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Date: 11 April 2007

Our ref: Case 84ICO

Dear Mr Ward

Freedom of Information request – The "Wells" Report

I am writing to explain that in the process of preparing for the Information Tribunal the Department reconsidered its position in respect of your Freedom of Information request made for the "Wells Report" in January 2005. The Department has undertaken a full review of the determination of the public interest in this case.

At the time of the request the Wells report was a recent document, and concerned current changes in policy of the Department of Health. It was the opinion of the Department that the release of the report so close to the time of the review itself would prejudice any future reviews which might be conducted by the Department into the economy, efficiency and effectiveness of sponsored bodies. The Department has re-evaluated the public interest in withholding the Wells report at this time.

It is the opinion of the Department of Health that the likelihood of prejudice is more remote than in 2005, and that the public interest now favours the release of the report (delivered by Sir William Wells in two parts) enclosed.

Yours sincerely

Jill Moorcroft
Freedom of Information Unit Head

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REVIEW OF NHSU

PROGRESS AND PERFORMANCE

PURPOSE AND STRATEGY

THE ORIGINAL CONCEPT

1.1 The idea of an NHSU first emerged into the wider public gaze in the Labour manifesto for the 2001 General Election. This promised that "we will set up a University of the NHS to guarantee for staff at all levels opportunities for training and career development". Discussions with some of those closely involved at the time indicate that the idea was driven by three distinct objectives -

- *improving access to lifelong education and training,* in particular for the "non-professional" staff groups. This in turn was based on the view that "lifelong learning and development are key to delivering the vision of patient-centred care in the NHS" (*Working Together, Learning Together,* DH, November 2001)
- *enforcing corporacy*, in other words helping unite the NHS round shared values (for example, customer care), and increasing the effectiveness of staff by improving their knowledge of the NHS system
- *improving value for money and quality from education and training procurement*: there was a strong sense (supported by previous Audit Commission and NAO reports) that the NHS should obtain better value for its >£3bn. annual expenditure

EARLY EVOLUTION OF PURPOSE AND ROLE

1.2 Early work to pin down the strategic purpose of NHSU was led by the DH Strategy Unit. An August 2001 paper proposed that NHSU should –

- provide a core curriculum
- signpost existing provision for all staff
- commission new products
- quality assure and accredit

1.3 This helped clarify some early priorities for the proposed organisation. However, it did not set out where NHSU should be positioned in the training and education provision workflow –

- as a national level needs analysis and intelligence-providing body?
- as a purchaser?
- as a broker / facilitator of access to improved training?
- as a direct provider of training?

1.4 Nor was there anything more than a broad-based description of NHSU by reference to other players in the already crowded health education and training

sector, nor how they would relate to each other (for example, what the principles of the NHSU business model should be or, put differently, what levers it would have to deliver the ambitious remit proposed for it).

STRATEGIC DEVELOPMENT OF NHSU SINCE 2001

1.5 The development of NHSU's strategy and remit since 2001 has taken place in two main ways – through NHSU's own work, taken forward with the help of an extensive consultation and communication process, and through periodic discussions in a number of high level oversight groups with DH / NHSU membership, and with consultation of SHAs. This process was characterised by –

- *insufficient answering and tying down of the hard questions*, especially around the limits of NHSU's role and the boundaries with other organisations. There was discussion in the (DH-chaired) NHSU Strategy Board in mid-2003. This went some way towards setting out how NHSU would operate within the system and in particular how its provider role (where much of the early focus lay) could be squared with an influencing and commissioning role. NHSU followed this with a Strategic Plan (July 2003, approved October 2003). However, neither this work nor NHSU's consultation on its Strategic Plan fully overcame the fact that no rigorous analysis of the gaps in the system which NHSU should fill had ever been completed. Nor was there full resolution of the potential for overlap of role with a number of other players, in particular –
  - Skills for Health, the newly set up health Sector Skills Council, with a sector-wide role covering needs analysis, competence development and influencing an expansion of relevant training provision
  - SHA Workforce Directorates (formerly WDCs) whose regional role matched closely some of the roles NHSU hoped to play national level
- one high profile exception - where clarification of roles was achieved - was the November 2001 Memorandum of Understanding with Universities UK which ruled out a role for NHSU in pre-registration medical and nursing education. This severely limited the scope for NHSU to be involved in the provision of degree-level education – a prerequisite of any application for University status. We are not aware that the aspiration for University title was reviewed at the time as a result and certainly pursuit of it subsequently continued unabated
- *NHSU continuing to paint on the broadest possible canvas*: NHSU's developmental documents have described a wide role for the organisation. Its Strategic Plan describes its core purpose as "to contribute to the radical change and improvement in health and social care through the transformation of learning" (NHSU Strategic Plan, 2003). A number of discussions, including with DH, took place in 2003 about the possibility of NHSU's remit being widened further through absorbing the Postgraduate Deans and some DH R&D functions. NHSU's ambition is openly acknowledged - "Step by step NHSU is expected to assume an umbrella responsibility of all learning in health and social care" (Bob Fryer

to William Wells, June 2004). By contrast, rigorous work to set boundaries has been less evident, and this has contributed to suspicion of NHSU's acquisitiveness on the part of important partner organisations and confusion as to the organisation's focus

- *a discrepancy between the remit described by NHSU and its leverage*: NHSU has few powers (and, in particular, no power either to fund or to direct). Until recent discussions (still under way) about formal mechanisms for obtaining SHA commitment to its own-badged training provision, its strategy for making an impact on the NHS rested almost exclusively on its ability to influence and the "pulling power" of its products. This reliance on persuasion sits uneasily with the substantial investment of public money in NHSU
- *a lack of emphasis placed on responding to customers' wishes*: NHSU appears to have given relatively little weight to identifying what services its customers are interested in and would be prepared to buy, although some relevant work was undertaken on behalf of NHSU to inform its *Learning Needs Obervatory* report in 2004. The MORI survey commissioned by NHSU focused on attitudes to training rather than a harder-edged survey of the market. Only recently has NHSU developed a *Gateway* process through which SHAs can systematically influence the development of its provision from an early stage
- *a lack of recognition of the changing NHS system in NHSU's strategic planning*: the emergence of Foundation Trusts (FTs), with greater autonomy within the NHS, will test NHSU's power to influence still further. We have not found evidence that NHSU's strategic planning has taken this into account, nor recognised the need to link more closely with the newly emergent NHS regulatory bodies (including the FTs Regulator).

SUMMARY

1.6 We have been struck, in the course of our review, by the absence of simple, clear descriptions of NHSU's purpose and the parameters of its role. Therefore it is not surprising that we have been given different descriptions of the NHSU role from within the organisation and by stakeholders. We have spent some time setting the context, describing the relative lack of clear boundaries round NHSU's role and the organisation's ambitions because these are fundamental to an assessment of its progress -

- it has made it difficult for NHSU to focus on key early priorities, and equally difficult for it or its stakeholders to assess its progress and performance
- the lack of clear boundaries between NHSU's role and that of other organisations in health education and training has caused confusion and friction. This, in turn, has created a difficult climate for the establishment of strong and effective partnerships with stakeholders on which NHSU is crucially dependent.

- if the intention is for NHSU to have an "umbrella" role, there is a mismatch between these ambitions and the organisation's power to realise them. It has no power either to fund or direct. This therefore places massive (arguably unrealistic) emphasis on its ability to influence and persuade others.
- NHSU has under-played the importance of understanding its *customers'* wishes and obtaining their support from an early stage. Some effort has recently been made in this area but this is probably too little, too late given the need to change perceptions of NHSU which have developed over the past couple of years

THE PURSUIT OF UNIVERSITY TITLE

PROGRESS

2.1 Since NHSU was set up its priorities have been influenced by its efforts to acquire University title. Use of the title is tightly controlled and NHSU as currently envisaged neither conforms to the standard criteria nor has the necessary track record. It is now clear, from extensive exploration by NHSU, that neither of the two routes to a title is currently open to it –

- the Royal Charter route is not supported by DfES and any application would face the risk of credible legal challenge
- the alternative – obtaining title through primary legislation – would be contentious and unlikely to get a slot in the legislative programme.

2.2 NHSU has also explored a number of other possibilities, including affiliation to an existing University (which would, however, make it subject to another organisation) and, more recently, the possibility of becoming an independent chartered body rather than a University.

IMMEDIATE IMPACT OF QUEST FOR UNIVERSITY TITLE

2.3 NHSU's quest for University title has already had an impact on its development –

- it has created a perception that NHSU's prime aim is to be a provider of degree-level education, adding to the uncertainty about the organisation's role
- it has created suspicion that NHSU is "trying first and foremost to be a University, rather than getting on with the job", undermining its credibility with key stakeholders

THE CASE FOR UNIVERSITY TITLE

2.4 NHSU has argued that the 2001 Labour Manifesto carries a commitment for NHSU to seek University title. However, the manifesto wording ("we will set up a University of the NHS...") can also be read as a way of conveying the idea of a corporate university, rather than necessarily meaning University in its technical sense. The early papers produced by the DH Strategy Unit emphasised the corporate university model, although they also looked at the possibility of NHSU moving to become a formal grant-awarding body.

