

**“We need to radically transform the way we deliver services. Innovation is the way – the only way – we can meet these challenges. Innovation must become core business for the NHS”**

David Nicholson, 2011<sup>1</sup>

## Introduction

This paper was produced following a meeting between Professor Patrick Maxwell FMedSci and Professor Edwin Chilvers FMedSci (on behalf of the Academy), with representatives of the Department of Health in November 2011, to discuss the Government’s proposals to reform workforce planning, education and training within the health service. The Academy was asked to articulate its view regarding the structure of the proposed local education and training boards (LETBs) in the context of the need to better engage NHS providers in local workforce planning.

The Academy supports the need for local flexibility to enable areas to develop their own solutions and innovative practice. However it is essential that this is undertaken in full partnership with educational providers.

## Key messages

1. It is of critical importance that postgraduate education and training is run by effective academic-health service alliances throughout the UK, in line with other developed nations.
2. Engaging both health and education providers with the education and training agenda will be facilitated by introducing joint responsibility for these endeavours.
3. The Government has made strong commitments towards strengthening the relationship between academia and the NHS. The ‘Strategy for UK life sciences’ endorsed academic-health partnerships as an essential component of our economic recovery.<sup>2</sup> The recent NHS innovation strategy, ‘Innovation, health and wealth’ committed to:  
*‘ensure that innovation is ‘hard-wired’ into educational curricula, training programmes and competency frameworks at every level. We will work with Medical Education England and other professional advisory groups (and in the future Health Education England), NHS Employers and the academic sector to ‘hard wire’ innovation into managerial and clinical curricula and CPD’.*<sup>3</sup>

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<sup>1</sup> Department of Health (2011). *Innovation, health and wealth: accelerating adoption and diffusion in the NHS*.

[http://www.dh.gov.uk/dr\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131687.pdf](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131687.pdf)

<sup>2</sup> Office for Life Sciences (2011). *Strategy for UK Life Sciences*.

<http://www.bis.gov.uk/assets/biscore/innovation/docs/s/11-1429-strategy-for-uk-life-sciences>

<sup>3</sup> Department of Health (2011). *Innovation, health and wealth: accelerating adoption and diffusion in the NHS*.

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4. In short, these commitments must be reflected in the reforms to workforce education and training; without this, it will not be possible to fully realise the goals of these strategies. Further, the reforms to workforce planning, education and training provide an ideal context for fostering academic-health partnerships.

## Background

5. The Academy welcomes the Government's objective to deliver the best and most responsive healthcare system in the world and considers that academic excellence and a world-class healthcare education system is essential to achieve this.
6. The Academy's response to the Government's consultation, 'Developing the healthcare workforce', stressed the importance of partnership working to allow universities and healthcare providers to achieve their shared tripartite mission of excellence in clinical care, education and research.<sup>4</sup> We believe that the highest quality of education and innovation, and ultimately health provision, is built on strong scientific foundations. This will only be achieved if there are real and structural linkages between academia, industry and the organisations that deliver healthcare. The structure and operations of LETBs must support this research-teaching-care mandate. They should reflect the need for partnership working and utilise fully the expertise that universities and Deaneries have in this domain.
7. There are excellent models of these partnerships in the UK and abroad. For example, the current Academic Health Services Centres and the National Institute for Health Research Integrated Academic Training programmes provide clear evidence that such partnership working delivers real benefits to patients. This model of partnership working will expand significantly through the development of Academic Health Science Networks across the country.<sup>5</sup>
8. The Academy strongly believes that only these kinds of alliances have the organisational reach to act as 'systems integrators' to drive the transformation of medicine along the 'discovery-care continuum'.
9. Curricula must be co-produced by academia and service providers to ensure the workforce is fit for purpose and properly educationally informed.
10. The role of Universities (as well as NHS organisations) as employers of large numbers of medical trainees must be recognised.

## The proposals

### *Health Education England*

11. National planning and coordination will continue to play a major role in workforce planning (especially within medicine). Sufficient oversight must exist through Health Education England (HEE) to ensure high quality and consistent standards across the UK and that sufficient numbers of trainees exist across all specialties. LETBs will need to be responsive

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<sup>4</sup> Academy of Medical Sciences (2011). *Response to the Government's consultation, 'Liberating the NHS: Developing the healthcare workforce'*.

<http://www.acmedsci.ac.uk/download.php?file=/images/project/132075187126.pdf>

<sup>5</sup> For more information: Office for Life Sciences (2011). *Strategy for UK Life Sciences*.

<http://www.bis.gov.uk/assets/biscore/innovation/docs/s/11-1429-strategy-for-uk-life-sciences>

to the national priorities set out by HEE, which in turn will be informed by the Centre for Workforce Intelligence and nationally determined healthcare priorities.

12. More specifically, HEE must be able to manage overall trainee numbers on a UK-wide basis. For example, it should provide indicative numbers for professional training. This is particularly important for medical specialties, where the planning cycle needs to take account of the length of medical training (typically 14+ years from entry into medical school) and the need to sustain critical mass in small volume but crucial areas (e.g. community paediatrics, medical ophthalmology, allergy, public health).

#### ***Local education and training boards***

13. LETBs must remain responsible and answerable to HEE. National priorities and needs must be able to shape local education and training plans: ideally LETBs should operate as 'sub-HEE boards' rather than independent legal entities, while still having the autonomy to be responsive to local training and health service needs. LETBs should report to HEE and be responsible for commissioning education and training, and for monitoring the quality of delivery. Education providers will in turn bid to the LETBs and this forms the key purchaser/provider split.
14. A single model for LETBs should exist to enable consistency across the country. Neither universities nor health service providers are truly independent. Thus, the only option to minimise conflicts of interest is to place academic-health alliances at heart of LETBs.
15. LETBs must be robustly independent of both employers and HEIs, to hold them to account effectively. Individuals on the board must operate independently of the Trust(s) and HEIs that nominated them.
16. The boards must be sufficiently small to ensure functionality; we suggest a maximum of 11 members. They should have an independent Chair and a balance of executive and non-executive members. Full representation of all stakeholders cannot be achieved and would stifle effective board function, but this board membership must include individuals from service providers, HEI and Deaneries.
17. The executive arm should consist of a paid LETB Chief Executive and Financial Director, with the balance of the board being non-executive members drawn from HEIs and health service providers, including the Postgraduate Dean.
18. LETBs should support the current work of the postgraduate deaneries that are responsible for the quality and delivery of medical training. Within the new arrangements Postgraduate Deans must retain significant independence from LETBs to allow them to move trainees from domains where training is below standard and to report concerns regarding the quality of training to the regulators. The individual responsible for heading up the provider function of postgraduate deaneries should be employed within a university.
19. LETBs must operate in a way that encourages flexibility throughout the career pathway. The Academy regards the need for a flexible workforce that can adapt to the ever changing scope of health care delivery as essential. As such, there is no end-point to training and lifelong learning should be the accepted norm.

#### ***Funding***

20. It is essential that education and training budgets are of sufficient size to provide for high quality education and training across the full range of professions and specialisations. The

budgets allocated for both the training funded via HEE and the continued professional development supplied by service providers, should be ring-fenced to protect them from being diverted to meet short-term pressures of service delivery.

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### **The Academy of Medical Sciences**

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