needed as this is crucial to improving the effectiveness of the process.

b) There is scope to link education and training requirements more closely to service developments

Education and training needs are not linked closely enough to Health Improvement Programmes

2.8 Health Improvement Programmes, produced by all health authorities, were introduced in 1998 as the key to setting the direction for local service development[22]. The Department requires them to be backed by comprehensive, realistic and credible workforce plans looking 3-5 years ahead, and to include details of employers plans for recruiting and replacing staff, developing and changing services, changing skill and grade mix and for tackling staff shortages and retention problems. Health Improvement Programmes, in turn, provide Consortia with a strategic input to their commissioning of health professional education and training.

2.9 The Consortia covered all 99 health authorities in England, each of which had produced a Health Improvement Programme. However, in the view of the Consortia, only two of these programmes fully addressed both workforce planning and education and training issues. Over a quarter did not address these issues at all.

2.10 A third of Consortia had arranged meetings and conferences to emphasise the importance of addressing education and training issues (**Case example 1**), but Consortia told us they had had little influence over almost half of the Health Improvement Programmes produced by their health authority members.

Case example 1 - Ensuring that the Health Improvement Programmes of health authorities address education and training plans

The West Yorkshire Consortium hosted a strategic level conference for Chief Executives and HR Directors, followed by a series of patch workshops to support their four health authorities in developing at least four local workforce advisory groups.

As a result the Consortium now has in place an electronic workforce profiling and forecasting system which links workforce development to Health Improvement Programme priorities.

The Consortium members between them have 15 workforce planners who are conversant with the tool. The Consortium believe that this has significantly improved the quality of workforce profiling information and has increased service confidence in the quality of the information.

Education and training workforce planning is beginning to take account of the new National Service Frameworks

2.11 The Department's National Service Framework programme, which was launched in 1998[23], builds on established frameworks for cancer and paediatric care. Topics include the Mental Health National Service Framework, published in September 1999[24], the Coronary Heart Disease Framework published in March 2000[25] and the NHS Cancer Plan of September 2000[26]. Each framework was developed with the assistance of an external reference group bringing together health and social care professionals, service users and carers etc. All of these frameworks set challenging targets for measuring achievement with recognition that there are workforce development and training issues that need to be addressed if the targets are to be met.

2.12 The Department's 1998-99 guidance on workforce planning[27] required Consortia to give priority to the impact of the frameworks. Because the frameworks were published between September 1999 and September 2000, this limited the scope for Consortia to do this in 1999-2000. By the time of our survey, in July-August 2000, work on evaluating staffing implications as a result of the frameworks was underway in all but one of the 39 Consortia. Two had completed this work, and one had reflected it in their education and training commissioning plans. The pace at which Consortia are addressing the education and training requirements of the National Service Frameworks is an important factor in NHS workforce planning, particularly if the right numbers and types of staff are to be available to help meet the framework targets.

Progress towards the NHS objective of integrating medical and health professional workforce planning has been slow and continues to pose problems

2.13 In 1996, Departmental guidance on establishing education and training Consortia required the new Consortia to work towards integrating medical workforce planning with workforce planning for the other health professionals[17]. The new NHS workforce planning proposals[3] also seek to address this problem. However, most Consortia have found it difficult to develop integrated plans. By August 2000, only thirteen had done so, while 18 expected to produce these plans within 12 months. The remaining eight expected to take longer than 12 months.

2.14 Consortia identified a number of factors which slowed progress including:

- difficulties integrating IT systems, databases and planning cycles into a coherent whole; and
- problems identifying individuals with the skills, time, and commitment to carry out the work at employer level.

c) Ensuring that commissioning of education and training meets demand

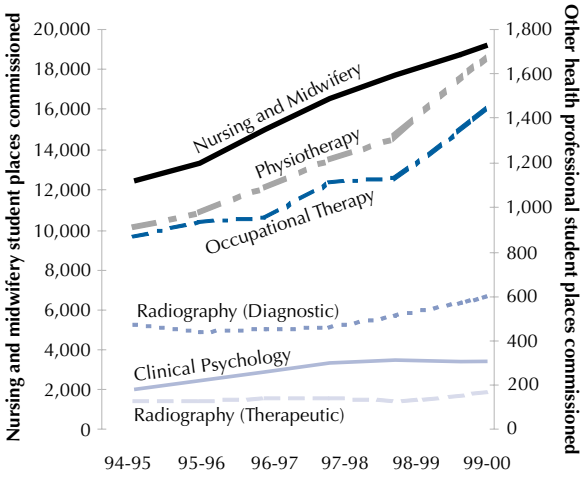
Though some demand increases could not be foreseen, around two-thirds of Consortia believe that past commissioning levels have been insufficient to meet current demand

2.15 In the early 1990s, when responsibility for educating and training new nurses and midwives was being transferred from NHS Colleges of Nursing, Midwifery and Health Studies to the higher education sector, workforce planning projections suggested that the demand for new staff for the NHS would decrease. As a result the number of training places commissioned for these and other health professionals was reduced. For example, entries to pre-registration nursing and midwifery programmes decreased from around 17,000 in 1991-92 to just under 12,000 in 1994-95. However, as is now widely acknowledged by the NHS, these projections proved to be inaccurate.

2.16 Over the last eight years, there have been increases in the number of student places commissioned by the NHS, particularly for nursing and midwifery and for physiotherapy and occupational therapists, **Figure 4**. For example, since 1995-96, the numbers of nursing students in England, (the largest student group) have grown by 50 per cent, and by 14% in the last 12 months.

4 Change in numbers of student places commissioned from 1994-95 to 1999-2000

Student places commissioned for nursing and midwifery, clinical psychology and some allied health professionals



Note: Nursing and midwifery student numbers are on the left hand axis and other health professionals on the right hand axis

Source: The Department of Health

2.17 Despite the increases in the second half of the 1990s, nearly two-thirds of Consortia considered that the additional numbers of qualified students being produced in 2000-2001, because they were based on past commissioning levels, were still not sufficient to keep up with the demand for newly trained staff. Consortia told us that the main reason for these shortfalls in numbers being trained are underestimates by NHS Trusts of future need and failure to take account of retirements. Other reasons include:

- insufficient numbers of students of appropriate quality applying resulting in inability to fill the number of places commissioned (although this has changed recently following the NHS advertising campaigns);
- shortage of suitable practice placements particularly in some nursing branches, physiotherapy and radiography. These placements provide the practical experience needed to enable trainees to be fit to practise and for each of the healthcare professions there is a statutory requirement to undertake a set number of hours of training in the practice environment. For nurses, the requirement equates to 50 per cent of the training programme time;
- higher than estimated numbers of students leaving programmes, and some who decide not to work in the profession for which they have trained; and
- higher than expected demand for newly qualified staff from other non-NHS employers, particularly the private sector, including operators of nursing and residential homes.

2.18 In nursing, the reported shortfalls are most acute in the mental health and learning disability branches, and for the allied health professionals, in radiography, (**Case example 2**), with London having the most critical shortages.

Steps are now in hand to meet increased demand for health professionals through increasing the numbers from pre-registration training

2.19 A third of Consortia told us that, prior to the publication of the NHS Plan in July 2000[4], their current commissioning levels were unlikely to be sufficient to meet future demand. They also said that constraints such as the availability of practice placements, the capacity of the higher education institutions, and uncertainties

Case example 2: The imbalance between supply and demand for therapeutic radiographers

Radiotherapy is the most clinically effective treatment for cancer after surgery. It involves the use of high energy x-rays to kill malignant cells. A radiotherapy booster after breast surgery has been shown to increase survival rates by 50 per cent. Over the last few years the number of newly UK-trained therapeutic radiographers entering the NHS has been insufficient to compensate for those leaving the profession. The NHS Cancer Plan noted that at March 2000, across the country 103 therapeutic radiography posts had been vacant for more than 3 months (7% of posts). The additional equipment to be installed as part of the Government's commitment in the Cancer Plan will require a further 160 posts to operate them.

In March 2000, the College of Radiographers undertook a survey of registered non-practising therapeutic radiographers and found that the numbers who would be prepared to return to work were very low (less than 10 nationally). There is also limited scope for overseas recruitment. Only therapeutic radiographers from a few countries such as Australia, New Zealand and Canada are considered to have equivalent qualifications, and all three countries currently have there own shortages and are themselves targeting UK trained therapeutic radiographers who are generally highly valued overseas. There is currently a net outflow of qualified staff from the UK.

The only realistic option for increasing the supply is to increase the numbers in training, although there would be a time lag of 3-4 years before this would have any sufficient impact. Over the last three years the number of radiotherapy places commissioned by the NHS have been increasing by approximately 10 per cent per year. Like other health professionals, therapeutic radiography students are required to undertake a significant amount of their training within a practice environment under the supervision of qualified practitioners. The availability of suitable practice placements is a critical limiting factor on the number of training places that can be commissioned. Given current staffing levels, most hospital departments are already close to or have reached their capacity for supervising students.

Radiotherapy is also associated with dealing with terminally ill patients, often in stressful working conditions. There are problems with student recruitment and retention. In recent years there has been an average 20 per cent under-recruitment against available places (with five higher education institutions experiencing shortfalls of over 38 per cent for the current intake). In 2000-01, 197 places were on offer, but only 159 students were recruited. Student attrition from therapeutic radiography programmes has averaged around 27 per cent in recent years, however, the programme is demanding and the reason for attrition in almost a third of cases is academic failure. A number of universities have introduced continuous assessment to target learning support more effectively and in the belief that some students will find the smaller components easier to handle.

Source: College of Radiographers and the National Audit Office

over student demand would prevent them increasing commissions to the required level.

2.20 However, achieving an increase in student numbers completing pre-registration education and training is seen as key to meeting the future staffing demands. Under the NHS Plan[4] the Department has set targets so that by 2004 there will be an extra 5,500 nurses and midwives and 4,450 therapists and other health professionals being trained each year.

2.21 To date, increases in commissioned numbers have been accommodated by the higher education institutions that provide the health professional training. However many higher education institutions told us that they are at, or near, full capacity and that if they are to continue to expand student numbers, there will need to be investment in the capital infrastructure, in teaching staff and in the number of practice placements.

Steps are being taken to improve the capacity of the education and training system for the health professional workforce

2.22 Initiatives are being introduced to help expand the number of training places available, in partnership with the higher education institutions and the statutory and professional bodies. These include:

- working with the higher education institutions to identify more practice placements (**Case example 3**);
- developing more and better prepared mentors and teachers within the context of new framework guidance issued in January 2001[28];
- promoting longer term contracts between the NHS and current higher education institutions, through securing their commitment to fund capital developments with increased running costs reflected in contracts with Consortia; and
- tendering for new providers, for example an additional provider of physiotherapy training is currently being sought.

Case example 3: Identifying additional practice placements for undergraduate physiotherapists in the Trent Region

Problem - Consortia workforce plans in the Trent Region identified a need to address predicted shortages of physiotherapists by increasing the number of student commissions. However, their ability to do this was constrained by a lack of practice placements. The lead Consortium formed a Physiotherapy Commissioning Group, and sought ways to expand the number of placements available locally and nationally.

Solution -They identified a number of changes to increase the availability of placements:

- appointed a placement co-ordinator and data base manager across higher education institutions;
- encouraged local NHS Trusts to give priority to Trent students rather than those outside the area;
- introduced a system whereby two students are allocated to a practice educator rather than one;
- targeted new areas for elective placements including the armed forces and private hospitals;
- increased awareness, communication and collaboration among all those concerned, including the higher education institutions, the commissioning sub group and NHS Trusts;
- engendered a culture of clinical education in health care organisations by facilitating practice placement issue workshops and conferences; and
- introduced monitoring mechanisms to review progress and plan future strategic direction.

Outcome - These initiatives identified sufficient practice placements to meet the 1999-2000 requirements and led to 37 additional placements being found to assist the increase in commissions. Of the 31 NHS Trusts providing placements, there were offers of additional placements in a variety of specialities such as neurology, orthopaedics, respiratory and women's health. With the changes outlined above, the number of placements available are expected to increase still further and will significantly contribute to the planned 2003 workforce targets.

Other initiatives are helping to increase the number of students taking up and keeping places

2.23 The NHS Executive and the Committee of Vice Chancellors and Principals (now Universities UK) issued guidance in 1999 on Good Practice in recruitment and retention of nurses in higher education[29]. Consortia and higher education institutions have also adopted a number of initiatives which are aimed at widening participation by attracting new types of people onto NHS training programmes as well as retaining them once they have started the programme. These include:

- more pro-active recruitment from the local health economy together with ensuring that students identify with one "home" NHS Trust, in the belief that staff recruited and trained locally are more likely to take up a job there;
- developing fast track entry routes to adult diploma programmes;
- expanding the number of health care assistants sponsored to go onto nursing diploma programmes (Consortia fund 80 per cent of salary costs to health care assistants and the other 20 per cent is expected to be provided by the employer NHS Trust);
- initiatives to increase numbers of black and minority ethnic applicants;
- developing cadet schemes to be rolled out across the country;
- providing financial support to help NHS Trusts set up cadet schemes which take school leavers at 16 and provide them with on the job training and experience until such time as they are eligible to enrol on a nurse diploma programme. "Making a Difference"[13] required all Consortia to have a cadet scheme operating in their locality by September 2000;
- using local colleges to provide access programmes for potential students whose education qualifications would prevent them being accepted through the normal entry route;
- developing relationships with Training and Enterprise Councils (and in future the Learning and Skills Councils) to promote the health professions as a career; and
- one higher education institution is piloting a programme for deaf students to train as nurses in the learning disability branch.

2.24 The Department has also been working in partnership over the past 12 months with the English National Board and other professional and statutory bodies, higher education and NHS staff, to develop national guidance on building placement capacity and improving the quality of practice placements[11]. This will be reinforced by a new national practice placement working group and strengthened partnerships with the independent health sector.

Staff vacancies provide an indication of the extent to which demand is not being met

2.25 In 1999, the Department conducted its first survey of vacant nursing posts that NHS Trusts were actively trying to fill across the NHS in England[30]. This survey found that 7,285 posts (3.5 per cent of posts) for qualified nurses and midwives had been vacant for three months or more in England. A survey in March 2000[31] showed whole time equivalent 3 month vacancies had increased to 10,053 vacant posts (3.8 per cent of posts). The highest vacancy rates were in London, the South East and Eastern Regions, and by work area, in acute, elderly and general, psychiatry, paediatrics and learning difficulties.

2.26 These vacancies partly reflect increases in staffing complements but also the fact that insufficient numbers have been commissioned in the past and may have implications for the NHS in achieving the challenging objectives set in the NHS Plan. Although increasing current commissioning levels will contribute to the expansion of services in the longer term, the Department will need to build on current initiatives in order to meet short-term demand, such as targeting potential returners to the workforce, international recruitment, and improving retention.

