Transforming Learning in the NHS: reflections on the experience of NHSU

This paper is the product of the NHSU quality assurance process, supplemented by the one external evaluation which NHSU commissioned, and discussions among teams of staff and individuals within NHSU during the three months prior to closure.

The paper is a reflection on some of the detail of the NHSU experience and may be of some use to those seeking to develop national processes for promoting learning in the NHS in the future. It is not an impartial evaluation, and has only considered the views of stakeholders or customers from outside the organisation where these are captured through the quality assurance process itself (which generated 174 separate reports, on programmes, units, regions and Trusts). It has been produced by NHSU staff during the preparation for closure. Its strength is that it was written when all the staff involved were still in post and all the documentation was available for reference. Its limitation is that it is inevitably coloured by the perceptions of staff who were deeply immersed in, and committed to, the NHSU project. It should be read in that light.

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Contents

1. Introduction....3
2. The NHSU and its policy context....3
The policy context....4
The nature and function of NHSU....5
Securing a mandate and authority....5
Understanding stakeholders and customers....5
Bridging cultures....6
Defining functions....7
Securing appropriate continuity and autonomy....8
Crossing the boundaries of Government Departments....8
The closure decision....9
3. The conditions for learning in the NHS....11
Embedding learning in the NHS....11
Demand and participation in learning....12
Learning programmes – management and delivery....12
Building learning capacity....14
Developing a curriculum....16
Creating a framework for information advice and guidance....17
Creating a Virtual Campus....17
4. An institution to support learning in the NHS....19
Governance and external relationships....19
Organisational development....19
Finance and business models....20
Performance and accountability....22
Human Resources....23
Quality management....23
Branding and public image....24
External partnerships....24
5. The Impact of NHSU....26
Changes in NHS staff....26
Changes in Trusts....27
Research into Learning in the NHS....27
6. Some conclusions....28
Annex 1 – NHSU's Learning Programmes....29
Annex 2 – NHSU Expenditure 2003-4 to 2004-5....35

1. Introduction

In 2001 the Labour Party Manifesto announced the intention to create a "University for the NHS" to transform learning for all those working in the service, and in 2002 NHSU was created as a unit within the Department of Health. It became a Special Health Authority in Autumn 2003 and its first programmes were launched in Spring 2004. However, less than six months later, following a global review of all Arms Length Bodies in the NHS, Ministers decided that NHSU should close in summer 2005.

During its short life, substantial resources were committed to NHSU, and it is important to understand what has been learned: about how learning can be managed and supported in the NHS, and the conditions which make this possible and effective. This paper therefore reflects on NHSU's experience of three years developing innovative solutions to the training needs of the service, and trying to bridge the cultural divide between the NHS and the world of education. It aims to distil lessons for those who seek to solve similar problems in the future, either within the NHS or in other sectors.

2. The NHSU and its policy context

Like most large organisations, **the NHS is constantly undergoing change**, but the pace of change has accelerated in recent years, and the decision to create NHSU was announced in the 2001 Labour Party Manifesto which argued that

> *the NHS needs radical reform to fulfil its founding principle of quality treatment based on need, not ability to pay*
> *(Labour Party Manifesto 2001)*

NHSU must be seen then as essentially the product of a political perception of a policy problem, and unlike most "corporate universities" it did not spring from demand within the organisation itself. This helps to explain some of the problems of authority and credibility which it struggled with (albeit with growing success) throughout its life.

Three years later, the political agenda had moved on, and a new set of challenges faced the service. A new set of transformations were being proposed, which were to affect what its staff need to know and be able to do, and the nature of the organisations in which they will be doing it. Some aspects of these changes include:

- devolution of control closer to the front line of delivery
- increasing diversity of service delivery systems and structures
- focus on patient choice, and patient and public involvement in the service
- payment by results
- patient based commissioning
- changing staff roles and increased interdisciplinary working
- pay modernisation
- more coordinated approaches to training and qualification

The policy context

1. NHSU did not operate in a policy vacuum, and the NHS is well known for the scale and frequency of policy initiatives and reorganisations. **Throughout NHSU's lifetime the NHS itself was experiencing major changes**, many of which had implications for education and training in the service. In some cases NHSU was asked to take on a key role in helping the service to respond, while in others, structural changes involving NHSU were proposed to address issues (like the planned mergers with the Leadership Centre and the Information Authority). However, in some cases developments happened without any cross reference to NHSU. Some key changes included:
    - Devolution of responsibilities and budgets from DH to SHAs, changed the stakeholder relationships for NHSU
    - Conversion of WDCs to WDDs, changed the ways in which education and training was supported on the ground
    - Creation of Skills for Health, created some ambiguity about relative roles
    - Dissolution of the NHS Information Authority, with the plan to merge NHSIA into NHSU (not carried out)
    - Launch of the National Programme for IT, with major potential learning issues for staff throughout the NHS
2. **By early 2005 revealed that NHSU was providing support for 10 of the major policy initiatives in progress**. These were:
    - Agenda for Change
    - CNST Risk Management Standards
    - Improving Working Lives
    - Investors in People
    - Knowledge and Skills Framework
    - NHS core Principles
    - NHS Plan/Improvement Plan
    - Skills Escalator
    - Standards for Better Health
    - Working Together: Learning Together
3. **There were also relevant developments in national policy outside the NHS**, not all of which were well articulated with the changes inside the service. These included:
    - Publication of the Government's Skills Strategy
    - Publication of e-learning strategies by DfES and HEFCE
    - The closure of the national Individual Learning Accounts programme, which NHSU continued for the NHS
    - The closure of the e-university, a parallel major IT based learning initiative
    - Major initiatives to encourage widening participation in both FE and HE

The nature and function of NHSU

Securing a mandate and authority

4. **A national organisation which is to have a strategic effect on the whole NHS needs a mandate acceptable both to Government and to the service,** in addition to relevant technical expertise and knowledge. Where it also engages with the public and private education and training services, its authority must also be recognised there. Without such a mandate its work is likely at best to be more difficult, and probably impossible.
5. **Securing such a mandate from the NHS is difficult** since the service is strongly fragmented, with a growing degree of devolution of authority to local and semi-autonomous entities, and a great deal of power over education and qualification issues resting with professional and regulatory bodies. It is important therefore not to believe that a mandate from Government, nor from SHAs or Trusts alone, is sufficient to secure support.
6. **The idea of NHSU was owned by Ministers, but not sufficiently by DH, the NHS or the FHE system**. While it had constitutional legitimacy, none of the key stakeholders felt any obligation to support or defend it, and at times some were actively hostile. One result was the early abandonment of the aspiration to undertake substantial work in HE, in the face of strong resistance from the HE sector.

Understanding stakeholders and customers

7. **Learning in the NHS involves a very wide range of agencies**, some devoted exclusively to the Health sector (or some part of it, like the Royal Colleges), and others, like FE and HE institutions for whom health is only one of a number of concerns (although for some of these it is critical to their survival).
8. **A national agency therefore needs to work with a wide range of stakeholders, partners and customers**, and understand the difference between these. It also had to respond both to priorities from the field, and urgent and politically sensitive national priorities. At an early stage NHSU took an active decision to focus its attention on what it saw as its primary customers, the Trusts, but in doing so probably neglected the strategic importance of support from the SHAs and WDDs. The difficulty of managing these conflicting relationships at times resulted in a lack of focus, leaving staff, customers and stakeholders confused about precisely what NHSU was seeking to achieve. This was exacerbated by the organisation's tendency to try to respond to every new initiative.
9. The key stakeholders were:
    a. **Department of Health.** As a Ministerial initiative, NHSU sought to respond to Government political priorities to bring about change in the NHS. NHSU was relatively successful in addressing these. In the event, all but two of the programmes developed resulted from such national concerns. One particularly important area was in widening participation in learning by those who have traditionally received the least training. Here NHSU set ambitious targets, which Ministers and staff saw as important, but which were not always seen as a high priority for the NHS in the field.

b. **The NHS "front line"**. Priorities perceived by the service on the ground (where training happens) did not always correspond to these national views, creating a perception that its work was not responding to real service need. The Regional structure sought to mediate this, but the result was some tension within NHSU between centre and regions. Two programmes (Statutory/Mandatory Skills and Hospitals at Night) resulted from direct demands from the NHS in the field.

c. **SHAs, WDCs and WDDs.** The regional structures of the NHS were undergoing transformation at the time when NHSU was created, making communication difficult, and the building of stable relationships problematic. The result was that SHAs and WDDs were less involved in the development of NHSU and its agenda, and when their structure settled down, they were not always clear what value NHSU added to what they were already doing

d. **Special interest groups**. A range of special interest groups and agencies within and outside the NHS sought to use NHSU as a vehicle to promote learning related to their special interests. Some of these collaborations were very effective, especially in informing the design and delivery of particular programmes (e.g. Diabetic Retinal Screening), but sometimes they diverted energy and reduced focus on core business.

e. **Higher and Further Education institutions**. FHE institutions had mixed views, sometimes seeing NHSU as a source of funding for their own work, sometimes as a commercial competitor, sometimes as a resource provider.

f. **Trainers.** Trainers within the NHS saw it as a potential ally to raise their skills and standing within the service. Sometimes this relationship was mistaken for strategic engagement with Trusts themselves.

g. **Quality agencies.** The national agencies responsible for the quality and coherence of post school education and training were happy to collaborate with NHSU, and formal agreements were reached with the relevant agencies in FE and HE. However, NHSU sought to operate across the boundaries of the various organisations, which at times made procedures cumbersome and complex.

