Education and Training Committee - 16 September 2010

Workforce planning and educational commissioning

Executive summary and recommendations

Introduction

The Council has received a paper from Council member, Professor Jeff Lucas, regarding Educational Commissioning for the health and social care professions.

The paper has been submitted to the Committee for information as it concerns a number of issues which are the remit of the Committee.

Decision

The Committee is invited to note the paper, and provide any comments to the Council.

Background information

None.

Resource implications

None.

Financial implications

None.

Appendices

Workforce Planning and Educational Commissioning

Date of paper

1 September 2010

Workforce Planning and Educational Commissioning

Educational Commissioning for the health and social care professions is designed to meet a Future Work Force (FWF) need. In all four countries this is, to a degree, centrally managed by Work Force Review (WFR) Teams.

The simplified algorithm they work with is:

FWF = WR + (T – A x DT + PG ± I/E) where

WR = Working Registrants
T = Trainees
A = Attrition of Trainees
DT = Demographic Trends, including:
- age at start of work and working age profile
- % working Part-Time
- % due to retire in next five years

PG = Planned Growth
I/E = Import/Export net effect

Trends in the variables have required (T) which has, historically, been the balancing figure, to vary significantly over the years. This boom/bust phenomena created significant instability in the HE sector and some training providers closed or withdrew from some of this provision. In recent years Planned Growth (e.g. New Medical Schools) and Import (particularly Doctors and Nurses) have been used to balance the equation. Over the years, however, the perceived return on investment has worsened. This is due to three key factors:

- Feminisation of the workforce and PT working (see Annex 1)
- Worsening attrition during pre-registration training
- Ageing workforce (See Annex 2)

Key Issues from Demographic and Health Patterns

It has been widely reported that the population of the UK is growing and ageing. The growth is primarily a factor of immigration and immigrant fertility rates (FR); population stability is predicated on an FR of 2.1 (replacement level), the current indigenous population FR is 1.8. The net effect is that health and social needs and tomorrow's health workforce will be increasingly influenced by this immigration pattern.

Immigration/emigration movements over the years has been a significant factor for the NHS workforce, particularly where the boom/bust fluctuations in educational commissions have led to a 'post bust' influx of economic migrant health workers, e.g. in 2005 the WFRT reported:

- 34% of UK working Doctors trained abroad, 65% of them were ESL trained (English as a Second Language).
- 41% of UK working Dentists trained abroad, 52% of them were ESL trained.

- 5% of UK Nurses trained abroad, 75% of them were ESL trained. In 2003/2004, for example, 41,406 Nurses from overseas applied to NMC for registration,14,746 were accepted mostly from the Philippines, India and South Africa; in the same year we exported 7,619 Nurses to the USA, Australia and Canada. The potential mobility of this workforce is significant and makes Boarder Controls and the Points Based approach to premium skills, increasingly important to workforce planning.

New tactics are now being used to mitigate against balancing the equation by increasing Trainees. Two approaches have been used extensively:

1 Returners (to support the WF Plan, particularly in Nursing and Midwifery)
2 Use of unregulated Assistants/Support Workers (across professions)

In the 1970s, where FWF = 100, T needed to be 117 (attrition stood at -12% and all other variables -5%).

In the 1980s, where FWF = 100, T needed to be 121 (attrition worsened to -15%; all other variables worsened to -11% but Import gave a +5%)

In the 1990s, where FWF = 100, T needed to be 143 (attrition worsened to -18%; all other variables worsened to -28%, particularly PT working; and Import continued to moderate at +3%). In the late 1990s the cost of balancing the equation through Trainees on full professional programmes became untenable and Educational Commissioners started to set attrition penalties (over 12%) on HEIs and service providers recruited 'support workers' mostly to be trained 'in service'.[1]

In the 2000s, where FWF = 100, T needed to be 159 (attrition, despite penalties, worsened to -20% mostly in Nursing), all other variables worsened, Import declined because of the political pressure on recruiting doctors and nurses from third world countries who could least afford the loss and the non-regulated workforce became the fastest growing (+ 40%) in the decade (see Annex 2).

