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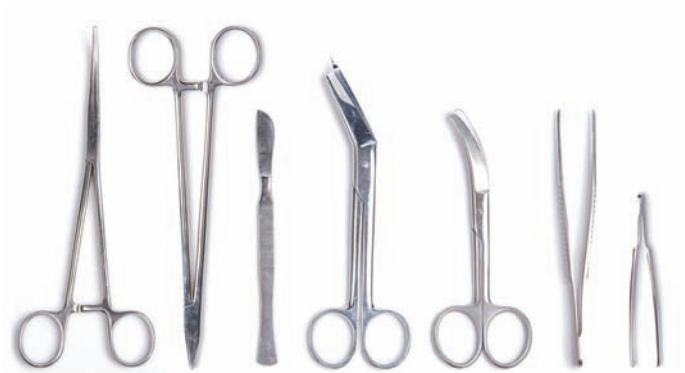

ACQUIRING THE RIGHT SKILLS

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NON-CLINICAL SKILLS

BUILD YOUR SKILLS

The NHS is changing as clinicians get more of a driving seat in commissioning. But what new skills will they need to fulfil this role – and how will they acquire them? Helen Mooney investigates

How do we turn today's NHS staff into the staff we need for tomorrow? It is a question being asked time and again as the NHS gears up for what could lead to the biggest reconfiguration of services since its creation.

If the government's controversial Health and Social Care Bill manages to get through Parliament and gain Royal Assent the issue of training and upskilling the current and future workforce will be paramount.

But what training do those working in the NHS need to ensure that the skills and attributes are in place to make the reorganisation a success?

Clinically led commissioning has raised questions about the non clinical skills of clinicians. Do GPs and other healthcare professionals have the right skills to be able to manage commissioning and commissioning groups?

Clare Gerada, chair of the Royal College of GPs, does not think that GPs have business management skills "over and above anyone else".

"Clinicians are bright but it is not the norm that GPs are amazing businessmen and most only manage small practices," she says.

She believes that top level commissioning and redesign will still need to come from getting a range of stakeholders to agree to change and to redesign the services that are needed.

"I hope people don't think there is a holy grail of management skills out there in GPs when what we have already is really competent NHS managers who are as dedicated as clinicians".

"GPs are good at general practice, we do what we do because we want to make a difference for patients. I don't come home at the end of the day and say to my son that I had a good day because I was in balance [financially]."

Nevertheless the RCGP has recently set up its Centre for Commissioning in partnership with the NHS Institute for Innovation and Improvement in a bid to help "equip GPs, practices and clinical commissioning groups with the skills, competencies and expertise required to deliver healthcare commissioning".

'Clinicians are bright, but it is not the norm that GPs are amazing businessmen and most only manage small practices'

Dr Gerada says the purpose of the centre is to provide GPs with the "practical support they need to successfully commission services for their patients".

