ROUNDTABLE

A LOT TO LEARN

NHS training costs up to £5bn a year. Alison Moore reports on the lessons from a lively *HSJ* debate over radical government plans to reform it

Will the government's bold restructuring of NHS education and training deliver what is needed? And does it address the training and education needs of all NHS staff – including those without professional qualifications? With £4bn-£5bn being spent on education each year, a great deal is at stake.

An *HSJ* roundtable, sponsored by law firm Capsticks, brought together leading figures in healthcare education for a lively debate about the new education system and what it should aim to achieve.

The government's proposals in its recent report, *Liberating the NHS: developing the healthcare workforce*, include setting up a new body – Health Education England – greater involvement of employers through local NHS education and training boards and potential new methods of funding the service.

Chair Alastair Henderson, chief executive of the Academy of Medical Royal Colleges, set the scene by saying that the debate was about education and training for the whole workforce. "Are we clear what the problem is that we are trying to solve?" he asked. "Are we seeing another example of Department of Health policy and positions being a solution in search of a problem?"

Rob Smith, head of education commissioning and workforce planning at NHS London, said the reality was that resources were not always deployed on what the service needed and employers did not feel the system responded to their needs.

NHS Employers director Dean Royles added: "We can't just continue to do what we have been doing. We have to get more responsive to what the patients need and what employers will need."

But Professor David Sowden, chair of the Conference of Postgraduate Medical Deans of the UK, said he was not convinced the architects of the proposed changes understood the problems. Simplified quantitative data meant it was difficult to know exactly what was needed and it was a mistake to think of England as heterogenous – as there was inequality of funding that needed to be addressed.

Failed central planning?

Dr Andy Jones, medical director at Nuffield Health, argued that over the past 10 years there had been several attempts to resolve the problem that centralised planning of education did not seem to have worked. He reminded the panellists that: "For most organisations, adequate is not enough. Everyone has specific needs around their training." There needed to be links between the quantity of training and its quality, he said.

Capsticks partner Chris Brophy

'We can't do what we have been doing. We have to get more responsive to what patients and employers need'

Dr Jones pointed to the future NHS. Integrated care might demand different things of the workforce – such as clinicians with the skills to follow the pathway and potentially update pathways once they were established.

Siobhan Clarke, managing director of Kingston-based social enterprise Your Healthcare, raised the issue of the different planning cycles healthcare providers had to contend with. Service development might only be looking a year ahead, while workforce planning might have a five to seven year timespan and research and development might be looking 15 years ahead. "Until we get some alignment of these cycles then we have a problem," she said.

John Pope, managing director of London Commissioner for Medical and Dental Education, said the aim should be to improve care; whereas in the past healthcare professionals had been trained as individuals, training now needed to reflect their roles as members of teams and across pathways.

He recalled that as a chief executive he had been told that junior doctors were "a bit like a monastic organisation, they move through your organisation – they were good people but worked to someone else's rules". There needed to be a closer alignment to the employer.

Academics vs professionals

Paul Thomas, a GP and professor of primary care, pointed out the gap between education and service, and the need for increased understanding across it. "If we are serious about having academics and professionals working together we have to resolve some of these issues," he said.

What was needed, argued Professor Ieuan Ellis, chairman of the Council of Deans of Health, was change that improved patient outcomes. The question was how to break away from historic funding silos towards a multiprofessional workforce, based on evidence for

the medium to long term.

But Professor Sowden said: "We have started to articulate what the problems are but we are already presented with a part solution which was offered up before many of these issues were on the table." He was not convinced that what was on offer was the whole solution, yet there would be compulsory change from 2013.

"We need to be very careful about investing too much in structural architecture which may not prove to be fit for purpose," he said. There was a need for a flexible system that could evaluate change as it progressed and respond to it.

Mr Smith pointed out that different parts of the country might need different approaches. London had a market in training healthcare workers, with many providers, while other parts of the country were not in the same position and might have only one educational provider.

Professor Thomas said: "We need to rethink it from the point of view of the patient. What is it like to be an elderly person at home with four or five problems." Approaching it from this angle pointed towards case management, advance directives, social support and greater integrated care. There would be a need for generalists in the system but they would need real time access to specialist advice. "That turns education on its head," he said.