In the coming few years we will see the impact of the next Comprehensive Spending Review (CSR) which has already signalled that Educational Commissioning in England over the next three years will be subject to a 14% savings target.

The WFRT annual reports for all professions (2009)[2] do not signal PG (Planned Growth) in any of the health professions. Social work, which is 'planned' separately, is signalling PG. In all other respects, the growth is in higher skills/CPD needs of the existing WF to meet Service Reforms and Clinical Priorities, particularly in public health contributions; diagnostic services; and services associated with 'wellbeing' as a way of reducing the costs of 'assisted life years' of an ageing population. We should not forget that 90% of our Life Time Health Spend is in the last six months of our lives and clearly not targeted at being curative. Some of these 'staying well' agendas are being co-ordinated by Medical Education England which looks at Doctors/Dentists/Pharmacists and Clinical (Health Care) Scientists as a group of professions with similar funding (mostly HE Funding Councils) and the potential for extended roles in public health, especially through Practitioners with Special Interest.

The cost of education and training

General Medical Services (GMS) budgets in England are top sliced to pay for the associated education and training of most Health Professionals who work in the NHS. This top slice is called the Multiprofessional Education and Training Levy (MPET).

Teaching Hospitals also get a preferential tariff for Clinical Services (+ 5-8%) because patient through-put is slowed down by 'teaching'. This tariff is designed to reflect the overarching concept of Payment by Results (PbR).

The Levy is in three parts:

(1)

- Medical and Dental Service Increments for Teaching (M,SIFT/D,SIFT) are terminologies used in England and Wales. In Scotland the levy is called ACT (Additional Cost of Teaching) and in Northern Ireland it is called STAR (Supplement for Teaching and Research).

  This money goes to Teaching Hospitals (90%) and Medical/Dental Schools (10%) to pay for Clinical Academics' teaching time. Approximately 80% of this funding is for 'Facilities', 20% is for 'Student Placements' which are increasingly involving Primary Care. This is a very poorly audited resource envelope which has been subject to some scrutiny by the Resource Allocation Working Party (RAWP) and, more recently, by the DoH Workforce Directorate. The MPET Review (8/2/10) being the most recent). Some of the observations within this Report are worthy of note.[3]

- SIFT allocation to NHS Trusts varies from £5,000 per student per annum to £200,000 per student per annum and that almost half the total allocation goes to London Teaching Hospitals. This significantly distorts PbR.

  Recommendation (1): That SIFT should be rebased in the range £34.1K pa - £45.9K pa, depending on Market Forces Factors (MFF) eg London weighting and that this should be signalled in the NHS Operating Statement 2010/11 (done). This will release £99 million p/a.

- Although MPET is a multiprofessional levy, SIFT is only allocated to Medical and Dental undergraduate training, yet all health professional training in practice settings bears a cost.

  Recommendation (2): That there should be a Non-Medical SIFT allocation. This has initially been set at the de-minimus level of £94 per week (same as Social Work). Market Forces Factors will apply, giving an annual range of between £1.6K and £2.2K per year. The published Benchmark Price being £1740 per wte student. This will cost £54 million per annum.

(2)

- Medical and Dental Education Levy (MADEL) for post graduate training of Doctors and Dentists. This levy is managed through SHAs via Post Graduate Deaneries (some of which are becoming multiprofessional). This again is a poorly audited resource and GR13567 recommended some changes but no consensus was reached on the best way forward. The Post Graduate Deans want 100% salary support for every doctor/dentist undergoing Specialist Training, NHS Trusts would prefer a common placement rate (circa £1200 p/a) with variable salary support depending on grade. Regardless of the detail, this reform is likely to cost £45 million p/a in steady state.

(3) Non Medical Education and Training (NMET) levy. This pays for some Foundation Degrees in Health and Social Care (for Assistant/Support Worker Training), most of the NMC/HPC professions' initial training (including part-time Biomedical Scientists) and needs-led Continuing Professional Development for all the above.

