NHS

Liberating the NHS:

Developing the Healthcare Workforce

A summary of consultation responses

DH Department of Health

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- Trust Boards should be made financially accountable and responsible for education and training;
- There should be separate Board level representation for education at Trust level;
- It is worth slowing the transition to the new system in order to undertake an impact assessment to inform transition planning;
- Skills networks should be able to carry forward surpluses to enable long-term reinvestment in workforce development;
- All funds for education and training should flow transparently through commissioners to allow full public scrutiny;
- The role of HEE should be clearly articulated in 2011/12, together with links to other key bodies, such as Care Quality Commission, Monitor, the NHS Commissioning Board and the Clinical Commissioning Groups;
- The deanery function should be retained to ensure a focus on quality - within Skills Networks;
- A proportion of MPET funding should be set aside to encourage innovation, including pump priming of innovative local schemes.

The full results of the DELPHI were fed into the consultation.

3. Key Messages

3.1 Responses to the consultation varied in their scope and there was an overarching call for greater clarity. High level themes emerged from the consultation analysis in four key areas:

- Vision and values
- Quality and Standards
- Safe transition
- Fair and Transparent Funding

Vision and Values

3.2 There was overarching support for the objectives and design principles that form the foundation for the new framework with a particular emphasis on achieving value for money and ensuring security of supply. Many respondents see the new framework as an opportunity to develop a more flexible approach, with stronger links to the quality of care and the values and behaviours of staff.

> *"A unique opportunity to reshape the education and training of the future workforce to ensure that the NHS is able to achieve the best possible health outcomes for patients and service users."*[1]
>
> *We agree with the principle of multi-disciplinary working and welcome the fact that the proposals potentially allow workforce decisions to be taken closer to service delivery and the population's health needs*[2].
>
> *"The new framework needs to achieve high quality education and training that supports safe, high quality care and greater flexibility"*[3]

3.3 The principle of taking an integrated and multi-professional approach was broadly welcomed, provided the unique needs of individual professions are not lost. In addition, there was a call to be mindful of the need to represent and involve the *whole* workforce including social care and public health; also, that the voice of the education sector needs to be involved in every level of the new framework.

3.4 The majority of respondents supported the proposals to enhance the providers' role and the need for providers to work in partnership alongside professionals on workforce planning, education and training. Providers were particularly enthusiastic

[1] Council of Deans of Health
[2] Royal College of Nursing
[3] General Medical Council

about taking ownership of new proposals and welcomed the opportunity to take a lead role in the new framework.

> *"Giving providers the autonomy and flexibility to manage their staff resource appropriately will enable a responsive system that is efficient, effective and best-geared towards meeting patients' needs"*[4].
>
> *"Healthcare providers, (working in the proposed Provider Skills Networks), are ready to take on full responsibility for planning and developing their own workforce with strong clinical and professional leadership"*[5]

3.5 There was a clear message that this was an opportunity to build in greater links between service, financial and workforce planning and strengthen relationships across the whole system between regulators, commissioners and educations providers.

3.6 Professional groups and the education sector expressed concerns about the capability and capacity of some providers and the extent to which they will give education and training issues sufficient attention. There was a call for clearly defined 'checks and balances' to be built into the system to manage these risks and that a strong accountability framework needs to be in place with clearly defined roles and responsibilities for all stakeholders.

Quality and Standards

3.7 Respondents to the consultation widely expressed the opinion that quality of education and training is a vital component of the new framework and the need to reiterate its importance. Many professions, particularly the medical community, emphasised the importance of clear accountability for the quality assurance of professional training and the importance of clinical leadership both locally and nationally to ensure quality and standards. Also, the need to maintain national standards and the regulatory framework for professional regulation within a UK wide context.

Safe transition

3.8 There was widespread support for the new bodies proposed in the consultation, specifically the role Health Education England (HEE) will provide, offering national oversight of the whole system. However, there were numerous requests for greater detail and clarity on HEE's role and functions. The need for HEE to demonstrate how the investment in education and training reflects the strategic commissioning intentions of the NHS Commissioning Board was particularly welcomed. There were

[4] Foundation Trust Network
[5] Association of UK University Hospitals

a range of views on the appropriate accountability framework and balance of power between HEE and the skills networks such that there is appropriate assurance, financial control and space for local drive and innovation.

3.9 The main areas of concern raised in consultation centred on the pace of transition and need to maintain stability for current students. A large number of respondents discussed the importance of retaining expertise and there is a clear need to build on what works in the current system such as existing partnerships between the education and health sectors.

Fair and Transparent Funding

3.10 Respondents supported the move to fairer and more transparent funding. However, there are concerns about the possible destabilisation of service and education programmes which might result if these changes are introduced too rapidly. Possible changes to the scope of central funding also need to be clearly defined and phased over an extended period to ensure that funding is protected.

4. Summary of Responses

4.1 In this section, we have summarised the key findings from each of the consultation questions. Not all respondents answered every question; some respondents chose to answer each question directly while others commented more broadly on the overall content of the consultation document.

Question 1: Are these the right high-level objectives? If not, why not?

4.2 The overwhelming majority of respondents agreed with the objectives outlined in the consultation document. Different respondents placed different levels of importance on each of the objectives, with no one objective clearly selected as the most important. Many respondents who answered this question chose to reiterate the need for the objectives such as value for money and security of supply to be achieved and their importance in the success of the new framework. While the objectives were broadly accepted a large number of respondents called for some to be broken down to more explicitly emphasise the importance of three areas, quality, aspiration to excellence and the centrality of patient needs.

"We particularly welcome the opportunities within the proposals to place the provision of high-quality medical education and training at the forefront of the mission of NHS organisations in England".[6]

"The importance of the security of supply remains paramount if we are to manage the impact of wider system interdependencies such as the increased individual personal accountability for health and social care, and new regulatory frameworks proposed in the initial white paper"[7]

4.3 A number of respondents were concerned as to whether the proposals could achieve these "aspirational" objectives in such a tight timeframe, believing the success of the new framework would be contingent on both adequate funding arrangements and effective service alignment. A large number of respondents believed that more detail was required to confirm the achievability of the objectives, particularly relating to the objective on 'widening participation'.

