



Learning to Care: Education of health professionals in Scotland:

A discussion document by the Scottish Funding Council (SFC) and NHS Education for Scotland (NES).

Executive Summary

The purpose of this discussion document is to act as a “think piece” on the education and training of health professionals in Scotland and on how this education and training is funded and delivered. The document flows from the work undertaken to map and analyse the provision of health education by SFC, and the analyses undertaken for NES’s Commissioning Plan for Education during 2006.

The document aims to explore how NES and SFC can work better together to secure best value from their investments, to maximise efficiency and productivity and to ensure sustainable long term services. It identifies key issues that influence funding, the supply of health education, and NHS demand with case studies to illustrate each issue. A brief overview of how health education is organised in other countries will follow.

The document then suggests what a successful health education structure would look like for students, universities and colleges, NHS Boards, the Scottish Government, the users of the health service and the public.

The key themes to be considered are:

- while the current provision is, by and large, providing the number of graduates required for the majority of health related professions, there are pressures in the system, especially with regard to the time it takes to train a health professional, the delivery of health education in remote and rural areas, meeting the educational needs for the new

roles in the NHS, and the expectation that all graduates should have a job in the NHS when they complete their studies. New demands from the Health Professions Council and healthcare science groups are also stressing the system;

- there is a perception that the current system of funding and delivering education and training of health professionals is not flexible enough to ensure that the workforce needs of the NHS are met. We need to investigate if this perception is accurate or if one of the key issues is the way that partners and institutions operate within this system;
- could these tensions be addressed by encouraging a better understanding of the funding system, and better partnerships between universities, colleges and the health service? Should new ways of providing education and training, such as common cores to courses for different health professions, be considered and encouraged to ensure that we are delivering the best health education in the most effective, flexible and transparent way?

The way forward:

Addressing the issues identified above is central to the work of both SFC and NES. The ways in which SFC support colleges and universities and NES supports the territorial NHS Boards have a significant impact on how they can respond to the needs of the health sector:

Some of this work is already happening, and both organisations are jointly and individually funding and supporting key projects and actions related to health education and research. Singly and jointly, NES and SFC are also well placed to facilitate improved understanding between the NHS and universities and colleges. There are also existing forums for discussion including NES's national strategic forum.

At SFC, the Skills Committee has given new focus to the allocation of funding to support skills needs, explicitly including needs in health.

At the same time, NES is undertaking a strategic engagement with the territorial NHS Boards and developing a "toolkit" to provide a guide for the more efficient commissioning of education.

However, both organisations also need to consider the impact of the choices made by learners and potential learners, to consider how best to match the choices people make in their career pathways, the role education

plays in encouraging people to remain and work in Scotland, and the needs of the health service.

Both organisations can also work towards a more efficient and effective system by brokerage and discussions with colleges, universities and other parts of the health service, the Health Directorate and Skills for Health (the sector skills council for the health sector).

As an important next step, the NES Board and the Scottish Funding Council have developed a Memorandum of Understanding. This memorandum includes:

- **a statement of the role of each organisation;**
- **a statement of the ways in which the two organisations will interact; and**
- **a commitment to develop annual action plans which will identify actions and projects with tangible outcomes under each key issue.**

The Scottish Funding Council and NES Board are holding a joint meeting on the 9 May to discuss these key issues and agree the way forward.

SFC and NES will also prioritise consulting with key stakeholders on the actions arising from our discussions, and on the future joint action plans.

Both organisations will also ensure that all actions relate to Scottish Government strategic policy drivers in consultation with the Government's Health Directorate and the Education and Life-Long Learning Directorate.

In addition to the joint actions and activities planned within the Memorandum of Understanding, we expect that there will be an important role for Skills Development Scotland and the relevant Sector Skills Councils.

Format of Paper:

This discussion document is not intended to map the education and training of health professionals, nor to provide statistics related to the number of medical students, attrition rates in pre-registration nursing programmes or the number of dentists needed in the Highlands, although these issues appear as case studies within the report. Its primary function is to assist both SFC and NES to develop their thinking on the strategic direction, and to consider and agree the most appropriate options for the delivery of more efficient and effective health education, to meet corporate objectives.