The Initial Training Allocation is according to a Benchmark Price (BMP), see Annex 2 and Education and Training Commissions (see Annex 3), the CPD is funded at a BMP per credit (currently £53.79).

The BMP allocations from SHAs to universities and colleges pays for 'Tuition' fees. Students can draw down support costs from the NHS Business Services Authority. Students on BMP non-medical programmes, therefore, have their Tuition Fees paid for them and do not have to repay them through the 'Graduate Tax' which is a payroll deduction for all other graduates, including Doctors; Dentists; Health Care Scientists; Pharmacists; Optometrists etc; earning more than £15,000 p/a. Students on 5/6 year training courses now have a 'debt' of circa £34K at the start of their careers. Three year programmes are associated with debts between £18K and £22K. Students on NHS Bursaries have significantly lower debts, averaging around £9K.

Annex 1

a) Proportion of female practitioners in HPC regulated professions

Profession	Percentage	Since
Speech & Language Therapists	97% ± 1%	2001
Dieticians	96% ± 1%	1962
Occupational Therapists	93% ± 1%	1962
Nurses	90% ± 1%	1984
Radiographers	84% ± 2%	1962
Physiotherapists	84% ± 2%	1962
Podiatrists	71% ± 2%	1962
Biomedical Scientists	61% ± 1%	1962

b) Change in proportion of female students and practitioners in a range of professions

Profession	From	To	Students
Pharmacists	1970 (25%)	2005 (53%)	2009 (62%)
Doctors	1992 (46%)	2005 (53%)	2009 (57%)
Optometrists	1997 (43%)	2005 (49%)	2009 (54%)
Dentists	1997 (30%)	2005 (34%)	2009 (46%)
GPs	1993 (29%)	2005 (39%)	2009 (61%)
Social Work	1998 (76%)	2005 (79%)	2009 (82%)

c) Part Time Working

	1990	2000	2010
Nurses	40%	48%	52%
Pharmacists	27%	32%	36%
Optometrists	26%	29%	33%
Doctors	25%	30%	33%
Scientific & Technical	44%	46%	48%

Annex 1 on the previous pages shows the trend over time which has seen an increase in the proportion of female practitioners in a range of healthcare professions.

This trend in professions which have, historically, been male dominated (Annex 1b) is due to a number of factors.

Firstly, women now have better educational outcomes at every level of the qualifications framework from GCSE to PhD, by every mode of study (FT, PT, DL)[4]. They also dominate the Participation Index, are more likely to successfully complete their studies and more likely to get good honours[5]. They have made the most significant improvement in the natural sciences and, therefore, dominate the applicants for Medicine, Pharmacy etc. The endangered specie amongst medical students is now the white male. These professions, particularly Family Medicine (GPs) are also dominated by part-time working practices.

The trends, as set out in Annex 1, are likely to persist for the next 20 years, namely as life expectancy increases the burden on health services will be targeted to serve older people with either long term conditions or age related problems. Services will be increasingly provided by a female dominant workforce often working part-time, and the percentage of the workforce over 50 years of age will continue to increase. (See Annex 2)

