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THE ENHANCEMENT OF QUALITY IN H.E.

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FOR INFORMATION

The enhancement of quality in Higher Education - Implications for health care education and training

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Introduction

This paper seeks to inform the current debate on enhancement and quality assurance with particular reference to the pre- and post-registration education and training of health professionals. It takes account of government priorities to promote new ways of working and the emergence of the NHS University. At the time of writing, new proposals for the external quality assurance of HEFCE funded programmes in Higher Education (HE) are under consideration (1) and separate and quite different arrangements are about to be piloted for NHS funded courses. The Learning and Teaching Support Network has, in response to advice from Universities UK (UUK) and the Standing Committee of Principals, commenced a debate on what is meant by enhancement and how this relates to quality assurance and accountability (2). This paper explores quality enhancement in a health context where the debate will have particular significance for funding bodies, professional bodies, statutory regulatory bodies, students, employers and patients.

Enhancement and the education and training of health professionals

Defining enhancement for the health disciplines is not difficult although achieving it is much more problematic. Enhancement can be considered to be the process by which changes to the education and training of healthcare professionals that better prepare them for professional practice, and enable them to work more effectively to achieve better patient care, are implemented. There are many external drivers that have been used to influence health curricula to bring about enhancement and these are briefly described in this paper. Enhancement simultaneously encompasses fitness for practice, fitness for academic award and fitness for purpose.

The commissioning of health care education and training and the implications for quality and enhancement

Over the past decade there has been a transfer of the hospital-based education and training of many healthcare professionals into HE, a process that has changed the shape of the HE sector. Furthermore, the funding requirements have involved the negotiation of contracts between the NHS and preferred HE Institutions. The arrangements for negotiating these contracts have changed significantly over the past decade and have recently been considered by the National Audit Office (3). In the mid 1990s, there was a very strong emphasis on applying the discipline of the market economy to the commissioning of NHS funded HE. This had its origins in a White Paper, Working for Patients, Education and Training (4), and resulted in a clear separation of the purchaser (the NHS) and providers (HE). An Executive Letter from the NHS Executive (5) specified new arrangements for the commissioning of education and training. The newly established Education and Training Consortia had responsibility for the quality of education and training including "fitness for purpose". A major limitation was, however, the restriction of their remit to only cover disciplines funded through the Non-Medical Education and Training levy.

The political climate at this time created a high level of competitiveness amongst HE providers. Contracts were lost and transferred to other education providers. Where contracts existed, they were

often short term and frequently less than three years. The good networks that had existed amongst the Principals of the former hospital based Schools were threatened as now they were under pressure to maintain a competitive edge over each other. Where good practice had once been disseminated, there was now a reluctance to do so. Although definitions of quality were far from clear, and purchaser and provider perceptions often different, there was an emphasis on delivering it because it was primarily quality issues, along with price, that would provide the NHS with evidence to support termination of contracts.

There was at this time a misguided view that the NHS could achieve better quality, and reduce costs, through this competitive environment that failed to take account of the advantages that collaboration might bring. Sharing good practice was frustrated as cross-talk between HE institutions was viewed as working against the market economy that had been established. In some cases, confidentiality clauses were written into contracts but these were primarily in relation to price. Institutions were unable to play to their strengths and sought to develop areas where neighbouring institutions were stronger and a collaborative approach would have been healthy. There were limited opportunities for institutions with a restricted portfolio of health care disciplines to develop interprofessional education and training which was also a key government priority.

The weaknesses in the arrangements introduced in the mid 1990s were identified and the NHS and the Committee of Vice Chancellors and Principals (now UUK) agreed a partnership statement (6) that identified the need for long-term relationships, working together in partnership, the dissemination of good practice but also recognising the need for performance monitoring. The emphasis on partnership working was further emphasised by proposals in a Department of Health Consultation document, now being implemented, for further changes to the arrangements for the commissioning of education and training (7). These included the replacement of the Education and Training Consortia by Workforce Development Confederations which would include HE as members (7). It is hoped that the new arrangements will improve multiprofessional workforce planning, improve education and training, and deliver the workforce necessary to deliver the objectives of the Government's NHS Plan (8) including integrated and seamless care.

