GATEWAYS TO THE PROFESSIONS

# Growing our own professionals for the new NHS

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## Workplace learning

*Part of the*
Thames Gateway Project

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## Background

In 2004 the Secretary of State for Education and Skills commissioned an independent report to examine routes into the professions. Sir Alan Langlands, Vice-Chancellor of Dundee University and former Chief Executive of the National Health Service in England from 1994-2000* led the work and made recommendations to Ministers on action that could be taken by employing organisations to provide clear, accessible gateways for people who wished to pursue a career in the professions; his report was submitted on 20 July 2005. There was a concern that the introduction of variable tuition fees would have an adverse impact on recruitment to the professions. The Langlands Report highlighted the challenging issue of how to widen access to the professions.

The Government's response was published on 1 November 2005. One of the key elements of the response was the establishment of a 'Gateways to the Professions' development fund. The aim of the fund was to support projects tackling the full range of issues and barriers faced by people seeking to enter the professions through higher education. The importance of collaborative working between professional bodies, employers and education providers was a key issue raised by Sir Alan Langlands and consequently the fund placed a strong emphasis on such collaborative partnerships.

** http://www.dundee.ac.uk/principalsoffice/biographies/siralanbiog.htm*

*Bids were invited in two phases which addressed:*

- **widening participation**
- **diverse learning needs and diversity of higher education provision**
- **issues relating to equality & diversity**
- **issues relating to recruitment & retention in the professions**
- **issues relating to access to the professions**
- **fair & equitable recruitment practices**
- **social mobility**
- **flexible learning/training routes; and**
- **access to information about career choices.**

The Department of Health's Widening Participation Unit was successful in securing a second round bid on behalf of a stakeholder group from the Thames Gateway area, where it was thought that given the scale of the area, the findings could be comparable across other healthcare economies and so form the basis for introducing similar approaches to staff development in other healthcare organisations and communities.

The second round bids were announced by Bill Rammell, Minister for State at DIUS, at the Widening Participation in Higher Education conference, 10 May 2007.

" Today I'm pleased to announce that the second round of the Gateways to the Professions Development Fund is supporting thirteen organisations in the delivery of projects focused on a range of cross-cutting issues. These include:

**widening participation;**
**social mobility;**
**equality and diversity in the professions; and**
**access to information and resources.**

"Contracts have been signed with four Aimhigher Partnerships, the DH on behalf of the Thames Gateway Project, the Social Mobility Foundation and QED-UK (an organisation from Bradford representing ethnic-minorities), amongst others.

"These projects will encourage students from a range of backgrounds to take up professional career paths.

"Our investment of time, money and resources to widen participation in HE and beyond continues. This fight demands focus, strong partnerships and commitment. But it's essential.

"Giving everyone with talent and ability, whatever their background or circumstance, the chance to go to university and succeed is essential to our future economic prosperity and social well being."

## The Thames Gateway Project

The project theme was based on developing progression routes into the professions for staff already employed in lower grades.

The aim of the project was to identify and create innovative workforce solutions that will prepare professionals to respond to the service improvement requirements of the NHS as it seeks to develop integrated care pathways for clients and patients, and to meet the key performance standards identified in the NHS plan.

The project encompassed nursing and the allied health professions. The intention was to develop effective ways for the NHS to grow its own professionals. Given the financial constraints in the NHS, the emphasis of the project was on better utilisation of the talents and potential of the current workforce, in particular enabling support staff to develop and extend their skills. The project assessed how foundation degrees (FDs) could be used to enable staff to grow into much needed Associate/assistant practitioner (AP) roles.