In addition to increasing the numbers of training places under the NHS Plan, the Department has taken a number of other steps to meet current and future demand for health professionals

2.27 While newly qualified health professionals are expected to provide the main and most predictable source of increased staff for the NHS, the Department has adopted a number of other measures to meet demand. These have been profiled in a number of documents including, Improving Working Lives[20], Working Together[21] and Developing the NHS workforce[3]. The Department's commitment to these have also been restated in the NHS Plan[4] and the subsequent Human Resources Performance Framework in October 2000[19]. For example:

- recruitment campaigns to increase the number of returners. Since 1997-98 the Department has spent £4 million per year on "Return to Practice" campaigns. These have resulted in some 5,800 nurses returning to work in the NHS (of which about 60 per cent were part time). The Department's "Return to Practice" target for 2000-01 is a further 6,000 nurses;
- improving recruitment and retention through a range of incentives such as improved pay, including plans to introduce a new, more flexible pay system, help with accommodation and the introduction of an Improving Working Lives Standard[19,20];
- the NHS Plan proposes an increase in targeted international recruitment as a means of boosting staff numbers in the short term. There are no national statistics on the number of nurses working in England who trained and qualified overseas. However, in 1998-99 some 3,184 nurses and midwives joined the UKCC register from overseas. Provisional data for 1999-2000 show some 7,361nurses and midwives from abroad registered for the first time. Shortages of health professionals is an international issue and competition for qualified staff is strong, there is therefore a possibility that other countries may take steps to recruit from within the NHS; and
- introducing changes to the skill mix, for example, bringing paramedics on to wards, recruiting new radiography assistants and more flexible use of clerical resources to free up qualified staff for more direct patient care.

d) The performance of higher education institutions in meeting demand for newly qualified health professionals

Recruitment campaigns have been successful in increasing interest in the health professions

2.28 During the last two years, the Department has run two national television recruitment campaigns, and a number of Consortia have run local radio or television campaigns or used NHS leaflets/flyers/newspaper adverts to attract recruits. The Department's analysis of the impact of their two advertising campaign shows that:

- the 1997-98 and 1998-99 campaigns generated 42,258 and 48,638 responses respectively, with nearly 90 per cent from potential new entrants;
- there was a 73 per cent increase in the number of applicants for nursing and midwifery diploma programmes between 1997-98 and 1998-99 (18,732 to 32,404); and
- there was a 24 per cent increase in the number of applicants to nursing and midwifery degree programmes in 1999-2000.

2.29 The higher education institutions and NHS operate a number of recruitment strategies. Increasingly these are being run as joint exercises. The most common strategies used by higher education institutions were opens days at the institution (85 per cent) or NHS Trust (60 per cent) or schools recruitment fairs, either solely run or jointly with the NHS (around 42 percent of the institutions run joint recruitment fairs). Other measures include running access programmes (65 per cent) or introducing more flexible curriculum timetabling (27 per cent). Around 50 per cent of the institutions offer fast track or part time programmes to attract students who might not otherwise apply.

2.30 Higher education institutions we visited believed that the overall improvement in applications for most of the NHS programmes was strongly influenced by the active recruitment campaigns in both the NHS and higher education sectors. The Department's initiatives to widen entry gates[13,32] also helped to increase the number of potential applicants.

Rigorous, joint selection procedures are used to help ensure students are suited to the programme, and vice versa

2.31 In order to help minimise the number of students who might later drop out of a programme, higher education institutions use a range of in-house selection procedures to determine candidates' suitability for the programme and that the programme is appropriate for the student. For example, for nursing and midwifery students:

- as a first sift, all institutions apply minimum academic selection criteria set by the professional bodies;
- joint interviews with the NHS are conducted in the case of almost all candidates;
- over forty per cent of the institutions also used group selection, most of which were run jointly with the NHS to allow employer, student and university to interact; and
- just under a fifth of institutions required candidates to complete a written assessment or invigilated exam, to help gauge likelihood of academic success.

For physiotherapy, occupational therapy, clinical psychology and radiography students:

- all candidates had to satisfy degree level entry requirements;
- two fifths of institutions also use group selection or set a written paper or exam; and
- almost all institutions interview applicants before offering them a place. Over two-thirds of these interviews were run jointly with the NHS.

2.32 Higher education institutions continually review their selection criteria and procedures and are already undertaking work in this area to address widening the entry gates at the same time as needing to reduce attrition rates.

The number of therapy students starting programmes generally met commissioning targets, but nursing and midwifery student starters did not

2.33 For physiotherapy, radiography and occupational therapy, the numbers starting in 1999-2000 were only slightly below the numbers planned. For nursing and midwifery training, the final numbers were about 3 per cent lower than the number of commissions. This was a significant improvement over the previous year, when the shortfall had been 15 per cent. One reason for this is the increase in suitable candidates applying following the national recruitment campaigns.

2.34 Other reasons given by Consortia management teams for the shortfalls between the numbers of places commissioned and the numbers starting the programme were:

- insufficient students meeting the selection criteria;
- the number of students rejecting the offer of a place; and
- students failing to take up their place. Experience of institutions providing health professional education is that on average four per cent of students enrolled on a programme do not turn up on the first day although some may turn up late to register.

2.35 Nursing and midwifery education and training has two intakes, Autumn and Spring, and institutions told us that they find it much more difficult to fill the places for the latter, as this is outside the normal student recruitment cycle. In addition, Consortia often increased commissions after the recruitment process had been completed, and these late notification places were difficult to fill.

The extent to which students complete programmes is an important performance indicator, but consistent data on completion and attrition rates are not available

2.36 Although some level of non-completion is to be expected from a professional educational training programme, an important measure of the effectiveness of the health professional education and training system is the proportion of students who complete their programme. Both the NHS and higher education institutions recognise that students who do not successfully complete their programme, yet meet the academic criteria, represent a waste of potential human resources and NHS funding. However, there are no nationally available comparable data across higher education institutions on NHS funded student completion or non-completion (widely referred to as attrition or discontinuation) rates. Indeed, an internal Departmental report on nurse attrition, commissioned by the Minister for Health in March 2000, noted that the data available were not comprehensive or consistent and that few contracts with higher education institutions contained attrition targets.

2.37 However, the extent of attrition is monitored regularly by the English National Board for Nursing, Midwifery and Health Visiting and also by Consortia and higher education institutions as part of the contract review process. The data from these sources are not directly comparable and during 2000-01 the Department has been working with Consortia to validate English National Board attrition data.

Attrition rates are slightly lower than for students elsewhere in higher education and the proportion of students completing programmes have improved over time

2.38 Overall, the data[33] for the cohort starting in 1996-97 show that around 83 per cent of nursing students completed their programmes (an attrition rate of 17 per cent). This compares with the average completion rate of 82 per cent for other non-NHS funded programmes (average attrition rate is 18 per cent).

2.39 The data also indicate that there have been year on year reductions in nursing student attrition, from 19 per cent for the cohort starting in academic year 1994-95, to 17 per cent for the 1996-97 cohort. Unpublished data for students who started their programmes after academic year 1997-98 indicate that the average attrition rate for nursing students may have reduced to around 15 per cent.

2.40 While most other health professional programmes have lower attrition rates than the nursing programme, radiography has higher rates. A report by the Joint Validation Committee of Radiographers[34] showed that attrition from diagnostic radiography programmes completing in 1998-99, was 22 per cent or 78 per cent completion rate while student attrition from therapeutic radiography programmes was 27 per cent. However the programmes are demanding and the reason for attrition in almost a third of cases is academic failure.

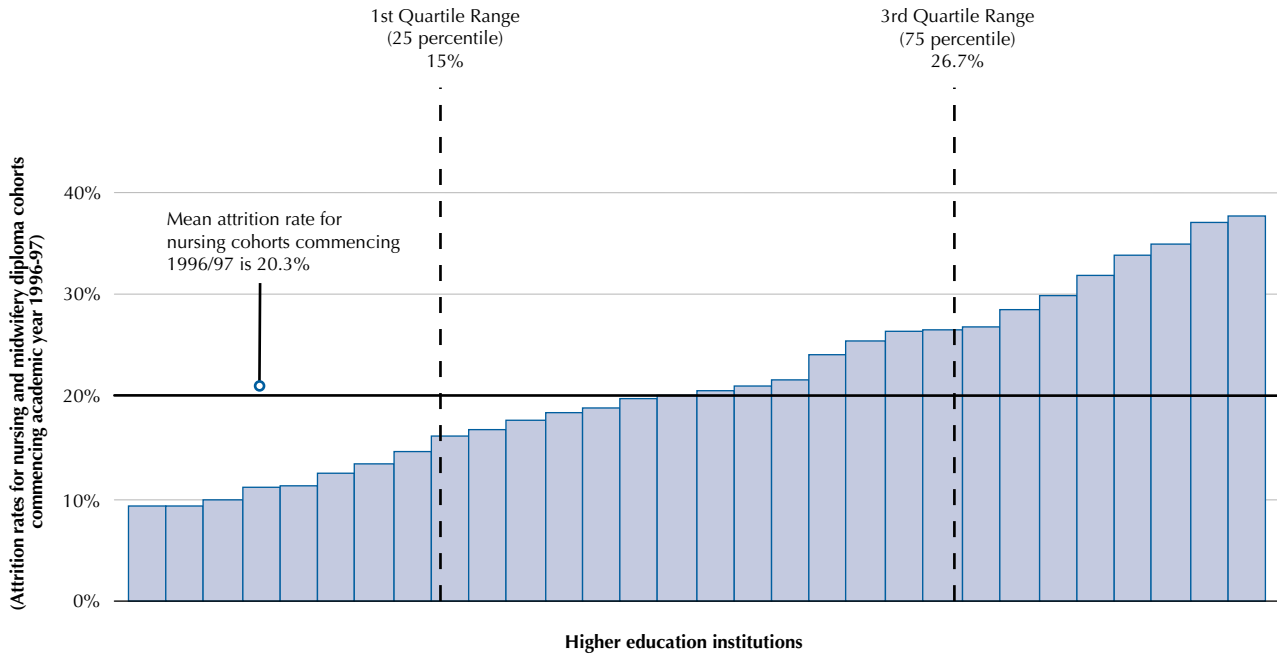
2.41 In order to develop a comparable database we collected information from higher education institutions using an agreed definition of attrition. This was as follows:

$$\frac{\text{starters } \textit{plus} \text{ transfers in, } \textit{less} \text{ transfers out, } \textit{less} \text{ numbers completing}}{\text{starters}}$$

There are wide variations in attrition rates across higher education institutions and the potential to improve performance

2.42 We found that while student attrition is a feature of all education and training programmes the extent and therefore its significance for the NHS and higher education institutions varied widely. Our data for nursing and midwifery, by far the largest group of NHS funded students, show that the attrition rate for students who started in 1996-97 varied across universities from around 5 to 37 per cent with an inter-quartile range of 15 and 27 per cent, **Figure 5**. The average rate of attrition was 20 per cent. These figures from our survey may be overstated, since a feature of nursing and midwifery training is that students can step off and then back on to programmes but interruptions are counted as non-completion even though a student may resume studies at a later date.

5 Attrition rate for nursing diploma contracts commencing in academic year 1996-1997, the most recent available data



Notes: 1. 30 out of 42 higher education institutions provided attrition data on nursing and midwifery. In total 8,900 students started and 6,950 completed their studies at these institutions.

2. Attrition defined as starters plus transers in, less transfers out, less numbers completing. Rates calculated using starters as the denominator.

Source: *National Audit Office survey*

2.43 We also found that attrition rates for allied health professionals, with the exception of both diagnostic and therapeutic radiography, are much lower than for nursing and midwifery. For example, the average attrition rate for students starting in 1996-97, was as follows:

- for clinical psychology students 6.8 per cent;
- for physiotherapy students 8.6 per cent;
- for occupational therapy students 12.8 per cent; and
- for diagnostic and therapeutic radiography students 18 and 28 per cent respectively.

However, these variations need to be interpreted carefully, as on some programmes, student numbers are very small, and two or three discontinuations can result in high attrition rates.

2.44 Despite the potential difficulties of interpretation, the variations in attrition rates, particularly for nursing and midwifery, indicate that there may be scope for improvement for both higher education institutions and Consortia. There is currently limited understanding of the reasons behind variations in attrition rates. A number of higher education institutions and Consortia have carried out research to investigate the reasons for attrition see **Case example 4**. These examples also illustrate some of the difficulties in understanding and interpreting attrition rates. In reality, the scope for improvement will depend on individual circumstances and the stage reached in developing more effective strategies at the local level.

Academic failure and personal circumstances are the main reasons for non-completion; programme quality was not identified as a main cause

2.45 Exit interviews carried out by most higher education institutions provide information about why students leave programmes. Academic failure and personal circumstances, including financial pressures are given as the two main causes of non-completion, **Figure 6**. Consortia and higher education institutions told us that pressures within the NHS are having a detrimental effect on the quality and availability of practice placements and consequently on the students experience, increasing the chances of these students leaving.

Case example 4: Investigation into student attrition from the Diploma in higher education nursing programme at the University of Hertfordshire

Problem - Staff at the Department of Nursing and Adult Health at the University of Hertfordshire were concerned at the general level of attrition amongst student nurses at pre-registration level. They were also aware that attrition rates vary considerably throughout the UK and at the lack of consensus as to the reasons for nurses discontinuing their education. To address the issue of attrition among student nurses locally, they undertook a research project to identify the main reasons for attrition, identify factors associated with this attrition, and suggest strategies for reducing attrition levels.

Analysis - The study team examined the files of all 345 students who interrupted or discontinued from the Diploma programme between September 1996 and December 1999. They devised and distributed a questionnaire to those students and to a representative sample of those who continued on the programme. They also conducted in-depth telephone interviews with a small number of students who failed to continue with the programme.

Outcome- The overall attrition rate was 26 per cent, or 22 per cent if those that interrupted for a short time were added back in. Three significant exit points were identified. These were: after the 4th month (the point at which students are due to submit their first written assignment, this also follows the first practice placement); after the 12th month (usually follows a holiday period); and after the 21st month (the results of common foundation exams are announced). More than 70 per cent of the students leaving or interrupting did so during the Common Foundation Programme and younger students (21years or under) tended to stay longer than older leavers (22 years or above) do, an average of 12 months compared with 13.7 months. More than half the early leavers had academic difficulties during the first formative assessment and most of these were young early leavers (aged 21 years or under). Official reasons for attrition included: trainees' request, 37 per cent; personal/domestic reasons, 13.9 per cent; academic failure, 29.3 per cent (including students who were retaking the subject while bursary was temporarily discontinued); illness, 10.4 per cent; and pregnancy, 4.4 per cent (even though a number planned to return). The study team developed a more meaningful set of categories which showed that academic difficulties (not necessarily academic failure) was the largest group (24 per cent) followed by emotional difficulties, family commitments and other personal difficulties (together these accounted for 40 per cent of discontinuations).

Strategies - Some of the main recommendations emerging include: the need to develop a more transparent and sensitive recording system which can also compare genders and ages to identify whether significant difference exist, also to ensure personal tutors and others involved in pastoral care are aware of exit points and offer support to mature students fairly early on in the programme, and also to identify individuals with possible academic difficulties at as early a stage as possible so as to provide them with support and encouragement to attend study skills sessions.

6 **The main reasons for students attrition (discontinuation) from programmes in academic year 1998-99**

	Number of Students					
	Physiotherapy	**Occupational therapy**	**Radiography**	**Clinical psychology**	**Nursing**	**Midwifery**
Reasons for students attrition (discontinuation)						
Academic failure (of either or both the academic or clinical component of the programme)	35	35	34	5	353	30
Personal circumstances (including financial pressures)	18	28	23	1	374	48
Took up employment/other career choice	2	9	7	0	111	19
Illness	6	8	2	0	56	9
Transfers to other NMET funded programmes	2	3	2	0	118	6
Transferred to other non-NMET programme	4	0	7	0	14	1
Dissatisfaction with the quality of the programme including cost and quality accommodation /practice placement/timetable	0	0	1	0	39	5
Reasons not specified in survey	4	1	8	1	143	10
Not known	4	2	1	0	178	6
TOTAL Number of students discontinuing in 1998-99 as provided in response to Survey	**75**	**86**	**85**	**7**	**1386**	**134**

Source: National Audit Office survey of higher education institutions - 34 of which provided nursing and midwifery and 36 who provide other health professional programmes

2.46 However, only 3 per cent of nursing students cited dissatisfaction with the quality of the programme, including the component delivered in the practice environment, as the main reason why they left.

