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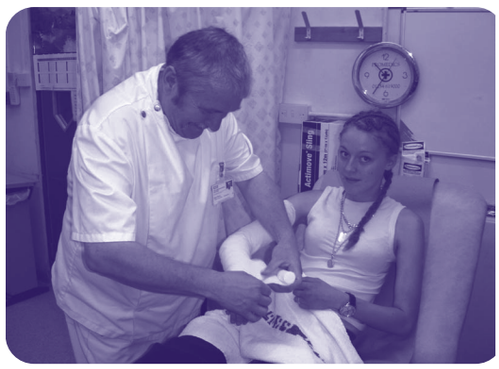

A Key Issues Paper: Underpinning the Future of Health Professional Education in the UK.

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Preface
by Sally Hunt, UCU general secretary

Understanding the central place that the NHS has as an expression of collective purpose, social solidarity and as a community good is crucial to understanding UCU's perspective of the UK's health system. Not only do our members employed in health professional education play a vital role in underpinning the NHS, they and their families are also users of the service.

When Strategic Health Authorities began to raid education and training budgets for short-term political expediency, we opposed it. Perhaps it is obvious that as a trade union representing those whose jobs are funded by these budgets, we would oppose measures that result in job cuts and increased workloads. We have become increasingly alarmed that plugging gaps in NHS funding with education and training budgets is having a cumulative, and damaging, effect on the UK's ability to train the next generation of key NHS health professionals. That is one of the reasons why UCU commissioned this report. It backs our view that the boom and bust approach in health education fails to heed the demographic predictions pointing to significant staffing gaps in the NHS equally apply to health profession education.

But we also wanted a report that looked beyond the two dimensions of existing staffing complement and funding; one that started to look at the bigger picture. There are a number of contemporary debates about the need to change the way that healthcare is provided; and we wanted to provide focus on what this could mean for the future provision of health professional education.

In this report, Professors Basford and Kershaw highlight the many developments that influence public policy towards the NHS. In addition they have produced a number of discussion points to stimulate debate among UCU members and those involved in the current debates at national level such as the NHS Next Stage Review led by Lord Darzi.

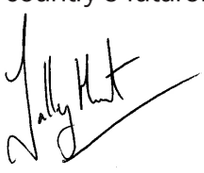
Clearly there are different perspectives on what the future may hold but, at the outset, let me make it clear that UCU will always stand-up for high-quality publicly funded and publicly provided services. We recognise that change is often desirable but we will oppose the linking of service re-organisation to proposals that seek to commodify, marketise, outsource or privatise our public services: education or health.

We all want our healthcare system to be efficient and effective. We want the NHS to be able to respond to the multiplicity of factors influencing how it functions. We do not pretend that there are easy answers but what is abundantly clear is that healthcare education is an essential component for any successful transformation in health service provision.

UCU has argued for:

- An expansion of the narrow operations focus on workforce planning mechanisms to include education and training needs;
- The direct involvement of stakeholders from the health professional education community in planning mechanisms;
- Health education and training budgets to be ring-fenced and, once set, under the strategic control of higher education funding bodies;

Whether you agree with us or not, please join the debate on this issue of crucial importance to our country's future.



Sally Hunt
General secretary
University and College Union

Contents

Abbreviations

CHI.	**Commission for Health Improvement**
CPD.	**Continuing Professional Development**
DH.	**The Department of Health, UK**
EBP.	**Evidence Based Practice**
ECTS.	**European Credit Transfer System**
EEA.	**European Economic Area**
EU.	**European Union**
ICN.	**International Council of Nurses**
ILO.	**International Labour Organisation**
IPL.	**Inter-Professional Learning**
ISTC.	**Independent Sector Treatment Centres**
KSF.	**Knowledge and Skills Framework**
NICE.	**National Institute for Clinical Excellence**
OECD.	**Organisation for Economic Cooperation and Development**
RCN.	**Royal College of Nursing, UK**
POC.	**Primary Care Organisations**
PROMS.	**Patient Reported Outcomes Measurement Systems**
SIFT.	**Special Increment for Teaching**
WHO.	**World Health Organisation**

Project Aims and Objectives

Project Aims:

To provide a synthesis of information that assists in the understanding of the key issues underpinning the future of health education.

Objectives:

- Identify domestic drivers for change, e.g. the type of health care required for the future; workforce changes
- Consider the international factors impacting on the provision of health care, e.g. Bologna.
- Signpost relevant issues emerging from the EU directives
- Provide a comparative study of funding sources against the MPET system
- Identify future models of health professional education and
- Explore other relevant public policy considerations.

Executive Summary
Introduction and Background

- According to the UK media the National Health Service (NHS) is in crisis and requires radical changes to be made with regard to service provision and the education and training of Health Professionals who operate within it.
- We can be forgiven for thinking that such calls for change are new and warrant urgent radical resolution. Upon examining the literature it became evident that a plethora of policy directives have been produced since the inception of the NHS in 1948. Demand for change has seemingly been a perennial feature of the NHS (Sines, 1995; WHO, 1978, & 1987; Parliament, (1990), DHSS, 1988; DH, 1983-2007b, Darzi, 2007) that has impacted on the ways in which health professionals are educated and trained.
- Currently, demands for change have been influenced by the impact on the advancements in health care technology and therapeutic interventions, changes in demography and epidemiology, health care as a global commodity, public scrutiny and demands, National, European and International policy, professional competency movement and financial imperatives that require fiscal savings whilst delivering quality care.
- The increased scrutiny of the NHS and the competence of its employees is directly related to repeated service failures that have been examined by the judiciary system and highlighted by the media, and a better educated and sophisticated public (DH, 2006a). On the one hand, this is a positive element ensuring patient's views are represented at every level of debate and policy formation and that true accountability is assured (DH, 2000c, Darzi, ibid). On the other hand there is a danger that changes have occurred not through a unifying strategy nor through thoughtful critical reflection or an eye to the future but as a reactive disparate programme of change that has not been fully evaluated or allowed to embed in practice before another round of changes are made, (DH, 2000a). This factor has recently been observed by Lord Darzi (2007) who states that the NHS is perhaps "*two thirds of the way through its reform programme set out in 2000 and 2002*" and any further changes should be limited in the knowledge that the workforce is disenfranchised with perpetual change that not only impacts on service delivery but also on the education and related funding of clinical staff.
- Within the changing nature of health care provision there is a need to ensure that there are sufficient numbers of health professionals who have the competence, confidence and capacity to deliver care of the highest standards within dynamic and cultural sensitive structures, (DH 2007a, Tooke, 2007).
- This is of major concern to educational institutions and workforce planners who have to establish the skill mix required and appropriately design and implement curricula that meet contemporary requirements.
- The nature and scope of workforce planning is a complex phenomena requiring sophisticated tools and mechanisms through which information can be analysed. Attention must be given to the international mobility of health professionals and their levels of competence to practice, the demographic nature of the population and increasing ethnicity that will both impact on service delivery and demand. Furthermore thoughtful consideration is required regarding the demographics of the workforce.
- The last few decades have drawn attention to the fitness for practice and fitness for purpose debates to ensure that the health professional workforce is competent to practice at the point of registration and that their level of competence is upheld throughout their working lives (Basford, 2003, UKCC, 1999, & 2000b, 2001). This is not without challenges in that most of the health professional clinical experience is focused in hospital acute care settings which is juxtaposed

towards the increasing demand for competent health professionals to work across boundaries, in new settings and in primary care (DH, 1997, 1988a, 1999a, 1999b, 200c, 2001; 2006 a,)

- There have been repeated calls for health professional education and training to address the competency deficit. However, this has been compounded by the need to reconfigure funds from hospital services to a growing primary and community care sector and the lack of suitably prepared mentors, placement experience, and lecturers (Longley et al, (2007).
- Clearly, the pursuit of clinical excellence in the delivery of health care must be everyone's focus. However, this cannot be achieved if the workforce lacks the capability and capacity to deliver. Therefore it is essential that education and training institutions play a pivotal role.

  The Government is pressing for improved skill mix and efficiency through the development of new roles and new ways of working (DH 2001b, 2007e). Therefore, attention should be given to the following questions:

  - What are the changes needed to the roles and responsibilities of health professionals working within a reformed health care system?
  - What changes are required to the standards, kind and content of education and training programmes both at the pre-registration and post- registration levels?
  - How should health professional education be commissioned and funded?
  - What data should be collated, analysed and synthesised to arrive at a coherent decision regarding workforce planning that reflects a 5-10 year projection?
  - In the new agenda for change, what is required of regulatory bodies and quality agencies?
  - Should the health professional workforce be treated as a commodity that responds to political change and global markets?
  - What are the competencies and career structures needed for health professional educators?
  - What impact will migration, EU and International Directives have on Education and Training Institutions?

Executive Summary
Summary of Key Issues and Challenges

NB. The Key issues and challenges presented below are taken from the discussions that are addressed in the main document and for further explanation should be read in conjunction.

Domestic Drivers of Change

- Continuing inequalities in health
- Repeated service failure
- Pursuit of clinical excellence
- The need to increase efficiency and effectiveness of health care, whilst addressing the fiscal consequences.
- Demography and epidemiology
- Advancements in technology and therapeutic interventions Genetic engineering, Telecare, integrated medicine.
- A shift in the balance of power: patient, and consumer influence and an increasing focus on Primary Care.
- Shifting paradigms regarding health and health care practice such as the move towards a primary care led NHS.
- Changing emphasis on workforce roles and responsibilities, the need for skill mix and a new genre of Health professionals.
- The need for a sophisticated model of workforce planning that addresses changing models of practice
- The notion of shared Governance.
- The complexity surrounding Regulation.
- The move towards a patient centred approach using a multi-professional and multi agency model.
- Increased integration between the NHS and the Independent, Private and Voluntary sectors.
- The need for leadership.

EU Directives and significant policy initiatives

- The implication of Bologna/ Tuning have a serious impact on health professional curricula.
- Attention must be given to the design and amendments to curricula to accommodate the Declaration's requirements especially as this affects the nursing diploma/degree and specialist/generalist debates
- The free movement of all health care workers within the EU will continue to add external and internal pressures.
- Universities will need to address ECT and their implications.
- Consideration will need to be given to Inter-professional education.

Health Professional Migration

- The global shortage of nurses and other health professionals will continue to rise in the foreseeable future.
- There remains an international imbalance in the health professional workforce between developing and developed nations and between rural and city areas.
- Health Professionals are an important global commodity which boosts the economy and meets health targets of developed nations and provides financial stability for donor countries from migrant workers.
- There are international concerns regarding the ethical issues underpinning health professional migration.
- Given the increased global need for a competent health professional workforce there are calls for international standards relating to education and training.
- Ease of Health Professional migration is improved through trade agreements between governments which address the requirements of professional regulatory bodies.
- There are positive benefits to Health Professional migration both in terms of financial reimbursement, and knowledge and skill enhancement/ dissemination that can be used to promote clinical excellence in both the donor and host countries.