Bridging cultures

10. **Bridging the very different cultures of the NHS and the education service is a serious challenge**. While the NHS maintains a long term continuity of service, its structures and policies are accustomed to reacting rapidly to changing political priorities. It therefore tends to be reactive, short-term and target driven. The public education service, on the other hand, is accustomed to a greater degree of institutional autonomy, recognising the long term processes of learning, which require continuity from conception of a course through design, and delivery to graduation. It is therefore used to long lead times and elaborate accountability processes. For a significant University programme, for example, two years in development and a further three years to graduation is not unusual.
11. Furthermore, within education, **the cultural divide between FE and HE is also substantial,** and again NHSU sought to bridge the gulf. This involved

considerable work, for example, to try to meet the quality assurance requirements of the two sectors.

Defining functions

12. **While there is a case to be made for a national organisation or initiative in education in the NHS, it does not follow that all the possible cases are necessarily compatible**. The possible options include: a strategic need to identify priorities and needs; an agency to commission programmes and strategies; a provider of programmes or consultancy to the service.
13. **There was no clear consensus on the overall function of NHSU**, and as a consequence, it was seen as a potential competitor by FE and HE institutions, which were nervous about collaboration, and in some cases actively hostile. While some NHSU quality reports on individual Trusts and SHAs report that fear of competition led to change in those institutions, this ambiguity was probably counterproductive.
14. **The balance between addressing the learning needs of individual staff or the strategic priorities of the service was not clearly articulated**. There was a continuing tension between meeting the needs of individuals (the core purpose of a conventional educational institution) and the needs of the service (the concern of the NHS, and the business of a corporate University). This is arguably a more serious issue for NHSU than for other corporate universities because of the scale and range of what NHSU was seeking to achieve. It is clear that the primary focus of a national agency must ultimately be on the needs of the service, achieving this calls for motivating all staff to become successful learners, which requires that they feel some ownership of their learning and priorities. Furthermore, some of the long term underpinning problems of the service arise from a failure to tackle issues like literacy and numeracy which limit the flexibility and growth of the service. NHSU achieved remarkable success in raising the profile of such needs within the service, and in developing strategies to address them.
15. **The need for, and implications of seeking, university status was never clarified or agreed**, internally or externally, although in retrospect it is clear that something like University status was required to give the organisation sufficient long term stability to carry out its core purposes. University status was implicit in the Manifesto commitment, and remained a priority for Ministers, but there was never a consensus about how far, and in what sense, NHSU was to be a "university**".** Not all those within, and few outside, believed that a University was needed or wanted by the NHS. The metaphor of a "university" created inappropriate mental models of the organisation (e.g. treating learners as "students" when they thought of themselves as "staff", enrolling them as students of NHSU, although programme delivery was almost entirely through partners; and seeking to meet the requirements of a quality assurance regime designed for a conventional university). One consequence of the quest for University status was a distortion of priorities in the early stages of planning, when it was felt necessary to generate sufficient programmes and learner numbers at HE level to satisfy requirements for HE status, regardless of service priorities, operational practicality, or institutional competition. Although this priority was later abandoned, in the face of

opposition from the mainstream HE system, its legacy remained in some of the structures and thinking.

Securing appropriate continuity and autonomy

16. **The development and maintenance of high quality learning programmes and materials requires organisational stability.** Creating learning programmes which can guarantee the quality of subsequent learner performance in the workplace and can be delivered consistently on a very large scale is necessarily a slow process, especially if the learning is to be accredited and recognised within the FE and HE system. It also depends on the creation of a solid body of knowledge and staff expertise which itself requires long term stability. Furthermore, it takes time to build trust among partners, customers and stakeholders, and in the early stages of development the scepticism of many Trusts about the capacity of NHSU to help them address their problems was exacerbated by NHSU's attempts to project a high quality brand, before it had any products available in the field. By Spring 2005, when Trusts had used the programmes, and Regional teams had established their credibility on the ground, this scepticism had largely been dispelled, but it was still widespread in summer 2004 when the closure decision was made.
17. The question of **how much autonomy the NHSU needed** was never resolved, but was clearly the cause of considerable unease in the service and the Department of Health. Although corporate universities do not generally have the degree of autonomy which is regarded as necessary to achieve this in a conventional HE institution, the NHS is well known for frequent and rapid structural changes, and only agencies with very sharply focused functions survive for more than a few years. In the education sector this would be regarded as impractically short lived. Without this stability, and a degree of independence it is difficult for an educational body to operate.

Crossing the boundaries of Government Departments

18. **As the largest employer in the UK, the NHS has a particular place in the national employment scene**, where Government was actively developing a national Skills Strategy (two national Skills Strategies were published during the life of NHSU). It is not clear that the decision to close NHSU was informed by the thinking behind the second Skills Strategy, which was published at the same time as the decision to close NHSU was announced.
19. NHSU was intended **to operate across the boundaries between the Departments of Health and Education and Skills**. However, it was not always clear that the DH and DfES were effectively communicating about how the NHSU was to operate, and its implications for the established FE and HE sector. In the event, NHSU was successful at brokering a range of partnerships between agencies like the Learning and Skills Council and the HE Funding Council and the NHS, generating innovative approaches to problems, and securing funding for major initiatives, which had previously proved difficult for the Departments to do directly. However, strategic engagement across Departmental boundaries was less successful.
20. The **boundaries between Health and Social Care** are also relevant, and necessarily complex, since staff work together in the field as a matter of course, but organisational structures and accountabilities are very different.

Although NHSU was asked to address learning issues across the divide, this proved problematic, since DH resources could not properly be used for the learning needs of Local Government employees. In practice some NHSU resources, and staff time was used productively, especially with mixed staff groups across the divide, but this was despite, rather than because of, the engagement of the two Departments.

The closure decision

21. **The decision to close NHSU was made as part of the overall review of all Arms Length Bodies in the NHS**, in the context of a policy to streamline national agencies, reduce civil service manpower, and move control of the service close to the front line. However, the cultures of health and education are accustomed to very different timescales, and different expectations about the continuity of organisations and speed of delivery. It is not uncommon in the NHS for national organisations to exist for only a few years, and to expect delivery of results within months. By contrast, the normal life of an educational institution is measured at least in decades, and the timescales for developing and delivering educational programmes are usually measured in years. This clash is fundamental to understanding the problem of the closure of the NHSU: for many in the NHS, the organisation had failed to deliver, while for those from an educational background, the decision to review its future was clearly premature. Most of those responding to the two reviews in the summer of 2004 had not seen finished NHSU material, and attitudes changed markedly in the following year.
22. **The electoral cycle was also relevant**. Immediately after General Elections all Governments set out with enthusiasm to create new structures and systems to implement their manifesto commitments. However, as the next election approaches, the focus of attention shifts to accountability and value for money. The development of NHSU was out of step with this cycle, created on the upswing of this cycle, but evaluated on the downswing, before it had put in place many of the services and programmes which it had been developing. The large scale impact, and support in the field which had been achieved by the summer of 2005, was not demonstrable in the summer of 2004 when the review took place. It is possible that, had the review taken place a year later, with learner numbers approaching 10% of the workforce, and learner satisfaction levels very high, there would have been stronger pressure from the field to retain the organisation.
23. **Developments in the NHS itself also had a bearing on the nature and extent of support** for NHSU. The service was passing from a period of strong centralisation to a much more devolved model. NHSU began life with close linkage to the Department of Health. However, as devolution to the SHAs developed, decision making moved closer to the front line, where the central agendas were seen as of lower priority. NHSU found itself torn between loyalty to a top down centralist view of the service and its needs on one hand, and a bottom up service led one on the other. In retrospect, the decision to concentrate on relationships with the primary customers, the Trusts, at the expense of the emerging major stakeholders, the SHAs may seem a mistake.
24. **If these factors had been understood, and it had been possible to anticipate the policy changes which took place between 2001 and 2004, it**

seems likely that Government would have approached the creation of NHSU in a different way, and that its work plan would have been radically different. This conclusion rests, of course, on the benefit of hindsight, but one might speculate that Government would have put less emphasis on the issue of University status, and NHSU would have spent less energy building an institution capable of surviving for a decade, and more on "quick wins" in terms of immediate service impact, if these issues had been better understood. In the short term, the result might have been better for the NHS. Whether this would, in the long term, have been better for the service than what was attempted will never be known.