Definitions of quality have been controversial during this time with there often being unnecessarily tensions amongst developing competence at the point of first registration, academic capability, research capacity, and the ability to work in a multiprofessional team. Quality measures have also, for the purpose of contracting, taken account of price, ability to recruit to target, and attrition. However, there has never been any doubt that the NHS has sought to use quality in a positive way as a means to achieving enhancement even if the measures and the techniques used may have at times been open to question. So enhancement could have been demonstrated as improving competence at the point of registration, reducing the costs of education and training, reducing attrition depending on the perspective of the observer.

The drive for inter-professional education and training and enhancement

From the early days of the transfer of hospital based schools of healthcare into HE there has been pressure placed by commissioners of education and training to promote and encourage the development of interprofessional education and training at pre- and post-basic levels (9). In 1996, consortia were being encouraged to develop strategic plans for education and training that would facilitate developments in the multiprofessional team delivery of health care (10). Consortia were also aware of the need for further work to improve collaborative team-working and mutual understanding of roles, responsibilities and expertise amongst health professionals (10). All of this has gained even more significance with the publication of key policy documents by the Labour government. The NHS Plan stated that radical reform of NHS education and training was necessary to deliver its objectives of placing the patient at the centre of care (8). It emphasised interprofesisonal education through joint training across professions, a common foundation programme and a core curriculum for NHS staff (8). Strategies for nursing, midwifery and health visiting (11), allied health professionals (12) and healthcare scientists (13) along with the UKCC

Commission for Education and Training (14) have all placed emphasis on interprofessional education and training being used to support new ways of working. There is an assumption that exposure to shared teaching and learning will lead to better qualified professionals graduating from programmes, and that enhancement will have occurred.

It has been pointed out that the policy pressure to implement interpriofessional education and training is not supported by a strong evidence base to demonstrate that it will lead to better team working (9). Finch (15) has stressed the need for clarity about the purposes of interprofessional education pointing out that it might help professionals know about each others roles, promote team working, facilitate role substitution, and allow flexibility with career pathways. Nonetheless, despite the lack of a strong evidence base to show that enhancement will be the outcome, there continues to be the highest policy imperative to implement interprofessional education and training.

Changing curricula and enhancement

The NHS has little difficulty through policy documents defining what it means by enhancement. The White Paper, The New NHS Modern and Dependable (4) sought to put the needs of patients first ensuring that they received an integrated system of care and were not passed amongst different agencies and health and social care professionals. The policy documents referred to above identify that these ambitions are dependent on having an adequately skilled workforce in sufficient numbers. There is an emphasis on new ways of working and on changed roles and that education and training will underpin this.

There has been great haste to implement curricular change for all NHS funded provision to meet the new strategic objectives. Following publication of the nursing strategy (11) HE institutions, in partnership with NHS Workforce Development Confederations, were invited to bid for pilot site status and funding to implement the new model of pre-registration nurse education. Weaknesses in the existing arrangements of nurse education were identified as including insufficient emphasis on practical skills and a system that was insufficiently responsive to the needs of the NHS (11). The invitation to bid for pilot site status required HE to demonstrate refocusing of nurse education programmes to take account of the Government's objectives. There is it seems, amongst the policy makers, no doubt that these changes to the pre-registration nursing curricula within HE will lead to an better prepared workforce and, by definition, enhancement. Parallel changes are taking place for the Allied Health Professions and are in hand for the Healthcare Scientists. Further emphasis to the policy imperatives to drive change come from the soon-to-be established NHS University which aspires to ensure better qualified staff through real learning based on clinical practice, not theory, and which also seeks to provide a core curriculum and act as a signpost to existing training.