2.5 NHSU has always argued that there are good reasons for seeking University title. Its main arguments are that such title would –

- give it credibility in influencing and commissioning from the higher education sector
- enable it to attract high calibre academic staff
- symbolise and reinforce its position as an autonomous and challenging *critical friend* to the NHS.

2.6 The first two of these arguments carry some force, but there are a number of potential disadvantages of University title -

- as a University NHSU would be fully independent of DH and the NHS. It would set its own objectives and would not be tied to those envisaged by its creators. It is doubtful whether such a degree of independence would be compatible with its corporate role. It is worth noting that, as far as we know, no corporate university has acquired University title
- there is an inherent conflict between the role of a University - essentially a provider – and NHSU's intended strategic and commissioning roles. At best, intricate arrangements would be needed to ensure that conflicts of interest did not arise
- NHSU has assumed that, while it will seek funding from a range of sources, direct subsidy from DH will continue to form a significant revenue stream. It is questionable whether, as one University among many, an NHS *University* should receive such significant direct funding without market-testing
- the inevitable focus of a University is degree-level education and research. It is unclear whether, from the outset, this could be squared with the priority Ministers placed on NHSU's role in basic training for less skilled NHS staff groups. This became even more of an issue with the signing of the Memorandum of Understanding with Universities UK, which reduced the scope for NHSU involvement in degree-level training for health professionals
- The impact of the MoU was reinforced by a MORI poll of NHS learning needs commissioned by NHSU which indicated that by and large doctors and nurses consider themselves to be relatively well served already compared to other NHS staff groups.

2.7 It appears that, until recently, the impact of these factors – and the full implications of University title – were insufficiently understood.

SUMMARY

2.8 We believe that the disadvantages identified are significant. In our view NHSU's quest for University title –

- carries major strategic implications which have not been fully thought through
- has added to confusion over NHSU's role

- has been a distraction for NHSU; and
- the implications were, till recently, insufficiently understood by Ministers

DELIVERY AND VALUE FOR MONEY

3.1 We have assessed NHSU's performance and value for money using its own objectives for stage one of delivery of its strategic plan (up to March 2004) –

- to establish initial programmes to meet immediate NHS needs (taking particular account of the imperative to improve corporacy)
- to launch a range of learning services (taking account of the need to improve access, education and training for staff at the lower end of the skills escalator)
- to set up and test delivery operations and processes

INPUTS AND INVESTMENTS

3.2 NHSU's performance need to be measured against its inputs. The key figures are –

- a forecast staff complement of 412 by March 2005, including 46 interims / consultants
- a budget of £28m in 2003-04, and £44m in 2004-05 (with a budget bid of £73m for 2005-06).

DELIVERY OF INITIAL PROGRAMMES

3.3 NHSU has a portfolio of some 35 programmes at development, pilot or very early rollout stage. The majority fall into the categories of corporate training (e.g induction and material on customer care or statutory mandatory skills) and material aimed at staff / future staff at the lower end of the skills escalator (for example Foundation Degrees and Health Learning Works). A list of the programmes is attached (*Annex C*). In the view of SHAs and Trusts we have spoken to the content of material is generally of high quality but development times have been slow (material to support *Agenda for Change*, developed for NHSU by the MA, has been quoted as an example).

3.4 The portfolio of NHSU programmes is reasonably weighted towards corporate or generic training and initiatives aimed at staff at the lower end of the skills escalator and, as such, is in line with two of the original objectives. We believe there are two deficiencies in the NHSU approach -

- until recently, NHSU has not had a systematic approach to agreeing development priorities with DH and NHS stakeholders. Such an approach would reinforce the credibility and logic of NHSU's offer which some stakeholders consider is weak. Work on a systematic approach has only now been finalised. To date, most NHSU programmes have been commissioned directly by DH

- As a result, NHSU has done little to identify what its customers want and are prepared to pay for. A detailed market survey, including options around pricing, would have brought more robustness, earlier on, to NHSU's business planning.

3.5 NHSU forecasts that it will achieve 103,000 "learners" in 2004-05. However –

- some 30% (29,500) is accounted for by basic induction training; other course take-up numbers are almost all in the hundreds or low thousands
- The numbers are heavily end-loaded and, in some cases, assume a very rapid ramp-up of learners. Nevertheless, NHSU is confident that these will be achieved
- As agreed with DH for this year only, training is currently provided free of charge. This is not sustainable for the longer term and means that projected volumes are not grounded in what the market will bear
- There are no projections of forecast learner numbers for 2005-06

3.6 These uncertainties, coupled with the NHS perception of slow development time, are significant given NHSU's strategy of "focusing on providing training to give NHSU credibility to start acting as a change agent".

LAUNCHING A RANGE OF LEARNING SERVICES

3.7 NHSU is putting in place a number of initiatives to help improve access to education and training for NHS staff. These include -

- Ui: NHSU has put in place this information and guidance helpline / internet service for NHS staff. This is forecast to have over 13,000 contacts by March 2005
- a network of Local Learning Resource Centres (LLRCs) in NHS and social care organisations for delivering learning. NHSU forecast 400 of these by March 2005. This is on track
- programmes to help employers identify and meet training needs (eg. Skills for Life and Health) or for mutual support by staff groups (CHAINS – Contact, Help, Advise and Information Networks)
- work with other skills development bodies to ensure the adaptation of provision to suit health sector needs

3.8 This adds up to an ambitious set of initiatives to improve access. Our discussions with SHAs and Trusts indicate that their development has not been matched by sufficient work to explain or win their "ownership" by the NHS. There is a risk that, without such engagement, take-up of initiatives will be limited. There are particular concerns around the setting up of LLRCs, which SHA Workforce Directorates have had little involvement in and which they regard as part of the creation of networks which duplicate theirs.

3.9 Over the past 18 months, NHS has developed the concept of a "virtual campus", an e-hub for NHSU advice and some learning activities as well as administration and management functions. Procurement of the campus (at an estimated contract value of £20-50m over 5 years) had reached invitation to negotiate stage with two bidders, but has recently been terminated. The termination coincides with receipt of findings of an independent study into the virtual campus concept and procurement commissioned at the NHSU Chief Executive's request from Professor Keith Baker of Reading University. This stressed the need for improved stakeholder involvement, highlighted a lack of clarity of purpose of the campus and emphasised the need for better inter-operability with other systems eg. NPfIT. Clearly such steps should have been taken at or near the start of the procurement process.

3.10 There are a number of established providers of e-learning (including LearnDirect and the Open University) as well as e-based learner management systems. A number of those we have spoken to have expressed surprise that NHSU has tried to procure a bespoke solution rather than adapting an existing system, a number of which have already received a significant investment of public funds. We are unclear whether the option of adaptation was rigorously explored during the early stages of work on the virtual campus.

SETTING UP AND TESTING DELIVERY AND OPERATIONS PROCESSES

3.11 NHSU has work in hand to put in place a number of key business systems and processes to underpin its work.

3.12 It has set up a Learning Needs Observatory (LNO) to carry out an NHS-wide analysis of learning needs. The first LNO report has recently been completed. There is a strong case for an overview of NHS learning needs of this sort and as such the report has been welcomed by many in the service. Some SHAs consider that the report has insufficiently integrated local intelligence – in other words, what NHSU's customers believe is needed. It has also been developed primarily to inform the development of NHSU's offer, and only secondarily to serve the needs of all NHS commissioners and funders. Yet the latter role is a crucial one which could serve to enhance NHSU's credibility with the service.

3.13 A common concern voiced to us has been that, several years on, NHSU lacks a business model. NHSU has spelt out its wish to operate through a combination of DH subsidy, others sources of funding (e.g. from the Learning Skills Council) and through charging for NHSU-badged courses.

3.14 Until recently there was no clarity over who would pay for NHSU-badged courses or what the charges would be. Nor was it clear what extent NHSU was operating on a pure commercial basis, marketing its provision to employers, as opposed to reaching up-front agreement with SHAs on courses to be developed and these SHAs then ensuring their use. During the course of this review, for the first time NHSU and SHAs have together made significant progress towards the agreement of a business model under which:

- NHSU will propose education and training priorities
- SHAs will agree it (through a multi-stage *Gateway* process)
- NHSU will commission or develop it
- SHAs will then exert local influence to secure use and payment through consortia of SHAs

3.15 Progress on the business model is welcome if overdue. In particular, proposed costings have not yet been devised for the existing portfolio of NHSU courses or tested on customers. This means major uncertainty – and risks – for course volumes once charging begins in April 2005.

3.16 Given that the business model appears to rely on SHA agreement to secure local buy-in to NHSU-badged provision, and involve payment of NHSU by consortia of SHAs, it is unclear why NHSU should require such a large comms. and marketing function (a budgeted complement of 31).

3.17 NHSU has recognised the importance of portability of qualification and has started to develop a credit system to underpin portability of the programmes it offers. There would be advantages in the system being extended, over time, to cover a wider range of learning programmes used by NHS employers, and not just those developed by NHSU.