The document includes background information on each key theme and some case studies which illustrate where there are tensions and pressures in the system, and the underlying issues. We are also gathering information on the health education systems in other countries to help explore examples of best practice. An initial review of this information may be included in a later report.

Terminology:

When referring to health education, we mean: the training and education for the NHS and the wider health care workforce.

The scale of investment in the education and training for the NHS and the wider health care workforce.

The NHS is Scotland's largest single employer, employing nine per cent of all employees in Scotland. At September 2006, there were 157,986 staff in NHSScotland: 43 per cent in nursing and midwifery, 11 per cent medical and dental staff, 8 per cent therapeutic staff, 3 per cent healthcare science staff and one per cent pharmacy staff. The remainder (34 per cent) are non-clinical senior management, administrative, clerical, technical, ancillary and trade and works staff.¹

In the academic year 07-08, SFC will provide £160 million² to universities for the training of doctors, dentists, nurses, allied health professionals and for health-related postgraduate courses. This sum does not include funding for the training of healthcare scientists. Funding is also allocated to colleges to provide the early component of pre-registration and access courses in nursing, other health-related access courses and the training of dental technicians and dental nurses.

In the financial year 06-07, NES provided more than £343 million for the training and education of doctors, dentists, clinical psychologists, pharmacists, nurses, midwives, allied health professionals and other staff groups working in NHS Scotland. This included more than £290 million towards the salary costs of doctors, dentists and clinical psychologists in training. Funding to meet the costs incurred by NHS Boards in providing support to undergraduates in medicine and dentistry (ACT) is included in this figure.

In 2007-08, SFC provided £62 million to universities in Scotland to undertake health-related research. In addition, £27 million was awarded in 2007 to introduce pooling in life sciences which includes medical research. The Scottish Government Health Department Chief Scientist's Office will invest £62 million in NHS related research in 2007-2008. The Medical Research Council spent approximately £44.4 million on research in Scottish universities in 2006-2007, and there is also research funding made available from the Biotechnology and Biological Science Research Council to themes associated with medical research.

Information about the training budgets available within NHS Boards is limited because training budgets are allocated to departments on a historical basis. Departments then have discretion over whether and/or how budgets

¹ Source: ISD workforce statistics.

² All figures are rounded down and are for illustrative purposes only.

are used. Training is also often constrained by service delivery requirements. However, in an economic review undertaken by NES in 2005, the total expenditure on training by NHS Boards in Scotland for 04-05 was estimated at £22,550,000.³

³ Colin Tilley, *Commissioning Plan for Education, Training expenditure and output- a preliminary analysis*, (November 2005) section 9.

Policy background and current partnership arrangements

Scottish universities and the NHS are providing high quality graduates and opportunities for postgraduate training and education. The system is, on the whole, functioning well. However, it is a very complex system. Both SFC and NES recognise the importance of developing a closer partnership to improve the system and to make it more transparent. Enhancing the links between the two organisations is also a key objective in both corporate plans:

- aim 2 of SFC's Corporate Plan 06-09 states that "there are also opportunities for colleges and universities to contribute to the development of skills in the public sector. This includes the National Health Service- one of the largest employers in Scotland- where NHS Education for Scotland is taking forward a major strategy for workforce development in the health service".
- aim 2, objective 2 priority action 19 states that "SFC will work closely with NHS Education Scotland and others to support the Education and Training Policy Statements for NHS Scotland and to establish closer links between colleges, universities and health service providers".
- NES's Corporate Plan 07-08 states that NES will take forward the "Planning for Education" work on a partnership basis. Work within the "Planning for Education" remit includes a range of key activities, including strategic engagement with the Health Boards and developing a toolkit of resources to assist the NHS in commissioning education. Planning for Education work will be developed on four key principles to ensure best value and outcome for the NHS in Scotland
- The Scottish Government have also signalled the importance of partnership working within the context of *Better Health, Better Care*. It places a duty on the NHS to use public money effectively. *Skills for Scotland, A lifelong skills strategy* highlights the need for flexible provision which is increasingly responsive to the needs of individuals, employers and the wider economy.
- Recently, the Tooke report *Aspiring to Excellence*, the independent inquiry into modernising medical careers, recommended that there should be a strengthening of collaboration, particularly the health education sector partnership.

