Introduction

The comments presented below were developed as a result of an iterative process involving individual members of The British Computer Society (BCS) Health Informatics Committee (HIC) and its constituent specialist health informatics groups (see Appendix 1), and in particular its Education, Training and Development (ETD) Taskforce. All contributors to the response work, or have worked, in or for the NHS, either directly as NHS employees, or in organizations providing support and services for the NHS. Many have been involved in direct patient care, and most are or have been involved in the delivery of education for NHS staff, both in in-service training, pre- and post-registration professional education, and in further and higher education. Many have considerable knowledge and experience of open and distance education and e-learning development and delivery for health professionals.

Our response is somewhat lengthy with deliberate intent. A large number of questions are posed in the consultation document, and our response encompasses both the consensus views of our members and the breadth of particular individual comments that have been expressed, but that may not be common to all.

We are particularly grateful to Mr. Rod Ward, Lecturer, University of Sheffield School of Nursing and Midwifery, who provided an extremely thorough response to the questions, and whose words very succinctly captured the prevailing views of other members of the Education, Training and Development Taskforce. In many instances, we have used his responses verbatim.

We have structured our comments in the following way:
1. Executive summary and general comments on the overall plan
2. Specific comments, mainly on the Full Development Plan (Learning for everyone)
3. Miscellaneous comments on the consultation questions and other issues not covered elsewhere.

Executive summary of comments

1. The BCS HIC support, in principle, the idea that the NHS must become much more of a learning organization, for the benefit of the organization itself, its employees and, most importantly, for patient care. Education and training should be a right for all working in and for the NHS.

2. If NHSU is to succeed, it must be inclusive of all professional groups.

3. We advocate the appropriate use of sensible approaches to e-learning, but e-learning is not a ‘magic bullet’.

4. If NHSU manages to achieve ‘protected time for learning’ for NHS staff, this in itself will have been a major success.

5. The development of NHSU simply to support existing practice and the delivery of the NHS Plan potentially fails to provide avenues to personal development, and to new and improved practices.

General comments

We would begin by noting, with some regret, that many of the issues that we highlighted in our response submitted in November 2001 (Appendix 2) to the original outline proposals for an NHS ‘university’ seem to have progressed little in the interim period. We noted at that time that: overall, the British Computer Society Health Informatics Committee (BCS HIC) has significant grave reservations about the proposed NHS University. These concerns cover the core purpose of the NHS, educational issues, organizational logistics and the technological solutions required to deliver and sustain the concept over time.

We went on to suggest that:
key challenges for the development of an NHS University to include:
• balancing the declared aim of all NHS staff ‘reaching their full potential and achieving their ambitions’ with the agendas of effective, efficient and value for money service delivery, the goals of external educational providers and the limited resources available to bring this about
• provision of support for staff doing education, development and training (EDT) whilst maintaining quality of service (this includes provision for locums and financial inducements)
• allaying concerns that continuing professional development (CPD) may be used as an alternative way to monitor competence and a proxy for performance
• breaking down inhibitors to professional development including the current management culture
• the development of a knowledgeable workforce by harnessing existing informatics & communications technologies and a range of learning styles and modes, rather than diverting funds from care priorities
• there is a strong view from the BCS HIC that the NHS should be looking to accredit qualifications from those focused on educational provision rather than creating a new vehicle.

Many of these issues remain, and have not been thoroughly addressed in the proposals, so are again raised in the responses we provide to specific questions.

We support, in principle, the idea that the NHS must become much more of a learning organization for the benefit of the organization itself, its employees and, most importantly, for patient care. Education and training should be a right for all working in and for the NHS.

The current ‘agenda for change’ proposals make it even more vital that staff are able to develop their knowledge and skills and that these are transferable and applicable wherever they might work. The NHSSU proposals have the potential to achieve some of these aims and encourage the recognition of learning wherever it has been acquired rather than certificate collecting from a succession of Trust training departments.

Some have argued that NHSU will be nothing more than a glorified Trust training department, and this
is certainly a potential risk. It is important that, if NHSU is to succeed, it is inclusive of all professional
groups, including medical education, and is seen as ‘high status’, so as to increase uptake of learning
opportunities. A major challenge will be to undertake the research needed to even apply for university
status.

We advocate the appropriate use of sensible approaches to e-learning, and some of us have for many
years argued that NHSnet could provide a cost effective medium for education and that education could
be the ‘killer application’ for many staff from the NHS IT expenditure. However, e-learning is not a
‘magic bullet’, and is not applicable to all learning outcomes or all students, and currently completion
rates are low. Anything requiring broadband access is likely to be unavailable to many individuals for
the foreseeable future, particularly to those in most need of such access, and there are many issue
around accessing materials within NHSNet or its successor for students and patients at home. Previous
NHS achievement in the IT arena doesn't bode well for these developments.

‘Protected time for learning’ for NHS staff is mentioned several times within the document and if NHSU
achieves that it will have scored a major success. Along with calls for the NHS to become a ‘learning
organisation’ this will take effort, money and most importantly a huge cultural shift within the
organisation.

