SECTION THIRTEEN
EDUCATION AND TRAINING

This section considers:

- developing an education and training strategy that derives from the PCTs clinical and developmental priorities
- monitoring the impact of training on improved performance and outcomes
- patient and public involvement in education and training activities.

The new management task

'The new management task:

Partnership in managing clinical processes and service delivery

Full engagement with patients staff and local communities

New skills to deliver lasting change.'

Department of Health, 2002a

The Boards and PECs of PCTs need to keep the education and training needs of the staff group and the PCT's investment of public resource and of time cost under active review. This will enable them to demonstrate that, like all other aspects of the organisation's business, education and training is effectively governed within the overall context of 'integrated governance'.

They must (in collaboration with the local Workforce Development Confederation and the post-graduate Deanery) target the NHS's enormous investment in education and training at those needs that will have the greatest impact upon their clinical priorities and through this upon the quality of patient care and upon the morale and job satisfaction of the workforce. This consideration needs to give equal value to the needs of management and administrative staff alongside those of professional staff who have, historically, been the prime focus of education and training investment.

Staff are the most expensive and the most important resource in almost all NHS organisations. Thoughtful and imaginative investment in staff development that is shown to improve the quality of patient care and of the staff experience is one key indicator of an organisation's commitment to clinical governance. Such focussed investment can only occur where there is clarity and accountability in terms of the systems and processes that are in place to govern, plan, implement and evaluate training strategies and training outcomes.

Key learning from the pilot programme

Very few PCTs within the pilot sample had developed a comprehensive education and training strategy that proceeded explicitly from their current clinical and corporate priorities.

In most cases, education and training activities derive from historical precedent and are often unsupported by robust evidence of impact upon standards of care or the quality of the patient experience.

Given both the above-the-line cost of NHS training spend with Universities and other training providers and the opportunity cost of the down time that staff spend in off-the-job training, conferences, etc., it is essential that the NHS is able to demonstrate robust evidence that this investment represents 'best value' for local communities and for patients.

PCTs need to work systematically with WDCs, the NHSU and the Modernisation Agency to address and resolve these long-standing issues and to develop national guidance that will enable all PCTs to make more rational and informed decisions about their investment in effective education and training.

Across all of the PCTs in the pilot programme, the section on Education and Training was the third lowest scoring at 4.5 on the progress scale (range 2.8 to 6.5). Even though the pilot sample included a number of Teaching PCTs, the highest recorded section score of 6.5 was the joint third lowest top score for any section.

Predictably, given the timescale in which they had to absorb and identify the training needs of their inherited staff groups, the more recently-formed PCTs were likely to find this even more challenging than those that had longer to come to terms with this issue. The 25 PCTs that were under a year old when they completed the questions scored an average of 4.0 whilst the remainder scored an average of 4.9.

Very few Boards and PECs had given sustained critical attention to the PCTs investment in education and training – or developed clear strategies and time lined action plans to do so – even though all of them recognised the importance of investing in their staff groups. In part this stemmed from a failure (described more fully in Section 16) to undertake a baseline measure of the fitness for current and future purpose of their inherited (and dispersed) staff groups. Since no 'gap analysis' had been completed against their clinical priorities (where these had been identified) there were no clear criteria for prioritising education and training activity and investment.

Almost no PCTs had made the important conceptual distinction between:

- developing an education and training strategy to embed a felt understanding of the values, principles and processes of clinical governance across the entire staff community, and

- the more general issue of providing education and training activities that support the delivery of clinically governed and high quality care.

The first of these is a vital stepping-stone to fostering ownership of clinical governance across a dispersed PCT community (see Section 4 for a fuller exploration of these issues).

Most Boards recognised that patterns of education and training activity were still predominantly based upon historical precedent and the local repertoire of training provision offered. Few Boards or PECs could point to examples of training processes that they had commissioned in relation to specific and newly-identified clinical governance priority needs. Even fewer Boards were able readily to identify the annual time cost investment in training – and many did not have the systems and processes in place that would enable them to do so.