Health Care Education and those who Teach

- As with the health professional workforce, health educators are an ageing community and during the next decade a large percentage will retire. This will undoubtedly put a strain on the capacity and capability of the lecturing community to fulfil its obligations to teach a new genre of health professionals. It is therefore incumbent on Universities, service providers and workforce planners to address career pathways that would facilitate expert practitioners disseminating knowledge and facilitating learning to a range of student groups.
- Without a doubt the complexity and cost of developing a changing workforce involving inter-professional and interagency teaching cannot be underestimated. The issues include:
    - Developing compatible Human Resource policies, Regulatory Frameworks and Quality Standards around the recruitment, preparation and updating of staff.
    - Ensuring equitable pay, conditions of service, pensions and transferability of pensions between NHS, HEI's and Social Services.
    - As the NHS and Social Care sector increasingly place patients and clients in the Independent and Voluntary sectors their incorporation into any plan will need addressing.
    - Flexibility of career progression.
    - How non Health and Social care staff will fit the new structures.
    - Over and above this are the problems of devolving SIFT (Special Increment for Teaching) and equitably sharing funding that for many years has favoured the teaching of Medical and Dental students.

Health Professional Regulation

- Should all healthcare professionals share the same regulatory body?
- How are Health support workers to be regulated?
- How do we regulate for new roles and those who work inter-professionally and across boundaries?
- How non health care professionals are regulated who have access to patients/clients (ie Managers)?

Workforce Planning

- To develop a competent workforce planning team with the capacity and confidence to fulfil the task in hand.
- To ensure that the workforce planning team are able to understand the internal and external factors that impact on the needs of a newly reformed and dynamic health service.
- That the team have at their disposal sophisticated systems that can collate and maintain intelligent data and can assist in futuristic modelling highlighting the consequences of action.
- Operate within a fully integrated system between medical and non-medical staff groups including a single financial framework which fully involves the independent sectors.
- Accurate short term planning is a requirement, but so too is the need to develop a formal long term planning perspective, particularly with regard to education and training needs.
- Ensure that there are sufficient Health educators who have the competence and capability to facilitate new ways of learning for a transformed service.
- Effectively produce more flexible education and training capacities that are responsive to service demand, and which better recognise the lead in time for education and training.
- Producing a workforce who can more readily accommodate flexibility and transferability of skills as a pre-requisite requirement within transformed and transforming organisations. This can only be done through the process of education and training and adequate mentoring if patient safety is to be upheld. (It is suggested that the competency framework can assist in this process (HOC, ibid)).
- Stepping on and stepping off programmes through a modular education and training framework would enable greater flexibility and empower individuals to engage in career progression from care assistants to expert or advanced practitioner status. Thus maximising potential on human resources.
- Increasing productivity of staff can be achieved through the proper use of KSF (the Knowledge and Skills Framework) and the recently introduced, '*Better care, better value*' indicators which highlight the need for education and training.
- Ensure the workforce can work across and between organisational boundaries, including a greater emphasis on primary care.
- Address the issues of recruitment and retention of staff.
- The Quality and Outcomes framework should be used to improve targets and to measure the standards and performance of all staff.
- Review, and if necessary, reform education and training.

- Serious appreciation needs to be given to the statements of Darzi and others regarding the damage the constant cycle of reform is causing including adding to the complexity of accurately predicting workforce needs and education and training. HOC (ibid) Darzi (ibid) and others state that a period of stability should be considered so current changes can be actualised and evaluated for efficiency, effectiveness and economy.

MPET System/Alternative Models

- Funding/Contractual arrangements for MPET(Multi-professional Education and Training) programmes need to be aligned with those for other courses to better enable Universities to manage these courses.
- Non Medical Healthcare lecturers should be paid the clinical lead when they contribute to direct care teaching in hospital or community.
- Health care communities that support students should have access to the SIFT budget.
- The payment of bursaries/awards should be equitable for all healthcare students regardless of professional course or level of qualification and should follow a through review of student status and funding.

Executive Summary
Summary and Discussion Points

- The nature of health care provision in the UK is a highly complex phenomenon that responds to local, national and international policies resulting in a cyclical change process that has no beginning and no end. Whilst this comment can be viewed as facetious it does underscore the feelings of many health professionals who carry out their duty to care in the midst of such uncertainty. Their position is a one of constant challenge and their professionalism is to be commended.
- Current debates have called into question the competence and readiness of the health professional workforce to accommodate change whilst continuing to provide quality care and seek/achieve excellence. Fitness for practice and fitness for purpose debates abound and continue to make demands on the curricula and education provision.
- The shift in emphasis on care delivery from acute to primary care settings has, and will continue to have demands on the preparation of the workforce. Whilst this is not new its high political profile suggests the need for key stakeholders to give this issue due attention.
- The following discussion points, whilst not exhaustive, have arisen from the paper and are highlighted to stimulate further debate. Others will have ideas which widen and broaden the discussion and add value to the final document. Furthermore the results of currents debates at national level, such as the Darzi review will demand further consideration.

Discussion Points

- This paper has raised many issues that warrant further consideration by the group of professionals or whom they are most important before it can be considered a finished document. Many of these issues are interlinked and interwoven so cannot be dealt with in isolation.
- An attempt has been made to summate the main issues under five headings. All are open to further expansion and debate. They are in no particular order.

Education

- Healthcare education is essential to the continuation of Healthcare delivery, and those who teach are a valuable resource. Points to consider:
  - Funding, from DES or DH? Direct to Universities or through contracts developed with SHAs, the DH or “new” groups? How are numbers to be linked to accurate workforce planning?
  - How do we support the wider entry gate?
  - How can the Inter-professional learning agenda best be addressed? Is it the best way of preparing undergraduate students for practice?
  - How are students to be funded? Do we pay all Healthcare students bursaries? Should these all be means tested? Are there other ways to fund that should be considered? Should they continue to be exempt from fees?
  - What should be the level of Qualification and Award? How should recently qualified staff be supported in practice?
  - How should the new generation of Teachers be prepared?
  - How much attention should be paid to EU directives/Bologna?

Environment

- Education needs to prepare students for constant change, in the way care is delivered and the population who use our services. Added to that Darzi reminds us that all aspects of the NHS have been subject to ever-increasing Government control (including the Universities who provide Healthcare Education). Points to consider:
  - How are students to be prepared for the move from Acute to Primary Care?
  - How can they be best prepared to care for the ageing community?
  - How is the expected shortage of healthcare workers, due to the ageing workforce, best addressed?
  - In-equalities in Health can be often related to environmental issues, eg poverty.
  - How can we help students address the public health agenda?

Equity

- The issue of equity affects all aspects of health and social care, those who learn and teach the subject and, of course those who use the services. Points to consider:
  - Access to service delivery, free at the point of delivery.
  - How do we prepare students to work in an environment where services are said to be subject to inequalities based on, for example, age, post-code, ability to travel?
  - Widening Access for students entering undergraduate courses, using APL/APEL for those seeking graduate programmes and for recognising overseas/EU applicants' qualifications. Is "Bologna" a help or a hindrance? Do we really understand the implications? Are our Universities ready?
  - Inter-professional learning means staff on different salary scales are teaching the same students. This affects pensions too. Placement providers receive money (SIFT) for some students but not others, those who teach our students in practice are also paid differently. Lecturer's roles are changing, bringing added responsibilities. Should we be looking to standardise all Healthcare lecturers on the same scales? What about security of employment? Does experience, especially with the raiding of the MPET budget and the resultant reduction in teaching posts mean non medical and dental lecturers are more secure? How do we ensure equity in Career progression?

E-Technology

- Perhaps the major growth area in Health of the next decade.
- Are lecturers "up to speed" to use and teach this tool.
- We are required to teach aspects of genetics and Nano-Technology. How do lecturers acquire the skills and knowledge not just to teach the subjects but to relate them to change in practice?
- What is the best way of integrating simulation into the curriculum?
- Who will fund all this development?

Expectation

- Everyone expects more, from the NHS, from Governments, from HEIs. How can students be best prepared to meet the following expectations?
- Patient focussed services.
- UK wide standards delivering a seamless service.
- Safe competent practitioners who can work within a constantly changing environment, a multi cultural society and one that is ageing.
- How are these practitioners to be regulated? One body, or separate ones? Who regulates HCAs?

Section 1
Methodology, Introduction and Background

1. Methodology

- The commission was to address the following questions: What are:
  - The key domestic drivers for change; e.g. the type of health care needed and the workforce changes and public policy considerations necessary to deliver it.
  - The international drivers impacting on the provision of health care;
  - The relevant EU directives that impact on education.
  - The funding issues relating to MPET and how these link to he future needs of health professional education.
- A literature search was undertaken of relevant and contemporary papers and policy documents. In addition advice was sought from experts regarding the literature review and issues of finance, funding and policies. Some have also reviewed the penultimate draft to ensure meaning and accuracy of content has been maintained during the synthesis of information.
- The main limitations were due to the tight deadlines, the volume of material to be reviewed, and the fact that current debate re future is still ongoing. Nonetheless, we believe that a synthesis of the key issues has been elaborated on within this document through which debate can be manifested.
- Throughout each section, a summary of the 'key issues' have been identified to offer a clear and concise perspective for the reader.
- An executive summary has been produced highlighting the key issues to be addressed.
- The final document is in '*Word File*', made available via electronic file to Michael MacNeil, Assistant General Secretary, University and College Union.

2. Introduction and Background

- According to the UK media the National Health Service (NHS) is in crisis and requires radical changes to be made with regard to service provision and the education and training of Health Professionals who operate within it.
- We can be forgiven for thinking that such calls for change are new and warrant urgent radical resolution. Upon examining the literature it became evident that a plethora of policy directives have been produced since the inception of the NHS in 1948. Demand for change has seemingly been a perennial feature of the NHS (Sines, 1995; WHO, 1978, & 1987; Parliament, (1990), DHSS, 1988; DH, 1983-2007b, Darzi, 2007) that has impacted on the ways in which health professionals are educated and trained.
- Currently, demands for change have been influenced by the impact on the advancements in health care technology and therapeutic interventions, changes in demography and epidemiology, health care as a global commodity, public scrutiny and demands, National, European and International policy, professional competency movement and financial imperatives that require fiscal savings whilst delivering quality care.
- The increased scrutiny of the NHS and the competence of its employees is directly related to repeated service failures that have been examined by the judiciary system and highlighted by the media, and a better educated and sophisticated public (DH, 2006a). On the one hand, this is a positive element ensuring patient's views are represented at every level of debate and policy formation and that true accountability is assured (DH, 2000c, Darzi, ibid). On the other hand, there is a danger that changes have occurred not through a unifying strategy nor through thoughtful critical reflection or an eye to the future but as a reactive disparate programme of change that has not been fully evaluated or allowed to embed in practice before another round of changes are made (DH,2000a). This factor has recently

been observed by Lord Darzi (2007) who states that the NHS is perhaps "*two thirds of the way through its reform programme set out in 2000 and 2002*", and any further changes should be limited in the knowledge that the workforce is disenfranchised with perpetual change that not only impacts on service delivery but also on the education and related funding of clinical staff.