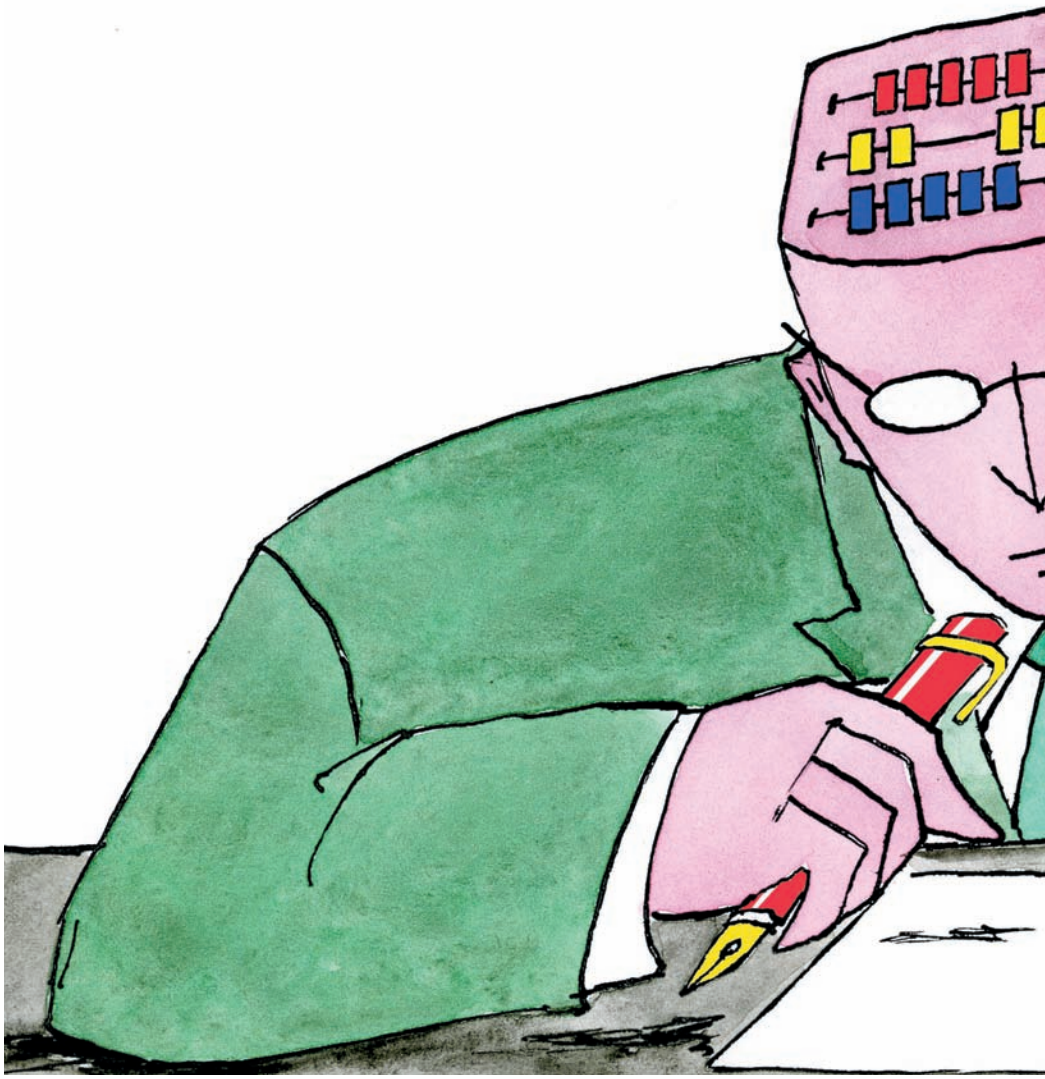
Candace Miller, director of strategic workforce transformation at Skills for Health, believes that the clinical workforce will need new skills if it is to deliver for the NHS of the future.

"People working in clinical commissioning groups will need to look at where they are and whether they have got

The Darzi Fellowship places junior doctors in NHS organisations

the skills around leadership, negotiating, reaching a consensus and working in groups, which you can only develop to some extent in general training, clinicians will have to be much more focused on developing these so-called softer skills, because they will have much more accountability.

"It is easy to assume that because people have reached a certain level they automatically understand what their skills are when, in fact, they may have overlooked skill areas. However in terms of communication and management skills these are considered to be the areas where the main gaps are and that needs to be addressed," says Miller.



'If you tell people for long enough that their contribution is tokenistic you run a high risk that that is how people will view their contribution'
Howard Catton

She says that those in charge of commissioning will also need to understand the "totality of workforce design and development in order to commission effectively".

There are already several courses and schemes in place to promote training for clinicians in leadership and management and to help them develop "softer skills".

One such programme is the clinical leadership or Darzi Fellowship programme run by NHS London, the London Deanery and The King's Fund. The scheme sees junior doctors become fellows for a year. They are placed in an NHS organisation that has bid for a fellow to work on a specific project.

Mentored by medical directors, the fellows lead on a variety of priority service change projects within their trusts. During the year fellows also participate in a bespoke leadership development programme that aims to support the organisational and leadership skills necessary for their future roles as consultants and clinical leaders.

Respiratory registrar Toby Hillman worked as a Darzi fellow in 2009 at Hillingdon Hospitals Foundation Trust. He says as well as working on a project trialling a new piece of software for discharge summaries, the programme was also geared towards learning leadership theory, applied leadership techniques and personal development. "Often doctors don't have those softer skills," he admits.

Some clinicians, however, are wary of clinicians morphing into NHS managers.

Nigel Watson, chair of the British Medical Association's GP commissioning and service development subcommittee, warns that clinicians should only get involved where they can "add value".

"If they are just going to be jumped-up managers there is no point... where things work well is where managers and clinicians work together."

He says that the NHS will still need specialists in HR, finance and management who will need to be alive to the information clinicians need to work effectively in future.