3. The conditions for learning in the NHS

The quality of staff skills and knowledge in the NHS is literally a matter of life and death. However, there are many pressures on resources and especially on staff time for training. It is vital therefore to understand how learning can be best embedded in the everyday working of the service, so that it is a part of the service, and not an inconvenient diversion from the main business.

Embedding learning in the NHS

25. The primary concern of a health service is to deliver patient care. While it is important that staff have appropriate skills and knowledge, developing these, once in post, is always likely to take second place to the delivery of care. **If learning is to happen, and play a significant part in the evolution of the service, it is critical that approaches are developed which embed it firmly in the day to day working of the service**.
26. **Getting practical commitment to training in Trusts is problematic**. The experience of NHSU's Regional teams was that Trust Chief Executives endorse the importance of learning to the quality and development of the service, but in practice pressured middle managers often give it a low priority, and some Trusts lack a robust training infrastructure (both human and technological). The result is a "training" culture in which short term and instrumental models are adopted, rather than educational models which could strengthen the learning capacity of the system as a whole, and its ability to respond to changing and rising skill needs. This dynamic was not always understood by staff within NHSU.
27. There are many day to day problems which make committing staff time to learning difficult in practice. Where learning activities called for release of staff from their normal work **there were often problems with freeing staff time and backfill** in many Trusts, resulting in poorer take-up than expected. In the early stages this was exacerbated by the need to provide Trusts with very long planning lead times, although as relationships developed, and materials had been trialled these problems reduced.
28. **One strategy for overcoming some of the time problems of learning is the development of work based learning models** which allow learning and work to be more closely integrated. NHSU did considerable work to analyse models of work based learning, but had not, by the date when closure was decided, succeeded in building this knowledge into programme design and delivery.
29. **There were significant problems with technical infrastructure for e-learning** in Trusts. These were underestimated in the initial planning, and a great deal of staff time was devoted to solving technical problems. Some Trusts felt that the technical specification required to use NHSU e-learning was too high, but by Easter 2005 most of these problems had been resolved in those Trusts participating in the e-learning programmes. The relevance of the National Programme for IT to the future development of e-learning capacity needs further examination.

30. **Internal communication in Trusts was not always good**, leading to problems with accommodation and technical support. Again, these arrangements improved as relationships were built over time.

Demand and participation in learning

31. The NHS employs 1.2M staff, and the numbers rise considerably if all those working in allied fields like social care are included. Within this population the range and diversity of staff roles is enormous. **A variety of changes now in progress will make learning needs, and the approaches needed to meet them, still more complex.** Relevant factors include more part-time working, staff retention later in life, increased numbers of people returning to the service after substantial breaks, entrants trained in other health systems abroad, closer working relationships with social care, a more patient focused service and a more complex public/private interface. Responses to this diversity come from professional bodies, Universities, Awarding Bodies, private training organisations, publishers, as well as from Government and the NHS itself. Mapping what the needs are, and how they are being met is a substantial and ongoing task, which now falls to Skills for Health as the Sector Skills Council. A critical part of this must be to identify and prioritise needs.
32. **The Baseline Report of the NHSU's Learning Needs Observatory represents an important tool in considering future priorities for learning in the service**. The LNO was created to provide a central focus for both reviewing needs and monitoring participation in learning across the NHS. It sought to understand who participated in what, and with what effects, produced a number of documents and commissioned various pieces of research. The "Baseline Report" published in summer 2004 is a very substantial comprehensive review of learning needs across the service.
33. **Widening participation in learning to those who have participated least in the past, remains a priority for the service**, and was a key priority for NHSU. It was clear that a very large proportion of the least skilled workforce were receiving little or no training directly related to their current roles, nor the underlying basic education which would enable them to progress to more responsible posts in the service. In the early stages of planning, the NHS Staff Survey identified the fact that 46% of staff received less than 2 days training per year. Providing appropriate education for this group was a key priority for NHSU, and the majority of its learners and programme were aimed at this group. National programmes (like Customer Care, and Statutory/Mandatory Skills) were aimed particularly at this group. Regional staff also helped Trusts, with advice and funding through Regional sources, to develop schemes to address the issues locally.

Learning programmes – management and delivery

34. **For learning to play its full part in the NHS it is important to develop a more coherent and widely shared view of how it can best be managed and delivered.** Issues include:
    a. Definition of effective models for embedding learning in service practice
    b. Balance between transmissive and transformational models of learning
    c. Models of work based learning

d. Economical strategies for securing the quality of learning opportunities
e. Ways of making central materials and programmes adaptable to local and specialist circumstances
f. Engaging the patient and public view in design and delivery
g. Understanding the circumstances where e-learning and blended learning approaches are cost effective (and where they are not)

35. **Reforming learning across an organisation as large and complex as the NHS required underpinning both with evidence of practice and with theory and analysis of models and approaches.** NHSU created a unit (the NHSU Institute) with the remit to undertake such work. Much good work was done, and it produced a range of policies and guides, for NHSU itself and for others in the service. A teaching and learning strategy was produced, but not before most of the programmes which actually reached delivery were already well developed. This left each programme with its own unique approach, making local management more complex, and progression for students more difficult. This was compounded by the fact that several programmes arrived part made from other agencies. This multiple approach to programme development was expensive, but might, had NHSU continued, to have provided a rich body of evaluative evidence for the design of future programmes.
36. **If learning programmes are to be effective at changing service delivery they need not merely to instruct but to enable individual staff to play a part in redesign of practice and delivery**. NHSU regional staff spent a considerable amount of time working with individual Trusts to develop approaches to organisational development in which learning was embedded. However, NHSU did not succeed centrally in reaching agreement about the balance between transmissive and transformational models of learning, with the result that programmes varied greatly in style and pedagogy, and the attempt to shift approaches to learning towards a more transformative approach was inconsistent.
37. **The quality of learning programmes, materials and activities mattered** to the service, which needed guarantees that programmes would produce competent staff, to individuals, who needed to know that the outcome of their learning would be valuable both to their practice and their careers, and to NHSU, for its credibility in the education and training world. Ensuring quality was a complex task, because the learning needs spanned a range from basic skills to postgraduate work. A major piece of work was undertaken, in consultation with relevant external bodies, to create a Quality Monitoring and Enhancement Framework which laid out procedures which would ensure that the quality of the work would be recognised by relevant national agencies, and that all relevant systems and procedures were in place. Alongside this a Quality Handbook was designed to assist in programme design, together with a range of quality assurance processes. However, the complexity of the task caused frustration, especially for staff without experience in the education sector. An unresolved challenge is how to secure quality without the processes seeming unacceptably burdensome to hard pressed staff in Trusts.
38. **In a service as complex as the NHS there will always be room for innovation in how learning is delivered.** NHSU was flexible in remodelling programmes and allowing materials to be adapted to local needs and

circumstances In response to the view in some Trusts that some programmes (e.g. Customer Care) were too long, shorter versions were produced, or Trusts used only some elements of the programme. This flexibility was valuable, but makes consistent evaluation and feedback difficult. A particular strength was the use of the programmes with multi-professional groups. Feedback indicates that this led to improvement in cross professional communication and teamwork.