[6] General Medical Council
[7] National Workforce Commissioners Network

"These provide a clear underpinning to what the future education and training system should look like in the future but it will be important that the reality of the detail match the aspirations of the consultation"[8]

Question 2: Are these the right design principles? If not, why not?

4.4 The majority of respondents believed that these were the right design principles on which to base the new framework for education and training, however, as with Question 1 there was a call for further detail and clarity. Particular emphasis was placed on the need to achieve alignment with the wider system design for commissioning and service provision, and the importance of strengthening links to the education sector. The majority of respondents welcomed the principle of '*doing at the national level only what is best done at the national level*' believing that it would promote local innovation and flexibility. However, this was tempered by the need to effectively balance local and national needs and the call for a fair and transparent method for determining what is done nationally.

"If these design principles are realised appropriately, employers will have a sound basis on which to take a leading role in workforce development"[9]

"Skills for Health fully supports the need to undertake workforce planning and development in a strategic and co-ordinated way integrating workforce planning with service and financial planning"[10]

"We agree with the principles underpinning the proposals and fully support stronger linkages between workforce planning and financial and service planning"[11].

4.5 There was a great deal of support for taking an integrated and multi-professional approach to workforce planning, however many respondents qualified their support by calling for the need to also recognise the distinct needs and training pathways of the different professions. A number of respondents called for greater emphasis to be placed on the role of professionals in workforce planning at all levels of the new framework, not simply quality and safety assurance.

4.6 There was a call for clarity regarding the use of the term multi-professional and a widely held belief in the need to include and acknowledge the *whole* workforce specifically Bands 1-4. Many respondents emphasised the need to promote research within the new framework.

[8] Allied Health Professions PAB
[9] Foundation Trust Network
[10] Skills for Health
[11] KSS Deanery Pharmacy Leads

"Improved partnership with universities, transparent investment in education, training and development and taking an overall multi professional approach are appropriate and welcome"[12]

Question 3: In developing the new system, what are the key strengths of the existing arrangements that we need to build on?

4.7 A large variety of aspects of the current system were highlighted as strengths and there were calls that they should be protected or built on in the new framework. The most commonly mentioned included the successful partnerships that exist at all levels of the current system, such as relationships between the health sector and Higher Education Institutions and the Royal colleges. A large number of respondents mentioned the important role that Deaneries play in the current system particularly providing independent quality assurance and the need to protect their functions. The importance of Medical Education England, the Medical Programme Board and Professional Advisory Boards were also frequently mentioned.

4.8 A number of respondents discussed the importance of national standards and their role in maintaining high quality education and training. The benefits of regional working was mentioned as an effective means to balance local and national needs by providing both local oversight and economies of scale. Many respondents also chose to highlight examples of local best practice and pre-existing local innovation and flexibility to be built on and developed.

"A major strength has been the setting and maintenance of standards for training and education by the Medical Royal Colleges."[13]

"Undergraduate education at our universities remains among the best in the world. The creation of effective local partnerships between health providers and academia (for example Academic Health Science Centres) has been successful in bolstering health research and driving the UK's future prosperity".[14]

Question 4: What are the key opportunities in developing a new approach?

4.9 There was a diverse response to this question, with respondents building on opportunities mentioned within the consultation and suggesting their own. Some

[12] Royal College of Ophthalmologists
[13] Faculty of Intensive Care Medicine
[14] Academy of Medical Sciences

examples of the key opportunities described include stronger provider and professional involvement in workforce planning and the ability to modernise training, particularly through greater integration with social care and public health. A large number of respondents mentioned the need for more training in the community and primary care setting. Multi-professional working was promoted as a way to benefit from different perspectives and expertise. There were also a number of responses mentioning the ability to strengthen workforce data, improve quality, strengthen partnerships and increase flexibility and local innovation.

"*We see this work as an important opportunity to present a new vision for a workforce, a vision which challenges people to think differently about their roles and responsibilities*"[15]

"*There is a huge opportunity to ensure that the education funding system is modernised to meet the future requirements of the NHS and the patients it serves"* [16]

"This is a once in a generation opportunity to align and apply the established tenants of FT commercial freedoms and strong accountabilities with and to it's main resource- people".[17]

"We would welcome the opportunity to plan a workforce that relates to services and skills and teams required to deliver them and that creates an opportunity for commissioning to support integrated care".[18]

Question 5: Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce?

"In order to ensure that the planning processes are transparent, holistic and responsive to the population, we must ensure that those who use, or may use, services are consulted."[19]

4.10 The majority of respondents believed that healthcare providers should have a duty to consult on their workforce plans, although it was noted that by grouping such a diverse group of stakeholders together it was difficult to address the specific issues attached to each group. The most frequently mentioned issue was the need for any consultation to be meaningful and done properly. There was also the concern that the capacity to engage meaningfully in complex workforce planning issues may not currently exist within smaller groups and this would need to be developed. It was

[15] The Health Foundation
[16] Cornwall and Isles of Scilly PCT
[17] Foundation Trust Network
[18] Royal College of Nursing
[19] Cornwall & Isles of Scilly PCT

suggested by a large number of respondents that consultation may be more effective if it is coordinated on a regional scale via the skills networks or Health and Wellbeing Boards.

"Yes, in theory. But obvious risks are that such wide ranging consultation will be overly time consuming and/or tokenistic, and not result in a harmonised solution, especially if each provider consults: would it be better for Skills Networks to co-ordinate consultation?"[20]

4.11 While a large number of respondents supported patient consultation a small number believed that patient consultation on workforce plans may not be appropriate, as they are more suited to comment on services that are being delivered and developed as opposed to the internal staffing mechanisms. Therefore, the need for expert patients comes to the fore.

"*Whilst we respect that patients and local communities should be considered at the heart of services, we believe that their input is more valuable in understanding health outcomes required, rather than in influencing the education and training requirements necessary to achieve these outcomes*"[21]

Question 6: Should healthcare providers have a duty to provide data about their current workforce?

4.12 The overwhelming majority of responses supported the proposal that healthcare providers should have a duty to provide data on their current workforce. A large number of people felt that there was a need for accurate, reliable, robust data. Some felt that this required a uniform reporting system to ensure consistency and comparability across the NHS while a small number suggested this duty needed to be part of the contractual process. It was also suggested that this duty apply to all providers.

