Note

The attached letter from the Chief Executive of Skills for Health was tabled at the Education and Training Committee on 4 December 2007. It was considered as part of enclosure 6.

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3rd December 2007

Dear Anna, Eileen, Marc

QA Framework Consultation

Thank you for your letter dated 21st November 2007. I was surprised by both the content, and timing of the letter.

With regards to the timing, HPC have been kept informed of developments with regard to the QA Framework Consultation on an ongoing basis through the Partners Forum, and through the many opportunities which have been offered to participate in the work which led to the development of EQuIP, including an invitation to a residential seminar in July. If HPC had such serious concerns, I would have expected these concerns to have been raised well before the commencement of the consultation process.

With regard to the content of the letter, I believe that there are a number of key misunderstandings. The attachment to this letter directly answers your specific questions/concerns, but it is also helpful to clarify a few baseline points:-

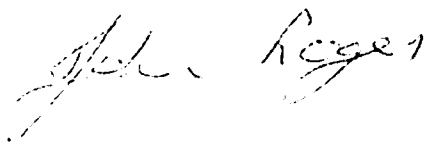
- The QA Framework is not a Skills for Health (SfH) framework and SfH will not be the body that implements the framework. SfH have been asked to develop the framework on behalf of the Department of Health and the Strategic Health Authorities (SHAs).
- The QA Framework is intended to be an integral part of the new national contract with Higher Education Institutions (HEIs). It will apply to all Strategic Health Authorities commissions to HEIs (i.e. in England only).
- Strategic Health Authorities already have a range of quality assurance arrangements in place (which already run in parallel with current HPC mechanisms). The effect of the QA Framework will be to standardise the quality assurance mechanisms that SHAs operate.
- As you will be aware, the original brief to SfH from the Department of Health was to try to agree a standardised approach to QA between all parties (including SHAs and regulatory bodies). Following a meeting between SfH, Marc Seale and Sarah Thewlis (NMC) it was apparent that this objective was unachievable. We subsequently agreed to work on "broad principles" which would include mapping and data sharing. The shared statement of principles agreed at the Partners Forum, which was attended initially by Marc and latterly by Rachel Tripp, is attached. It was also agreed that we (SfH) would work specifically with SHAs to help them develop their standard QA framework.
- We are absolutely clear that this framework in no way seeks to replace HPC mechanisms. HPC has a clear statutory duty with regards to its regulatory functions.

- SHAs spend circa £750 million on higher education programmes. From our perspective it does not seem unreasonable that they would wish to have some form of QA over the outcomes of this expenditure. However, this is a decision for SHAs, and if HPC feel that SHAs should not be undertaking QA on their commissions then they should make representations directly to the SHAs.

I regret that I am unable to attend your meeting on the 4th December, 2007. However, given the level of your concerns I would suggest that we arrange an urgent meeting to discuss these issues. In addition to the four of us (John, Anna, Eileen & Marc), I would look to include Chris Hannah (Chair of Skills for Health), Christina Pond (the Executive Director at SfH with responsibility for the QA work) plus representatives from the Department of Health and SHAs. We will seek to arrange this meeting as soon as possible.

Kind regards.

Yours sincerely,



John Rogers
Chief Executive

Annex 1

Specific Responses to Concerns

- The Skills for Health consultation document has only one brief reference to the HPC on page 39. No explanation is made to HPC's statutory roles and responsibilities for either education and training or standards of proficiency. It is therefore unclear how the Skills for Health process would interact with our process and that of education providers.

ANSWER: No general references are made to HPC's statutory roles as these are a given. The document is not looking to affect HPC's statutory role. The criteria in appendix 2 of the consultation document make regular reference to the need to meet regulators' requirements.

- Readers of the Skills for Health consultation document may infer from the reference to partners that the HPC has been jointly responsible for the proposals. This is not correct. The HPC does not regard itself to be a partner of Skills for Health. Neither do we endorse the contents of the consultation document.

ANSWER: The point that there is an inference that HPC has been jointly responsible for the document is rather at odds with the first point above (that there is only one brief reference to HPC on page 39). The introduction to this document makes it very clear that the purpose of the document is to support the national contract. Having re-read the document twice, there is an interpretation that could infer HPC involvement – but this would only be the case if the overall purpose/introduction had been ignored or misunderstood.

- The Skills for Health consultation makes no proposals on how the process will be funded.

ANSWER: QA is already undertaken and funded by SHAs. It will be the decision of SHAs and the Department of Health as to how the framework will be incorporated in the national contract, and how the QA will be funded. An impact assessment will be carried out which will explore costs more fully.

- The Skills for Health consultation document does not explain how the additional quality assurance framework will address the findings of the National Audit Office 2001 report on healthcare education. We also note that the NAO report did not directly address quality assurance issues and was published before HPC implemented its processes.