IMPROVING PROCUREMENT – THE ROLE OF ACADEMIC PARTNERS

3.18 Securing the portability of training is one way of improving the value that the NHS obtains. The centrepiece of NHSU's work to improve the offering from the education sector to the NHS has been its academic partner programme. NHSU has undertaken a procurement to secure a number of consortia of higher education providers (distributed so as to achieve national coverage), in order to -

- exert real influence with and co-operation from the higher education sector
- carry out joint development work on approaches to training
- work together to develop high quality material on quality standards.

3.19 The NHSU philosophy is that close relationships with a number of selected providers will lead to a better understanding of the needs of the NHS, a better focus by universities on the needs of their customers and therefore offer better value. The partnerships are fairly young and NHSU has indicated that it is "only just getting going on practical application". What is clear at this stage is that -

- both the higher education sector and the NHS are confused about the role of the partnerships
- the partnerships suggests a strong dependence on the role of influence as opposed to improving the robustness of procurement processes themselves
- it is unclear what, if anything, the partnerships have delivered to date

- crucially, the partnerships **cannot** (because of the way they were set up) be used as a shortlist for future procurements of education and training provision

SUMMARY

3.20 NHSU delivery of training programmes is the most easily measured part of its remit and one against which – as NHSU acknowledges – its early reputation will be built. While the quality of NHS output is acknowledged, its speed of response, rollout plans, lack of prices, and late development of a prioritisation system give cause for concern.

3.21 It would be wrong to measure NHSU purely against delivery of training products. On any interpretation, this is only one part of its remit. NHSU's significant expenditure is only justifiable against a much more ambitious remit – that of creating an infrastructure to improve access to education and training and that, of acting as a co-ordinating body in this sphere. Although it is clear that significant groundwork has been done we continue to have concerns -

- NHSU has been very late to start to address the need for a systematic relationship with its stakeholders, be they NHS purchasers or higher education providers (witness the uncertainty over the role of the academic partnerships) and has perhaps relied too much on the development of informal relationships
- linked with this, the infrastructure it has sought to put in place is poorly understood by stakeholders and much work will be needed if it is to be utilised as intended by NHSU
- there are real risks in NHSU proceeding with major infrastructure initiatives ahead of clarification of its role and fit within the education and training systems. Procurement of the virtual campus is a good example and we support its termination pending clarification of its purpose and greater stakeholder involvement. The use of or adaptation of existing infrastructure (eg. LearnDirect, OU) needs to be fully considered before bespoke systems are commissioned
- NHSU's expenditure of £72m in 2003-05 can only be justified as large-scale investment which will reap major dividends in the future. This creates a potential for embarrassment if questions are asked about the value for money of NHSU. The risks identified above mean that very rapid steps will need to be taken if the threat of embarrassment is not to be prolonged well into the future
- NHSU's approach has placed too little weight on establishing constructive relationships with and a close understanding of what its customers need and are prepared to pay for. Yet paying attention to this is crucial in the new NHS, where power and budgets have largely been devolved to the front line

- NHSU is delivering too little and too late to establish credibility in the eyes of the NHS. The loss of credibility it has suffered will make it much more difficult to achieve a turnaround.

RELATIONSHIPS WITH STAKEHOLDERS

5.1 NHSU's reliance on influencing and on delivering in partnership with others means that constructive stakeholder management is crucial. NHSU has made extensive efforts to obtain the views of a full range of stakeholders and develop partnership working throughout its period of development –

- its key developmental documents were all subject to wide-ranging consultation
- it is clear, from our discussions with NHSU, that significant senior management time has been invested in developing working relationships with key partners
- one of the roles of the NHSU regional structure is to build partnerships with the NHS at SHA and local level. There are signs that it is beginning to make a difference
- NHSU has developed a network of academic partners and engaged with organisations (eg. Learning Skills Council) involved in wider education and training provision

5.2 Despite this, NHSU stakeholders, in particular in the NHS but also in social care and the education sector, have voiced major concerns -

- about the quality of their relationships with NHSU. They consider that debate has frequently failed to shift from generalities to substance, that views have not been taken on board and that they have been left out of key decisions (for example SHAs with respect to recruitment of NHSU's Local Learning Co-ordinators). A stark illustration was the resignation last year of two NHS representatives on the stakeholder group for the virtual campus procurement on the grounds that key meetings had been cancelled at short notice and they had been left out of significant decisions. NHSU has acquired a reputation as an organisation that "does not listen"
- relationships have suffered from the widespread confusion about the role of the NHSU and suspicion at what are seen as its efforts to encroach on the functions of others. An example, already quoted, is the setting up of the NHSU regional structure and the role of SHA workforce directorates. The situation is exacerbated by NHSU's own positioning. NHSU describes this as being of the NHS but with autonomy. The perception is that in reality NHSU has insufficient meaningful links with the NHS and that its organisational culture and way of working mark it as separate
- the higher education sector is confused about the purpose of NHSU's academic partnerships and frustrated at the lack of action. In addition it is concerned about NHSU having a privileged position as both commissioner and provider
- social care providers do not understand the relevance to them of NHSU
- there is little evidence that NHSU has recognised the importance of the future roles of NHS regulatory and standard-setting bodies and built relationships with them

SUMMARY

5.3 These views – which have been put to us with great consistency by a large number of stakeholders – are seriously damaging NHSU's prospects. The overall sense is one of stakeholders who are alienated and disengaged. There is some (limited) optimism linked to early good work following appointments to the NHSU regional structure, but the overall view of the NHS and the education community is one of disappointment and growing scepticism over NHSU's purpose and performance.

5.4 This view will clearly affect NHSU's future influence and impact. Significant damage has been done to its standing with stakeholders. This will be very difficult to overcome, requiring very significant effort. This will need to be accompanied by a recognition that identifying *customers* and taking account of their views is crucial in an NHS where the old levers of "command and control" by and large no longer apply. NHSU will need to position itself as a genuine partner within the NHS rather than an autonomous critical friend.

NHSU ORGANISATION AND GOVERNANCE

STRUCTURE

4.1 NHSU is divided into 4 groups -

- Distributed Learning (access and stakeholder relations, total budgeted complement of 191)
- Learning Programmes and Services (training and education content development, budgeted complement of 102)
- Corporate Services (budgeted complement of 70)
- The CEs Group (strategy, resources, budgeted complement of 49)

4.2 A more detailed organisation and staffing chart is at *Annex D.*

4.3 Significant features of the organisation and resource distribution are -

- NHSU has a regional structure of 119 staff with a role of networking, contributing to local planning, developing an NHS trust *affiliate* network, and marketing NHSU products. SHAs feel strongly that an opportunity was missed with the setting up of the regional structure to achieve much closer collaboration between NHSU and SHA Workforce Directorates, for example through the sharing of functions and joint appointments. Although the regional structure is seen as starting to provide better information about NHSU's activities and a platform for better collaboration, the way it has been set up has undoubtedly complicated relations with the SHAs and produced some overlaps of functions. For example, both SHA Workforce Directorates and NHSU are talking directly – and often separately - to Trusts / PCTs about their learning needs and, in some cases, setting up separate stakeholder networks.
- a combined corporate function (made up of the corporate services and CEs groups) of 119 staff which, at nearly 30% of the total budgeted staffing, seems disproportionately large. We understand that this imbalance was explicitly raised as an issue by DH during early discussion of the 2004-05 NHSU business plan.

CULTURE AND STYLE

4.4 By its own admission as well as in others' opinion, NHSU has the culture and style of a *start-up* enterprise. At best this means a real vigour and enthusiasm for making an impact on education and training in the NHS. But it is also perceived by stakeholders as being stronger on vision than on structure and systems, making it harder for them to understand and relate to it. Stakeholders have told us that the frequent changes of structure and individual roles in NHSU (for example in the finance function) have hampered their efforts to establish effective working

relationships. Matters cannot have been made easier by the three relocations which NHSU has had to make since its inception.

4.5 Until recently, NHSU has been light on senior staff with significant senior NHS management experience. This may have contributed to the difficulties the NHS considers it has had in engaging with NHSU. Recent appointments of senior NHS managers to its regional structure should help overcome this.

GOVERNANCE AND DH OVERSIGHT

4.6 Arrangements for managing the relationship between NHSU as a Special Health Authority and DH follow established arrangements for oversight of ALBs.

4.7 At a senior level, the sponsorship of NHSU by DH has moved from the Strategy Unit (in 2001) to the HR directorate and now to the Director of Health and Social Care Delivery. This had made consistency of strategic directions setting by DH and oversight of follow through by DH harder to achieve and, overtime, has added to the uncertainties over NHSU purpose and fit.

4.8 Mechanisms to achieve strategic oversight and ownership jointly by the NHS and the Department and DH were under-developed in the period prior to the setting up of NSHU as an SHA. NHSU has now set up a new *Joint Strategy Committee* to provide such oversight. It has met once (July 2004) and it is too early to comment on its effectiveness.