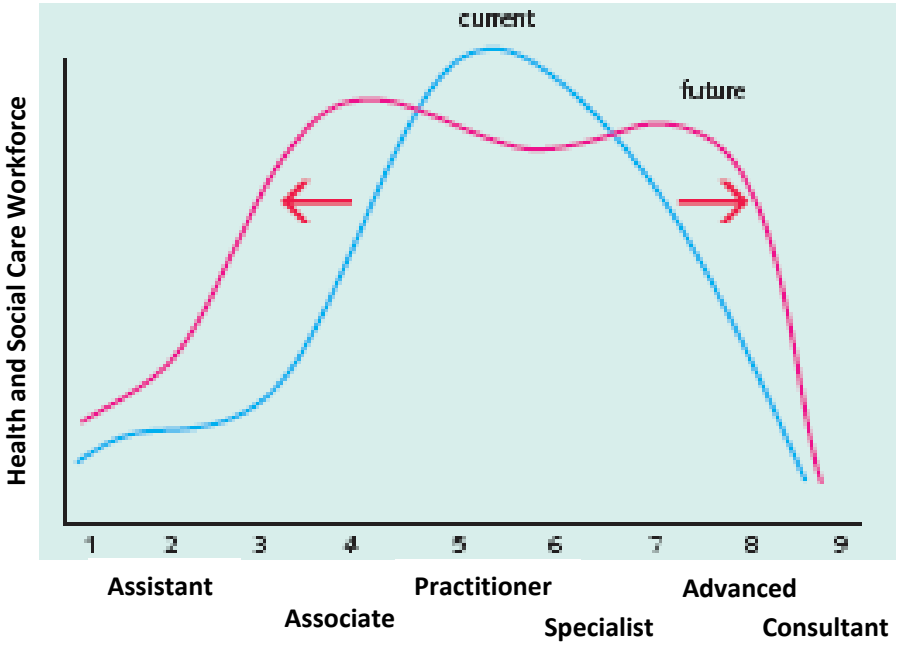
Annex 2

a) Key Demographics

	2008	2031
Population	61.4m	70.9m
16-44	39.9%	36.4%
65+	19.2%	22.3%
Female	50.9%	↓
Male	49.1%	↑
Life Expectancy ♀	81.9y	↑
Life Expectancy ♂	77.7y	↑
NHS Workforce		
Female	85.0%	↑
Part-time	50.0%	↑
50+	30.0%	↑

Source: National Report on Population Statistics 2010 and Annual Report on the NHS Workforce 2009[6 & 7].

b) Changes in the Workforce by Grade



Source: Based on a Career Framework for Healthcare Scientists, Skills for Health 2006[8]

ANNEX 3

a) % of newly qualified obtaining professional employment within six months (1st Destination statistics derived from DELHE 2007/08)[9]

Doctors	98.3%
Dentists	96.3%
Nurses	89.6%
Dietitians	48.0%
SLTs	77.1%
Other AHS	51.8%
Pharmacists	71.0%
Opticians	85.3%

DELHE is a self declaration survey and is likely, therefore, to 'halo' those in employment.

b) % of FTE Registrants working in/for NHS (NHS Workforce Statistics 2007/08)[10]

Doctors	50.1% ↑
Dentists	56.6% →
Nurses	43.1% ↑
AHPs	42.3% →
Pharmacists	68.3% ↓
Opticians	65.8% ↓

Annex 4

a) Benchmark Price per WTE student paid from the Multiprofessional Education and Training Levy (NHS)

		09-10	10-11	HEFCE ≡
Nursing	Dip/BSc	£7708	£7843	D
Op Dept Practitioners	DipHE	£7708	£7843	
Physiotherapy	BSc	£8138	£8280	
Occupational Therapy	BSc	£8138	£8280	C
Midwifery	BSc	£8363	£8509	
Speech & Language Therapy	BSc	£9358	£9522	
Chiropody & Podiatry	BSc	£9358	£9522	
Dietetics	BSc	£9358	£9522	B
Orthoptics	BSc	£9358	£9521	
Prosthetist/Orthotist	BSc	£9751	£9922	
Radiography D&T	BSc	£9751	£9920	
PT Biomedical Science	BSc	£5783	£5783	
Health & Social Care	FD	£3223	£3223	

HEFCE Funding	**09-10**	**10-11**
Band A (Medicine/Dentistry)	£15573	£15804
Band B (Biomedical/Clinical Scientists)	£6619	£6717
Band C (Social Work/Applied Psychology)	£5061	£5136
Band D	£3893	£3951
ug Tuition Fees (TF)	£3050	£3290

The BMP is broadly equivalent to the HEFCE band funding, plus the current regulated tuition fee.