"We don't need to be spending hours playing with spreadsheets, we want information provided to us that is useful and will help affect change... we need to focus on developing contracts that drive clinical quality and outcomes rather than being heavily into the finance."

Although the current debate at a national level does talk about all clinicians and about leading and developing their skills for the future, much of it is still centred on doctors and specifically GPs.

'It is easy to assume that because people have reached a certain level they understand what their skills are when, in fact, they may have overlooked areas'

Howard Catton, head of policy at the Royal College of Nursing, is not convinced that people understand why the involvement of nurses and other healthcare professionals is critical.

"If you tell people for long enough that their contribution is tokenistic you run a high risk that that is how people will view their contribution," he warns.

He says that nurses working in CCGs will already have the skills and ability to focus on the quality agenda.

"Nurses are used to working across boundaries and organisations... I think they bring a range of skills which historically people have said are soft skills like relationship building, negotiation and finding solutions, this is the new type of professionalism that we want at the heart of the system, actually these soft skills in the new system are the hard skills that will make the system work," he adds.

That new skills will be needed for the workforce of the future is clear. One thing is for sure, even if the future make up of the NHS and how it is organised is not yet set in stone: staff will need to learn to adapt and develop their own ways of working if the NHS has a chance of success in the long term. ●

CLINICIANS AND FINANCE SKILLS

Clinicians will be expected to play a big part in ensuring the NHS makes the £20bn efficiency savings the government has demanded of it and yet there remains very little in doctors' or nurses' training programmes on finance.

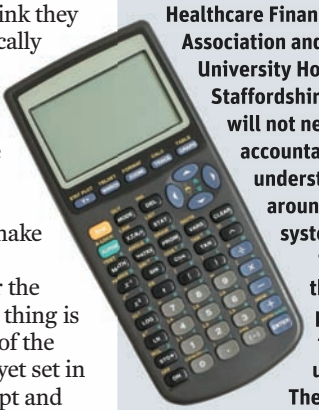
So what do they need to know about the mechanics of NHS finance if they are to help the NHS to succeed in future?

Sir Richard Thompson, president of the Royal College of Physicians, admits most doctors are "literate rather than numerate" but says that doctors should be given the information as they need to know how much they are spending.

"With blood tests and lab tests for example I think there should be a list of how much they cost... if tests A and B are fairly similar but test A is much cheaper most doctors would go for that but we just don't know the cost," he says.

"I personally don't know the difference in cost between an MRI or a CT scan," he admits. The BMA's Nigel Watson agrees and says that doctors need to be given financial information that is "relevant".

"I want financial information given to me in bite size chunks from non-clinical staff, I don't need to go on a financial course, I need the details when I need them," he says.



Chris Calkin, national media officer at the Healthcare Financial Management Association and finance director at University Hospital of North Staffordshire, thinks that clinicians will not need to be qualified accountants. But they will need to understand the core principles around how the NHS financial system works.

"They need to understand that they can also have a positive impact or that their actions can lead to unintended consequences. They will need to understand how to read a budget and challenge a business case," he says.

ALAMY, REFLEXSTOCK

The NHS is changing rapidly - but its need for leaders with the skills and attributes to manage that change has never been greater.

A leadership development programme offered by Yale University and South Essex Partnership University Foundation Trust, one of the NHS's top-performing mental health and learning disabilities trusts, aims to equip leaders for the future, drawing on expertise from the UK and globally.

'Leadership is needed more than ever now in the NHS and social care. This programme is really about leadership - it will help you demonstrate it and give you the tools to help you develop as a leader,' says Professor Patrick Geoghegan, chief executive of the trust. 'It is a very practical approach - it is not about reading a book, this is where you have to get your hands dirty!'

The joint programme has been run for five years but has now been extensively revised to reflect the changing environment NHS leaders need to work within. There is increased emphasis on a team-based and whole system approach, leadership development and strategic problem solving.

Participants will spend a week on a residential course in the UK in the spring of 2012, and are then expected to apply what they have learnt to a challenge or opportunity in their local health and social care system. This project management enables them to put this learning into practice, often working alongside colleagues from different backgrounds to produce an integrated solution.

A second week-long residential course is held at the Yale campus in the US in the autumn of 2012. Both courses are taught by eminent Yale professors and include discussions on healthcare reform, leadership and quality improvement, and case studies. This brings a valuable global perspective to the scheme. The US-based week also includes visits to healthcare providers, with opportunities to exchange ideas and spark new thinking on health and social care partnerships.