Capsticks partner Chris Brophy said: "Despite all the NHS changes over the last few years, quite a lot of the documentation does not seem to have changed. There's an issue around aligning the governance with what is happening.

"How do we have something which is flexible enough but which is useful, which can be followed and has performance criteria that can be managed?"

Dean Royles said there was an opportunity to change the level of employer involvement. "You would not get British Airways saying that they are not interested in the quality of their pilots," he said.

What the HEE wants

Health Education England will be at the heart of the proposed changes. Chris Outram, senior responsible officer for the shadow organisation, revealed some of its thinking, saying: "The first aim of this must be to be responsive to changes in society and changes in need, including public health needs.

"This has to go beyond transactional processes. It has to look at behaviours and attitudes as well as skills and competencies – though we do need to do skills and competencies. It has got to be more than just a lot of separate silos of professionals with sets of skills and competencies that work okay in their box but not with everybody else.

"We have to incentivise quality. We had some trainees come to a workshop we held recently and it was clear that when they got good training from a hospital, that hospital got no reward."

Mr Henderson took up the theme of quality to ask whether clinicians were being trained well. Mr Pope said medical staff were being trained quite well at postgraduate level but there was the question of whether they were being trained in the right things – they were not trained in leadership or population health, for example.

Professor Ellis said the truthful answer was probably that training was mixed but the onus should be on partnership between universities and employers [to develop it]. And for healthcare professionals other than doctors the focus tended to be on the three years of a degree course and less on further training beyond that.

Ms Clarke agreed the situation was variable and there tended to be a focus on training for one particular area such as acute care. "But people don't live in acute and primary care, they live in communities," she said. "If I was starting again I would have a core foundation for everyone in the public sector – looking at humanity, not just your skills but your attitudes. That would include everyone with a public facing role."

Health Education England

ROUNDTABLE PARTICIPANTS

Alastair Henderson roundtable chair and chief executive of the Academy of Medical Royal Colleges
Chris Brophy partner at Capsticks
Siobhan Clarke managing director, Your Healthcare
Professor Ieuan Ellis chair of the Council of Deans of Health
Dr Andy Jones medical director, Nuffield Health
Kate Lampard chair of the steering group for Health Education England
Christine Outram senior responsible officer for Health Education England and current managing director of Medical Education England
John Pope managing director, London Commissioner for Medical and Dental Education
Dean Royles director, NHS Employers
Rob Smith Head of education, commissioning and workforce planning, NHS London
Professor Paul Thomas GP, clinical director of Ealing Primary Care Trust and professor of primary care at Thames Valley University
Professor David Sowden chair, Conference of Postgraduate Medical Deans of the United Kingdom

Skills are not enough: (from left) Siobhan Clarke of Your Healthcare, who wants to see broader training for NHS staff; Ieuan Ellis; Alastair Henderson; Andy Jones; and Kate Lampard. Below: Christine Outram

steering group chair Kate Lampard said: "I have a strong suspicion that we don't focus on the people who are about to be released on patients and public and connect between their experience and what we think is their experience." This needed to be captured in the new architecture.

So how can good education and training be identified? Professor Sowden said it was very easy to measure education processes but any changes to outcomes would only emerge much further down the line and data would need to be collected over that time – a task every government had ducked out of starting.

Dr Jones argued there was a lot going right in medical education – the standardisation of foundation training had largely gone well, for example. But there had been an element of getting lost in the middle with some hospital training, although some royal colleges had done much work on both specific schemes and standards.

Shaky foundation?

But Professor Thomas was more sceptical about the state of medical education. "It takes five years to become a competent GP, because it takes that long for new doctors to realise they were only told a small part of the truth at medical school." He said: "I don't find it acceptable that foundation training leaves people so adrift with large bits of the truth." There was not enough emphasis on listening and synthesising which led to "silo, fragmented healthcare" with different disciplines not understanding each other.

Mr Brophy added there was also something about taking on board what patients and service users felt – something that social enterprises were trying to get close to with people who were potentially members.

Ms Clarke said that patients did not want to be visited by people from a vast range of professions – and this highlighted the need for a core foundation to training.