NES and the SFC are already collaborating on a number of projects:

- SFC is represented on the NES National Strategic Alliance which includes representatives from the Association of Scotland's Colleges, Universities Scotland, SQA, and Skills for Health;
- SFC has recently awarded a grant towards curriculum re-alignment of Allied Health Professionals;
- NES and SFC along with SGHD have been working in collaboration to develop the infrastructure for Nursing Midwifery and Allied Health Professionals (NMAHP) research in Scotland. In 2003, a joint funding scheme was agreed to develop the infrastructure for capacity and capability building for NMAHP Research. The total funding package for the project was £12.5m;
- NES and SFC have jointly funded the Clinical Skills Alliance as part of the Scottish Clinical Skills Strategy;
- NES and SFC are working together on the Remote and Rural Healthcare Alliance;
- NES and SFC jointly fund the Scottish School of Primary Care; and
- NES and the SFC are jointly developing the Scottish programme for training for academic medicine (Scottish Clinical Research Excellence Scheme, SCREDS)

The current system of funding and delivery of the education and training of health professionals.

For most subject areas at colleges and universities, the number of students admitted on each course and the courses on offer are decided by the college or university. These decisions are normally based on the demand for the particular subject, and the choices made by learners and potential learners.

However, the number of students who study medicine, dentistry and nursing and midwifery are controlled. This means that SGHD through SFC set a target for the number of students to be recruited in these subjects. With other health professions and healthcare support workers, including allied health professionals, psychologists, healthcare scientists, and pharmacists, the decision on how many students are recruited to the university or college is a decision of the institution.

At present, the funding from the Scottish Funding Council is in the form of a grant provided as part of the annual recurrent (core) teaching grant to each university. It is not paid directly to a department delivering health-related courses. In 07-08, the amount of funding provided for every preclinical dentist and doctor was £7,780 per year. At a clinical level, the amount increases to £15,395 per year. Universities receive £6,640 per year for each student on a course leading to an allied health profession or nursing degree.

The Scottish Funding Council funds academic teaching for all the health courses, while SGHD and NES cover the clinical placement costs and costs for teaching in clinical settings.

The SGHD and NES contribution comes in several ways:

- funding to NHS Boards to cover clinical teaching in hospitals and general practice (Additional Costs of Teaching – ACT) for both medical and dental students;
- funding for some teaching posts;
- funding for new courses – both start-up and sometimes recurrent – for some professions; and
- additional student places in dentistry.

Additionally, some students receive support in the form of bursaries (nurses, audiologists and dentists) which are funded by SGHD and administered through the Student Awards Agency for Scotland (SAAS). Under a special arrangement with the Department of Health, SAAS supports English, Welsh

and Northern Irish domiciled students taking an AHP or nursing and midwifery course in Scotland. Therefore, student support for these courses depends on the location of training rather than the residence of the student before training or after qualification. This differs from the conventional student support mechanism and also from the methods of funding universities.

NHS Boards also take a significant role in the training and development of their workforce. Departments are allocated a budget and decisions on any training to be commissioned or undertaken in the workplace are taken within that department. The Knowledge and Skills Framework within Agenda for Change is providing an opportunity for a more structured approach to training, but places an additional pressure on budgets.

An illustration of the funding of health professionals is included in appendix A.

The funding system in England has some similarities but is different in many respects. Both HEFCE – the English equivalent of SFC – and the NHS fund the training of undergraduate medicine and dentistry, with HEFCE’s funding allocated within the main recurrent teaching funds to each university as it is in Scotland. However, for nursing and allied health professions the health service contracts with HEIs directly. Funding does not flow through HEFCE for these courses.

In England, NHS funds are directed through the multi-professional education and training budget (MPET) which includes the non-medical education and training budget, the medical and dental education levy and the service increment for teaching (SIFT- England’s equivalent of ACT). These funds are managed by Strategic Health Authorities.

In England funding for training in academic medicine is ring-fenced funding for the Walport scheme, whereas in Scotland NES, CSO and SFC are working to develop a joined up system of career development for academic trainees (SCREDS).

The way in which these nursing and allied health professional contracts are managed in England has been the subject of recent discussion in the press. There is also debate over whether this funding system increases the likelihood of a ‘boom and bust’ situation as the strategic health authorities seek to meet competing targets and priorities.