4.9 The governance arrangements for NHSU are standard for an SHA. The non-executive Directors have indicated that they are comfortable with their role and supportive of NHSU direction of travel, albeit that the Board has only been constituted for some 6-7 months.

CONCLUSION

6.1 Overall, our assessment of NHSU's performance in its first years can be summarised as follows.

PROGRESS IN THE FIRST TWO YEARS

6.2 Much of NHSU's effort over the last two years has gone into laying foundations for future delivery – whether through the development of training provision or the setting up of infrastructure to improve access to training and influence over providers. Therefore the crucial questions are whether this investment has been appropriate and over what timescale is it likely to bear fruit.

6.3 We have reservations on both counts –

- our primary concern centres round the fact that NHSU's investment has not been preceded by sufficient clarification of purpose nor complemented by sufficient effort to set up the systems or stakeholder engagement that will ensure full utilisation and success
- some work is now underway to remedy this – in particular with respect to the selection of NHSU's priorities for training and development and a new business model. Both are late in the day.
- the absence of robust market surveys or prices for NHSU's provision means the real extent of take-up – once prices are available – is hard to judge
- significant and rapid further work will be needed to clarify the purpose of projects, and secure full stakeholder engagement if a return on the £72m investment up to March 2005 is to be realised
- at best, this return will take some time to materialise and NHSU will need to make real strides to overcome a reputation for over-promising and under-delivering. The damage that NHSU's reputation has already suffered means that radical change is likely to be needed if lost ground is to be regained
- in the meantime, DH is exposed to the risk of significant embarrassment if the value for money delivered by NHSU were to be probed.

GOVERNANCE

6.4 We have three observations -

- the successful development of the *Joint Strategy Committee* as a key mechanism for engagement with and oversight of NHSU by its DH and NHS stakeholders will be crucial

- NHSU needs to retain the best characteristics of its open "start-up" culture while concentrating on building a constructive and serious relationship with its many stakeholders, based on a systematic approach and clarity of purpose
- NHSU governance needs to focus on prioritisation of functions and value for money

UNIVERSITY TITLE

6.5 We believe that the pursuit of University title by NHSU has been a distraction to the organisation, and added to the confusion felt by stakeholders. We believe that a number of features of University title which are inconsistent or incompatible with NHSU's prime objectives have not been properly thought through. In our view these outweigh any possible advantages of University title and we recommend that the quest for this is abandoned.

ENGAGEMENT WITH STAKEHOLDERS

6.6 Despite NHSU's efforts, it has acquired a consistently poor reputation amongst stakeholders in the NHS, social care and education sector. Many stakeholders are alienated and close to "giving up" on NHSU. There are some signs that NHSU is starting to address this but serious harm has been done and this will be difficult to redress. Sustained effort will be needed if damaged relationships are to be repaired. At the heart of this should be a shift in NHSU culture and attitude to one which -

- recognises the importance of identifying and listening to customers in the new NHS
- places NHSU as a genuine partner within the NHS rather than an autonomous critical friend.

PORTFOLIO TO MATCH HEALTH CARE PRIORITIES

6.7 In terms of overall direction, NHSU's portfolio achieves a good fit with the intended focus on corporate/generic training and training for those at the lower end of the skills escalator. Continued interest in degree-level and medical education has caused confusion. We believe there is a need for explicit *prioritising* of particular staff and groups and areas of training, rather than an attempt to cover the field, and *a more rapid response to emerging needs.*

NHSU STRATEGIC PURPOSE

6.8 We have examined closely NHSU's strategic purpose and fit in the education and training system. We believe this is complex and insufficiently clear. The matter has been worsened by the quest for University title. We believe that this lack of

clarity of purpose has been a crucial factor over the last two years, producing a diffuse - and therefore less effective - drive towards delivery as well as complicating relationships with key stakeholders.

ANNEX A

NHSU REVIEW TERMS OF REFERENCE

The review of NHSU is being carried out against the following headings –

- has NHSU made sufficient overall progress in its first two years
- are its current proposals for its governance structure, business and financial model and strategic plan appropriate to deliver the objectives set for it
- in the context of the above, has NHSU developed an appropriate approach and timetable for the planned move to seek full University status and have all the implications of University status been properly explored
- has NHSU put in place arrangements to ensure proper engagement of its key stakeholders particularly the NHS
- has it defined a portfolio that matches NHS and Social Care priorities

ANNEX B

TIMELINE OF NHSU DEVELOPMENT

Spring '01	Labour Manifesto commits to setting up a "University of the NHS"
Oct. '01	PM announces decision to establish a "University for the NHS"
Autumn '01	Initial prospectus (*Everyone*) published
Nov. '01	Memorandum of Understanding between DH and Universities UK
Feb. '02	Prof. Bob Fryer takes up post as CE Designate
Nov. '02	Development plan (*Learning for Everyone*) published for consultation
(prior to 1/12/03)	NHSU hosted by the Prescription Pricing Authority while remaining formally part of DH, with funding provided by DH and budget held by the HR Directorate
1 Dec. '03	NHSU established as a Special Health Authority
11 Dec. '03	NHSU's "launch"; Board members announced; draft strategic plan (*Towards Delivery*) published
30 Jan. '04	Strategic plan signed off by the NHSU Board

LIST OF NHSU PROGRAMMES

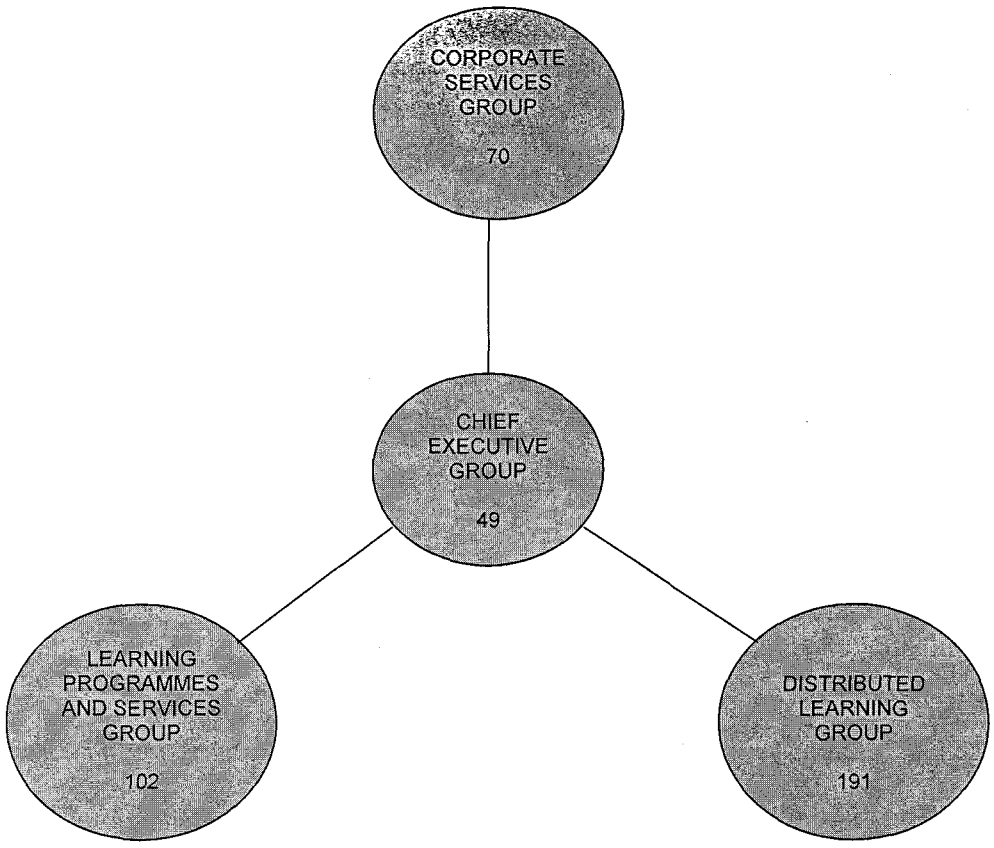
PROGRAMME TITLE

Advanced Comms. Cancer
Agenda for Change Appraisal Training
CHAIN
Child Protection
Cleaning Infection Control
Clinical Microsystems
Customer Care
Disability Awareness Training
Estates Upskilling
First Contact Care
Foundation Degrees
Health Learning Works
Hospital at Night
Infusion Devices
Introduction to today's NHS
Junior Scholarships
Learning Accounts
Managing Patient Complaints
MFE e-Elements
MFE Sub-modular Delivery
Modern Apprenticeships
Modernising Medical Careers
Pre-Operative Assessment
Prison Healthcare
Skills for Life and Health
Statutory Mandatory Skills
Team Dentistry Modules
Training for Assistant Practitioner
Tutor Orientation
UI Information Advice and Guidance
Ultraversity BA in Learning Technology Research
Working for the NHS

NB. With the integration of the NHS Leadership Centre into NHSU, the portfolio of existing Leadership Centre courses will become part of the NHSU offer