Mr Henderson brought up the question of local education and training boards – the local bodies which will represent the views of employers from across the sector and play a pivotal role in future training and education. It was not yet clear how many of these bodies there would be and how wide an area each one will cover – how would this affect employer buy-in?

Mr Royles said he expected to see some variation around the country in terms of size and the possibility of some "sub LETBs". But the critical thing was whether they were seen to be influential. "It is less about the size and more about whether people feel they are having influence within their local community and have the authority to do the things they want." It was important that this involvement and influence, which had been promised, was delivered.

'It takes five years to become a competent GP, as it takes that long for new doctors to realise they were only told a small part of the truth at medical school'

Professor Sowden added: "One of the difficulties that we have is that we were launched on this path several months ago and we are effectively in planning blight because of the pause [in reform]. If we are not clear very quickly about the model they [managers] will move into then we will find it hard to get the management involvement. If we talk to them about 2013, a lot of chief executives say they are not even sure they are going to be around by then!"

Uncertain reforms

Chris Outram agreed the sooner they could be definite about organisational form the better – and they would be able to be soon. But the organisational form of the NHS did not alter the need for flexible organisations that could respond to local workforce needs.

Mr Henderson – who jokingly suggested that the new NHS organisations could be called workforce development confederations – then asked whether employers knew what they wanted in terms of education and could articulate this.

Ms Clarke said she thought employers were very good at this but suggested that health and wellbeing boards could be given

WILDE FRY

New national player: (from left) Chris Outram, who is overseeing the new Health Education England body, Dean Royles, John Pope (top), Rob Smith and David Sowden. Below (from top): Paul Thomas, Siobhan Clarke and Ieuan Ellis

a stronger role – along with the input of the director of public health who had a needs assessment and knew what workforce was needed.

Mr Smith pointed out that sometimes there was a need to look at the bigger workforce picture – such as when thinking about small specialist groups of workers or where training new workers would take a long time. There was a need to look at the supply side too: the London area had more foundation level doctors than it needed, but it was effectively training for a wider area and these doctors would go to posts elsewhere.

Mr Royles responded: "Employers are uniquely placed. We trust them to run organisations that are responsible for the care and safety of their communities. In a way, an employer view has a clinical view and a patient view.

"The other thing they have got is about the whole workforce – including bands one to four. We tend to focus on the registered workforces but about 40 per cent of the staff are not in that category but do 80 per cent of the patient contact." Employers could bring their perspective on what these lower band workers ought to be doing.

Employer power

But Professor Sowden pointed out that existing workers needed to be thought about as well. "The drip feeding of the new workforce has very little impact on the swimming pool that is the NHS. There is a lot of talk about the new workforce which is coming through not being adequate but much less about the workforce that is there being right for the service today. The employers have direct control over that."

'Existing workers need to be thought about. The drip feeding of the new workforce has little impact on the swimming pool that is the NHS'

This raised issues about training and development needs – and how they fitted into team and organisational needs.

For instance, Professor Sowden said he was surprised that some consultants simply determine which courses they went on without reference to this wider picture and team approach.

Professor Ellis said the aim should be to create a workforce that could improve patient outcomes – and not all were employed directly by the NHS: many healthcare staff were employed by universities as lecturers and research staff but they were not included in the government's thinking.

Dr Jones said great providers around the world put a significant part of revenues – between 3 and 7 per cent – into training their workforce. "The best organisations that engage in training will end up with the better workforce," he said.

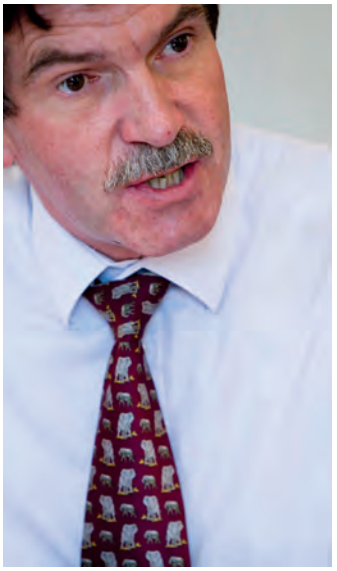
"I would hope that the best organisations are planning three to five years ahead in terms of strategy, services and where they are going to put their resources – both capital assets and people."