## Sub projects

Seven sub projects were commissioned from the Thames Gateway area to undertake work to review specific elements of learning and progression for this population.
These projects were:

- **E-learner support system (led by the Open Learning Partnership);**
- **E-mentoring programme (led by the Brightside Trust);**
- **A good practice guide on negotiated curriculum design and co-delivery, National Vocational Qualifications and Foundations Degrees (partnership between London South Bank University and Newham University Hospital NHS Trust);**
- **Patient and public involvement (led by Benedict Taylor Associates);**
- **Workplace learning (led by Jan Walmsley Associates);**
- **Careers information and advice (led by Anne L. Sabine Associates); and**
- **Utilising credit and qualifications frameworks to support learning and career progression (led by Canterbury Christ Church University).**

**The project that follows makes recommendations and develops a business case and checklist on workplace learning, with particular reference to progression to Associate/ assistant practitioner and professional roles.**

# Workplace learning

## Objective

To undertake a study, make recommendations and develop a business case and checklist on WPL, with particular reference to progression to associate/assistant practitioner and professional roles.

The full report is available at
www.skillsforhealth.org.uk/gateway/workplacelearning

## Methodology

Research through Literature survey and site visits, comprising interviews with people responsible for WPL in a range of healthcare organisations.

Stakeholders were brought together in three project teams to take forward the detailed work of each of the seven sub projects, under delegated authority given by the Project Steering Group. Project team three stakeholders were responsible for the e-learner support, the e-mentoring and careers information and advice sub projects. The members of this project team are recorded at the end of this document.

## Summary

We have adopted the following definition of workplace learning (WPL):

*Workplace learning is learning that is organised in or by the workplace, and that supports employment role and progression.*

This includes both formally accredited and informally acquired learning.

Drivers for investment in WPL for unregistered staff in health are:

* Changing demography, meaning healthcare has to become an employer of choice to improve recruitment and retention. In particular, healthcare employers in the Thames Gateway have a huge challenge in meeting growing demand and replacing an ageing workforce from a decreasing pool.

* Local regeneration, including employment of hitherto poorly represented socially excluded groups.

* Improving the quality of care.

* The demands made by changing healthcare practice leading to the need for new more flexible roles.

* Efficiency and productivity gains.

* The Leitch Report has put employers centre-stage as a means of increasing the skills of the workforce.

* Organisational transformation.

The case for investment rests on an assumed correlation between enhanced skills in the workforce and high performance organisations. The HR and OD literature indicate that maximum impact comes from 'bundles' of high performance work practices (HPWPs) including training and development, but led by appraisal and personal development plans. In the health sector patchy use of appraisal, personal development plans and the Knowledge and Skills Framework has inhibited the development of HPWPs, meaning that WPL is not consistently driven by key underpinning supports which link both to the needs of the service and individual learners' needs.

An impressive number of supports are in place for employers to draw on in implementing WPL. This includes Sector Skills Agreements, a requirement for Strategic Health Authorities to develop workforce action plans, for Trusts to develop workforce development plans, and the Joint Investment Framework (JIF) which provides funding for three years to support the learning agenda for unregistered staff. This is an unprecedented opportunity to develop this agenda.

The Knowledge and Skills Framework (KSF) has the potential to ensure that training is linked to current or future job roles. However, our findings are that it is relatively uncommon for the KSF to drive the WPL agenda. We found three employers who use the KSF explicitly to identify training needs, linked to PDPs, and to meet them. Others recognised the importance of explicitly linking KSF to training but most acknowledged that in the absence of annual appraisal and personal development plans for many staff in bands 1-4, the links were largely aspirational.

Explicit progression routes linked to completion of WPL for bands 1-4 were unusual. In most organisations, people are expected to apply for new roles after training. There is tension between the aspiration to develop the Skills Escalator, and the projected increase in roles at associate/assistant practitioner level indentified in Sector Skills Agreements which will require major expansion of band 4 posts, and contraction or stagnation at band 5. Barriers to progression beyond band 4 are in part due to existing professional dominance, and are

unlikely to be broken-down by individual organisations working alone. However, funding availability is important, particularly to fund secondments and job rotation, and this needs to be sustained over several years if it is to yield significant results.

Improving the quality of care will mean experimentation with training and development for multi-disciplinary teams working with a patient pathway focus. This is an important area for further investigation.