"Imperative that workforce data is accurate to appropriately reflect the current workforce and enable future workforce planning that is informed and genuine."[22]

"This must be in the form of a national dataset and agreed standardised definitions to enable proper comparisons to be made"[23]

4.13 Some risks were identified, including concerns over the commercial sensitivity of the data and the potential conflict of interest of providers. There were also a number of

[20] SHA Library Leads in NHS England
[21] NHS West Midlands
[22] British Association of Psychotherapists
[23] Coventry & Warwickshire Workforce Locality Stakeholder Board

concerns surrounding the viability of this duty; these centred on potential resource implications particularly to small providers and concern about the current lack of accurate data and the complexity of data collection and analysis. There was call from a small number of respondents for national oversight and guidance with many referencing the Centre for Workforce Intelligence (CfWI) as an organisation to oversee and co-ordinate national data.

Question 7: Should healthcare providers have a duty to provide data on their future workforce needs?

4.14 The majority of respondents who chose to answer question 7 agreed with a duty to provide information on future workforce needs. Some respondents provided the same response to both questions 6 and 7. Many respondents believed meaningful data was required to support the need for long term planning but as with the past question acknowledged the potential difficultly in collecting this data. A large number of respondents also referenced the difficulty of future planning. The risks associated with this duty mirror those for question 6, that there is an issue surrounding commercial sensitivity of data; all providers should be included, that there may be cost implications and a need for national oversight.

"In order to ensure future supply there will be a necessity to provide a level of workforce information. The level of data required needs to be determined i.e. not commercially sensitive or onerous for providers" [24]

"The Centre for Workforce Intelligence working on behalf of HEE should seek to develop long term plans based on realistic estimates."[25]

Question 8: Should healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?

4.15 The majority of respondents supported a duty placed on providers to co-operate. One of the key issues surrounding this duty was the provision of placements for training; it was widely believed that organisations should contribute if they are to benefit from trainees experience once qualified. It was also mentioned by a large number of respondents that all providers should be involved in workforce planning including the independent sector. Support for this duty was balanced by the suggestion that there may need to be incentives to encourage co-operation.

"If an employer does not provide placements, it must contribute to the cost of placements as the trainee member of staff is available to all employers, once qualified."[26]

[24] Great Western Ambulance Service
[25] Medical Schools Council

4.16 Key risks identified included issues surrounding commercial sensitivity of information and the need to balance sharing good practice and innovative delivery versus maintaining competitive advantage in the market. Other risks linked to the capacity of providers to co-operate specifically for smaller or specialty providers. In areas such as pharmacy there was a belief that there may be duplication of effort while specialists felt that national co-ordination may be required.

Question 9: Are there other or different functions that healthcare providers working together would need to provide?

"*Could facilitate innovative approaches to cross organisational workforce planning and development, workforce support, career-planning, and the identification of service improvements.*"[27]

4.17 There was no clear consensus in response to this question although the highest proportion did believe that there were potentially additional functions that healthcare providers working together would need to provide. There was strong support to include deanery functions and a number of responses mentioned CPD, clinical placements and the use of networks to safeguard funding and provide a collaborative and coherent approach. There was a call for clear links between networks with commissioning, higher education institutions and quality assurance; also a need to cooperate with other networks to share standards and good practice. It was widely suggested that they would need to take account of the *whole* workforce specifically recent shift towards community and social care and the roles of bands 1-4.

4.18 Of the small number of responses that did not believe any additional functions were required some commented on a potential conflict of interest for providers to commission education. Others noted that if deanery functions were to move to networks it would be more appropriate to keep the deaneries as they are at present because they are best placed for delivering post graduate medical training.

Question 10: Should all healthcare providers be expected to work within a local networking arrangement?

4.19 The majority of respondents agreed that all healthcare providers, including the independent sector, should be part of networks. A wide range of arguments were made to support this belief, such as the risk of fragmentation if all providers were not included and the difficulties to ensure consistency and quality of education locally. It was also noted that all providers receiving public funds should share both the benefits

[26] National Workforce Commissioners Network
[27] NHS East Midlands

and the liabilities. A small number of respondents mentioned that there should be financial penalties if providers did not carry out appropriate training.

"We recognise that not all healthcare providers may provide education and training opportunities but all providers will deliver their services using staff trained at public expense so education and training should be part of the local arrangements."[28]

4.20 A small number of respondents argued that the messages of the consultation was one where co-operation would not be compulsory. There were calls for clarification over what role the independent and voluntary sector would have in networks. Respondents also suggested that it was important to recognise that different providers would have different levels of engagement and different professions have different needs. Also, that providers may wish to be part of more than one network. This was balanced with concerns over the size and scale of networks and the need to balance adequate representation with a network that would be too large and unworkable. There were calls to protect smaller organisations to ensure proportionality and allow flexibility in the level of control.

"It needs to be remembered that in smaller specialties wider geographical, even national, partnerships will be required to deliver and oversee PGME provision and outcomes effectively."[29]

Question 11: Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?

4.21 A large proportion of responses supported the duties proposed. Respondents believed that it was important for providers to be accountable and that this should be supported by clear leadership and a clear governance framework. Many agreed that there must be consistency across the country and larger providers should not be able to dominate the new system. Many respondents also chose to re-iterate their belief that duties must cover the whole system including independent and voluntary organisations. There were a number of questions raised as to how these duties would be enforced, specifically relating to any financial incentives or penalties. This fed into the concern over whether the duties would be sufficiently robust.

"The duties will ensure equity between skills network partners which will be bound or managed within a legal framework."[30]

[28] Royal College of Surgeons
[29] COPMed
[30] Liverpool Heart and Chest Hospital NHS Foundation Trust

4.22 There were a number of concerns that the duties needed to address the risk of 'short-termism' A large number of respondents also mentioned quality and suggested a specific duty surrounding quality assurance. A number of the risks which related to specific duties were mentioned again in response to this question, particularly issues surrounding the additional workload created for providers, specifically smaller providers that may lack capacity to deal with an additional workload. Also, complex governance systems could stifle innovation and flexibility.