2.47 From discussions with higher education institutions, we obtained further insight into factors underlying the reasons for non-completion given at exit interviews. These factors, which the higher education institutions and Consortia can jointly influence, included:

- poor advice and information during student recruitment, resulting in students being surprised about either or both the academic and clinical aspects of the programme, and the reality of the career they are embarking on, and even recruitment to the wrong programme; and
- selection processes that do not identify all potential problems such as the need for learning support.

Action is being taken that should help address student attrition

2.48 The NHS and higher education institutions have launched a number of significant initiatives to improve attrition and increase completion rates, other initiatives are in the pipeline. These include:

- a new model of nurse education, Making a Difference[13], which incorporates the option to 'step on and off' programmes to encourage more people to continue (though this will make monitoring attrition even more difficult than at present);
- increasing bursaries by 2.5 per cent from September 2000 to ease financial problems, together with initiatives to increase affordable housing for nurses;
- higher education institutions providing students with a number of different support packages to increase retention, including personal tutors, counselling services, practice placement travel costs, access to a hardship fund and a subsidised crèche. A smaller number also provide fee remission schemes, free or subsidised transport costs and support for childcare;
- new work to resolve issues around career guidance for potential healthcare students, to ensure a better balance between academic capability and clinical experience prior to pre-registration training;
- initiatives to increase the availability of affordable housing[3];
- the issue of Health Service Circular (1999) 219[35], which asked Consortia to work with the higher education sector to improve clinical experience through the development of standards and outcomes for practice. In addition, the NHS Executive, in conjunction with service representatives and the statutory bodies, are introducing further national practice placement standards[11];

- research, including looking at the drivers of attrition, expected to be published in March 2001 which will be followed by the development of a range of good practice material; and
- improved data on attrition rates and better feedback of these data to education commissioners.

2.49 National policies to widen participation and introduce stepping on and stepping off points will also impact on the calculation of attrition rates, as it will no longer be appropriate to count interruptions as attrition. Also the general findings in the higher education sector are that the higher the academic qualification of the cohort the lower the attrition. Therefore, the impact that widening the entry gates has on attrition rates will be a factor in interpreting attrition rates in future.

National targets have been set for attrition rates

2.50 The Department's Human Resource Performance Framework[19] includes targets to reduce attrition rates. In particular, for the 2000-01 intake, non-completion is targeted not to exceed 13 per cent for nursing and midwifery and 10 per cent for allied health professionals nationally. The new targets were introduced by the Department to address concerns about attrition, but were not consulted on externally.

2.51 Although offering clarity, a single national target which is not tailored to the individual circumstances of each higher education institution, introduces the risk that they are unattainable for some, while for others they offer little incentive to improve further. Irrespective of the type of target used, we note that their usefulness for improving and monitoring performance depends on:

- having a nationally consistent definition of attrition rates, which is either the same as, or is readily comparable to, the measures already used by the Higher Education Funding Council for England;
- consistent use of the measures in contracts with higher education institutions; and
- the NHS and higher education institutions working together to deliver the targets.

2.52 The Further and Higher Education Funding Councils in the UK have already put a considerable amount of effort into developing strategies for improving student completion and progression. This includes the development of performance indicators, the agreement of targets at individual level aimed at encouraging the identification and implementation of good practice, and targeted support for the worst performers. The lessons learned from this work could provide some assistance in further consideration of the development of performance improvement strategies for education and training programmes for health professionals.

Most newly qualified health professionals go on to work in the NHS but there is not yet systematic tracking of employment thereafter

2.53 Most institutions collect first destination data for employment that started within the first six months after student graduation. Data for 1998-99 show that overall, 84 per cent of nursing graduates and 90 per cent of midwifery graduates were known to have taken up posts in the NHS. Similarly 84 per cent of physiotherapy graduates, 89 per cent of radiography graduates and 94 per cent of clinical psychology graduates were known to have taken up posts in the NHS. While only 73 per cent of occupational therapy graduates took up posts in the NHS, 6 per cent went to work in social services. Overall, around 5 per cent of those not going on to work in the NHS took up posts in the independent sector. A number of these will be working in nursing and residential homes, and will therefore provide a service back to the NHS.

2.54 In follow up surveys by higher education institutions, students mentioned a wide range of factors that influenced their first choice destination. The main factor that encouraged working in the NHS was the quality and experience of placements while training, particularly the final placement. Nursing graduates also mentioned the importance of feeling valued as a team member and as an integral part of the host trust. Other factors were the availability of suitable posts on qualification, including rotation posts to enhance experience and the prospect of career progression. As might be expected, remuneration was a factor, as was whether employers had family friendly policies.

2.55 The Audit Commission's work[1] at study site NHS Trusts found that personnel systems did not record destinations of staff leaving their employment in a comprehensive way. It is therefore not possible at the moment to measure longer- term retention in the NHS. The NHS intend, however, to use payroll records over time as a way of measuring longer term retention.

Part 3

Achieving value for money from NHS education and training contracts

3.1 This part of our report examines how far good quality health professional education and training has been delivered at least cost. We looked at:

- price per student for NHS funded contracts and the transparency of higher education institutions pricing policies;
- what quality is expected from education and training; and
- what quality has been achieved. This depends on a number of factors including the quality of contracts and their monitoring, course content, the quality of teaching staff and facilities, and on good quality practice placements.

The NHS and higher education institutions operate under a joint commitment to provide quality education while securing best value for money

3.2 In May 1998, the NHS Executive and Committee of Vice Chancellors and Principals issued a "Joint Declaration of Principles" which set out a commitment to provide quality education for healthcare professionals whilst securing the best value for money for the NHS[10]. In 1999, the Department produced good contracting guidelines[6], which require that purchasing should be based on best value and goods and services should be acquired by competition, unless there are convincing reasons to the contrary. The "Joint Declaration of Principles" is re-iterated in the Department's Good Contracting Guidelines.

Price per student is expected to fall, yielding forecast savings of over £7 million in 2000-01

3.3 Figures provided by the Department show that the average annual contract price per student in 1998-99 for pre-registration nursing students at 2000-01 prices was £11,348. Equivalent figures for Occupational Therapy and Physiotherapy courses were £7,951 and £8,329 respectively. These prices, which include the cost of the student bursary, are forecast by the Department to fall slightly in real terms in 2000-01. Against the planned population of students, this equates to expected cost savings for the NHS on pre-registration training of £7.1 million (**Figure 7**).

7 A comparison of the 1998-99 outturn and 2000-01 forecast unit costs of educating and training health professionals and expected efficiency savings

	1998-99 Cash out-turn £	Real term out-turn at 2000-01 prices £	2000-01 Cash forecast £	Real term forecast at 2000-01 prices £	Number of students in 2000-01	Estimated efficiency saving £
Pre-registration nursing[1]	10,790	11,348	10,959	11,233	44,962	5.2 million
Occupational therapy[2]	7,560	7,951	7,608	7,798	3,524	0.5 million
Physiotherapy[2]	7,920	8,329	7,783	7,978	3,897	1.4 million
					Total	**£7.1 million**

Notes: 1. Pre-registration nursing diploma students receive non-means tested bursaries
2. The unit cost of physiotherapy and occupational therapy are lower than that for nursing because the training costs are based on lower means-tested bursaries.

Source: Department of Health

Prices for training programmes that produce the same qualification vary widely

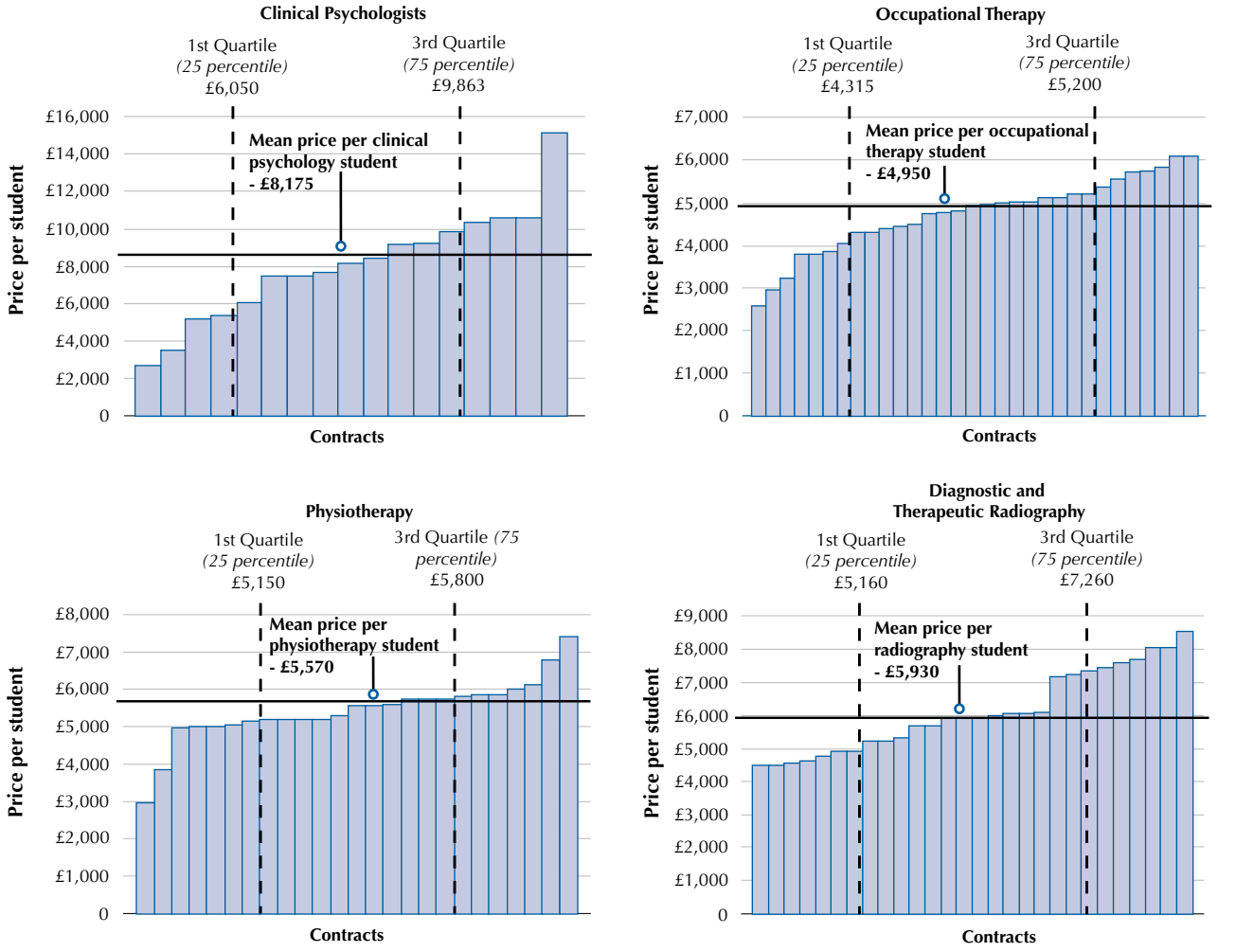
3.4 The contract price per year, paid by the Department to higher education institutions for pre-registration students (excluding bursaries), at 1998-99 prices varies widely within each of the five health professions covered in our surveys, **Figure 8a**. For clinical psychology the full range was £2,700 to £9,863; for occupational therapy £2,958 to £6,088; physiotherapy £2,955 to £6,804 and for radiography £4,508 to £8,513. These variations were particularly wide for nursing and midwifery contracts, from £2,569 to £10,570 - **Figure 8b**. Also variations remain, even allowing for local factors (**Figure 9**). It should be noted, however, that the inter-quartile range calculation shows that the variations around the mean for half of the contracts is relatively small.

3.5 All of the Consortia management teams have undertaken a major contract review over the last few years and many of these have led to reductions in the price per student in real terms. These reviews have also reduced the extent of price variations.

3.6 There are a number of historical and structural factors which have contributed to the variations in the price per student:

- under Project 2000, responsibility for providing nursing and midwifery education and training transferred from NHS Colleges of Nursing, Midwifery and Health Studies to higher education institutions. The terms of the transfer varied widely, in particular the pension costs of teaching staff;
- further variation occurred due to the different approaches to contracting in NHS regional offices (some had agreed rolling contracts others had fixed term contracts) and the different types of contract adopted (for example block contracts, fee per student, core contract plus marginal cost per student);
- competitive tendering naturally leads to price variations;

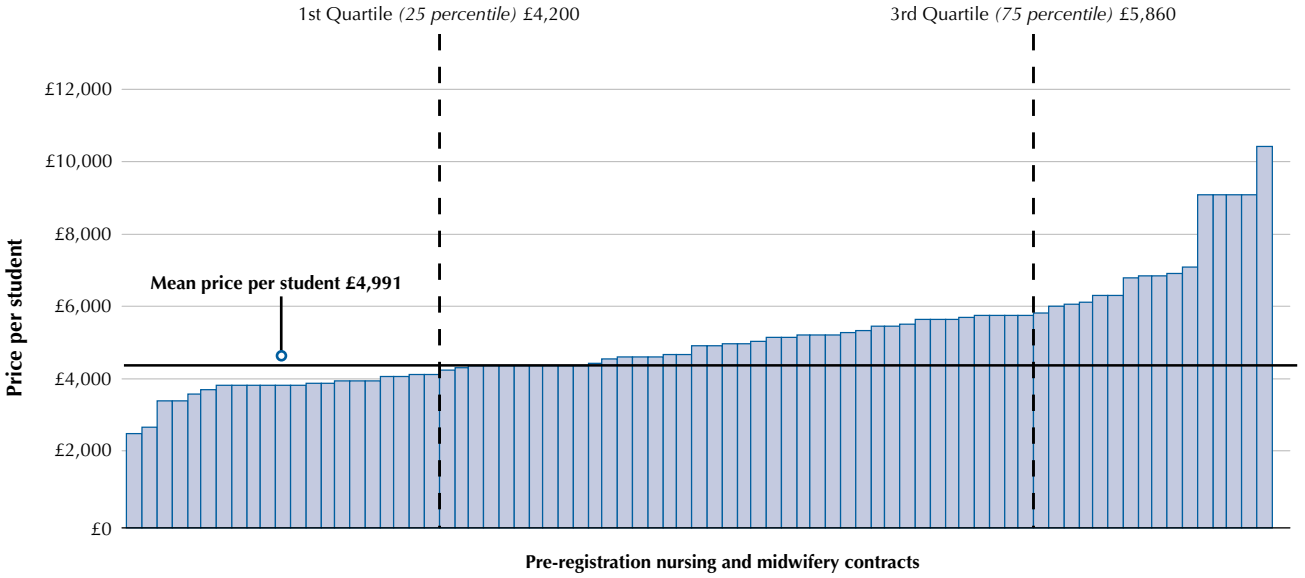
8a **Price per student in 1998-99 for each contract held by higher education institutions, for the four health professions covered by the survey**



Note: The survey asked the higher education institutions to provide "Price per student in 1998-99" for each pre-registration contract held with NHS Education and Training Consortia. Some higher education institutions with block contracts did not provide this information. While there is wide variation the inter-quartile range shows only small variations around the mean.

Source: National Audit Office survey of Higher Education Institutions (Summer 2000).