The programme is aimed at leaders from all disciplines who want to enhance their skills to guide the health and social care system through a period of immense change. They will

*gain expertise in addressing challenges in service delivery

*acquire the tools needed to solve diverse problems

*learn how to work effectively in groups across different sectors, agendas and disciplines

*build networks with colleagues from the NHS and beyond

*develop their own leadership potential within a changing system.

'It's helping people realise their full potential,' says Professor Geoghegan. 'This is a course which will parachute leaders up the career ladder and give them back their confidence.'

More details are available from programme manager Kay Richards on 07970 812973 or Kay.Richards@sept.nhs.uk

FLYING SOLO IS NOT AN OPTION!

Over the last five years Yale and SEPT's International Healthcare Management programme has enjoyed a proven track record of success. This year we are refocusing the content on the challenges faced by executives and providers across the NHS and social care as system reforms are implemented. The new programme will have an emphasis on a team-based approach and will give prominence to the principles of strategic problem solving and leadership development.

The programme consists of two weeklong residential sessions in 2012 – in the spring in the UK and in the autumn in the USA on the Yale Campus. The sessions consist of lectures delivered by eminent Yale professors and UK healthcare leaders on key issues in healthcare reform, leadership and quality improvement as well as case studies and other activities to promote application of these principles.

Its ultimate goal is to catalyse partnership working across all disciplines to influence system wide improvements.

If you are interested in finding out more about participating as an individual or a team, please contact the Yale and SEPT Health and Social Care Leadership Development Programme Manager, Kay Richards on 07970 812973 or kay.richards@sept.nhs.uk

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STAYING IN

With media calls for the training of nurses to go 'back to basics', would basing courses on site really foster a feeling of connection with a particular trust and provide the best possible education? Alison Moore investigates

There's nothing like nurses' training to get the media in a tizzy with accusations that university-based training does not equip nurses to deliver basic care.

But a scheme proposed two-and-a-half years ago that could have seen training provided entirely within a hospital has yet to get off the ground.

In early 2009, Heart of England Foundation Trust suggested it wanted to train its own nurses. Chief nurse Mandie Sunderland was quoted as saying: "I think there has been a particular focus on the academic side of nursing with less focus on nurses' individual abilities to undertake practical skills."

She suggested pre-registration nurses could be trained within the trust's planned faculty of nursing and midwifery and would have a sense of belonging to the trust. "We will recruit them and they will spend their entire training as students of Heart of England trained by a faculty of more than 100 staff – in our hospitals."

Heart of England's faculty of nursing and midwifery was opened this year – with Peter Carter, RCN chief executive attending. Nurses and midwives can choose from an impressive range of courses and in-service training.

But progress on the planned pre-registration course seems much slower. In early summer the trust was still talking of launching a pilot of 30 students this autumn but its board minutes noted that there was "some resistance" from the current university provider and that while the board supported the concept it was "mindful of the challenges".

But now the trust says: "We had proposed a pilot to explore the potential for a service situated pre-registration nursing programme delivered to Nursing and Midwifery Council standards in collaboration with a university. We have not as yet achieved consensus on the model of delivery and continue to work in partnership with our local university.

"We welcome further discussions on this issue and look forward to working closely with key stakeholders to enhance academic learning and experience in practice."

What factors are likely to be the barriers for trusts wanting to bring nurse training in house? One is that, contrary to popular mythology, nursing students already have to spend 50 per cent of their time on placements in a healthcare setting, with that proportion prescribed by the Nursing and Midwifery Council.

GEOFF CRAWFORD/REPORT DIGITAL

Trainee nurses examine the internal workings of a dummy patient at Canterbury College

Matthew Hamilton, head of policy at the Council of Deans for Health, says this means that the academic side of their degree is backed up with practical experience. He describes this balance as nurses mopping the brow – but understanding why they are mopping the brow.

Trust boards may not see the point of establishing a nursing training programme – which must incur some costs – if they can't change this ratio of academic learning to practical experience.

And any undergraduate course would have to be accredited at degree level by a university (as nursing is set to become an all degree entry profession within two years) and accepted by the NMC as meeting its standards.

That means a university might have to place some of its own staff in a hospital setting which potentially could be isolated from its main academic base. There might be concern about the effect on academics and also that students don't get exposure to different ways of doing things, as they would be based in one setting. And it could be argued that reflective practice is harder to encourage without direct experience of other approaches.