"Employers agreed that placing 'duties' on providers would be an appropriate way to manage…risk . But duties alone would not drive the whole shift in culture required to make this a success"[31]

"*Integrating skills networks with service providers gives too much weight to employer's interests and will result in the prioritisation of short term service commitments over long term goals*" [32]

Question 12: Are there other incentives and ways in which we could ensure that there is an appropriate degree of co-operation, coherence and consultation in the system?

4.23 Financial incentives or financial sanctions were the most common suggestion. With incentives built into contracts or a formal framework agreement. There was a call for clear accountability and a number of respondents believe this should be enforced by HEE.

"There may need to be legal duties and financial penalties to ensure that the specified duties are kept and that quality is maintained – relying on the self-interest of providers to invest in education and training at a time of many other financial pressures will not be sufficient."[33]

Question 13: Are these the right functions that should be assigned to the Health Education England Board?

4.24 The majority of respondents agreed that the functions outlined in the consultation were appropriate however, a significant number of respondents indicated that they need more information and understanding of how HEE and the new system architecture would work before being able to come to a definitive view. Following on from this, a major theme was around understanding how the national role of HEE would fit with the local planning expected of the networks. Depending on the perspective of the respondent, this could range from, concern that HEE would interfere with local decision-making; and the opposite concern that there needed to be a national overview and some form of control. There was a clear appetite for greater clarity about how this tension would be resolved or played out in practice.

[31] NHS Employers
[32] British Medical Association
[33] Royal College of General Practitioners

"Must be a clearer remit for HEE, with better defined responsibilities and power over local skill networks to ensure wider workforce objectives can be met".[34]

4.25 Another major concern was confusion over responsibility for Quality Assurance and therefore clarity on the relationship to regulators and CQC who are currently responsibility for quality.

"*There must be an independent quality assurance function at a local level, separate from provider led skills networks and answerable and accountable to HEE*" [35]

4.26 Many respondents used this question as an opportunity to comment on the potential composition of HEE and its relationship to other national bodies. A significant number of respondents highlighted the importance of ensuring key links to the work of the NHSCB, given its central role in setting the agenda for the NHS. Others made similar points about other organisations such as Public Health England and social care authorities. A significant number of respondents highlighted the need to ensure the appropriate representation at HEE to ensure all interests were covered, including smaller professions and there was a balance between the professions and between service and educational interests. Many respondents took the opportunity to stress their view that HEE should reflect the interests of their particular staff group or interest.

"safeguarding education arrangements for small specialities/specialist roles must not be overlooked"[36]

"*We believe [HEE] should reflect the diversity of the workforce, we would in particular wish to see some members who have expertise in developing the roles of bands 1-4"* [37]

Question 14: How should the accountability framework between healthcare provider skills networks and HEE be developed?

"*HEE and local skills networks need to attain a dynamic relationship with effective dialogue*"[38]

4.27 A large number of respondents believed that the accountability framework should be developed in partnership and consultation with the skills networks and based on clear principles. A number of respondents thought that existing frameworks should be built on such as the SHA SLAs, MPET SLA and the SHA learning and development

[34] University and College Union
[35] Royal College of Physicians
[36] Cambridge University Health Partners
[37] UNISON
[38] Royal College of Nursing

agreement. When developing the agreement two way accountability within a flexible framework was a concurrent theme highlighting that local networks should be able to push-back on unrealistic targets & expectations.

4.28 There was a broadly held belief that financial penalties for those who are underperforming is essential to enforce the framework. Many respondents wanted the relationship and responsibilities of the skills networks and HEE to be clearer to ensure accountability for performance. The idea of having sublevels, an intermediate tier or regional outposts for HEE was thought to be of benefit to ensure HEE representation at a local level and reduce the gap between HEE and the skills networks.

4.29 A number of risks were identified as a large number of respondents' highlighted possible tensions between HEE and the 'skills networks' in terms of priorities (skill networks - short-term, HEE long term) as such the balance between local imperative and national needs was seen as essential. A number of respondents thought that HEE should be given the power to alter local plans where necessary to counter the risk for security and stability of supply. However, it could be difficult to get an appropriate balance of accountability and autonomy. There were concerns around the size and resources of HEE and its ability to monitor and hold the skills networks to account effectively.

"Not convinced that a 'lean' HEE Board will be able to carry out the proposed range of functions effectively and hold the healthcare provider skills networks to account."[39]

Question 15: How do we ensure the right checks and balances throughout all levels of the system?

"*An independent mechanism with the power to impose significant financial penalties must be created in order to protect the investment in education and training and to drive up standards"* [40]

4.30 Quality assurance, transparent governance and clear terms of reference were all suggested by many respondents as essential checks and balances. There was a strong belief that quality assurance needs to be outcome based. Many respondents suggested use of audit trails and annual reports, outcome data from providers and independent scrutiny, for example by CQC.

4.31 A number of respondents thought that it was not clear how conflicts of interest would be managed between HEE and skills networks and within skills networks. There was also a perceived risk of generating another layer of bureaucracy and targets. Many

[39] National Association for Voluntary and Community Action
[40] Medical Schools Council

respondents thought that the role of the General Medical Council and other regulators was not discussed appropriately or in enough detail.

Question 16: How should the governance of HEE be established so that it has the confidence of the public, professions, healthcare providers, commissioners of services and higher education institutions?

4.32 A large number of respondents thought that it was important for the HEE board to have an independent chair and multi-professional membership with equitable representation and both executive and non-executive members in order to gain the confidence of the service and other organisations. A large number of respondents also mentioned the need for HEE to include representation from the regulators. Many respondents also thought that the board must be free from political interference, with a transparent appointment process. Transparency in decision-making was one of the most commonly desired attributes.

4.33 There were mixed views around the possible dominance of the medical professions with some respondents saying that the importance of the Medical Programme Board needs to be retained and others concerned about a medical dominance with HEE, or HEE becoming an extension of MEE and following a medical model. The majority of respondents thought that it would be difficult to achieve a fully representative board if it also aimed to be a lean organisation. A number of respondents did not feel there was enough clarity around the responsibilities and functions of HEE to be able to suggest appropriate representation to ensure meaningful governance and dialogue.

"It is essential for HEE to be truly multi-professional and well integrated with the rest of the system so as it does not duplicate functions performed elsewhere, and become much larger than it needs."[41]

"must work effectively with all the key stakeholders in health care, most particularly those with regulatory powers"[42]

Question 17: How do we ensure that the Centre for Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?