As a result, the governance of education and training activities was weaker than that of almost any other component of clinical governance. This is compounded by the fact that, with few exceptions, PCTs had no identified Education and Training Unit; nor did they have within their communities any significant professional education expertise, especially with respect to the analysis of the impact of training.

As a result, they had particular difficulty in dealing with the specific question that explored the extent to which the impact of training on patient outcomes and satisfaction is actively monitored (2.6/10 – one of the lowest scoring of all of the 120+ questions in the survey).

This phenomenon is not unique to primary care. It reflects a general failure within the NHS to explore systematically the (admittedly complex) issue of the evidenced return in terms of improved clinical practice, quality of care and/or patient outcomes from the £1.4 billion per annum that is spent on education and training. While absence of evidence is not the same as evidence of absence, it may well be that some forms of investment show a better return than do others. PCTs, WDCs, the NHSU and the Modernisation Agency need to work together to provide answers that will improve both the overall and the organisational quality of governance of education and training activities.

Lifelong learning

An Organisation with A Memory and *A First Class Service* emphasised the importance of ongoing learning from and through practice:

- for individuals
- for teams
- for the individual organisation
- for the NHS itself.

In a health care environment characterised by rapid structural, social and technological change, the demands made upon the NHS workforce are constantly changing. As the competencies that staff need to carry out their work evolve, an on-going investment in education and training is necessary to ensure that the workforce remains 'fit for purpose' and able to provide the sustained quality of care that clinical governance demands. The nature and type of training activities that produce the best return on direct and time cost need to be identified so that they can be given priority over those that show less – or perhaps no – return on precious investment.

Evolving 'competence'

Clinical governance is everybody's business. All staff need to be competent and motivated if they are to provide the quality of care to individual patients and to local communities that clinical governance demands.

REFLECTION

To what extent are the overall education and training needs of the professional staff community kept under active review by the Board/PEC?

To what extent are the overall education and training needs of the support staff community kept under active review by the Board/PEC?

What evidence is there to support your views?

Within the health service, 'competence' is a dynamic construct that interlocks values, skills and knowledge into behaviours that serve the needs of patients and communities and that thus enable staff effectively to carry out their professional (or other) caring or support role.

The foundation of these competencies for professional staff is laid down during their initial qualifying training. This foundation is then built upon, in response to the changing needs of the service, through participation in continuing professional education and training events. It is now mandatory that all professional groups keep abreast of new and evolving skills and knowledge.

The NHS also has a particular responsibility to ensure that non-professional staff embrace the values that underpin care. They should either possess or acquire the specific values, skills and knowledge they need to carry out their work safely, effectively and with confidence, even without the benefit of the foundation laid down by professional training.

Just as professional staff should have the opportunity to refine their expertise, so mechanisms such as the 'Skills Escalator' (developed by the UNISON for its members) should open up progression opportunities for other staff groups.

Training in clinical governance and the values that underpin it

Like clinical governance itself, the care task is built upon the values of respect, justice and compassion. Although these fundamental values are a constant, within an evolving society the way in which they are expressed will, inevitably change over time. In the new NHS and at the heart of clinical governance there is a strong and persistent emphasis upon:

- the rights and entitlements of patients
- the need to engage both patients and local communities actively in all aspects of the planning, implementation and evaluation of their care
- to respond creatively and positively to the diverse needs of a multi-faceted community.

In a society that is increasingly diverse, staff need to understand and respect the specific physical, emotional and spiritual needs of different ethnic and cultural groups. They then need to find imaginative ways to overcome obstacles of language, culture, physical or intellectual impairment so that all patients have equal access to care that is attuned to their own needs.

As the Secretary of State has pointed out

'a uniform public service has failed to create equality ...The nature of uniform provision of the health service for the last 50 years has failed poorer people ...amongst babies of mothers born in Pakistan the infant mortality rate was 11.4 per 1000 live births, a rate more than double the overall mortality rate of 5.3. The uniform health service does not provide race equality in health outcomes'.

Reid, 2003

Increasing diversity of provision is a response to this issue — and increasing diversity of provision demands diversity of a broad range of professional skills and the development of new and adaptive forms of competence.