Case Study:

Audiology:

As a result of technological developments in hearing aids, the then Scottish Executive Health Department funded an audiology modernisation project which included targets on patients being tested and assessed by trained staff.

Universities were unable to introduce a new course to meet this skills need from their core grant from SFC. In order to meet this Health Department target, SGHD provided NES with resources to fund the introduction of a BSc course and a related BSc conversion course which aimed to produce an additional 20 trained audiologists from 2007 and 70 from 2009 onwards.

Although the funding awarded from the Scottish Government will ensure that the shortfall of audiologists will be met by 2011, should the higher education system be able to respond to identified shortfalls or workforce needs without additional resource from the health sector?

Issues:

- The providers of training (universities and NHS Boards) have a close and long-term relationship which means that the current system of funding from two separate departments (with different priorities and objectives) may interact in ways that lead to the wrong outcomes. While universities need long-term stability to maintain capacity, the health service is driven – and often has to be – by more immediate priorities such as waiting lists.

Can we find ways to meet health service priorities while at the same time ensuring sustainability for the education sector?

- The funding map in appendix A displays how difficult it would be to track real costs of the education and training of health professionals. A Higher Education Policy Institute report concluded that “what is undeniable is that it is simply not possible for the Government to know if it obtains value for the very substantial resources expended on medical schools”.⁴

Can we find ways of ensuring we are getting the best value for investment in education and training?

⁴ T. Sastry, *The Education and Training of Medical and Health Professionals in Higher Education Institutions* (Higher Education Policy Institute, 2005) paragraph 26.

Supply and demand, workforce planning and the education of the NHS and the wider health care workforce

Background:

Although there are exceptions, in most health professions, demand for entry to courses is high.

In part, it could be argued that this high demand is because there is an expectation that entry to a course will lead to entry to a particular career. For many courses and for many years this has been a reasonable expectation; most dental students become dentists. However, this is not always the case. There have been recent concerns about the number of physiotherapy graduates who cannot find work (see the case study below) and, for different reasons, concerns about the number of medical graduates who have not found training places.

The Scottish Government determines the number of pre-registration nursing and midwifery students through the National Nursing and Midwifery Workforce Planning Process (formerly Student Nurse Intake Planning (SNIP) process). The process examines trends and future projections to support decision-making regarding student nurse and student midwife intake figures. Data is gathered through individual NHS Boards' workforce plans and through information supplied by non-NHS employers.

The numbers of medical and dental students are set by SGHD based on workforce needs identified by the National Workforce Planning Unit and NHS Boards.

The number of allied health professional students (along with all other health-related courses) is not determined by SGHD and therefore the number of students admitted on courses is based on demand for the subject. More recently, NES has been part of an integrated approach to consider the workforce needs and employment issues of all Allied Health Professions across Scotland.

Case studies:

Physiotherapists:

In 2005, the Scottish Executive Health Department calculated that there was a lack of physiotherapists. However, less than two years later, a survey, by

the Chartered Society of Physiotherapy, of Scottish physiotherapy graduates found that, following graduation, 80 per cent were not employed in permanent positions.

Is this a failure in workforce planning or in the educational system which is unable to respond quickly to changes in NHS workforce needs or changes in service delivery?

Nurses:

The numbers of nurses in education and training is set by SGHD based on data provided by NHS Boards. Although there has been an increase of 1,893 students entering nursing between 2000 (7,833) to 2005 (9,726), planning is particularly challenging in this area of health education for a number of reasons:

- unlike other health care subjects, nursing has a very high attrition rate. Between 2000-2003, the attrition rate in Scotland rose from 23.7% to 28.9% with variations in each NHS Board area;
- unlike other health care professions, nurses tend to study and enter the workforce close to their homes. This adds an additional layer of complexity in planning for the number of student nurses in each NHS Board, the contracts for their education and training with local providers; and (although the number of student nurses is rising) the number of nurses wishing to specialise in areas such as mental health and care of older people is not sufficient to meet the growing need in these areas of health care.

Some of the responses to these challenges include the development of initiatives, such as bursaries and the offer of a year's employment following graduation.