4.34 Respondents felt that CfWI needed to work closely with HEE, providers, the national regulators and the professions in providing support to the system on workforce planning. In particular, support to the local networks was seen as key to improving the evidence base. To aid this, respondents felt it was important that the CfWI was given a

[41] Nursing and Midwifery PAB
[42] National Association of Clinical Teachers

clear remit and that clarity of the roles of CfWI, HEE and the NHS Information Centre for Health and Social Care was required.

4.35 A common view was that there needs to be a significant focus on the quality and robustness of data, with CfWI supporting the drive towards this. The CfWI should also support the movement towards planning across pathways and a multi-professional approach to workforce planning.

4.36 To support CfWI in improving the evidence base, respondents felt that access to good quality, uniform data sources was important. The need for the use of qualitative as well as quantitative information was also highlighted.

"It is fundamental to the success of any workforce planning and delivery on education and training that we have the relevant data and intelligence to inform that planning and commissioning."[43]

"The relationship between the CfWI, NHS Employers, LHPSNs, HEE and individual provider organisations needs to be defined"[44]

Question 18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?

"Should be a close relationship between HEE and the NHSCB and complimentary mechanisms to engage with the service"[45]

4.37 There was a clear message from respondents that communication is vital both locally and nationally to ensure a link between strategic commissioning intentions and strategic workforce planning. At the national level a large number of respondents suggested that there should be cross representation between HEE and the NHS Commissioning Board with a member of each, possibly the Chair sitting on the others board. At a local level it was suggested that there should be similar links between GP consortia and skills networks.

"It is essential that the HEE's work be aligned to the intentions of the Commissioning Board. There are a variety of ways in which this can happen and representation of the Commissioning Board on the HEE Board, and vice-versa, may be appropriate"[46]

"Skills Networks will need to demonstrate that their workforce plans are consistent with the service commissioning intentions of NHSCB."[47]

[43] Royal College of Nursing
[44] Foundation Trust Network
[45] NHS Trafford
[46] Royal College of Surgeons of England

Integration and alignment between HEE and the NCB would be essential to balance providers' tendency to short term focus with a longer term view of both NCB commissioning intentions and CfWI Horizon Scanning activities.[48]

4.38 There was broad agreement that any relationship needed to be reciprocal with workforce and service planning developed together to prevent one from driving the other and both demonstrating this alignment in their planning. However, there were some concerns over the appropriate balance of this relationship particularly the need to balance workforce planning with the shorter service commissioning cycles. There were also risks surrounding conflict of interests highlighted specifically within skills networks and particularly with GPs acting as both commissioners and providers.

Question 19: Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and cooperation in planning the workforce and in the planning and provision of professional education and training?

"It would appear that this responsibility may continue to be managed adequately by existing regulatory bodies and other relevant organisations. However, with the breadth of changes proposed, it is possible that a new body with over-arching responsibilities may be best placed to enforce requirements and regulate the system as a whole."[49]

4.39 A number of different organisations both individually and in combination were suggested including CQC, Monitor and the professional regulators however, the majority of respondents recommended HEE as the most suitable organisation to have the responsibility for enforcing duties on providers. Many respondents believed that regardless of who was responsible for enforcing these duties it would be important to have cross communication between all bodies involved in healthcare regulation, with clearly defined roles.

4.40 Respondents who recommended HEE welcomed utilising a multi-professional national body to oversee workforce planning to link local workforce planning to national priorities. It was also viewed as an opportunity to streamline the current regulation provided it was managed effectively and did not create an added layer of 'bureaucracy'. There were requests for greater clarity regarding the accountability process and the need to work in partnership with CQC and Monitor and other regulators to prevent duplication of functions. There were also concerns that if HEE is to be a 'lean organisation' whether it will have the capacity to carry out both its functions and role in monitoring providers.

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[47] Bradford Teaching Hospital NHS Foundation Trust
[48] NHS West Midlands
[49] Faculty of General Dental Practice (UK)

4.41 Both Monitor and CQC were suggested by a small number of respondents as they believe education could simply be added to their current remit. However, there were concerns that this would be beyond both CQC and Monitor's scope and resource capabilities.

Question 20: What support should Skills for Health offer healthcare providers during transition?

4.42 There were some concerns that the training and development of bands 1-4 would not be properly supported within the new system. Many respondents believed that it would be appropriate for Skills for Health to focus its expertise on Bands 1-4 education and training and continue to support the principle of widening participation. The majority of respondents felt Skills for Health should utilise its existing tools to provide support and ensure appropriate linkages with skills networks.

Question 21: What is the role for a sector skills council in the new framework?

4.43 There was wide support for the health and social care sectors working more closely together. A number of organisations support a full merger between Skills for Health and Skills for Care.

"It is vital that the proposals support greater links between the training of health care and social care staff, which will work to support joint working" [50]

Question 22: How can the healthcare provider skills networks and HEE secure clinical leadership locally and nationally?

"Must achieve strong professional ownership and influence"[51]

"*HEE should be informed by independent clinical expertise at every level*"[52]

4.44 The most common suggestion was to use existing expertise as it was considered very important to retain organisational memory. This could involve utilising current deanery staff or working with existing clinical leaders, groups and networks. Respondents also suggested HEE and skills networks should work closely with professional bodies and Royal Colleges. Professional involvement could include representation on HEE's Board and the skills network boards. Respondents also re-iterated the need for representation of higher education institutions' at every level of the system.

[50] Alzheimer's Society
[51] COPMED
[52] Royal College of Surgeons

4.45 Concerns were voiced over resourcing pressure to release clinical staff in order for them to engage with the new framework. It was suggested that there could be financial support and the potential for secondments. Leadership programmes and training were also mentioned as a way to foster leadership skills within clinical staff.

Question 23: In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?

4.46 From the responses, it was suggested that it would be important to embed leadership into all levels of training and development and that opportunities should be available to acquire and develop these skills in the work place. Leadership and management functions should be accompanied by a requirement to demonstrate that they make a difference, they must be coupled with good staff appraisals and CPD. Some respondents suggested that HEE should identify the requirements for these skills, with HEIs and skills networks also having a role, and that there should be clarity of both provision and evaluation.

