hidden talents
education, training and development for healthcare staff in NHS trusts
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Website: wwwaudit-commission.gov.uk
Getting the Best from Training and Development

Education, training and development are too important to patient care and too costly to be left to chance.

Identifying Training and Development Needs

Needs are often not identified or planned for at either the individual or organisational level.

Access to Education, Training and Development

Who you are, what you do, and where you work can determine access to training and development as much as your training needs.

Improving Access and Appropriateness

There is a range of actions that trusts should take to ensure priority training and development takes place.

The Way Forward

Staff development should be everyone’s business and boards and senior managers have a key role to play in engendering the right culture.
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Simon Denton (p64), Crispin Hughes/Photofusion (p45), David Mansell (pp7, 11), Julia Martin/Photofusion (p19), National Medical Slide Bank (p33), Joanne O’Brien/Format (p17), Hilary Shedel (p19), www.third-avenue.co.uk (p31), Mo Wilson/Format (cover, pp3, 44, 73)
Preface

The Government has made clear its determination to ensure consistently high standards in NHS patient and client care. Clinical governance, the modernisation of service delivery, and an increased intake of newly-qualified staff all have a major part to play in making this happen, and all depend on the education, training and development of healthcare students and staff at all stages of their careers.

This report, and the complementary reports by the National Audit Office (NAO), focus on the education, training and development of:

- nurses, midwives and health visitors;
- allied health professionals such as physiotherapists and occupational therapists; and
- other scientific, therapeutic and technical staff such as pharmacists and laboratory technicians.

Neither study covers the special arrangements for doctors and dentists, because historically these have been separately funded and organised – although aspects of medical and non-medical training will increasingly be managed together in future. Even excluding doctors and dentists, education, training and development is still a major expenditure item. The NHS in England and Wales spends more than £1.2 billion a year on training pre-qualification students and developing a current healthcare workforce over 600,000 strong.

Both the Audit Commission and the NAO have responsibilities for reviewing economy, efficiency and effectiveness in the use of public funds. The two bodies have accordingly worked together to review how education, training and development are planned and provided for these staff and students:

- This report reviews education, training and development for existing staff in NHS hospital and community health service trusts in both England and Wales.
- The NAO’s two reports, one for England (Ref. 1) and one for Wales (Ref. 2), look at the effectiveness of the current systems for educating and training new health professional staff. Their reports are available at www.nao.gov.uk.

Taken together, these reports provide a comprehensive picture of education, training and staff development, and make significant practical recommendations for improvement. These recommendations closely complement the goals of the Department of Health (DoH) in England, as described in A Health Service of all the Talents (Ref. 3) and the Human Resources Performance Framework (Ref. 4), and the offices of the National Assembly for Wales (NAW) in the human resources strategy Delivering for Patients (Ref. 5). For this reason, the Audit Commission will not be including this topic in external auditors’ reviews of NHS trusts. Following
the recommendations in this report will help NHS trusts to work towards accreditation against the *Improving Working Lives Standard* (Ref. 6) – which all NHS employers in England must meet by April 2003.

During the course of the study, the Commission team visited eight NHS trusts (‘study sites’) to interview staff and collect data, and carried out three sample surveys of NHS trusts (Appendices 1 and 2). The NAO visited the NHS Executive and its eight regional offices, the offices of the NAW, eight education and training consortia in England, and ten higher education institutions (HEIs) in England and two in Wales. They carried out surveys of the latter two types of organisation. This division of the fieldwork reflects the different statutory remits of the NAO and the Commission. Throughout the study, the teams shared findings and data from visits and surveys. A joint advisory group was established to support the development of the studies, with membership drawn from both the NHS and higher education (Appendix 3).

The Audit Commission team consisted of Zoë Cohen (project manager), Geoffrey Rendle and Gabrielle Smith, under the direction of Dr Ian Seccombe, and supported by Clare Hazard, Amy Kerbel and Anna Davies. The team also received advice from Lesley Stephen and Megan Goodall. The NAO study was led by Karen Taylor under the direction of Dr James Robertson. The Commission is very grateful to the members of the joint advisory group, and to trust staff at all levels, for the time and information they contributed. Responsibility for the findings and recommendations rests solely with the Commission.
Introduction

1. Patients and clients depend on the skills and knowledge of NHS staff. Education, training and development are crucial to maintaining and enhancing the abilities of the more than 600,000 healthcare staff in NHS trusts [EXHIBIT 1]. These staff provide most of the direct care and services to NHS patients and clients and are the focus of this report. Creating and leading the changes required for modernisation will depend to a great extent on maximising the potential of staff who are already employed by NHS trusts; increasingly involving new and extended roles. A key aspect of this is lifelong learning for every individual, which is at the core of clinical governance and supports the management of risk to patients and staff. Opportunities for personal and professional development can also play an important role in the recruitment and retention of healthcare staff.

The words, ‘education’, ‘training’ and ‘development’ can have various overlapping meanings and not all writers use them in the same way. In this report ‘education’ refers typically to learning that leads to a formal qualification, based on a university or other academic institution. For simplicity, the terms ‘training’ and ‘training and development’ are used interchangeably in the report to cover the full range of learning activities, from formal education to short in-service courses and on-the-job learning. Examples of on-the-job learning include coaching, mentoring, secondments and supervised practice.

For ease of reference the term ‘healthcare staff’ is used in this report to refer to the staff groups who were the focus of the study, that is, nurses, midwives and health visitors, allied health professions, other scientific, therapeutic and technical staff together with nursing auxiliaries and assistants, helpers and other healthcare staff without a professional qualification. Doctors and dentists were outside the scope of the study. Medical education was covered by a previous Audit Commission report, The Doctors’ Tale. Staff such as ancillary workers and administrative staff were also outside the scope of the study.

EXHIBIT 1
The healthcare workforce in England and Wales, excluding doctors and dentists
There are over 600,000 healthcare staff in NHS trusts.

<table>
<thead>
<tr>
<th>Wales</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>22,900</td>
<td>311,000</td>
</tr>
<tr>
<td>9,800</td>
<td>120,000</td>
</tr>
<tr>
<td>1,700</td>
<td>25,000</td>
</tr>
<tr>
<td>1,800</td>
<td>23,000</td>
</tr>
<tr>
<td>6,600</td>
<td>105,000</td>
</tr>
</tbody>
</table>

Note: In addition there are approximately 10,700 and 530 whole time equivalent practice nurses in England and Wales respectively, although these staff were outside the scope of the study.

2. Training a greater number of students is also vital, particularly in view of the current significant shortages of nurses\(^1\) and other health professionals such as physiotherapists and radiographers. Each year the NHS in England and Wales spends in excess of £1.2 billion on education and training for healthcare staff (other than doctors and dentists). Around 80 per cent of this is spent on the pre-qualification education and training of students, and is entirely drawn from national levies. The remainder (around £350 million) is spent on the existing healthcare workforce; approximately 50 per cent comes from national levies and 50 per cent from local trust sources.

3. Together, the Audit Commission and the National Audit Office (NAO) have reviewed education and training for healthcare staff and students [EXHIBIT 2]. The Audit Commission report examines ways in which NHS trusts can get the best for patients, clients and the service from training and development activities needed by their existing healthcare workforce. It is aimed primarily at boards, managers and training specialists in hospital and community trusts, although many of the principles would also apply to staff working in primary care trusts. The NAO’s reports (Refs. 1 and 2) review the effectiveness of the current arrangements for

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\(1\) The term ‘nurse’ is used frequently in this report and for conciseness refers to registered nurses, midwives and health visitors.

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EXHIBIT 2

The scope of the Audit Commission and NAO studies

Together, the Audit Commission and the NAO have reviewed education and training for healthcare staff and students.
educating and training health professional students (the reports can be found at www.nao.gov.uk and www.agw.wales.gov.uk). Taken together our reports provide a comprehensive picture of education, training and staff development and make significant practical recommendations for improvement.

4. Education, training and development for healthcare staff covers a wide range of areas and takes many forms [EXHIBIT 3]. Many of these activities are provided in-house by trusts for their own staff complemented by courses – and other methods of learning – commissioned from external providers, most commonly higher education institutions (HEIs). Trusts also purchase training from further education institutions and private sector providers as well as from other NHS bodies. Some external training, particularly that provided by HEIs in England, is not purchased by individual trusts, but by education consortia. These consortia consist of 39 geographically based groups of NHS employers, and include representation from social services and the private and voluntary sectors. Consortia members are jointly accountable for spending an annual budget from the non-medical education and training (NMET) levy. Each consortium has a small team of dedicated staff and is normally chaired by the chief executive of one of the

### EXHIBIT 3

#### Examples of types of education, training and development

Education, training and development for healthcare staff covers a wide range of areas and takes many forms.

<table>
<thead>
<tr>
<th>Core clinical skills and knowledge, eg:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• annual in-house training on basic life support</td>
</tr>
<tr>
<td>• clinical updates provided by other trust staff</td>
</tr>
<tr>
<td>• national vocational qualifications (NVQs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information management and technology skills, eg:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• in-house training to use patient administration systems</td>
</tr>
<tr>
<td>• education in the interpretation and use of data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist/advanced clinical skills and knowledge, eg:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• higher education programmes at diploma, degree or post-graduate level</td>
</tr>
<tr>
<td>• secondments or supervised practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal/personal effectiveness skills, eg:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• in-house training on presentation skills</td>
</tr>
<tr>
<td>• workshops on valuing diversity</td>
</tr>
<tr>
<td>• training on personal safety and dealing with violence and aggression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management and leadership skills and behaviours, eg:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• supervisory level management programmes</td>
</tr>
<tr>
<td>• mentoring</td>
</tr>
<tr>
<td>• in-house training on topics such as appraisal skills</td>
</tr>
</tbody>
</table>

*Source: Audit Commission*
member trusts. Consortia have responsibility for planning the local healthcare workforce and for commissioning pre-qualification training as well as some types of post-qualification training. They are soon to be replaced by a smaller number of workforce development confederations (WDCs). In Wales, the Professional and Managerial Education and Training Branch (PMETB)\(^1\) purchases certain types of HEI course, but Welsh trusts have a greater part of the responsibility for commissioning post-qualification training than trusts in England.

5. Recent years have brought a succession of major changes to arrangements for healthcare education, training and development and further changes are occurring (Appendix 4):
   - The relationship between HEIs and health providers has been changing – closer working partnerships are being recommended.
   - Human resources issues have been gaining prominence – the importance of ongoing personal and professional development in particular, have been emphasised in national policy.
   - New organisational structures and processes are being set up – in England healthcare employers will become involved in integrated planning for the development of the whole workforce through WDCs; NHS Wales is also reviewing its workforce planning processes.
   - Professional regulation is changing – new statutory regulatory frameworks for the health professions include explicit powers to link the periodic renewal of registration with evidence of continuing professional development (CPD).

These factors emphasise the need for individual staff to maintain and update their skills, and for trusts as employers, to play their part in the strategic planning for the development of the local healthcare workforce.

6. Changes in service structures and delivery such as primary care trusts (PCTs), health and social care partnerships and the implementation of national service frameworks mean that services will increasingly be provided by teams of staff working across professional and organisational boundaries. These changes have implications for the planning and provision of education, training and development, and the final chapter of this report returns to these issues.

7. Developing the skills and abilities of trust staff is so important to the quality of patient and client care, particularly in a period of such major changes in service provision, that it should not be left to chance. The NHS cannot afford not to actively manage the significant sums of money involved. Chapter 1 shows that the average trust spends £1 million per year on this area and, although it is not practicable to identify every benefit, trusts need to proactively manage education, training and development for their staff.

Purpose and structure of this report
Employees, line managers, professional heads, human resources departments and board members of NHS trusts all have a part to play in making best use of the resources invested in training and development. Getting the best for patients, staff and the service means having an organisation-wide culture that values and expects training and learning [EXHIBIT 4], coupled with effective supporting systems for:

- identifying training and development needs;
- enabling the training and development to happen; and
- monitoring, reviewing and evaluating.

Although healthcare staff are a large and diverse group, these principles apply in any organisation and to any staff group. Therefore many of the report’s messages are also relevant, for example, to administrative staff and general managers who are not covered by the study.

EXHIBIT 4
Getting the best from training and development

Getting the best for patients, staff and the service means having an organisation-wide culture that values and expects training and learning, coupled with effective supporting systems.
9. Chapter 2 shows that training needs are not always well identified at either the organisational or individual level. Significant numbers of staff providing services to patients and clients do not have their training needs identified or recorded, and where this does occur the process can be of poor quality. There are messages both for senior managers and NHS trust boards about their strategic planning processes, and also for individuals, teams and their immediate managers when considering training and development needs.

10. Chapter 3 describes how access to education, training and development opportunities depends on where you work, who you are and what you do, as much as on individual or service needs. In order for staff to undertake the training and development they need, various factors should be in place. These include: the necessary funding and time, as well as appropriate and convenient training interventions and, in some cases, the availability of mentors/assessors. But problems with these factors cause barriers for staff and services in meeting training needs. Chapter 4 describes these problems further and how trusts can reduce their effects. Individuals, managers and training specialists all have a role to play in the review and evaluation needed to complete the cycle.

11. Chapter 5 describes how well-organised systems alone are not enough. Trusts need to have a culture where everyone’s role in training and development is clear. It is up to trust boards and senior management to give the lead, including playing their part in strategic workforce issues in the wider health economy.

12. Recommendations for individuals, managers, professional heads, training specialists and the board are drawn together at the end of the report.
Getting the Best from Training and Development

Managing and developing people well does make a difference – and well-managed training and development is a key part of this. Although education, training and development can bring a range of benefits for patients and staff, it can be difficult or impracticable for trusts to demonstrate the impact. Trusts should therefore make best use of the various sources of funding by ensuring that processes for targeting and providing access to training and development are well managed.
13. Education, training and development can bring a range of benefits. It can help to:

- improve patient and client care;
- reduce risks to patients and staff;
- improve productivity; and
- have a positive effect on recruitment and retention.

In practice the impact on patient and client care can be difficult or impracticable for trusts to demonstrate. Trusts should therefore ensure that the processes for targeting and providing access to training and development are well managed. This means that trusts need to get an overview of the diverse sources of funding that can look small in isolation, but on average add up to £1 million.

14. Specific cases of well-designed education and training have been shown to improve services and reduce risks to patients and staff [BOX A]. There is more general evidence (both qualitative and quantitative) of beneficial effects on the confidence, motivation, knowledge and practice of healthcare staff (Ref. 7, 8).

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**BOX A**

**Minimising risks to patients and staff**

The need to move or lift patients cannot be avoided and is a potential risk to both patients and staff. Adverse consequences (sickness absence, loss of skilled staff and compensation claims) can be minimised with regular training, along with safe systems of work underpinned by risk assessment. The Health and Safety Executive (HSE) (Ref. 9) has stated that staff must undertake refresher training at least once a year if training is to remain effective:

- A single personal injuries claim against one trust in 1998 amounted to over £250,000 as the court ruled that the trust had not had proactive systems in place for ensuring staff had the necessary up-to-date skills in moving and handling (Ref. 10).

- One trust described by the HSE invested in equipment and comprehensive training, reducing the hours lost due to manual handling accidents by 84 per cent and saving an estimated £400,000.

- Another trust halved the number of adverse incidents on wards by introducing an intensive programme of risk assessment, investment and training.

*Source: Audit Commission*
Managing and developing people well does make a difference…

15. Managing and developing people well does make a difference – and well managed training and development is a key part of this. Recent research in the manufacturing sector has indicated that good human resources practices, the most important being the acquisition and development of skills, are associated with higher profitability and productivity (Ref. 11). There seems no reason why these findings should not apply to the NHS.

16. In some circumstances personal and professional development opportunities help to attract staff and retain them within an organisation. Previous Audit Commission work (Ref. 12) has stated that although the regional or even national employment markets for some healthcare professionals are outside the direct influence of individual NHS employers, trusts can influence recruitment and retention through the development opportunities available to their staff.

17. The outcomes of training in terms of patient and client care, and service delivery are often difficult to assess, sometimes because formal evaluation would be disproportionately costly, or because the learning outcomes defy objective measurement. It is therefore not practicable to demonstrate conclusively that every training and development activity trust staff undertake benefits patient care.

18. However, there are good practice management principles that trusts should use. The Industrial Society (Ref. 13), for example, has highlighted the use of training and development strategies, the line manager’s role in setting training objectives, the use of competencies, access to a range of learning activities to suit differing situations, and the need to share learning and to evaluate such activity.

19. The Investors in People (IiP) framework, developed across many sectors of the economy, calls on organisations to achieve four standards:

- commitment to people development throughout the organisation;
- planning people development so that it clearly supports the organisation’s aims and objectives;
- effective action by managers and individuals; and
- evaluation so that the organisation understands how people development impacts on performance.

Many of the principles underlying these approaches can help to improve value for money.
The amount invested in education, training and development

20. Education and training for the healthcare workforce at an average trust costs at least £1 million per year – a total of at least £350 million across England and Wales, and equivalent to 2.5 per cent of payroll costs, or £440 per employee. These figures are underestimates because they exclude elements that are difficult to quantify, such as:

- the cost of much on-the-job training;
- much of the cost incurred covering for staff while training takes them away from their workplace; and
- the sums contributed by staff themselves.

21. Information on aggregate spending has not been available thus far. One of the reasons for this is that education and training for trusts’ healthcare staff is funded from a (sometimes confusing) variety of sources [EXHIBIT 5]. The Audit Commission carried out a special enquiry to establish expenditure in a sample of NHS trusts (Appendix 2).