Universities may be concerned about any loss of control over the course and its delivery and may not be willing to accredit the degree. While non-public sector institutions can now apply to award their own degrees and are interested in developing portfolios of professional qualifications, the position with bursaries and tuition fees may put them off getting involved in nursing courses.

RCN student and acting education adviser Gill Robertson believes the motivation behind Heart of England's plans was very much to bring student nurses on site and make them feel part of "the hospital family".

One aspect which appealed was the idea of a small cohort rather than the hundreds of students on some university courses. "We know that small cohorts work better than big ones. The lecturers are likely to know them better... they are a small close knit cohort," she says. The RCN has argued that big cohorts in schools of nursing should be broken down into smaller groups to encourage this.

Nursing training was last solely hospital-based in the 1980s. Despite the calls in the media for a "back to basics" approach, it will be some time yet before we see student nurses spending their entire training in hospitals. ●

CHANGE FOR BETTE

Plans to give employers more of a say in the training of doctors and other clinical staff are causing concern, says Ingrid Torjesen

Fears are rising that the government's planned reforms to medical education and training risk undermining ambitions to move services out of hospital and improve management of long term conditions.

Under the plans, medical training will be commissioned by provider-led networks, known as local education and training boards once strategic health authorities are abolished. The boards will be made up of local healthcare employers and membership is expected to be heavily skewed towards secondary care. As a result boards may not prioritise investment in the training needed to develop primary care and community services.

LETBs will be responsible for the educational needs of the whole workforce, including the training of healthcare assistants and the continuing professional development needs of more senior nursing staff, as well as doctors. Their size and shape will be determined by the partners involved. It is yet unclear whether they will be social enterprises or special health authorities.

Currently it is the role of deaneries to recruit trainee doctors, to plan their programmes of education, assess them formally every year, and remediate and support those who get into difficulty.

Responsible

In its response to the NHS Future Forum report in June, the Department of Health said deaneries will continue to be responsible for training until the new structure is in place. Many people read this as meaning that after this deaneries would be abolished and their responsibilities and key staff transferred to LETBs.

However, in a letter to *The Times* at the end of September health secretary Andrew Lansley wrote: "I would like to make it clear that we have no intention of abolishing the deaneries. They play an essential role in the quality assurance of medical education and supporting doctors in difficulty as well as recruitment.

"As we stated in our response to the NHS Future Forum, 'the postgraduate deans and SHA staff involved in planning and developing the workforce will continue to manage and assure education and training, including the training and recruitment of junior doctors and dentists'."

His letter followed one from Tom Dolphin, chairman of the BMA's Junior Doctors Committee, which raised concerns about the detrimental effect the abolition of postgraduate medical deaneries would have on the training of junior doctors.

Professor David Black, vice president of training at the Royal College of Physicians, says the driver behind the government's education and training reforms is that they wanted to improve them and make the service itself take more responsibility. As a result employers will be able to ensure that sufficient numbers of the workforce they need – such as particular certain types of doctor, healthcare assistants or midwives – are trained and those employers will be able to influence the curriculum they are trained to.

"There are very clear curricula that we have to train doctors to, but getting the service to buy into those curricula, to influence them when they are being written, has proved a real struggle," he says.

He believes the DH has now realised that deaneries are needed. "I think there often wasn't the understanding of the complexity of role that deaneries undertook, and we do that hand-in-hand with the Royal Colleges," says Professor Black, who is dean of Kent, Surrey and Sussex Deanery.

One of the tensions is going to be how much training is going to be commissioned nationally and how much will be left to regional decision making. The RCP believes that large parts of defining what needs to be done in medicine will need to be done at a national level and driven by Health Education England because medicine has a national curriculum and national regulator. Poor workforce planning in medicine is an expensive business.

The overwhelming view is that it is the deanery brand that is being protected rather than the deaneries themselves. A DH spokesman told *HSJ*: "The SHAs will continue to be accountable for postgraduate deaneries until 31 March 2013. It is expected that deans and many of their staff will continue to take forward the work of deaneries in the new system architecture."

Transferring deanery staff to LETBs, seems the most likely option, the alternative is to link them to a medical school, a foundation trust or an academic health science centre such as UCL Partners, says

Local boards will be responsible for the educational needs of the whole workforce

'It is expected that deans and many of their staff will take forward the work of the deaneries in the new system architecture'

R... OR WORSE?