Eg £3951+ 3290 ≡ £7843 (D)

£5136 + 3290 ≡ £8280 – 8509 (C)

£6717 + 3290 ≡ £9522 – 9920 (B)

Source: Benchmark Price for SHA Educational Commissioning 2010/11.[11]

Annex 5

a) Number of NHS Funded New Starter Training Commissions 2009/2010 [number funded from SHEFC]

		England[i]	Scotland[ii]	Wales[iii]	Northern Ireland[iv]	Total new students All modes	No of Providers
	Pre-Clinical Medicine	6,790	1,020	470	250	8,530	35
	Pre-Clinical Dentistry	900	180	65	45	1,190	13
(1)	Total UG Medical / Dental	19,097	1,289	542	295	21,223	35 (13)
	PG Medical (FT)	1,580	165	80	10	1,835	-
	PG Dentistry (FT)	210	30	-	-	240	-
(2)	Total PG Medical / Dental	42,917	1,083	1,008	650	45,441	-
(3)	Nursing & (Midwifery)	23,030 (2,177)	3,060 (292)	1,282 (110)	825 (86)	28,087 (2,665)	138 (61)
(4)	Physiotherapy	1,748	[173]	97	69	2,087	14
(5)	Occupational Therapy	1,782	[215]	73	60	2,080	30
(6)	Diagnostic Radiography	1,156	[101]	369	60	1,356	24
(7)	Radiotherapy / Oncology	365	[28]	17	-	410	12
	Orthoptics	79	-	-	-	79	2
	Speech & Language Therapy	806	[20]	35	30	936	17
	Prosthetics & Orthotics	29	[30]	-	-	59	2
	Dietetics	403	[110]	40	18	571	22
	Chiropody / Podiatry	395	[61]	30	15	501	13
	Health Care Scientists (including Clinical Psychology & Child Psychotherapy	1,170	N/K	N/K	N/K	-	-
	NHS Technicians	331	N/K	N/K	N/K	-	-
	Total						

Source: **i** Hedley Hilton, DoH
ii Susan Malcolm, CNO, SCOTLAND
iii Will Oliver, NLIAH, WALES
iv Robert Stewart, DHSSPS, NI [12]

(1) Total UG Medical / Dental includes students on Access programmes, Foundation years, Graduate Entry programmes, Clinical Science / MBChB articulations, pre-clinical first years progressing onto pre-clinical intercalated degrees and Common Foundation courses with routes into other professions. The WFRT forecast for annual entry into medical and dental service is circa 10,000 p/a for the UK and is currently perceived to be marginally in oversupply.

(2) Total PG Medical / Dental includes qualified staff on all modes of speciality training (SpR) etc through PG Deaneries / Royal College programmes, the minority of which is full-time. The WFRT forecast for speciality training is to re-profile more into the needs of diagnostic services, long term conditions and care of the elderly; in all other specialisms we are currently perceived to be in marginal oversupply.

(3) Total Nursing and Midwifery includes Diploma, Advanced Diploma and Degree Nursing programmes and 18 month conversion and three year ab-initio Midwifery Degrees. The WFRT is reporting a disproportionate number of Community Based Nurses nearing retirement age and the service needs to be greatest in this area. The WFRP forecast for annual entry into these professions is 14,246 p/a, of which approximately 10% is midwifery. The attrition in training in Nursing is still worryingly high and Community Nursing programmes under commissioned. In all other regards the WFRT is not forecasting growth in commissioning but a reduction in attrition and more CPD credits focussed on community based services.

(4) Physiotherapy commissioning is perceived to be in steady state, WFRT is not forecasting growth and is working within a UK/WFRP of 1.820 p/a and is marginally in oversupply.

(5) Occupational Therapy commissioning is perceived to be in steady state, WFRT is not forecasting growth and is working within a UK/WFRP of 1,772 p/a and is marginally in oversupply.

(6) Diagnostic Radiography commissioning is perceived to be in steady state, WFRT is not forecasting growth and is working within a UK/WFRP of 1,064 p/a and is marginally in oversupply. Growth in specialist imaging modalities (pg provision) is needed to meet diagnostic service targets.