EXHIBIT 5
Sources of funding for education and training for healthcare staff (1999/2000)
Funding comes from a (sometimes confusing) variety of sources.

<table>
<thead>
<tr>
<th>External/ring-fenced funding*</th>
<th>Central directorate control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding controlled by NHS trust</td>
<td>Line directorate control</td>
</tr>
<tr>
<td>Various training posts</td>
<td>Charitable funds/endowments</td>
</tr>
</tbody>
</table>

Each coin represents £50,000 to an average trust

*‘External/ring-fenced funding’ includes NMET-levy funding in England, and ring-fenced contracts with HEIs and funding from the PMETB in Wales, and in some trusts other external sources such as funding from training and enterprise councils (TECs).

Source: Audit Commission survey of NHS trusts (summer 2000)
22. About one-half of the costs are met from national levies (the NMET levy in England, and Towards 2000 funds from the PMETB in Wales) and other funds committed to higher education. These funds can only be used for certain purposes; in particular, national levies can only be used for staff groups specified by the health departments. Other education and training, such as in-house provision and training purchased from organisations other than HEIs, is mostly funded by NHS trusts out of normal revenue.

23. Even within NHS trusts, the detailed funding arrangements can be complex and each component can account for differing amounts:

- In-house training departments often account for only a small part of this spending.
- Other costs, such as external training activities and training-related posts may be borne both by central departments such as human resources and nursing, and by line directorates.
- Both central and line directorates sometimes use income generation to support training and development.
- Spending decisions can be made by central or line directorates. The proportion spent in line directorates can range from zero to as much as 50 per cent of all education and training expenditure.
- NHS charitable funds, endowments and special trustees can be an important further source of funding, although not guaranteed. For example, in teaching hospitals they can fund as much as 10 per cent of all healthcare education and training costs.

24. Few NHS trusts have systematically reviewed how these various sources of income are being applied, but doing so can raise important questions about how resources are managed and used throughout the trust and what opportunities are open to which staff [CASE STUDY 1, overleaf].

25. A trust’s review of their training investment should be informed by the identified training priorities of individual staff and the wider organisation. Identifying training needs is the subject of Chapter 2.
CASE STUDY 1

Reviewing the resources invested in education and training

Finance staff in one recently merged acute trust found that:

- the pre-merger trusts had very different systems for organising and funding education and training;
- there were ‘pockets’ of money and training activity all over the Trust. Some were restricted to nursing or to particular departments;
- senior managers were signing education contracts with the consortium without the knowledge of the Trust’s consortium representative;
- policies and procedures on providing replacement costs for staff on training differed across the organisation; and
- neither the human resources nor nursing/professional functions had an overview of all the resources available or how they were being used, nor did any of the related committees on research or clinical governance.

The process of gathering information on the various sources of training expenditure helped to raise the profile of education and training arrangements within the Trust. The Trust was not previously aware that the direct investment in training for its healthcare staff amounted to over £2 million per year. A range of measures is now being implemented aimed at improving the management of these resources:

- Human resources, nursing and finance staff are meeting to identify all training activity and costs within the Trust.
- Training policies have been issued to ensure consistency between sites.
- Nurse training budgets have been reviewed so that they support or extend local or national initiatives.
- A nominated contact person has been agreed to improve communications between the Trust and local consortium officers.
- The local consortium’s guide to education and training funding arrangements has been circulated to departmental heads.
- There is a proposal to establish an education and training panel with links to workforce planning.
Identifying Training and Development Needs

Staff within the NHS should undertake training and development that support their organisation’s business plan and the strategic direction of services for patients, while also relating to individuals’ and teams’ perceptions of need. But many trusts need to improve the identification of training and development needs from business plans, health improvement programmes and clinical governance processes. And there are significant numbers of staff whose training and development needs go unidentified or for whom the process is poor.
26. Staff developing their skills and abilities is one of the main ways of ensuring that services continue to meet evolving patient, client and policy needs. Trusts should identify training and development needs appropriately (and act upon them) in order to help to:

- achieve desired service changes;
- use resources for training to best effect;
- reduce clinical risks to patients; and
- develop the potential of individual staff.

27. This chapter is about identifying training needs to help ensure that the right staff are undertaking the right training and development. Across the NHS healthcare staff undertake millions of days of training and development activities each year. But participation by individuals is very uneven [EXHIBIT 6], and there are significant numbers of staff providing clinical services to patients and clients, whose training and development needs go unidentified (and may remain unmet). Some trusts are developing a range of more objective methods, such as competencies, to supplement individuals’ own views, but their use is not yet widespread. Training priorities should reflect local strategies or service changes but evidence of this is not always clear. There is scope for many trusts to improve.

28. Staff within the NHS should undertake training that supports their organisation’s business plan and the strategic direction of services for patients. Training and development also needs to relate to individuals’ and teams’ perceptions of need. NHS trusts are expected to have personal development plans (PDPs) or equivalent in place for their staff. The target set by the NHS Executive, is to have training and development plans for all health professional staff, and personal development planning extended to all staff groups, by April 2001 (Ref. 4). Delivering for Patients, the NHS Wales human resources strategy, states that PDPs for individual staff ‘will identify and balance their personal, educational and professional development needs with those of the organisation’ (Ref. 5).

EXHIBIT 6

Days of training and development activities undertaken by healthcare staff in the last 12 months

The number of days that staff spend on training and development varies widely.

Note: Data from 2,591 staff (headcount) in 7 trusts. Figures do not include time spent in on-the-job training.

Source: Audit Commission surveys of trust staff (1999/2000)
29. Research has shown that doctors sometimes choose educational interventions that fit in with what they already know or are comfortable with [Ref. 14] and anecdotal evidence suggests that the same may be true for other healthcare staff. A range of evidence should be used to identify training and learning needs [Ref. 15]. To achieve the necessary balance between the organisational and individual views of needs, trusts must combine a variety of information [EXHIBIT 7]. The structure of this chapter follows this model.

30. Trusts need to target their resources at providing and commissioning the training that is necessary for delivering patient services. They must be able to identify and plan for changes in those services [CASE STUDY 2, overleaf]. Training needs identified from an individual’s point of view are important, but on their own may not reflect longer-term service changes. Trusts should combine bottom-up information, identified from individuals, with training priorities distilled from business plans, service changes and clinical governance processes. This top-down information also needs to take into account the implications of the health improvement programme and the diversity of the local population.

EXHIBIT 7
Identifying training and development needs
To achieve the necessary balance between the organisational and individual views of needs, trusts must combine a variety of information.

Source: Audit Commission
Most human resources functions promote top-down approaches to identifying training and development needs. But in trusts visited by the Commission, formal statements of staff training needs at directorate or organisational level were not commonplace. Although training needs analysis may be happening informally, through discussions between managers, without formalisation it may be overlooked.

### Identifying training needs from clinical governance processes

NHS trusts should routinely identify learning and training needs from trends in adverse clinical incidents and individual incidents [CASE STUDY 3]. But the Chief Medical Officer (Ref. 16) recently reported that the NHS must improve its learning from adverse events and that training is vital in enabling changes to be disseminated and acted upon. Trusts should ensure that they have systems to identify training needs connected with incidents, complaints and other clinical governance processes [CASE STUDY 4] and that these link to wider processes for planning training.

CASE STUDY 2

**Lifespan Healthcare NHS Trust**

*(see also Case Study 22, page 61)*

In September 1997, Lifespan Healthcare NHS Trust was required to disinvest in children’s services and developed a structured approach to managing the workforce/human resource implications of this change. The Trust decided that they would move towards an integrated child and family service rather than separate school nursing and health visiting services. This meant that these staff would have to learn and practise new skills. A project group, including health professionals, identified eight common, ‘universal’ events that the children and family service would cover, for example, the primary birth visit. The skills, knowledge and attitudes associated with each of these events were identified together with learning activities and assessment strategies. A professional portfolio was developed for the nurses in the child and family service so that they could assess their development needs.

Training interventions were devised to ensure competency for each of the eight universal events, supported by supervised practice, reflection with an expert practitioner and opportunities to build confidence. The approach was developed jointly with the local HEI, Homerton College, Cambridge: School of Health Studies.
The service changes required by local health improvement programmes (HImPs/HIPs) to meet the needs of client groups are likely to have implications for the skills and knowledge of multidisciplinary teams of trust staff. However HImPs/HIPs are not yet having a significant influence on the training and development being provided or commissioned by trusts. A survey of education consortia found that nearly one-third of HImPs produced by health authorities in England did not address training issues for the local healthcare workforce while two-thirds only partly addressed them1.

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**CASE STUDY 3**

Camden and Islington Community Health Services NHS Trust

The Trust published its internal inquiry into a series of incidents of physical abuse of people with mental and physical health needs associated with old age, occurring between 1993 and 1996. Of the 61 recommendations 13 related to, or had consequences for, training. These included the recommendation that ‘a trust-wide training programme should be developed and implemented for all staff to enable the timely identification, intervention and management of abuse of vulnerable adults’. The Trust has now developed a comprehensive learning package including using learning materials developed by Action on Elder Abuse.

**CASE STUDY 4**

Worthing and Southlands NHS Trust

The Trust is seeking to highlight training and learning implications through clinical governance action plans with achievement against the targets monitored at board level. For example, the clinical governance department identified a trend in adverse clinical incidents relating to the care of patients with diabetes. Action to date has involved identifying the need to further develop training and awareness around good diabetic management, including extending support for a diabetic training post. The diabetic educator provides both clinical and educational support. Pre-training questionnaires are completed to assess knowledge levels. Post-training questionnaires demonstrate a considerable improvement in knowledge. Educational packs have been developed for ward staff, doctors and community staff.

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**Health improvement programmes and diversity of the local population**

33. The service changes required by local health improvement programmes (HImPs/HIPs) to meet the needs of client groups are likely to have implications for the skills and knowledge of multidisciplinary teams of trust staff. However HImPs/HIPs are not yet having a significant influence on the training and development being provided or commissioned by trusts. A survey of education consortia found that nearly one-third of HImPs produced by health authorities in England did not address training issues for the local healthcare workforce while two-thirds only partly addressed them1.

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1 Survey conducted by the NAO in summer 2000. All 39 consortia responded.
34. Equally, seven out of ten human resources directors indicated that the local HIMP/HIP had not yet had a significant influence on the training and development provided or planned for by the trust. Human resources and training managers need to ensure that they are engaged in the HIMP/HIP development and implementation processes in their local health economy.

35. One of the strategic aims of the Equalities Framework for the NHS in England (Ref. 17) is ‘to recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals’. In addition, the Human Resources Performance Framework (Ref. 4) states that ‘organisations should work with the education sector to ensure that curricula address skill gaps and competencies to enable staff to respond appropriately and sensitively to patient need in a non-discriminatory and culturally sensitive way’. Therefore staff at all levels should consider training needs to help individuals to appreciate and provide appropriate care for different groups and communities [CASE STUDY 5].

CASE STUDY 5

South Derbyshire Acute Hospital NHS Trust

Southern Derbyshire has a population of 567,000, and an Asian population of around 30,000, speaking mainly Punjabi or Urdu. There is an increased prevalence of non-insulin dependent diabetes among British Asians. In order to be able to provide a service sensitive to the needs of the local Asian population, members of the Trust’s diabetes team run sessions for hospital, community and primary care staff as part of an accredited programme. These cover:

• specific issues about diabetes and associated complications amongst the Asian population;
• how to use an interpreter through role play;
• issues that affect access to diabetes services by Asians and other ethnic minorities;
• understanding Asian culture; and
• attitudes of health service staff to ethnic minorities.

Training is also provided for the Trust’s interpreters so that they are aware of diabetes symptoms and the problems that they can cause.
The identification of individuals’ development needs is one of the main purposes of most organisations’ appraisal or performance development systems (Ref. 18) (along with setting objectives and giving feedback on performance). A good appraisal and PDP process should ensure that the training staff undertake is appropriate to their needs but is also focused on the needs of the service. Where appraisal is not in place there is a risk that identifying training needs is an ad hoc process characterised by individuals highlighting what training they want to do. Recording training needs in a PDP means that progress can be monitored and reviewed (as well as collated to inform planning). Staff who have a PDP undertake more training than their peers and are more likely to report that some or all of their training needs are met. But even if trusts have appraisal policies and paperwork in place, the coverage and quality of PDPs can be inconsistent.

Coverage of personal development plans
37. In the Commission’s surveys, one in three staff reported that they had not had their training and development needs identified with their manager in the last 12 months. And in some trusts fewer than one-half of the staff have their training and development needs recorded in a PDP (EXHIBIT 8). This supports the conclusion that management culture – taking training and development seriously – plays an important part in recognising and acting on the needs of staff.

EXHIBIT 8
Identifying individuals’ training and development needs
In some trusts fewer than one-half of the staff have their training and development needs recorded in a PDP.

Note: Excludes staff who had been in post for less than 12 months.
Source: Audit Commission surveys of trust staff (1999/2000)
Some trusts have achieved [PDP] coverage of a large majority of staff through top management commitment and regular audit.

Senior managers need to know which staff have PDPs (or equivalent) and which do not. Ideally, this information would be in an electronic format, but it is seldom recorded routinely or electronically and is therefore difficult to report regularly. Better information systems for training and development can have several benefits [BOX B] and a new national human resources and payroll system is being introduced over the next three years. Until this is implemented, the best source of information is likely to be the annual staff surveys trusts in England have been required to carry out since 1999/2000. These are now required to include questions about whether staff have a PDP. (The NHS in Wales is planning to introduce annual staff surveys in future.) Trusts need to target action at areas where fewer staff are engaged in the process. Some trusts have achieved coverage of a large majority of staff through top management commitment and regular audit [CASE STUDY 6].

BOX B

Potential benefits from better information systems in training and development

With good management and networking, electronic records could help trusts to:

- monitor whether PDPs have been completed for all staff groups;
- inform service managers of how many of their staff have had what training and development (for example, training on specific equipment, as required by the Clinical Negligence Scheme for Trusts in England);
- aggregate information on competencies and training needs across the organisation, allowing better co-ordination of in-house training and commissioning of external training;
- report on whether all staff groups are accessing training;
- issue reminders to staff due for mandatory updates; and
- provide analyses (for example, on study leave) for reports to senior managers and the board.

In an Audit Commission survey only 8 per cent of human resources directors indicated that all the training records of staff were held electronically. And of those trusts with at least partial electronic training records, less than one in six had systems that were networked and available for managers to access locally. This means that it is often difficult for either directorate managers or the central training team to use such information to help them to plan training.

Source: Audit Commission
Quality of personal development plans

There is no single, correct format for appraisal or PDP paperwork. However, it should support a system that:

- involves both the individual and their manager agreeing specific training needs linked to the requirements of the job as well as to their personal or professional development;
- enables clear actions to support the individual’s development to be agreed and prioritised, and responsibility assigned for their implementation; and
- encourages review of the previous PDP to see if agreed development activities and learning took place, as well as interim review of the current PDP.

CASE STUDY 6

Performance and development review, Chester and Halton Community NHS Trust

The Trust has successfully increased the coverage of its individual ‘performance and development review’ (PDR) from 55 per cent to 83 per cent of staff in two years. The keys to achieving this change are described as:

- regular audit;
- leadership; and
- top management commitment.

Annual staff surveys are used to monitor coverage, while regular quality audits are undertaken. These gauge staff views on the value of the process. The most recent audit found that:

- 87 per cent of staff were involved in the PDR process, of whom 86 per cent stated that it had been beneficial or very beneficial; 96 per cent had the outcome of their discussions recorded;
- 79 per cent of staff stating that their PDR provided them with opportunities for development and 64 per cent stated that it improved their competency/skills; and
- areas for improvement were also identified, for example, the need to improve managers’ feedback skills. Coverage of this topic has now been expanded in the Trust’s PDR training workshops.

The results of this audit were reported to the board in order for them to assess progress. Regular monitoring of coverage and quality allows the Trust to follow up problem areas if they occur.
The Audit Commission reviewed samples of PDPs (114 in total) from eight trusts against these criteria. This took into account the extent to which the paperwork supported these points as well as the comprehensiveness and quality with which the PDPs were completed [EXHIBIT 9]. The standard of PDP completion varies widely and can be very poor, sometimes raising questions about the value of the process and the likely outcome.

**EXHIBIT 9**
The quality of completed PDPs and the comprehensiveness of paperwork
When PDPs or equivalent are in place, the standard of completion varies widely and can be very poor.

<table>
<thead>
<tr>
<th>Characteristic of a personal development plan (PDP) or equivalent</th>
<th>Whether present in samples of PDPs reviewed (114 total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous PDPs are reviewed to check whether agreed development took place</td>
<td>✔</td>
</tr>
<tr>
<td>Individual and manager have both expressed their views</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Reference to skills and competencies required in the job</td>
<td>✔ ✔ ✔ (by implication more often than explicit)</td>
</tr>
<tr>
<td>Training/development needs are specified</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Actions are agreed</td>
<td>✔ ✔ ✔</td>
</tr>
<tr>
<td>Actions are prioritised</td>
<td>✔</td>
</tr>
<tr>
<td>Responsibility for actions is clear</td>
<td>✔</td>
</tr>
<tr>
<td>Interim reviews are encouraged/undertaken</td>
<td>✔ ✔</td>
</tr>
</tbody>
</table>

Source: Audit Commission analysis of PDP samples from study sites
Some PDPs were completed only by the individual or by their manager; less than one-half were clearly signed by both. Few completed PDPs made *explicit* reference to the skills and competencies required in the job. It was common for training needs to be poorly identified and specified. That is, ‘attend relevant courses’ or ‘attend study days’ appeared as the need, rather than the actual skill, knowledge or experience required. Although actions to meet training needs were usually given, they were not always specific and agreed and rarely prioritised. Only one-half of the PDPs showed evidence of planned or actual review, and only one of the formats explicitly encouraged review of activities undertaken in the last year and the effects on the individual’s job performance.