- Within the changing nature of health care provision there is a need to ensure that there are sufficient numbers of health professionals who have the competence, confidence and capacity to deliver care of the highest standards within dynamic and cultural sensitive structures (DH 2007a, Tooke, 2007).
- This is of major concern to educational institutions and workforce planners who have to establish the skill mix required and appropriately design and implement curricula that meet contemporary requirements.
- The nature and scope of workforce planning is a complex phenomena requiring sophisticated tools and mechanisms through which information can be analysed. Attention must be given to the international mobility of health professionals and their levels of competence to practice, the demographic nature of the population and increasing ethnicity that will both impact on service delivery and demand. Furthermore thoughtful consideration is required regarding the demographics of the workforce.
- The last few decades have drawn attention to the fitness for practice and fitness for purpose debates to ensure that the health professional workforce is competent to practice at the point of registration and that their level of competence is upheld throughout their working lives, (Basford, 2003, UKCC, 1999, & 2000b, 2001). This is not without challenges in that most of the health professional clinical experience is focused in hospital acute care settings which is juxtaposed towards the increasing demand for competent health professionals to work across boundaries, in new settings and in primary care (DH, 1997, 1988a, 1999a, 1999b, 200c, 2001; 2006 a).
- There have been repeated calls for health professional education and training to address the competency deficit. However, this has been compounded by the need to reconfigure funds from hospital services to a growing primary and community care sector and the lack of suitably prepared mentors, placement experience, and lecturers (Longley et al (2007).
- Clearly, the pursuit of clinical excellence in the delivery of health care must be everyone's focus. However, this cannot be achieved if the workforce lacks the capability and capacity to deliver. Therefore it is essential that education and training institutions play a pivotal role and attention should be given to the following questions:
    - The Government is pressing for improved skill mix and efficiency through the development of new roles and new ways of working (DH 2001b, 2007e). Therefore this raises questions with respect of what are the changes needed to the roles and responsibilities of health professionals working within a reformed health care system?
    - What changes are required to the standards, kind and content of education and training programmes both at the pre-registration and post- registration levels?
    - How should health professional education be commissioned and funded?
    - What data should be collated, analysed and synthesised to arrive at a coherent decision regarding workforce planning that reflects a 5-10 year projection?
    - In the new agenda for change, what is required of regulatory bodies and quality agencies?
    - Should the health professional workforce be treated as a commodity that responds to political change and global markets?
    - What are the competencies and career structures needed for health professional educators?
    - What impact will migration, EU and International Directives have on Education and Training Institutions?

Section 2
Domestic Drivers for Change.

1. The Principles of the NHS

- The National Health Service (NHS)- Britain's flagship institution was conceived by Bevan in 1948 to provide equality in access to health care, free at the point of delivery, in an attempt to eradicate the 'five giants' of want, disease, ignorance, squalor and idleness. Since its creation, the NHS constitution has been rapidly internalised as a utopian health model for others to emulate and is ingrained in the British psyche and cultural expectations. But despite the rational behind its inception, the NHS has failed to destroy the giants that it set out to conquer 60 years ago.

2. The Need for Health Reform

- Although many of the deadly diseases prevalent in the first half of the 20th Century have been eradicated, due in part to an improved environment, clean water and sanitation, advancements in treatment regimes and technological advancements, elements of the five giants remain. Rather than health improving on an equitable basis, major inequalities continue to exist, particularly between social classes (DH, 2000a, 1997, 2004). Renamed and revamped the contemporary five giants of poverty and inequality in employment, education, social and physical environment persist as the major causative factors of poor health and they remain key targets for the government to address. (DH, 2000a,c; 2003b; 2004b).
- The failures of the NHS can be attributed to:
  - A high focus and associated high costs of a curative and restorative model that was engineered around hospitals rather than preventative models that were population focused and delivered within the aegis of Primary Care.
  - Demographic and epidemiological changes.
  - Lack of competence and capability in the workforce to deliver high quality health care in a backdrop of incessant change, and the failure to effectively work together to improve health outcomes.
  - Conflicting political ideologies (DH, 1998 & 2001a).
  - Lack of leadership and strategic direction.
  - Insufficient human and fiscal resources.

3. In Pursuit of Excellence

- Seeking to improve quality and achieve clinical excellence has increased the need for clinical evaluation and audit to assure organisation and professional accountability (Scally & Donaldson, 1998, DH, 2000a, 2007a, HoC, 2007).
- Clinical Governance has become a standard feature of the NHS through which all aspects of care can be examined that includes the monitoring of health outcomes, the competence of the clinical workforce and the coordination, communication and unification of services that enhance the patient's journey and experience (Commission for Health Improvement, DH, 1998).

4. Fiscal Management

- The growth of services and the rising costs associated with salaries and the delivery of health care has exponentially increased since the humble beginnings of the NHS. Successive governments have attempted to manage the Health Care budget through the examination of waste and control of expenditure. More recently, the slogans of increasing efficiency, effectiveness and economies have been government mantras in the guise of streamlining the health service in readiness for the population health needs of the 21st century.

- Reducing health care costs are proverbial requirements of governments. This has led to organisational changes, role changes, attention to increasing skill mix of the workforce and health care rationing.
- Health care rationing is always contentious, but as technology and therapies continue to evolve the ethical and moral imperatives associated with rationing are highlighted by the media. Currently, rationing is addressed through the position of evidence through which the NICE rejects individual interventions according to efficacy and cost implications. Another way is to define the functions of the NHS in specific terms that excludes areas that do not fall into its jurisdiction (Longley et al, 2007). Such approaches will continue for the foreseeable future often compromising the ethical standards and codes of conduct of the health professional workforce.

5. Advancements in Health Technology and Therapeutic Interventions

- The last few decades have led to changes in health care brought about by scientific discoveries, advancements in health technology and therapeutic interventions. All of which has impacted on the competence and capability of the health professional workforce and their roles and responsibilities. It is a position that will continue as knowledge continues to advance. Of particular note is the developments in genetic engineering; Tele-care, bio-technology; and integrated therapies. The DH has produced a Genetics white paper that calls on all health professionals to build a genetic knowledge infrastructure by 2015.
- The delivery of care will also be facilitated through the use of technology through the medium of Tele-care (Building Tele-care in England, DH, 2005). The DH believes that 35% of older people could stay in their own homes through the use of Tele-care. Based on this proposition it is assumed these services will expand by 2015. In addition there will be more emphasis on advancements made in bio-technology and bio-engineering and robotics.
- The growth towards integrated medicine takes the view that traditional and complementary therapies can affect positive patient outcomes whilst also achieving a greater freedom of patient choice within a multicultural society.
- Genetics, Tele-care and Integrated Medicine has, and will continue to make demands on health professional curricula and the range of competencies required of the health professional workforce.

6. Public Involvement and Power Politics

- Despite its prominent stature as part of the British constitution, the NHS is under attack from the British public who are becoming increasingly sophisticated and informed consumers (Baggott, 2000).
- Empowerment of the public and implementation of public health and community perspectives are argued to shift the balance of power towards local communities, so that they reconnect with their services and have real influence over their development (DH, 2002a). Concordance with these strategies can be demonstrated by initiatives such as the Expert Patient Programme, Information for Patients and Public (IPP), and the commencement of the Patient Advice and Liaison Services (PALS). More recently policy documents such as, 'Our Health, Our Care, Our Say' (DH, 2006) illustrate the development of people power. The 'personal' is now 'political' and increasingly communities, pressure groups and individuals have the potential to influence change (Baggott, 2000).
- The major tensions within the NHS are between those who provide, those who deliver, and those who consume, and the inherent struggles within the organisation and attempts to overcome them

endorse the NHS as a major political tool and a vital component of the electoral manifesto (Baker, 2000).

- Notwithstanding the above, radical reform needs joined up thinking, adequate resources and a competent, capable workforce who have the capacity to work flexibly across multi-agencies and within multi-dimensional teams.
- The Labour Party has repeatedly promised to invest in, modernise and restore public confidence in a health service that is fit for the 21st C. The publication of "A New Modern Dependable NHS" (DH, 1997) heralded the beginning of the reforms that the British public are currently experiencing. This agenda incorporates modernisation (DH, 2000a), increases in the Public Health function of the NHS (DH, 1998a), quality improvements (DH, 1998b), and patient and public empowerment (DH, 2004, 2005, 2006a, 2006b).
- Part of the reform agenda was the need to re-orientate the deployment of resources, with increasing emphasis placed upon Primary Care Organisations (PCO), to provide increased and diverse health care services and Health Promotion/Improvement (DH, 1999a, 2000, 2001b & HC, 2006-2007).
- Under the current NHS reforms, PCO's have become the centre of health care delivery with revenue allocation being placed directly with Primary Care Trusts rather than Strategic Health Authorities in England (Elsewhere funding is dispensed in a variety of ways centrally).
- The core functions of the PCO's are to assess local need, secure health services and improve health through partnerships forged with local communities, local government and other PCT's (DH, 2002a).
- Increasingly, as Primary Care Trusts have evolved the core functions have been translated into organisational development strategies linking local need to service planning, commissioning and delivery.

7. From Cure to Prevention

- The NHS has supported and developed General and Specialised services that adhere to the principles of caring for people with acute (secondary) intervention needs or with the demands of long term or terminal care needs. It is an individualist approach that does not address the causative factors of disease, or promote population health. More recently, there has been a pragmatic approach levelled at shifting 5% of hospital activity yearly into primary care (DH, 2006a).
- The shifting or blurring of boundaries and activities is underscored by the need to have increased capacity and a workforce that is capable of undertaking new roles within the Primary Care sector with a focus on preventative models of care (DH, 2004, DH, 2006c). NHS employers stated clearly that *"……. will require expansion of numbers of staff working in public health and new roles such as personal health trainers and care navigators…"* (DH, 2006a). Most importantly it will require careful consideration relating to workforce planning which considers redistribution of staff from Acute to Primary Care settings, advancement/change in roles and responsibilities with attention to the demands made upon educational establishments and their academic workforce.
- The concept of Public Health (Population Health) has an established history in the domain of societal development and health care delivery. In this sense public health is not a new concept however, over time the focus has changed. Today, health care practitioners will be more familiar with the definition offered by Acheson (DH, 1998a) that discussed public health as both the science and art of disease prevention using the organised efforts of society to promote health and thus prolong disability free and an enhanced quality of life.
- Several recent drivers have influenced and made demands for organisational change. These include: the White Paper: New, Modern, Dependable (DH, 1997), Saving Lives: Our Healthier Nation (DH,

2000b); Making a Difference (DH 2000d) The Acheson Report, (DH, 1998a); A Health Service for all the Talents: Developing the NHS Workforce (DH, 2000c); The NHS Plan (DH 2000a), The Public Health Practice Resource Pack and the Health Visiting and School Nurse Tool Kit (DH, 2001b); Liberating the Talents: Helping Primary Care Trusts and Nurses Deliver the NHS Plan (DH, 2002); Modernising Nursing Careers: Setting the Direction (DH, 2006), and Workforce Planning (HC, 2006-7).