39. **Increasing the involvement of patients and the public in the running of the service is a national priority.** NHSU was strongly committed to the principle, and created a Unit specifically devoted to promoting this. However, procedures were never adequately in place to ensure that this impacted on the processes of prioritising or on programme design.
40. There is no doubt that **e-learning has a role to play in the development of learning across the NHS**. It enables learning to take place at more manageable times, to be delivered systematically to larger numbers, to be assessed and accredited more reliably. However, it is not a panacea, and is not necessarily more cost effective than traditional face to face training. The professional consensus is that the best mix of e-learning and other modes depends on a range of factors, including the learning objectives, the subject, the learner and other factors. NHSU programmes adopted a variety of mixes, from pure e-learning (as with Statutory and Mandatory Skills) to intensive residential programmes (like Advanced Communications Cancer Care) . A coherent e-learning strategy was produced, to support the planned Virtual Campus, and programmes offering a range of blends of electronic and face to face learning. However, this followed, rather than preceded the development of relevant programmes. The evidence of the NHSU programmes on modes of learning is potentially a rich resource for future development, but in most cases insufficient numbers of students had participated by the time of closure to provide solid evidence.
41. **Evaluation of programmes and other activity was problematic**. The broader absence of clear agreement about priorities for NHSU fed back into problems with monitoring and evaluation. Partly because of the diversity of programmes, there was never a common agreement about precisely what information was to be collected, and how it should be analysed and presented. Individual programmes adopted their own models, making it difficult to aggregate data for the NHSU as a whole The model adopted for gathering information on capacity building at local level relied heavily on the individual judgements of regional staff, and would have needed further development.

Building learning capacity

42. **Helping the NHS to become a learning organisation involves more than the development and delivery of learning programmes**. It also requires an understanding of how learning can be managed within the service itself. As one Regional Director observed,

> *Once available, the programmes began to be a platform for looking at how NHSU could provide opportunities for sustainable change, in supporting the NHS improvement agenda and incorporate this different and blended style of learning into organisations. Generating ideas, giving organisations space to think "out of the box", and*

sharing best practice have all been key ingredients to this process. These processes take time to come to fruition and we are at too early a stage in this development to be sure what the long-term impact will be. "The development of a learning organisation does not happen overnight".

43. **Trusts are very varied, and some are small, without strong local training infrastructure.** NHSU recruited a team of regional staff who worked with Trusts and their staff to find the best ways of ensuring that their learning needs were met effectively and economically, and with minimal disruption to the business of delivering care. They did this through six distinct approaches: policy/strategy development; brokering new provision; training facilitators and tutors; supporting managers; networking and leading projects.
44. **NHSU staff worked with SHAs and individual Trusts to develop policies and strategies for learning** and review the resources available to deliver these. Some of these were general learning policies, including policies and strategies for e-learning, while others focused on particular needs. Strategies were developed for Widening Participation and Skills for Life and Health in most regions, either at SHA or Trust level.
45. **Trusts often need support to broker relationships with potential educational partners, or to engage with national schemes and funding sources**. NHSU staff, with access to national education and training networks and resources were able to carry out such brokerage In several regions Learning and Skills Council funding was negotiated to enable Trusts to address basic skills needs. The Widening Participation team created new qualifications and negotiated their inclusion in the National Qualifications Framework, where they can now be used by Trusts and their staff, and will attract LSC funding as a consequence. NHSU's Skills for Life and Health staff worked with Trusts, UNISON and the LSC to produce a national strategy for Skills for Life and Health across the Health and Social Care sector, and to work with Jobcentre Plus to agree interpretation of benefit regulations to enable individuals to participate in the Health Learning Works programme. The creation of the Quality Toolkit helped to enable individual Trusts to achieve Awarding Body Centre approval so that their staff could secure accreditation for their learning.
46. Considerable **effort was devoted to training facilitators, tutors, mentors and Union Learning Representatives** within Trusts. Some of this was specific to particular programmes like Customer Care, where large numbers of facilitators were trained by the central NHSU team. Others were more generic, with regional staff providing staff development for Trust staff with tutoring and teaching roles. One important role was in training Trust staff in the use of information resources about learning, and assisting them to achieve accreditation in the provision of advice and guidance about learning through the national Matrix accreditation scheme.
47. If learning is to be embedded in the work of Trusts, it is vital not only that training staff are well qualified, and good resources available, but also that managers are committed and supportive. **NHSU regional staff provided individual support to key managers** in understanding the links between organisational performance and learning, particularly in relation to key policy

priorities like Agenda for Change and the Skills Escalator, and in providing access to experience from elsewhere in the country.

48. Finally, in some cases **NHSU staff took the lead in initiating innovative projects,** bringing together consortia including NHS staff. This was a particular feature of the Widening Participation work, where, for example NHSU convened a consortium to carry out an EU funded project to develop learning programmes to enable second language speakers to enter the NHS. In the North West regional staff led an Aim Higher consortium to widen participation in HE.

Developing a curriculum

49. **If learning is to be transformed in the NHS, the range of learning programmes available will need to be more coherent and consistent**. Furthermore, the learning offered to individuals will itself need to move away from attendance at individual training courses, towards a more coherent curriculum. However, the NHSU experience is that the notion of "curriculum" in the sense of a coherent range of related learning activities is not widely understood in the service and decisions on what training to support, and how to link it into broader workforce and organisational development processes was not well understood. Sometimes the service demanded materials without recognising the need to embed these in programmes and organisational structures.
50. The task of developing such coherence now passes to other agencies, and **Agenda for Change, the Skills Escalator and the Knowledge and Skills Framework together provide a set of powerful levers to achieve this**. When a post hoc mapping of the NHSU core programmes against these produced a good match in many areas. However, there was relatively little liaison between the Department and NHSU about these, although they might have formed a basis for prioritising the NHSU curriculum, and NHSU might have played a more strategic part in supporting them had this happened. The idea of a coherent curriculum framework was first addressed by NHSU in Spring 2004, and was incorporated into planning later that year, with plans to integrate a range of programmes into a "curriculum" for the NHS.
51. **A key question in developing learning support at national level is the balance between developing new programmes and materials ab initio, against endorsing existing resources, or modifying them** to improve them or make them appropriate for wider audiences. At first there was some uncertainty about how NHSU was to create or develop programmes or materials. Some expected it to endorse materials and programmes submitted by Trusts and WDCs and then disseminate them more widely, and this model was adopted in some cases. Others expected it to provide support to Trusts in getting their own programmes accredited by awarding bodies, and expected the Accreditation Consortium to do this. One legacy of NHSU is the Consortium, which has the capacity to do this if required.
52. The question of **the value of accreditation is a continuing source of debate** in work related learning circles. It is often suggested that formal qualifications

matter more to teachers, and perhaps individuals, than to employers[1]. The debate about how far NHSU resources ought to lead to formal accreditation was debated, and some programmes pursued this, while others did not. NHSU procured an accreditation consortium of three national agencies, capable of accrediting short "bite sized" learning and more substantial programmes at all levels from basic education to postgraduate. This addressed the lack of a coherent framework which would enable individuals to progress through a variety of routes from lower to higher levels of qualification, and this could have been a support to the Skills Escalator. However, the Consortium did not succeed in progressing to much implementation before the dissolution of NHSU, although it did have some notable achievements, like the dual accreditation (by NOCN and City & Guilds) of the Infusion Devices and Diabetic Retinopathy programmes, and the production of guidance for Trusts on how to secure Centre Approval from national Awarding Bodies.

Creating a framework for information advice and guidance

53. **A continuing problem for individuals with training needs and for their managers is lack of reliable, consistent and relevant advice on where to find appropriate education and training.** Without this, good provision is wasted, and many staff go untrained. For this reason one key function of NHSU was the development and operation of a national IAG service specifically for the Health and Social Care sector.