(7) Radiotherapy commissioning is marginally in undersupply, bearing in mind Cancer Waiting List reduction pressures. The attrition in training is low and falling so any increase in commissioning will be marginal.

WFRT forecasts for other Professions show similar ‘no planned growth’ projections.

[13] UK Workforce Review Plans by Health Professions 2010.

Issues and Risks

The health and social care professions have been popular and usually oversubscribed over the last 35 years. Jobs have been almost guaranteed because training places have been aligned to a workforce plan. A number of professions have attracted bursaries and commissioned places have been tuition free to the student. This has mitigated against fears of student debt and concerns about employment. As the Higher Education Participation Index (HEPI) has risen from (1 in 12 in 1966, 8.3%) towards the Labour Government Target of (1 in 2 in 2012), we are now at (1 in 2.2 in 2010, 45%). HE is now perceived as a mass market, it has successfully reached out to underrepresented groups, widened participation, adopted flexible access policies and delivery methods. It has, however, become increasingly concerned about student quality.

Quality of applicants is becoming difficult to assess. After 28 consecutive annual improvements in A Level Grades; these grades are becoming less discriminatory for the more highly selective health programmes, particularly at the most highly ranked universities. These are now setting entrance exams and aptitude testing. Some programmes, however, are now becoming less popular, particularly Learning Disability and Mental Health Nursing, and more recently Adult Nursing and Social Work. Such programmes are at risk of moving from selective admissions policies to recruiting admissions policies and in Nursing some educational commissions have not been filled. This is worrying because the health and social care needs of vulnerable children and adults is forecast to grow and if these professions become less popular the workforce remedy, particularly in community care terms, will be to choose to use unregulated assistants. This is a worrying trend in terms of patient safety and public protection.

Where HE providers are under pressure to fill less popular courses we also see high attrition. Less able students often breach assessment regulations, may falsify data or breach professional codes of conduct[14 (a,b,c)]. Whether these breaches are subject to student Fitness to Practice (SFtP) procedures and whether the Regulators 'receive every outcome' (CHRE 2010)[15] is a question of the moment. Some Regulators have become formally involved with SFtP by virtue of Student Registration (GOC) and presiding over the hearing; others are considering this (RPhS and GSCC).

Such student breaches are becoming increasingly common. Yates has recently reported that men of lower estimated social class who had difficulties in their early years of medicine training are an 'at risk' group of subsequent professional misconduct. She has previously reported such 'academic strugglers' as less likely to achieve consultant status or qualify as a GP. Misconduct in professional life puts the professional at risk age as 'most likely' 35-54 years old with 55-64 as the second most likely age band and in both cases the risk groups are men. David has also reported that related student breaches are becoming more common. What is beginning to emerge in retrospective studies is that Fitness to Practice hearings that go against the Registrant uncover breaches during their training, most of which would not be known by the Regulators. Universities would normally (where needed) sign off students as being 'of good character' regardless of breaches, for fear of

double jeopardy. If such students are more likely to be risks to patient safety and public protection as registrants, perhaps Regulators need to know more of these incidents and possibly use a more targeted approach to CPD Audits.

Much has also been written about the positive outcomes of professional peer support and observation of practice on clinical outcomes. Group Practices are now common place in Medicine and Dentistry and, more recently, in Optometry and Pharmacy. Benefits to patients in terms of good clinical governance, promoting action on clinical effectiveness (PACE), better compliance to National Institute (NIHCE) clinical guidelines and good referral practice and good audit reports, particularly around prescribing, have all been in part attributed to the peer on peer support to professionalism. In the wider context of how hospital services are now grouped into, for example, Medical Imaging; Diagnostic Services and Rehabilitation Therapies, these also provide the group support that underpins continuous improvement in clinical outcomes and patient satisfaction. Across professional boundaries these benefits are also seen in the evaluation of service delivery in Community Health Centres and Diagnostic Treatment Centres. It is clear that the NHS has configured services more into 'group' and away from 'single handed' as a positive move towards continuous improvement and risk mitigation[16]. HPC still has, and will have for the foreseeable future, a significant number of private provider single handed practitioners, many do work in effective networks and communities of practice and are actively engaged in continuing professional development. However, others I suspect are less engaged and, at an intuitive level, may constitute a possible risk to patient safety.