- The government clearly aims to make the patient the centre of public health delivery and for this to happen practitioners require a number of skills (DH, 2000a & 2005; NHS, 2006). These skills will include the ability to undertake health needs assessment and audits, to use research skills, manage risks, demonstrate leadership, empowering others, networking, demonstrating self-awareness, social awareness, being a change catalyst, conflict management and conflict resolution, team working, working across boundaries and collaborative working. In addition, staff should focus on the needs of vulnerable groups and respond to the Clinical Governance agendas (DH, 2007c). Notwithstanding the above, there is a need to understand the requirements of Health Improvement agendas at both national and local levels, whilst encouraging and maintaining open access to data and the provision of statistical and epidemiological information that will aid understanding of the population's health profile and subsequent health needs.
- Promoting positive life styles, changing negative behaviours and improving living conditions constitutes the frameworks through which Public Health policy and interventions are conducted. More specifically the DHSS (1998) has proclaimed that the art and science of Public Health was to *"….prevent disease, prolong life and promote health through organised efforts of society"*. The emphasis on community and societal engagement distinguishes the difference between preventative medicine and 'curative' secondary intervention.
- Change in the function and effectiveness of the NHS, particularly in relation to health improvement and disease prevention does not rest solely in the hands of government or health care workers. Health care philosophy and activity has migrated away from the paternalistic provision of secondary services towards the adoption (for all) promotion programmes influenced by organisations such as the World Health Organisation (WHO), the Ottawa Charter (1986 &1998) and the European Union Treaties for Health, and the impact of the Human Rights Act (HMSO, 1998).

8. Human Resource and Workforce Planning

- The reality of the existing structural climate within the NHS means that if key targets set out within documents such as Saving Lives (DH,2000b), A First Class Service, (DH,1998b), and Shifting the Balance (DH, 2002a), are to be achieved then human resource management will have to improve at all levels of the organisation. Attention needs to be given to the whole framework of the workforce, i.e. numbers, skill mix, roles and responsibilities, leadership, management, education and training, team working, shared accountability, demographics, career structures etc, whilst decommissioning existing structures, roles and responsibilities (DH, 2000a, 2001c, 2006).

9. Role Changes

- The dynamics of change have necessitated the expansion of roles and in some instances the reduction of roles. For example, it is proffered that within the next 5-10 years much of the General Practitioner's work-load will transfer to nursing (DH, 2002a). This implies activities such as triage, prescribing and consultancy roles for nurses and other health professionals will continue to increase. However, in the thrust to make changes happen the DH, (2001d) has stipulated that the Agenda for Change must not unnecessarily create casualties and attention should be given to minimise the effect of change through the offering of support, education and training and career counselling.

10. Working Across Boundaries

- Working across boundaries e.g. between primary, secondary and tertiary settings, and between the commercial, independent, private and voluntary sectors has required greater understanding of the need to ensure the patient's journey and experience is the best. In achieving this it is required that health professionals have the skill and capacity to work across boundaries in a 'seamless' manner through an increased coordinated and team approach.
- There is an increase in commissioning and outsourcing of health care with organisations such as the Independent Sector Treatment Centres who adhere to standards and governance policies akin to the NHS but the partnership arrangements are not without challenges. Whilst these experiential arrangements have evolved the future model (s) for the Health Service remains unclear. However, there have been calls for unification under the auspices of an NHS corporation or commissioning by local government (Edwards and colleagues, 2007, HC, 2006 -2007).

11. Health Professional Regulations

- Historically, the evolution of health professional bodies has focused on their own discipline both for the purposes of education and training, codes of practice and political rhetoric. More recently there has been a call for unification that is still to be manifested in reality based on the premise of improving patient safety. In the 2007 Professions white paper it is highlighted that employers will be required to take an active and major part. Nonetheless, the debates continue with questions been raised regarding, the role and functions of Health Professional Regulatory Bodies in a new and much changed world.

12. Leadership

- The government has recognised the value of effective leaders who can maximise change whilst minimising the adverse risk of demoralising staff in the process. Indeed the Department of Health in Modernising Nursing Careers (2007), have called for new healthcare graduates to have leadership qualities and competencies and for those in employment to have suitable leadership training with an increased emphasis in leading multi-professional groups with various skills. Over the last decade there have been a significant number of nurses and other healthcare managers who have undertaken the national leadership programmes. Currently, the Tooke report (ibid) is calling for management and leadership training within the undergraduate medical curricula. This already forms part of many other relevant studies.

13. Concluding Remarks

- Reform of the NHS in some form or other has been an ongoing feature since its inception. What is of particular relevance now is the nature and velocity of change that is directed through a plethora of policies geared to engender change to meet health service demands of the 21st Century. which are economically sustainable whilst promoting the health and well being of all British citizens regardless of race or creed.

Summary of Key Issues and Challenges:
Domestic Drivers of Change

- Continuing inequalities in health
- Repeated service failure
- Pursuit of clinical excellence
- The need to increase efficiency and effectiveness of health care, whilst addressing the fiscal consequences.
- Demography and epidemiology
- Advancements in technology and therapeutic interventions - Genetic engineering, Telecare, integrated medicine.
- A shift in the balance of power: patient & consumer influence & a focus on Primary Care.
- Shifting paradigms regarding health and health care practice: eg. A move towards a primary care led NHS.
- Changing emphasis on workforce roles and responsibilities, the need for skill mix and a new genre of Health Professional and the need for a sophisticate model of workforce planning that addresses:
    - Changing models of practice
    - The notion of shared Governance.
    - The complexity surrounding Regulation.
    - The move towards a patient centred approach using a multi-professional and multi agency model.
    - Increased integration between the NHS and the Independent, Private and Voluntary sectors.
    - The need for leadership.

Section 3
International Perspectives

1. Introduction

- The geographical size of planet earth has, in a virtual sense, decreased due to our increased relationship, interconnectivity and interdependence with, and between, communities and nations. Various discourses refer to the notion of global markets that are debated in the context of social capital, social justice, moral and ethical imperatives, social economics, and more recently, the issue of public health and public safety. The argument offered is that as humans have evolved so too has the pluralistic and sophisticated nature of societies that allows for the growth in cultural diversity and religious beliefs (Basford & Dann, 2002).
- The UK is a partner in such societal changes and is said to be the largest multi-cultural and multi-racial society in the EU. This position offers challenges to the ways in which the health service is delivered and to the availability and competence of the health professional workforce to work with diversity in a non judgemental and anti-discriminatory manner.
- It is argued that societal changes are due in part to the advancement in technological communications, increased social mobility and social economics. Other reasons relate directly to individual needs and desires, social displacement or escapism from the effects of sustained wars and political unrest.
- More recently, encouragement and greater assistance in the migratory process has been influenced by the lowering of trade barriers, removal of capital controls and liberalization of foreign exchange restrictions (Martineau et al. 2002). In particular, the influences of the North American Free Trade Agreement and those of the European Union have been instrumental in encouraging increased migration in the spirit of free market enterprise and increased employment opportunities, (Woodward, et al, 2001, Kingma, 2007). The business of health care is without doubt a global and fundamental part of social (global) exchange, be it for raw or manufactured materials, or for the increasing lucrative exchange of health professionals that enables government's to address the health needs of domestic populations and, in the case of migrant remittances, augment the national purse. This has moral and ethical implications that must be fully understood.
- Health Professional mobility is to be commended and encouraged, a sentiment that is truly embedded within the frameworks of the European Union through its legislative directives and the wider implications set down for Education in the Bologna Process and in numerous Labour Policy statements.
- In this section, the discourse will centre on the issues of health professional migration through the lens of the EU directives and policy initiatives, the Bologna Process and the broader elements that relate to global migration.

2. EU Directives and Significant Policy Initiatives

- In section two and three domestic drivers for change were elaborated on. But the influence of the European Union is also of major significance particularly, the current issues concerning the Bologna Process and significant EU directives that have influenced patterns of education, training and working practices.

The Bologna Process

- The Bologna Process is an inter-governmental initiative that aims to create a European Higher Education Area (EHEA) by 2010 and to promote the European system of higher education worldwide. There are now 46 participating countries who conduct their business outside the formal decision-making framework of the European Union. Decision-making within the process rests on the consent of all the participating countries.

  (http://www.ond.vlaanderen.be/hogeronderwijs/bologna/pcao/index.htm).

- The Bologna Process was launched in 1999 with a clear mandate to facilitate harmonisation of the academic systems across Europe and beyond so that students can choose from a wide and transparent range of high quality courses and benefit from smooth recognition procedures. Underpinning the move were agreed principles that aimed to remove the obstacles to student mobility across Europe; enhance the attractiveness of European Higher Education worldwide; establish a common structure of higher education systems across Europe, and for this common structure to be based on two main cycles of university education (undergraduate and graduate). (European Unit, 2005).
- The Bologna declaration further identified six major objectives that would have far reaching effects on Higher Education Institutions: (i) Adopt a system of academic degrees, easy to read and compare, including the introduction of the diploma supplement; (ii) Adopt a system based on two cycles- the Undergraduate Cycle geared towards the employment market and lasting three years; and the Graduate Cycle for masters and doctoral degrees, conditional upon completion of the undergraduate cycle; (iii) Establish the European Credit Transfer System (ECTS); (iv) Promote the mobility of students, teachers, and researchers; (v) Promote cooperation in quality assurance; and, (vi) Promote European dimensions in higher education.
- Since 1999, there have been regular meetings to assess progress of implementation and the development of tools and policies that would aide the process of assimilation and harmonisation of Higher Education within the participating states. During these processes other objectives have been established, e.g. (i) the development of lifelong learning; (ii) promote the involvement of students in instuitions of Higher Education; and (iii) the promotion of the attractiveness and competitiveness of EHEA to other parts of the world through trans-national education and (iv) quality assurance through the process of programme evaluation.
- Other areas include frameworks that ensure the building of systems and the capacity for the harmonisation of credits, developing a common framework of qualifications for graduate and post graduate levels, and reaching common agreements between all key stakeholders on the recognition of degrees and study time. Sanctions were also given to support the mobility of workers throughout Europe.
- All systems must be operational by 2010 supported by suitable legislation. The UK has undertaken the necessary legislative reforms but how this will affect Health Professional Education and Training is still to be fully established. Nonetheless, there are areas that will need attention such as:
    - Health Professional curricula will need to address the issue of Honours and Non-Honours Degree status within a three year framework. If the European decision is for an Honours Degree award this will affect Medicine and Dentistry in particular as current qualifications are at Non-Honours status. Nursing awards in the UK can vary between, Diploma, Advanced Diploma (Non-Honours Degree equivalent), or Honours Degree. England is particular disadvantaged with this regard and with the NMC consultation currently underway a resolution is keenly awaited accrediting all elements of learning linked to student's effort.
    - Harmonising the standard, kind and content of curricula and competency standards required for professional qualification across all participating countries to facilitate mobility of the workforce, but also to ensure patient safety is maintained.
    - Create greater opportunities that allow for flexibility in the learning process, increasing part time study, greater flexibility to step on and stepping off programmes, whilst also recognising and valuing learning to date. For example, the Common Foundation Programme (Nursing Curricula) is mapped against the competency requirement of National Vocational Qualifications (NVQ), giving students who exit at this point an NVQ level three award that has currency value for Health Care Assistant posts.