The consultation document states that part of the aim will be to ‘support effective delivery and
implementation of NHS Plan’. If this is ALL it will do, many opportunities may be missed to encourage
personal development. The development of education, training and development simply to support
existing practice potentially fails to provide avenues to new and improved practice.

There is confusion in many places in the consultation document as to when, and to what degree, social
care will be involved; different parts of the document seem to suggest contradictory views.

Generally, the development plan contains many good ideas and grand phrases, but it will be
considerably more difficult to make many of them happen in practice. The documents contain frequent
repetition of high level statements, many of which are of the ‘motherhood and apple pie’ aspirational
type, and therefore not stringent enough to be adhered to in any sense contractually with partners, staff
as subjects, participants and recipients of proposed services. One finds the same few high level
statements being recycled time and again in many sections, with little detail as to how some of the
ideas might be implemented.

A significant effort will be required to establish, and to encourage a critical mass of participation in
NHSU activities and to sustain quality in an effective corporate university for internal knowledge
exchange. The current documents do not seem to portray this as other than a small step on the path to
full chartered university status. A world-class corporate university could, of itself, bring significant
benefits to the NHS and to the delivery of healthcare in the UK; for pro-active and public relations
purposes if no other, such benefits could be promoted.

The documents state clearly that the initial aspirations are to become a corporate university, and then
to become chartered. We have concerns about the wisdom and achievability of the latter approach,
although recent developments (e.g. in respect of the definition of universities in the Education White
Paper of January 2003, The Future of Higher Education) would seem to be more than coincidental in
facilitating such developments.

Full Development Plan comments

The comments provided by BCS HIC are structured around the questions posed in the consultation
documents.

Section 2 of the plan.
What do you think of the proposed overall vision for NHSU?

We support, in principle, the idea that the NHS must become much more of a learning organization for
the benefit of the organization, its employees and, most importantly, for patient care. Education and
training should be a right for all working in and for the NHS.
The proposed overall vision is considerable, but has many gaps in it, and little detail as to how some of the ideas might be implemented. The documents contain frequent repetition of high level statements, many of which seem to ‘motherhood and apple pie’ aspirations, and therefore not stringent enough to be adhered to in any sense contractually with partners, staff as subjects, participants and recipients of proposed services.

It is stated (section 2.3) that the long-term aim is to become ‘umbrella for ALL learning within NHS’. This has potentially profound implications for pre- and post-registration nursing, medical, and other professions’ education and training, currently provided mainly through Higher Education institutions, and which in the early stages are meant to be excluded. We suspect that changes to this will meet strong resistance, not least because in recent years, much of this provision has moved out of the NHS, and it will be difficult to see where the workforce with appropriate skills will come from to allow its internal provision.

The overall vision is ambitious, extending the definition of University beyond the ‘normal’ one, but in line with the title of the document, i.e. “Learning for Everyone”.

What, if anything, do you think is missing from the proposed overall vision?

The subsections of section 2 do not contain an explicit and detailed re-iteration of the aim of improving healthcare. This must be central and focused around “systematic improvements in healthcare and patient-centred services”; it is a core aspect and the development of NHSU must not lose sight of this.

Other items that our members have identified include:
• mention of affordability, by potential students, by service providers at local levels, including Trusts, by the NHS as a whole;
• recognition that management concepts can also improve practice, and so should be in the portfolio alongside clinical skills;
• concerns that once such formal arrangements are in place, there seems to be no mechanism for how new and innovative providers get into the market to provide materials, or get accredited;
• in section 2.9, if the NHSU achieves its aspirations to be a full university, what happens to the arrangements it has made with its service provision partners that it took on board during its development phase? The transition will require considerably more detailed explanation before good providers will enter into partnerships with a body which declares its aim to take over ‘all learning within the NHS’;
• in section 2.10, the Memorandum of Understanding (MoU) not to compete on pre-registration courses seems incompatible with the stated aim of providing all learning in the NHS. While the MoU is interesting, it needs considerable clarification;
• also missing is recognition of the impact and synergy created by greying the boundaries between health and social care in terms of public welfare concepts;
• there is opportunity for considerable confusion if (section 2.8) the ‘strategic partners’ UfL/LearnDirect, The Open University, Universities UK and UK e-Universities, are both advising on the direction and also bidding to supply the products or services (potentially contrary to CCTA Regulations).

What do you believe the main focus of NHSU’s work should be?

It should concentrate on becoming an excellent corporate university, that is ensure it keeps all the NHS staff updated on key issues within and impacting on its domain from whatever angle. It should also ensure that the mechanisms for the self-development of its staff are effective, ongoing, equitable and readily accessible. The corporate university has to not just provide ad hoc or periodic ‘meetings’ / announcements / briefing papers, but should provide the channels for self-enquiry and searching of corporate knowledge banks on a day to day basis.