Matthew Shaw, co-founder of junior doctors' pressure group Remedy UK and a member of the NHS Future Forum group looking at education and training.

Manage training

While deanery staff will continue to manage training, it is likely that administration and HR functions will be passed on to the host organisation, possibly the LETB or even a trust. Mr Shaw emphasises that it will be essential for the education aspect to be independent from the host organisation, and for it to have a separate budget. If this does not happen the host organisation would effectively be both a commissioner and provider of training – a conflict of interests.

LETBs would be responsible for assessing the quality of training and the final sanction would be withdrawal of training from an underperforming organisation, and there are concerns this might not happen if the offending organisation is part of or represents one of these employers.

Steve Mowle, vice chairman of the Royal College of GPs, says: "That is a fault which we don't have within the deanery structure at the moment."

Dr Dolphin says: "Everybody is trying to work out how we can avoid these conflicts of interests within LETBs."

Dr Mowle predicts there will be additional costs associated with having LETBs, because of the loss of some economies of scale.

"There is real concern that in any transition there will be large opportunity costs and we will lose our momentum in actually developing a workforce fit for the future," he adds. He is also concerned the restructuring might impact adversely on existing educational networks.

But Dr Mowle acknowledges that allowing LETBs a say in workforce planning is not a bad idea, as it will give "greater employer buy-in locally". "There is a general feeling that workforce planning could be done better, in particular in primary care, and developing a workforce that we need in the right place. For example, we're probably not developing enough practice nurses in the community and there has been a recent push to increase health visitor numbers, so having a joined up strategy that reflects the current landscape of increasing community care."

He says there is a danger that LETBs will be driven by hospital needs, because hospitals would be the dominant force within them because of the difficulties of ensuring adequate primary care representation with there being so many small primary care providers, and as a result training needs within the community could be neglected. "Hospitals are the commissioners and providers of healthcare, will they develop the workforce that is fit to develop community services, which is our agenda of integrated care and community services?" he asks.

Dr Mark Purvis, director of postgraduate general practice education at the Yorkshire and the Humber Postgraduate Deanery, says not only is there a danger the new system will be "secondary care dominated", but also "medically dominated". "Andrew Lansley has gone to some lengths to say that deans will continue but hasn't said that about some of the non-medical roles," he points out.

"A move towards a more integrated multi-professional approach to workforce commissioning is entirely sensible, not least because we are in a very cash constrained system and if you train more doctors you can't train as many nurses."

He says it will be difficult to train sufficient GPs to meet the needs of the population in Yorkshire and Humber. "An appropriate thing to do would be to ensure that we are training sufficient practice nurses and nurse practitioners and healthcare assistants to broaden the front-line in primary care and to address the skill mixing." But this will require barriers to be broken down between training budgets for different professionals and for Health Education England not to overrule workforce planning decisions made by LETBs.

He says changes to training gave some real opportunities for improvements but adds: "There is a danger that we will be too conservative and won't try to do things differently and better.

"At the end of the day the Royal Colleges will continue to define the curricula against which the trainees will need to demonstrate their competences and the General Medical Council will set down their standards so as long as the Royal College and GMC standards are adhered to, localising how they are delivered could be a strength rather than a weakness." ●

ALAMY

WORKING IT OUT

At its best a stint of work experience can inspire and inform. But you have to get the right systems in place to make it satisfying for both student and organisation, writes Alison Moore

Work experience has become a rite of passage for school students – and can be important for getting a place at university. But is the NHS doing all it can to attract these potential employees?

Last year University Hospital Southampton Foundation Trust opened its door to 920 people seeking work experience – nearly half of whom were still of school age. Many spent a week in various settings in the hospital while others came for a one day session on healthcare science.

For some, the experience may have convinced them they want to work in the NHS in the future – and led them to apply for related courses. Others may have decided it was not for them – but have made that decision before they have committed themselves to years of training.