**Managers’ skills**

Training specialists can provide support but unless managers have the skills, confidence and commitment to identify training and development needs with their staff, and to link these to the requirements of the service, then it will not be effective. All study site trusts provided at least some training for line managers in carrying out appraisal and PDPs. However, this was sometimes described as insufficient to cover all those needing it, leaving some service managers inadequately equipped to identify and plan the training and development with their staff. Trusts need to ensure that sufficient training is provided for line managers, particularly when new appraisal systems are launched, and that this is ongoing for new appraisers [CASE STUDY 7].

**Using structured or objective approaches**

Structured methods, such as those that use competencies, are one way of supplementing individuals’ own views of their training needs with an objective framework. The principles of clinical governance and the registration requirements of professional bodies also emphasise the need for healthcare staff to demonstrate competence. This trend is also reflected in the national nursing strategies’ move towards competency-based pre-registration training. It is further supported by the national training organisations for health and personal social services and their emphasis on national occupational standards.

**CASE STUDY 7**

Appraisal training, Royal Bournemouth and Christchurch Hospitals NHS Trust

The Trust has achieved organisation-wide IIP accreditation for over six years. Training for appraisers is considered a mandatory requirement and there is a cascade of appraisal skills. Appraisal training is provided as a half-day event by eight ‘lay’ trainers, who work in pairs.
44. The Audit Commission’s survey of trusts found that methods such as assessment of staff knowledge/competence, job/role analysis and assessment against national occupational standards, were promoted by human resources functions in around one-half of trusts. There were examples of structured or competency-based approaches to identifying training needs in some of the trusts visited, but these were often still developing and were not yet widespread [CASE STUDY 8]. The approach used in midwifery supervision provides one useful model. Each professional and their Supervisor of Midwives rates the individual’s competence against identified areas of practice, and agrees actions to meet development needs which can be reviewed at the following session.

45. Trusts need to use the sources of information on individuals’ needs and those highlighted from business plans, service changes and clinical governance processes to prioritise and plan which training and development needs can be met in the coming period.

46. In an Audit Commission survey nearly nine out of ten human resources directors indicated that they promote aggregating PDPs to identify needs. Training managers interviewed cited this as one way in which they determine in-house training provision. However, the variable coverage and quality of PDPs may give a skewed and incomplete view of organisation-wide needs.

47. Staff surveys offer another way of bringing together information on the training needs of staff across the trust and helping to target in-house or external training [CASE STUDY 9].

CASE STUDY 8

Speech and language therapy, Rochdale Healthcare NHS Trust

The department head developed a set of competencies to assist Grade 1 therapists and their appraisers with their development and transition to Grade 2. The manager wanted evidence that staff had the skills necessary to progress. The competencies detail skills and knowledge required by each therapist on areas such as screening, caseload management, administration and development of personal skills. The competencies have been in place for over two years and therapists see them as helpful. The head of department finds it easier to identify and prioritise applications for training as these can be linked to the competencies.
Training planning is beneficial as it can help trust managers to:

• set priorities for the use of resources;
• meet common needs more efficiently;
• target and schedule in-house provision; and
• organise staff release.

In some trusts visited, individual departments produce their own training plans from PDPs, managers’ views and other information [CASE STUDY 10, overleaf]. Wider planning of training across the organisation is less common but maximises the benefits [CASE STUDY 11, overleaf].
CASE STUDY 11

In order to develop a more corporate approach to training and training priorities, the Trust held a workshop involving all clinical and operational managers. Managers brought with them their department/unit business plans, which are required to highlight training implications. This enabled a more strategic approach in which common training needs were discussed in the context of the direction of the Trust's services as well as national policy. For example, the workshop highlighted the need for a range of staff groups to develop cognitive behavioural therapy skills at different levels. In the past, individual managers might or might not have identified such training for their staff in response to these needs. Through this approach the Trust has been able to commission a tailored programme to be run in-house, thereby meeting local needs and providing the training at a lower cost.

Key training needs identified from the workshop were then linked to the resources available – from the Trust as well as external sources such as NMET levy funding from the consortium. As training needs outweighed the funding available, a costed, prioritised list was produced for the Trust Board which enabled decisions to be taken about which training could not proceed in that year, and for some additional resources to be identified.

CASE STUDY 10
Departmental training plans, Royal Bournemouth and Christchurch Hospitals NHS Trust

There is a Trust-wide policy of departments/directorates drawing up their annual training plans that identify all needs, however funded. Each plan is built up from individual appraisals and identifies the:

- business goal;
- training need and name or number of trainee(s);
- cost of fees, travel and subsistence and source of funding;
- days of planned absence and cost of planned locum cover if applicable; and
- success criteria.
49. Once priority training needs are identified staff need to undertake the right activities to meet these needs in order to improve their skills, knowledge or behaviour in the desired way. But individuals’ access to training varies in relation to where they work, the staff group they are part of and other characteristics – not necessarily in relation to training needs. This is the subject of the next chapter.
In order to identify the needs for training (which should lead to training activity being more effectively targeted):

1. NHS trust senior managers who are involved in business planning, service development, health improvement programmes or clinical governance should regularly identify the implications for staff training and development.

2. Human resources departments should ensure that the coverage of PDPs is monitored, and that samples of them are audited to identify the most serious weaknesses.

3. Human resources departments should provide sufficient training so that all line managers are competent in conducting appraisals and personal development planning (particularly when new systems are launched), and that competence is maintained.

4. Individuals, with their line managers, should review their training and development needs at least once a year, and agree and document what action each will take.

5. Trusts should combine information from ‘bottom-up’ processes such as PDPs with the corporate needs identified in the first recommendation above, and use the results, in discussion with service managers and professional heads, to plan future training. The plan should cover in-house training and external provision, including post-qualification training at HEIs.

In order to improve the identification of training needs and the management of training and development generally:

6. Trusts should make best use of any existing information systems for training and development and seek to implement fully the new human resources/payroll system when it is rolled out nationally.
Access to Education, Training and Development

Once training and development needs have been identified and prioritised, staff need to undertake the right activities to meet them. But cultural, organisational, historical or financial barriers can mean that who you are, what you do and where you work affect access to training and development as much as your training needs. It is possible that important training and development, which could be benefiting patients, the service and staff, may not be happening in some trusts.
50. Once training and development needs have been identified and prioritised, staff need to undertake the right activities to meet them. A number of things need to happen if identified needs are to be met [EXHIBIT 10].

51. The extent to which individuals engage in training and learning activities and apply these in practice is also influenced by factors such as their motivation and desire to develop (Ref. 19). Some interviewees referred to staff who do not want to undertake training or to develop their skills, so as well as providing the necessary supporting conditions, trust boards and managers also need to establish a culture that expects and values training and learning.

52. National policy stresses the importance of the NHS as a good employer achieving equality of opportunity and fair outcomes in the workplace (Ref. 20). The Improving Working Lives Standard (Ref. 6) indicates that trusts should provide personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns.

53. But evidence in this chapter shows that who you are, what you do and where you work can determine access to training and development as much as your training needs. It is possible that important training and development, which could be benefiting patients, the service and staff, may not be happening in some trusts.

EXHIBIT 10
Meeting staff’s training and development needs
A number of things need to happen if identified needs are to be met.

Source: Audit Commission
54. The ability of healthcare staff working in different trusts and departments to undertake training is affected by financial, operational and other factors.

Financial factors
55. Trusts vary substantially in the overall level of resources that are invested in education, training and development for their healthcare staff [EXHIBIT 11]. In terms of spend per head of healthcare staff the variation is from under £200 to over £1100 per year⁷ (or from 1 to 5 per cent as a proportion of the pay bill).

56. Regression analysis⁸ of data from a sample of trusts helps to throw light on this variation; some of it appears to reflect differences in trusts’ circumstances and requirements, but the remainder (taken together with other sources of evidence presented later in this chapter) supports the finding that there are substantial differences in access to training. The following trust characteristics together account for 47 per cent of the variance in spend as a proportion of the pay bill.

- **Trust type**: acute non-teaching and multi-service trusts on average spend less than other types of trust, particularly community and teaching hospital trusts [EXHIBIT 12, overleaf].
- **Trust size**: larger trusts spend less from their own sources than smaller trusts, whereas both have similar access to other funding sources such as the levies. Economies of scale seem likely to explain this.
- **Location**: there is no evidence that trusts in London and the south-east spend more as a percentage compared to the pay bill. They do, however, spend more per head than comparable trusts elsewhere; this is almost certainly due to the higher costs in the region.

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**EXHIBIT 11**

*Investment in education, training and development for healthcare staff in 1999/2000*

Trusts vary substantially in the overall level of resources that are invested in education, training and development for their healthcare staff.

Note: these spending figures include actual expenditure from trust budgets and other sources such as NMET levy funds (or in Wales funding from the previous education purchasing unit) as described in Appendix 2.

*Source: Audit Commission survey of trusts (summer 2000)*

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**Percentage spend as a proportion of pay bill**

<table>
<thead>
<tr>
<th>Percentage spend</th>
<th>Number of trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>1</td>
</tr>
<tr>
<td>5%</td>
<td>6</td>
</tr>
<tr>
<td>4%</td>
<td>15</td>
</tr>
<tr>
<td>3%</td>
<td>29</td>
</tr>
<tr>
<td>2%</td>
<td>32</td>
</tr>
<tr>
<td>1%</td>
<td>20</td>
</tr>
<tr>
<td>0%</td>
<td>22</td>
</tr>
</tbody>
</table>

*Mean = 2.55%*
EXHIBIT 12  
Investment in education and training for healthcare staff in 1999/2000

Acute non-teaching and multi-service trusts on average spend less than other types of trust, particularly community and teaching hospital trusts.

Source: Audit Commission survey of trusts (summer 2000)

- **Labour market factors:** these might be expected to affect the amount of training; for example, a high turnover rate could mean that more staff continually need preparation for new jobs, whereas persistently high vacancy rates could make it harder to release them for training. The data provide some evidence of such effects, particularly for turnover, but show that they contribute little to the overall variation.

- **Part-time working:** trusts with larger proportions of part-time employees spend less per head from their own sources. This is of concern, for example, the regression results are consistent with part-time employees’ training investment being proportional to their hours worked rather than comparable to that for full-time colleagues. And external/ring-fenced sources do not compensate for this.

57. These factors leave the majority of the differences between trusts unexplained. Therefore, much of the variation appears to be cultural, reflecting the relative importance trusts give to training and development – or historical, based on budgets or contracts that may have changed little over the years. In England, 1999 NHS Executive guidance expected trusts to ‘take stock of their current investment in CPD, including that accessed by their local education consortium, as part of the their preparations for implementing clinical governance’ (Ref. 20). But in the Audit Commission survey only one in three trusts had reviewed their investment in training since the guidance.

58. Around one-third of the investment that trusts make in training from their own budgets, or approximately 15 per cent of the total investment, is spent at the level of individual departments or directorates. And four out of five trusts have training budgets at directorate or department level. Of these, over one-half are allocated historically and only one-sixth are based on agreed training needs.
59. It is difficult to demonstrate the overall impact of a relatively high or low investment in training. And it is not possible to say whether too much or too little is being spent in any one trust. But there is some evidence from the Audit Commission’s surveys that variation in levels of investment makes a difference. For staff in lower spending trusts:

- funding was more likely to be seen as a barrier to meeting training needs; and
- a higher proportion of staff reported that they had contributed to the costs of their own training, even if it was viewed as necessary for their current job.

60. In addition to differences in the overall level of investment, the make-up of these resources varies considerably from trust to trust. Trusts’ own contribution varies from one-quarter to three-quarters of the overall training investment. Even among trusts with similar levels of investment the make-up of the spending varies considerably [EXHIBIT 13].

61. This variation has consequences for the package of education, training and development opportunities available to staff. For example, where NMET levy funding predominates it can be limited to training for certain staff groups with a single local higher education provider. Alternatively a trust can have a high proportion of their investment in a large central training function but less money available at departmental level to fund specialist external training.

**EXHIBIT 13**

The breakdown of spending on education and training in a sample of trusts with average levels of investment

Even among trusts with similar levels of investment, the make-up of the spending varies considerably.

Source: Audit Commission survey of trusts (summer 2000)
62. Much of the post-registration training for nurses in England is funded from the NMET levy, usually via contracts with consortia. In Wales there are specific sums held either by trusts or health authorities that fund service level agreements (SLAs) with universities. An Audit Commission survey found that registered nurses in some trusts have more than ten times as much higher education-based training available to them than their counterparts in other trusts. The most common methods used by consortia for allocating post-registration courses were by bids, pro-rated or on the basis of historical spends\(^1\). Although these allocations may be influenced to some extent by how much trusts request, they must also be determined by the overall size of the contract with the higher education provider.

63. The training and development opportunities available to staff funded by trust sources also varies. National vocational qualifications (NVQs) for staff without a professional qualification provide an example [BOX C].

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\(^1\) Results from NAO survey of consortia.

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**BOX C**

**National vocational qualifications**

NVQs are work-based qualifications that provide staff with relevant underpinning knowledge and enable them to demonstrate their competence at a range of levels. They can form an important part of the training package for healthcare assistants (HCAs) and other staff without a professional qualification. Providers have to be accredited by an awarding body. NVQs are assessed and internally verified by staff with specific qualifications whose work is also quality assured by the awarding body.

Gaining a relevant level 3 NVQ can be used as an entry requirement for existing healthcare staff to access professional training. The benefits are commonly described as increasing employees’ confidence and motivation (Ref. 21, 22) as well as ensuring that staff are trained and working to national occupational standards.

But trusts have very differing levels of involvement. Trusts’ NVQ activity is said to be limited to use in some parts of the trust by 45 per cent of human resource directors, a small number have no involvement in NVQs at all. One quarter of these trusts gave insufficient knowledge or expertise as a reason for not having wider involvement in NVQs and national occupational standards (NOSs). The NHS Plan (Ref. 23) guarantees all staff without a professional qualification access to either an NVQ or an Individual Learning Account (ILA) over the next three years. This means that some trusts have considerable changes to make.

*Source: Audit Commission*
Operational and other factors

64. Even where funding is available, identified training needs can remain unmet. Other factors – such as information – also affect access to training. In one trust one in ten staff stated that they were not at all informed or were poorly informed about the training and development opportunities available, while in others the figure was nearer four in ten. Without information either directly, or via their managers, staff may be missing out on developing their skills and knowledge.

65. Training provision may not be appropriate or flexible enough. Pressures of work in the clinical environment can mean that staff are not available to act as mentors/assessors for others, provide on-the-job training or to be released to undertake training themselves. Staff are more likely to report that these factors act as barriers to meeting their training needs in some trusts than in others [EXHIBIT 14].

66. The approaches trusts can use to reduce the impact of these barriers will differ depending on the types of problems experienced and local circumstances. Further discussion of these issues, and the actions trusts can take, are in Chapter 4.

67. Local management culture and practices can mean that staff in some parts of a trust are more likely to have their training and development needs met than in others [CASE STUDY 12, overleaf]. Training application and approval policies can also differ within a trust.10

**EXHIBIT 14**

**Barriers to meeting training and development needs**

Staff are more likely to report that these factors act as barriers to meeting their training needs in some trusts than in others.

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Note: includes data from 3,699 staff in seven trusts. 17 per cent reported that all their training and development needs had been met, 62 per cent that some, and 21 per cent that none had been met.

*Source: Audit Commission surveys of trust staff (1999/2000)*
Access can also vary depending on which staff group you are part of, your caring responsibilities and working patterns.

Access to training by different staff groups

There are differences in access to training and training resources between healthcare staff groups in trusts. Although the NMET levy in England is allowed to fund post-qualification education and training for many non-nursing groups, at the local level it has not always been used in this way. Local arrangements relating to historical funding patterns, contracts and the implementation of guidance means that funding for staff such as physiotherapists, speech and language therapists and others varies from consortium to consortium1.

1 In an NAO survey of consortia, non-nursing groups were often not covered by contracts for post-qualification courses. For example, physiotherapists and occupational therapists were covered in less than one-half of consortia responding, while one-quarter or less provided courses for staff such as speech and language therapists, clinical psychologists and bio-medical scientists.
70. If less levy funding is available for non-nursing groups then priority training and development must be funded from trust sources, by income generation or by staff themselves. In one English study site trust therapists received no NMET funding and described having to generate income through putting on courses to supplement the small trust training budget. In Wales, most continuing professional development is the responsibility of trusts rather than being funded through the levy. Therefore, the availability of these training resources for different staff groups will be influenced by the amount trusts invest and how they allocate that funding. Trusts need to determine whether funding arrangements are disadvantaging non-nursing groups locally; and then consortia/confederations in England and trusts in Wales should use this intelligence to review the allocation of their funds overall.

71. Education and training levies in England and Wales do not cover all healthcare staff.\(^{11}\) For example, the funding of training for staff such as nursing auxiliaries or healthcare assistants has tended to be the local responsibility of trusts. Staff surveys suggest that the development of this staff group is not generally taken as seriously as that of qualified healthcare professionals. Compared to registered nurses, nursing auxiliaries and assistants [EXHIBIT 15] are less likely to have:

- their training and development needs identified with their manager;
- their needs recorded on a training or PDP;
- undertaken more than two days training in the last 12 months; and
- their training and development needs met.