Creating a Virtual Campus

54. **Although e-learning is not a panacea for all learning problems, it clearly has an important, and growing place**, and learner feedback on the NHSU's offerings has been very positive. However, **to manage this effectively calls for an appropriate platform,**
55. As a result, an early decision was taken to procure an IT platform to support delivery, to manage resources and learner information, and to support its own processes (including the operation of a devolved regional structure). However, **creating such a platform raises complex conceptual, technical and political issues for any organisation**. Because of the scope and scale of the proposed procurement, including the development of technical specifications, and the time taken to advertise the procurement and to consult about its likely future uses, this whole process began in parallel with – indeed long before - NHSU's development as a mature organisation.
56. Because of this parallel development, partly because of the general unfamiliarity with leading edge use of technology for education and knowledge management, and partly because of the general turbulence around NHSU's early months, **there was never a whole-hearted, well-informed commitment to the technology platform** (rebranded as the 'Virtual Campus'), and because the procurement proceeded in parallel with the development of a non-technological vision of the organisation's future, by the time the Executive was asked to endorse a multi-million pound purchasing decision, the gulf between the proposed functionality of the Virtual Campus

[1] However, a recent study by PricewaterhouseCoopers suggests that there are clear benefits to both *Boosting Business Performance through Programme and Project Management* (June 2004)

and the trajectory NHSU was pursuing had grown too wide. By that time, many people felt that it was extraneous to the organisation and, in the light of the recent collapse of the UK e-University, and uncertainties about NHSU's future, the procurement was abandoned.

4. An institution to support learning in the NHS

57. **Much of the activity of the first two years was directed to creating a robust organisation, capable of delivering at scale in a complex environment over the long term.** NHSU was to be a new institution, unlike anything previously created, with a remit to provide coherence and quality to learning across the whole NHS and its 1.2 million employees. The organisational development issues were therefore formidable, and consumed a large proportion of staff time.
58. **NHSU was created ab initio, and although there were precedents for corporate universities, none had sought to operate on such scale, nor across such a wide range of learning needs**. Furthermore, the NHS is not a "corporation" in the normal sense. In staff numbers it is vastly larger than any corporation, in turnover it is larger than almost all, it is much more complex in the range of staff roles, and its staff and units do not in general behave as if parts of a single corporation[2]

Governance and external relationships

59. **An organisation with a remit to transform learning across the NHS needs clear focus, and legitimacy from the relevant stakeholders and customers**. Initially NHSU was formally a part of the Department of Health, and only took on Special Health Authority status in Autumn 2003. As a result the organisation had been in existence for two years before a Chair and Board were in place, and the Board met for the first time in January 2004, less than six months before the review which led to closure. The attempt to bridge the differing cultures of Higher Education and the NHS led to some ambiguity about roles, including a protracted debate about the Board's role in performance management[3]. This uncertainty left the Chief Executive unreasonably exposed. The Board would also have benefited from some expertise in large scale delivery of commercial services which might have assisted in the move from innovation to mainstream operation. A clear Governance structure from the beginning could have helped clarify mission and purpose and helped in the management of priorities. It might also have strengthened the legitimacy of the organisation in the service, and secured support when the organisation came under threat.

Organisational development

60. **A new organisation requires access to expertise in organisational creation and development**. The original Design and Implementation Team was constituted to undertake the initial design work for NHSU and explored a wide range of issues. However, it did not succeed in establishing sufficiently rapidly

[2] .This was an issue identified by early work by the Learning Needs Observatory, which found that most NHS staff were proud of their own unit, but did not connect this with "the NHS" about which they often had negative views. The NHSU induction programmes "Introduction to Today's NHS" and "Working for the NHS" were explicit responses to this issue.

[3] In HE it is regarded as normal that governing bodies should play little role in the management of performance, which is the responsibility of Senate or Academic Board. This is not the case in the NHS.

some of the key frameworks needed by the future organisation. The business model, curriculum model, priorities for programmes and initiatives, and the learning and teaching strategy were all developed further later, some necessary structures were never created. Some of these problems might have been avoided by some investment in formal organisational development work.

61. **A new organisation has to move, at some point, from start-up to mainstream operation**. This calls for substantial change in staff behaviour, usually associated with significant growth and diversification of roles. This can, and did in the case of NHSU, lead to reorganisation and increased problems of internal communication. It is arguable that NHSU never succeeded in making the transition, and creative and enthusiastic staff who were invaluable in the start-up phase were frustrated by the attempts to create robust systems to underpin large scale operation. A series of systems and structures were developed, including a Source Book for each programme, a Quality Handbook to assist in consistent programme design, a Business Investment Group to ensure that development ideas rested on a sound business basis, and a Quality Management and Enhancement Framework to secure the quality of the organisation's work. However, these were perceived as cumbersome and irrelevant by some in the service (and some within NHSU itself) and by those seeking quick solutions to problems, and were never consistently applied. The processes of implementation, following formal approval, did not always operate effectively. The attempt to specify and procure a Virtual Campus naturally required a high degree of clarity about business processes and procedures, and this level of precision challenged some of the more idiosyncratic and ad hoc approaches which had served the organisation in its growth phase.
62. **NHSU prepared itself for the transition to delivery at scale by reorganisation.** However, in practice this also led to uncertainty about roles and relationships, and discouraged collaborative working. It also sometimes led to an undue interest in internal structures at the expense of attention to customers and stakeholders, and some staff suggested that there was a tendency to work around difficult issues through reorganisation, rather than to address them head on.

Finance and business models

63. **Any agency seeking to develop learning in the NHS needs to know what the various functions cost, and how to assess value for money**. Unfortunately, because of its early termination the NHSU experience does not provide a simple guide, since much of the expenditure during the first three years cannot properly be related directly to the numbers of learners registered in the first year of operation. The annex provides a basic breakdown of costs, but it would be quite inappropriate to try to relate this to learner numbers. In understanding the costs of NHSU it is important to distinguish the organisational set up costs, the one-off development costs of programmes and services (to be recovered over the long term), and the running costs of the organisation itself.
64. **A major part of NHSU's expenditure was on organisational set up.** Creating a national organisation is inevitably expensive, and the target set in the initial Strategic Plan, to achieve 250,000 learners by 2008, called for a

substantial organisation with robust procedures. During the first few years resources were committed to planning, recruitment, and the creation of business and academic processes and systems for an organisation delivering programmes and capacity building work on a very large scale. The Gateway process for managing programme development went through a trial process, and would have needed revision had NHSU continued. The finance model for long term operation was prepared for programmes in rollout, but very few programmes reached this stage before closure (most were still in pilot of some form).

65. **A second major component was one-off programme development costs**. High quality national programmes, to be delivered reliably to very large numbers of learners, are expensive to develop, especially where patient and public safety is involved. Consultation with professional, clinical and management experts, development of e-learning resources, and of high quality printed material, the creation of assessment systems and securing accreditation are all expensive and time consuming processes. From the beginning, the assumption was that these programmes would be delivered to large numbers over several years before needing updating. Much of the programme development expenditure should therefore be seen as start up costs, and the unit cost per learner, which in any event was not large by the standards of FE and HE institutions, would have fallen dramatically over two or three years.
66. **Much of the NHSU's mission cannot properly be described through simple learner numbers.** In addition to designing and delivering programmes, it sought to strengthen the capacity of the service itself to support and encourage learning through a wide range of capacity building with Trusts and others, and through the provision of infrastructure for learning (through initiatives like CHAIN, the Accreditation Consortium and the Learning Needs Observatory). This was as important to the overall mission as learner programmes, but more difficult to quantify.
67. There are two key lessons to be learned from the NHSU experience. Firstly, **an organisation needs a clear matching of resources to the needs it is to meet**. This is particularly important for a publicly funded organisation, which may be less subject in its business planning to the disciplines of the market. The initial budget of NHSU appears to have been created without such a clear evidence based assessment of needs, based on a clear mission. This allowed a rapid growth in staff numbers and special initiatives, which generated great enthusiasm and creativity, but which contributed to the organisation's lack of focus, and a lack of clear identity within the NHS.
68. Secondly, **an organisation needs a clear and generally understood long term business model.** The plans implied that, in the long term, the Department of Health would provide funding for development work and programmes in new areas but that the programmes themselves would be "sold" to the service (and that this income would match DH funds by the end of 2005/6). However, in the initial stages, programmes and other support were offered free on a trial or pilot basis. This raised the profile of NHSU, and gave Trusts an opportunity to see the quality and relevance of the materials, but made the development of a sustainable relationship with Trusts, as the primary customers, difficult since there was no real basis for knowing how the market

might behave in the longer term. This was particularly difficult for regional teams trying to engage the service.