4.47 It was also suggested that it would be important to build on the existing body of good practice, for example the work of the National Leadership Council and NHS Institute for Innovation and Improvement. Some respondents suggested utilising the NHS Leadership Framework and referenced the work coming on-stream from the Faculty of Leadership and Management. The need for appropriate funding was also mentioned.

Leadership development needs to be joined up and build on the good work done by the National Leadership Council.[53]

Question 24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?

4.48 A significant proportion of respondents agreed with the proposal for there to be a national strategic focus to ensure the success of system-wide leadership development and programmes, for both clinicians and managers. The view was that this would be a good opportunity to link services across pathways, to the benefit of patients, and to promote a stronger multi-professional approach. It could also be a way of overcoming any potential distrust that may emerge from having separate career paths.

4.49 It was mentioned that there would need to be appropriate capacity for funding that links with professional bodies should be present, and also that skill networks should have a role at local level.

[53] NHS East Sussex Downs and Weald / NHS Hastings and Rother

A whole system approach that brings together management with clinicians will start to link the important logistic side to managing workforce with the clinical leadership to drive standards and secure patient safety.[54]

Question 25: What are the key opportunities for developing clinicians and managers in an integrated way both across health and social care and across undergraduate and postgraduate programmes?

4.50 The key opportunities highlighted included multi-disciplinary working, and bringing managers and clinicians together early in their under-graduate careers. Opportunities should include local authorities, Public Health England, and health and social care. Many respondents mentioned that multi-professional education and training should be 'the rule rather than the exception,' and that it would enable managers and clinicians to tackle 'real world' problems together. This was viewed as an opportunity to make graduate training schemes more about change management and service improvement, and less about observing the current system. It was suggested that both skills networks and HEIs should be involved in integrating development.

4.51 Core standards would be required, but there were several comments to the effect that that profession-specific training and requirements must not be lost through integration as each profession bring something different to the table. A very small minority expressed the view that integrated training, particularly at undergraduate level when professionals are learning core skills, would not help. From a funding perspective a number of respondents believed that adequate funding was essential and organisations should be able to see a return on investment from leadership and management interventions

We support the desire for a strong central commitment for a national leadership vision, investment and profile supporting all clinical professions and service organisations.[55]

There is a clear opportunity for a nationally led multi-professional training programme in leadership and management which can be applied across health and social care settings.[56]

Question 26: How should Public Health England, and its partners in public health delivery, be integrated within the new framework for planning and developing the healthcare workforce?

4.52 The largest number of respondents felt that Public Health England and its partners in public health delivery should be integrated within HEE in some way and be represented on skills networks. There was a belief that linkages with Local Authorities and social care employers, and public health, need to be clearer.

[54] Age UK
[55] NHS Institute for Innovation and Improvement
[56] UK Clinical Pharmacy Association

4.53 There were several concerns regarding the impact of the new framework and significant implications of any failure in this system for the public health agenda. Some respondents were concerned that local authorities were behind the NHS in the promotion and use of evidence-based approaches to decision-making and intervention. There were also concerns that if skills networks cover too small a population size, there is a risk that the quality of effective specialist public health training will be seriously compromised and requirements in the public health curriculum not delivered.

"There is great overlap and movement between the workforces and one of the challenges of the new NHS will be how to incorporate prevention and public health into the new organisations, both commissioners and providers"[57]

"The important aspect will be for PHE to work closely with HEE, supported by CWI, and influenced by the NHS Commissioning Board, in order to align the public health workforce with the rest of the workforce; they should not be seen as a separate entity"[58]

Question 27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities; and what funding mechanisms should be employed with regard to the public health workforce?

4.54 The majority of respondents believed that Local Authorities should become members of skills network arrangements. There was no consensus on the most appropriate funding mechanism for the public health workforce. The two most popular suggestions were central funding rather than a levy or funding via a levy on Local Authorities. Many respondents supported ring fenced funding.

4.55 There were some concerns about the capacity of Local Authorities to engage properly in the new system and a fear that networks could become unwieldy representing so many providers. There was concern voiced from some Public Health colleagues that they would not wish their move to Local Authorities to put them outside the NHS system, in recognition of the benefits of current NHS system. There was a call for clear guidance on the composition of skills networks to ensure participation of local providers can be consistently assured and more detail on how the NHS and Social Care workforce might be better integrated.

"*Local Authorities would be useful partners in the skills networks especially in relation to the interface between health and social care."*[59]

[57] North West SHA
[58] Oxford Brooks University
[59] Royal College of Midwives

"*Local authorities should be members of healthcare provider skills networks to ensure greater collaboration regarding training, education and developing the public health workforce and embedding public health in all local workforce development strategies*"[60]

Question 28: What are the key issues that need to be addressed to enable a strategic, provider-led and multi-professional approach to funding education and training, which drives excellence, equity and value for money?

4.56 Respondents proposed a number of key actions to ensure a strategic, multi-professional approach to education funding. These included protecting education and training monies so they cannot be spent on other parts of the service, ensuring transparency of how funding was invested, being flexible to adapt to changing needs and to support local requirements, and ensuring a strong link between healthcare and education providers.

4.57 The proposal to 'ring-fence' education and training monies received strong support from educators. Healthcare providers and those responsible for commissioning education and training tended not to make this recommendation.

"a degree of central funding and 'ring-fencing' of funding is essential"[61]

4.58 Many respondents felt there should be greater transparency in education funding. There were views that the scope of the central investment should be clearer, along with the methodology for allocating the central funds and how it was invested locally.

"The retention of the MPET funding in the short term is welcomed as is the acknowledgement of the need for greater transparency of funding allocation and the need to move away from historical approaches which no longer represent true costs (or benefits) of training to the system"[62]

"The PAB recommend the need to have funding structures that are truly multi-professional and transparent in the new system"[63]

4.59 There were some respondents who felt that some elements of the proposals may not support excellence, equity and value for money.

"We have concerns that developing a system that is provider led and multi-professional may be at odds in places with the commitment to excellence, equity and value for money"[64]

[60] NHS South Central
[61] Royal College of General Practitioners
[62] NHS West Midlands
[63] Nursing and Midwifery Professional Advisory Board
[64] Royal College of General Practitioners

Question 29: What should be the scope for central investment through the Multi-Professional Education and Training budget?