Issues:

- The fourth report of the House of Commons Health Committee on Workforce Planning (session 2006-2007) sets out the key issue clearly and succinctly:
“Workforce planning should be simple: decide what workforce is needed in the future and recruit and train it. In reality the task is difficult and complex. The future workforce is difficult to predict: technology and social changes mean some skills become quickly redundant... Even basic numbers are difficult to forecast: we may for example require fewer nurses and more doctors in 10 years- a problem which is exacerbated by the length of time it takes to train staff: three years for a nurse, 3 years for a physiotherapist, about 15 years for a surgeon. In addition, workforce planning has to be co-ordinated with financial and service plans.”

Workforce planning in the NHS in Scotland has developed greatly in recent years. How do we match workforce planning with the output of colleges and universities? Can we do it in a way that does not damage the capacity of colleges and universities to respond flexibly?

- Students studying for courses in the health professions, make a large investment in acquiring skills and knowledge which may be worth little outside the health sector. The health sector also makes an investment in these students through placements and supervision. These unique traits of health education raise uncertainties and higher risks for the students whose skills are not always transferable, for universities and colleges, and for the NHS if there is a mismatch between the output of the education system and the needs of the health sector.

Can we work in partnership to reduce this risk?

- There is a perception amongst graduates in the health professions that they will have the opportunity to find work in their chosen profession and undertake further training in circumstances which meet their needs.

Is this a reasonable expectation? Can these aspirations be met without damaging consequences?

The changing role of the health professional and skill enhancement

Background:

In order to meet changing health needs, the role of many traditional health professionals is changing. These changes are all set within the context of regulation.

In medicine and nursing, new roles such as anaesthesia practitioners, physician assistants, nurse endoscopists, and out of hours care practitioners are being developed, and GPs and other health professionals with a special interest are being trained in most areas of Scotland. In addition, the unregistered clinical workforce is being upskilled in a range of procedures. Work is currently underway to develop an education and training framework for health care support workers and assistant practitioners who will deliver protocol based clinical care under the direction and supervision of a registered practitioner. More specifically, education is currently being delivered to prepare maternity care assistants to support midwives, women and babies and to promote breastfeeding and good parenting.

Pharmacists are being given additional training to help them manage common conditions such as asthma and epilepsy and undertake supplementary prescribing. Pharmacist assistants are able to perform a range of tasks once restricted to pharmacists.

A key development in the provision of dental treatment is the upgrading of the professions allied to dentistry (now known as the Dental Care Professionals or DCPs). These include dental therapists and dental hygienists whose role is now combined into the new role of oral health therapist. The oral therapist is able to treat both adults and children and undertake clinical procedures in primary care. This was prohibited previously. In addition, the role of dental nurses is being augmented, so that some simple clinical procedures can be delivered by this group of staff.

Academic medicine is also becoming more specialised as research is increasingly undertaken in multi-disciplinary groups. The contribution that clinically trained scientists make to research in new therapies and drugs is also increasing. We also need to consider any changes to the role of doctors within the wider UK context and how the recommendations included in the Tooke Report will impact on postgraduate medical education.

These developments require changes to the training provision at pre-registration level and upskilling of existing staff. It may also require the recognition of prior learning and a greater understanding of how

this, and the learning required to address any skills gaps, align with the SCQF.

Case Studies:

Anaesthetics is the largest hospital medical speciality in the NHS. Recruitment of sufficient numbers of trained anaesthetists is proving difficult, jeopardising the achievement of NHS targets. The Anaesthesia Practitioner (AP) is a new member of the anaesthesia team in the UK recently introduced at a limited number of pilot sites. In Scotland, SGHD has commissioned NHS Education for Scotland to implement a phased introduction and assessment of this role.

The University of Edinburgh has been commissioned to provide academic support. SGHD has committed funding towards this programme.

Should this kind of educational provision be something that we should expect from the education sector without additional specific funding from the SGHD?

Psychology:

The Scottish Government has set a series of ambitious targets on access to evidence-based psychological interventions. In addition, to date, there has been no national plan for the role of psychologists in Scottish healthcare. To meet these challenges, SGHD is setting up a working group. NES, SFC and educational institutions will need to ensure that they align educational priorities with priorities and targets identified by the working group.