Mr Henderson raised the question of how private and other providers see their relationship with the LETBs. Dr Jones said they had found it difficult to engage with traditional approaches to healthcare education but Health Education England might change this. More innovative models could emerge and organisations such as Nuffield could become involved in providing choice and distinctive programmes for training.

Professor Thomas suggested that the definitions of public and private would need to be rethought – for example, many providers might be technically private but have a public sector ethos depending on the definition. Your Healthcare's Ms Clarke said it was crucial for her organisation to still be seen as part of the health and social care environment – especially as it was the local statutory provider.

Quality of local boards

An emerging issue with LETBs is whether they can quality assure themselves – especially if they are assessing the training offered by their members. Professor Sowden stressed the importance of governance arrangements and the need for checks and balances – but there were risks associated with it. "There must be a line of accountability from the



postgraduate dean both to the regulator and Health Education England. On occasions, it will mean the postgraduate dean would have to do things the LETB does not want them to do," he said.

But providers were concerned about quality and would drive to uphold it, said Ms Outram. "If you have to wait for an external regulator to come in then something has gone very wrong," she said. A nurse director or medical director would have levers to pull if they felt something was going wrong.

There was concern from Mr Royles that too many barriers should not be set up. Kate Lampard added: "We have to accept that life is quite complicated ... if we try to impose a perfect system that is madness. We have to put into place a light touch but generally accepted system. We have to accept that within that system we have to be very smart and rely on common sense."

And Ms Outram reminded panellists this was a system that was going to be built on local plans and needed to be in touch with local reality. But the HEE would need to think about the longer term security of the workforce – for example if LETBs were proposing not to train sufficient numbers of some staff groups. "I think HEE will have a kind of brokering role but it won't make sense to just impose by diktat," she said.

Professor Ellis pointed out the difficulty LETBs would have in identifying how many people they needed in some smaller staff groups – for example small allied health professions. And he was concerned that long term views of the workforce needs could lose out to short term cash problems.

Lack of planning

Professor Sowden pointed out the importance of good data in planning the workforce – and of taking it into account. In general practice, for example, there had been a lack of planning in the past 20 years. "We are staring down the barrel of a gun ... We are looking at areas of the country which will not have a single GP for many tens of miles – how has this happened?" he asked.

Mr Henderson raised the issue of whether postgraduate medical training was provided by organisations committed to

CHRIS BROPHY ON THE NEW TRAINING MODEL

There is often a point in any process of transformational change when you have deconstructed the original model with all the remaining useful parts laid out, but you are staring into the abyss because you do not have anything new in its place yet. Perhaps, like taking a car apart to give it a good service, it's rather scary looking at the pile of parts.

If people have had those scary moments in the field of training and education, we are able to pass on the evidence of the roundtable which seemed to consolidate and isolate some key components that everybody agreed needed to be built into the new system. We can perhaps just begin to start to breathe a little more easily because of the following consensus:

- We must use the funds in a more effective and efficient way. This must be a key feature of any major NHS project in the context of the Nicholson challenge but it applies to education and training in particular. It has become increasingly apparent that this area has had some quite immovable blocks of hard currency, difficult to break up and not able to be easily slotted directly into those areas in the system which really needed resource from time to time. Instead of money following individuals through their education and training journey, it seems at times to have just been fed through particular traditional points – lessening its impact. As Rob Smith said, resources are not always deployed on what the service needs.

'The way local education boards function will underpin, or undermine, the whole training structure'

- A service that is responsive to the changing needs of the whole system is crucial and this ties into more flexible funding flows, because if we do not have the latter we are unlikely to create the former. Conversely, there would not be much in point having a sophisticated cash-injection system without some sort of "valve" or mechanism to regulate and alter its flow to ensure that it gets directly to where it needs to be. As David Sowden said, there is a need for a flexible system which can evaluate change as it progresses and respond to it.
- Quality is really important. Given the type of services we are talking about, quality must be attained, maintained and assured. One of the really interesting aspects of the quality discussion was its linkage to the holistic nature of the training. As Chris Outram said, it has got to be more than just a lot of separate silos of professionals with sets of skills and competencies that work okay in their box but not with everybody else. Siobhan Clarke went on to comment that people do not live in acute and primary care, they live in communities. Professor Thomas commented that there was not enough emphasis on listening and synthesising.
- Not only is there a need for a better understanding between the different professionals, but also between the different provider organisations. The importance of the local education and training boards here cannot be underestimated and the way in which they will operate and function will underpin, or undermine, the whole education and training structure. An important issue will be how private providers link with the LETBs. As Siobhan Clarke said, it is crucial that her social enterprise organisation, which has a public sector ethos but a private sector vehicle, is still seen as part of the health and social care environment. The other key tool for LETBs is data. Professor Sowden pointed out how important this is in planning the workforce and taking it into account.