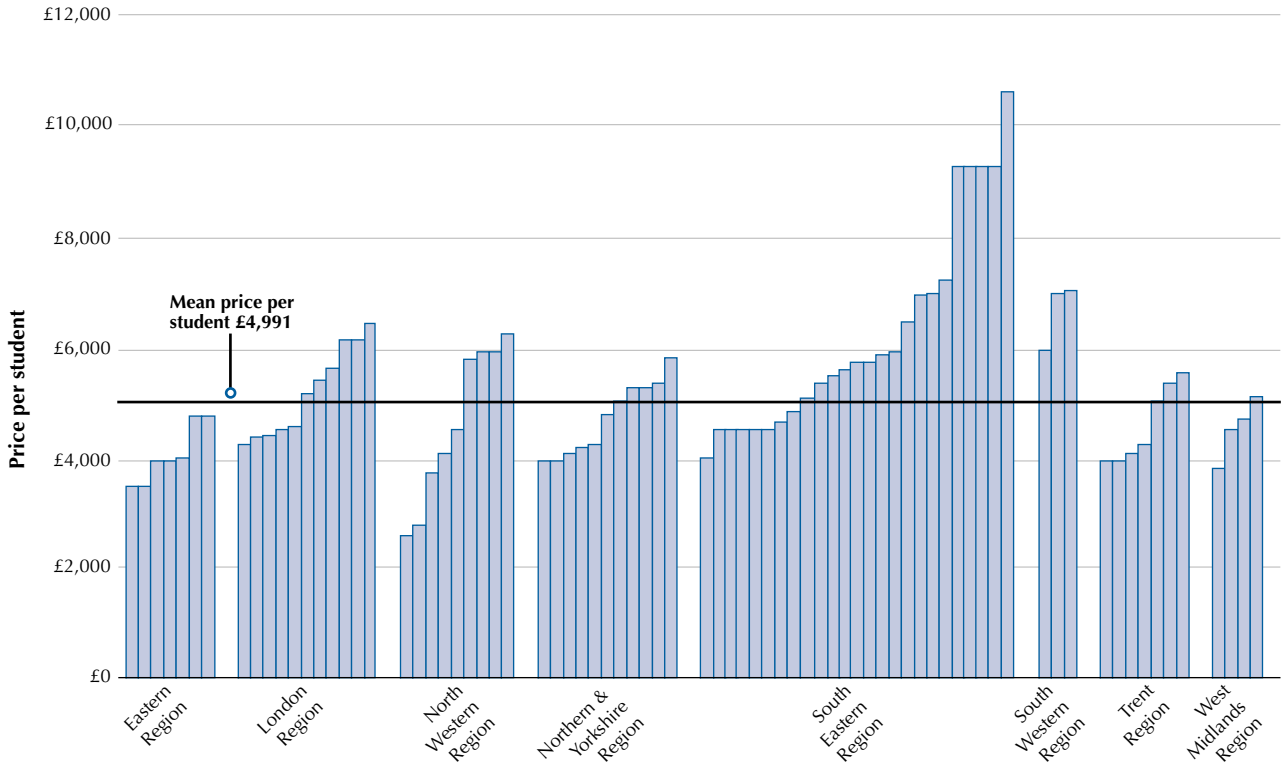
8b **Price per student nurse for each nursing and midwifery contract in 1998-99**



Note: The survey asked the higher education institutions to provide "Price per student in 1998-99" for each pre-registration contract held with NHS Education and Training Consortia. Some higher education institutions with block contracts did not provide this information.
While there is wide variation at the extremes, the inter-quartile range shows that the variation around the mean for half the contracts is relatively small.

Source: *National Audit Office survey of Higher Education Institutions (Summer 2000).*

9 **Price per student nurse for each nursing and midwifery contract in 1998-99 by region**



Note: The survey asked the higher education institutions to provide "Price per student in 1998-99" for each pre registration contract held with NHS Education and Training Consortia Some higher education institutions with block contracts did not provide this information.

Source: *National Audit Office survey of Higher Education Institutions (Summer 2000).*

- changes in the numbers of education and training places that the NHS commissioned have also affected the price per student. The Department expects Consortia to achieve efficiency gains when increasing the numbers commissioned. However the gains required vary;
- since 1996, around 84 contracts (46 per cent) have been renegotiated or re-tendered as part of a major contract review. Some higher education institutions admitted to offering deliberately low prices or lowering their price during contract negotiation in order to win or retain the contract.

3.7 A range of local factors reflect costs and hence prices:

- staff salaries, especially in the South East;
- pension commitments, particularly at the older higher education institutions;
- accommodation costs, particularly in London and the South East and at those institutions that operate from a number of different sites;
- the cost of supporting students on placements (including student and staff travel to the placement), particularly for institutions that cover large geographical areas; and
- the cost of providing IT, Library services and equipment, particularly when the institution has multi-site accommodation.

The lack of transparency in contract price means that the NHS cannot determine whether it is paying an appropriate price

3.8 A further reason why prices vary is that higher education institutions have adopted a number of different approaches to pricing NHS contracts. Higher education institutions are free to set prices at whatever rate they deem commercially acceptable. Thus it is inappropriate for the NHS to make judgements on the value for money based on price alone as they are unlikely to be comparing like with like. For example:

- in 15 per cent of higher education institutions pricing policy was described as price equals cost,
- in ten per cent, price had been set below costs;
- in 71 per cent of institutions the pricing policy was cost plus a contribution to overheads. However, the overhead contribution varied. For nursing and midwifery contracts it ranged from 3 to 58 per cent with an average overhead contribution of 28 per cent. And for the other health professional programmes, physiotherapy had the lowest average overhead contribution at 15 per cent whilst the others varied with averages between 24 and 26 per cent. This may reflect either real cost differences or decisions to incorporate only part of overheads into prices; and
- while there is no standard overhead rate for Higher Education Funding Council for England funded contracts, around half of the institutions in the survey provided an estimate. This showed that the average overhead rate charged for these programmes was around 41 per cent, which is higher than the 28 per cent average for nursing and midwifery programmes or the 25 per cent average for other health professional programmes.

3.9 This evidence of a varying relationship between price and cost may not have led to the best allocation of resources. Consortia management teams told us they had concerns about whether the costs they faced were comparable, while some higher education institutions made the point strongly that they felt disadvantaged by pricing policies of other local institutions.

3.10 A number of institutions told us they believed that competitive tendering has encouraged this lack of transparency and that they are more likely to be open about costs in a constructive contract negotiation that has an agreed set of benchmark prices as a guide. While the NHS has developed an internal contract price database, and has shared this information anonymously with Consortia for use in contract negotiations, this has not been shared with higher education institutions. Indeed, many of the contracts between NHS and higher education institutions include a confidentiality clause that prevents the sharing of cost and price data with parties outside the contract.

There is now a basis for defining quality of outcomes in contracts

3.11 Value for money is about cost and quality of the training and the extent to which the student is fit for purpose on qualification. Health professional education and training programmes leading to registration or recordable qualifications are subject to approval by the respective statutory and professional bodies, which gives assurance about students' fitness for practice against national standards. Historically, however, contracts between the NHS and higher education institutions were based on inputs, rather than on a clear definition of what employers expect in terms of outcomes and competencies.

3.12 Practising clinicians have expressed concern about newly qualified health professionals' ability to function effectively in the practice setting, particularly in relation to nursing. These concerns were addressed in the United Kingdom Central Council for Nursing, Midwifery and Health Visiting Education Commission report *"Fitness for Practice"*[14] and by the Department's introduction of changes to the delivery of nursing and midwifery education *"Making a Difference"*[13]. They included proposals to introduce longer practice placements.

3.13 Following the proposals in "Making a Difference[13]", the NHS agreed with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting a set of competencies for entry onto the professional register[36]. The competencies to be achieved by the end of the first year nurse training were endorsed in February 2000 and the outcomes at the end of the third year of the new three-year pre-registration programme were agreed in June 2000. These provide, for the first time, a clear set of outcomes and competencies that can feed through into new contracts.

3.14 In addition, the Department, Consortia, higher education institutions and the statutory and professional bodies have been working together for a number of years to try and streamline the quality assurance and review systems. The Department and the Quality Assurance Agency for Higher Education are currently working with regulatory bodies and other stakeholders to develop an integrated framework of quality assurance for NHS funded health professional education provision[8]. The Department has also commissioned the Quality Assurance Agency to facilitate the development of UK wide core and profession specific benchmark standards, with the aim of meeting the requirements of all stakeholders[9]. The new system of quality assurance in England is expected to begin with a number of prototype reviews from October 2001 and anticipates the creation of new regulatory bodies for nursing, midwifery and health visiting[37] and the Allied Health Professions[38] and which will involve Workforce Development Confederations.

3.15 In the absence of explicit outcome measures in contracts, we examined the perceived quality of pre-registration provision in terms of:

- the content of contracts with higher education institutions and the adequacy of contract monitoring;
- the extent of competition in awarding contracts to higher education institutions;
- course content;
- the quality of teaching staff and facilities; and
- the quality of practice placements.

Most Consortia management teams carry out regular contract reviews and are generally content with the overall performance of their higher education institution

3.16 In addition to a major contract review, which is required towards the end of a contract to determine whether or not to renew it for another term, the Department's Good Contracting Guidelines[6] identify two other levels of contract monitoring review:

- continuous review as part of the education contract requirements to ensure that the higher education institution is adhering to the terms of the contract; and
- an annual review procedure, normally involving submission of an annual report by the higher education institution, a formal review visit by the consortium members, and an agreed action plan to address any matters of concern.

3.17 All the higher education institutions submit monthly or quarterly returns to Consortia, usually about student numbers. All Consortia management teams use some form of formal review meetings to monitor performance in relation to their contracts. Half hold quarterly meetings, and the rest hold meetings either six-monthly or annually. Consortia sub-groups, such as the nursing or physiotherapy sub-group, hold additional meetings on a more informal basis.

3.18 Action taken as a result of the reviews includes increased monitoring of contracts, for example, to improve quality or reduce attrition rates. Consortia management teams also use the information from reviews in contract renegotiations and one Consortium had decided to re-tender as a result of a monitoring review.

3.19 For others, the reviews led to joint action with the institutions. This included redesign of programmes, reviews of recruitment procedures, improved access to library facilities and the introduction of quality monitoring and development of performance indicators.

3.20 Annual review meetings almost always covered issues such as recruitment and retention, attrition, and practice placements. Programme design was reviewed by around four-fifths of the Consortia management teams but this was not seen as particularly high priority. Price and cost per student, quality of the lecturers and student accommodation issues, were monitored by two-thirds of Consortia.

3.21 Consortia rated the overall performance of their higher education institutions for us, for each contract. Although Consortia have different approaches to quality assurance and their views may not be strictly comparable, some useful results emerged from the analysis. One higher education institution's delivery was given an overall rating of outstanding, and most of the others were rated as highly effective or effective. Only seven out of 138 contracts on which comments were provided were rated as less than effective, but none was given an overall rating of weak.

There is a clear framework for ensuring the quality of programme design

3.22 Higher education institutions generally involve Consortia in programme/course design (**Case example 5**).

3.23 The English National Board for Nursing, Midwifery and Health Visiting issued guidance in January 2000 (Education in Focus: Strengthening Pre-registration Nursing and Midwifery Education)[39] to support all those with responsibility for developing and delivering pre-registration nursing and midwifery programmes based on an outcomes and competencies based approach. The guidance follows the recommendations of both the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in its Education Commission report[14], and the Department in "Making a Difference"[13]. The English National Board also currently sets standards to be met by higher education institutions for the approval of nursing, midwifery and health visiting programme programmes.

3.24 Many higher education institutions are also responding positively to the requirement for more flexible programmes, in particular in their design of new curricula in response to the Department's new approach to nurse education, *"Making a Difference"*[13]. In addition, many higher education institutions are developing fast track (61 per cent), part-time (64 per cent) and distance learning (38 per cent) pre-registration programmes to attract students who might not otherwise apply.

Short term contracts and a lack of research funding is undermining higher education institutions' ability to recruit and retain high quality teaching staff

3.25 The majority of teaching staff are recruited from within the NHS and many higher education institutions identified problems recruiting and retaining staff, particularly in nursing. The reasons given for this include lower pay and pension rights in the education sector compared with the NHS, a perceived lack of status in the higher education sector, the predominance of short term staff contracts and lack of support for research.

3.26 Most contracts for the delivery of NHS education and training programmes are for either three or five years. The short term nature of these contracts, and the possibility that the contract might be changed, or indeed be lost, means that many higher education institutions are reluctant to give permanent contracts to teaching staff. This affects both the recruitment and retention of staff.

Case example 5: How the University of Brighton ensures the quality of design of health professional courses

The University's physiotherapy and occupational therapy courses are designed by a Course Development Committee, which includes representatives from the University, Service (these are nominees from clinical managers groups), and the social services in the case of occupational therapy. As part of the course development process the University runs focus groups involving patients/clients to ensure that the views expressed in the Course Development Committee are fully representative of all interested groups. A separate Course Committee for each discipline meets three times a year to review existing course provision, to consider any suggestions for changes in course structure or changes to course regulations. The membership of the Course Committee includes representatives from Service and Consortia and, in the case of occupational therapy, from the social services.

This system facilitates the adaptation of current courses to meet NHS Trusts' demands, but such changes are dependent on the NHS Trusts' ability to provide relevant practice experience to support any change in course content. The University also takes the lead on issues such as the development of part-time courses for Continuing Professional Development purposes. The University has developed some distance and open learning provision at post-registration and masters level. All new developments go through the process outlined above. To date the Consortium has also funded 2 research projects looking at multi-disciplinary learning.

In order to assess the quality of health professional courses, the Course Board receives a number of items of evidence - for example, student evaluations, lecturers' evaluations, statistical data on results and progression, external examiners reports and a selection of different types of feedback from Trust representatives. The Course Board for each discipline produces a report which is considered at the School Board of Study. An annual summary report is produced, which is scrutinised at Faculty level, the University Academic Standards Committee and at the University's Academic Board. This report is sent to external examiners, the Consortium manager and relevant NHS Trusts.

3.27 One of the fundamental principles of higher education is the need to undertake research to improve and develop the learning environment. Three higher education institutions told us that they received funding for research from Consortia in relation to the provision of health professional education and training. However, most higher education institutions were concerned that they were unable to attract funding for research and that this could undermine the quality of education and training provided. They believe that this also makes it harder to recruit high quality teaching staff.

3.28 Research funds are available from other sources in the higher education sector, for example funding for research infrastructure is the responsibility of the Higher Education Funding Council for England. Funding for research projects and programmes is available through the Department's NHS Research & Development funding schemes and the Research Councils. Historically nursing and other allied health professional programmes have been relatively less successful than other higher education programmes in attracting Higher Education Funding Council for England funding as a result of poor quality ratings in the last Research Assessment Exercise. The Department and the Higher Education Funding Council for England recognised that there was a problem with the quality of nursing bids in the last Research Assessment Exercise and that a more strategic and developmental approach was needed. In order to develop a more coherent approach to addressing these problems a number of steps have been taken.

- In August 2000, following a commitment in *"Making a Difference"*, the Department published "Towards a Strategy for Nursing Research and Development" [40] - a consultation document on proposals for a more coherent strategy to strengthen the nursing contribution to research. The proposals include additional investment to pump-prime a handful of designated centres of research expertise. A Nursing Research Advisory Group is being set up to take forward the recommendations in the report in the light of responses to the consultation and the Department have begun to develop a research strategy for Allied Health Professionals.
- To improve strategic development and joint working in relation to the support of nursing and Allied Health Professional research.
- A joint Department - Higher Education Funding Council for England Task Group on research relevant to nursing and Allied Health Professionals has been set up to consider how they might promote better integrated and better targeted public investment in high quality research relevant to nurses and health professionals.
- To inform the Task Group's work a study has been commissioned to map current capacity in, and provision for, nursing and Allied Health Professions research and to identify successful funding models.
- As part of its wider strategy for developing research workforce capacity the Department will be making significant NHS Research and Development resources available for a number of research training and career awards in nursing and Allied Health Professions to be initiated in 2001-02.

The quality of teaching accommodation can also affect the quality of education provision

3.29 We asked the higher education institutions with NHS contracts for nursing and midwifery to rate the standard of their teaching accommodation. On average, the overall standard of accommodation was rated as acceptable. The main area of most concern was the institution's inability to accommodate expansion in student numbers without affecting the quality of education provision (47 per cent or 16 of the 34 institutions). There were similar results in the survey of institutions providing programmes for the Allied Health Professions contracts with 52 per cent (19 out of 36 institutions) concerned about their ability to accommodate expansion in student numbers.