Nursing auxiliaries and assistants were also less likely to report having undertaken on-the-job training and more likely to report that their training needs had not been met due to a lack of mentors/assessors and a lack of on-the-job training. In order for these staff to play a full role in patient and client care in support of professional staff, trusts will need to review their approach to developing this section of the workforce.

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EXHIBIT 15

Differences in access to training between nursing auxiliaries and assistants and registered nurses

Nursing auxiliaries and assistants are less likely to have their training needs identified and met.

Note: Excludes staff in post for less than 12 months. All differences significant to at least 0.05 level.

Source: Audit Commission surveys of trust staff (1999/2000)

<table>
<thead>
<tr>
<th>Percentage of staff</th>
<th>Registered nurses</th>
<th>Nursing auxiliaries and assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training needs identified with manager in last 12 months</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Training needs recorded on PDP</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Undertaken more than 2 days of training in last 12 months</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Some or all of training needs met</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>
Access to training and caring responsibilities and working patterns

72. NHS staff have personal and professional development needs associated with their job and the changing requirements of the service, regardless of their caring responsibilities and working patterns. But certain groups of staff can experience poorer access to training and development opportunities. This may deplete the skills of staff such as those who work part-time, and, in the longer term, may undermine their ability to perform new extended roles and the retention benefits of flexible working. In order to target action, trusts need to use their staff surveys and other sources of information to assess whether their part-time staff, staff with caring responsibilities and differing working patterns experience poorer access to training opportunities.

73. The finding that part-time staff undertake fewer days of training than their full-time colleagues, despite similar skill requirements, is also supported by the evidence that trusts appear to invest less per person when they have a higher proportion of part-time staff. With national policy increasingly emphasising family-friendly, flexible working, trusts who plan to increase their number of part-time staff will also need to consider increasing their investment in training and development.

Access to training for staff from black and ethnic minority backgrounds

74. Once employed in the NHS, some black and ethnic minority staff have perceived discrimination in relation to training opportunities. The potential for discrimination exists when appraisal and the identification of individual training needs is patchy and unsystematic. Therefore, it is important that trusts monitor appraisal/PDP coverage, and application for and uptake of training opportunities in relation to ethnic origin. However, the lack of comprehensive electronic training records described in Chapter 2 often makes this problematic. Where information systems do not yet exist trusts need to make full use of their annual staff surveys in this respect.
Access to training and development opportunities: who misses out?

**Part-time staff** (one-third of staff):
- generally undertake fewer days of training than full-time staff, although they have similar skills requirements;\(^{12}\)
- are more likely to feel that they do not have the same access to training and development opportunities as their colleagues;
- are less likely to contribute towards the costs of their training and development, and are likely to have less money to do so;
- are more likely to cite inconvenient and inflexible training events as a barrier to meeting their training needs; and
- may have less opportunity to practise and develop skills necessary for promotion (Ref. 25).

**Staff with caring responsibilities** (one-half of staff):
- one-half feel that their caring responsibilities affect their ability to take up training and development opportunities;
- are less likely to report that their training needs were met;
- are more likely to highlight inconvenient/ inflexible training events as a barrier to meeting their training needs; and
- caring responsibilities appear to further limit part-time staff’s ability to be engaged in longer periods of study/training.

**Night staff and those who work shifts other than days:**
Staff who have work patterns other than ‘days only’ are more likely to feel that they:
- are unable to take time off for training;
- can only develop their skills if they are prepared to do it in their own time;
- are poorly informed about the training and development activities available through the trust; and
- undertake less training than staff who work days.\(^{13}\)

In addition, staff who work permanent night shifts are:
- less likely to have undertaken a higher number of training days (more than 10) in the last 12 months;
- more likely to feel that their manager does not discuss the skills they need with them;
- more likely to feel that they do not have the same access to opportunities as their colleagues; and
- less likely to have done any on-the-job training.

**Bank staff:**\(^{1}\)
- are less likely to have their training and development needs identified and recorded in a PDP;
- are more likely to undertake only one or two days training in the last year; and
- are more likely to feel that they are ill-informed about opportunities available, that they have to develop their skills in their own time, and that none of their needs have been met.

*Source: Audit Commission*
The next chapter examines further the barriers to meeting training needs and the actions trusts should take to reduce their effects. Recommendations on these areas are brought together at the end of Chapter 4.
Improving Access and Appropriateness

There is a range of measures which trusts can and should take to help ensure that staff are able to undertake priority training and development. Trusts should assess and address the barriers existing locally, including managing the finance better, easing the problems of staff release, working with education and training providers to increase the appropriateness and flexibility of provision, and managing the supply of mentors/assessors. Review and evaluation is needed to complete the cycle.
76. The NHS is the largest employer in the UK. For patients to benefit from the skills and potential of all the healthcare workforce, staff need to be able to access training and development that meets the identified needs of the service and the individuals. But financial, historical, cultural and organisational factors appear to influence access to training as much as training needs. This chapter examines some of the ways in which trusts can reduce their effects, illustrated by three types of training:

- Mandatory training – such as moving and handling and basic life support skills.
- National vocational qualifications (NVQs) – for staff such as nursing auxiliaries and assistants, therapy assistants or pharmacy technicians.
- Post-qualification training – for registered nursing and midwifery staff provided by or in partnership with higher education institutions.

77. Trusts need to review what is spent from their own sources and how this is allocated. They also need to consider whether they are making best use of the levy resources available. This chapter starts by looking at how both of these can be done. Staffing levels and the pressures of clinical workload can mean that staff are unable to be released to attend training. Trusts can use a variety of approaches to ease the problems of staff release, but they will not always be solvable. The need for qualified staff to act as mentors/assessors for learners is set to increase, creating a further pressure on existing staff. Flexible, appropriate training provision is required to meet service needs and enable staff to undertake it, and partnerships with education providers are key.

78. The final section of this chapter describes how individuals and managers have a role to play in getting value from training and learning. But just as a significant proportion of staff do not have their training needs identified, so a proportion do not discuss what they have got out of training afterwards. Trusts often want to carry out more and better evaluation of training programmes. However, evaluating the benefit to staff, services and ultimately patients of every single training activity is not possible. With limited resources a sensible approach is to focus on training programmes that support significant service changes.

79. Lack of funding has been part of the problem for staff in some trusts. In future, additional resources are being invested nationally in training and development; in England the NHS Plan announced an additional £140 million to fund CPD for professional staff and to invest in NVQs and ILAs for staff who do not have a professional qualification (Ref. 23). The DoH plans to move towards funding confederations for post-qualification training on the basis of a weighted formula. This may not take account of the amounts spent by trusts; trusts in consortia that are losers in this process may find that they need to spend more from local sources to maintain current levels of training activity.
80. Trusts need to review their overall spending on training and how it is allocated to budgetholders, in light of identified needs and priorities, and in comparison with similar trusts. This may suggest that total spending should be revised or that some areas of the trust should benefit more. For example, in developing its education and training strategy, one trust had reviewed all the sources of funding available against local priorities and decided more resources were required to provide sufficient mandatory training for all staff. This was included in the trust’s business planning for the following year.

81. Trusts need to examine how internal training budgets are allocated and, if necessary, move towards allocation on the basis of identified needs and priorities. For example, in one trust visited directorates make bids each year against a central training budget [CASE STUDY 14].

82. Trusts can also prioritise their own spending on staff who do not receive levy or other ring-fenced funding locally. They should ensure that training which could be funded through the national levy is not being funded by the trust.

83. Trusts need to ensure that they are making best use of levy and ring-fenced resources. An important element of this is the funding available for post-qualification training for nurses and midwives.

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**CASE STUDY 14**

**Conwy and Denbighshire NHS Trust**

The Trust has a central budget for training that is allocated to directorates through an annual bidding round. Directorates are asked to submit their costed training requirements linked to their local business plan and rank each with priority A, B or C. The Director of Human Resources and Training Manager then assess all the bids against the cash available. The highest priority requirements are fully funded by the central budget. Directorates may be part-funded for the lower priority training for which they have to find the remaining money in local budgets.
Post-qualification training provided by higher education institutions

84. Registered nurses and midwives in trusts access post-qualification courses and study days at local universities. The number of courses/days available vary widely between trusts (Chapter 3). And some trusts are not making full use of the available places. One in five of trusts used three-quarters or less of their allocation in 1999/2000 [EXHIBIT 16]. Over one-half of all HEI contracts were under utilised in the academic year 1999/2000. Although in some cases the HEI provided alternatives or carried forward credits, in 17 contracts no such arrangements were made. This means that some higher education providers have had spare capacity and the NHS is missing out on opportunities to meet further training needs.

85. Trusts with higher allocations tend to have lower take up. For example, trusts that receive lower monetary allocations report an average take up of 93 per cent compared with 82 per cent for those reporting higher allocations. Therefore some trusts appear to be allocated, or request, more than they can use. Nursing vacancy rates are likely to affect the ability of services to release staff to attend this training, but trusts with low take-up have a wide range of vacancy rates. Therefore, although pressures on the service do make releasing staff more difficult, this is not the only influence on take-up rates.

86. For these resources to be used effectively and efficiently, trusts need to ensure that:

- the allocation requested is based on identified education and training needs;

EXHIBIT 16
Take-up by trusts of post-qualification course allocations for nurses and midwives

One in five trusts used three-quarters or less of their allocation in 1999/2000.

Source: Audit Commission survey of directors of nursing (summer 2000)
they have systems in place for monitoring take-up and for re-allocating places that they cannot use (so that they can be used elsewhere in the trust or offered to other trusts); and

• they work with their education provider, either directly or via the consortium/confederation, to reduce the problems of staff release.

Some trusts and consortia have made significant improvements in their take up rates [CASE STUDY 15].

CASE STUDY 15

Improving take-up of post-qualification allocation – Cambridgeshire Education and Training Consortium

The consortium holds a block contract with the local higher education provider that includes £1.3 million for post-qualification nurse education and training.

In 1997, take-up was only 40 – 45 per cent. The remaining value was lost to the NHS – more than twice as many staff could have undertaken training. The education provider was also running courses inefficiently with only small numbers of participants.

Trusts in the consortium increased take up to 85 per cent in 1999 and this is expected to improve further to around 90 per cent in 2000. Factors that are considered to have helped make this change include:

• trusts making their initial demand more realistic by taking account of their ability to release staff;

• the involvement of the HEI in gathering the demand data from trusts;

• trusts responding to feedback from the HEI, via the consortium, on who actually attended;

• a consistent, single point of contact in the trust for the consortium and HEI on post-qualification course take-up, combined with interest and commitment from executive board members such as the director of nursing; and

• increased close working between trusts and the education provider to help plan courses at more appropriate times, for example, avoiding peak periods of winter pressures.

The next step in this improvement will come from linking trust demand to trust business plans and to their staff development plans.
Some trusts have reduced costs by providing training in different ways or in partnerships [CASE STUDY 16]. One trust described making a saving on the cost of providing first aid training for its staff by bringing it in-house. Provided that the training is of suitable quality, these types of changes can increase efficiency and release resources for other training priorities if required.

Staff’s own contributions supplement the amount invested by the NHS. In some study sites almost one in four healthcare staff had contributed to at least some of the costs of the training and development they had undertaken in the last year. While almost all trusts expect staff to contribute financially to training which is mainly for the individual’s benefit, trusts have differing approaches to other training. In an Audit Commission survey of trust human resources directors:

- 59 per cent indicated that staff would be expected to contribute to the costs of training which is non-essential and benefits both the trust and the individual; and
- perhaps worryingly, 7 per cent said staff would be expected to contribute even when the training is essential for the individual’s job and the service.

This means that, for example, a radiographer or bio-medical scientist working in one trust can be paying for part or all of the costs of training and development activities, which in a neighbouring trust would be fully funded. In addition, some staff are less able to pay some or all of the costs of training than others. For example, nursing auxiliaries and assistants are much less likely to have contributed financially than their registered nurse colleagues. This could cause friction and demotivation, especially as two-thirds of staff felt that it was not reasonable to expect them to contribute towards the cost of training and development for their job. Trusts need to have clear policies, consistently implemented, on self-funding external education, training and development.

CASE STUDY 16

Partnership with further education

Rochdale Healthcare NHS Trust, together with nine others in the north west, have a formal partnership with the Manchester College of Arts and Technology (MANCAT). Trainers employed by the college work in the Trust, training Trust staff, funded by Further Education Funding Council (FEFC) income. For example, the Trust’s Management Educator is employed by MANCAT and provides accredited supervisory, management and leadership programmes for clinical and non-clinical staff.
90. Shortage of funds is not the only barrier to meeting identified training needs. Access to training and development is also affected by whether:
• staff can be released for training;
• the training interventions available are appropriate, flexible and convenient; and
• mentors/assessors are available if required.

Releasing staff for training

91. Staff in the health service are under increasing pressure to care for more patients and clients, carry out more laboratory tests and so on. This pressure can be exacerbated by recruitment difficulties and staff vacancies. As a result, staff cannot always be released from their jobs to undertake training. In some trusts up to 22 per cent of staff gave inability to be released as a reason why some or all of their training needs had not been met in the last 12 months.

92. Approaches to lessening the problem can include:
• ensuring that establishments allow for study leave;
• improved planning of training and staff rostering;
• funding for replacing staff if they do need to be away on training and cover cannot be provided by colleagues; and
• redesigning training interventions so that they take staff away from the workplace for fewer days or at more convenient times for the service, or by making greater use of work-based or on-the-job learning.

93. Trusts’ staffing establishments allow for varying amounts of cover for study leave. For example, ward nursing establishments’ cover for annual leave, sickness absence and training range from 12 per cent to 26 per cent. Allowing minimum amounts for annual leave, average sickness absence and only two days out of the workplace for training per person per year, requires an allowance of 19 per cent. Nearly one-half of the trusts that gave a figure allowed less than this amount and making up the difference implies considerable cost implications. Even when trusts allow more, in practice, staff vacancies and increasing workloads may negate its effect.

94. Clinical managers can sometimes release staff more easily for training by better planning and rostering of study leave, provided that staffing or activity levels allow capacity to release staff. One theatre department visited reported that they were able to release staff to meet identified training needs by planning it into rosters well in advance, avoiding the need for agency cover at the last minute.

95. When staff do need to leave the workplace to undertake priority training, they may have to be replaced. Replacement cover funding is available for some staff groups for certain long training courses from the levies (for example, for nurses to gain a second registration). But for other training and for other staff groups, trusts rarely have budgets for the costs of replacing staff and this can put pressure on bank and agency spending. If regulations were changed to allow other replacement costs to be funded from the levies, the investment available for training further healthcare students would reduce. Consortia/confederations (and individual trusts in
Wales) may wish to consider creating a ring-fenced resource locally for this purpose. This could also involve trusts (and other NHS employers) contributing towards the costs of releasing their staff as an incentive to ensure that the training is relevant to service needs.

96. Trusts may be able to make more use of work-based or on-the-job learning for certain types of training and development. In some trusts three in ten staff reported undertaking on-the-job training activities such as coaching, mentoring, shadowing or secondments, in the last year, whereas in others the figure was nearer one-half. This can be more appropriate and some approaches also reduce the time staff need to be away from their clinical area [CASE STUDY 17]. Learning theory suggests that many people learn and retain more from doing and practising activities than from attending courses (Ref. 26). National policy intends that an increasingly large proportion of CPD is work-based (Ref. 20), and seeks to encourage more of this type of development. There is potential for the NHS to make greater use of information technology and web-based learning. The DoH and NAW could, in partnership with higher education, facilitate nationally available work-based learning packages that build on local initiatives and allow local tailoring, thus avoiding duplication of effort.

CASE STUDY 17

Carlisle Hospitals NHS Trust

The Trust uses laptop computers and CD ROM packages purchased with NMET funding to support learning opportunities for staff and to reduce the time needed away from wards and departments. In addition to supporting students on the Diploma in Cancer Care with up-to-date interactive learning materials, the resources were used to assist midwives in gaining underpinning knowledge of cannulation.

The maternity service needed more midwives to have skills in cannulation in order to reduce junior doctor call-outs, but there were problems releasing staff to attend training. The standard course the Trust had used was a half day at a local college which was run at a set time twice a year. This also involved travel time and costs and did not include opportunities to practise the skills in the workplace.

Maternity staff work rotating shifts and were able to use the CD ROM package while on night shift and work through sections during quieter periods on the ward. The midwives then completed a knowledge questionnaire, which they could use as evidence of their learning. The Trust’s resuscitation training officer reviewed the questionnaires and followed up the theory with a brief session to practise the skills in a safe environment. This system was felt to be novel, flexible, instantly accessible and fun to learn, and enabled more than 30 staff to be trained in cannulation in six weeks. The Trust’s training manager felt that the learning was also of a better quality than the traditional approach as individuals practised the skills and were assessed by an expert practitioner.
Mandatory training

97. Trusts need to ensure that the appropriate staff regularly update their skills in areas such as moving and handling, and basic life support [BOX E]. Trust managers describe difficulties releasing staff as one of the reasons why attendance at mandatory training such as moving and handling is poor.

98. None of the trusts visited by the Audit Commission were achieving the desired coverage of staff each year. Trusts sometimes prioritise nursing staff to receive this training, as they often have the most patient contact. But even for these staff, in the majority of trusts one-third or more had not received training to update their basic life support skills in the last 12 months. The picture was similar for training in moving and handling [EXHIBIT 17]. But some trusts have made changes to improve coverage [CASE STUDY 18, overleaf].

BOX E

The clinical negligence scheme for trusts (CNST) in England (Ref. 27) states that there is a public expectation that clinical staff should be competent to undertake basic life support. At the minimum level of accreditation trusts are required to have a policy in place making clear which staff are to be trained and to maintain records of individuals’ training and when updates are due. At the higher level of accreditation trusts are expected to ensure that 90 per cent of appropriate staff received training in the last 12 months. The Welsh risk management standards also emphasise that agreed levels of mandatory training should be received by appropriate staff (Ref. 28).