4.60 There were a number of views expressed on what the future scope of MPET should include. Some respondents felt that certain elements of continuing professional development should be centrally funded, others that only education and training directly related to producing the next generation of clinical staff should be included. It was clear from the responses that there are a range of views of what constitutes CPD and that a clear definition is required of what will be included within MPET and what will be the responsibility of providers.

"Planning is not solely about new recruits; it must also consider how to develop and invest in new skills and new working patterns for incumbents….investment in the current workforce is as important as investment in the next generation"[65]

"[MPET should fund]…the next generation of clinical staff (including all medical and non-medical staff) as well as postgraduate professional and academic qualifications which are necessary for career progression of the current workforce"[66]

4.61 Other respondents proposed that funding for smaller specialties and professions should continue to be funded from MPET, and some that support for those employed in Agenda for Change bands 1 – 4 be included.

"we would specifically wish to propose that a specified proportion of MPET funding is available to be invested in bands 1 – 4 workforce at employer's discretion"[67]

4.62 There was also support for having one multi-professional funding stream, rather than the distinct funding streams that exist within MPET at present.

"there is a clear need to have funding structures that are truly multi-professional…. There should be a common allocation for all clinical professions, rather than distinctive funding streams. This would address variations in funding and take the significant inequality out of the service"[68]

4.63 It is clear from responses that any changes to the scope of MPET would need to be managed carefully to ensure a safe transition.

[65] The Health Foundation
[66] UNITE
[67] Skills for Health
[68] Royal College of Midwives

"it is important that the CPD funding is transferred to the provider networks with safeguards to ensure CPD requirements are supported"[69]

"Funding should not be diverted without taking account of the needs of the current workforce and the impact on contractual commitments (which should not be endangered by the transition)"[70]

Question 30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?

4.64 Respondents felt there were a number of ways in which we could ensure funding supported innovation in education and training. Proposals put forward included allowing flexibility in the use of funding, ensuring education commissioning and provision was linked to service commissioning, ring-fencing funding to protect it from other pressures, and creating specific innovation funds.

"if innovative approaches are planned by skills networks, based on evidence from the CWI and in congruence with the commissioning plans of local consortia, local authorities and the NHS Commissioning Board, funding streams should be flexible enough to adapt."[71]

"Networks will need to innovate to meet the needs of providers whose workforce priorities will change over time to reflect the changing patterns of care for the population"[72]

"funding streams for education and training need to be linked to service commissioning strategies and QIPP initiatives"[73]

"Evolution in the skill mix is essential to ensure the continued delivery of high quality care to patients. Funding streams should be appropriate to the development of a cohesive and integrated NHS workforce"[74]

4.65 The need to ensure that service providers benefit from the training provided to individuals, to maximise the benefit from the investment, was also highlighted.

"Thought needs to be given to ensuring that the training and education staff receive does not stay entirely with them but is diffused to the organisation and leads to fundamental improvements that outlast the individuals concerned"[75]

[69] NHS North West
[70] NHS West Midlands
[71] Royal College of General Practitioners
[72] The Health Foundation
[73] Royal College of Nursing
[74] Faculty of General Dental Practice UK
[75] NHS North West

Question 31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?

4.66 Respondents supported the need for a safe transition to education and training tariffs that ensured stability and minimised disruption to education and training. A small number of respondents proposed that tariffs be piloted before being introduced. Others suggested a phased approach to introducing tariffs. It was proposed that this could be achieved by capping the losses and gains of each provider in each transitional year.

" The RCM would suggest that if tariffs are envisaged there should be a process of piloting the system and evaluating it prior to rolling it out into the service"[76]

"tariffs should be introduced with a transitional period for capping potential gains and losses to individual institutions"[77]

4.67 The need for clear transition plans for providers and good communications about why tariffs are being introduced and how transition would operate was also highlighted.

"[…we would] suggest that early consultation takes place and that a degree a transparency and openness is incorporated into that consultation"[78]

"a clear transition plan for implementation is required but over a single spending review period; it is essential to maintain momentum and minimise any opportunity for derailment of the objectives of equity and transparency to be delivered"[79]

4.68 Some respondents stated that they do not support the move towards tariffs for education and training, whilst others believe that further work should be undertaken to understand the impact of introducing tariffs before implementation begins.

"We don't support the transition to tariffs, as we do not believe there is evidence that transition to tariffs will improve on the current system and may have significant negative consequences[80]

"a formal project should be initiated by the Department of Health to enable a controlled transition to the new funding arrangements"[81]

[76] Royal College of Midwives
[77] AUKUH and Foundation Trusts Network
[78] Royal College of Nursing
[79] National Commissioners Network
[80] Royal College of General Practitioners
[81] The Health Foundation

"committing to tariffs at the outset, before an assessment of the impact of their implementation has been made, may be short-sighted. There are major implications….and policy makers need to have a full understanding of the potential impact before proceeding further"[82]

Questions 32: If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?

4.69 There were mixed views among respondents whether the education and training tariffs should be managed as part of the same framework as service tariffs. A number of respondents felt that, as the costs associated with education and training are different to those of delivering service, a separate framework is necessary.

"No, the costs for education and training are based on different principles"[83]

"[it is] critical to the stated principles of stability, fairness and minimining risk that there is a real time parallel process to pick up such unrecovered costs into the setting of tariffs for clinical services for the concurrent financial year at the point where implementation of the revised clinical education tariffs begin"[84]

"Placing costs and tariffs within the same framework runs the significant risk that service demands will unduly influence training plans in the short-term"[85]

4.70 Other respondents felt that it would be too difficult to separate the costs of education and training from service costs so tariffs should be set as part of the same framework.

"Untangling service contribution from the costs of training is fraught with difficulty. We should accept that it is impossible to do it with any degree of precision – some degree of cross-subsidisation will occur and is an inevitable feature of current arrangements"[86]

"Yes, although education and training tariffs should be clearly identifiable from service tariff"[87]

Questions 33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?

[82] NHS North West
[83] Universities UK
[84] University Hospitals Birmingham NHS Trust
[85] British Medical Association
[86] NHS North West
[87] NHS West Midlands

4.71 Very few respondents commented on whether there was an alternative to an average national cost. Of those who did respond, there was some support to use average national cost as the basis for tariffs, with some caveats.