Patient complaints, both informal and formal, often involve issues of communicative competence. This is often complicated by transcultural issues resulting in complaints against, in particular, Doctors and Dentists who trained overseas in a language other than English; where the patient doesn't understand the outcome of a consultation; or where English trained health professional working with migrant patients who don't speak English have to use a translator or children of the family to provide the health professional with diagnostic information. Both scenarios can, and often do, lead to misunderstandings and complaints[17].

Universities are also increasingly exposed to the realities of selectivity, contestability and league tables. This creates Centres of Excellence or Beacons of Best Practice, very often associated with thriving cities where all aspects of regeneration are self evident. These hot spots are becoming bigger and stronger; Academic Health Science Centres, for example, now attract the best health students, the best teachers and researchers and are associated with the best patient/client services. The Golden Triangle of London, Oxford and Cambridge now has Edinburgh, Manchester/Birmingham and Newcastle all acting as quality magnets leaving cold spots, particularly coastal cold spots struggling to attract students and fill academic and health service posts. This was why, for example, Anglia, Peninsular and Hull/York attracted New Medical Schools and have, in part, rectified these areas' dependency on 'importing' their health and social care workforce.

In public protection terms all these issues constitute ‘Risks’ that are currently not factored into how HPC manages FtP issues involving students or how HPC Audits CPD. In CPD Audits our current ‘sampling’ is not purposeful, nor is it a sample of the Register as a whole and is this appropriate? This paper raises some ‘Risks’ that might need to be factored into a purposeful sample approach.

Things already known:

- Single handed practice
- Men of a certain age
- Poor communication / language skills

Issues emerging:

- Student FtP issues
- Cold spots

7 June 2010

So, what direct consequence does all this have for HPC?

HPC income is dependent on Registrant Fees. Registrant numbers are a reflection of 'active' and 'dormant' in workforce terms and 'potential' for those that have allowed their registration to lapse.

A 14% cut in CSR allocations to SHAs for E&T will (I suspect) mean that the Future Work Force need will be met by (1-7) below. Some patient safety risks (8-9) are also noted:

1 Reducing Pre-Registration Training Commissions by say 5% p/a over the next three years **(threat)** and the possibility of HE closures or mergers **(threat)**

2 Additional use of 'regulated' support workers **(opportunity)**

3 Refreshing 'returners' as NMC does **(opportunity)**

4 Maximising new diagnostic technologies and possibly annotating Registers with CPD awards **(opportunity)**

5 Creating more 'dual awards' to accommodate 'both existing and new roles' which may join HPC or cross Regulator boundaries **(possible opportunity)**

6 Using non-medical SIFT to stabilise the training provider control of practice education, should reduce attrition and improve completion **(opportunity)**

7 Being less dependent on 'importing' trained health professionals/students from overseas eg Border Agency rules, Public Protection Interest **(threat)**

8 Using demographics and commissioning plans to inform HPC planning assumptions **(opportunity)**

9 Using other issues and trends to inform a more risk based approach to Fitness to Practice policies and procedures and auditing CPD **(opportunity)**

References

1 NHS Annual Workforce Supply Reports (1970-1999)

2 NHS Workforce Review Team Annual Report by Profession (2009)

3 The Multiprofessional Education and Training Levy Review GR 13567 (8/2/10)

4 Patterns of Higher Education Institutions in the UK 8th Report (2008)

5 Male and female participation and progression in higher education: further analysis. Higher Education Policy Institute Report 48 (July 2010)