3.30 In transferring the responsibility for providing education and training to higher education institutions the position with regard to funding capital development was not always explicit. For example 50 per cent of institutions providing pre-registration training programmes considered that they were contractually responsible for the future capital development of teaching accommodation, 12 per cent the NHS and the higher education institution in partnership and eight per cent the NHS. Thirty per cent of contracts (nine nursing contracts and 13 Allied Health Professional contracts) did not specify where the responsibility lay.

3.31 The Department's Good Contracting guidelines in 1999[6] clarified that the NMET levy is a revenue budget and should not be used to fund capital development. Also that, in general, where the higher education institution provides a new build the institution should be responsible for funding capital development, but that NMET funding may be used to support the revenue costs of capital expenditure.

3.32 Many of the contracts pre-date the Guidelines and we found variations in the approach of different Consortia to capital funding. For example, two out of three institutions told us that they had undertaken one or more capital development projects since the contract was established. The level of investment varied from new, purpose built facilities to refurbishment and redevelopment of existing buildings. Most of the capital projects involved teaching accommodation and the majority of the capital funding for these projects was financed by the institution (31 out of 50 contracts), however institutions told us that Consortia financed six developments and thirteen involved a partnership between the institution and Consortia.

3.33 While the institutions acknowledged their responsibility to provide good quality accommodation and that they should take the lead in discussing how best to achieve this, the short-term nature of the contracts is a constraint to entering into a long term financial commitment to build new, or improve existing, accommodation. Lack of certainty about the future (as regards whether the contract would continue and, if so, the number of students to be funded) has led them to question whether to allocate funds for capital development. Indeed some Vice Chancellors consider that it would exceed their powers as Accounting Officers to incur risks associated with capital development based on a short-term contract. Nevertheless, a number of institutions, on the basis of professional advice, have entered into major capital developments despite the short-term nature of the contract (**Case example 6**).

Case example 6: How the University of Kingston resolved the capital development issue

Problem - Until 1995, nursing and midwifery training was delivered by three NHS Colleges which had been formed from a large number of hospital based schools and were merged into a single entity shortly before incorporation into higher education. During early discussions on the contract, the University and Regional Health Authority, agreed that these premises were unsuitable in terms of efficiency and quality. The Regional Health Authority considered commissioning new teaching accommodation, creating a NHS asset, which would be used by the higher education institution. An option appraisal was carried and the preferred option was the Kingston Hill site, on the University campus. However, there were issues associated with building a NHS owned asset on the University's land, particularly if the contract was terminated after five years. Both parties agreed, that without investment in teaching accommodation the contract could not proceed. The University therefore investigated funding the investment.

Solution - A key issue for the University was the mismatch between the period of the contract and timetable for the repayment of the capital - 5 years against 25 years. The University's Board of Governors were concerned that if the contract was terminated the University would be unable to finance the outstanding loan repayments. The University commissioned Touche Ross to comment on the costing of the nursing and midwifery contract and evaluate the risks associated with the contract. Touche Ross concluded that, in financial terms, the investment was not "an attractive proposition" and that the contract was only worthwhile over "a longer time scale than the five year term of the contract". However, the report did recognise that the contract may have strategic benefits for the University. For instance:

- by becoming known as a provider of nursing education, the University may be able to generate further business in the area of subjects related to medicine (the University has been successful, jointly with St George's Medical School, in winning a contract to deliver physiotherapy education);
- there was the opportunity to form a collaborative working relationship with the Medical School and the University which would benefit from their established clinical knowledge and reputation and generate more income if commissions were in excess of the core numbers in the contract;
- the University could provide commonly taught modules with science courses already on offer, which could strengthen the quality of education and achieve cost savings.

Outcome - On the basis of the comfort obtained from the revised terms of the contract, specifically payment of rent until 2016 then a market rental and the expectation of further contract extensions, the University, agreed to proceed. The total value of the investment was £16 million, of which £11 million was attributable to the nursing and midwifery contract. The University used a re-financing agreement to fund the capital development. The consortium finances the cost of the £11million capital investment through a quasi-rent of £1.175 million per annum as part of the £9.7 million contract price.

Consortia could do more to monitor the effectiveness of placements

3.34 The quality of practice placements has a direct bearing on the subsequent ability of the students to work effectively. While higher education institutions are responsible for securing sufficient practice placements and supporting the student during the placement, employers, mainly NHS Trusts, are responsible for the supervision of the practice experience. Higher education institutions, therefore, have limited direct control over whether NHS Trusts and other placement providers deliver the quality requirements. *"Making a Difference"*[13] asked Consortia to work with higher education institutions to ensure that the sequence and balance between university and practice based study is planned to promote the integration of knowledge, attitude and skills.

3.35 The NHS is aware of its responsibility to ensure that students obtain good quality practice placement experience and just over a third of Consortia had undertaken reviews of the effectiveness of their practice placements. These reviews found that monitoring of availability and quality of placements was very mixed. As a result, in some Consortia placement co-ordinators had been appointed to work with Consortia members and higher education institutions to identify more and alternative practice placements. Other routes taken were to share places and information with other Consortia, develop databases and form sub-groups or working parties to develop innovative solutions. In addition, in January 2001, the Department and the English National Board for Nursing, Midwifery and Health Visiting, in collaboration with other statutory and professional bodies, published guidance on practice placements[11]. At the same time they issued guidance on adequate supply, preparation and quality of qualified mentors and teachers responsible for practice placements[28].

Part 4

Developing effective partnerships

4.1 Effective planning, delivery and good value for money from health professions clinical education and training depend on co-operation and joint working between members of Consortia and the higher education institutions. In this part we examine how effective these relationships are, looking at what leads to success and where further progress could be made. The statutory and professional bodies also have an important regulatory relationship with the NHS and higher education institutions, but this is currently under review [39,40] and we have not examined it in any detail.

Consortia Chairs do not always have the authority, experience or time they need

4.2 The workforce planning review consultation paper[3] proposed that Confederation Chairs should be a health authority or Trust Chief Executive. Our findings support this proposal as effective partnership working requires Consortia Chairs to have appropriate experience and authority so as to have the right profile and influence with all of the employers of Health Professionals and the higher education institutions. At the time of our survey, in July 2000, six Consortia did not have a Chief Executive or equivalent as their Chair and two posts were vacant. Recent guidance on Confederations[5] makes it clear that the new Chairs of Confederations must be Chairs or Chief executives of NHS Trusts or health authorities.

4.3 Consortia Chairs are accountable for a budget of £22 million a year on average (ranging from £7 million to £48 million). Despite these substantial budgets, the Chairs, as well as the other members of the Consortium Board, are required to fit their responsibilities around their main job. A third of Consortia Chairs, who between them manage budgets totalling £199 million a year, told us that their employing organisation did not allow time for the required level of input. Many of the Chairs were concerned about conflicting and growing time demands, and the real risk of overload.

There is wide variation in the experience of Consortium management teams

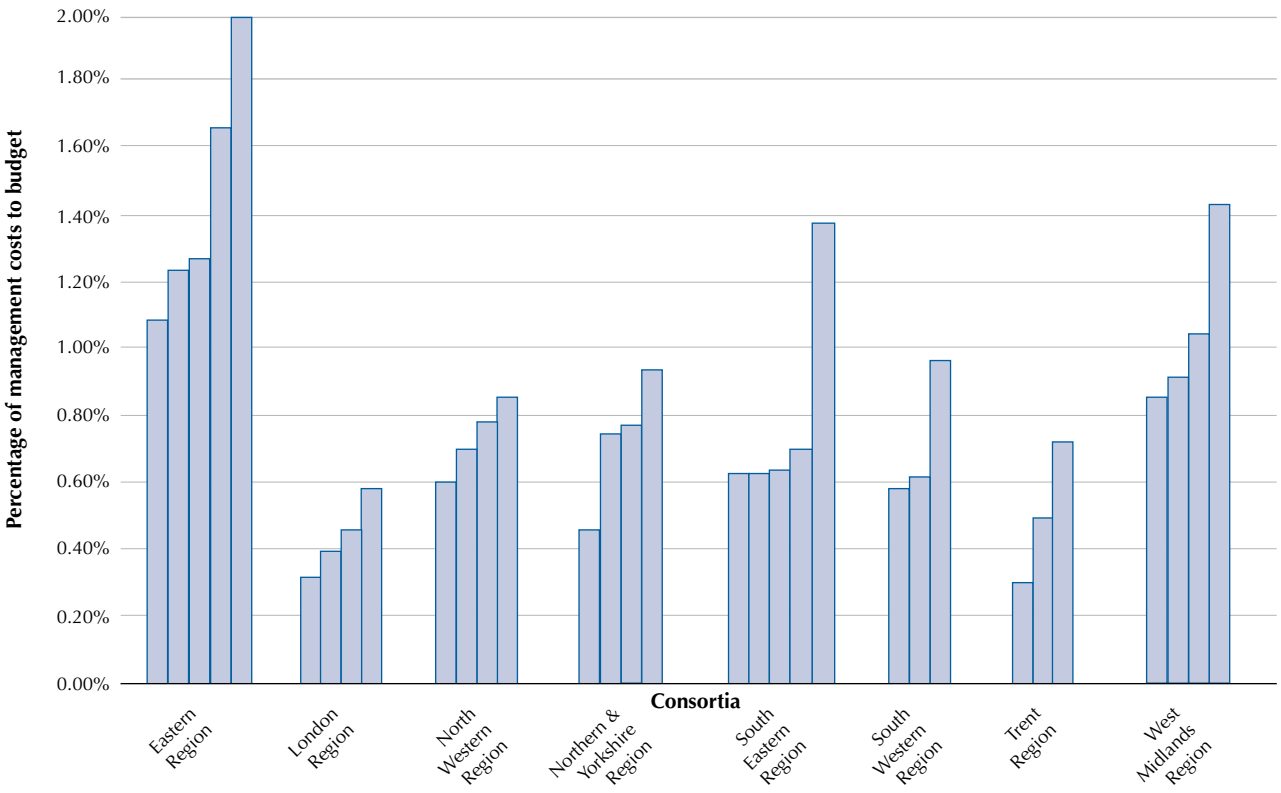
4.4 The Consortium management team provides the day to day input to its Consortium's business and is the main contact point for employers and education institutions. In the past three years all Consortia management teams have increased their staffing complement to reflect the increasing demands on the management team. In 1998-99 there were 7 Consortia with fewer than 2 full time members of staff and the largest team had 6 members. By 2000-01 there was only one Consortium management team with fewer than two staff but fifteen had more than six (over this period the average size of a management team increased from 3 to 6). The skills available to the team vary accordingly, as does the percentage of management costs to the budget being managed (**Figure 10**).

4.5 We found that there were no standard job descriptions for the management team and the skills, and salaries of individual team leaders (some teams have a lead manager others a director) vary. Of the 32 Consortia who gave us details of salaries, the range for the 26 consortium managers was from £29,500 to £49,400 (some of the managers were part time and their salaries have been pro-rated for comparative purposes) and for the nine Directors the range was from £35,000 to £83,333. Regional variations account for some, but by no means all, of the variation.

4.6 The new Workforce Development Confederations will become operational in April 2001(see Appendix 1). In preparation for this the Department has already taken the following actions:

- confirmed that there will be 24 new Confederations, with boundaries allied to groups of health authorities and their constituent NHS organisations;
- placed advertisements for full-time Chief Executives for all the Confederations with a recruitment exercise taking place in early 2001;

10 **Percentage of management costs to Consortium budgets for 2000-01 (each bar represents a consortium)**



Note: Derived from the 32 consortia who supplied the information requested.

- issued guidance to enable Regional Offices to prepare specific job descriptions for each Chief Executive post;
- set a clear salary range, dependent on the size and complexing of the Confederation, for each Chief Executive post; and
- specified the core elements of the senior management teams of Confederations.

4.7 Developing effective partnerships requires good working relationships at the operational level. Most higher education institutions considered that they had good relations with Consortia management teams and that where these had been poor in the past they were improving. Also that relationships would improve further if management teams had more executive power and acquired and demonstrated a more strategic view and understanding of the institution. While the actions taken in establishing the new Confederations should help address these points, the Department acknowledges that it will be important for the new Confederations to actively seek to build good working relationships between their management teams and the higher education institutions.

Consortia have had varying success in developing local partnerships with the wider NHS, other health care providers and the education sector

4.8 The Consortium, and in future the Confederation, Board is the main forum for developing effective partnerships. While all NHS Trusts and health authorities nominated a member to represent them on the Executive Board of their Consortium, Consortia Chairs and management teams noted that the authority of the nominated representative, within the employer organisation, varied. They believe that this impacted on the perception of the employer as to the role and effectiveness of the Consortium. We also found that some key players in the provision of health professional education and training, notably the higher education institutions, are rarely involved, with only one Consortium Board including such a representative. In the 39 Consortia:

- only five had a representative from the allied health professions (whereas all had at least one and often several members with a nursing background);
- four Consortia had no representation from the primary care sector;

- thirteen Consortia did not involve local authority Social Services;
- nineteen Consortia did not involve the private and voluntary health care sectors;
- thirteen Consortia did not involve anyone representing medical workforce issues (either from the medical deanery or a Local Medical Workforce Advisory Group representative).

4.9 As a result of these variations the agenda of many, if not most, Consortia has been largely driven by NHS Trusts, with a significant emphasis on nursing issues. Non-NHS and non-nursing Consortia members have been generally under-represented. In our view, this is a barrier to effective multi-professional development. Wider representation would also provide a platform for promoting the modernisation agenda, for example, between social services and the NHS. Similarly higher education institution involvement at Board level would help improve partnership working and improve mutual understanding of each other's agenda. At the same time a balance is needed between representation and the effective operational size of the Board. Again the proposals for Workforce Development Confederations address these issues, including an explicit commitment to have higher education institutions represented on the Board. However, their effectiveness depends on them being applied consistently.

Competition has brought some benefits but has created tensions with higher education institutions

4.10 Competitive tendering is a fundamental premise of the NHS's approach to the commissioning-contracting relationship between Consortia and higher education institutions. NHS Consortia members told us that the main advantages were that it allowed them to explore more fully with their higher education institutions the basis for their pricing policy and to agree beneficial terms for increasing student numbers. In some cases it has also been an opportunity to determine explicitly the different roles and responsibilities between the two parties, for example as regards capital development and practice placements. Other benefits that are capable of realisation include more competitive prices, clearer expectations and better output measures.

4.11 Higher education institutions have recognised and supported the principle of obtaining value for money through contracting, as stated in the joint NHS Executive and Committee of Vice Chancellors and Principals Joint Declaration of Principles[6,10]. However, the majority of higher education institutions told us that competitive tendering was not necessarily effective in achieving this in practice, particularly given the short duration of contracts. They considered that competitive tendering:

- reduces price transparency and inhibits the exchange of good practice, because individual higher education institutions are in a negotiating relationship where information is guarded and price information is commercially sensitive;
- rules out efficiency gains that higher education institutions believe could be achieved through benchmarking; and
- undermines long-term planning and development because it is not clear that assets can easily be transferred if a contract is lost. It has also resulted in staff being given short-term contracts, which higher education institutions believe affects the quality of staff, and there is also less incentive to invest in programme development.