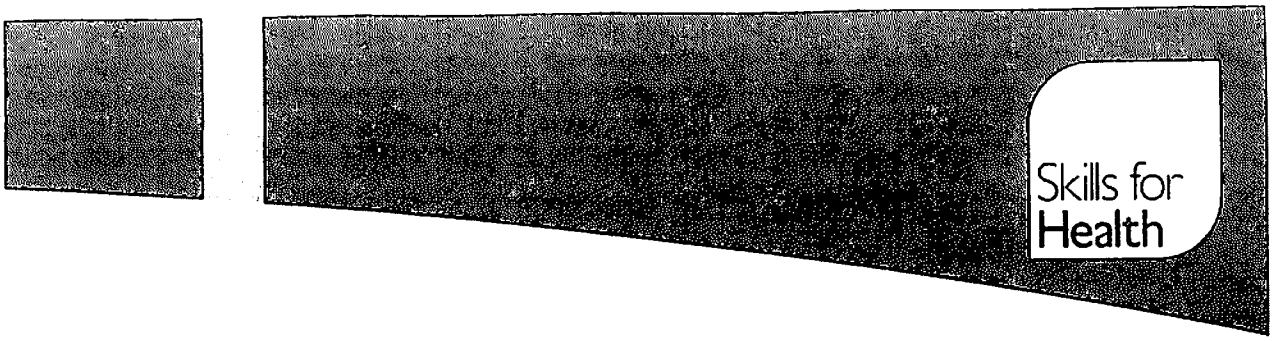
ANSWER: The National Audit Office 2001 reports asked the Department of Health to "work with the regulatory bodies, the new Confederations, the Quality Assurance Agency and other stakeholders to implement new integrated arrangements for the quality assurance of NHS funded health professional education." (page 6 of the report). As per the general comments in the covering letter, we note that this recommendation to integrate arrangements has not been achievable.

- The Skills for Health consultation document makes a limited reference to the three devolved health administrations in Northern Ireland, Scotland and Wales and does not address how this will impact UK-wide statutory regulation

ANSWER: The QA Framework only applies to SHA commissions in England and is the SHA mechanism to QA their commissions.

- The consultation provides no evidence, nor is the HPC aware of any, which supports recently qualified registrants who have completed approved programmes of education and training are not fit for purpose.

ANSWER: There is no suggestion in the document that recently qualified registrants are not fit for purpose. However, just because HPC processes ensure that qualified registrants are fit for purpose does not mean that this meets all SHA's QA needs as commissioners. As commissioners of programmes, SHAs are equally interested in aspects such as the safety of students, attrition rates, value for money, the quality of the process of learning and issues such as diversity and inclusion. There are potential overlaps of interest between HPC and the SHAs (which is why our original brief was to try and agree an integrated framework). The criteria in appendix 2 of the consultation document make extensive reference to the need to meet regulatory body requirements.



Statement of Shared Principles in relation to the Quality Assurance of Healthcare Education

Introduction

This Statement of Shared Principles is derived from discussion of partnership values at meetings of the Partners Forum for Quality Assurance of healthcare education in 2006. It is built upon the QA principles within the National Standard Contract framework agreed between the Department of Health (England) and Higher Education representative bodies, and it is compatible with the Concordats of the Higher Education Regulation Review Group (HERRG) and Healthcare Commission, and thereby with wider government policy on effective regulation..

Purpose

The identification of Shared Principles in relation to the quality assurance of healthcare education is intended to:

1. Facilitate effective and efficient quality assurance activity that is conducive to the enhancement of the quality of health care education, thereby enriching learners' experience and supporting the development of a competent and skilled healthcare workforce. This will in turn enhance the quality of health care provision and ultimately patients' experience of care.

2. Ensure that the rationale and values underlying quality assurance processes are clear and transparent.

3. Provide a shared point of reference when considering the appropriateness of quality assurance activity.

4. Provide a basis for delineating areas where partners consider shared interest/action to be appropriate from areas which are identified as being a specific function/responsibility of an individual partner organisation.

Shared Principles

The quality assurance of health care education seeks to support:

- Public safety, through accountability of commissioners and providers and public confidence in the quality and appropriateness of provision

- Public choice, through publication of information

- Proportional and risk based approaches which offer value for money whilst also assuring agreed standards are maintained

- Quality enhancement, through the identification and dissemination of good/notable practice and action plans designed to remedy any shortcomings where identified
- Minimisation of burden and duplication through the identification and sharing of existing evidence, where this is available
- Parity of practice based education with academic education
- Delivery of health care education through effective partnerships
- The engagement of learners and service users in quality assurance judgements and processes, thereby informing future education commissioning and quality enhancements, and leading to demonstrable change
- Inter-professional learning approaches where two or more professions learn with, from and about each other where possible
- Recognising and valuing the different roles, contributions and responsibilities of individual stakeholders involved in quality assuring health care education
- Organisational and individual reflection upon and evaluation of the quality of provision