Meeting these challenges may require SFC and NES and the institutions to consider how undergraduate curricula meet the needs of the healthcare sector and articulate with post-graduate provision. It may require exploring the potential for a common foundation programme in applied psychology which would allow psychologists in training to transfer with greater ease between specialist areas; and helping to ensure that universities providing postgraduate clinical psychology training are working collaboratively to make the best use of resources.

Issues:

- **Can we find ways to design courses and to fund colleges and universities so that they can better respond to emerging changes in professional roles?**

- As some of these roles will be at different levels on the NHS careers framework from existing professions, **should we be seeking ways of having more people entering the workforce with different levels of qualifications and developing better relationships between Scotland's colleges and the universities through improved articulation arrangements to educate people for new roles?**
- **How do we encourage multi-disciplinary research in universities and colleges which will have a direct impact on the patient experience?**
- **How do we ensure that the learning which will be required for these new roles are properly recognised and credited within the Scottish Credit Qualifications Framework?**

Remote and Rural Issues

Access to education and training and health care in remote and rural areas of Scotland is a key priority within the NES Corporate Plan.

Background

A key element of the training of health professionals at both pre-registration and post-registration stage is clinical training. Traditionally, for medicine, a 'clinical' course lasted a minimum of three years, during which students worked under supervision in hospital wards. Although there have been some changes to the curriculum with more time devoted to communication skills, problem based learning and practical clinical tasks, these changes have increased the time which a student spends within the hospital or healthcare environment. The requirements for nursing and midwifery have been amended as a result of European and other legislation, but 50 per cent of their training is in practice based settings.

Health education for the professionals is, on the whole, delivered in cities, such as in Edinburgh, Glasgow, Aberdeen and Dundee.

Case Study

As part of the Dental Action Plan, NES is funding the revenue costs of teaching dental students in remote and rural situations in Scotland.

A dental nurse training scheme which serves the Highlands and the Islands is run in partnership with Inverness College by NES North Dental staff. This course attracts students from a wide geographical area and is supported by an on-line educational programme.

In the last two financial years (2006/07), out of 83 dental nurses undertaking a pre registration qualifications in the Highlands and Islands, 50 came from rural or island clinics or practices.

In addition, post qualification courses in oral health education were delivered on the Islands or block-release on the mainland. Of the 31 dental nurses who were successful, 17 came from rural or island clinics or practices.

Issues:

- Scotland has 20 per cent of its population in remote and rural areas. Access to education by practitioners providing health care to these areas is hampered by the distances to centres where educational programmes are usually delivered, and the time away from surgeries and places of work. NES is already addressing this issue through the Remote and Rural Healthcare Educational Alliance (RRHEAL) which is intended to deliver a nationwide approach to educational support for rural healthcare and providing support to rural initiatives, but there are still barriers to accessing education and training in remote and rural areas.
- In many professions it would be impossible to create the critical mass needed to recreate the traditional methods of delivering education in rural areas.

How do we make better use of the educational infrastructure we have in rural areas – the UHI Millennium Institute, the Crichton University Campus, the Open University and Scotland’s colleges – to deliver education and training in remote and rural areas?

Access to education and training for all NHS and health care workers

Background

In addition to the staff working in healthcare-related roles, there are over 50,000 other NHS staff who work in non-clinical roles such as support and administrative services. They provide services which are vital for ensuring a successful patient journey. Their work includes ensuring that operating theatres and hospital wards are cleaned to the high standards required to meet the stringent requirements for patient safety and that facilities are functioning safely and efficiently. They are also vital in ensuring that communication with patients over the course of their journey is timely and effective, and that patient notes are accurate, up- to-date and available when required by clinicians. The latter duties are carried out in a context in which data protection and information handling are under increasing scrutiny and regulation

NES has recently completed a major scoping study of the educational needs of these staff groups. The study revealed that:

- although the majority of staff hold academic qualifications, few have access to specific skills training related to the healthcare context in which they work;
- access to educational opportunities for this staff group is limited; and 50% of all respondents felt that they had little or no training in areas which are key to improving the patient's experience, such as communication skills. This was considered important since administrative staff are often the first point of contact for most patients in a healthcare context.