4.12 One university, in response to the main survey (see Appendix 1), estimated that the costs in negotiating the contract review were £500,000 plus legal and accountancy fees and that the cost to the NHS would have been very similar. Our short re-survey of higher education institutions found that many Consortia and higher education institutions were unable to determine, or estimate the costs of the contracting process. Of those that were:

- twenty Consortia provided cost data for some 36 out of 135 of their contracts. The average in-house cost of the contracting process was around £4,500 and the average expenditure on legal fees was £5,500. In total the 20 Consortia estimate that they spent £375,000 on negotiating the 44 contracts, which between them were worth £110 million a year;
- twenty-eight higher education institutions provided their costs of contracting for some 75 contracts (over two thirds of contracts). The range of in-house costs was from £125 to £137,000, with an average of £19,000 and legal costs ranged from £300 to £70,000 with an average of £7,000. The cumulative expenditure of the higher education institutions who provided cost data was £2.4 million on contracts worth £164 million a year. This includes the £500, 000 above; and
- nine institutions told us that their in-house costs together with legal fees were over £100,000, of these, half were competitively tendered contracts and the others were the result of detailed negotiation.

4.13 In addition to providing data on costs, a number of higher education institutions told us that their experience of the contracting process was that it was not transparent or handled as well as it might have been. Also that the extra work involved has not altered outcomes materially.

4.14 To date, only two higher education institutions have lost a contract as a result of competitive tendering. This was the result of a complex rationalisation and re-tendering exercise in the South-West Region that took place between April and November 1997. A Purchasing Effectiveness review by the Regional Office identified concerns that the contracted activity in the Region did not match demand, there were variations in price, wastage and the institutions ability to fill commissioned places. The competitive tendering process and the outcome of the exercise raised a number of contentious issues on the part of the unsuccessful higher education institutions involved about the transparency of the process including: the level of pre-tender consultation; the feedback of the results; the high costs they had incurred; and whether Transfer Undertaking (Protection of Employment) applied. But there were also benefits achieved, including savings on the contract and a clearer specification of NHS requirements with output measures for assessing improvements in value for money. There were a number of important lessons learned from this example and the Department's *Good Contracting Guidelines*[6], issued in 1999, address a number of these issues.

4.15 Some of the points highlighted above indicate that there is scope for the process to be designed and handled better, to cut administrative costs, and to provide greater transparency of outcomes. Competitive tendering can provide an opportunity and incentive to clarify the purchasers output and outcome requirements. However, the fact that few of the contracts in place at the time of our survey specified outputs or outcomes suggests that this particular advantage has not been exploited in NHS contracts with higher education institutions.

4.16 Competitive tendering may not be the only way to obtain best value for money. Increasingly, the NHS is using more collaborative approaches. There are also a number of other models that could be used as alternatives or additions to competitive tendering, which offer the potential to improve value for money through better partnership working:

- standard national benchmark pricing for the core elements with adjustments to reflect local staff, accommodation, library service and other costs, following the approach of the Higher Education Funding Council's for England for many non-NHS university programmes; and
- local benchmarking groups to facilitate sharing of information, **Case example 7**.

Steps have been taken to improve partnership working in the organisation of practice placements

4.17 There are a number of examples of good practice involving higher education institutions, Consortia and local employers working together to improve the quality of practical training provision. These include the growing use made of jointly appointed staff whose main responsibility is to co-ordinate practice placements, the provision of support to both students and assessors in the practice environment, and joint review of local service issues and programme design to meet local skills needs.

Case example 7: Southern Universities Management Services Health Care Forum for benchmarking NHS funded education and training provision

In early 2000, a group of eight higher education institutions established a formal benchmarking group (Health Care Forum) to examine areas of mutual interest in the delivery of health related education and training under contracts with the NHS. Independent consultants facilitated the benchmarking exercise.

Work is at a relatively early stage. The group has established terms of reference and protocols for the sharing of information on a confidential and non-attributable basis to ensure compliance with confidentiality clauses in contracts. It is currently in the process of establishing a best practice directory across a wide range of relevant topics. Nurse and midwifery education and training has been identified as a priority area, focusing on:

- the cost of training pre and post-registration students;
- student attrition; and
- the management of practice placement circuits.

Members of the group have already submitted information on costs and other key performance ratios. Preliminary analysis and comparison has highlighted key differences in the approaches adopted to contract costing and the need to further refine the specification for costs and related benchmarking information to ensure meaningful comparison. The group is also putting together detailed descriptions of innovative strategies designed to improve student attrition and address increasingly constrained practice placement circuits.

4.18 Ultimately the NHS and higher education institutions acknowledge that they have a joint responsibility for ensuring that students receive a good quality practice experience in a range of clinical settings. Consortia contracts with higher education institutions make it clear that the higher education institutions are responsible for arranging and supporting suitable placements that provide practice experience for students. The exact details of how much practice experience is needed is set down by the statutory and professional bodies. Consortia members, particularly NHS Trusts, provide the vast number of these placements and hence there is an important role for the Consortia management team. Only seven Consortia told us they felt that they had any contractual responsibility for identifying suitable placements, and six that they had any responsibility for managing the process. However many Consortia management teams have been working with Consortia members and the higher education institutions to improve the management of practice placements, see **Case example 8**.

4.20 Another way forward is for Consortia, and in future Confederations, to appoint placement facilitators or co-ordinators and to appoint placement committees or groups with members from both higher education institutions and Confederations. By July 2000, twelve Consortia had appointed a clinical placement officer and 11 had plans to appoint one in the near future. Fifteen Consortia were planning to develop a database of all practice placements within the next 6 months and 7 within the next 12 months.

4.21 In January 2001, the English National Board for Nursing, Midwifery and Health Visiting and the Department issued a joint publication, *Placements in Focus*[11] which provided guidance based on cumulative research findings from the ENB and the NHS Executive Clinical Placements Working Group. This guidance identifies ways of increasing placements and ensuring national consistency in standards and quality. This, together with guidance aimed at increasing the number and quality of placement mentors and teachers[28], should help improve the students' overall experience on practice placements.

Consortia and higher education institutions have introduced joint appointments to improve the clinical input to programmes and improve partnership working

4.22 An example of effective partnership working at local level is the development of joint Lecturer/practitioner appointments, part funded by the NHS Trust and higher education institutions. Joint appointments between the NHS and higher education institutions have been established for a number of reasons, most usually to provide clinical input and to support both teaching and practice. These joint appointments have aided staff recruitment, promoted research and bridged the gap between theory and practice. Nearly two out of three of the institutions surveyed in both the nursing and Allied Health Professions had one or more joint appointments with the NHS. Indeed, the Department's nursing strategy, "Making a Difference",[13] acknowledged the

Case example 8: Collaborative approach to managing practice placements

Four closely located higher education institutions have contracts to deliver training in physiotherapy with South Essex Consortium. Building on progressive and sound relationships at all levels, the Consortium and the higher education institutions recognised that significant benefits could be realised from a more co-ordinated and collaborative approach to the management of practice placements.

In 1997 a project was initiated to rationalise the complex process of developing and allocating practice placements and to centralise the collation and administration of all physiotherapy placements across the region. A single real time database was developed and a jointly funded administrative team put in place within one of the higher education institutions. The Consortium provided funding with revenue costs shared with the higher education institutions and Consortium. The database is accessible at all times by all participants, with academic managers using one set of common forms and with one central contact point. The central administrative team is currently organising around 10,500 student placement weeks for just under 700 students at some 230 clinical placement sites across the region.

All the participants have realised significant efficiency gains and savings in administrative costs. Other benefits include:

- improved ability to overcome unforeseen shortfalls in, or short notice cancellation of, practice placements;
- improved Consortium workforce planning and decision making on region-wide commissioning of education and training for physiotherapists; and
- reduced administrative workload for academic staff, freeing up time to support students and assessors, and enhance the quality of existing, and develop new, clinical placement sites.

The system was created to facilitate expansion and already, at the request of a neighbouring region, two further higher education institutions and Consortium are being integrated into the system.

importance of joint appointments to improve the quality of education provision and recommended an increase in the numbers of joint appointments. **Case example 9** shows how one higher education institution has used joint appointments to raise the quality and relevance of their programmes.

4.23 Of the institutions that currently have joint appointments, about half have experienced constraints or problems in making them. Examples were problems between the institution and NHS Trust in agreeing split of responsibilities for shared appointment, difficulty in finding appropriate staff with credentials in both academic and practice settings, arranging timing of recruitment to suit both employer parties and the stress and demands on staff with joint appointments. Nevertheless, all parties viewed joint appointments as a positive and welcome development in improving partnership working.

The process of bidding for "Making a Difference" pilot sites was a successful illustration of partnership working

4.24 In 1999-2000, Regional Offices were asked to recommend two sites per region to the NHS Executive to take forward the Department's new agenda for nursing, *"Making a Difference"*[13]. Around three quarters of the Consortia prepared a bid with their higher education institutions for an allocation of funds to implement the new proposals and sixteen of these were successful.

4.25 Consortia found that the process of preparing and presenting a bid required both parties to work closely together and enabled them to overcome a number of the problems inherent in the normal contractual relationship. Overall, the exercise helped develop the partnership between the two sectors and this is having benefits on other areas of working. There has also been a positive involvement by statutory and professional bodies, demonstrating their willingness to work with both sectors to the benefit of nurse education, **Case example 10**. Consortia and higher education institutions that we met saw no reason why such benefits could not be replicated outside of a bidding process if there was a mutual will to achieve them.

There are a number of examples of where education and training consortia and higher education institutions have been particularly successful in developing effective partnerships

4.26 There are a number of Consortia and institutions that have developed an effective working relationship, which could help provide a model for other partnerships. **Case example 11** illustrates how one such partnership has developed.

4.27 In this case and others, the benefits obtained included:

- better and more regular day to day communication;
- the ability to respond more quickly to the changing NHS agenda; and
- less tension over pricing policies and confidence that the cost of training is good value for money to the NHS and the higher education sector.

Case example 9: Brighton University's use of lecture/practitioners to raise the quality and relevance of their programmes

Physiotherapy and occupational therapy currently employ two part-time lecturer/practitioners and there are approximately 20 lecturer/practitioners employed by nursing and midwifery. All lecturer/practitioners posts are joint appointments, with employment contracts held by NHS Trusts. Lecturer/practitioners are subject to tripartite management by the University, NHS Trusts, and Account Managers. The University perceives a number of advantages flowing from the appointment of lecturer/practitioners: students are exposed to contemporary practice; risks are shared between the health and higher education sectors which permits greater flexibility in staffing; and staff and students are provided with support while in practice.

Case Example 10: Greater Manchester West Education and Training Consortium and Salford University a successful bid to implement the new model for pre-registration nurse education and training

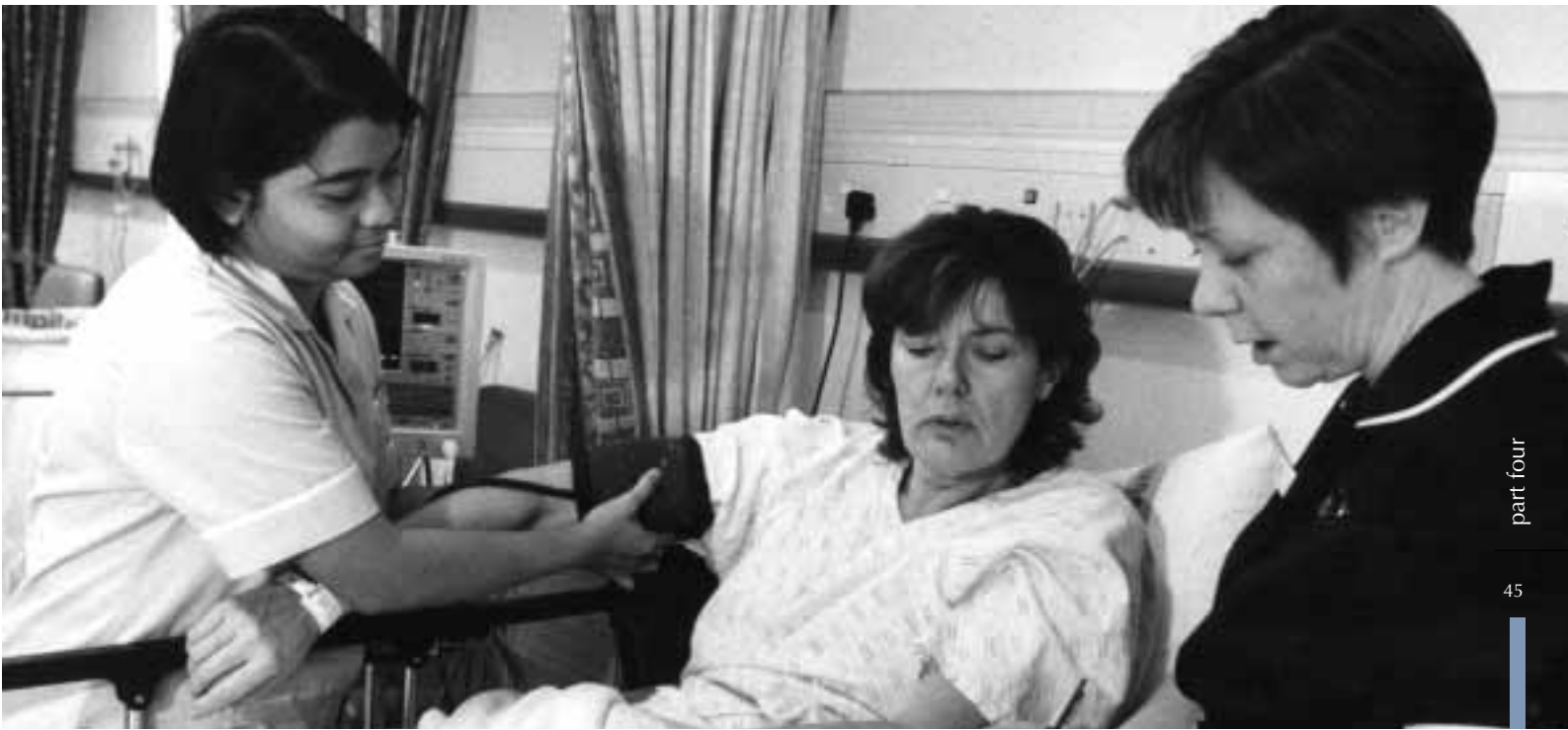
The successful bid plans:

- more flexible career pathways into nursing and midwifery education;
- increasing the level of practical skills within education programmes; and
- an education system that is more responsive to the needs of the NHS.

To achieve this, the Consortium members and University acknowledged the importance of collaboration and close working with others such as the English National Board for Nursing, and Midwifery and Health Visitors, Regional Office, Training and Enterprise Councils, Further Education and Social Services. The impact of wider initiatives such as National Service Frameworks, Clinical Governance and the Human Resource Strategy[19] was also taken into account. To demonstrate value for money, the Consortium is implementing the EFQM model. The proposal is to comply with the "Making a Difference"[13] requirements as stated in the HSC 1999/219, through:

- introducing an outcomes approach within a competency framework, approved by the English National Board for nursing, midwifery and health visiting and the University quality assurance process;
- introducing a one year common foundation training programme and a two year branch programme - including developing innovative ways of delivery;
- utilising Accredited Prior Learning systems, with a designated access co-ordinator in the institution, with more flexible entry to pre-registration nursing and midwifery education programmes within the first year, including financial support for health care assistants with NVQ level 3 and members of cadet scheme;
- managing stepping off point at end of year 1 and beyond;
- explicit standards, outcomes and supervision for students undertaking practice;
- developing a portfolio of practice experience to demonstrate a student's fitness to practice, including introducing a stronger practice focus in the programme; and
- facilitating inter-professional learning and practice.

The cost of the proposal was around £130,000, including a 3 year evaluation - the early indications are of improved recruitment and retention and enhanced fitness for practice.