There have been significant barriers which have hampered strategic and consistent development of WPL for this group of staff despite consistent policy messages since 2001, in particular, lack of capacity in healthcare organisations, inconsistency of funding, funding restrictions and funding which does not cover backfill costs. Training is seen as a cost, not an investment. Metrics to demonstrate the cost effectiveness of investment in WPL are crude. It is important to develop simple metrics which can capture the value of WPL for improving quality and productivity. WPL students are mainly non-traditional learners who need support sensitive to their needs, clear progression routes, and support from line managers and mentors.

A considerable and growing proportion of the unregistered workforce in healthcare is employed in contracted-out services. There was little evidence that NHS employers had addressed the challenge of motivating such employers to prioritise training and development. Ways of private and not-for-profit employers to work with statutory employers to meet the Leitch agenda and demographic challenges in the Thames Gateway need to be found.

Union Learning Representatives (ULRs) have the potential to support WPL for unregistered staff. Although most interviewees recognise the value of ULRs, none were satisfied with the quantity or availability of ULRs. Several indicated a falling-away after a promising start. It is important that Unions prioritise this agenda as ULRs appear to be critical in motivating unconfident learners and acting as role models for others.

WPL is challenging for providers of education and training. Many rise to the challenge but it is important to record that not only does it require a culture change to work in partnership with employers, there are also challenges around timeframes, and ensuring that WPL students have the time necessary to undertake substantial part time or full time programmes of study. If WPL were to develop, there is some concern relating to capacity in HE and FE to meet the demand.

Organisational cultures that support workplace learning are proactive and have Board level support. They are also informed by strategic workforce development

goals; have clearly articulated costs and benefits linked to organisational strategy, combined with use of data to analyse cost and benefit; consistently provide material support including training centre and staff, funding, project management of a high order, management information systems, libraries; and have close partnership working between HR and Training / Learning and Development Managers, use of appraisal, PDPs and KSF to drive training, and motivation of first line managers.

Few organisations surveyed displayed these characteristics. In particular, the absence of Workforce Development Strategies linked to a business case for Training and Development was striking. The organisations surveyed were unable to produce a cost benefit analysis.

**Recommendations**

*For healthcare organisations*

Link training and development to the DH Operating Framework 2008 requirement to produce workforce plans.

Identify a Board level champion for training and development for bands 1-4, ensure that HR and training and development are working in close partnership to deliver.

Work with finance to develop the business case and identify costs and simple, meaningful metrics to measure impact.

Protect the training budget and maintain consistency.

Make use of brokers to ensure that all available external funding is identified and used.

Prioritise appraisal, and link PDPs to training.

Get line managers interested and motivated; offer them training.

Personalise support for learners, and backfill.

Articulate progression routes to motivate learners.

Include specifications setting minimum requirements for training and development in commissioning contracted-out services.

Evaluate the impact of the investment in training.

Consider training for multi-disciplinary teams around patient pathways.

*For Skills for Health*

Maintain momentum initiated in sector skills agreements.

Avoid ‘top down’ prescriptions; use levers to encourage and build on good practice.

Work with SHAs to ensure that employers have easy access to advice and resources.

Foster a dialogue between local WPL champions and SHAs in deciding how to make use of the opportunities represented by the Joint Investment Fund.

Identify good practice in PPI and application of the single equalities framework as applied to WPL.

Urgently progress the development of metrics which will enable training managers to cost and capture the benefit of investment in WPL.

*For providers of learning and training*

Develop close personal relationships with training managers.

Understand the business case and strategic drivers.

Build the curriculum around real work tasks.

Offer multi-disciplinary learning opportunities aimed at teams.

Be prepared to troubleshoot when problems arise.

Work closely with employers to assist them in understanding your own context.

*For trades unions*

Review expectations of ULRs, focus on ULRs as peer motivators.

Prioritise ULR recruitment, training and motivation.

Include training and development entitlements in collective bargaining.

*For Thames Gateway*

JIF provides a fantastic opportunity to drive WPL as a mechanism for social inclusion, vibrant communities, regeneration, improved health and social care, equity, and a mechanism to deliver Leitch targets.