- Other aspects of fine tuning will occur as a definitive competency framework is agreed within and between all key stakeholders. Currently, there is a concordant between Countries in the EU for nursing. Instrumentally, nursing curricula are subjected to two directives regarding the qualifications of '*nurses responsible for general care*' 77/453/EEC of June 27, 1977 and *'On the recognition of Professional Qualification'*, 2005/36/EC, that requires that a registration programme must be either three years long or, 4,600 hours. In the UK this was internalised as three years and 4600 hours, a position of much debate. There are no requirements for Higher Education; indeed, German nursing qualifications are gained out-with HE. A review of nursing programmes across Europe demonstrated an array of organisations that were independent, affiliated, or fully integrated with HEIs, (Zabalegui et al, 2006). It is therefore believed that the Bologna process will synchronise such anomalies.
- Under the framework of activities relating the Bologna declaration, work has been undertaken to identify a competency framework for nursing. In the process international experts identified 30 generic and 40 specific nursing competencies. Not only has this process far reaching effects across the European Communities it also has the potential to harmonise nursing competencies at pre qualifying level throughout the globe. Whilst there is a focus on nursing competencies, other work is ongoing to determine those of medicine and the AHP's.

European Working Time Directive

- The consequences of the European Working Time Directive (93/104/) has had far reaching effects, both on the national stock of doctors, the resulting need to recruit from oversees, and the need for other professionals, chiefly nurses, to extend their roles and responsibilities to fill in the gaps.
- In effect the directive restricted employees to working a maximum of 48hours per week coming into effect in the UK October 1998. By 2004, the directive stipulated that doctors in training would be limited to working no more than 58 hours per week and that 'on-call' duties would be counted as part of the doctors working week. The latter has been a mute point and is subjected to a legal challenge that is still to be resolved.
- Currently, the resident 'on-call' system has been replaced by more structured working patterns. Thus, it is clear that the European Working Time Directive has been a major driver for change, particularly with a restructuring and design of clinical roles and new patterns of working.
- Whilst it is almost ten years since the directive was implemented, the length of time to train a doctor with relevant expertise is of similar length and the full ramifications of this directive is yet to be experienced. What is known, is that there have been significant increases in numbers of medical students in the intervening years and sad to say, in 2008 not all medical graduates can find internship positions to continue their learning and develop further expertise. The reasons are three-fold, inadequate workforce planning, pressures from increased doctor mobility throughout the EU, and the short term recruitment of doctors from oversees to fill in gaps.

Summary of Key Issues and Challenges:
EU Directives and significant policy initiatives

- The implication of Bologna has, and will continue to have serious impact on health professional curricula.
- Attention must be given to the design and amendments to curricula to accommodate the declarations requirements, in particularly, nursing diplomas/ degrees, and specialist/generalist.
- The free movement of all health care workers within the EU will continue to add external and internal pressures.
- Universities will need to address ECTS and their implications.
- Consideration will need to be given to Inter-professional education.

3. Health Professional Migration

- Over the last ten years the Health professional workforce has increasingly relied on overseas and EU migrants to support deficits in its indigenous workforce. All types of Healthcare professionals are being recruited from developed countries and "Old Europe" but the developing countries are losing the only healthcare professionals they train, namely doctors and nurses leaving developing countries without competent workers to deliver healthcare (UN., 2002, Lowell and Findley 2002, ILO 2003,).
- Migratory patterns are either 'transient', or 'permanent'. For both nurses and doctors permanent migration is sometimes linear as they move on from the first host country which acted solely as a stepping stone enabling the professional to acquire a "kite-marked" Registration which allows world wide employment (Stilwell et al. 2003).
- Drawing on the political demands of African leaders especially, and others the WHO (2006), supported the development of a new global partnership whose primary aim was to address the global shortage of health care workers. "*Working Together for Health*" (2006) identified a fast track training initiative designed to rapidly increase qualified health professionals in countries of need. Oulton (ICN, 2006), however points out that "*the political will to address the critical issues contributing to nurse shortages remains weak in most countries, despite growing recognition of the critical issues*" (www.intelnursemigration.org/news.shtml. p2). For example, 90 Nursing Associations representing 69 countries have reported nursing shortages (Global Issues, 2003).
- In the UK newly qualified nurses and AHPs are having difficulty finding posts due to vacancies being held against the NHS funding deficit. Many of these so called, 'surplus graduates', are been heavily recruited to work in USA, Canada, Australia, New Zealand, and the Middle East where acute health professional shortages remain. However, it is clear that the UK will need an increasing number of these staff in a few years time as the demographic issues relating to the current workforce has full impact through their retirement. For this reason the Government is exploring managed migration programmes between certain countries whereby training will be supported and staff come into the UK for a fixed period of time before returning home with support (Kershaw 2005/6/7/8).
- Governments are also charged with addressing the 'poaching' of health professionals from disadvantaged countries. The UK government in particularly has been galvanised into action producing, '*A Code of practice for the international recruitment of healthcare professionals*' (www.dh.gov.uk/publications). The Code also stipulates that "*Developing countries will not be targeted, unless there is an explicit government to government agreement with the UK to support recruitment activities*". Managed migration agreements are seen as one way to address this "poaching".
- Health professional migration is not always negative and a pragmatic planned approach can have positive advantages both for the home and host country through increasing the home countries economy and social development, whilst supporting the host countries human resource needs and recognising the dependency on remittances (Addy et al, ibid).
- There are other influences that have an affect on migratory patterns of health professionals which include Government Agreements on Trade and Service (GATS) and the need for Professional Regulation. GATS4 is likely to affect the migratory direction of nurses (Stilwell, et., al., 2004), particularly through bilateral agreements between countries. It is hoped such cross fertilization will also facilitate a common education and training curricula for health professionals thus addressing the harmonization of qualifications (Stillwell, ibid), competencies and standards (Fleming, 2006).

Summary of Key Issues and Challenges
Health Professional Migration

- There is a global shortage of nurses and other health professionals that is said to continue to rise in the foreseeable future.
- There remains an international imbalance of health professional stock between developing and developed nations and between rural and city areas.
- Health Professionals are an important global commodity both to booster the economy and meet health targets of developed nations and provide financial stability for donor countries from migrant workers.
- There are international concerns regarding the ethical issues underpinning health professional migration.
- Given the increased global need for a competent health professional workforce there are calls for international standards relating to education and training.
- Ease of Health Professional migration is improved through trade agreements between governments and the requirements of professional regulatory bodies.
- There are positive benefits to Health Professional migration both in terms of financial reimbursement, but knowledge and skill enhancement and knowledge dissemination that can be used to promote clinical excellence in both the donor and host countries.

Section 4
The Role of Education and those who Teach; Health Regulation; and Workforce Planning

1. Introduction

- A transformed health service demands a workforce who have the ability to deliver care at all levels of expertise and transfer these skills to work in different settings and across organisational boundaries for the benefit of patient care. However, the process of knowledge and skill acquisition is vested in Education and Training. Unfortunately, and perhaps unfounded, critics of the health professional education and training process suggest that it is unable to provide the student with the necessary range and level of competence required for contemporary practice.
- Notwithstanding the above, it is evident that HEIs do not set the standard, kind and content of Health professional curricula. Indeed these are invested with professional bodies, government expectations re employability, continuing professional development and lifelong learning, and any European mandates. The challenge is to marry all these elements in a framework that can easily respond to market forces and /or political and professional policy (Basford, 2003).
- Maintaining and enhancing professional competence is a requirement of health professional regulation and is embedded in the notion of Continuing Professional Development. How this occurs is subject to the needs of the individual, organisation and patient needs. Nevertheless, all professional practice is expected to be underpinned (wherever possible) by supporting evidence.
- Emphasis on professional competence is usually centred on clinicians, but it is of significant importance that all health professional educators are suitably prepared to undertake their role within the new and challenging agendas. For this reason we have focused on Health Care Education and those who teach.
- As part of the move towards the identification of professional competence there has been several attempts by governments to promote the notion of professional groups learning together in the hope that they will gain the ability to work more co-operatively with collegiality and mutual respect.

2. Health Care Education and those who Teach

- The transformation occurring in service provision will continue to challenge the currency of education and training practices. Whilst the Government seems convinced of the need to educate all Healthcare Professionals, education including Doctors, more inter-professionally and criticises what it sees as “silos”, the professions see a need to validate the students’ professional focus and competency to ensure fitness for purpose. This rift is not insoluble but does need careful co-operation and flexibility.
- Government policy documents on health since 2000 have identified to the fact that change is needed in the way we educate and train the health professional workforce ensuring graduates have the competence, confidence and capability to work flexibly within multi-professional teams leading service reforms and managing change effectively. But Inter-professional Learning is complicated by a myriad of different funding mechanisms that support the health professional educating workforce. For example, the teaching of Medical and Dental students in Clinical Practice is supported by SIFT (Special Increment for Teaching), which provides income to the hospital for facilities and supports the payment of an increment to clinical staff who facilitate learning in the practical setting. By contrast, no money is paid to either placement providers or those who teach in the practice for nurses, midwives or AHP’s without one of the (rumoured) very few special agreements made between individual universities and the contractors. Clearly, an unfair advantage for professions other than medicine and dentistry. It is suggested Darzi is looking to introduce some form of payment for placements for those funded under the NMPET agreement. This would be most welcome.