6 National Report on Population Statistics (2010)

7 Annual Report on the NHS Workforce (2009)

8 Career Framework for Healthcare Scientists, Skills for Health (2006)

9 Destination of Leavers from Higher Education (2007/08)

10 NHS Workforce Statistics (2007/08)

11 Benchmark Price for Strategic Health Authority Educational Commissioning (2009/10 & 2010/1)

12 NHS Training Commissioning by Country (2009/10)
- England (Headley Hilton DoH)
- Scotland (Susan Malcolm CNO Office and SHEFC University Places 2010)
- Wales (Will Oliver NLIAH Wales)
- Northern Ireland (Robert Stewart DHSSPS, NI)

13 UK Workforce Review Plans by Health Professions (2010)

14 (a) Yates J, risk Factors at Medical School for Subsequent Misconduct: multi centre retrospective case-control study, BMJ Vol 340 p2040 (2010)
(b) Papadakis M et al, Disciplinary action by Medical Boards and prior behaviour in Medical Schools, N England Journal of Medicine Vol 353, p2673, (2005)
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15 CHRE Report, Student Fitness to Practice: Should the regulators receive every outcome? (February 2010)

16 Kapur N, On the pursuit of clinical excellence, Clinical Governance Vol 14 No 1 p24 (2009)

17 Handling Complaints in the NHS: good practice tookit for local resolution, DH pub 4108465 (2009)

Appendix - Social Work

In July 2010, the Department of Health published 'Liberating the NHS: Report of the arms-length bodies review' which said that the Government plans to abolish the General Social Care Council (GSCC) and transfer the registration of social workers in England to the HPC.

This appendix provides some information about pre and post-registration education and training awards in social work.

A Social Work qualification can be achieved through one of seven routes:

		% in 2008
Full Time Post Graduate	College Based	23.0%
Full Time Post Graduate	Employment Based	1.0%
Part Time Post Graduate	Employment Based	0.5%
Full Time Undergraduate	College Based	64.5%
Full Time Undergraduate	Employment Based	3.5%
Part Time Undergraduate	College Based	1.5%
Part Time Undergraduate	Employment Based	6.0%

The total number of enrolments to Social Work Degree Qualifying programmes in 2007/08 in England was 5452 and the total number of awards achieved in 2007/08 in England was 4445. The gender balance of students in England in 2007/08 was 86.4% female and 23.6% male, of whom 57% were English, 9% African and 4% Caribbean. The pass rate at the first attempt in England is 60% with 27% Deferred/Referred, 11% Withdrew and 2% Failed. In 2007/08 the last of the Diploma Qualifying route saw 552 Social Workers qualify in the UK. The steady state level of entry into Social Work training by all routes in the UK is predicted to be circa 8,000 per annum with an anticipated completion rate of 85%.

There are 82 provider institutions of initial Social Work training; 74 are universities, 8 are Further Education Colleges. Between them, they offer 265 Approved Programmes. There are 52 providers of PQ courses offering another 255 Approved Programmes.

Full-time BA courses are typically 3 years, Part-time BA courses are between 4 and 6 years. There are 10 BSc courses leading to dual registration awards in Social Work and Nursing. PQ awards at either PG Diploma or Masters are typically 2 years Full-time and 3-4 years Part-time.

The total number of enrolments to post qualifying programmes in the UK in 2007/08 was 2785. There are three routes to Post Qualifying.

Undergraduate Full Time	College Based	0.5%
Undergraduate Part Time	Employment Based	28.5%

(for SWs with Diploma level awards)

Post Graduate Part Time	Employment Based	71%

(for SWs with Degree or PG awards of which 34% were Graduates and 37% were already Postgraduates)

PQ awards are at three levels: Advanced / Higher Specialist / Specialist; in five specialisms:

1	Children/Families	52.0%
2	Leadership/Management	2.5%
3	Mental Health	18.5%
4	Adults	21.0%
5	Practice Education	6.0%

In 2007/08 of the 2785 enrolments in the UK to such PQ awards, 80% were female and 68% were over the age of 35.

Jeff Lucas
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