ANNEX D

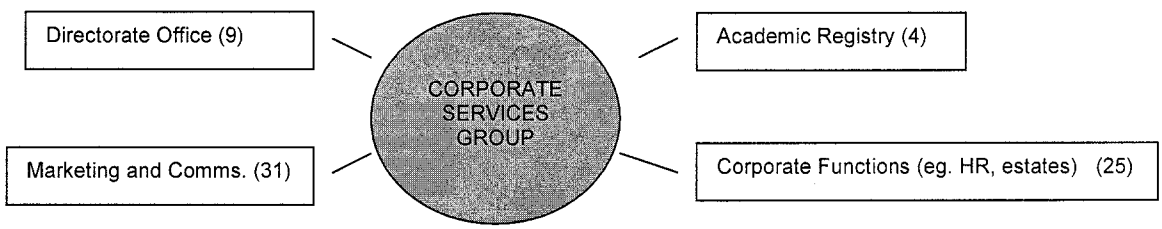
NHSU STRUCTURE AND BUDGETED COMPLEMENT

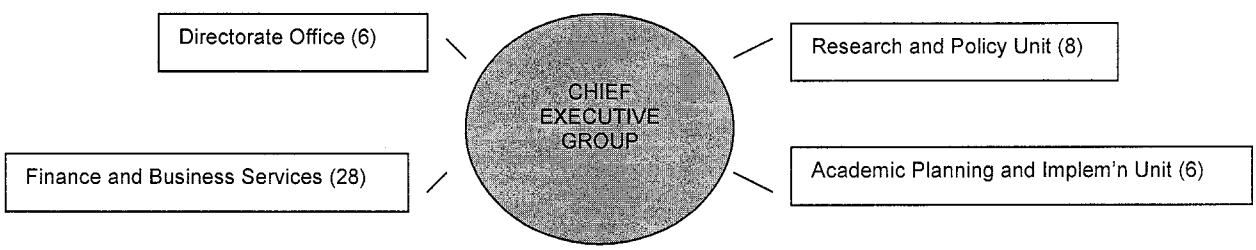


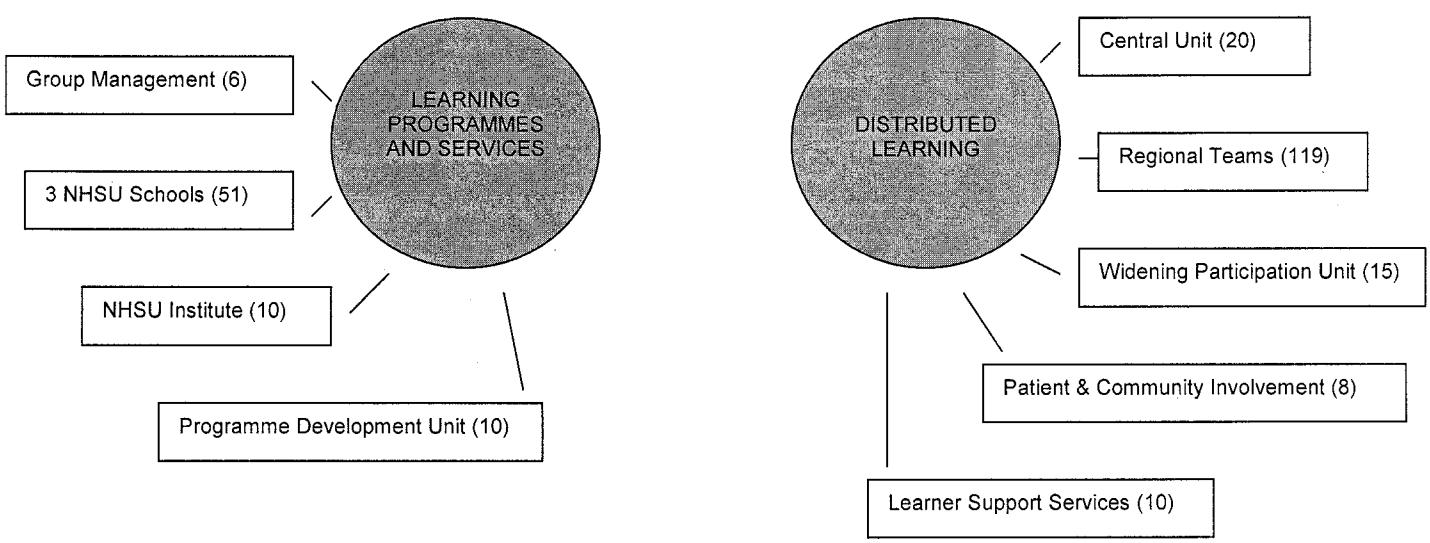
	Established posts	Interims / consultants	Total budgeted complement
CE Group	48	1	49
Corporate Services Group	69	1	70
Distributed Learning Group	172	19	191
Learning Programmes and Services Group	77	25	102
Total	**366**	**46**	**412**

NHSU STRUCTURE IN MORE DETAIL

(Note: staff numbers are established posts and exclude interims / consultants)







REVIEW OF NHSU

LOOKING FORWARD

A FOCUSED ROLE FOR NHSU IN THE WIDER HEALTH EDUCATION AND TRAINING SYSTEM

INTRODUCTION

1.1 The announcement of the setting up of a corporate university for the NHS took place in October 2001. The three main objectives were –

- *improving access to lifelong education and training,* in particular for the "non-professional" staff groups.
- *enforcing corporacy*, in other words helping unite the NHS round shared values (for example, customer care), and increasing the effectiveness of staff by improving their knowledge of the NHS system
- *improving value for money and quality from education and training procurement*: NHS expenditure on this currently runs at >£3bn. a year

1.2 The new organisation, which took the name NHSU, initially formed part of the Department of Health. In December 2003 it was established as a Special Health Authority.

1.3 Since it inception NHSU's priorities have been to –

- develop its strategic plan
- set up and test its delivery operations and processes
- establish an initial portfolio of learning products - a range of some 35 programmes is in development or at pilot stage
- launch a range of learning services to improve access to training and education for NHS staff
- identify the most appropriate route to obtaining University title (which would give it degree-awarding powers)

1.4 Since NHSU was announced a number of significant and relevant changes have taken place in the NHS and the education sector. These include –

- greater devolution of power and resources to the frontline
- the emergence of greater plurality of provision, including Foundation Trusts and independent sector providers alongside conventional Trusts
- a growing role for independent regulators (for example the Healthcare Commission) and standard-setting bodies
- the emergence of Skills for Health and SHA Workforce Directorates in the health education and training sector
- the recent Arms Length Bodies Review conducted by DH
- ongoing changes to the structure of higher and further education

1.5 The original vision behind the setting up of NHSU remains firmly in place. But the time is now right to review NHSU's objectives, ways of working and relationships

with other organisations in the health education and training field. The purpose of this report is to carry out a review and to make proposals for the way forward.

HEALTH EDUCATION AND TRAINING: WHAT ARE THE NEEDS?

2.1 To help us reach views about the future of NHSU we have looked at the health and social care education and training system and, even more widely, the future course of development of the NHS and social care system. We have considered –

- what are the gaps to be filled – in other words functions not currently being carried out, or which need to be reinforced?
- how do these relate to the current roles of NHSU and other organisations in the education / training sector. In other words, what synergies might there be?
- based on this, what role might NHSU play in future

FACTORS WHICH HAVE DRIVEN THE ANALYSIS

2.2 The drivers which gave rise to the concept of an NHSU in late 2000 / early 2001 were the need to –

- *reinforce NHS corporacy*
- *improve vfm from education and training procurement*
- *improve access to education and training, especially for staff groups at the lower end of the skills escalator*

2.3 These remain DH objectives.

2.4 However, there are other drivers. Since 2001 a much clearer picture has emerged of the longer-term direction of travel of the NHS –

- the *shifting the balance of power* process has moved forward, with the increasing devolution of budgets, the establishment of the principle that *the centre should do what only the centre can do* and the evolution of SHAs into their role as the local HQ of the NHS
- the shift to greater plurality of provision, with NHS Trusts moving to Foundation Trust status and a greater role for independent sector providers, complemented by a growing role for independent Regulators (in particular the Healthcare Commission and the FTs Regulator)

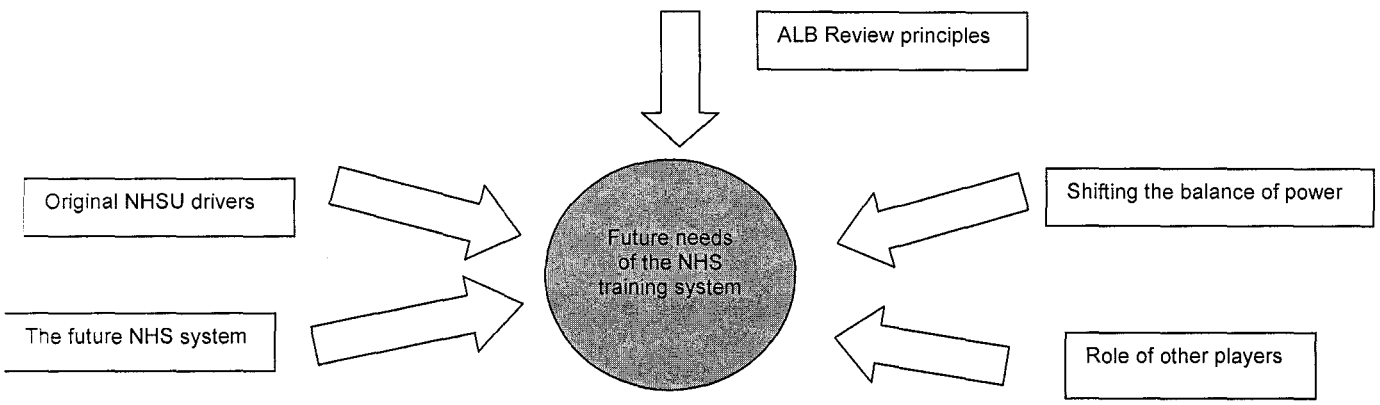
2.5 Any future NHS and social care education and training system will need to be robust against this direction of travel.