- To compound the situation further, medical and dental educators who are employed by Universities also get clinical salaries, receiving a special lead recognising their teaching role in practice. This lead is paid only to a few Speech and Language therapy lecturers as the result of a pay settlement in the 1980's. This lead is noted in the recent review of Benchmark Prices (2008) par. 2:5. where five individual returns for Speech and Language Therapy show that the average lecturer in this profession is paid 6.5% more than the average for all other AHP professions. The authors note the number of lecturers involved is so small as not to be statistically significant. Nothing suggests Darzi is moving to address this anomaly so it will continue to demonstrate disparity between University Health Professional Educators salaries and has been called into question for its fairness and validity as shared education and shared teaching opportunities increase. Indeed the arguments for equality have been championed for some 20 years or more. Firstly, by Royal Colleges of Nursing and Midwifery and UNISON during the negotiations prior to incorporation of Schools of Nursing and Midwifery within Universities, followed by representation from a widening group of Health Professional bodies. The same organisations have also been pressing for the sharing out of SIFT monies, that was promised some several years ago, but yet to become established practice.
- **Teaching across the Theory/Practice Gap:** Most AHP lecturers already support learning for those students in placement, and use clinical colleagues to develop that learning and assess it. This is facilitated by honorary contracts between University and the Trust. Information is leaking out that some Trusts are withdrawing these contracts. The reasons for this are unclear and it needs validating. The funding for nursing and midwifery lecturers similarly supports their time teaching in practice. But as Universities constantly raise the staff:/student ratio time for practice teaching continues to reduce.
- **The Level of Award:** All AHP students and from 2007 all midwifery student across the UK enter degree level courses and for most the entry is once a year. Nursing students in Scotland, Wales and Northern Ireland are also following degree programmes. England is different in that for the most part nursing students undertake a diploma route, driven by the commission and the higher student bursary support. Students entering the diploma are much more likely to enter through the Widening Access routes. Diploma courses continue to intake twice a year a process that exhausts teaching resources and challenges lecturer's ability to follow students in the practical settings because of constant timetable commitments (RCN, 1985). Darzi and the NMC are rumoured to be supporting a graduate exit profession.
- **Joint Appointments:** In pursuit of ensuring that learning was routed in the currency of practice and to address the demands on nursing lecturers to be in the classroom setting the model of joint appointments was pursued. Joint appointments enable lecturing staff to have a contract that splits their time between the University and the Practice settings. The first clinical nursing ones were set up in 1975 between the University of Manchester's School of Nursing and the Manchester Royal Infirmary, The Royal Marsden Hospital in London and Sutton had posts well established by the early 1980's for both their Nursing and the Radiotherapy Schools. Whilst these were the pioneers of practice based learning and teaching several studies have indicated that joint appointees with distinct University and practice duties are overloaded with work activities in both environments thus increasing stress levels and potential burnout. More recently, sensitive approaches towards the management of joint appointees have limited the potentiality for overload by having the post holder managed by one or other of the partners. Shared appraisal has also helped.
- **Clinical Career Pathways:** The Council of Deans of Health in their summer 2007 strategy statement emphasised their commitment to the development of a Clinical/Academic career structure for university staff where they could maintain practice competence at the level needed to teach in both university and placement setting, with a good grounding in research to ensure, where possible, teaching was evidence based. They identified a need for able diplomats and graduates to

have support necessary to move into these roles in the future. Donna Mead, Dean of Health at the University of Glamorgan reports on the creation of joint doctoral posts for able health professional graduates in which they work in practice at level 5 for half time each week and undertake PhD studies, supported by a grant, for the other rest of the time. These posts are developmental and at an early stage but do offer all the components necessary to develop into new roles as clinical academic staff. The Darzi review is expected to support all lecturers having the opportunity to develop new lecturers in this way.

- It is envisioned that each University/ Community/Acute Trust and Social Care setting should offer students the opportunity to be taught by faculty staff who are employed in one off three ways:
  - wholly employed by the HE.
  - wholly employed in health or social care.
  - Jointly employed.
- Also seen as important is the development of leadership and management skills plus grounding in all aspects of curriculum development at all levels, and especially into the field of inter-professional learning. This brings the discussion back into the sharing of SIFT and an expected recommendation of the Darzi report.

Summary of key issues and challenges:
Health Care Education and those who Teach

- As with the health professional workforce as a whole there are concerns regarding the notion that the health educators are an ageing community and in the next decade a large percentage will have retired. This will undoubtedly put a strain on the capacity and capability of the lecturing community to fulfil its obligations to teach a new genre of health professionals. It is therefore incumbent on Universities, service providers and workforce planners to address career pathways that would facilitate expert practitioners disseminating knowledge and facilitating learning to a range of student groups
- Without a doubt the complexity of a changing workforce to reflect inter-professional and interagency teaching cannot be underestimated and it will have cost implications too. The issues include:
- Ensuring compatible HR policies, Regulatory Frameworks and Quality Standards around preparation and updating of staff.
- Ensuring equitable pay, pensions and transferability of pensions between NHS, HEI and Social Services. As NHS and Social Care increasingly place patients and clients in the Independent and Voluntary sectors there incorporation into any plan will need addressing.
- Flexibility of career progression
- How non Health and Social care staff will fit the new structures.
- Over and above this are the problems of devolving SIFT and equitably sharing funding that for many years has favoured the teaching of Medical and Dental students

3. Health Professional Regulation

- **The Regulation of Nurses, Midwives and Allied Healthcare Professionals:** Any review of these professions needs to address, albeit briefly, the current on-going debate concerning the UK Government's position on Regulation and the future
- In March 2005 the then Secretary of State for Health, John Reid set up a Review of non-medical

professional regulation. The Review was summarised in July 2006 in a published report *"The regulation of the non-medical healthcare professions"*, and has directly influenced the situation today. The terms of reference of the review focussed on proper protection of the public requiring examination of professional practice to advise the Secretary of State on the measures needed to: determine health professional performance and competence regarding patient safety, ensure continuing professional development was undertaken embracing the currency of evidence, and, effectively regulate and monitor staff who were working in new roles.

- **Nursing and Midwifery:** The focus of all regulation of professionals is primarily centred on patient/public protection. The Nursing and Midwifery professions have been regulated by the Nursing and Midwifery Council for over 80 years and are part of the global regulatory process co-ordinated by the International Council of Nurses (ICN). Since 1993 there has been a biennial International Standing conference attended by all ICN member countries aimed at developing regulatory processes in all these countries and in providing support to do this. In order to bring consistency this first meeting set its goals as:
  - securing at least minimum standards of education, practice and conduct,
  - enabling practice to be relevant and responsive to the changing nature and demands of health need and health care,
  - improving standards demonstrably in the public interest,
  - giving strategic lead in professional development, and,
  - calling nurses and midwives to account when their actions do not honour their special obligation to society and, indeed, the ethical and other expectations of the professions. (Proceedings of the First Conference on International Regulation of Nurses Madrid Spain 1993 ICN Geneva).
- These are standard Governance expectations, familiar in the UK to the General Medical and Dental councils and recognised within the legislation controlling the movement of these professional within the EU.
- There is a further expectation laid on those Professional Bodies whose members have freedom of movement under EU Workforce legislation, namely the Regulatory Body has to ensure compliance of its functions with the appropriate EU requirements.
- **Allied Health Professionals:** The consultation process around the regulation of these professions ran its course throughout 2005 and asked for responses around the following areas;
  - Demonstrating Fitness to Practice on entering the register. Discussion ranged from the indexing of students (which is carried out by the GMC and GDC in some format), was discontinued for nursing and midwifery students when the NMC came into being in 2001 and has not been introduced by the Healthcare Professionals Council, to the structure, content and assessment approaches within the curriculum.
  - Demonstrating Continuing Fitness to Practice, which addressed the myriad of complexities around CPD especially in this time of changing roles, changing patterns of employment and the growth in Inter-professional working.
  - Resolving concerns about Fitness to Practice which explored the Professional Conduct and Health Committees, the use of Police Checks, and the difficulties in ensuring equity when several professional bodies are involved in hearing the same case but for different professionals. The most common example of this was the citing of numerous occasions when there had been drug errors and the nurse and physician had received different judgements without any clear reason why. These cases raised the issue of transparency and open the date on how Fitness to Practice is addressed within a multifaceted workforce.

- Regulation of Support Staff, a debate that is still on-going, but very obviously needed. Also under current discussion is the regulation of those who provide such services as Beauty Therapy and Complementary Medicine.
- Regulation of New Roles, perhaps an example here is when Nurses move into Social Care or Physiotherapists into Sports Medicine.
- Regulatory Bodies: Do we need one to cover all Healthcare professionals including Doctors and Dentists, or is there a different approach? The jury is still out on this question too.

- The outcome of the 2005/6 review and report resulted in the setting up of the Health Professionals Council (HPC) which regulates thirteen of the Allied Healthcare professions namely: Art Therapists, Biomedical scientists, Chiropodists/Podiatrists, Clinical Scientists, Dieticians, Occupational Therapists, Operating Department Practitioners, Orthoptists, Paramedics, Physiotherapists, Prosthetists and Othotists, Radiographers, and Speech and Language Therapists.
- A review is in progress on the regulation of Pharmacists; one for Clinical Psychologists is due to be set up shortly with a report date in July. The debate is open on the regulation of Support staff and how the increasing number volunteers who have access to vulnerable people are governed.
- There is no doubt that we are working with a time of major change which affects Regulation. All Regulatory Bodies are now established by government with a majority of lay members sitting and with professional members drawn from partner professions. The public are increasingly concerned over ethical issues and those which affect their privacy and confidentiality whilst the professions would wish to see equity and efficiency, both in time and cost. Everyone, professional, public and parliament is requiring more openness and transparency whilst expecting protection of the individual's rights to confidentiality. Over and above this, Regulation has to meet the needs of a public being cared for in a changing world, with changing expectations and by those delivering care often working in transitional or newly developed posts.
- The National Board for Scotland's statement in (1998) summarised this very well.

Professional self regulation should:

- secure at least threshold standards of practice, education and conduct in keeping with the practitioner's level of autonomy and decision making,
- enable practice to be relevant and responsive to the changing nature and demands of healthcare needs and care,
- maintain and improve standards in keeping with societal expectations and in pursuance of public safety,
- provide a strategic lead in the evolution of regulation and in collaboration with other bodies, facilitate the development of the profession of safe, efficient and affective care can be delivered and
- call members of the profession to account when their actions fall short of the practice that should be guaranteed by a self-regulating professional.

- Whilst the debates continue regarding Professional regulation it is clear that professional self protection is unacceptable. What will transpire is a sharing of responsibility in the interests of patient safety, risk management and in the pursuance of clinical excellence and clinical governance.
- All health care systems are committed to the importance of regulation as a central feature of ensuring standards are developed and maintained.

Summary of key issues and challenges:
Health Professional Regulation

- Should all healthcare professionals share the same regulatory body?
- How are Health support workers to be regulated?
- How do we regulate for new roles and those who work inter-professionally and across boundaries.
- How non health care professionals are regulated who have access to patients/ clients (ie Manager).