Source: Audit Commission

EXHIBIT 17

Coverage of basic life support and moving and handling training in seven trusts visited

In the majority of trusts, one-third or more of nursing staff had not received training to update their basic life support skills in the last 12 months.

Source: Audit Commission surveys of trust staff (1999/2000)
A lack of information can also contribute to poor coverage. In an Audit Commission survey one in six trusts did not know the numbers of nursing staff who had received resuscitation training in 1999/2000, and nearly one in three were only able to provide an estimate. With good central (and local) information trust boards and training managers would be better able to monitor who is receiving this type of training (see Box B, page 24).

Staff contributing their own time to training and development

Three in five staff reported that they had undertaken at least some training and development activities in their own time in the last 12 months. This may be because of an individual’s own motivation for personal and professional development. It is reasonable for individuals to give some of their own time to training which benefits their careers as well as the organisation. Most trusts expect this and other sectors such as social care are formalising this requirement (Ref. 29). However, difficulties releasing staff or providing cover may also cause individuals to undertake training in their own time. In some trusts nearly one-third of staff felt that they could only develop their skills if they were prepared to do it in their own time. One in six even reported that they undertook mandatory training either wholly or partly in their own time. Here, as for staff contributing to the costs of their training, trusts need clear policies that are consistently implemented.

Although there are actions trusts can take to make training and learning activities easier to engage in, the difficulties of releasing staff are likely to get worse before they improve. Increasing expectations in national policy about the training that health professionals should

CASE STUDY 18

Mandatory training – St Mary’s NHS Trust

The Trust had provided mandatory training through a number of separate sessions which staff would be expected to attend each year. However, it was felt that it was easier for staff to be released for a whole day which could be planned for rather than several shorter sessions at different times. The Trust therefore designed a single day to cover their mandatory requirements including moving and handling, and resuscitation training. This is tailored for different staff groups’ needs such as staff working in adult wards or paediatric services. The sessions are planned so that there are enough places for each group each year. The invitation and recall system is administered using a specially designed database. This also enables the take up of the training to be monitored and followed up through the Trust’s risk management department.
undertake (for example, nurse prescribing and therapist consultants) will exacerbate the problem until the effect of the increased number of students qualifying and other recruitment strategies is felt.

102. A lack of appropriate courses was the most common perceived barrier to meeting training needs – highlighted by one in four staff. This suggests that some staff still see going on a course as the main way to meet development needs and may reflect some of the poorly identified and specified needs described in Chapter 2.

103. It may also be the case that courses available do not meet service or staff needs. One-third of managers surveyed by the Audit Commission felt that the range of courses currently available at the main higher education provider was not appropriate to the needs of the client groups or staff. But it is up to trusts to work in partnership with education providers (either directly or through the consortium/confederation), to improve the match with service needs.

104. Despite the fact that many trusts are working with their local HEI on course development, 18 out of 33 HEIs providing nursing and midwifery post-qualification education do not believe that trusts (or consortia) are effective commissioners. Comments made by some of these HEIs show that they perceive there to be poor identification and planning of individual and organisational training needs in trusts (as already described in Chapter 2):

‘training needs analysis not yet sophisticated, still very much a ‘tick list’ approach, rather than looking at organisational and individual needs’

‘there is not strategic planning of trust needs. The Trusts allow staff to use prospectus as a shopping list/personal wants’

‘there remains a historical approach. Does not appear to be linked effectively to national/regional priorities and HImPs’

‘no clear steer which signals areas of demand so the contract remains supply driven’

105. At the same time some trusts express concern over HEIs’ ability to respond quickly or flexibly enough to their requests. While this may be true in some cases, both parties need to appreciate each other’s service and operational pressures. Clearly there is scope for some trusts (and consortia/confederations in England) to work more closely with their higher education providers to improve both relationships and the commissioning of post-qualification training. Some trusts are working with local HEIs to improve the match between the training available and service requirements [CASE STUDY 19, overleaf]. Proactive joint planning is key to this process. For example, HEI staff may be able to work with trust managers to support the process of assessing training needs.

Ensuring that training interventions are appropriate

I Results from NAO survey of HEIs (summer 2000). The figure was four out of five for institutions providing courses for allied health professions.
106. Individuals in joint posts between trusts and HEIs, such as lecturer-practitioners, can be involved in designing more responsive post-qualification provision. The UKCC has recommended an increase in joint posts to strengthen the link between theory and practice (Ref. 30). Three out of four directors of nursing report that their trust has at least one joint healthcare post with their local university. In partnership with their HEI, other trusts should consider whether these types of posts would bring benefits.

107. Both in-house and external training can be difficult for staff to access due to its timing, location and other aspects. HEIs are generally responsive to requests for new or innovative models of delivering training. Trusts need to consider the nature and extent of these issues locally in order to develop approaches to the problems with their education provider [CASE STUDY 20] or in-house [CASE STUDY 21].

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**CASE STUDY 19**

Support for Learning in the Clinical Environment (‘SLICE’), St Mary’s NHS Trust

St Mary’s NHS Trust has worked with Wolfson Institute of Health Sciences at Thames Valley University (TVU) and the London West Sector Consortium to develop an alternative to the nursing course ENB 998 (Teaching and Assessing in Clinical Practice). The Trust was concerned about the appropriateness of ENB 998 to the current needs of the service in terms of its content, the number of days (15) it took nurses away from patient care and its unidisciplinary nature. ‘SLICE’ is a modular programme with two modules each of three days. Module 1 is about evaluating the individual’s own practice and facilitating training and development in the workplace (the focus is on reflection on an individual’s own performance and identifying their own development needs if they are to act as coach and facilitator).

Module 2 is about developing others in their workplace (the focus is primarily on assessing others and giving feedback). Module 3 is being developed and will focus on the role of co-ordinating and supporting all learning activity in a clinical area. The first two modules have been evaluated by TVU and other trusts are now beginning to purchase them via their consortium. The ENB has now endorsed this programme as equivalent to the ENB 998. The modular programme is designed to be multidisciplinary although to date only nurses have been recruited. The programme meets the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) standards on mentorship and preceptorship, which take effect from September 2001.

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Ensuring that training events are convenient for staff

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1 In an NAO survey, more than two-thirds of consortia had requested new models of delivery such as distance learning, open learning and web-based learning, and all except one had had their requests completely or partially satisfied by their provider. More generally one in five viewed their providers as not very responsive, the main problem being that providers were unable to respond within the preferred timescale.
CASE STUDY 20

Kettering Hospitals NHS Trust

The Trust’s Education Council carried out a training needs analysis, looking at the implications of service developments and national policies. One of the issues highlighted was the expanding role of nurses in outpatients, requiring them to develop new skills. However, these staff were unable to be released from clinical practice during the week to attend training, and the family responsibilities of part-time staff meant they were unable to attend courses on their days off. Therefore, since 1998 the Trust, through the contract for post-registration nurse education with the University of Luton, have negotiated a range of courses as evening classes. These have been timed to fit in with staff’s home commitments and are supported by the use of distance learning material, and tutorials. Nurses who work night shifts and those working on the Trust’s nurse bank have also been able to access the courses.

CASE STUDY 21

Camden and Islington Community Healthcare NHS Trust

In line with their Lifelong Learning Strategy the Trust uses a wide range of approaches to try to ensure that all staff are able to engage in the training and development that they need. Examples include:

• a night-staff learning programme where staff who act as Lifelong Learning Leaders provide work-based supervision and support to reinforce special training programmes designed specifically for the needs of night staff. Subjects that have been covered include infection control; tissue viability; record keeping and care planning; managing continence; and managing challenging behaviour; and

• cascades of training that use videos so staff can undertake the learning activity at a time and place that is convenient for them. Examples of where this approach is being used include health and safety, and adult protection training.
Providing sufficient numbers of mentors/assessors

108. The demand for learners to be mentored or assessed [BOX F] is set to increase. The NHS Plan has made a guarantee of training to NVQ level two and three (or an individual learning account) over the next three years for staff without a professional qualification. At the same time there is a commitment to increase the numbers of students being trained – by 2004 there are to be 5500 more nurses, midwives and health visitors and 4450 therapists and other key health professionals entering training each year.

109. This issue needs to be actively managed in order to ensure sufficient mentors/assessors are available for all types of learners. But over 40 per cent of human resources directors either did not know how many staff were qualified as assessors for care NVQs or could only provide an estimate. In those trusts where the figure was known the number of assessors varies widely compared with potential candidates [EXHIBIT 18]. Staff with full clinical workloads are only able to act as assessors for one or two individuals at a time, but over 40 per cent of trusts potentially had 20 or more staff per assessor.

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**BOX F**

**The need for mentors/assessors**

Some types of course require staff to be mentored or assessed – for example, a registered adult nurse undertaking training to gain a second registration in order to become a children’s nurse, or an occupational therapy assistant undertaking an NVQ. Appropriately qualified staff in the individual’s department or another part of the trust usually perform the role of mentor/assessor.

In study sites up to one in eight staff gave lack of mentors/assessors as a reason why their training and development needs had not been met. Nursing auxiliaries and healthcare assistants were more likely to cite this as a problem than registered nurses. (In England, consortia also cite the lack of suitably qualified assessors as one of the main reasons for a shortage of clinical placements for pre-qualification students[3]). Staff may lack the time to act as assessors for NVQ candidates because of clinical workload or the competing demands for mentoring and assessment time for other learners in the workplace. Students on clinical placements, staff who undertake a pre-registration period such as pharmacists, second level or ‘enrolled’ nurses converting to first level registration and those people returning to practice after long periods all require mentoring/assessment. Currently, staff are often required to undertake separate training in order to act as mentors/assessors for students, professional staff or NVQ candidates. There could be significant benefit from developing a common preparation for staff to act as assessors/mentors for all types of learners.

*Source: Audit Commission*

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Some of the trusts visited had built up considerable knowledge and experience in setting up and running NVQ programmes in general and in making assessing simpler and quicker. For example, one trust was introducing matrix assessment where experienced staff assess an individual’s competence across a number of units at one time rather than unit by unit. Trusts ought to share their expertise about NVQ training; and consortia/confederations, the DoH and NAW need to facilitate this.

Individuals and their line managers have important roles to play in the review and evaluation of training and learning. IpR recommends that staff have pre- and post-training discussions with their manager as part of the overall process of getting best value out of investment in training and development. But for significant numbers of trust staff this does not happen. While most staff were clear why they had undertaken recent training and development activities and usually used and shared what they had learnt with colleagues, one-third of staff had not discussed with their manager why the training was necessary and what they had got out of it. This raises questions about how well some training and development is linked in to service and organisational objectives, particularly for those individuals who do not have their training needs identified with their manager or for whom the process is poor.

Evaluation of training programmes

The impact of education and training programmes can be assessed at various levels:

- Did the participants feel satisfied with the event?
- Have their skills and knowledge increased?
- Has their clinical practice been changed for the better?
- Have the quality and outcomes of patient and client care improved?
Ideally education and training should be judged by its effects on the overall standard or outcome of care. But demonstrating this is much more complex and time-consuming than evaluating at a more basic level [EXHIBIT 19]. Effective evaluation cannot be done as an afterthought; the approach needs to be designed at the outset and the experiences of those affected followed up.

Evaluation of training programmes in study sites was generally limited to post-course questionnaires. These methods are not without value, for example, regular review by a trust of their induction training helped keep it up to date and relevant to the needs of new joiners. Satisfaction questionnaires or ‘happy sheets’ can elicit useful feedback for adjusting the content or delivery of a training programme. However, these do not show what happens in the workplace as a result of the training.

Trust training and development specialists, with managers, should aim to evaluate some education and training programmes in terms of their effect on staff’s skills or patient care. Because this is complex and time consuming it is sensible to focus on training that is high cost, frequent or of particular importance to service delivery. Trusts should particularly focus their efforts, in partnership with education providers in the case of external provision, on those programmes that are designed to support significant service changes. There are experiences in practice that others can learn from [CASE STUDY 22].

**EXHIBIT 19**

**Levels of evaluation**

Demonstrating the effect on the overall standard or outcome of care is much more complex and time-consuming than evaluating at a more basic level.

<table>
<thead>
<tr>
<th>Evaluation of reaction</th>
<th>Increasing complexity and time needed to assess effects of training and development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of learning</td>
<td></td>
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<tr>
<td>Evaluation of behaviour</td>
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<tr>
<td>Evaluation of results</td>
<td></td>
</tr>
<tr>
<td>Assessing staff satisfaction with the format or content of a training session</td>
<td></td>
</tr>
<tr>
<td>Testing staff's skills or knowledge on a topic before and after training</td>
<td></td>
</tr>
<tr>
<td>Following up to determine whether staff change their clinical practice after training</td>
<td></td>
</tr>
<tr>
<td>Assessing whether training had led or contributed to improved outcomes for patients</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Adapted from Kirkpatrick in Hutchinson, 1999 [Ref. 31]*
Getting the best value from investment in training and development requires the involvement of trusts’ staff, line managers and the board. The right culture and a commitment at all levels are needed. This is the first topic addressed in the final chapter.

CASE STUDY 22

Lifespan Healthcare NHS Trust children’s services changes (see also Case Study 2, page 20)

In September 1997 Lifespan Healthcare was required to disinvest in children’s services. The Trust decided that they wanted to move towards an integrated service model provided by children and family nurses rather than separate school nurses and health visitors. Training was devised to be supported by supervised practice, reflection with an expert practitioner and opportunities to build confidence. The training was delivered jointly with Homerton College, Cambridge: School of Health Studies.

The training events were evaluated. The children’s services staff completed anonymous questionnaires after the changes and the training had been implemented. These asked each individual whether they felt their practice was ‘novice’, ‘safe’ or ‘expert’ for each of the areas of practice covered by the training. Six months later the same staff were surveyed again so that changes could be seen as staff gained in confidence. The evaluation also identified factors that were preventing staff from learning the new skills, for example, culture and resistance, some lack of opportunities for supervised practice or for staff to reflect on their practice; enabling these to be addressed.

The Trust’s Public Health Consultant also carried out an evaluation of the model of service itself. This suggested that clinical staff need training in how to function in multiprofessional primary care teams as much as in extending their clinical roles.
In order to monitor access to training and development activities trust-wide:

1 Human resources directors should use their staff surveys and information systems on finance and study leave, to assess whether any professions/groups of staff experience poorer access to training opportunities, and why. These should include:
   • different professions/staff groups;
   • staff with differing working patterns and caring responsibilities; and
   • staff from different ethnic backgrounds.

2 Directors of nursing should work with human resources departments to review local approaches to developing nursing auxiliaries and assistants; so should other professional heads who are responsible for staff without a professional qualification.

3 Human resources directors and directors of nursing, with management accounts staff, should review:
   • the total amount being spent in the trust;
   • how this is distributed across directorates; and
   • how it compares with similar trusts;

in the light of identified training and development priorities.

In order to reduce the barriers to staff undertaking appropriate training and development:

4 Trust training functions and line managers should make sure that information is available to all staff on the training and development opportunities open to them and how they can be accessed.

5 Trusts need to determine whether funding arrangements are disadvantaging non-nursing groups locally; and then consortia/confederations in England and trusts in Wales should use this intelligence to review the allocation of their funds overall.

6 Directors of nursing need to make best use of the available post-qualification nursing and midwifery education and training resources by ensuring that:
   • the allocation requested is based on identified education and training needs;
   • they have systems in place for monitoring take up and for re-allocating places that they cannot use (so that they can be used elsewhere in the trust or offered to other trusts); and
   • they work with their education provider, either directly or via the consortium/confederation, to reduce the problems of staff release.
Improving Access and Appropriateness

7 Training managers and those managers responsible for liaising with HEIs on post-qualification training should ensure that in-house and external training interventions take staff away from the workplace as little as is consistent with quality of learning.

8 Human resources directors and professional heads should develop more flexible training opportunities (with HEIs where appropriate) to improve access for part-time staff, night staff, staff with caring responsibilities and others for whom release from clinical activities is often a barrier to meeting their training and development needs. These opportunities should make full use of the potential of IT and web-based solutions.

9 Human resources directors, directors of nursing, professional heads and service managers should review their current and likely future need for numbers of appropriately trained mentors/assessors to ensure that they have sufficient for staff undertaking NVQs as well as professional training.

\textit{In order to reduce any perceptions of inequity, which could adversely affect staff morale, human resources directors should ensure that:}

10 The trust has clear, consistently implemented policies on self-funding and the use of staff's own time for education, training and development; and

11 Staff do not normally have to contribute towards specific training that is essential to patient and client care, and safety.

\textit{In order to ensure that training activities are as effective as possible:}

12 Service and clinical managers with HEIs should seek further opportunities to review the content of available education and training and how well it matches service requirements. Trust managers should take the lead, working closely with HEIs, in ensuring that the post-qualification training commissioned relates to identified service needs.

13 Board directors should promote and support evaluation of the impact of training through focusing efforts in terms of assessing the effect on staff's skills, practice and patient/client care on those programmes that are designed to support significant service changes.