All of these issues demand targeted training investment since the values that underpin clinical governance express themselves most directly and forcefully through the 'humanity of care' that patients experience. This cannot be taken for granted, but needs to be kept under active review by a staff community and by the teams that make it up.

REFLECTION

How does 'humanity of care' express itself in primary care and community care?

What evidence does the Board or PEC have of the humanity of the care that is currently provided?

'The values of a professional group are precarious, unless they are put into concrete practice on a daily basis ... and are then subject to periodic and critical review.'

Smith, 1969

Time and money may need to be invested to ensure that all staff:

- understand and share the values of clinical governance
- routinely and systematically enact them in their dealings with patients and with each other.

'Humanity of care' needs to be kept alive as a topic of discussion and debate within the PCT community and kept under active review by the Board and the PEC — not least by non-executives.

Caring skills

The skills that staff need to carry out their tasks safely and to the highest achievable standards change as new techniques and new technologies impact upon the NHS. Periodic audit of the skill needs of individuals and of teams — to identify deficits or overlaps — is an essential expression of a commitment to achieving and sustaining quality provision. Responsibility for undertaking such audits needs to be clearly specified within the boundary of management or leadership roles.

There must be systems to enable managers and staff to identify and communicate training needs through clear channels so that they shape discussions with the Workforce Confederation and investment and training provision.

REFLECTION

Is there evidence that the PCT has identified clear systems and processes for identifying and responding to emergent training need?

PCTs generally lack the formal training infrastructure that exists in some acute NHSTs. Systems and processes of delegation, accountability and reporting on skill and other training needs must, therefore, be clearly defined and communicated to all locations and teams. PCTs can lead the way in ensuring that the promotion of learning from and through practice and work become an integral element within the Job Description of all professional and organisational management and leadership roles. This will ensure that staff:

- are aware of relevant learning opportunities
- are aware of training opportunities
- recognise that the implementation in practice of new skills or knowledge is an inescapable professional obligation
- decisions to allocate places to some rather than others are seen to have been arrived at transparently and justly.

The knowledge base

New technologies have fundamentally changed access to sources of knowledge and expertise and have played a major role in further 'internationalising' the research and knowledge base of health care. Information overload is an ever-present danger, particularly for generalist health care staff, whose scope of clinical responsibility is almost limitless.

In such an environment, knowledge management becomes essential – as does the prioritisation of knowledge-based learning needs. GP and other staff appraisal systems should enable individual staff to keep under active review the emerging research and knowledge base that should underpin evidence-based and clinically effective care.

Emerging NICE guidelines and NSFs provide clear national foci for investment in new training. As far as NSFs are concerned, some of the most effective interventions are likely to proceed from training strategies that address the needs of systems of care (often across organisational boundaries) rather than concentrating on the knowledge needs of individuals.

REFLECTION

How are the knowledge needs of staff kept under active review?

Are there processes in place to ensure that information from individual appraisals informs an overall picture of education and training priorities?

The role of the Workforce Development Confederations

The role of Workforce Development Confederations (WDCs) is vital in bringing strategic coherence to the investment in education and training. They have recently undergone structural and location changes designed to unite them with Strategic Health Authorities so that local education and training investment maps not only against the priorities of individual NHSTs, but against the needs of disparate professional groups, the health economy and local and regional communities.

Workforce Development Confederations were established on 1st April 2001, following consultation on *A Health Service of all the Talents*. As their title implies, they are confederations of PCTs, NHSTs and other employers in both the health and social care fields.

'They bring together local NHS and non-NHS employers to plan and develop the whole healthcare workforce. This new approach to planning recognises that (organisations).... need to work together if workforce planning and development is to be effective and meet the healthcare needs of local populations.'

Department of Health, 2002b

Through and in collaboration with their SHAs, PCTs need to engage purposefully with them to ensure that their own needs are articulated and that they receive a just allocation of the education and training funds that are available to the regional community.