4. Workforce Planning

- Providing a predictive accurate 5-10yr forecast relating to the numbers of health professionals required is extremely challenging. Both the internal and external factors are not always known, or understood, leaving planners in a state of flux. In the past the uncertainty of the future resulted in maintaining a position of status quo in that similar numbers of students (pre and post reg) were contracted for education and training with a view that this would suffice demand. Unfortunately, history foretells that such an approach created a discord with what was actually needed for effective service provision and what was produced. Several attempts have been made to change this situation, but all too often the intelligence of the information is flawed and insufficient, and workforce planning manpower lacked the necessary skills (DH, A Health Service for all the Talents, HOC, 2007).
- It is suggested that the intelligence system regarding workforce planning needed to take account of the level of domestic and international stock, accurate levels of retirement, attrition, role changes, service reforms and the related need for a different set of skills, and to the demands made through technological and practice advancements (HC, 2007).
- The situation is further exacerbated due to the time delay between the shift in services or roles and responsibilities, and the time required to educate and train staff (3 years for most health professions and up to 20 years by some senior doctors) (HC,2007). Furthermore, there is relatively little understanding of the health professional need by the growing private sector markets and the consequences of health professional movement around the European Union Nation States.
- Whilst the complexities and debates surrounding workforce planning can be understood, and therefore its services questionable, it is still considered to be an important function to maintain so as to enable health service efficiencies and effectiveness to be achieved within a given financial situation. The discussion and debates identified in the HC (2007) paper clearly provides an in depth dialogue relating to the subject covering its many facets including the financial debacle brought about by the government's blueprint for action contained within the document 'A Health Service for All the Talents' (2000).
- Principally, there was to be an overall expansion of the workforce in line with increases in services, and synergistically, a significant increase in the training places for health professionals. With regards the later point, there was a positive response made by educational institutions who made great strides to ensure that there were; (i) adequate education and training resources, including supervisor and mentors and clinical experience (ii) addressed new pedagogies and innovative ways through which learning and teaching could be implemented in cost effective manners and (iii) ensure that there was an educational workforce who are commiserate with the future requirements of health care and the competencies required for a new genre of health professional workers (the latter point is a significant challenge and will be discussed later).

- In the short term, due in part, to the time delay between educational contracts being made and the production of a new supply of health professionals, health employers increased the workforce by recruiting heavily from the international stock. By 2005, health spending was reaching highs that could not be sustained. Posts were frozen, redundancies were made and training budgets cut. More importantly new graduates remained unemployed, a situation that continues today.
- The public educational establishments and all those involved in workforce planning sympathise with the extravagance of unemployed health graduates given the amount of funds required to educate and train one health professional and to the loss of much needed potential pool of experts. Much of this unemployed pool either gains employment into other work environments or migrates to other countries. Whilst sometimes seen by policy makers as a short term issue it can be a permanent drain on health human resources at a time when there is growth reduction, service expansion, potential reductions on the recruitment of international stock and an ageing workforce who will have the capacity to leave service within an undetermined period. The demographic time bomb awaiting service employers is also a major feature of the health education workforce as mentioned earlier. The recent cuts on education and training have shown a total disregard of how these dimensions will impact on the workforce availability in the long term future (Council of Deans and Heads of Nursing, 2008).
- Complicating the growth of health professional employees was further compromised due to substantial pay awards that were consequences to the proposals that underpinned *A Service for all the Talents*. Arguable these were foreseeable issues to have been considered during the workforce planning process and as the HOC (ibid) document concludes that there are serious questions to be asked regarding, '*the effectiveness of the current workforce planning system*'. (p103).
- In 2001 there were attempts to unify workforce planning systems under the umbrella of Workforce Confederations whose chief role was to address workforce planning needs and secure and monitor education and training. The process was set in motion, however the enterprise was short lived through further re-organizations. Unfortunately, it would appear that a central focus for the operations of workforce planning has seriously undermined the access to intelligent information and limited the involvement of the Independent Communities and Educational establishments in the process. This point was made by the Council of Heads of Dental Schools (2007) who pointed out that the demise of Workforce Confederations limited expertise and the focus on workforce planning given that attention to service needs took precedence. Currently, there are growing concerns with the ability of the health service to accurately forecast workforce needs in the foreseeable future without a unified team of experts whose sole function is to gather, synthesise intelligent information and make accurate predictions. However, prior to building workforce planning capacity attention should be given to the areas identified in the Key Issues section overleaf.

Key Issues and challenges:
Workforce Planning

- To develop a competent workforce planning team who have the capacity and confidence to fulfil the task in hand.
- To ensure that the workforce planning team are able to understand the internal and external factors that impact on the needs of a newly reformed and dynamic health service.
- That the team have at their disposal, sophisticated systems that can collate and maintain intelligent data and can assist in futuristic modelling highlighting the consequences of action.
- Operate within a fully integrated system between medical and non-medical staff groups including a single financial framework, and to involve the independent sectors.
- Accurate short term planning is a requirement, but so too is the need to develop a formal long term planning perspective, particularly with regards education and training needs.
- Ensure that there are sufficient Health educators who have the competence and capability to facilitate new ways of learning to the requirements of a transformed service.
- Effectively produce more flexible education and training capacities that are responsive to service demand and to understand more fully the lead in time for education and training.
- Producing a workforce who can accommodate, more readably, flexibility and transferability of skills is a pre-requisite requirement within transformed and transforming organisations. This can only be done through the process of education and training and adequate mentoring if patient safety is to be upheld. (It is suggested that the competency framework can assist in this process. HOC, ibid).
- Stepping on and stepping off programmes through a modular education and training framework would enable greater flexibility and empower individuals to engage in career progression from care assistants to expert or advanced practitioner status thus, maximising potential on human resources.
- increasing productivity of staff can be achieved through the proper use of KSF and the recently introduced, *'Better care, better value'* indicators that can highlight the need for education and training.
- Ensure the workforce can work across and between organisational boundaries, including a greater emphasis on primary care.
- Address the issues of recruitment and retention of staff.
- The Quality and Outcomes framework should be used to improve targets and to measure the standards and performance of all staff.
- Review, and if necessary, reform education and training.
- Serious attention should be given that a constant cycle of reforms, adds to the complexity to accurately predict workforce needs, including, education and training. It is therefore suggested by HOC, ibid, and Lord Darzi (ibid) and others that a period of stability should be considered so that current changes can be actualised and evaluated for efficiency, effectiveness and economies.

Section 5
A Comparative study of funding sources against the Multi-Professional Education and Training (MPET) System

1. Introduction to MPET and the Funding Models

- The Multi-professional Education and Training (MPET), budget is the primary source of financial support to Universities for the education of nursing, midwifery and Allied Health Professionals (AHPs). The MPET Funding team sets the Benchmark prices that decides on the level of funding and agrees them with UK Universities. The most recent report was released in January 2008 (www.dh.gov/publications) The preparation of the report was overseen by representatives from the Department of Health, Universities UK, the UK Council of Deans of Health and a financial advisor from a Strategic Health Authority (In England the funding is devolved through the Strategic Health Authorities (SHAs), and a Workforce Commissioner).
- The costs of all courses were reviewed with the exception of Clinical Psychology. However, Clinical Psychology is subject to a separate review that is due to report in the summer of 2008. As with the 2008 report (a precursor to the 2003 report) the exemplars used were nursing, midwifery, physiotherapy and podiatry. Estimates were made on the applicability of these costs to other named professions, namely speech and language therapy, occupational therapy and radiotherapy.
- One of the problems for Universities receiving MPET funding is that the Benchmark prices (BMPs) are set from the 1st of April each year based on the midpoint of the relevant academic year. e.g. the benchmark prices applicable from April 1st 2007/08 are considered to be based on the mid-year pay and prices for 2007/08 i.e. 1st January 2008. Such an approach towards financial modelling and relevant time lines are in keeping with the fiscal budgeting and management systems of the NHS, but ones that are totally at variance with those of the Universities. Unfortunately, the monies allocated for a given year flows from the 1st April each year for a fixed twelve month period. Little leeway is allowed to carry money forward year on year creating a conundrum for universities who facilitate Education and Training Programmes out-with the NHS fiscal year.

"Raiding" of the MPET budget

- The situation for Universities is largely one of insecurity and a lack of confidence in and about the way they receive MPET funds. Until 2005 MPET funding was ring fenced. The Government has consistently refused to re-instate ring-fencing offering instead a Service Level Agreement with the Budget holders (in England the SHAs).
- The universities appear to lack confidence in this especially since last year (2006-7) the DH admitted that 9% of MPET funding had been used to support the shortfall elsewhere (House of Commons Official report). As a result, there was an average cut in the number of students commissioned of 10% across Nursing, Midwifery, and AHP's. The figures were variable; as high as 30% in one university, with only a few reporting no reductions. Most of those Universities who lost over 10% are now reporting voluntary redundancy requests and a failure to fill vacancies. Reduction in staffing means universities will be able to respond when commissioners seek to increase students' numbers.
- The UK Council of Deans further report continuing reductions in some areas over the present financial year. Since MPET also funds post registration and CPD costs these have also been affected by the cuts.
- J.M.Consulting were contracted to examine the issues underpinning MPET and the following table summarises their findings.

Table 1. Summary of Findings JM Consulting.

- The actual costs since the first report have risen between 28% and 29% in the six years since the price was set. NHS inflation uplift has been 16%
- Estates costs have risen by 44%. This may be partly accounted for by the growth in Skills/Simulation Labs over the past few years. If this is so this cost will continue to increase as more are developed
- Speech and Language therapy staff receive a salary of 6.5% more than other staff in the study.
- 2008/09 pay awards are yet again likely to take the cost higher than the NHS inflation allowance.
- Their cost per students (2007/8) is given as follows (actual NHS BMP figures paid are in brackets).
- Nursing £8180 (6816)
- Midwifery £9322 (£7838)
- Physiotherapy £6517 (£7196)
- Podiatry £9633 (7886).

- NHS contracts are set for five years, usually with yearly external and internal review. The relationships between Higher Education Institutions (HEIs) and the NHS contractor was severely challenged last year as commissioned numbers fell and funding was withdrawn resulting in staff redundancies and a reduction in courses offered as Universities tried to balance a budget already stretched. These redundancies are continuing into this financial year in some parts of the UK. Numbers are contracted very strictly and health care course places cannot be sold to overseas students (***"not even for ready money"***). Course places unfilled cannot be transferred to an over subscribed courses, nor can a course undersubscribed this year be filled over target next.
- Parallel to the NHS funding of salaries and on costs identified within the BMP is the issue of student funding which adds considerably to the NHS costs as well as making NHS students entirely different from other University students. This issue will be addressed later in this section.
- Most other funding comes to Universities through the Department for Innovation, Universities and Skills (DIUS), sometimes direct, but more often devolved to HEFCE (Higher Education Funding Council) in England, The DELNI (Dept. of Education and Learning Northern Ireland), The Scottish Funding Council (SFC) or HEFCW (Higher Education Funding Council Wales). Funding is based on the number of students enrolled, the University's research statistics and their track record of widening participation. Within agreed limits, universities can increase student numbers to attract more funding and student numbers can be moved from one course to another to ensure all places are filled. Funding is usually on a six year rolling contract with yearly internal reviews (www.universitiesuk.ac.uk). Contracting for nursing and midwifery courses is usually done directly from the SHA/ DH with individual provider Universities, but for smaller professional groups (eg Orthoptics, Therapy Radiography), the commissioning is taken on by one SHA on behalf of the rest.
- **Student Fees:** The impact of student fees on Universities has yet to take full effect, but from 2009/10 there should be a regular input based directly on the number of students enrolled. Currently all students except those following undergraduate healthcare, social work or teaching courses have to pay £3000 per annum in direct fees. The tuition fee will be allowed to rise to £3,145 in this coming academic year. Medical and dental students are exempt from fees for their clinical years. The UK Government meets the cost of fees for these students within the BMP (www.nhs.gov.uk/student grants).