Issues:

- **Are universities and colleges providing the most appropriate training to ensure that present and future non clinical staff have the appropriate skills to meet the high standards required of the healthcare environment?**
- **How can we enhance the partnership between universities and colleges and the NHS to ensure that the skills acquired by students meet the needs of the employer?**

Issue:

SFC undertakes periodic reviews of its policy on e-learning and has completed a programme of funding for collaborative programmes whose aim is to bring about transformational change in its institutions. NES is in the process of developing an e-education strategy, and the capacity of its e-library to include more e-learning resources. This strategy is currently out for consultation. In addition, universities and colleges have developed their own e-learning resources to match the learning needs of their students.

How can we use existing e-learning resources in both organisations and in the education and health sector to improve access to education and training for all health workers no matter where they are in Scotland?

Widening access and diversity in all health professions

In June 2004, The British Medical Association (BMA) Board of Medical Education published a discussion paper on the demographics of undergraduates in Scotland's medical schools. The national data on applicants and accepted applicants to Scottish medical and dental schools by socio-economic groups in 2003 were:

	Applicants (%)	Accepted Applicants (%)
High managerial and professional	34.1	38.4
Lower managerial	25.3	25.7
Intermediate	9.5	9.5
Small employers	4.3	4.4
Lower supervisory	2.2	2.1
Semi-routine	6.0	5.7
Routine	2.0	1.8
Unknown	16.6	12.5

Source: Board of Medical Education, *The demography of medical schools: A discussion paper*, (June 2004) table 3.

These statistics show the disproportionately high percentage of applicants and acceptances to Scottish medical schools from high managerial and professional and lower managerial socio-economic groups (64 per cent).

In addition, the Calman review of basic medical education in Scotland stated "that diversity is not only about widening participation and entry from those from a disadvantaged background. It should also include those with greater maturity, different experiences, different motivations, and from different disciplines. This has an important effect on the profession and on the learning process"⁵.

The British Medical Association has also stated that it is important for health professionals to be as representative as possible of the society they serve to provide the best possible care to the UK population.⁶

⁵ Sir K. Calman and M. Paulson-Ellis *Review of Basic medical education in Scotland Report and Conclusions* (June 2004) paragraph 52.

⁶ Board of Medical Education, *The demography of medical schools: a discussion paper* (June 2004) pgs 5-6.

Case Study

In 2003, SFC, NES, the Brightside Trust and the “Determined to Succeed” programme (in Argyll and Bute) funded a joint pilot to raise awareness of study and career in the health professions and to do so in Scottish Schools which have a lower than average transfer of pupils to higher education or are in rural/island locations where recruitment to health services is a priority.

This programme has now been extended across Scotland (with additional funding from SFC, the Diversity Task Force of the then Scottish Executive Health Directorate, the regional access forums and local authorities) and includes a greater range of professions. In addition, the range of school pupils from communities and social backgrounds who would not generally consider such a professional future has also been extended.

There are also examples of widening access to the health professions from other parts of the UK which could be adopted in Scotland.

Issue:

How do we ensure that health profession graduates reflect the populations they serve? And, given the very high demand for places in medical and dental courses, what is the most effective method of widening access to these courses?

What would a successful system for educating and training health professionals look like?

1. For the patient:

A service where the patient has good access to appropriate care and has the confidence that the person responsible for their care has the appropriate knowledge and expertise. The mechanism and delivery of this requirement is not important to the patient.

2. For NHS Boards:

High quality, innovative, responsive, accessible, timely and modern educational provision to help deliver the best care for those who access their services, and which represents value for money.

3. For universities and colleges:

A system which is, overall, consistent and stable, so that institutions can plan for the future but one which also encourages responsiveness and flexibility through effective partnership and dialogue so that institutions, employers and funders can set and agree ambitious objectives and priorities.

4. For the future health care workforce:

High quality, relevant education delivered in modern facilities which are locally accessible, including first class educational, IT and student support, and the opportunity to obtain qualifications which facilitate future work force flexibility at a range of levels suited to their abilities and ambitions.

5. For the current NHS workforce:

Clear career pathways and accessible development opportunities along with the opportunity to train and develop the skills and knowledge needed not only to do their job efficiently and effectively but also to develop their careers.

6. For the Scottish Government Health Directorate:

An educational system that is flexible and responsive to the needs of the NHS workforce. A clear and transparent system of funding which represents value for money, and contributes to the continued improvement of patient services.

Appendix A