Work with SHAs to assist them in developing strategies to meet the considerable challenges healthcare employers will face between 2007-2014 in recruiting and developing sufficient staff to sustain high quality healthcare for a growing population.

Consider the challenge of coordination across three SHAs.

Identify steps which can help to promote WPL within TG in the context of partnership working between key players.

*For policy makers*

Maintain consistency in requiring adherence to annual appraisal, use of the KSF, workforce development strategy.

Seek to protect funding - inconsistency hampers progress.

Encourage commissioners to make provision of WPL a contractual obligation when contracting-out services.

Allow local autonomy; use levers to encourage employers to submit comprehensive workforce development strategies.

Ensure that deployment of the JIF funding does not create unnecessary barriers.

**Conclusions**

There is a strong case for prioritising WPL for bands 1-4, as they have a key role to play in healthcare delivery, and there is a historic backlog. The case is made more urgent by employment projections which indicate a considerable growth in demand for workers in the Thames Gateway area, due to increased competition as the area develops, and the replacement requirements.

There is a long way to go if training and development is to support redesigned and modernised services. We found some outstanding organisations with a comprehensive strategy for workforce development of which WPL bands 1-4 is an integral part. Most organisations have an ad hoc approach tied into historic patterns or local organisational needs. There is a sense of trial and error in the

way different organisations have gone about implementing WPL, with little evidence that development is informed by knowledge of what has worked where, under what circumstances and at what cost. Few organisations appear to have a workforce development strategy informed by understanding of present and future demographic drivers, and business needs. Inconsistent funding has been a barrier, alongside critical weaknesses in putting in place an infrastructure which guarantees staff their entitlement to annual appraisal and personal development plans. WPL is seen as a cost, not an investment. Organisational buy-in is hampered by the absence of an understanding of the connection between training and development, and improvements in quality, and of robust and sensible metrics which demonstrate value-for-money and service improvement.

It is a matter of concern that, other than in two PCTs which prioritise outreach where equality is a driver, attention to issues of diversity and equality has been, at best, an afterthought. Similarly, other than in two outreach projects, and the two mental health trusts surveyed, involvement of patients and public has not been considered.

Supports for developing WPL are largely in place. Knowledge of these supports is often poor amongst key personnel, though we found evidence that the hands-on approach taken to allocating JIF moneys by two of the three local SHAs was beginning to change this. There has as yet been no coordination of approaches within the Thames Gateway's three constituent SHAs, which are taking different approaches to ensuring that the Joint Investment Framework moneys are spent wisely. The way funding is made available, and its consistency, is vital. It needs to avoid creating unnecessary and often unanticipated barriers, but there also need to have measures to ensure it is spent on unregistered staff.

The SHAs have developed workforce strategies. There is potential to link this duty with consideration of strategic use of the JIF, and to use it to incentivise linking of WPL to development of Trust Workforce Development Strategies.

Particular attention needs to be given to ensuring that staff working for non-statutory employers can access high quality training. The mechanism to do this is likely to be through including training requirements in contracts, and by ensuring that employers of contracted-out staff are included when WPL is being planned strategically and at implementation stage.

**Outstanding issues**

The Report authors have identified the following outstanding issues where more research is urgently needed.

How can contracted-out employers be incentivised to meet Leitch agenda?

How can contracted-out employers work effectively together with NHS to meet the demographic challenge?

What is good practice in PPI in T and D for bands 1-4?

What is good practice in equality and diversity in T and D for bands 1-4?

What information systems are needed to support training managers to understand costs and benefits?

What metrics can be used to capture improvements in quality and efficiency attributable to T and D?

How can training and development be delivered to support teams working on patient pathways?

How can JIF work for national services such as the National Blood Transfusion Service?

What infrastructure will be needed in TG to support a coordinated approach across the three SHAs?

## Project Team

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|---|---|
| **Tom Aird** | London South Bank University |
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| **Doug Gowan** | Open Learning Partnership |
| **Lisa Hughes, AHP Officer** | Department of Health |
| **Jim Lewis** | Learning and Skills Council |
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