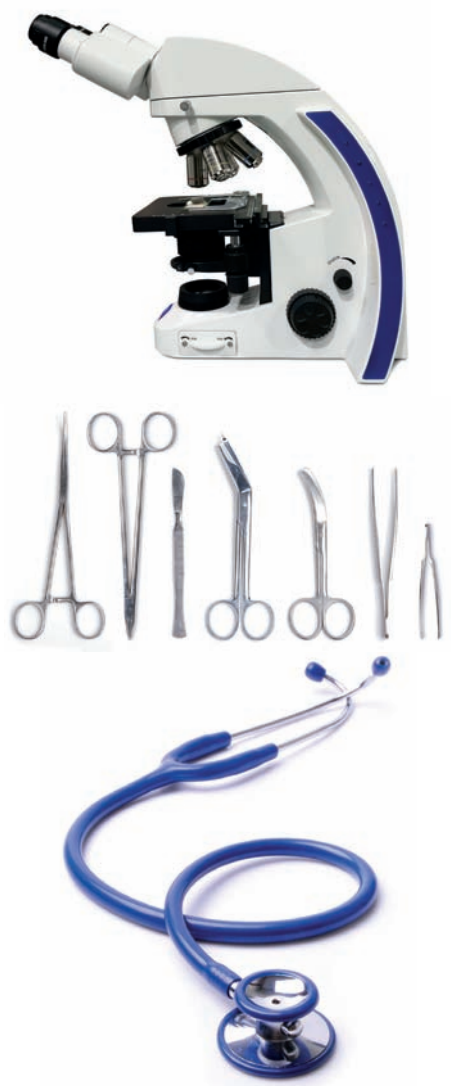
Southampton has a centralised work experience scheme run by Kim Sutton. "We need to see if you are okay around patients and you need to see if you are okay with poo and vomit," she quips. Students in clinical areas get to see the importance of multi-disciplinary team working. But with 350 careers in the NHS, they don't have to want to be doctors and nurses to get valuable experience.

Caroline Waterfield, deputy head of employment services at NHS Careers, urges employers to remember that work experience students are their workforce of the future. "This is very much about making certain that you have the skills that you need locally," she says. "This is about the medium to long term workforce supply chain. Don't think about it in a short-sighted way."

She says organisations which have centralised work experience have often found this is successful in dealing with the administrative burden. NHS Careers publishes guidance and examples of good practice in running work experience schemes – including busting myths around the need for criminal record bureau checks.

But there can still be practical difficulties in offering work experience. Year 11s, for example, are often allocated a week to do work experience in – ensuring a glut of students for a few weeks a year. Older students may not get the same protected time and may want to come out of term time.

And many Year 11s will still be 15 during their allocated week – but find many NHS organisations will limit what they can do if they are under 16. This may mean they can't get any experience in a clinical area until they have made their A-level choices.



Tools of the trade: work experience helps young people decide on a future in healthcare

But there is also a strong social mobility aspect to work experience – especially when it is highly rated by universities for courses such as medicine and nursing. Former health secretary Alan Milburn highlighted the difficulties pupils from disadvantaged backgrounds faced in getting work experience in all industries in his social mobility report *Unleashing Aspirations* in 2009.

His inquiry was given evidence that "a high quality placement is often dependent upon contacts among friends and family" and called for bright, disadvantaged pupils to be given work experience in professional jobs.

'It's not just if your mum's a doctor, we target the less advantaged schools'

Is the NHS guilty of this at all? While it may not have the excesses of the internship system there is a risk that who you know can determine whether you get work experience, especially where it is less organised.

University Hospitals Bristol Foundation Trust tries to overcome this by sharing out its work experience places among local schools. Students get a tailor-made experience after filling in an application form, having an interview and submitting references and health checks. "We have a very fair and equitable system," says Sue Cotterell, redeployment and outreach co-ordinator. "It's not just if your mum's a doctor or your dad a GP, we target the less advantaged schools."

That's not universal however; some hospitals still tell pupils to write to individual consultants and leave it at that. Finding a sympathetic doctor who will offer them a place may be the first hurdle for any youngster aiming for a medical career. ●

CASE STUDY

Ella Bedells, 19, is hoping to become a specialist children's nurse after spending an "unforgettable" week on a children's ward at Southampton General Hospital.

"During my time there, I observed and interacted with the nurses as they cared for each child, providing for all their physical, emotional, intellectual and social needs," she says. "I saw how the team involved a child's family in the care and provided vital support for them. Speaking to several nurses, I gained insight into their thoughts and feelings for their work." She was able to help take vital signs, and accompany patients to x-ray and theatre – as well as playing with the children.

She was prepared for the reality of NHS life to test her desire to be a nurse but found that she was even more enthusiastic. She is now applying to volunteer at both the hospital and a local children's hospice and hoping to go to university in September 2012.

FOTOLIA

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