Regulatory Changes and Enhancement

The Government believes that improved care will only be achieved by breaking down the "old-fashioned" demarcations that exist between staff (8). The need for changes to the regulatory arrangements for the health professions is identified in key policy documents (7, 11) and new regulatory bodies for health professionals are being put in place. From April 2002, the Nursing and Midwifery Council will assume responsibility from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the Health Professions Council will replace the Council for Professions Supplementary to Medicine. There is therefore in place, at a time when other changes are occurring to promote enhancement, new regulatory arrangements as yet untested which may allow innovation that previously might not have been possible.

External Quality Assurance and Enhancement.

At the time of writing, different arrangements for the external quality assurance of NHS-funded

provision in England have been agreed from those that will apply to HEFCE funded courses. One of the advantages with the new arrangements being proposed for the NHS-funded disciplines is that there is a very strong possibility that all stakeholders may sign up to a common approach with a single set of data requirements. There is, therefore, the potential for professional bodies, statutory regulatory bodies, NHS workforce development confederations and the QAA to agree to a common approach and this would greatly reduce the burden of accountability placed on institutions whilst meeting the needs of public accountability. Prototype reviews will shortly take place piloting this approach and following evaluation it may be implemented across the sector. The downside is that health disciplines funded by HEFCE such as medicine, dentistry and pharmacy will be reviewed externally by a different methodology and this will depend on the outcome of the recent consultation exercise. There are clear disadvantages for health care in having separate approaches particularly with the priority that exists for interprofessional education and training. Shared learning for health professions will frequently involve both NHS and HEFCE funded disciplines.

New ways of working and post qualification quality assurance.

It is an interesting time to work in the NHS. New ways of working, extended and expanded scopes of practice and new health care workers are emerging from a mix of local initiatives and government priorities (7,8). Whether it is nurses who have asked their local radiology department to set up half day training workshops on ordering X-rays, or a local hospital that has provided a three month training for nurses to take on a nurse practitioner role or physiotherapists who spend four months shadowing medical staff prior to developing their own extended physiotherapy practitioner clinics, all are worthy projects. Yet some of the interest, almost excitement, comes from the haphazard way these changes have come about. The professional bodies of those who are going forward and taking on tasks traditionally done by other groups have been slow to suggest guidelines or minimum standards for the additional training required. Similar trusts may develop different training for the same reasons, or the same training for different reasons. It all lacks coherence, co-ordination and most importantly, quality assurance. No one knows whether a nurse practitioner has done a postgraduate degree or a three month NHS based individual training package.

The problem lies in the lack of an organisation that is not predominantly uniprofessional. The new Health Professions Council may be able to address some multi and interprofessional agendas, but excludes the two largest groups, the doctors and nurses. Hence the National Health Service University (NHSU) (16). If the NHSU manages to provide minimum standard setting, benchmarking and dissemination of good practice whilst avoiding the temptation to centrally control curricula and assessment, then it will have done well. Over prescription will stifle the local initiatives which are currently driving the changes. We are in an early phase of the cycle of change with innovation and action being dominant before documentation, prescription and central control threaten stagnation. Sensible criteria for the education and training for certain health care tasks would be welcome but detailed curricula that can only be delivered by small numbers of accredited higher education institutions would not.

The other theme that is clearly coming through is the move away from theory. The skills escalator, the skills based curricula for the UK version of physician assistants, the numerous ways hospitals have created new part ward clerk, part phlebotomist roles under a number of titles; all these are skills or outcome based. When NHS professional courses moved into HE in the 1990s, theoretical underpinning became the buzz phrase but soon resulted in the complaints that graduates knew it all but could not practise. It needed prescribed ratios of theory to practice time to unpick the damage. Is the move to even more skills base an extension of this swing of the pendulum mixed with a desire to get people into post as quickly as possible? Will these roles and their training be complimentary to existing roles and training or a substitute that is no better, and even worse. The pace of change mitigates against attempts to evaluate each change for enhancement, yet we are increasingly stepping into new territory with little more than good faith and hope.