14 Individuals and line managers should discuss the planned and actual benefits of training before and after training takes place.
The Way Forward

Staff development, in principle, is everyone’s business. In practice, however, attitudes vary from trust to trust, and both within and between directorates. The right culture is one in which everyone’s behaviour – individuals’, managers’ and the board’s – plays a part in getting the best from training and development. The board needs to provide a lead both within the organisation and in the development of the workforce in the wider health economy. New organisations and ways of working in the NHS also have implications for education, training and development.
117. Staff’s training and development is vital to achieving the Government’s aims for modernising the NHS. To implement these changes all staff need to develop their skills and abilities to meet the needs of patients, clients and the service. But evidence in this report shows that, although there are specific examples of good and developing practice, many trusts need to make improvements in:

- reviewing and managing education and training resources;
- identifying training needs and priorities at both the individual and the wider service levels; and
- ensuring that all staff can access appropriate opportunities for training, development and learning according to identified needs rather than where they work and what they do.

118. This final chapter sets out to:

- draw together the report’s theme: that getting the best from education, training and development is in part a cultural issue involving staff at all levels, as well as requiring effective systems for planning and management;
- provide some examples of what this might mean in practice for trust boards and senior managers; and
- highlight some of the implications for staff development of the new organisations and ways of working developing in the NHS.

119. Staff development in principle is everyone’s business. In practice, however, attitudes vary from trust to trust, within and between directorates. As this report has shown, trusts often have scope to improve their systems for planning and managing training and development. But effective systems on their own are not enough (see Exhibit 4, page 9). Getting the best for patients, staff and the service requires an organisation-wide culture that values and expects training and learning by all staff. This can be demonstrated through many aspects of organisational life, for example:

- the routines and rituals of how people behave to one another, both internally and with external stakeholders; and
- what the trust measures, monitors and rewards.

120. The right culture is one in which everyone’s behaviour – individuals’, managers’ and the board’s – plays a part in getting the best from training and development [EXHIBIT 20, overleaf]. Progress takes time and senior management commitment. A good place for trusts to start is by making everyone’s responsibilities explicit [CASE STUDY 23, overleaf]. (Making such changes is likely to have benefits trust-wide. When clarifying responsibilities, improving systems for identifying needs and ensuring access to priority training, trusts are likely to want to look across all staff groups, including medical and non-clinical staff.)
**Examples of responsibilities and actions to get the best from training and development**

Individuals, managers and the board need to play their part in getting the best from training and development.

<table>
<thead>
<tr>
<th>Examples of responsibilities and actions</th>
<th>Every member of staff, eg:</th>
<th>Dept/line managers, eg:</th>
<th>E/T/D specialists, eg:</th>
<th>Board/senior management, eg:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify and prioritise training and development needs</strong></td>
<td>Identify own needs and engage in jointly agreed PDP</td>
<td>Agree PDPs with all staff</td>
<td>Support managers in identifying needs and the planning process</td>
<td>Set T&amp;D priorities in line with HmP/HiP and service plans</td>
</tr>
<tr>
<td><strong>Ensure enabling factors, such as resources and release time, are in place</strong></td>
<td>Act as mentor/assessor for other learners based on appropriate experience</td>
<td>Plan staff release effectively</td>
<td>Support development of flexible and work-based training and learning to meet identified needs</td>
<td>Ensure request for post-registration training is realistic/in line with needs</td>
</tr>
<tr>
<td><strong>Undertake training and development activities and put learning into practice</strong></td>
<td>Engage in learning and put into practice (professional staff have a responsibility to maintain their competence)</td>
<td>Support individuals and teams in putting learning into practice</td>
<td>Deliver/facilitate training and development activities as appropriate</td>
<td>Engage in joint working with HEI (direct/via confederation) to help provision match needs</td>
</tr>
<tr>
<td><strong>Monitor, review and evaluate the learning and the training programmes</strong></td>
<td>Reflect on learning and effect on practice and share with others</td>
<td>Engage with staff re: effect on practice</td>
<td>Specialist support to evaluate effect of major training programmes on practice</td>
<td>Regular monitoring and periodic review of T&amp;D programme and systems</td>
</tr>
</tbody>
</table>

Source: Audit Commission
NHS trust boards should be keeping training and development under review. Doing so signals that it is to be taken seriously within the organisation’s culture. This should ensure that links are being made between high-level strategic initiatives and the training and development programme. Trust boards should undertake periodic reviews of the overall strategy and processes, supplemented with regular updates on progress, activity and performance. Although most trusts visited had some form of overall strategic documentation on training and development, few of their boards received regular reports on training and development. Such reports can usefully cover a review of progress as well as quantitative data [CASE STUDY 24, overleaf]. When fully implemented, the new national human resources and payroll system at a local level will have the potential to provide trust boards with valuable information for planning, monitoring and reviewing training and development.

A lead from the top

Camden and Islington Community Health Services NHS Trust

The Trust’s education, training and development strategy focuses on lifelong learning (LLL) and CPD and forms a core part of the local approach to clinical governance. The strategy resulted from extensive review and consultation about the existing education and training activity in the Trust. The Trust recognises that the challenge is ‘to create an organisation in which every member of staff and every team considers lifelong or continuous learning to be central to the delivery of care’. In order to achieve this the Trust has set out the expected roles and detailed responsibilities at each of the following levels.

<table>
<thead>
<tr>
<th>Accountable for</th>
<th>Role is to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief executive</td>
<td>LLL systems and procedures</td>
</tr>
<tr>
<td>Director/professional head of service</td>
<td>LLL performance</td>
</tr>
<tr>
<td>Service manager</td>
<td>LLL management</td>
</tr>
<tr>
<td>Team leader</td>
<td>LLL team leadership</td>
</tr>
<tr>
<td>Each member of staff</td>
<td>Maintain a LLL portfolio</td>
</tr>
</tbody>
</table>

The Trust is now putting further systems and mechanisms in place – in line with the strategy – to encourage and enable all staff to take responsibility for their learning, for example, a key standard framework for individual development portfolios and a lifelong learning guide which brings together for the first time information from all services on the opportunities for education, training and development.
Organisations measure, monitor and reward the issues they consider most important. For the first time NHS employers in England are to be formally performance managed on a range of people management issues through the Human Resources Performance Framework (Ref. 4). By April 2003, trusts are to be accredited against the Improving Working Lives Standard (Ref. 6) by regional offices of the DoH. Regional offices will also need to provide encouragement and help to share good practice. Trust boards should signal that they take training and development seriously by ensuring that it is built into the trust’s own performance management systems. This is particularly important given the increasing size and devolved management of many NHS trusts. Directorates have considerable freedom over detailed spending decisions and service objectives and should be accountable for adhering to the organisation’s policies and targets for training and development [CASE STUDY 25].

As major healthcare employers, trust boards and senior managers should be helping to lead the strategic development of the workforce across the local health economy. This includes:

- their input into identifying and acting on the workforce implications of health-authority wide health improvement programmes (HImPs/HIPs); and
- membership of education consortia in England – soon to be replaced by a smaller number of larger workforce development confederations. In Wales, trust members sit on the Education and Training Group.  

Health improvement programmes are expected to set out the implications for human resources and organisational development in the health economy. A Health Service of All the Talents (Ref. 3) envisages trust chief executives being responsible for producing and delivering their...
organisation’s workforce plan. In addition, health authority chief executives will be held accountable for integrated workforce plans that match service plans and resource availability, and for providing clear leadership in this area, for example, through their strategic roles in service quality and performance.

125. Progress in this area is relatively slow; one in three consortia state that local HImPs did not address workforce and training issues. The coverage of human resources issues by HIPs in Wales is also reported to have been poor. One reason is that human resources issues have, in the past, been seen as matters for employers – health authorities have previously had few responsibilities in relation to education, training and development for the local workforce. These were:

- paying claims for training costs from practices under general medical services terms and conditions; and
- being members of education consortia in England, where their contribution has varied and has sometimes been limited to providing data on practice staff numbers for workforce planning.

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CASE STUDY 25

Human resources directorate review – Conwy and Denbighshire NHS Trust

The Trust’s human resources department conducts an annual review with each clinical and support directorate. This system has been in place for four years. It is a two-way process, reviewing the support that human resources (including the training and development function) provides to the directorate as well as the directorate’s performance.

Prior to the review meeting, each directorate completes a proforma covering their performance and current status/issues across a range of human resources topics from absence management to equal opportunities. This includes a number of training and development issues: local induction, the staff development review (appraisal system), training and development plans and priorities, NVQs, and health and safety-related training. The human resources director and team meets with clinical directors, nurse and business managers of each directorate, using the proforma as an agenda to discuss the directorate’s progress, local problems or issues requiring action and the support received from human resources colleagues. The main issues and action points are recorded in a memo from the director to the directorate team.

This system provides a method of local audit for the Trust and improvements have been seen over time, for example, in increases in the coverage of appraisal. It allows local good practice in directorates to be identified and encouraged in other areas. The results of the reviews also feed into the board’s overall annual review of each directorate’s performance.

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1 Results from NAO survey of education consortia.
As a result, most health authorities have neither the staff with experience of leading change in the development of the workforce, nor the information bases to facilitate it. Nevertheless, some health economies are formalising ways of working together to co-ordinate human resources and workforce development issues and action [CASE STUDY 26].

**CASE STUDY 26**

Examples of health economies working together to co-ordinate human resources issues

In North Essex, NHS and social services human resource leads meet monthly to co-ordinate the response to national and regional strategy goals, and a more broadly based forum aims to ensure that there is human resource support for the strategic changes associated with primary care groups and primary care trusts (PCGs/PCTs). The North Essex Consortium is funding team development within PCGs, and facilitating collaboration between PCTs and community trusts.

Cambridgeshire Health Authority is using training to help bring about the change management needed in HImP areas covering specific services such as mental health. For example, the local mental health HImP group has recently received £100,000 from the consortium to use directly on commissioning training and development initiatives to support implementation of the National Service Framework (NSF). The concept is to devolve a budget to each HImP group. The group will take responsibility for multi-agency training and develop an inter-agency training plan, which complements the separate streams of funding from each agency. The HImP group is held accountable to the consortium via the agreed joint training plan and monitored on its implementation. The group has prioritised training and development in a number of areas including:

- the Care Programme Approach and risk assessment;
- assertive outreach;
- mental health and primary care;
- user involvement; and
- NVQ developments in mental health.

The devolved budget has facilitated the development of joint training and the sharing of skills and resources across the county.
126. When education consortia are replaced by confederations the levies for medical and non-medical education and training will be merged. This will provide further opportunities to co-ordinate training and development across the professions. All local NHS employers will need to identify key staff groups and types of skill for which they are unable to arrange sufficient training and development opportunities. Confederations will need sufficient discretion to direct some levy funding creatively, for example, to multidisciplinary or cross-agency training.

127. One risk arises from the proposed large size of the workforce development confederations. Even at present, communication between consortium officers and representatives, and managers in NHS trusts can sometimes be seen as a problem. And managers’ understanding about their consortium and its role can be poor. Establishing effective communication about their purpose and function will have to be a high priority for confederations and member trusts.

New organisations and ways of working

128. It is not just hospital and community trusts that need a culture that values and supports training, development and learning. Over the next three years large numbers of staff from community and combined trusts in England will transfer to the employment of PCTs. More and more staff will also work in services provided through inter-agency partnerships in arrangements enabled by the 1999 Health Act. Primary Care Trusts will need to develop their human resource management capacity, including education and training expertise. When setting up these new service providers those involved need to ensure that experience and good practice is not fragmented and dissipated. They need to build on the strengths in training and development from all parties, whether coming from primary, secondary or social care. For example, ahead of becoming a PCT, one trust training lead began working with their primary care colleagues to develop a single personal development planning process and to review the accessibility of training opportunities for community and primary care staff.

129. These new organisations will increasingly deliver services through integrated teams whose members have a range of professional backgrounds. Historically, training has often been designed (and funded) for specific professions. Primary Care Trusts are starting to assess training needs and explore new ways of meeting them [CASE STUDY 27, overleaf], as are Health Act partnerships [CASE STUDY 28, overleaf]. In these organisations, clinical teams will work together across professions, and expect to train together and to draw on resources from each other.
CASE STUDY 27

In September 2000, Hillingdon Primary Care Trust appointed a joint education lead (jointly with North Thames Deanery) for GPs and for other healthcare staff. The postholder has responsibilities for education and training and also for workforce planning, reflecting the proposed arrangements in *A Health Service of all the Talents* (Ref. 3).

Early priorities include improving the coverage of mandatory training among primary care staff, and developing a multidisciplinary diabetes service. The diabetes training has to mirror the PCT’s commitment to integrated care pathways. Existing courses were of limited relevance to more experienced staff and did not relate to a primary-care delivered service. The PCT has commissioned a new course to meet these needs in collaboration with neighbouring health authorities.

CASE STUDY 28

**Manchester Mental Health Partnership**

Manchester Mental Health Partnership is an innovative joint venture by Manchester Health Authority and Manchester City Council, providing integrated adult mental health services from October 2000. The development of the partnership is seen as a way of challenging traditional barriers to good quality care by bringing local mental health agencies and organisations together. In the past education and training in Manchester has tended to be planned and delivered within individual agencies and organisations. Although there have been examples of agencies coming together for training, these have tended to be for one-off events and not linked to longer term strategies, shared goals or common ownership.

It is the partnership’s view that an integrated approach to education and training has much to offer, and learning together is seen as a good way of building bridges across different organisations and agencies. The partnership is currently trying to identify and analyse the differing learning needs of key staff and stakeholders involved in delivering and supporting mental healthcare. This includes not only statutory health and social care staff – but also staff from voluntary organisations and key stakeholders, notably users and carers. The process also includes other organisations as appropriate such as police, probation, education, housing and primary care staff. The partnership hopes that the results will offer useful insights into how to plan education and training to help staff meet the standards of the National Service Framework (NSF) for mental health.
130. In the past, education, training and development has largely been organised along professional lines. Higher education courses have led to qualification as, for example, a nurse or an occupational therapist. Further training, including continuing professional development, has also been primarily uniprofessional.

131. This profession-based model does not sit easily with current health policy which (rightly) starts with the experience of the patient or client seeking help, often from primary care. High-quality, community-based services require the various professionals caring for a patient to liaise better. If a patient needs hospital treatment, that too needs to be co-ordinated through pathways of care. New arrangements, such as PCGs and PCTs, are designed to make this a reality for all patients regardless of where they live. But staff who work in multi-professional teams will need co-ordinated training and development too. Staff at all levels have an important part to play in this, helping to reappraise development needs and to deal with the obstacles to meeting them. Such well managed training and development will be vital to the success of the new NHS.
In order to support the development of an organisation-wide culture that values training and learning:

1. Trust boards and senior management should make explicit the roles and responsibilities of individuals, managers and the board in getting the best from training and development.

2. Trust boards should periodically review the overall training and development strategy, policies and processes.

3. Trust boards should receive regular update reports on progress, activity and performance.

4. Trust boards should ensure that directorates’ adherence to training and development policies and their use of funds is reviewed within the trust’s formal performance management processes.

In order to ensure that staff and managers understand, and are able to benefit from, the changes involved in the formation of workforce development confederations (WDCs) and the merger of the levies:

5. WDCs and their members in England should ensure that effective communications about the new arrangements are in place.
### Recommendation

**In order to identify training needs (which should lead to training activity being more effectively targeted):**

1. Regularly identify the implications for staff training and development of business plans, service developments, HlmPs/HIPs and clinical governance processes.

2. Ensure that the coverage of PDPs is monitored, and that samples of them are audited to identify the most serious weaknesses.

3. Provide sufficient training so that all line managers are competent in conducting appraisals and personal development planning, (particularly when new systems are launched).

4. Review training and development needs at least once a year, and agree and document what action each will take.

5. Combine information from ‘bottom-up’ processes such as PDPs with the corporate needs identified in the first recommendation above, and use the results, in discussion with service managers and professional heads, to plan future training. The plan should cover in-house training and external provision, including post-qualification training at HEIs.

**In order to improve the identification of training needs and the management of training and development generally:**

6. Make best use of any existing information systems for training and development and seek to implement fully the new human resources/payroll system when it is rolled out nationally.

**In order to monitor access to training and development activities trust-wide:**

7. Review in the light of identified training and development priorities:
   - the total amount being spent in the trust;
   - how this is distributed across directorates; and
   - how it compares with similar trusts.

8. Use staff surveys and information systems on finance and study leave, to assess whether any professions/groups of staff experience poorer access to training opportunities, and why. These should include:
   - different professions/staff groups;
   - staff with differing working patterns and caring responsibilities; and
   - staff from different ethnic backgrounds.