2.6 Any analysis also needs to take account of the role of other organisations which have emerged onto the scene or whose role has developed since the conception of NHSU. The emerging role of Skills for Health (established in April

2002 and licensed as the health Sector Skills Council in July 2004), the new role of the NHS Modernisation Agency and the reconfiguration arising out of the Arms Length Bodies (ALB) Review, including a fundamental reshaping of NHS procurement, are relevant.

2.7 Finally, the analysis needs to take account of the five principles behind the ALB Review – devolution, closer working between health and social care, appropriate impact for minimal burden, public sector efficiency, and relocation.

2.8 These different drivers are set out below.



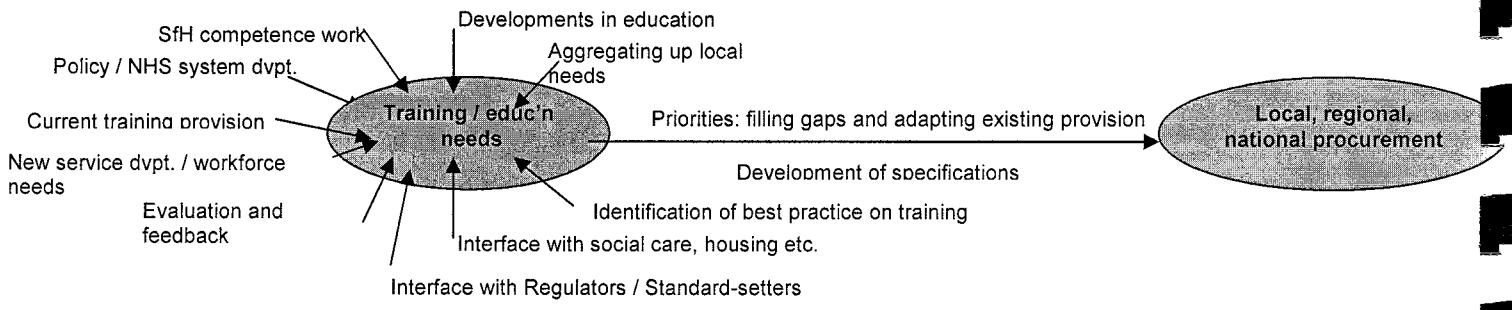
ANALYSIS OF SYSTEM NEEDS

2.9 We have identified the following key needs –

- a national capability to develop and maintain an overview of NHS education and training needs which is owned by DH and the NHS and includes robust outcome / feedback measures. Such an overview would inform and help ensure consistency in local training strategies and procurement decisions. NHSU's *Learning Needs Observatory* provides a helpful model which, with development, could deliver such an overview for the NHS. As a Sector Skills Council, Skills for Health has a closely related remit to identify health sector skills needs. We believe that there is a continuing, complementary need for an *NHS-wide* overview, linking closely with Skills for Health's work (and with clear boundaries between the functions), which takes account of corporate issues and policy, and then enables NHS bodies to set training priorities in a consistent way
- developing specifications for education and training provision in a way which meets the needs of SHAs, Trusts and NHS regulatory and standard-setting bodies (eg. the Healthcare Commission, the FTs Regulator and the National Patient Safety Agency). Such specifications would take into account the needs identified, the key areas of content to be covered, the preferred delivery mechanisms (for example the need for training to be predominantly work-based) and measures of effectiveness, linked to the competence frameworks developed by Skills for Health. They would provide SHAs, Trusts and others who procure training with a key, expert

service to help them obtain more relevant and cost-effective training provision

These needs can be illustrated as follows.

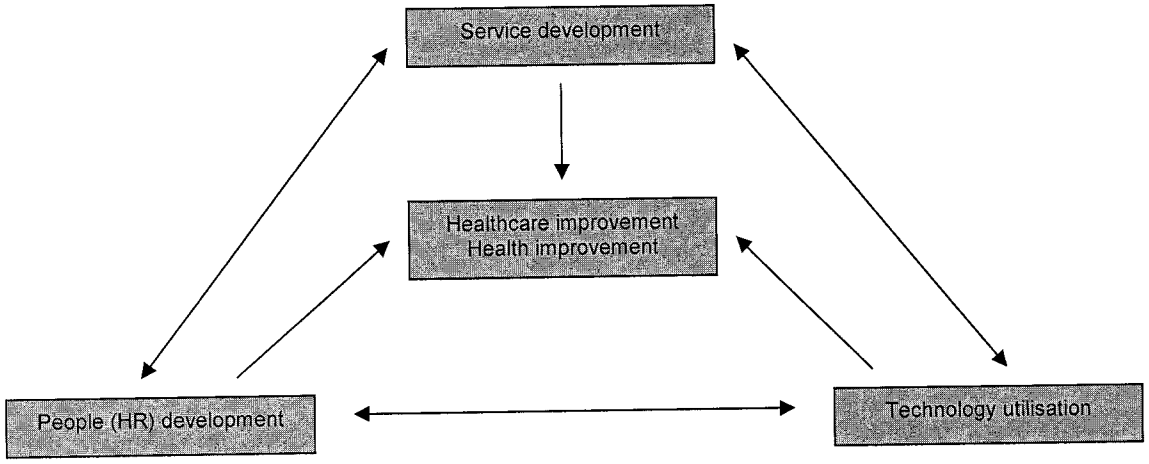


- sustaining and building capability to improve opportunities for lifelong learning / career development with a focus on staff at the lower end of the skills escalator. This would include building on existing provision and infrastructure (for example the Open University and LearnDirect). It would also involve ensuring that cross-sectoral strategies aimed at offering educational opportunities for less skilled staff groups (eg. Foundation Degrees) take account of or can be adapted for health sector use and promoting access to such opportunities for NHS staff. NHSU has undertaken the development of a number of initiatives to improve access to learning and these can be built on
- building capability to secure NHS leadership / corporate development – building on the work of the NHS Leadership Centre and enhancing NHSU's early work on eg. an NHS-wide induction programme
- ensuring portability of training through a "pre-qualification" process involving a national agreement by providers to reciprocity of credits / qualifications. A major issue for NHS employers is the current limited portability of training / qualifications other than professional qualifications already governed by explicit accreditation arrangements. Staff members who complete training in, say, risk assessment in one part of the country may find themselves repeating the training when they transfer to a similar post with different employers. NHSU has started work to achieve better portability of training and we believe there is a key continuing national role to facilitate such portability through the procurement function.
- a strong, professional and "intelligent" procurement function, with the capability to procure at local (Trust / PCT), regional and national level, with clear principles governing what is procured at which level, to improve the vfm and quality achieved for the >£3billion NHS investment in education and training

2.10 Looking more widely, tomorrow's NHS needs a capability to anticipate and respond rapidly to change in three key areas –

- people (HR) development
- service development
- technology utilisation

2.11 The three are closely linked. Developments in technology drive new ways of providing healthcare. Both can lead to the development of new skills and workforce roles. In turn, both often depend on a suitably trained workforce if they are to be fully exploited for the benefit of patients. This inter-dependency is illustrated below.



THE WAY FORWARD

3.1 We believe there is now an excellent opportunity to create a revised set of arrangements which capitalise on these inter-dependencies and help address the NHS' needs round education and training.

