hpc health professions council

Health Professions Council –20 May 2009

Reports from Council representatives at external meetings

Executive Summary and Recommendations

Introduction

The attached feedback forms have been received from the following Members of Council, reporting back from meetings at which they have represented the HPC:-

Professor Jeff Lucas
Mrs Jacki Pearce

Decision

The Council is requested to note the document.

Background information

None

Resource implications

None

Financial implications

None

Background papers

None.

Appendices

Copies of feedback forms

Date of paper

6 May 2009

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FEEDBACK SHEET TO BE COMPLETED AFTER THE MEETING

Name of Council Member	Jacki Pearce
Title of Conference/Meeting	ISBHaSC Board Meeting
Date of Conference	25-03-09
Approximate number of people at the conference/meeting	25

Issues of Relevance to HPC

1. The progress of the National cancer Data Set Review was discussed.
2. Consent issues: Some new proposed Standards are including a field to record "consent to share". However, ISBHaSC has concerns that this could mean, if each Standard is approved, a proliferation of " consent to share" mechanisms, which will not be interoperable. ISBHaSC proposal to suggest a continuation of current mechanisms to record "consent" e.g accepting implied consent, scanning paper consent forms etc, while NIGB formulate clear principles for an electronic consent mechanism.
   - NB " Consent to disclose implies a one way flow of information, "consent to share" implies a two way flow.
   - Boundaries (Who will get the information? How long should consent last?) need to be thought through.
3. Common User InterfaceStandards received conditional approval – conditional on consistant use of IAPT Guidance on Ethnic naming categories and NPSA guidance for patient name entries (i.e. first name/last name not given name/family name.
4. NHS Children's Service data set Requiement: Conditional approval if recommended changes to wording are made.
5. Proposed Standards for use of the NHS number in Adult Social Care were discussed. Currently all Social Services computer systems have the ability to use this identifier, approximately one third do so. ISBHaSC felt it was essential to clarify where the NHS number MUST be used in social care, where it MUST NOT be used, and where it may be used.
6. Jacki Pearce agreed to discuss with HPC whether new categories of staff in the " Improving Access to Psychological Therapy" would be regulated under HPC, when psychologists join the register.

Key Decisions Taken

Please complete as much of the above as you can and return by post to Alison Roberts, Council and Committee Secretariat, Health Professions Council, Park House, 184 Kennington Park Road, London, SE11 4BU, or alternatively by e-mail to alison.roberts@hpc-uk.org

February 2008

FEEDBACK SHEET TO BE COMPLETED AFTER THE MEETING

Name of Council Member	Professor Jeff Lucas
Title of Conference/Meeting	Universities UK Members' Meeting
Date of Conference	5 December 2008
Approximate number of people at the conference/meeting	
Issues of Relevance to HPC Please see attached.	
Key Decisions Taken	

Ensuring a Healthy Future

The University/NHS Relationship

1 NHS Foundation Trusts and Monitor
Dr Bill Moyes: CEO Monitor

The NHS is separating Purchasing and Provision, Purchasing being the responsibility of PCTs and Practice Based Commissioning from GPs using National Price Lists and standardised contracts. SHAs performance manage Purchasing and report directly to the Secretary of State. Provision will increasingly be provided by Foundation Trusts and Private Providers with autonomous Boards

The Comprehensive Spending Review identified a funding gap of 4% for the NHS services as are, and another 4.95% if Derek Wanlass' forecasts were taken into account, the pre-budget report has identified this as a £13 billion deficit.

There are now 112 Foundation Trusts with a turnover of £20 billion, these are Public Benefit Corporations accountable through Boards and Governors to

Parliament (not the Secretary of State). Monitor assesses FT applications, authorises them and where appropriate FT mergers. Monitor has a compliance role, assessing annual plans, risk rates their financial performance, controls their borrowing and can prevent the withdrawal of clinical services. Monitor can sack CEOs and set financial margins, at present FTs generate surpluses of around 5-8%. The future target (taken from the American Business Models) will be set between 10-15%.

FTs are required to Train and provide Training Placements, they are not required to do research although many do.