### For action by

- **Recommendation 1:** Trust senior managers involved in these activities
- **Recommendation 2:** Human resources departments
- **Recommendation 3:** Human resources departments
- **Recommendation 4:** Individuals, with their line managers
- **Recommendation 5:** Trust senior managers and training specialists
- **Recommendation 6:** Trust senior managers and training specialists
- **Recommendation 7:** Human resources directors and directors of nursing, with management accounts staff
- **Recommendation 8:** Human resources directors
### Recommendations

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<tr>
<th>Recommendation</th>
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<tr>
<td>9. <strong>Review local approaches to developing nursing auxiliaries and assistants and other staff without a professional qualification.</strong></td>
<td>Directors of nursing and other professional heads, with human resources departments</td>
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<td><strong>In order to reduce the barriers to staff undertaking appropriate training and development:</strong></td>
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<td>10. <strong>Make sure that information is available to all staff on the training and development opportunities open to them and how they can be accessed.</strong></td>
<td>Trust training functions and line managers</td>
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<tr>
<td>11. <strong>Determine whether funding arrangements are disadvantaging non-nursing groups locally. Consortia/confederations in England and trusts in Wales should then use this intelligence to review the allocation of their funds overall.</strong></td>
<td>Trusts senior managers and training specialists</td>
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<tr>
<td>12. <strong>Make best use of the available post-qualification nursing and midwifery education and training resources by ensuring that:</strong></td>
<td>Directors of nursing</td>
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<td>• the allocation requested is based on identified education and training needs;</td>
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<td>• they have systems in place for monitoring take up and for re-allocating places that they cannot use (so that they can be used elsewhere in the trust or offered to other trusts); and</td>
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<td>• they work with their education provider, either directly or via the consortium/confederation, to reduce the problems of staff release.</td>
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<td>13. <strong>Ensure that in-house and external training interventions take staff away from the workplace as little as is consistent with quality of learning.</strong></td>
<td>Training managers and those managers responsible for liaising with HEIs on post-qualification training</td>
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<tr>
<td>14. <strong>Develop more flexible training opportunities (with HEIs where appropriate) to improve access for part-time staff, night staff, staff with caring responsibilities and others for whom release from clinical activities is often a barrier to meeting their training and development needs. These opportunities should make full use of the potential of IT and web-based solutions.</strong></td>
<td>Human resources directors and professional heads</td>
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<tr>
<td>15. <strong>Review their current and likely future need for numbers of appropriately trained mentors/assessors to ensure that they have sufficient for staff undertaking NVQs as well as professional training.</strong></td>
<td>Human resources directors, directors of nursing, professional heads and service managers</td>
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</table>
**Recommendation**

_In order to reduce any perceptions of inequity, which could adversely affect staff morale:_

16. Ensure that the trust has clear, consistently implemented policies on self-funding and the use of staff's own time for education, training and development; and

17. Ensure that staff do not normally have to contribute towards specific training that is essential to patient and client care and safety.

**In order to ensure that training activities are as effective as possible:**

18. Seek further opportunities to review the content of available education and training and how well it matches service requirements. Trust managers should take the lead, working closely with HEIs, in ensuring that the post-qualification training commissioned relates to identified service needs.

19. Promote and support evaluation of the impact of training through focusing efforts in terms of assessing the effect on staff's skills, practice and patient/client care on those programmes that are designed to support significant service changes.

20. Discuss the planned and actual benefits of training before and after training takes place.

**In order to support the development of an organisation-wide culture that values training and learning:**

21. Make explicit the roles and responsibilities of individuals, managers and the board in getting the best from training and development.

22. Periodically review the overall training and development strategy, policies and processes.


24. Ensure that directorates’ adherence to training and development policies and their use of funds is reviewed within the trust’s formal performance management processes.

**In order to ensure that staff and managers understand, and are able to benefit from, the changes involved in the formation of workforce development confederations and the merger of the levies:**

25. Ensure that effective communications about the new arrangements are a priority.

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<td>16</td>
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<td>Service and clinical managers with HEIs</td>
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<td>Board directors</td>
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<td>Individuals and line managers</td>
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<td>Trust boards and senior management</td>
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<td>Trust boards</td>
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<td>25</td>
<td>Confederations and their members in England</td>
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Main study site trusts

The study team visited eight NHS trusts (main study sites) to gather data on the planning and provision of education, training and development for healthcare staff (other than doctors and dentists). This sample of trusts was selected in order to gain a spread between England and Wales (and of NHS region in England) and trust type (that is, acute/non-acute, teaching/non-teaching).

The main study sites were:
- Conwy and Denbighshire NHS Trust
- Harrogate Healthcare NHS Trust
- Lifespan Healthcare NHS Trust
- Pontypridd and Rhondda NHS Trust
- Rochdale Healthcare NHS Trust
- Royal Bournemouth and Christchurch Hospitals NHS Trust
- St Mary's NHS Trust
- Worthing and Southlands Hospital NHS Trust

The main fieldwork took place between October 1999 and April 2000. At the week-long, study-site visits, information was collected by semi-structured interviews and group discussions, and through documentation reviews. A number of data collection exercises were conducted. These are described below.

Other sites

In addition to the main study sites, short visits were made to 14 other NHS trusts and 7 health authorities, either to help with the early development of the study or, subsequently, to investigate specific aspects of training and development.

Study-site data collection tools

The following data collection tools were used at main study site trusts:
- survey of healthcare staff;
- collection of resource mapping data (Appendix 2);
- review of samples of personal development plans (PDPs);
- survey of managers who contribute to workforce planning returns; and
- survey of clinical ward/area managers on clinical placements.

Survey of healthcare staff

Surveys of healthcare staff were carried out in seven trusts. As well as demographic details the questionnaire covered staff views on how their training and development needs were identified and met, the barriers to meeting their needs, the volume and types of training and development...
they had undertaken in the last 12 months and a range of attitudinal questions. In six of the trusts, questionnaires were sent to all healthcare staff, while in the seventh, a 50 per cent random sample was used. Usable response rates of between 25 and 45 per cent were achieved.

**Resource mapping data (Appendix 2)**
A data collection tool was developed and piloted for use at study sites to collect data on local investment in education and training for trust staff other than doctors and dentists. This is described in more detail in Appendix 2.

**Review of personal development plans (PDPs)**
Samples of completed PDPs were collected from eight trusts. Forty PDPs were requested (20 from each of two service areas) from a mix of healthcare staff groups, although some trusts were unable to provide this number. In total, 114 PDPs were reviewed against a number of criteria.

**Survey of managers who contribute to workforce planning returns**
A brief questionnaire was distributed in eight trusts to those service managers and professional heads who contributed to the workforce planning submissions to the consortium/NAW. This covered their involvement in the workforce planning process, awareness of the consortium/NAW roles and their views on local higher education provision.

**National data collection tools**
Three national surveys were conducted as part of this study. These were:
- a survey of directors of nursing;
- a survey of directors of human resources; and
- a survey of directors of finance.

**Survey of directors of nursing**
A brief questionnaire was sent to the directors of nursing of all acute and non-acute trusts in England and Wales, excluding main study sites, trusts that merged in April 2000 and sites that were being surveyed by HealthWork UK (the healthcare national training organisation) in relation to a project on CPD. The survey included questions on post-registration nursing and midwifery education and training provided by HEIs, relationships with HEIs and pre-registration nursing and midwifery clinical placements. The total number of questionnaires distributed was 232 and a response rate of 74 per cent was achieved. Data from this survey were provided to the NAO to support their findings.
Survey of directors of human resources
A brief questionnaire was sent to the directors of human resources of the same trusts. The survey included questions on: identifying training and development needs, resources for training and development, provision of in-house training and development and evaluation. A response rate of 76 per cent was achieved.

Survey of directors of finance
A data request (in the form of an Excel spreadsheet) on resources invested in education and training for trust staff, other than doctors and dentists, in the financial year 1999/2000 was sent to 120 trusts (see Appendix 2). In order to ensure that trusts of different types and sizes were included a stratified random sample was used. A usable response rate of 42 per cent was achieved.
Resource mapping methodology

Appendix 2

The aim of the resource mapping tool was to capture readily identifiable and comparable information on the investment in education, training and development for healthcare staff.

The areas of potential expenditure on education, training and development of trust staff were identified [EXHIBIT 21] and differences between systems in England and Wales incorporated [EXHIBIT 22, overleaf]. The areas of expenditure that would be gatherable from routine data were also identified.

EXHIBIT 21
Cost tree for training expenditure on healthcare staff in trusts (England)

From early development and scoping, the areas of potential investment in a trust were identified.

Note: Text in *italics* represents areas not included in the resource mapping data collection.
* refers here to all trust staff, minus doctors and dentists.

*Source: Audit Commission*
EXHIBIT 22
Cost tree for training expenditure on healthcare staff in trusts (Wales)
From early development and scoping the areas of potential expenditure in a trust were identified and the differences for Wales incorporated.

The resource mapping tool covered all trust staff (other than doctors and dentists), not just the healthcare or clinical staff. This is because training budgets at trust and departmental level often do not differentiate between expenditure on clinical and non-clinical staff. For example, a ward or directorate’s training expenditure is not recorded in a way that enables it to be split between the costs of training for nurses as opposed to training for ward clerks.
In order to maximise consistency and comparability, the tool includes data on all readily identifiable expenditure on education, training and development for all trust staff, apart from doctors and dentists. That is, it excludes training budgets that are specifically for medical and dental staff. The following comparative measures were produced from the data provided by trusts relating to the financial year 1999/2000:

- Actual expenditure per head of trust staff, excluding doctors and dentists (using staffing data provided by the DoH and NAW); and
- Actual expenditure as a proportion of the annual pay bill, excluding that of doctors and dentists (using pay bill data provided by the trusts in accordance with the manual for accounts).
Appendix 3

Membership of the advisory group

A joint advisory group was established with the NAO to support the development of both the Audit Commission and NAO studies, with membership drawn from the NHS and higher education. The study team is grateful for the guidance provided by the advisory group members:

Keith Baggs  General Manager, South Essex Education and Training Purchasing Consortium and from January 2001, Director of Education and Training at Basildon and Thurrock NHS Trust

Mark Darley  Operational Services Manager, Faculty of Health, South Bank University, Essex and East London

Judy Gillow  Director of Nursing and Operations, Winchester and Eastleigh Healthcare NHS Trust

Caroline Gilmartin  Clinical Governance Manager, Tower Hamlets Primary Care Group

Alan Hanna  Offices of the National Assembly for Wales (from March 2000)

Jane Harris  Business Manager, Black Country Consortium and from July 2000, Postgraduate Manager, Regional Postgraduate Dean’s Office, West Midlands region

Hedley Hilton  Acting NMET Levy Co-ordinator, Department of Health (from January 2000)

Sue Hitchenor  Director of Finance and Service Planning, Lincoln District Healthcare NHS Trust

Ron Jones  Director of Personnel, Royal Shrewsbury Hospitals NHS Trust (until November 2000)

John Langham  Chief Executive, Kingston Hospitals NHS Trust

Richard Mundon  NMET Levy Co-ordinator, Department of Health (until January 2000)

Alison Raynor  Director of Human Resources and Corporate Affairs, Hounslow and Spelthorne Community and Mental Health NHS Trust

Lorene Read  Executive Nurse Director, Gwent Healthcare NHS Trust (until October 2000)

John Rushforth  Chief Auditor, Higher Education Funding Council for England

Pippa Sage  Director of Rehabilitation, Southend Hospitals NHS Trust

Jacqui Stewart  Director of Performance, East Kent Health Authority

Kim Tester  Offices of the National Assembly for Wales (until March 2000)

Simon Thompson  Deputy Director of Education and Training, North West Regional Office

Terry Tucker  Assistant Director of Organisation Development and Training, Surrey and Sussex Healthcare NHS Trust and from November 2000, Group Learning and Development Manager, Westminster Health Care Limited

Professor Tim Wheeler  Principal, Chester College of Higher Education

Professor Janet Finch  Vice Chancellor, Keele University
APPENDIX 3 • MEMBERSHIP OF THE ADVISORY GROUP

Frank Toop  Director of Finance, City University
Professor Jenifer Wilson-Barnett  Head of School, Florence Nightingale School of Nursing and Midwifery, King’s College London
Professor Mary Watkins  Head of Institute, Institute of Health Studies, Plymouth University
Appendix 4

A changing environment for healthcare education, training and development

The last decade has brought a succession of major changes [EXHIBIT 23] to arrangements for healthcare education, training and development. These changes are set to continue:

• the relationship between HEIs and health providers has been changing;
• human resources issues have been coming into greater prominence;
• new organisational structures and processes are being set up; and
• professional regulation is changing.

EXHIBIT 23

Changes affecting the education of healthcare staff
The last decade has brought a succession of major changes.

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<tr>
<td>ENGLAND</td>
<td>Transfer of NHS schools of nursing/midwifery/health studies to Higher Education*</td>
<td>ENGLAND AND WALES</td>
<td>Start of Project 2000 for many students</td>
<td>ENGLAND AND WALES</td>
<td>Start of Project 2000 for many students</td>
<td>ENGLAND AND WALES</td>
<td>Policy statement on funding of education</td>
<td>ENGLAND AND WALES</td>
<td>Start of Project 2000 for many students</td>
<td>ENGLAND AND WALES</td>
<td>Start of Project 2000 for many students</td>
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*Pre-qualification training for therapy and scientific professions has been brought into NHS funding incrementally and some still falls under the Higher Education Funding Council funding at present.

Source: Audit Commission

From 1989 to the mid 1990s, the schools of nursing were transferred from the NHS into the higher education sector. Following this move, both pre- and post-qualification courses were provided under contracts managed by regional health authorities in England and by the Welsh Office. Those schools of physiotherapy, occupational therapy and radiography, which were not already in HEIs, also transferred in this period. Responsibility for commissioning training places for certain therapy and scientific professions not already funded by the NHS, transferred from the Higher Education Funding Councils to the DoH; further extension of this process is still expected.
Other changes later in the decade have tended to emphasise the importance of links between higher education and NHS service providers, for example, through the establishment of education consortia in England [BOX G]. In 1999, the UKCC’s Commission for Education [Ref. 30] recommended closer working partnerships between HEIs and service providers to address the need to give more emphasis to practical skills earlier in the pre-registration nursing and midwifery education programme.\(^{23}\)

In the last few years government and the health departments have given greater prominence to workforce issues, and particularly to learning and personal and professional development by NHS staff [BOX H, overleaf].

**BOX G**

Arrangements for commissioning ‘non-medical education and training’

In 1996, the NHS Executive regional offices set up 45 education consortia, composed primarily of NHS employers (but also including local government and the private and voluntary healthcare sector). Major objectives [Ref. 32] were to involve NHS trusts and other employers more closely in the education of healthcare professionals, and then to devolve to each consortium the management of the NMET levy funding and contracts with HEIs [Ref. 33]. In Wales, these functions were exercised within the Welsh Office,\(^{24}\) with advice from the service provided through its Education and Training Group.

*Source: Audit Commission*
The human resources agenda

A First Class Service (Ref. 34) saw lifelong learning along with clinical governance and professional self-regulation as the keys to improving quality.

Working Together (Ref. 35), set out three strategic aims. To:

- ensure that the NHS has a quality workforce, in the right numbers, with the right skills and diversity, organised in the right way, to deliver the Government’s service objectives for health and social care;
- be able to demonstrate that the NHS is improving the quality of working life for staff; and
- address the management capacity and capability required to deliver this agenda and the associated programme of change.

Specific objectives included that by April 2000:

- HImPs were to be supported by human resources/organisational development action plans;
- training and development plans were to be in place for the majority of health professional staff; and
- annual staff attitude surveys were to monitor the quality of working life.

The NHS Plan (Ref. 23), published in July 2000 included a wide range of changes for education and training, both pre- and post-qualification:

- additional medical, nursing and therapist training places;
- a new common foundation programme to enable people to switch careers more easily;
- the proposal to develop new clinical roles such as assistant practitioners in radiography;
- a wider range of clinical tasks for nurses, midwives and therapists;
- an extra £140 million by 2003/04 for continuing professional development and NVQs or ILAs of £150 a year for staff without a professional qualification; and
- leadership development for clinicians and managers through a new Leadership Centre for Health.

The Human Resources Performance Framework, published in October 2000 (Ref. 4), sets the NHS in England three broad objectives:

- Improving working lives – including ‘providing personal and professional development and training opportunities that are accessible and open to staff irrespective of their working patterns’. All NHS employers are to be accredited against the Improving Working Lives Standard (Ref. 6) by April 2003.
- Working together – including personal development planning for all health professional staff.
- Developing the workforce – including increasing the overall capacity to train.

NHS Wales has also set out its human resources strategy, Delivering for Patients, (Ref. 5) published in June 2000. Its objectives for 2000/01 include:

- systematic examination of education provision to identify areas for common core training, and to ensure clinical placements meet workforce demand; and
- a full review of the workforce planning process.

Source: Audit Commission
Further changes are proposed or are about to happen. New organisational structures and processes are being set up [BOX I]; professional regulation is changing [BOX J]; and changes in service delivery will require changes to education and training [BOX K, overleaf].

**BOX I**

**A Health Service of all the Talents**

In April 2000 the NHS Executive issued a consultation document on workforce planning, *A Health Service of All the Talents* (Ref. 3), which contained several important proposals for arrangements in England:

- a multi-professional approach to workforce planning, integrating medical and non-medical planning processes, and merging the levies that historically provided separate funding streams;
- replacing education consortia with a smaller number of new ‘workforce development confederations’, to oversee commissioning and workforce planning decisions locally;
- health authority chief executives to be accountable for preparing workforce plans that support the HImP in meeting the strategic needs of local health economies; and
- the appointment of a director of workforce development in each regional office to oversee, co-ordinate and performance manage the process.

*Source: Audit Commission*

**BOX J**

**Professional regulation is changing**

In August 2000, the NHS Executive published proposals for new statutory regulatory frameworks for nurses, midwives and professions supplementary to medicine. The new Nursing and Midwifery Council would replace the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards, and a new Health Professions Council would replace the Council for Professions Supplementary to Medicine (CPSM) and its 12 Boards. Both aim to make professional regulation more open, responsive and accountable, focused on protecting patients and the public. Both will have explicit power to link the periodic renewal of registration with evidence of CPD. This confirms the present position for nursing, midwifery and health visiting, but extends this provision for the first time to therapists and scientific professions.

*Source: Audit Commission*
Example of changes in service delivery requiring changes to education and training

In order for mental health services to meet the needs of people with severe and enduring illness in line with the NSF (Ref. 36), many services will have to address gaps in provision such as home-based treatment and assertive outreach, crisis services, and 24-hour staffed accommodation. This will have repercussions both on the core training of newly qualifying staff and on the training of staff in service.

The NSF points to relevant skills and competencies that even recently trained staff may lack, such as cognitive behaviour therapy and complex medication management. The NSF action plan addresses such critical skill gaps as: competencies for working in a non-discriminatory and culturally sensitive way, risk assessment and management, and psychosocial interventions.