"average costs should be the starting point but there should be some discretion for local skills networks"[88]

4.72 There were very few suggestions for alternatives to a national average cost as the basis for education and training tariffs. Those who thought there may be alternatives suggested that further work be done to understand the cost differentials between providers to determine whether an average national tariff was appropriate.

"needs to be more understanding of why costs seem to vary so greatly between education providers before a decision is taken to establish an average national cost-based tariff"[89]

"smaller branches of nursing e.g. learning disability, cost more than larger ones"[90]

"a weighted capitation approach, with local variations, to meet local priorities and e.g. allow for historical levels of investment, would be more appropriate"[91]

"average costs should be the starting point but there should be some local discretion for local skills networks"[92]

Questions 34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

4.73 Again, there were a limited number of responses to this question. Of those who did respond, there was some support for a bottom-up approach to setting the education and training tariffs. However, it was suggested by some respondents that there need to be clearer definitions of the various elements that determine the costs.

"For fairness and transparency, we would expect a costing exercise to be necessary – this would need to be carried out nationally and be sensitive to regional variations"[93]

"A bottom-up costing exercise is the most effective way of ensuring consistency and avoiding unintended consequences from the introduction of a tariff for education and training"[94]

[88] University Hospitals Birmingham NHS Trust
[89] British Medical Association
[90] Royal College of Nursing
[91] Royal College of General Practitioners
[92] University Hospital Birmingham
[93] Royal College of General Practitioners
[94] NHS East Midlands

"the network believes that the current bottom-up exercise is sufficient, however a broader consultation on interpretation of associated costs and scope of funding would add greater transparency"[95]

4.74 There were very few alternative approaches proposed.

"a national average reference cost approach with top down costings based on expenditure across total activity would provide a useful starting point, suitably segmented by staff group through our FTN benchmarking shows that a bottom up approach is better as an end point once the market has developed the necessary information and sophistication"[96]

4.75 And, a small number of respondents who feel a costings exercise is not justifiable, with a proposal that the tariffs should continue to be based on those developed through the MPET Review, rather than updated through a costing exercise once implemented.

"This would not be an effective use of resource given the work that has already been undertaken in at least three reviews over the last decade"[97]

Questions 35: What is the appropriate pace to progress a levy?

4.76 Many respondents felt that it was difficult to provide considered responses to the specific questions around the levy until further information was available.

"more detail is required about the potential scale of the levy in order to address this"[98]

4.77 Of those respondents who expressed a view on the pace at which to develop a levy, a time period of between 4 and 7 years appeared to be the most desirable. Many respondents felt that proposals should be developed slowly, with widespread consultation, to avoid any unintended consequences. Some expressed the view that a levy should not be introduced until the new system architecture is embedded, and others felt that a levy cannot be safely introduced until the education and training tariffs are implemented.

"Given that a levy on providers would also lead to some redistribution of funds. This should only be introduced once the new tariffs have been fully played out"[99]

"introduction of a levy should take place at least 24 months after the full implementation of tariffs"[100]

[95] National Commissioners Network
[96] Foundation Trusts Network
[97] AUKUH
[98] University Hospitals Birmingham NHS Trust
[99] AUKUH
[100] NHS East Midlands

4.78 A smaller number of respondents felt that the levy should be implemented in a shorter timeframe to avoid missing an important opportunity for change.

"if the implementation pace is too slow, then there is a risk that we will miss the opportunities for change and efficiency"[101]

4.79 A number of respondents felt that there may be a number of risks associated with the introduction of the levy and these need to be further considered before a decision is taken whether to proceed. Others felt that more work needed to be undertaken to establish the benefits of a levy before we proceed.

"risk is that for small providers, including GP practices, this could be an additional burden and result in an exodus of senior staff"[102]

"a clear assessment to determine if a levy based system will be an improvement on a weighted capitation funding approach should be undertaken"[103]

"the plan to establish a levy to fund education and training in the future must be fully tested and trialled before it is rolled out to the system"[104]

Questions 36: Which organisations should be covered by the levy? Should it include healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse?

4.80 Of those who felt able to comment on the proposal to establish a levy, a large proportion were supportive of the levy covering all providers, including those who employ staff trained by the NHS but not delivering NHS services. However, some felt there should be a separate levy on providers of NHS care to those who provide no care to NHS patients.

"Yes, we believe all organisations should be covered by the levy, not just those delivering NHS funded services"[105]

"All providers of NHS commissioned services. A separate, additional levy could be considered for employers whose staff have been trained by the NHS but who do not provide significant services to the NHS.[106]

[101] National commissioners network
[102] RCGP
[103] NHS North West
[104] University and College Union
[105] RCN
[106] AUKUH

" we welcome the approach all employers of the NHS trained workforce should pay towards their education"[107]

4.81 A number of respondents felt that a levy was inappropriate for certain providers, or that there were alternative ways to ensure that the private sector contribute to education and training costs.

"We are concerned that the proposed levy on all healthcare providers would be unaffordable and act as a barrier for smaller voluntary and community sector providers. Therefore, we believe that the proposed levy should be proportionate both to the size of the provider and to its ability to pay"[108]

"the only mechanism that could really be considered is some form of taxation on organisations that make use of the trained output from the NHS… If a diverse market of willing providers is to be achieved, the assumption must be that funding for workforce development is diverted at source from PbR"[109]

"Monitor considers that the costs and complexity of such a system outweigh the benefits"[110]

"Top-slicing of the NHS budget is the preferable way to fund the levy"[111]

4.82 There were also alternative ways proposed to fund education and training.

"in the longer term, some of the costs could be met by individuals rather than organisations"[112]

Question 37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?

4.83 A number of respondents to this question proposed that an organisation's contribution to the levy could be based on the size and structure of its workforce to truly reflect the benefit that was being derived from the investment in education and training.

"the levy could be based upon the number of registered health professionals employed by or regularly providing care within the facility"[113]

"levy should be akin to a 'human capital charge' in which a fixed percentage of NHS funding

[107] FTN
[108] NAVCA and Regional Voices
[109] NHS East Midlands
[110] Monitor
[111] BMA
[112] Tees, Esk and Wear Valley NHS Foundation Trust
[113] RCM