Case Example 11: Higher education institutions and the NHS working well in partnership

The Epsom and South West London Consortium, its 13 member NHS Trusts and the faculty of Health and Social Care Sciences at Kingston University and St George's Hospital Medical School have together developed a partnership approach that involves:

- constructive and active engagement of staff at all levels, including regular formal and informal meetings between the Consortium Chair and the Head of the higher education institution, as well as Chief Executives of other Consortium members and other senior representatives of the wider health economy, to provide an opportunity for discussion of strategic issues;
- a Joint Contracting Group meeting every three months to discuss issues relating to the contract, over and above the regular ongoing contact between the Consortium management team and the Faculty Dean and Business Manager;
- sharing the costs of developing new teaching accommodation within the higher education institution campus, to both replace inadequate existing accommodation and integrate teaching staff and NHS students with the rest of the University. The Consortium contributes towards the cost of capital within the contract price;
- an increasingly open and transparent approach to the sharing of cost information. For example, as part of recent contract renegotiations, the Faculty and the Consortium management team devised an agreed costing framework against the education and training specification, enabling the Consortium to focus more clearly on content and quality and assess the financial impact of any changes;
- the Consortium facilitating joint working groups set up to address issues around clinical liaison, student retention, and practice placements. The groups meet frequency and comprise senior representatives from both the clinical and academic side to ensure proposed action can be implemented. The emphasis is on the acknowledgement and resolution of shared problems. For example, improving information on placement availability by developing an accurate practice placements database, and successfully piloting an improved practice placement audit tool to provide more useful information for both educators and clinical assessors at no extra effort; and
- close consultation between the Faculty, the Consortium and NHS Trusts on programme design through surveys, focus groups and practitioner involvement on programme design committees.

Appendix 1

Department of Health's plans for taking forward the recommendations from their workforce planning review "A Health service of all the talents"

A number of proposals in *A Health Service of all the talents*[3] were developed in the NHS Plan[4], published in July 2000. *Investment and Reform for NHS Staff - Taking forward the NHS Plan*[5] published in February 2001 sets out further plans for implementing the recommendations in the review. A report on the results of consultation on A Health Service of all the talents was also published in February 2001[5]. Key elements of the implementation plans relevant to this report are set out below.

Modernising Workforce Planning

The main recommendations in *A Health Service of all the talents* aimed at changing workforce planning arrangements, have been accepted and will be implemented from April 2001.

A National Workforce Development Board will be established to provide leadership in, and set the strategic direction for, workforce development. It will be chaired by the Permanent Secretary/Chief Executive and will have membership drawn from NHS service managers, including clinical managers, and from professional bodies, academic and research interests, trade unions, patients, and the independent sector working in partnership. It will have a key role in ensuring that a coherent and modernised pattern of workforce development is adopted throughout the NHS.

The Board will be supported by a number of **Care Group Workforce Teams** focusing on the workforce requirements for different care groups. The first teams will cover the priority areas of mental health, cancer services, coronary heart disease, children's services and services for older people. They will take a national view of the workforce issues in their areas, looking across all staff groups and identifying workforce and education and training changes which may be needed.

The Board will also be supported by a **Workforce Numbers Advisory Board** which will make recommendations on the numbers of undergraduate and postgraduate training commissions needed in each staff group, each year. In carrying out its work the Board will draw on Confederation plans and the recommendations from the Workforce Teams. The Board will look at requirements across all healthcare professions, bringing planning for medical staff and other clinical professions together.

At local level, all NHS organisations will need to develop workforce plans and contribute to the workforce plans which support Health Improvement Programmes. It will be the responsibility of Health Authorities to develop and ensure the delivery of these Health Improvement Programmes workforce plans.

Twenty-four new **Workforce Development Confederations** will be established to replace the current 39 Consortia and the Local Medical Workforce Advisory Groups. They will take the lead in developing integrated workforce planning for healthcare communities working closely with employers, education and training providers and organisations such as Learning and Skills Councils. They will have a broadly based membership including NHS employers, post- graduate Deaneries, higher education institutions, local authorities, private and voluntary sector employers, the Prison Service and others who employ healthcare staff. Fuller details of the membership, functions, staffing, accountability and governance arrangements for Confederations is set out in guidance issued by the Department in February 2001[5].

Modernising Education and Training

Investment and reform for NHS Staff[5] sets out a programme of action to develop more flexible and multi-disciplinary programmes of education and training, working in partnership with other stakeholders, particularly in the higher education sector, and plans to develop a lifelong learning strategy for the NHS.

To support the increasing emphasis on multi-disciplinary learning, and as recommended in *A Health Service of all the talents*, the three NHS funding streams supporting education and training (the Non-Medical Education and Training Levy, the Service Increment for Teaching and the Medical and Dental Education Levy) are being brought together into a single funding stream - the Multi-Professional Education and Training Levy - from April 2001.

Appendix 2 Audit Methodology

1 The main objective of the NAO study was to determine whether the existing arrangements for education and training the health professional workforce are efficient and effective and the extent to which adequate numbers of quality staff are and will be available to meet service needs. The issues examined were:

- how effective current education and training arrangements are in meeting the demand for new health professionals, what problems stand in the way of the new proposals to increase the number of training places and what needs to be done to help successful implementation of the workforce development review;
- the value for money obtained from the £705 million per year that the NHS currently allocates to the provision of pre-registration health professional education and training programmes; and
- the scope for improved partnerships between the NHS and other employers, the higher education institutions and regulators of education and training.

2 We used a variety of techniques to address these study issues.

- Joint visits with the Audit Commission to a number of NHS Trusts and other stakeholders during January to June 1999 to scope our respective studies.
- Detailed audit visits by the NAO to eight Regional Offices and at least one Consortium and an associated higher education institution in each Region during 1999-2000.
- Detailed self completion postal surveys in July- August 2000, for which 100 per cent response rate was achieved, from:
  - all 39 Education Consortia who are responsible for commissioning pre-registration education and training for the health professions (see map for distribution and geographical coverage of Consortia);
  - all higher education institutions in England who have an NHS funded pre-registration contract for Nursing and Midwifery; and
  - all higher education institutions in England who have an NHS funded pre-registration contract for Physiotherapy, Occupational Therapy, Diagnostic and Therapeutic Radiography and Clinical Psychology.
- A short re-survey of Consortia and higher education institutions, in December 2000, to obtain further information on the contracting process, including the costs incurred and views as to the value for money of this process for both sectors.
- Developed a series of case examples based on survey responses and follow up to illustrate key points emerging from the examination.
- Reviewed published literature and attended a number of conferences and workshops.
- Together with the Audit Commission, convened an advisory group of experts/practitioners to act as a reference party during the fieldwork of both studies.
- Consulted widely with regulatory and professional bodies and other stakeholders in the provision of education and training.

Joint visits to a number of NHS Trusts, Consortia and higher education institutions to scope the study

3 Much of the early part of the fieldwork between January and June 1999 was undertaken jointly with the Audit Commission. The aim was to identify the NHS systems for educating and training NHS health professionals to enable us to scope our respective studies. We also established a joint advisory group to provide advice and input to study development, methodology, analysis and interpretation of results (see paragraph 17 for membership).

4 Following this scoping exercise, the Audit Commission work focused on how NHS Trusts in England and Wales identify and meet the training and development needs of their existing healthcare staff (their methodology and report, Hidden Talents: Education, Training and Development for Healthcare Staff in NHS Trusts, is published simultaneously with this NAO report)[1]. Our fieldwork and report is concerned, primarily with the arrangements underlying the planning and supply of newly qualified health professionals in England. The resultant report will, in due course, be the subject of a Committee of Public Accounts hearing. The same methodology was applied to the arrangements in Wales and we have produced a report for submission to the National Assembley for Wales[2].

Detailed audit visits to Regional Offices, Consortia and higher education institutions to develop the survey questionnaires

5 During 1999 and May 2000 we carried out an extensive literature search and a series of detailed audit visits to the NHS Executive, its eight Regional Offices and a number of statutory and professional bodies involved in health professional education and training (see paragraphs 14 and 15). We also visited 10 Consortia (at least one in each region, except for the South West Region, which did not obtain full devolved responsibility until April 2000), and 14 higher education institutions (each of whom had a contract with one of the Consortia we visited). This allowed us to develop a detailed understanding of all aspects of education and training. We then triangulated the information we collected to devise an audit programme that captured the different facets of the contractual relationship.

The postal survey of Consortia and higher education institutions in England and analysis of results

6 Between July and September 2000, we conducted a postal survey in England of the 39 Education Consortia who are responsible for commissioning pre-registration education and training for the health professions (see map opposite). We also conducted a postal survey of the 73 higher education institutions that have an NHS funded contract to provide health professional pre-registration education and training to one or other of these Consortia.

7 The Audit programmes for these surveys were discussed and agreed with the NHS Executive and the Higher Education Funding Council for England and were endorsed by our Advisory Group.

8 The audit programme for the 39 Consortia was in three parts.

- Part 1 covered the membership and management of the Consortium, financial information, budgets and performance management.
- Part 2 was concerned with workforce planning and determining demand for training places; the extent of integration of workforce planning with service developments and medical workforce planning; student commissioning; return to practice; widening access; and developing the workforce.
- Part 3 was concerned with quality issues such as the type and content of contracts, clinical placements, course design, Making a Difference pilot sites, library facilities, capital development and accommodation.

9 There were two audit programme for higher education institutions, one for nursing and midwifery pre-registration education and training (sent to 38 institutions) and the other for the allied health professional courses (sent to 35 institutions). The questionnaires for the 14 institutions visited were completed by the audit team as part of the visit. These institutions provided education and training in both nursing and midwifery and at least one of the other health professions. Between them, 73 higher education institutions hold more than 100 NHS funded pre-registration contracts for nursing and midwifery and the Allied Health professions with a number of institutions providing training for more than one health professional discipline. Both questionnaires to the higher education institutions covered:

- general background data on number and types of contracts;
- data on pre-registration recruitment and selection strategies, numbers and characteristics of students, student retention, attrition and completion, timing of withdrawals and student destinations;
- prices and costs, including treatment of overheads in contracts;
- capital development;
- clinical placements; and
- student satisfaction.

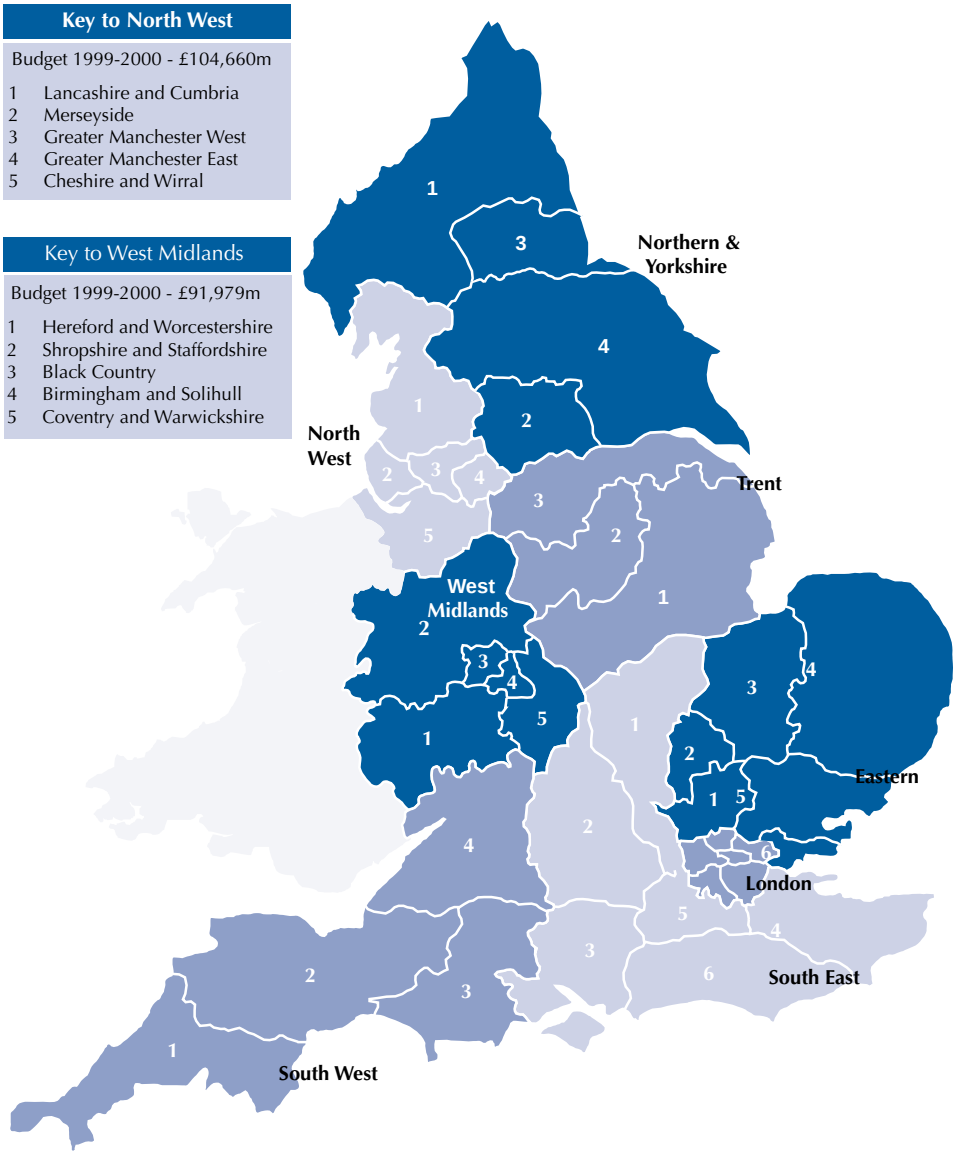
10 The survey administration, response follow up and data input was conducted by NOP Consumer (Social and Political). Extensive validation checks were carried out on the data provided by Consortia and higher education institutions which were "double-entered" to ensure a high standard of accuracy.

11 In December 2000 we conducted a brief follow up survey to obtain data on the costs of the contracting process and the impact of contracting on the price per student. We asked 10 supplementary questions to both Consortia and the higher education institutions about the cost of the contracting process and the impact on price and value for money. Responses were received from 26 Consortia, with responsibility for 135 contracts (including contracts for health professions such as podiatry, which were not covered in the main survey) worth £213 million. Also 35 higher education institutions responded. They provided education and training under some 108 contracts worth £193 million.

12 As well as informing our work we will be sharing the results of the surveys with the NHS Executive as a contribution to their thinking in taking forward the workforce planning review *A Health Service of all the Talents* (Appendix 1 refers). We will also be producing individual reports on each of the surveys to provide feedback to the Consortia and higher education institutions.

11 **Education and Training arrangements in England and Wales at the time of the survey in July - August 2000**

There are 39 Education and Training Consortia throughout England responsible for planning and commissioning education and training from higher education institutions. In Wales the arrangements differ with the responsibility vested in the Welsh Office's Education and Purchasing Unit.