69. **One factor generating work and at times delay was the need to satisfy the proper requirements for the use of public funds**. NHSU operated proper and effective procurement management processes, and one of the causes of delay introducing programmes and materials was sometimes the requirement to open development work to competitive tender. However, as its programmes came on stream, NHSU received a growing number of requests to use NHSU programmes and resources from agencies outside the remit of the Department of Health, which was funding the organisation. These included agencies in Social Care, FE and HE institutions, the Devolved Administrations and private contractors working in the service. While the educational, and service quality arguments for allowing this were powerful, no formal process for agreeing to allow materials developed with Department of Health funds to be used, for example, on pre-registration courses in Universities was developed. A similar issue would probably have arisen at some point over European competition law, where it might have been argued that public funds were being used to subsidise the production of learning programmes in competition with commercial agencies offering similar services, particularly in relation to generic issues like Customer Care. In the event this was never tested, but will continue to be an issue for any organisation seeking to carry out similar functions in future.

Performance and accountability

70. **Any organisation needs a system relating its priorities, to the remits for individual staff, and measuring their performance**. In the case of NHSU, the managerial structure and lines of accountability were not always clear and effective, and there was some duplication and overlap. Although decisions were made, they were not always communicated effectively or integrated with each other, and were sometimes not adhered to in practice or enforced by managers.
71. **An organisation needs a coherent and operational basis for performance management,** but in the early stages it was unclear how NHSU's performance was to be measured, and staff views of the priorities varied. As a result it sought simultaneously to:

    produce innovative ideas and knowledge about learning in the NHS,

    demonstrate delivery of programmes to large numbers (over 100,000 in its first year of delivery), and

    create very high quality learning products worth rolling out to very large markets.

72. In the second year, the Board approved a formal Performance Management Framework and a Risk Management strategy, which would have gone some way to addressing these issues, but they did not take effect before the closure decision was announced. In the event, they proved robust in the management of the closure process. Until the summer of 2004, when the concern to demonstrate performance through achievement of target numbers on core programmes was adopted, there were no clear performance indicators for staff, and in some cases the objectives set in different parts of the organisation conflicted. Some of these conflicts were resolved in the Autumn of 2004 at a

joint workshop of the Learning Programmes and Distributed Learning divisions (Buxton).

73. **No impact measures were defined**, although this might have provided a more robust basis for evaluating its performance. Nor did the performance measures always reflect successful practice on the ground. No recognition was given, for example, to the important capacity building and organisational development work carried out by Regional staff.
74. **The uncertainty about performance measures and priorities meant that some long term strategic activity** (like creation of online communities of practice through CHAIN, or long term futures activity through LNO) **was undervalued**, and ultimately sidelined in the pressure to deliver learner numbers (which had not been part of the original remit).

Human Resources

75. NHSU recruited an extremely **committed, enthusiastic and hard working staff**, but failed to focus their efforts on clear priorities, and HR management was not always sufficiently strategic. As a result some enthusiasts ploughed personal furrows, and others became frustrated. Problems sometimes arose with the transparency of recruitment procedures, role definitions; and skills mix in teams. More attention could usefully have been given to ensuring that staff had the opportunity to fill gaps in their own professional experience (e.g. people from an education background getting experience of NHS and vice versa)
76. Because of lack of clarity over mission, **staff skills did not always match the work in hand**, despite undoubted commitment and hard work (e.g. experienced project managers with no curriculum development expertise found themselves responsible for major curriculum development projects). There was no consensus over what skills needed to be treated as core and retained internally, and which could be bought in or supplied through consultancy. The organisation recruited people with a very wide range of experience and knowledge, from education, health and other fields, but it did not always make best use of this expertise
77. The recruitment of regional staff before there were any programmes available for piloting led to some **creative but very diverse local initiatives**, not all of which fitted well into the emerging national frameworks. There was an ongoing tension between central and regional staff. Those closest to the service felt frustrated by the time taken to produce high quality products centrally, while those at the Centre felt frustrated by a perceived lack of support from the regions for the programmes when they were produced.

Quality management

78. A national organisation which delivers learning programmes, directly or through agents, needs processes for the management of quality. However, **quality assurance is an expensive and time consuming process**, and one where practice in the education and health services is very different. The service needs systems which guarantee the competence of those who have participated in learning activities, while individuals who seek career progression need evidence which satisfies the requirements of educational bodies. Guaranteeing both is inevitably a complex and time consuming

process, with an unavoidable degree of bureaucracy, which hard pressed individuals and managers can often resent

79. **The organisation developed a rigorous methodology for the management of quality**, but the cultural tension between health and education views of quality, and growing uncertainty about the future, led to it not being fully implemented. The decision to create a central Quality Unit was overtaken by the review of the future of the organisation, leaving staff unclear about internal quality issues and plans for addressing these.
80. **Learner registration is important to the monitoring of quality and the development of services**, but Trusts did not always see the relevance of enrolling learners (especially for relatively short programmes). Furthermore, the systems for learner registration were cumbersome. For legitimate practical reasons, registration procedures were not applied to some shorter programmes like Introduction to Today's NHS, but the result was that the quality of learner data for quality assurance, programme improvement and future programme planning was poor.

Branding and public image

81. Creating a new organisation and **establishing its identity with its customers and stakeholders is in itself a major task**. Within the NHS, where communications are complex and unreliable, this is particularly challenging. It is also important to time promotional activity carefully, so that expectations are not raised before products are available for customers to use.
82. NHSU took a positive decision to invest in branding, and to seek to project a high quality image through all its interactions with the outside world, and began this process relatively early. Even so, awareness of NHSU among individuals and managers in the service remained relatively low for some time. On the other hand, awareness was successfully raised at an early stage among stakeholders and senior managers, but this happened before any materials were available. The result was that **in the early stages the organisation was sometimes perceived as more concerned with style than substance, (**and some feedback suggests that this contributed to a perception that NHSU was an arrogant organisation). Over time, however, this changed, and towards the end of NHSU's life feedback from Trusts and the Brand analysis report suggested that the brand had come to be associated with quality rather than extravagance.
83. **As the programmes became available and Trusts had practical experience, attitudes from the NHS became more positive**, indeed enthusiastic, but by that time the decision on the future had already been taken.

External partnerships

84. **A national organisation concerned with the development of learning in the service needs appropriate partnerships** both with the NHS agencies who commission, and often deliver, education and training, and the further and higher education agencies who are responsible for the majority of the learning provision, especially at the pre-clinical stage.
85. **NHSU created a range of mechanisms to build alliances with key stakeholders**, and this was successful with a number of interest groups in

relation to specific programmes, and with Trusts as Affiliates. However, appropriate alliances were not created with some key stakeholders, and in retrospect, the decision to focus attention on Trusts rather than SHAs may have been politically unwise.

86. **The role and operation of the Academic Advisory Board was not clearly defined**, and it did not succeed in becoming an effective support mechanism before the closure decision was made. Had it been constituted earlier and with a clearer remit, it might have contributed to the development of a more coherent approach to learning and a better engagement with the HE and FE system.
87. **The purpose of creating the network of Academic partners was never clearly laid out.** As a result, many educational institutions expressed interest, not all were accepted, and then those who were accepted were unclear about what they were contributing and gaining. The result was a loss of credibility among the academic community.
88. **The Patient and Community Engagement Unit was created** to help NHSU to become more outward facing, and to relate to the needs of the service and the wider patient perspective. The Unit developed a core curriculum for Trust staff, patient forum members, patient groups, service users and carers etc; established a mentoring programme and progression routes for expert patients, and prepared the infrastructure for a CHAIN network on PPI.

5. The Impact of NHSU

89. **In many ways it is premature, and perhaps impossible, to attempt to evaluate the impact of NHSU on the NHS**. As Annex 1 shows, most programmes were only completing piloting at the point of closure, and evaluation evidence is patchy at best. Although over 100,000 people were involved in one or more NHSU activities, many were not required, or did not choose, to submit feedback. Comment on impact must therefore derive from limited formal feedback plus the gathering of intelligence by Regional staff and Programme Managers.
90. However, it can be said that **the feedback received**, in learner feedback forms and from face to face discussions between NHSU staff and managers in the field, **was strongly positive**, and this is supported by the commitment which SHAs have given to continuing the core programmes after closure of NHSU itself. There was very little negative feedback on the programmes from any source.