There are paradoxes in the skills based approach. The training needed for people to take on traditional junior medical tasks is suggested as anything from a few days to learn the clerical tasks, to 2 years or so to become a 'physician assistant'. The justification is made that these roles will free up doctors to do the doctoring which begs the question of what is 'doctoring'. If it is about diagnosis and deciding management options then those are already no longer the preserve of the medical profession and will be increasingly protocol led. If it is about dealing with the more complicated cases, then we need to remember that in order to be able to do that it is common sense that one needs to be proficient and comfortable at the straightforward cases first. Trainee doctors will still need to deal with high volumes of 'simple' cases before feeling confident to take on more difficult ones. But then a nurse practitioner or the proposed physician assistant who has been running an asthma clinic, or diabetes one stop shop, or primary care drop in centre, they too, after much practise will be able and probably keen to take on more complex patients and tasks.

So we are in danger of creating a number of means to an end - the traditionally heavily academic medical course, the expansion of the nursing curricula and an even more skills based group of new health care workers. In itself that should not be a worry, indeed should be encouraged, but pay equity may become an issue if all end up performing the same services. Opportunities for promotion and further training need to be available to all without the restriction of going back to learn what you already do but in a different way, a flaw of the USA physician assistant system (17). Again, hence the NHSU and the NHS Plan comment about multiple entry and exit points.

The NHSU could provide the opportunity to add quality assurance and co-ordination to the changes we are currently witnessing. It could bridge the gap, allowing new education and training initiatives to remain predominantly in the NHS. HE has brought many benefits to professional pre-registration course education and the relationships between NHS and HE are entering a new collaborative stage. But the locus of control for post qualification workforce development should remain firmly in the hands of the service albeit in partnership. In that way it can respond more quickly to short term demands, while working closely with higher education to support the work based learning. The missing factor, a national standard setting and quality assurance mechanism, is likely to come from the NHSU unless the existing professional and education institutions move quickly.

Will enhancement occur? Some conclusions.

Whilst defining what enhancement might mean in terms of outcomes encompassing fitness for practice, fitness for purpose and fitness for academic award is straightforward, achieving it is significantly more complex. We have in England recently implemented changes to nursing curricula across the country. The rationale for these changes, like similar initiatives in the past, are highly laudable and will hopefully result in newly qualified staff that are better prepared for practice. However, it will be many years before we will know whether these changes have indeed produced enhancement or whether future students may actually be less well prepared than staff qualifying today. Furthermore, although competence at the point of registration may be improved as a result of changes to curricula, we need to be mindful that staff are being prepared to work in a rapidly changing Health Service for a lifetime and need to be responsive over a long time period. The success of curricular change should not, therefore, just be assessed on overall competence at the point of registration.

It would be timely to place continued emphasis on the evaluation of curricular change and developments with interprofessional education to asses their effectiveness. Implementing widespread curricular change is costly and there has been an imbalance between properly considering the weaknesses of existing programmes and the enthusiasm to implement change at great speed and without sufficient consideration of the possible implications of new curricular

interventions or the resource implications in delivering them. The value of an increased emphasis on practice will only be realised if there are sufficient quality clinical placements to support this. Care needs to be taken that policy does not become too aspirational with sufficient foundations in the reality of what is deliverable.

Care will need to be taken in the enthusiasm to implement new ways of working and to break down the barriers that exist between professionals that the interests of patients are paramount. There is certainly some risk in simultaneously driving forward widespread change to curricula, changing ways of working and removing the current safeguards that exist within the existing regulatory frameworks which have been successful in protecting the standards of education and training.

The NHS and HE cannot be criticised for their enthusiasm to drive change and enhancement. However, change alone is insufficient. It must take account of the evidence that exists. Unfortunately, the evidence base to support that the recent and current curricular changes will lead to enhancement is not convincing. Evaluation will not be assisted, particularly where shared teaching and learning has been identified, by quite different external quality assurance mechanisms. These in turn drive internal processes. The NHSU would be wise to consider the need for evidence to support change if it is to really ensure better qualified staff that will meet the changing agenda of the NHS. Real learning based on clinical practice, not theory, and a core curriculum may not be the signpost that existing training needs.

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