*Source: Audit Commission*
References


32. NHS Executive, *EL(95)27 Education and Training in the New NHS*.

33. NHS Executive, *EL(97)30 Devolution of Responsibility to Education Consortia*.


REFERENCES


42. Welsh Office, *Addendum to DGM (93) 10 Towards 2000: Manpower Planning, Education and Training – Addendum to DGM (93) 10*.


Allied health professions

A group of professions providing treatment and care across the range of health and social services, including those known in the past as professions allied to medicine. *Meeting the Challenge* (Ref. 37) lists them as: arts therapists, chiropodists and podiatrists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, diagnostic radiographers, therapeutic radiographers, and speech and language therapists.

Assessor

An assessor measures an individual student’s achievement against set performance criteria for an educational programme. The term is used in this report to describe a practising health professional who assesses performance in a clinical setting, especially for an NVQ or higher education qualification. Assessors should have qualification and experience appropriate to the role.

Clinical governance

A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment within which excellence in clinical care will flourish (Ref. 34).

Clinical Negligence Scheme for Trusts (CNST)

The Clinical Negligence Scheme for Trusts (CNST) is a financial pooling arrangement administered by the NHS Litigation Authority that helps NHS trusts and health authorities in England to manage their clinical negligence liabilities. Annual contributions are assessed on the basis of the type of activity, such as acute, community or mental health. Discounts can be obtained if the member meets certain standards in clinical risk management.

Clinical placement

Part of an educational programme that takes place within a clinical setting.

Competency

A description of the skills and behaviours required to perform a job/task successfully.

Consortium

See ‘education consortium’.

Continuing professional development (CPD)

See ‘lifelong learning’.

Council for the Professions Supplementary to Medicine (CPSM)

Along with the separate boards for each profession, the CPSM promotes high standards of professional education and conduct. The Council also provides an enabling framework for the Boards’ individual registration schemes. There is a proposal to replace these organisations with the Health Professions Council (subject to parliamentary approval).

Development, personal

See ‘training’ below.

Education

In this report ‘education’ refers typically to learning that leads to a formal qualification, based on a university or other academic institution (see also ‘training’ and ‘development’).
Education [and training] consortium
(In England only) A grouping of commissioners and providers of health services that also includes representatives from general practice, local authority social services and the independent and voluntary sector for workforce planning and commissioning education and training for healthcare staff other than doctors and dentists.

Education Purchasing Unit (EPU)
See the PMETB below, which has now taken over the EPU’s functions within the offices of the National Assembly for Wales.

Education and Training Group (ETG)
A group of representatives of NHS Wales that advises the offices of the National Assembly for Wales on all aspects of the education and training of health professional staff groups.

Health Act partnership
The Health Act 1999 provides for partnership arrangements to be set up between NHS bodies and local authorities to carry out NHS or health-related functions.

Healthcare assistant (HCA)
The Department of Health’s annual census of ‘non-medical’ NHS staff defines HCAs as support staff who are trained or undertaking training in job-related competencies through NVQs or other local training.

Health Improvement Programme (HImP/HiP)
An action programme led by the health authority to improve health and healthcare in the local health economy. Abbreviated as HImP in England and HIP in Wales.

Higher Education Institution (HEI)
Universities and colleges receiving funds from the Higher Education Funding Councils for England and Wales. This report is concerned only with those HEIs providing education and training for health professional students and staff, other than doctors and dentists, much of which is funded by the NMET and Towards 2000 levies in England and Wales respectively.

Individual learning account (ILA)
Individual learning accounts provide a way in which anyone aged 19 or over can manage, plan and invest in their own learning. Backed by the Government, and supported by learning providers, trade unions and employers, the accounts offer a package of discounts and make it easier for individuals to overcome financial barriers to lifelong learning.

Investors in People (IiP)
Investors in People is a national quality standard that sets a level of good practice for improving an organisation’s performance through its people. Investors in People UK was established in 1993 to provide national ownership of the IiP National Standard and is responsible for its promotion, quality assurance and development.

Lifelong learning
A process of continuing development for all individuals and teams, which meets the needs of patients and delivers the healthcare outcomes and priorities of the NHS, and which enables professionals to expand and fulfil their potential.

Mentor
Professional who, by example and facilitation, guides, assists and supports the student’s learning. The individual is selected by the student.
National Boards (ENB, WNB)  The English and Welsh National Boards for Nursing, Midwifery and Health Visiting aim to support the delivery of patient care through the development of high-quality, cost-effective educational programmes. One of their key functions is to approve education institutions and programmes. There is a proposal to replace these organisations with the Nursing and Midwifery Council (see below).

National Occupational Standard (NOS)  These standards specify from the perspective of service users, what needs to be achieved in the delivery of high quality services, no matter who is involved, in whatever service setting. They are validated through a nationally recognised development process. Possible uses include informing and structuring CPD and education programmes.

National Service Framework (NSF)  Evidence-based statements of what patients can expect to receive from the NHS in major care areas or disease groups.

National Training Organisation (NTO)  NTOs are the government-recognised ‘voice of employers’ within employment sectors. Their key strategic roles are to identify skill shortages and training needs, influence and advise government on policy, and lead the development of qualifications based on national occupational standards. Healthwork UK is the NTO for the health sector.

National Vocational Qualification (NVQ)  A work-based qualification that provides staff with relevant underpinning knowledge and enables them to demonstrate their competence at a range of levels. NVQs are based on national occupational standards (see BOX D, page 43).

Non-medical education and training (NMET) levy  NHS funding to support pre- and post-registration ‘non-medical education and training’ in England is raised by this national levy on health authorities. Most of it is spent by education consortia in contracts with higher education institutions.

Nursing and Midwifery Council  There is a proposal, subject to parliamentary approval, to set up a Nursing and Midwifery Council that would replace the UKCC and national boards. Consultation on this proposal ended in October 2000.

Personal development plan (PDP)  A formal, regular documented process whereby individual members of staff have their overall training and development needs assessed and recorded in discussion with their manager. The process may go under some other name. Sometimes it is integral to an objective-setting process such as individual performance review, sometimes it is quite separate.

Professional and Managerial Education and Training Branch (PMETB)  Within the offices of the National Assembly for Wales, the Professional and Managerial Education and Training Branch manages the Towards 2000 levy that funds certain health-related, higher education activities. These responsibilities were formerly carried out by the Education Purchasing Unit.

Towards 2000 levy  This levy in Wales provides the central funding for newly qualifying/registering healthcare staff (other than doctors and dentists) for NHS Wales. Some post-qualification courses are also funded.
Training

The terms ‘training’ and ‘training and development’ are often used interchangeably in the report to cover the full range of learning activities, from formal education to short in-service courses and on-the-job learning. Examples of on-the-job learning include coaching, mentoring, secondments and supervised practice (see also ‘education’).

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)

The UKCC regulates the professions mentioned in its title. It does so partly by setting standards for education. The national boards (see above) ensure that these standards are maintained. There is a proposal to replace these organisations with the Nursing and Midwifery Council (see above).

Welsh risk pool

The Welsh risk pool helps to reduce and control risks across NHS Wales. As member organisations, all NHS trusts and health authorities in Wales are required to achieve agreed risk management standards.

Workforce development confederation (WDC)

Groups of NHS and other employers (in England) which are to replace education consortia following A Health Service of All the Talents (Ref. 3), to:

- review and aggregate the plans of local employers;
- submit information to inform central planning for basic professional education;
- plan post-basic professional and other training where joint planning is of value;
- manage contracts with local education providers; and
- provide a focus for developing human resource strategies at above-employer level.

Workforce planning

In the NHS, ‘workforce planning’ has often been used to mean a process designed to ensure that higher education institutions deliver the numbers of staff – especially newly qualifying students in the various professions, but also other further professional qualifications – to meet the sector’s future needs. These plans take both demand and supply-side factors into account. The approach to workforce planning will change significantly as and when the recommendations of the NHS Executive’s review (Ref. 3) are implemented.
Notes

1 The PMETB is part of the offices of the National Assembly for Wales.

2 This level of spending on education and training appears not dissimilar to that in other non-healthcare sectors, although only broad comparisons can be made because it is difficult to get clear definitions and consistency across sectors. Studies have shown that employers from a range of sectors spend an average of between £397 (Ref. 38) and £600 per employee (Ref. 39) – data for organisations with over 500 employees, increased for inflation to 1999 levels).

3 Delivering for Patients (Ref. 5), the human resources strategy for NHS Wales also includes an objective to increase the understanding of equality and human rights by raising awareness of cultural and language issues for all frontline staff.

4 Audit Commission survey of trust staff at seven study sites. Regression analysis showed that having your training needs recorded in a PDP was associated with undertaking 1.1 days more training in the last 12 months, after allowing for other variables such as employing trust and working patterns (significant to 5 per cent level).

5 National Training Organisations (NTOs) are independent, employer-led sector organisations recognised by the DfEE to work strategically with their sectors and with government across education and training throughout the whole of Britain. NTOs draw together wide employment interests including professional bodies, education, trades unions and trade associations. Their outputs include national occupational standards and modern apprenticeship frameworks.

6 National occupational standards specify the knowledge, understanding, practical and thinking skills that underpin the outcomes that are required in the workplace.

7 Or from under £200 to over £1,300 per whole time equivalent (WTE).

8 A sample of NHS trusts provided the Commission with details of education and training expenditure as described in Appendix 2. In order to make simple comparisons between trusts, the team calculated two indicators: spending as a percentage of the total trust paybill excluding that for doctors and dentists, and spending per employee (headcount) excluding doctors and dentists. To analyse the differences between trusts further, they carried out linear regression analyses with eight simultaneous explanatory variables: healthcare staff paybill, three-month vacancy rate (all staff groups), turnover rate (for registered nurses), part-time working index (headcount divided by WTE for trust employees excluding doctors and dentists), and four dummy variables for London/south-east, acute versus community, specialist and teaching trusts. After excluding incomplete or questionable data, 33 trusts remained. For overall expenditure, the R-squared measure of goodness of fit was 0.57 for £ per head, and 0.47 for percentage of the paybill. The eight variables explained less of the external/ring-fenced expenditure than of the local trust.
expenditure; R-squareds were 0.45 and 0.35 respectively for external/ring-fenced expenditure, compared with 0.56 and 0.46 for local trust expenditure.

9 Audit Commission survey of trust staff at seven study sites. Regression analysis showed that, after allowing for other variables such as employing trust and working patterns, reporting that you are well informed about the training opportunities available to you through the trust was associated with undertaking 4.4 days more training in the last 12 months, than if you report that you are not at all aware of the opportunities available (significant to the 1 per cent level).

10 For example, in one trust visited, staff in one department were required to be marked on an assignment, presentation and interview by a panel of assessors in order to access funding and time off for a postgraduate course. No such processes were referred to for staff in other areas of the trust when applying for postgraduate courses.

11 Although in England the staff groups covered by the NMET levy is widening from those originally listed in HSC 1998 (044) (Ref. 40). From April 2001 medical laboratory scientific officers (MLSOs) (also known as bio-medical scientists), operating department practitioners (ODPs), medical technical officers (MTOs), pharmacy technicians and cytoscreeners are being included. In Wales, ODP training is funded by the NAW and MLSOs receive funding for the third year of their training. The staff groups covered by Towards 2000 funding are detailed in DGM (93) 10 and the subsequent addendum (Refs 41 and 42).

12 From the Audit Commission survey of healthcare staff in seven trusts, the median days in the last 12 months was five days for part-time staff compared with eight days for full-timers. Regression analysis showed that, after allowing for other variables such as employing trust and staff group, being part-time was associated with undertaking 2.1 days less training in the last 12 months, than if you are full time (significant to the 0.1 per cent level).

13 Regression analysis of staff survey results suggests that staff who work days only undertook 1 to 1.5 days more training in the last 12 months, than comparable staff on other shift patterns (significant to the 0.1 per cent level).

14 2 tailed t test result = 0.025.

15 In an Audit Commission survey of directors of nursing almost all trusts indicated that they monitored take-up, but one in four either gave an estimated figure or said they did not know the take up.

16 Examples mentioned in interviews included an ODP who indicated he had paid for the course to enable him to be an internal verifier for ODP trainees, and a nursing assistant who had paid for an Access course to gain entry to professional training.

17 However, the course costs for post-qualification study days or modules funded by NMET (via service level agreements with trusts or HAs in
Wales) are fully funded whether essential to the job or not. This may mean consistent application of a policy is difficult to achieve.

18 Data provided to the Audit Commission by acute hospital trusts during summer 2000.

19 Lack of sufficient trainer time can also be part of the problem. In one trust visited, prior to appointing a new resuscitation trainer, the trust bought in only 20 hours per week cover to provide and administer training for 4500 staff. Some trusts provide this training for their staff through central trainers, while others use cascade approaches where service staff are trained as trainers. However it is provided, trusts need to ensure that they have sufficient appropriate training which staff can attend.

20 These standards meet UKCC ‘Fitness for Practice’ (Ref. 30) recommendations numbers 21 and 28.

21 The Education and Training Group (ETG) advises the Professional and Managerial Education and Training Branch of the offices of the National Assembly for Wales.

22 The offices of the National Assembly for Wales intend to produce guidance for health authorities on covering human resources issues in future HIPs.

23 Shortly afterwards the NHS Executive (Ref. 43) and the National Assembly for Wales (Ref. 44) agreed that there should be more NHS/university joint appointments and more opportunities for experienced nursing staff to combine teaching and patient care.

24 These functions were originally exercised by the Education Purchasing Group (EPU) for the Welsh Office. Following reorganisation, they are now carried out by the Professional and Managerial Education and Training Branch (PMETB) within the offices of the National Assembly.

25 Since 1995, the UKCC has required nurses and health visitors to undertake a minimum of 35 hours learning activity every three years as a condition of remaining on the professional register. Other professions may follow, and set a minimum amount of CPD that their members must undertake. These requirements will undoubtedly increase pressure on all professionals and their employers to set aside time and resources for personal development.
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**Finders Keepers**  
**The Management of Staff Turnover in NHS Trusts**  
This Update focuses on the problem of staff turnover; in particular, reducing the high turnover rates that are causing problems for many trusts. It proposes a framework for action that is based on the experience of trusts where high turnover rates have been effectively addressed.  
*Update, 1997, 1862400148, £10*

**The Doctors’ Tale**  
**The Work of Hospital Doctors in England and Wales**  
With advances in medical technology and greater patient expectations, hospital doctors are under increasing pressure to improve the standards of healthcare. But NHS work practices and training have not changed to match the new patterns of care, and doctors’ jobs remain poorly specified. This report outlines the problems of staffing arrangements, suggests ways of overcoming them, and provides a clear framework for change.  
*National Report, 1995, 0118861492, £12*

The Update to this report, *The Doctors’ Tale Continued*, revisits the issues arising from the national study and reports on the audits.

**The Doctors’ Tale Continued**  
**The Audits of Hospital Medical Staffing**  
*Update, 1996, 0118864327, £10*

**Recruitment Titles**  
The Audit Commission has produced a number of reports in recent years looking at how recruitment and other human resource issues can be managed so that employers get the best from their staff and reap a better standard of service as a result. Although originally written for local government bodies, these publications contain advice and recommendations that are transferable across all areas of the public sector.  
**On Merit: Recruitment in Local Government**  
covers the development and replacement of non-manual staff in local government. It was updated in 1999 to review the progress made by authorities, and the extent to which they have implemented recommendations made in the original Bulletin.  
**Calling the Tune: Performance Management in Local Government**  
looks at how local authorities can get the best from their staff through specifying, communicating and evaluating aims and objectives at all levels. An update to this report, *The Melody Lingers On*, was published in 1997 to review the progress made since the original studies.  
**Paying the Piper…Calling the Tune: People, Pay & Performance in Local Government** draws on good practice case studies to act as a working manual for all managers involved in human resourcing issues.

**On Merit**  
**Recruitment in Local Government**  
*Bulletin, 1995, 0118864254, £6*

**On Merit**  
**A Review of Progress on Local Authority Recruitment and Training**  
*Update, 1999, 1862401845, £5*

**Calling the Tune**  
**Performance Management in Local Government**  
*National Report, 1995, 0118861344, £9*

**The Melody Lingers On**  
**A Review of the Audits of People, Pay and Performance**  
*Update, 1997, 1862400105, £10*

**Paying the Piper…Calling the Tune**  
**People, Pay & Performance in Local Government**  
*Management Handbook, 1995, 0118861387, £30*

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Patients and clients depend on the skills and knowledge of NHS staff. Education, training and development are crucial to maintaining and enhancing the abilities of more than 600,000 healthcare staff in NHS trusts. Creating and leading the changes required for modernisation will depend to a great extent on maximising the potential of staff who are already employed by NHS trusts; increasingly involving new and extended roles.

Hidden Talents reviews the planning and provision of education, training and development in NHS trusts for:

- nurses, midwives and health visitors;
- allied health professions;
- scientific, therapeutic and technical staff; and
- healthcare staff without a professional qualification.

In an average NHS trust, education, training and development activities cost the service about £1 million a year, or 2.5 per cent of payroll costs. Yet their effectiveness may be limited because development needs are often poorly identified. And even when needs are clearly identified, access to development opportunities is greatly influenced by who you are, what you do, and where you work.

This report has important messages for boards, managers and training specialists in hospital and community trusts. In addition, many of the principles would also apply to staff working in primary care trusts. The report’s recommendations reflect the goals of the Department of Health and the National Assembly for Wales. Following them should help NHS trusts in England to achieve accreditation against the Improving Working Lives Standard.