Changes in NHS staff

91. There was **evidence of changes in behaviour and attitude by learners**:

> *Good course, helps to improve computer skills as well as mandatory training'* Stat/Mand
>
> *Excellent for people who switch off during verbal lectures and the feedback is good on screen'* Stat/Mand
>
> *'I am more confident with the dialogue that goes on between medical staff and myself since starting on the course and I also have a better grounding in patho-physiology from which to talk and explain things to patients'* First Contact Care
>
> *'It was true to life. I would be proud to be part of the team that made the patient better';* Introduction to Today's NHS
>
> *'The use of patient experience was very effective for those who do not work in a clinical area and for reminding us why we are employed in the NHS';* Introduction to Today's NHS
>
> *"The Communications skills module has made me assertive and enabled me to understand standing up for your rights, and not disregarding the rights of others - listening to others more before commenting."* Working for the NHS
>
> *"When I first did the Communication Skills quiz my score was 46%. After working through the four scenarios, I sCd 73%. The programme definitely improved my knowledge and understanding. As a result of the programme informing me of the benefits of learning and showing me how to get started, I have now enrolled on an NVQ administration course and have had my first PDP with my line manager."* Working for the NHS

Changes in Trusts

92. There was limited evidence that **NHSU work began to change attitudes to learning in some Trusts**. However, in the time available, such change is heavily dependent on key individuals, and it is not certain that it would have produced lasting change. and in service delivery. In some cases **NHSU work was used strategically to support Trusts address particular national issues.** As a result of a request from the Prime Minister's Delivery Unit, First Contact Care was targeted at 9 Trusts which had failed to meet their GP access targets.

    'Complaints policy rewritten and new templates introduced' Managing Complaints

    'Partnership network set up for complaints managers, PALS and ICAS across a Health Authority area' Managing Complaints

    ''Demonstrated to Board link between complaints information and MRSA rating' Managing Complaints

    Improved credibility of complaints dept with senior staff' Managing Complaints

93. Some interventions **helped Trusts address new national initiatives**.

    ''The toolkit is an excellent way to deliver both KSF and PDR training to all staff' PDR Toolkit

    The toolkit itself - very comprehensive, structured resource' PDR Toolkit

94. There were examples of Trusts **using particular programmes to address local strategic needs.** For example, one Trust with poor performance indicators on customer responsiveness put 600 people through the Customer Care programme.

Research into Learning in the NHS

95. **NHSU commissioned a considerable body of research** into learning needs, levels and quality of programmes available, and into underlying issues in the development of pedagogy and Workbased learning. Much of this was of high quality, but its relevance to the immediate problems of the NHS was not always self evident, and insufficient effort went into disseminating its findings across the organisation.

6. Some conclusions

96. **The NHSU was a remarkable attempt to create a unique organisation**, to address a very complex set of challenges.
97. During its three year life **it achieved its agreed targets** in terms of learner numbers, and there is no reason to doubt that it would have achieved its target of engaging 250,000 learners a year by 2008. Although awareness of NHSU and support for it across the NHS, was low in summer 2004 when the closure decision was taken, by the time of actual closure, a year later, when 10% of all NHS staff had had some experience of it, support was much more positive.
98. **It created the institutional structures, learning programmes and services which would have supported long term delivery to Trusts**. Learner and manager feedback on its programmes was very positive, and as was the response from Trusts and units which received support with organisational development, with tailoring learning programmes to local needs and in other ways. The number of Trusts which affiliated to NHSU even after the closure decision was announced demonstrates that its credibility was growing as the programmes were rolled out.
99. In relationships with other organisations, **NHSU was welcomed by many organisations and groups**, who saw it as a tool to raise the profile of learning within the service. It was greeted, however, with hostility or suspicion by the HE system and by many in the NHS.
100. Ultimately NHSU met its end because **it failed to bridge the cultural divide between the NHS and the education system.** The two have different assumptions about the relationships between Government and national organisations, about governance, institutional continuity and stability, and about timescales for delivery. The decision to create a "University" created a set of assumptions, reflected in the recruitment of staff and the initial planning, which were not consistent with NHS practice and culture, and a lack of clarity over governance, and over the development of a business plan for the organisation led to confusion over objectives and timescales. The result was that when the review took place in 2004, NHSU had not yet built a sufficient body of support to secure continuity.
101. **Its failings were probably inherent in the notion of a "university**", which led to an undue focus on meeting academic expectations in programme and in structures, and made communication with both the FE and HE system, and with the NHS itself, more difficult.
102. Its **organisational weaknesses were primarily those of enthusiasm**: of fiercely committed staff pursuing original and ambitious projects, sometimes without sufficient focus and direction.
103. Perhaps **the two final lessons of the NHSU experience** are that:
    a. a major initiative of this kind needs more careful political preparation, to create a supportive environment, before its role in transforming a service already undergoing huge change is announced, and
    b. making such a large commitment of resource to an initiative of this kind can only be justified if continuity over a longer period can reasonably be expected.

Annex 1 – NHSU's Learning Programmes

This table lists all the learning programmes planned by NHSU which entered the pre-Gateway process of approval, summarises the nature of the programme and its status at the closure of NHSU. It also includes the target and achieved learner numbers for each.

Activity	Programme / Service	Description	Level	Status at closure of NHSU	Actual Learner nos.
AIG	Health Informatics Assessment Tool	40 min self administered online assessment tool to help identify areas where information management skills can be improved to perform more effectively & provide better, efficient care. Information only tool.	n.a.	Roll-out	886
AIG	Skills for Life and Health				
AIG	UI Information Advice and Guidance	Provides information to deal with a wide range of enquiries. Provides information to enable enquirers to plan their own learning and develop their careers in Health & Social Care	n.a.	Roll-out	12,720
C	Customer Care (full version)	1 yr course made up of 8 x 2hr modules to help develop better day-to-day working relationships & understand responsibilities to all customers, patients & colleagues. Accredited by National Open College Network (NOCN) in conjunction with NHSU. Learners will get four NOCN credits.	FE	Roll out	1,641
C	Customer Care (short version)			Roll out	
C	Disability Awareness Training	3hr interactive e-learning programme, to raise awareness of issues faced by people with a range of impairments. At pilot stage used generic materials	FE	2nd stage pilot.	304

		provided by a commercial supplier			
C	ECDL	Plan to transfer responsibility for programme (24,000 learner p.a.) from NHS Information Agency. Not implemented in view of closure decision	FE	On hold	0
C	Introduction to Today's NHS (including briefings)	1hr CD-rom to introduce you to the NHS and its values.	FE	Roll-out	31,083
C	NVQ 2 Support Services	Series of activities to prepare people working in NHS for NVQ accreditation at level 2.		Roll out for evaluation	0
C	Statutory Mandatory Skills	1-2hr e-learning progs to give staff skills in everyday activities of their work. Accredited by NHSU at Level 2& NOCN.	FE	Pilot	1,918
C	Working for the NHS (inc. tutor orientation)	CD-rom/powerpoint version which builds on the information and messages presented to staff during Introduction to today's NHS. Approx 12hrs.		Roll-out	1,674
NC	Advanced Communications Cancer Care	3 day workshop aims to improve communication between health professionals and cancer patients, their families & carers; FE level worth 18 category 1 CPD credits.	FE	Roll out	170
NC	Agenda for Change Appraisal Training	Toolkit of materials for appraiser and appraisee training, demonstrated throughout regions using workshops .	FE	Roll-out	5,847
NC	Agenda for Change Appraisal Training tutor orientation		FE	Roll-out	612
NC	Anaesthesia Practitioner	Post-graduate diploma(2 academic yrs) aims to produce competent & qualified Anaesthesia Practitioners who can work successfully as part of anaesthetic team.	?	In development	0
NC	Child Protection	Paper and e-learning format for raising awareness of CP in a health context.	FE	Materials trial completed	281