3.2 We believe this calls for a reconfiguration of roles and organisations. The health and education training system is crowded with a large number of organisations (the chart at *Annex A* maps these and sets out their main roles). However, we are not convinced that the needs identified above fall naturally within the brief of any existing organisation. NHSU is already involved in a number of such roles. However, our assessment is that NHSU needs clarification of its brief and some restructuring if it is to be truly effective. We therefore propose -

A NEW NHS INSTITUTE OF HEALTHCARE INNOVATION AND EDUCATION [1]

3.3 The new Institute of Healthcare Innovation and Education will combine expertise in three key areas -

- ***people development***
- ***service development***
- ***technology utilisation***

3.4 It will offer a central resource to boost the change capability, efficiency and effectiveness of other NHS organisations by –

- identifying national and international best practice in service development and piloting ways of embedding this in the NHS and in healthcare sector organisations working closely with it
- ensuring the lever of technological innovation is fully exploited to drive service development and increased quality and productivity
- drawing up analyses of education and training needs and priorities, specifications to assist in procurement, and arrangements to improve the portability of and access to training

3.5 The Institute will need to develop the capability to anticipate and respond to change nimbly and in an integrated way. The intelligence and expertise of the Institute will inform the work of -

[1] The title will need further discussion, including the appropriateness of use of the reserved term "Institute"

A NATIONAL PURCHASING UNIT

3.6 This unit will strengthen education and training procurement through –

- providing a national source of expertise for regional / local buyers to draw on. It will build on work to develop a model contract, including arrangements for auditing the impact of training on service quality
- procuring training which it makes sense to buy nationally (an example is the induction training which NHSU has developed)

3.7 Work is under way as part of the Arms Length Body review to restructure the NHS Purchasing and Supply Agency (PASA) and increase its ability to offer purchasing expertise across a wide range of health procurement. The new unit should be based in the restructured PASA. It will in turn enable and strengthen the capability of -

REGIONAL PURCHASING NETWORKS

3.8 The majority of procurement of education and training will continue to be undertaken at local level – either by SHAs or by individual employers (Trusts or PCTs), depending on the ideal critical mass required for effective procurement. The procurement function in SHAs should be reinforced, making it a more effective purchaser of education and training on behalf of the local health economy and, where appropriate, acting in consortia of SHAs to achieve economies of scale.

THE NEW NHS INSTITUTE OF HEALTHCARE INNOVATION AND EDUCATION IN MORE DETAIL

4.1 The new Institute will cover and enhance elements of the current roles of NHSU, the MA and the NHS Leadership Centre and should combine the best of all three organisations. This will include the academic links of NHSU, the credibility and influence of the MA and the track record of delivering training of the NHS Leadership Centre.

4.2 The Institute will span service development, technology utilisation and people development. We have deliberately not focused on service development and technology utilisation here. This does not imply that they are any less important. The Insititute's roles in these areas should be developed in detail as part of the next stage of work.

4.3 The Institute's education and training remit should be as follows.

KEY FUNCTIONS

4.4 The Institute will offer expertise to the NHS in identifiying needs, prioritising, specifying, and improving access to education and training. It will -

- work closely with Skills for Health in order to develop and maintain a responsive overview of NHS education and training needs and priorities, drawing on policy and system changes, national and international best practice, technological change and service developments, wider developments in education, and outcome evaluation
- develop specifications for the education and training to be procured (covering contentand a basis for portability of credits and qualifications)
- strengthen access to education and training, in particular in the workplace, making full use of existing national resources (eg. OU, LearnDirect), linking with other organisations (eg. NPfIT on e-information), and promoting an appropriate balance of work-based learning, e-learning and other approaches
- help drive a change in the culture of NHS education and training towards developing tomorrow's skills and developing the *whole* workforce

4.5 It will not be a University nor, indeed, a provider except where, exceptionally, suitable provision cannot be secured from third parties

PRIORITY AREAS / STAFF GROUPS

4.6 The Institute will focus on three core areas –

- skills development for staff at the lower end of the skills escalator, helping deliver the vision set out in *Working Together, Learning Together* (DH, November 2001). It will build on existing platforms to improve access to training, in particular in the workplace
- corporate / generic training. This will encompass induction training for all new NHS staff and development of generic skills across all staff groups (for example customer care, risk assessment, understanding of NHS systems reform, as well as other aspects of modernisation)
- leadership and management development. The NHS Leadership Centre (already being integrated with NHSU) should be integrated in the new organisation and its functions maintained and enhanced

4.7 The Institute's role will *not* extend to pre-registration medical or nurse training, where arrangements are well established, except where there is a link with generic or corporate training.

4.8 The Institute will not cover education and training of the social care workforce, where the Training Organisation for Personal Social Services (TOPSS) is developing a wide-ranging remit in conjunction with employers and other stakeholders. However, it will need to work with TOPSS to ensure that issues of shared interest are identified and included in their respective plans.

BUSINESS MODEL

4.9 In its initial phase the Institute should continue to be funded through central allocations. However, its areas of core expertise should be of interest to the range of providers and other employers in the NHS of the future. Provided the new organisation develops a good reputation it should have the potential to move from a funded to a mixed self-sustaining / funded basis over time by offering key services to two key sets of customers –

DH, as the national HQ of the NHS

- the development and, where appropriate, provision of training which it makes sense to procure nationally (for example induction courses or general management training
- expertise in service development or new technologies which are of national interest and which can, for example, help deliver policy development / system change

Health sector employers or regional NHS consortia

- leadership and management development
- expertise in the application of best practice in service development and technology utilisation
- consultancy in identifying training needs and developing plans to satisfy them

4.10 There may also be scope for the Institute to offer services to the devolved administrations, building on NHSU's contacts.

KEY RELATIONSHIPS

4.11 We have shown that the health education and training system is crowded with a large number of organisations. The new Institute will quickly need to establish strong and clear relationships with a wide range of stakeholders. The principal relationships will be with –

- DH and SHAs (on behalf of the wider NHS), respectively the national and local headquarters of the NHS, and who will play a key role in steering the Institute's agenda. This role needs to be reflected in the governance arrangements for the Institute
- Skills for Health (SfH). There will be a number of interfaces. SfH's work on competence sets will need to take account of the new workforce roles developed by the Institute's service development function (as it currently does with the MA's Changing Workforce Programme). In turn, the Institute will build on SfH's work on competency development and identification of sector-wide learning needs and ensure that new competence sets are reflected in the specifications it draws up. The need to work together across a number of dimensions must be reflected in both formal and informal co-operative arrangements
- the new National Purchasing Unit, which will be an integral part of the restructured PASA). The Unit will need to have an appropriate blend of commercial procurement expertise (which should be available from PASA, its parent body) and in-depth knowledge of the health education and training field, which might be achieved by fixed period secondments of staff from the Institute. The Purchasing Unit and the Institute will work closely together, for example on the testing of purchasing specifications, so that these both reflect emerging needs and are a suitable basis for robust procurement
- the NHS regulatory and standard-setting bodies, including the Healthcare Commission, the FTs Regulator, NICE, and the NPSA, who will have an increasing influence on the environment in which NHS employers operate

STAFFING AND EXPERTISE

4.12 The Institute will need to bring together –

- expertise of healthcare delivery and the NHS (including HR, service development and technology utilisation expertise)
- knowledge of the education sector
- a strong management consultancy capability

4.13 Its staffing will need to reflect this combination and its structure will need to blend these competences to derive maximum value from them.

4.14 These competences should be underpinned by a focused research capability, for example to enable the Institute to research the impact of new developments, or best practice in work-based learning, both nationally and internationally. This capability might be enhanced through a partnership with a leading established University. Such a partnership would also help the Institute recruit and develop a high quality workforce.

4.15 NHSU has selected Warwick University to be its principal academic partner and is developing plans to relocate to the Warwick campus. Our recommendations on the way forward mean that the detail of these must be revisited. However, there would be value in exploring the scope for reshaping the partnership with Warwick in a way which meets the needs of the Institute.

MAKING IT HAPPEN

5.1 Our recommendations will require a major reshaping of NHSU into the following organisations –

- the Institute, created by taking the best from the MA and the NHSU (with the Leadership Centre). We envisage that the combined organisation will be significantly smaller than the sum of its parts
- the National Purchasing Unit (to be integrated with PASA), which will include NHSU staff seconded into it
- the Regional Purchasing Networks will include staff from NHSU and from the procurement function within SHA Workforce Directorates. We envisage that the Networks will be smaller than the sum of their parts
- these changes will be accompanied by a deliberate shift in culture to one focused on delivering services in response to the agendas of DH and SHAs (on behalf of the NHS), and for which there is explicit demand
- a review of available skills and competences will also be needed to ensure they match the new remit

5.2 Achieving this change in a way which minimises disruption of delivery and impact on existing staff will be demanding. Success will depend on a number of crucial preconditions being met -

- the way forward needs to have explicit, senior-level commitment from DH and the NHS and, if possible, support from other stakeholders. The discussions we have held in the course of this review give us confidence that this can be achieved. We have informally tested our views on a small number of stakeholders but this now needs to be built on
- strong leadership will be needed to reshape NHSU, chart a course towards a merger with the MA and regain the confidence of the stakeholders
- DH will need to support this with well-resourced and senior oversight, ensuring a continued fit with central developments, including the implementation of the ALB Review
- a review of governance arrangements. These will need to reflect the position of the new organisation as a key corporate resource, serving DH and SHAs (and, through them, the wider NHS) as well as the proposed move, over time, to a self-sustaining organisation.