Chris Brophy is a partner at Capsticks

WILDE FRY

ROUNDTABLE: EDUCATION

Leading the debate: (clockwise from left) roundtable chair Alastair Henderson, Andy Jones, Kate Lampard, John Pope and Chris Outram

excellent training and whether this should be provided everywhere. Mr Pope said it should not be everywhere and they needed to move away from an addiction to trainees. "You can't have poor quality service and good training – they don't go together," he said.

Professor Sowden added: "How do you best provide care across the whole of the system? I would suggest a system which works on the basis that we have an untrained doctor and a trained doctor and nothing in between is not one that is rational.

"Somewhere along the line you have to redesign the system. It is no longer rational to say to someone that you will go to medical school and 15 years later you [will] become a consultant. I will probably be shot for saying that!"

Replacing the trainees

Ms Outram said that education had to support the service both in the future and now – though it was doubtful that everywhere would train in the future. But trained doctors would be needed to replace those trainee doctors. "It can't be locums. It has to be proper careers for people who are not yet and may not ever be consultants."

Dr Jones urged a more market-oriented approach to this. Providers should make it clear what they are looking for, he said, and trainees would decide what sort of place they wanted to be involved with: "If you really believe that markets clear themselves, there will always be a point of equilibrium."

How any new training system is going to be funded is always going to be contentious – and one contentious point was whether all providers who use qualified staff should contribute to the cost of their training.

'One contentious point was whether all providers who use qualified staff should contribute to the cost of their training'

Should providers pay a levy?

Dr Jones said: "This all comes down to the argument of the level playing field and whether all providers are going to be topsliced or pay a levy to contribute to training for the workforce of the future.

"But I think it is more complicated than that. It is only going to work if we embrace the level playing field aim and ensure that all aspects are going to be equal."

He added that topslicing private providers for training would not work if other aspects of provision – such as access to capital – were not on the same level playing field basis.

Ms Clarke suggested that contributions to training funds needed to be linked to contracts to deliver NHS services.

Other panellists were keen to point out the variety of training on offer to NHS staff – much of which was not paid for under the multiprofessional education and training funding stream and involved a wide choice of providers.

Finally, Mr Henderson asked the panel what they thought would be the most significant change as a result of the reforms and what their aspirations would be. Not surprisingly views differed – through there was general agreement with John Pope that having a debate about education and training could only be a good thing as it put it on the agenda. Mr Smith agreed that there was an appetite to define the structure around what the service needed.

Ms Clarke said there was a window of opportunity to ensure that the system did connect. Dr Jones said: "My hope for the future is that we create a marketplace for training." But he added that clinicians needed to be taught how to run organisations – something which they received little training on now. Mr Brophy raised the issue of procurement – and trying to get a process by which people could check that they are getting value for money. The changes were a chance to bring a bit of rigour into this.

Ms Outram reminded the participants that they were not dealing with a broken system: they needed to be evolutionary and to preserve good things that were already happening, while moving forward in areas that were not so good.

Professor Ellis suggested there was a need to look at some specific areas where they could look at quality such as the care of older people. But the danger was getting caught up in a transitional silo-based system.

Mr Royles said he was confident in people's ability to rise to the challenges but there was a need to keep them engaged. Professor Sowden highlighted the need to think long-term – beyond the timespan of a government – and said it was important to secure a system that provided the best possible care in the future.

Kate Lampard said she hoped the new arrangements would rebalance the contributions of those involved in training and education so that all the sector employers had the opportunity to make a contribution.

And Mr Henderson pointed to the potential for the NHS to finally obtain a clear picture of what quality in education and training looked like. ●

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