NC	Clinical Microsystems	This programme provides a framework & methodology that helps teams develop skills in understanding patients better &to improve their working processes & interprofessional team working relationships thus improving overall performance.	FE	Roll-out	45
NC	Estates Upskilling	4yr accredited (NVQ 2/3) training for engineering and maintenance staff throughout the NHS, and for people who are interested in entering the estates sector, delivered at local technical colleges.	FE	Roll-out	16
NC	First Contact Care	This programme helps develop the skills needed to provide an effective, efficient first point of contact for patients. It leads to a postgraduate diploma (2yrs) or MSc qualification (3yrs).	HE	Limited roll-out	270
NC	Foundation Degrees	New qualifications that blend academic and vocational learning, to get a higher education qualification that is relevant to the job. (F/T 2yrs, P/T 3yrs).	FE	On hold	0
NC	Health Learning Works	Aims to bring together trusts & other employers with vacancies, and people who would like to work in health and social care. Provides a 5-week training course.	FE	Roll-out	182
NC	Hospitals at Night	3x 3hr workshops and distance-learning materials that support safe & efficient service delivery in hospitals at night, following implementation of European Working Time Directive (EWTD).	HE	Pilot	40
NC	Infusion Devices	40 learning hours (online, face-to-face & practical training) to gain City & Guilds qualification, in helping NHS staff gain competence &confidence in using infusion devices.	FE	In preparation for pilot.	26
NC	Managing Patient Complaints (including tutor orientation)	9mth programme (facilitated w/s) designed to improve the way complaints are managed in the NHS. Achieve certificates & credits from Middlesex University.	HE	Roll-out	64

NC	Mentoring & Coaching	Workshops, seminars, online tutorials & workplace projects to provide academic training & professional educational support to networks of NHSU certified mentors & coaches.	FE	In development	0
NC	Modern Apprenticeships		FE		0
NC	Modernising Medical Careers	Online materials to teach principles of good communication & teamworking, and put them into practice.	HE	Pilot	100
NC	National Patient Safety Agency	Transfer to NHSU of 7 programmes with 24,000 learners		One off acquisition	24,000
NC	Pre-operative assessment	(Up to) 2yrs online programme to help achieve highest standards in pre-operative assessment services, assess patients' needs & make confident decisions about their care.	HE	In preparation for pilot.	0
NC	Skills for Life & Health (incl. raising awareness)	Aims to improve patient care by supporting the health and social care sector to develop strong literacy, language and numeracy (LLN) skills. Informal learning and raising awareness sessions	FE	Roll-out	7,804
NC	Support Services inc Infection Control	Help non-clinical support staff gain understanding of issues relating to infection control, develop awareness of risk & reinforce good practice. Complete course is 30hours leading to level 1 National Open College Network award.	FE	In preparation for roll-out	562
SLO	CHAIN I research and evidence-based practice (inc. Chain II workplace based learning)	CHAIN 1 was established in 1997 as part of the NHS Research and Development Programme. CHAIN 2 is for anyone interested in workplace-based learning including funders, mentors, recruiters and educators.		Roll-out	4,050
SLO	CHAIN III to VI			Not progressing	0
SLO	Junior Scholarships - Open Road	Flexible programme to provide 14-19yr olds with information and advice on the huge range of career opportunities in the NHS and social care.		Roll-out	696

SLO	Learning Accounts	Support NHS staff in the use of their learning accounts.	FE	Roll-out. No learner forecast	0
SLO	SECURE	CD-ROM information resource and national training programme on confidentiality, consent and human rights, for prison healthcare staff.	FE	One off acquisitio n	2,000
SLO	Ufi/LearnDire ct NHS hubs	NHS hub providing a portfolio of over 500 courses to NHS staff covering ICT, Business & Management and skills for life.	FE	Roll-out	4,932
	Disability Equality	Plan to produce a programme, but Disability Awareness bought in as a temporary measure	FE	Not progressi ng	0
	Learner Management System	System to allow the tracking of 100% of learners through 100% of learning interventions., including progress tracking.		Terminat ed	0
	Learning at Work Week	Promotion and support for NHS staff in the national learning at work week.		Ad-hoc	55
	Learning Events	Informal learning and/or raising awareness session		Ad-hoc	767
	Managing for Excellence		HE	Not progressi ng	275
	Managing Health and Social Care	Monthly facilitated sessions/online/CD-roms to give theories, tools & techniques for managing people, information & services.9mths to 2yrs to work towards accredited qualification at NVQ level 4 or 5 and undergraduate or post-graduate level.	HE	Pilot	714
	Matrix Standard	Outcome based quality framework for the development of people through effective delivery of info, advice & guidance.	HE	Terminat ed	0
	NHSU Institute Event	Informal learning and/or raising awareness session		Ad-hoc	97
	NHSU/Uniso n workshop	Informal learning and/or raising awareness session		Ad-hoc	14
	Prison Healthcare	Activity on Prison Health will be separately funded and is subject to an agreement with the DH.		Not progressi ng	0
	Tutor Orientation	Generic tutor orientations have been succeeded within programme-specific orientations.	FE	Not progressi ng	0

	Ultraversity BA in Learning Technology Research		HE	Not progressing	0
					103,845

Annex 2 – NHSU Expenditure 2003-4 to 2004-5

Table 1 shows that the total expenditure of NHSU over its two full years of existence was just over £66M, of which 54% was directly related to delivery activity, 17% to academic and quality assurance, and 29% to organisational overheads and dissolution costs.

Table 1 provides a summary breakdown of the areas of expenditure over the year and sets this in context with the achievement of over 103,000 people accessing NHSU Learning programmes and services.

Programme and Service Costs: (£35.8m) is the investment in developing learning programmes and services themselves, creating the delivery infrastructure and platforms for learning that were an essential part of NHSU's blended approach to the provision of learning.

Academic and Quality Development and Infrastructure: (£11.2m) is the investment made in establishing the infrastructure of a corporate university that could develop programmes and services ensuring they were of the highest quality and then ensure that they were delivered at sustained levels of quality for the benefit of learners and their employers. This area of investment ranged from developing a quality monitoring and enhancement framework through to the work of the Learning Needs Observatory and a registry function. These essential elements of NHSU were designed and established to support the organisation operating at scale. The early dissolution of NHSU after its short life has meant the full benefits of economies of scale have yet to be appreciated.

Organisational Overheads: (£17.7m) includes conventionally recognisable overhead costs including finance, human resources, estates (including 9 regional offices) and IT for example. As with the academic infrastructure the organisational overheads reflect the creation of a corporate structure designed for an organisation in start up prepared to operate at scale.

Costs of Dissolution of NHSU: (£1.3m) includes one off costs of dissolution of NHSU as a special health authority and includes some provision for related expenditure post 2004/05 where it is known it will be incurred.

Tables 2,3 and 4 provide a further breakdown of these three headline areas of investment.

Table 1

TOTAL NHSU Income and Expenditure Summary 2003/04 to 2004/05	
	£'000
2003/04 DH resources prior to Special health authority status	14,588
2003/04 DH resources under Special health authority status	13,304
2004/05 DH resources under Special health authority status	38,194
TOTAL DH RESOURCES	**66,086**
Programme & service costs	35,879
Academic and quality development & infrastructure	11,239
Organisational overheads	17,706
Costs of dissolution of NHSU	1,262
TOTAL EXPENDITURE	**66,086**

Table 2

TOTAL NHSU LEARNER NUMBERS 2003/04 to 2004/05

	No. of programmes & services	**Learner nos.**
Core Programmes & Services	7	49,110
Non core programme & services	17	27,982
Supported learning opportunities	3	6,746
Advice and guidance services	3	20,007
TOTAL	**30**	**103,845**
Average Full Cost per Learner		£636

	Total Spend 2003/04 to 2004/05 £'000
Creation & provision of new learning programmes and services	35,879
Academic & quality development & infrastructure	11,239
Organisational overheads	17,706
	64,824
Costs of **dissolution of NHSU**	1,262
TOTAL Expenditure	**66,086**

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Table 3. Costs of developing and delivering learning programmes and services

Creation & provision of new learning programmes	Total Spend 2003/04 to 2004/05 £'000
Programmes launched (pilot or roll-out)	12,129
Programme development & work-in-progress	2,891
E Learning initiatives	3,096
Delivery and capacity building	15,334
Information advice and guidance	2,429
	35,879

Table 4. Costs of developing and running academic and quality infrastructure

Academic & quality development & infrastructure		Total Spend 2003/04 to 2004/05 £'000
Accreditation and quality		2,732
Policy & Research		2,806
Patient & public involvement		1,547
Schools:		
1. School of Interprofessional Care	1,747	
2. School of Knowledge, Information and Personal Development	547	
3. School of Leadership Management and Improvement	578	
		2,872
Education support		1,282
		11,239

Table 5. Organisational Overheads

Organisational overheads	Total Spend 2003/04 to 2004/05 £'000
Chief Executives office	1,287
Finance, HR & IT	5,926
Estates (9 regional offices plus London head office)	4,219
Marketing & comms.	3,883
Other corporate services (incl. governance, legal)	2,391
	17,706