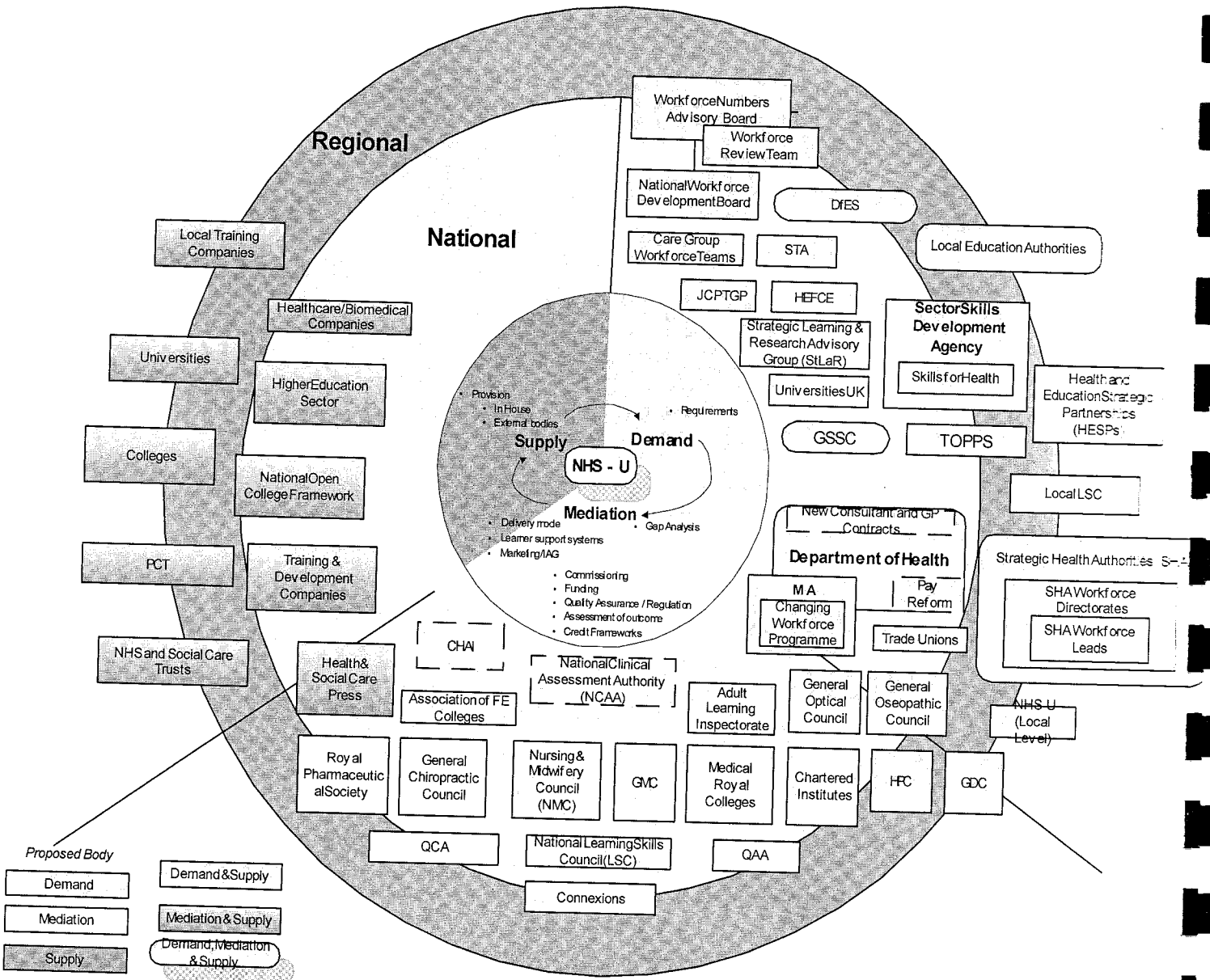
5.3 A review of the branding of the new organisation will also be needed. This should clearly signal a new direction as well as the links between the new organisation and its predecessors. One approach might be to adopt an over-arching brand name with sub-titles (for example *NHS Institute of Healthcare Innovation and Education, incorporating NHSU and the MA*)

TIMETABLE

6.1 We believe rapid action is needed to end uncertainty over the future of NHSU and to start the process of rebuilding confidence. Proposed key next steps are -

Step	Timing
Seek Ministers' agreement	Early September
Publish key recommendations for views from stakeholders	Mid-September
Next steps reviewed in light of views received	Mid-October
Implementation begins	November

HEALTH AND SOCIAL CARE EDUCATION AND TRAINING: THE PLAYERS



LIST OF THOSE CONSULTED AND VIEWS RECEIVED

NHSU

Jeffrey Defries	Director, Corporate Services
Non-executive Directors	Board non-execs.
Sue Eggleton	Director, Planning & Resources
Ed Ellis	Head, Academic Planning and Implementation Unit
Prof. Bob Fryer	Chief Executive
Derek Grover	Director, Distributed Learning
Richard Hill	Head of Research and Policy Unit
Neil Johnson	Director, Learning Programmes
Julie Kilgour	Regional Lead, North-East England
Prof. Dianne Willcocks	Chairman, Academic Advisory Board

DEPARTMENT OF HEALTH

John Bacon	Group Director of Health and Social Care Delivery
Kate Barnard	Director of Development
Ruth Carnall	Director, Change Programme
Prof. Paul Corrigan	SofS Special Adviser
Sir Nigel Crisp	Permanent Secretary and NHS Chief Executive
Prof. Sally Davies	Director of R&D
Prof. Sir Liam Donaldson	Chief Medical Officer
Helen Fields	Former Head of Access to Initial Qualifications and Pre-Registration Education, HR Directorate
Andrew Foster	Director of HR
Prof. Chris Ham	Former Head, Strategy Unit
Dimitrios Hatzis	Commercial Directorate
Jane Hare	Head of Forward Planning, Delivery Group
John Hutton	Minister of State for Health
Prof. Maggie Pearson	Former Deputy Director, HR Directorate
Martin Staniforth	Deputy Director, HR Directorate
Lord Warner	Parliamentary Under Secretary of State for Health (Lords)

DH ARMS LENGTH BODIES

David Fillingham	former Director, NHS Modernisation Agency
Penny Humphris	Director, NHS Leadership Centre
Sue Osborne	Joint Chief Executive, National Patient Safety Agency (NPSA)
Dame Denise Platt	Chair, Commission for Social Care Inspection (CSCI)

cont.

NHS

Jane Barrie	Chairman, Dorset and Somerset SHA
Annie Brough	NHSU lead, London SHA workforce directorates
Prof. Tony Butterworth	NHSU lead, Midlands SHA workforce directorates
Prof. Bernard Crump	Chief Executive, Shropshire and Staffordshire SHA
Julie Dent	Chief Executive, South West London SHA
Mariella Dexter	NHSU lead, southern SHA workforce directorates
Sarah Goodson	Education Adviser, Hampshire and Isle of Wight SHA workforce directorate
Nic Greenfield	Workforce Director, North Central London SHA
Ken Jarrold	Chief Executive, County Durham & Tees SHA
Kate Lampard	Chairman, Kent and Medway SHA
Judy Leverton	Chairman, South West Peninsula SHA
Anthea Millett	Chairman, Avon, Gloucestershire and Wiltshire SHA
Caro Millington	Chairman, North West London SHA
Prof. Elaine Murphy	Chairman, North East London SHA
David Nicholson	Chief Executive, Birmingham and Black Country SHA
Kathryn Riddle	Chairman, South Yorkshire SHA
Arthur Sandford	Chairman, Trent SHA
Marcia Saunders	Chairman, North Central London SHA
Derek Smith	Chief Executive, Hammersmith Hospitals NHS Trust
Linda Smith	Chairman, South East London SHA
Prof. Hilary Thomas	Medical Director, Royal County Hospital, Guildford
Sir Richard Tilt	Chairman, Leicester, Northampton and Rutland SHA
Stuart Welling	Chief Executive, Brighton Healthcare NHS Trust

EDUCATION SECTOR

Prof. Keith Baker	University of Reading
Prof. Celia Davies	Professor of Healthcare, Open University
Prof. Janet Finch	Vice-Chancellor, Keele University
Prof. Linda Jones	Pro Vice-Chancellor, Open University
Alison Kitson	UK Health Education Partnership
Sir Alan Langlands	Vice-Chancellor, Dundee University
Dr Ann Limb	Chief Executive, LearnDirect (Ufl)
Sir Howard Newby	Chief Executive, Higher Education Funding Council for England (HEFCE)
Keith Palmer	Dep. Chairman, IVIMEDS
John Rogers	Chief Executive, Skills for Health
Prof. Sir Ron de Witt	Chair, Skills for Health
Anne Wright, Andrew Bidewell	DfES

OTHER

Prof Carol Black	President, Royal College of Physicians
Prof. Julian Le Grand	PM Health Adviser
David Knowles	Head of Leadership Programmes, The King's Fund
Dr. Beverly Malone	General Secretary, Royal College of Nursing
Jenny Simpson	Chief Executive, British Association of Medical Managers
Simon Stevens	Former PM Health Adviser
Stephen Thornton	Chief Executive, The Health Foundation