- **Other sources:** Sometimes universities contract to train healthcare students from the non NHS. This can only be done with the approval of the NHS. The biggest of these contracts is the one held by Birmingham City University with the British Army for nurse training places (QA@army.med.uk.net). One or two Universities are thought to have very small contracts for private healthcare providers included within their overall contract numbers.
- **Student Funding:** There is no doubt that the costs of studying at University is now seriously impacting on the decision to enter university. The National Union of Students (NUS) has estimated that the average student will leave a three year undergraduate course £13252 in debt, despite the fact that 60% of students work during their degree studies. The Royal College of Nursing (RCN), report that nursing students leave university with debts of £10,000 despite working (RCN Association of Nursing Students) Frightening though these figures are Barclays Bank estimate debts for a three year course rising to £20,000 by 2010 when the impact of fees is fully felt.
- In England, as well as having fees paid (currently £9000, rising to £9435 in September) all health care students receive either a 'Means Tested Award', or 'Non Means Tested Bursary' depending on whether they are studying to diploma or degree level for professional qualification (NB the position for Scotland, Northern Ireland and Wales differs from this position). For example, in England students nurses on a three year diploma programme receive £6372p.a. with a higher rate in London, whilst those on a degree course receive a means tested award of up to £2128 (again there is an increase in London). Further to this there are other allowances that a student may have subject to: awards for children, child care, dependant partners and single parents and some travel expenses. AHP students are subject to the same assessment of support from parents or partners for the means tested award.
- In Scotland the non means tested bursary award is £6225, whilst the means tested one is between £1775 (living at home) and £2335 if living away from home. Nursing and midwifery students, whether following degree or diploma routes, are eligible for the bursary level award.
- Students in NI are also eligible regardless of route, but their non means tested award is only £5000 pa.
- It can be seen that the cost of funding students on Healthcare programmes significantly adds to the direct overall budget on the NHS for Education and Training. In addition, there are indirect costs which add a considerable increase to the NHS bill for training and no review of funding of such courses can fail to address this issue too.
- **Alternative Options:** With the increasing push towards Inter-professional Learning (IPL), especially where healthcare students are taught in practice alongside Medical and Dental students, there is pressure to extend the **SIFT** (Special Increase for Teaching) from the medical and dental budgets to support clinical learning across the sector. All Trusts that provide clinical experience for medical/dental students get a per capita allowance for each student to fund the teaching and assessing undertaken in practice. No such costs are recognised for any other health care student. A University Teaching Hospital Acute Trust can receive several thousand pounds each year for each medical student they have in their units. Whilst General Practices and Community Trusts receive a lesser amount it is still a significant some and is a great incentive to have medical and health care students per se, and certainly assist in the promotion of inter-professional teaching and learning.
- The sharing of SIFT would be better facilitated if the funding for Healthcare Courses came from the same HEFCE/DELNI/SFC/ HEFCW as that for all other courses. (This is one option Darzi is said to be exploring. Others include "the status quo", giving money to Foundation Trusts to directly purchase and setting up partnership agreements). It would flow through the HE financial year and would be audited, and quality reviewed in the same way. More flexible use would be possible and it could still be ring-fenced as is the budget for medicine and dentistry. Contracts would be more secure and would not be subject to NHS fluctuations and savings.

- Failing the move of the budget Universities would benefit from a price that reflected the Inter-professional learning and teaching costs, especially those which arise from simulation and practice placement learning/teaching. Furthermore the increased need for students from all professions to have more experience in the community will bring added costs in teaching and requests for payment for placement especially from General Practice.
- The heavy cost to the NHS of student funding also begs review.
- The UK is almost unique, in not only paying fees, but also making students a special case for support. Most of Europe, Canada, The USA, Australia, and New Zealand treat students admitted to health courses no differently from those on other degree programmes. i.e. expecting fees to be paid, that students apply for competitive awards and work to support themselves. However, their health care students are subjected to similar attendance requirements as other university students thus enabling greater opportunities to gain monies through employment, thus allowing self fund options for their programme of study. The position is greatly different in the UK in that the stipulated 45 weeks period of study per year particularly disadvantages nursing and midwifery students from being able to provide sufficient funds to cover their living expenses and course costs. In addition, their ability to work regular hours is compounded further by the shift patterns that are required during their clinical placement requirements, which makes up 50% of their three year programme. Any future funding decisions would need to take account of this.
- **Alternative modelling:** An alternative to the direct and indirect costs being borne by the students could be for the NHS to offer Bursaries and Fees only to those who have contracted to work in Health or Social Care upon completion. This would require robust workforce planning, but should not be unachievable. Universities could then increase income by taking overseas students, who constantly seek to train in the UK, until they had reached their capacity.
- There is a body of thought that suggests we only value what we pay for and drop out rates are considerably lower in USA and Canada where students/parents are meeting costs, or where hard won scholarship money has to be seen to be spent well.
- As an alternative to fulltime student status UNISON is arguing for a return to employment status for these students. It is hard to know whether this would be more satisfactory for employer or employee, but it is unlikely students would be paid more than the minimum wage and would therefore be little better off since they would be paid only for hours in practice. The minimum wage is currently £5.52 per hour for over 22year olds and £ 4.45 for those between 18 and 22. Over the three years students over 22 would earn £12696 in total. The payments would be irregular since they would most likely be paid against actual hours in practice. Thus a month in University would attract no income. Although it is possible the University 2300 hours would attract a 50% bursary. This would bring the student into Tax and National insurance payments.

Summary of Key issues and Challenges:
MPET System/Alternative Models

- Funding/Contractual arrangements for MPET courses need to be aligned with those for other courses to better enable Universities to manage these programmes
- Non Medical Healthcare lecturers should be paid clinical leads when they contribute to direct care teaching in hospital or community
- Health care communities that support students should have access to the SIFT budget
- The payment of bursaries/awards should be equitable for all healthcare students regardless of professional course or level of qualification.
- Student status and funding should be reviewed

Section 6
Summary and Discussion points

1. Summary

- The nature of health care provision in the UK is a highly complex phenomenon that responds to local, national and international policies that call for change in what appears to be a cyclical movement that has no beginnings and no end. Whilst this comment can be viewed as facetious it does underscore the feelings of health professionals who carry out their duty to care in the midst of uncertainties. The position is a challenging one for most but the professionalism of the workforce is to be commended.
- Current debates have called into question the competence and readiness of the health professional workforce to accommodate change whilst continuing to provide quality care and seek/and achieve excellence. Fitness for practice and fitness for purpose debates abound and continue to make demands on the curricula and education provision.
- The shift in emphasis on care delivery from acute to primary care settings has, and will continue to make demands on the preparation of the workforce. Whilst this is not a new entity it has been given high political profiling that suggests the need for key stakeholders to give this issue due attention.
- The following discussion points, whilst not exhaustive, have arisen from the paper and are highlighted to stimulate further debate. Others will have ideas which widen and broaden the discussion and add value to the final document. Furthermore the results of currents debates at national level such as the Darzi review will demand further consideration.

2. Discussion points

- This paper has raised many issues that warrant further consideration by the group of professionals or whom they are most important before it can be considered a finished document. Many of these issues are interlinked and interwoven so cannot be dealt with in isolation.
- An attempt has been made to summate the main issues under five headings. All are open to further expansion and debate. They are in no particular order.

Education

- Healthcare education is essential to the continuation of Healthcare delivery, and those who teach are a valuable resource. Points to consider:
  - Funding, from DES or DH? Direct to Universities or through contracts developed with SHAs, the DH or “new” groups? How are numbers to be linked to accurate workforce planning?
  - How do we support the wider entry gate?
  - How can the Inter-professional learning agenda best be addressed? Is it the best way of preparing undergraduate students for practice?
  - How are students to be funded? Do we pay all Healthcare students bursaries? Should these all be means tested? Are there other ways to fund that should be considered? Should they continue to be exempt from fees?
  - What should be the level of Qualification and Award? How should recently qualified staff be supported in practice?
  - How should the new generation of Teachers be prepared?
  - How much attention should be paid to EU directives/ Bologna?

Environment

- Education needs to prepare students for constant change, in the way care is delivered and the population who use our services. Added to that Darzi reminds us that all aspects of the NHS have been subject to ever-increasing Government control (including the Universities who provide Healthcare Education). Points to consider:
  - How are students to be prepared for the move from Acute to Primary Care?
  - How can they be best prepared to care for the ageing community?
  - How is the expected shortage of healthcare workers, due to the ageing workforce, best addressed?
  - the in-equalities in Health can be often related to environmental issues, eg poverty. How can we help students address the public health agenda?

Equity

- The issue of equity affects all aspects of health and social care, those who learn and teach the subject and, of course those who use the services. Points to consider:
  - Access to service delivery, free at the point of delivery.
  - How do we prepare students to work in an environment where services are said to be subject to inequalities based on, for example, age, post-code, ability to travel?
  - Widening Access for students entering undergraduate courses, using APL/APEL for those seeking graduate programmes and for recognising overseas/EU applicants' qualifications. Is "Bologna" a help or a hindrance? Do we really understand the implications? Are our Universities ready?
  - Inter-professional learning means staff on different salary scales are teaching the same students. This affects pensions too. Placement providers receive money (SIFT) for some students but not others, those who teach our students in practice are also paid differently. Lecturer's roles are changing, bringing added responsibilities. Should we be looking to standardise all Healthcare lecturers on the same scales? What about security of employment? Does experience, especially with the raiding of the MPET budget and the resultant reduction in teaching posts mean non medical and dental lecturers are more secure? How do we ensure equity in Career progression?

E-Technology

- Perhaps the major growth area in Health of the next decade.
- Are lecturers "up to speed" to use and teach this tool.
- We are required to teach aspects of genetics and Nano-Technology.
- How do lecturers acquire the skills and knowledge not just to teach the subjects but to relate them to change in practice?
- What is the best way of integrating simulation into the curriculum?
- Who will fund all this development?

Expectation

- Everyone expects more from the NHS, from Governments, from HEIs. How can students be best prepared to meet the following expectations?
  - Patient focussed services
  - UK wide standards delivering a seamless service.
  - Safe competent practitioners who can work within a constantly changing environment, a multi cultural society and one that is ageing.
  - How are these practitioners to be regulated? One body, or separate ones? Who regulates HCAs?

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