Key to North West

Budget 1999-2000 - £104,660m

1 Lancashire and Cumbria
2 Merseyside
3 Greater Manchester West
4 Greater Manchester East
5 Cheshire and Wirral

Key to West Midlands

Budget 1999-2000 - £91,979m

1 Hereford and Worcestershire
2 Shropshire and Staffordshire
3 Black Country
4 Birmingham and Solihull
5 Coventry and Warwickshire

Key to Northern and Yorkshire

Budget 1999-2000 - £105,746m

1 Northern England
2 West Yorkshire
3 Durham and Tyneside
4 North and East Yorkshire

Key to Trent

Budget 1999-2000 - £77,512m

1 Lincolnshire and Leicestershire
2 Nottinghamshire, Nottingham and Southern Derbyshire
3 South Yorkshire

Key to Eastern

Budget 1999-2000 - £90,592m

1 Hertfordshire
2 Bedfordshire
3 Cambridge and NW Anglia
4 Norfolk and Suffolk
5 North Essex
6 South Essex

Key to London

Budget 1999-2000 - £187,331m

1 Inner and West London
2 North London
3 Central and East London
4 Outer London
5 South East London
6 South West London and Epsom

Key to South West

Budget 1999-2000 - £67,656m

1 Cornwall and South Devon
2 Somerset and North Devon
3 Dorset and South Wiltshire
4 Avon, Gloucestershire, Bath and North Wiltshire

Key to South East

Budget 1999-2000 - £109,595m

1 Buckinghamshire and Northamptonshire
2 Berkshire and Oxfordshire
3 Hampshire and Isle of Wight
4 Kent
5 Surrey and Chichester
6 Sussex

Audit visits and wider consultations

14 In addition to the survey work, detailed audit visits were carried out to obtain further information, follow up examples of good practice, and test our audit findings. We undertook audit visits using structured interviews and topic plans at the following organisations:

- London Regional Office, South West London Education Consortium, Inner and West London Consortium, and Kingston and St George's University. We also visited the CELEC Consortium, the Guys, St Thomas' and Kings NHS Trust and the Florence Nightingale School of Nursing and Midwifery and City University;
- Eastern Regional Office, Cambridge and N W Anglia Consortium, Lifespan NHS Trust and the University of East Anglia;
- South East Regional Office, Surrey and Chichester Consortium, Sussex Consortium, Brighton University and Bournemouth University;
- North West Regional Office, Greater Manchester West Consortium, Cheshire and Wirral Consortium, Salford Community NHS Trust, Royal Shrewsbury Hospitals NHS Trust, Manchester University and Salford University;
- Northern and Yorkshire Regional Office, North and East Yorkshire Consortium and York University;
- Trent Regional Office, Lincolnshire and Leicestershire Consortium, De Montefort University and Hertfordshire University
- South West Regional Office, Plymouth University and Portsmouth University; and
- West Midlands Regional Office, Hereford and Worcestershire Consortium, Black Country Consortium, and Birmingham University.

15 We consulted widely with bodies such as: the United Kingdom Central Council for Nursing, Midwifery and Health Visiting; English National Board for Nursing, Midwifery and Health Visiting; Royal College of Nursing; Royal College of Midwifes; the Colleges of Radiographers; Occupational Therapists and Physiotherapists; the Institute of Biomedical Scientists; the Health Care National Training Organisation; the Quality Assurance Agency for Higher Education; the Council of Deans; the Committee of Vice Chancellors and Principles; the Council of Professions Supplementary to Medicine; the Higher Education Funding Council For England; and BUPA.

16 We attended a number of workshops and conferences on various aspects of health professional education and training.

Membership of the advisory group

17. Together with the Audit Commission we convened the following joint advisory group of experts to advise and assist us at strategic points throughout the study. Membership was drawn from the NHS and higher education sectors and both study teams are grateful for the guidance and support provided by the advisory group members:

NAME	ORGANISATION
Keith Baggs	General Manager, South Essex Education and Training Purchasing Consortium and from January 2001, Director of Education and Training at Basildon and Thurrock NHS Trust
Mark Darley	Operational Services Manager, Faculty of Health, South Bank University, Essex and East London
Judy Gillow	Director of Nursing and Operations, Winchester and Eastleigh Healthcare NHS Trust
Caroline Gilmartin	Clinical Governance Manager, Tower Hamlets Primary Care Group
Alan Hanna	Offices of the National Assembly for Wales (from March 2000)
Jane Harris	Business Manager, Black Country Consortium and from July 2000, Postgraduate Manager, Regional Postgraduate Dean's Office, West Midlands Region
Hedley Hilton	Acting NMET Levy Co-ordinator, Department of Health (from January 2000)
Sue Hitchenor	Director of Finance and Service Planning, Lincoln District Healthcare NHS Trust
Ron Jones	Director of Personnel, Royal Shrewsbury Hospitals NHS Trusts (until November 2000)
John Langan	Chief Executive, Kingston Hospitals NHS Trust
Richard Mundon	NMET Levy Co-ordinator, Department of Health (until January 2000)
Alison Raynor	Director of Human Resources and Corporate Affairs, Hounslow and Spelthorne Community and Mental Health NHS Trust
Lorene Read	Executive Nurse Director, Gwent Healthcare NHS Trust (until October 2000)
John Rushforth	Chief Auditor, Higher Education Funding Council for England
Pippa Sage	Director of Rehabilitation, Southend Hospitals NHS Trust
Jacqui Stewart	Director of Performance, East Kent Health Authority
Kim Tester	Offices of the National Assembly for Wales (until March 2000)
Simon Thompson	Deputy Director of Education and Training, North West Regional Office
Terry Tucker	Assistant Director of Organisation Development and Training, Surrey and Sussex Healthcare NHS Trust and from November 2000, Group Learning and Development Manager, Westminster Health Care Limited
Professor Tim Wheeler	Principal, Chester College of Higher Education
Professor Janet Finch	Vice Chancellor, Keele University
Frank Toop	Director of Finance, City University
Professor Jenifer Wilson-Barnett	Head of School, Florence Nightingale School of Nursing and Midwifery, King's College London
Professor Mary Watkins	Head of Institute, Institute of Health Studies, Plymouth University

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Glossary of terms

Term	Description
Allied Health Professions	A group of professions providing treatment and care across the range of health and social services, including those known in the past as professions allied to medicine. They include: arts therapists, chiropodists and podiatrists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, diagnostic radiographers, therapeutic radiographers, and speech and language therapists.
Assessor	An assessor measures an individual student's achievement against set performance for an educational programme. The terms is used in this report to describe a practising health professional who assesses performance in a clinical setting, as part of pre-registration education training. Assessors should have qualification and experience appropriate to the role.
Attrition	Not all students entering pre-registration training qualify. This is also described as wastage, discontinuation, non-completion and drop-out. For the purposes of this report the definition used was: $\frac{\text{starters } \textit{plus} \text{ transfers in, } \textit{less} \text{ transfers out, } \textit{less} \text{ numbers completing}}{\text{starters}}$
Audit Commission	The Commission is the statutory body that appoints external auditors to local authorities and NHS Trusts and Health Authorities. It aims to promote stewardship of public finances and help those responsible for public services to achieve economy, efficiency, and effectiveness. It carries out value for money studies in the sectors for which it is responsible and provides audit tools for use by the auditors that it appoints. The Commission and its auditors have a statutory duty to act independently of both government and audited bodies.
Benchmark prices	Prices derived from an understanding of the full cost of delivering a course which are used as a benchmark against which to assess the prices being offered by higher education institutions
Bursary (NHS Bursary)	A bursary is a grant awarded to eligible students, in this case students on NHS funded health professional pre-registration training courses. Students on these courses qualify for either non-means tested or means tested bursary. This is a level of financial support agreed by the NHS as part of its policy to train future health professionals. It comprises an allowance to cover day to day living costs plus a range of other expenses, such as practice placement expenses. In addition the NHS meets in full student tuition fees.
Cohort	A group of students admitted to the same higher education training programme at the same time.
Commissions(ing)	Committee of Vice Chancellors and Principals (CVCP). The term commissions refers to all intakes into NHS funded pre-registration training courses. Commissioning is the act of determining the numbers student training places that the NHS requires the higher education institution to provide.
Committee of Vice Chancellors and Principals (CVCP)	See Universities UK
Confederations	See Workforce Development Confederations.
Consortium (Consortia)	See 'Education Consortium'.
Contracting	Education and training is provided under formal contracts between the NHS and higher education institutions.
Costing policies	The methods used by the higher education institution to identify the costs of delivering courses.

Council for Professions Supplementary to Medicine (CPSM)	Along with the separate boards for each profession, the CPSM is the statutory body responsible for regulation of the allied health professions plus some groups of scientists in health care. Its primary function is protection of the general public. It promotes high standards of professional education and conduct. The Council also provides an enabling framework for the Boards' individual registration schemes. There is a proposal to replace these organisations with the Health Professions Council (subject to Parliamentary approval).
Degree	Most of the higher education programmes for health professionals, with the exception of nurse and midwife diploma programmes lead to the award of a recognised degree level qualification. Entry to degree level programmes is usually "A" level or equivalent.
Diploma	The majority of nurse and midwife education and training leads to a diploma level qualification. Entry to diploma level qualifications is usually GCSE level or equivalent.
Education	In this report 'education' refers typically to learning that leads to a formal qualification, based on a higher education institution degree or diploma programme.
Education (and training) Consortium	A group of commissioners and providers of health services that also includes representatives from general practice, local authority social services and the independent and voluntary sector responsible for workforce planning and commissioning education and training for healthcare staff other than doctors and dentists.
English National Board for Nursing, Midwifery and Health Visitors	See National Boards.
Fit for Award	Satisfy the higher education institutions assessment criteria leading to the award of a degree of diploma level qualification.
Fit for Practice	Satisfy the statutory and professional bodies that a person should be accepted onto the Register as a qualified health professional/practitioner.
Fit for Purpose	Implies new staff should not simply having a recognised qualification but also have the necessary skills, attitude and knowledge to do their job effectively and efficiently and hence practise safely.
Health-care assistant	The Department of Health's annual census of 'non-medical' NHS staff defines health-care assistant as support staff who are trained or undertaking training in job-related competencies through National Vocational Qualifications or other local training.
Health Improvement Programme	An action programme led by the health authority to improve health and health care in the local health economy. Abbreviated as HimP in England.
Health Professions Council	There is a proposal, subject to Parliamentary approval to set up a Health Professions Council that would replace the Council for Professions supplementary to medicine 12 boards.
Health professionals (health professional workforcethe investigation)	This term is used in this report to cover the different health care staff covered by They include nurses, midwives, health visitors, allied health professionals and scientists. Also dental hygienists and dental therapists. To qualify for entry to one of these professions requires successful completion of a degree or, in the case of nurses and midwives, a diploma level higher education training programme.
Higher Education Funding Council for England (HEFCE)	HEFC distributes public money for teaching and research to universities and colleges. It aims to promote high quality education and research within a financially healthy sector. The Council also plays a key role in ensuring accountability and promoting good practice.
Higher education institutions	Universities and colleges which provide higher education and training programmes at degree and diploma level.
Learning Skills Council	Set to replace Training and Enterprise Council network and funding responsibilities of Further Education Funding Council. It will have responsibility for funding around five million learners each year in England. 47 local LSCs will be responsible for matching learning opportunities to local skill needs, working with business to forecast and prepare to meet these needs.

European Foundation for Quality Management (EFQM)	An excellence model which provides a practical tool to help organisations become "Excellent" in all respects. It is a per non-prescriptive framework based on nine criteria evaluation.
Lifelong learning	A process of continuing development for all individuals and teams, which meets the needs of patients and delivers the health-care outcomes and priorities of the NHS, and which enables professionals to expand and fulfil their potential. In a higher education context, lifelong learning includes people of all ages coming back for other qualifications, which need not be professionally orientated.
Local Medical Workforce Advisory Groups	Co-ordinates workforce planning for medical and dental staff groups.
Means-tested bursary	Financial support available to all health professional pre-registration students (except nursing and midwifery diploma students) on NHS funded programmes. The income of the student's parent or spouse is taken into account in determining the level of support.
Mentor	A qualified health professional who, by example and facilitation, guides, assists and supports the student's learning. Students normally select their mentors.
National Boards (ENB, WNB)	The English and Welsh National Boards for Nursing, Midwifery and Health Visiting aim to support the delivery of patient care through the development of high-quality, cost-effective educational programmes. One of their key functions is to approve education institutions and programmes. There is a proposal to replace these organisations with the Nursing and Midwifery Council (See below).
National Service Framework (NSF)	Evidence-based statements of what patients can expect to receive from the NHS in major care areas or disease groups.
National Training Organisation (NTO)	NTOs are the government-recognised 'voice of employers' within employment sectors. Their key strategic roles are to identify skill shortages and training needs, influence and advice government on policy, and lead the development of qualifications based on national occupational standards. Healthwork UK is the NTO for the health sector.
National Vocational Qualification (NVQ)	A work-based qualification that provides staff with relevant underpinning knowledge and enables them to demonstrate their competence at a range of levels. NVQs are based on national occupational standards.
Non-means tested bursary	Financial support awarded to nursing and midwifery (diploma) students which provides a flat rate basic maintenance grant with no contribution required from their own or family income.
Non-medical education training (NMET) levy	NHS funding to support pre- and post-registration 'non-medical education and and training' in England is raised by this national levy on health authorities. Most of it is spent by Education Consortia in contracts with higher education institutions or on student bursaries.
Nursing and Midwifery Council	There is a proposal, subject to Parliamentary approval, to set up a Nursing and Midwifery Council that would replace the UKCC and National Boards. Consultation on this proposal ended in October 2000.
Practice placement	Part of an educational programme that takes place within a practice setting, for example in an NHS Trust.
Price per student	The price paid in a contract between a Consortium and a higher education institution for educating and training one student on the appropriate pre-registration training programme.

Quality Assurance	The process whereby assurance is given that each higher education institution is discharging effectively its responsibilities as a body granting awards that have national and international standing. This includes the need to judge: the effectiveness of the arrangements to ensure that all awards made in the name of the institution meet the required standards; the setting and achieving of appropriate standards for each programme of study; and the quality of the learning opportunities offered to each student.
Research Assessment Exercise	The process by which the quality of research produced by all higher education institutions in the UK is assessed. It is based on independent peer review, plus input from international referees and users of research. Information from this assessment determines the future allocation of research funding.
Return to practice	The pool of trained and qualified health professional, who are not working in the service for a variety of reasons, is a major potential resource. Given the right circumstances and support many of these people might return to work in the NHS.
Statutory and professional bodies	The various statutory and professional bodies established to regulate the standards and quality of professionals and their admission onto the respective Professional Registers. These include the United Kingdom Central Council for Nursing, Midwifery and Health Visiting; the English National Board for Nursing and Midwifery and Health Visiting; the Royal College of Nursing; the Royal College of Midwives; the Colleges of Radiographers, Occupational Therapists and Physiotherapists; and the Council of Professions Supplementary to Medicine.
The Quality Assurance Agency for Higher Education	The QAA was established in 1997 to provide an integrated quality assurance service to education institutions, the Agency is an independent body funded by and colleges of higher education.
Training and Enterprise Council (TECs)	A private sector company which manages local training and enterprise activities under a performance based contract with the Secretary of State for Employment.
Training	The term 'training' is often used alongside education in the report to cover the full range of learning activities, in both the the academic and practice setting.
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981. Protects the rights of employees upon the transfer of trading undertakings. In the event of a qualifying transfer the employment contracts of employees transfer with the activity
United Kingdom Central Council Nursing, Midwifery and Health Visiting (UKCC)	The UKCC regulates the professions mentioned in its title. It does so partly by for setting standards for education. The national boards (see above) ensure that these standards are maintained. There is a proposal to replace these organisations with the Nursing and Midwifery Council (see above).
Universities UK (formerly CVCP)	The body that represents the views of the heads of all the universities in the UK.
Workforce Development Confederation (WDC)	Groups of NHS and other employers (in England) which are to replace education Consortia following A Health Service of All the Talents[3], to: ■ review and aggregate the plans of local employers; ■ submit information to inform central planning for basic professional education; ■ plan post-basic professional and other training where joint planning is of value; ■ manage contracts with local education providers; and ■ provide a focus for developing human resource strategies at above-employer level.
Workforce planning	In the NHS, 'workforce planning' has often been used to mean a process designed to ensure that higher education institutions deliver the numbers of staff - especially newly qualifying students in the various professions, but also other further professional qualifications - to meet the sector's future needs. These plans take both demand and supply-side factors into account. The approach to workforce planning will change significantly as the recommendations of the NHS Executive's workforce planning review are implemented (Appendix 1 refers).