'The role of Workforce Development Confederations, as partnership organisations, is to give a clear leadership and direction to workforce planning and development, and to manage the Multiprofessional Education and Training budget and other relevant budgets (these will be allocated from the DH to SHAs which will act as paymasters for the Confederations).'

Department of Health, 2002b

WDCs can assist PCTs not only to address the current competence development needs of their workforce, but also to plan purposefully for the future.

'The Confederation will take a leading role in visioning the future healthcare workforce.

The Confederation will develop and lead an integrated approach to workforce planning for health and social care communities.

The Confederation will have overall responsibility for developing the existing and future healthcare workforce.'

Department of Health, 2002b

REFLECTION
Is there evidence to suggest that the relationship with the WDC is firmly established?

The Boards, PECs and clinical governance committees of PCTs must ensure that they have systems and functions in place to manage the relationship with the SHA and thus with the WDC. This will ensure that local patients and staff derive the maximum benefit from training and development opportunities. In developing an education and training strategy, it is important for PCTs to appraise, from first principles, the cost, the focus and the evidenced benefit which patients or the organisation itself derive/s from this investment.

Linking education and training strategies to national and local priorities

In determining their education and training strategies, the Boards and PECs of PCTs should ensure an explicit linkage between their current and future clinical priorities and their investment of time and other resources in training.

'Education, training and continuing personal and professional development does not reflect clinical governance priorities or draw on other clinical governance components such as audit, complaints and patient surveys, or staff surveys in some organisation ... education and training, which causes relatively little concern in the most common type of organisation, the acute trust, causes most concern to CHI in all other types of organisation.'

Commission for Health Improvement, 2002

Education and training are instrumental activities. They should never be undertaken as ends in themselves. A key outcome from education and training should be evidenced improvement in service to a patient or patients. This may be because a receptionist is able to make more effective and sensitive use of the telephone, or a General Practitioner improves her/his prescribing regime for older people suffering from depression. The Primary Care Collaboratives provide compelling evidence of the improvements that can be achieved when, for example, coronary heart disease becomes a focus of clinical priority and of consequent education and training investment.

In collaboration with SHAs and WDCs, PCTs should ensure that robust processes are in place to monitor and evaluate the impact and improvement that proceeds from this investment. Important lessons must be learned and shared within and across organisations. All NHS employers must also ensure that all mandatory training requirements (e.g. in relation to 'health and safety issues) are fulfilled.

REFLECTION

What evidence exists of clear and explicit linkage between the PCT's clinical governance priorities and its education and training provision?

Education and training on clinical governance

Because clinical governance is a relatively new approach to the health care task – or gives explicit expression to understandings and inter-connections that have previously been either tacit or (sometimes) unrecognised – it will not have been part of the foundation of professional competence that most staff will have absorbed through their basic training. Serious attention will therefore need to be given to ensuring that there is a clear and common understanding of its precepts and implications for all of the staff of a PCT.

Education and training to support the 'technical elements of clinical governance'

Clearly basic training in audit, risk management and other components of clinically governed care will form part of any recent professional qualifying process. These competences need to be kept under active review and will need to be periodically refreshed. In the meantime, other key competences in, for example ICT, may have emerged since many staff were trained. Systematic work in the north of England exploring the clinical governance-related needs of staff showed that:

REFLECTION

What evidence is there that a systematic analysis has taken place of the education and training needs of staff in relation to the range of technical elements of clinical governance?

Has a clear strategy been put in place to address these needs?

'The principal needs that emerged for all clinical staff were: basic clinical audit skill, including using IT for routine audit and measuring outcomes; risk management; and team leadership skills.'

Firth-Cozens, 2001

Leadership is crucially important, not only at the top of organisation, but throughout it. PCTs (as dispersed and multi-professional communities) need to pay particular attention to ensure that these leadership competences are embedded in all teams, in all locations and within all professional groups.

Education and training and patient and public involvement

Pro-active patient and public involvement are central to clinical governance. For some staff, this constitutes a significant departure from established patterns of care planning or delivery. Explicit consideration must be given to these training needs in relation to all management, professional and support staff within the PCT community (including the members of the Boards, the PEC and other key committees).