SIFT (Service Increment for Teaching) is to be replaced by Block Funding rebased at £35,000 per medical student per annum plus any other specific market force factors (London weighting), at present Norwich Teaching Hospital gets £10,000 per student per annum and Imperial gets over £100,000. This rebase and the removal of other anomalies will release funds for a non-medical SIFT for other MPET funded programmes (Nursing/AHPs) at around £100 per student per placement week. The FT SIFT allocations will, therefore, be used to serve a wider purpose.

FTs, although independent of the Secretary of State, are providing clinical and financial data to the DoH and apart from Southend, all are using national pay scales (Agenda for Change) and all are employing State Registered Practioners.

2 The Relationship Between the Health Service and Universities: Challenges and opportunities.
Prof Andy Haines: Chair of the UUK Health and Social Care Policy Committee

20% of universities' undergraduates are on 'Health' courses funded by MPET (Multiprofessional Education and Training) Levy worth £4.3 billion per annum. At present DH is forging greater functional links between the three funding streams within MPET namely SIFT, MADEL and NMET (Non Medical Education and Training) Levy. The primary driver is to provide equitable opportunities for CPD, which is still focused on Medical and Dental (MADEL) provision and Nursing from NMET. Nursing will become an all graduate profession and anomalies in Bursaries (Non-Means Tested for Diploma students, Means Tested for Degree students) will be removed.

Key Developments are: Medical Education England (MEE), a Non-Departmental Independent Advisory Board. The CEO will report to the Chief Medical Officer. MEE consists of HEFCE funded professions: Doctors, Dentists, Health Care Scientists and Pharmacists. It is assumed that they will have convergent CPD programmes around Public Health. MEE will also develop Modular Credentialing.

3 Next Stage Review (NSR)

The Darzi Report will also create a Non-Departmental Independent Advisory Board for the MPET funded professions, Nursing and AHPs.

HIECs (Health Innovation Education Clusters) will have delegated Education and Training authority from SHAs to directly commission a local workforce need or innovation in ICT or Pharmacy. Six expressions of interest have been received, 20 likely to be supported as early adopters in March 2009.

AHSC (Academic Health Science Centres) for World Class Research Centres forged between Research Intensive Universities and Foundation Hospitals. Based on Harvard, Karolinski Centres. Imperial has secured an AHSC status, about 5/6 others will follow.

Centre of Excellence for Workforce Planning

This WFP centre is currently being advertised. It will be linked to the Kings Fund and with SHAs around commissioning tomorrow's workforce. It will have an analytical function and will model future needs.

Health is Global
This is the Government's initiative to develop coherent policies across DIUS/DH and DFID. It will rebuild HEI/SHA relationships which were damaged by removing the need to have Academic Non-Executives. It will work to facilitate Dual Employment Status, Clinical Academics (HEIs/NHS).

4 Workforce Planning and Educational Commissioning
Julie Badon

6 Workstreams

1 MEE Advisory Board
2 N/AHP Advisory Board
3 WFP with Regional Advisory Boards
4 Education Commissioning and Provision, including HIECS
5 Education funding, Benchmark Price Review, MPET Review including SIFT and future placement funding, Value for Money Metrics

6 SHA Appointments, including Medical Directors and Clinical Excellence Awards

The Workforce Summaries

2007/08	*Attrition	°Wastage	^A VFM	WFP
Physiotherapy	7%	47% (12%)	61%	85% Female Net growth by 2015 47% Over 40 WFRT anticipates over supply
Diagnostic Radiography	35%	48% (10%)	31%	82% Female Net growth 19% by 2015 55% Over 40 PG Ultrasound needed
Therapeutic Radiography	50%	18% (6%)	41%	87% Female Net growth 30% by 2015 53% Over 40 WFRT anticipates supply imbalance
Occupational Therapy	15%	22% (10%)	81%	92% Female Net growth 25% by 2015 49% Over 40 PG needs around NSS and MHA
Speech and Language Therapy	10%	42% (11%)	62%	90% Female WFRT anticipates supply imbalance 51% Over 40 PG needs around NSS
Nurses	21%	45%	43%	

* Attrition = non completers as % of Education and Training Starters (Commissions)

° Wastage = % of Registrants not working in NHS (% of Registrants working outside NHS), in steady state. The % of completers who take a first post (first destination statistic is much higher; on average 90%).

^A % E/T starters (commissions) working in NHS as a % of return on investment VFM

NSS = National Stroke Strategy
MHA = Mental Health Act