Patients and the public should not only benefit indirectly from training – that is, through improvements in the performance of the staff who work with them.

'Empowering patients with information, and increasing their contribution to planning services, can greatly influence the development of clinical governance.'

Halligan and Donaldson, 2001

REFLECTION

What examples can the PCT identify of active patient or public involvement in training activities?

Wherever it is appropriate, patients, their carers and other members of local community or patient groups should become active participants in training alongside staff – and on some occasions be the deliverers or facilitators of training.

'The Confederation will actively promote patient, carer and student input to the development and delivery of healthcare education and training.'

Department of Health, 2002b

It was clear from the pilot activity that, with very few exceptions, this remained a generalised and non-specific aspiration for PCTs rather than being a consistent or effective factor is their strategic or operational education and training practice.

Priorities for action

Now that you have finished reading through this section, please identify three priorities for the PCT in relation to education and training.

1

2

3

References

Commission for Health Improvement 2002. *Emerging Themes*, December. www.chi.nhs.uk

Department of Health 1998. *A First Class Service: Quality in the new NHS*, London: DoH

Department of Health 2000a. *An Organisation with a Memory*, London: DH

Department of Health 2000b. *A Health Service of all the Talents: Developing the NHS workforce*, London: HMSO

Department of Health 2002a. *Managing for Excellence in the NHS 2002*, London: DH

Department of Health 2002b. Workforce Development Confederations *Guidance*

Firth-Cozens, J. 2001. *Clinical Governance Development Needs in Health Service Staff*, Newcastle: Centre for Clinical Psychology Research, University of Northumbria at Newcastle

Halligan, A. and Donaldson, L. 2001. Implementing Clinical Governance: turning vision into reality (Education and Debate), *British Medical Journal*, 322, 1413-1417

Smith, G. 1969. *The Sociology of Organisations*, Harmondsworth: Penguin

Reid, J. 2003. *Localising the National Health Service: gaing greater equity through localism and diversity.* London: New Local Government Network

Resources

Commission for Health Improvement – CHI's aim is to improve the quality of patient care in the NHS
www.chi.nhs.uk

Cochrane Library
www.nelh.nhs.uk/cochrane.asp

Department of Health – access all Department of Health information through their website.
www.doh.gov.uk

Doctors.net.uk is a peer led organisation created to improve health care through modernising medical communication throughout the UK, ensuring all doctors have access to the best medical knowledge, and reducing costs for medical organisation wishing to use the Internet to disseminate information.
www.doctors.net.uk

Electronic Library for Health
www.nelh.nhs.uk

Liberating the Talents update for community practitioners and health visitors
www.doh.gov.uk/cno/liberatingtalentscphu.htm

Knowledge and Skills Framework
www.doh.gov.uk/nhsksf/knowledgeandskills.pdf

The Modernisation Agency – the Modernisation Agency is a valuable source of information. You can access the different strands of the Agency through the website at:
www.modern.nhs.uk

National Clinical Governance Support Team – the CGST runs a series of programme to support the implementation of clinical governance 'on the ground'.
www.doh.gov.uk/clinicalgovernance/cgst

National Institute of Clinical Excellence – the NICE site contains details on the Institute, its ongoing work programmes, the methodology and processes it uses, the guidance it has issued to date, copies of all press releases and the minutes and papers from its Board meetings.
www.nice.org.uk

The National Primary and Care Trust Development Programme – the NatPaCT team helps PCTs with organisational development.
www.natpact.nhs.uk

The National Primary Care Development Team – the NPDT team helps to address access and service improvements for patients.
www.npdt.org.uk

National Service Frameworks – all the NSFs can be accessed at
www.doh.gov.uk/nsf/nsfhome.htm

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

13.1 To what extent is there a comprehensive education and training strategy derived from an analysis of the 'fitness for purpose' of the PCT 's workforce?

13.2 To what extent does the education and training strategy consider the needs of all clinical staff?

13.3 To what extent does the education and training strategy consider the needs of managerial and administrative staff?

13.4 To what extent is there robust evidence of improvement in patient experience or outcomes as a result of education and training investment?