The idea of ‘marketing programs overseas’ is perhaps too early to consider. Walking before it is able to run would not be a good idea, and the NHSU should take careful note of the experience of others who have tried to market overseas and failed, e.g. the experience of the OU-US scheme (The Open University’s attempts in the late 1990s to extend into the US market).
Some of our respondents have raised the question ‘why is the NHS engaging in this venture, and should it not focus on its own core remit, of providing health care?’ This is, we believe, an extremely valid point, and if NHSU is to progress, it will need to ensure that its main focus of work is to support the main focus of the NHS, i.e. the delivery of care.

What will be the main challenges to securing full university status?

Among issues indicated by BCS HIC members are:
• producing high quality research which is seen as of equal value to that undertaken in existing higher education institutions;
• the differences between further and higher education provision, and the (current, pre- 2003 Education White Paper) requirement for a university to have at least 55% higher education provision;
• section 2.4 (Foundation degrees) needs to be further expanded. The lessons in nursing have been that taking people from lower educational background / a wider entry gate have required higher levels of educational support. It is not clear how such levels of support might be provided in the NHSU model.

While we also welcome the statement of intent to involve the public, carers and social care professionals, this also makes the securing of full university status a complex challenge in itself, without engaging in battles with the whole of the rest of the academic domain, who may see their roles threatened by the development of NHSU.

At what stage will QAA and professional regulatory bodies be involved? They need to be in the equation from the beginning, even if complying with their requirements will increase costs and delay implementation. If QAA etc. are not involved from the beginning, then it will not be seen as a level playing field by higher education institutions, and students will soon pick up that NHSU provision is of a lower standard, so full university status will be difficult to achieve, or even if achieved, NHSU risks not been seen as ‘Ivy League’.

Are NHSU courses to have external validation/examiners in the same way as is required for all other higher education institution courses? The infrastructure for this takes considerable time and resources to establish and to maintain to consistent quality criteria.

How should NHSU include the needs of social care staff working within and alongside healthcare staff?

This is a crucial area as health and social care converge, and our clients / customer base frequently do not understand or make the formal division between the service providers and their products and services which impact on personal health and social welfare. The two domains are often inextricably linked organisationally and in visible outcome terms. Effort should no longer be put into developing uni-sectoral knowledge, but should be aimed at provision across these sectors (and possibly others that impinge on health and social care delivery).

There is mention explicitly about ‘services delivered by joint teams of health and social care staff’. This is one of many examples where the current and future relationships between health and social care, and the relationship of social care staff to NHSU are ill-defined, and in places contradictory. This whole area needs a great deal of further consideration.

Other issues from section 2

2.1 and 2.2 Multi-professional and team aspects are emphasized, and these are to be welcomed. But, what is ‘improvement science’ (paragraph 2 of 2.1) (or ‘healthcare improvement science, section 2.2?) – they need to be defined or clarified.

2.2 How will patients and carers REALLY be involved in ‘design, development, delivery’ (bullet 5)? – the ideas are to be welcomed, and are strongly supported, but are vague and ill-defined in the documents.

2.4 Clinical fellowships potentially address areas for innovation, etc. But, they will require funding and there will need to be a considerable number of them if they are to have real impact. How many will there be, and will they really stimulate new thinking, or simply be focused around existing ideas,
knowledge, etc; will they allow people to ‘think outside the boxes’?

2.5 Support for learners and learning. This is vital, but very expensive and difficult to achieve. What standards are to be put in place for learner support? How often will meetings be available (physical or online)? How quickly can students expect an answer to questions from those providing them with support, guidance, assessment, etc? Who will provide this for the thousands of students envisaged?

In terms of providing learner support, where will the ‘appropriately trained and skilled’ NHS staff come from to provide such support? The Open University’s tutor system is a model that bears looking at, and could provide a model for NHSU, but is potentially very resource-intensive and expensive, and requires considerable attention to infrastructure.

2.6 ‘Patient-centred learning’. This is a fundamental shift in approach and one that could take quite some time to implement (especially in professions that are not used to such ways of working and thinking). This seems to be an example of a high level ‘buzzword’ that has been put into the document but not well thought-through. How will the proposed ‘faculty/school’ operate? Where will real, or representative patients come from? Will there be patients on the NHSU governing bodies?

2.10 Partnership and collaboration. Partnership is vital, but the relationship of NHSU with many other existing bodies in tertiary education provision (e.g. HEFCE, JISC, LTSN) will need to be addressed. There will also be implications for the service level agreements between NHS bodies and higher education institutions, for example in terms of student numbers, placement provision, and agreements between university and Trust libraries. Will these sorts of issues be set nationally or negotiated locally, as is currently the case where service provision varies with each Trust? What is the role of WDC’s here?

Section 3 of the plan.
What do you think of the proposed NHSU guiding principles? Are there any missing?

The guiding principles see appropriate, and there seem to be none missing.

In respect of some of the principles, we would note:
3.1 Access. NHSU will be available to everyone who works in or for the NHS. This needs to be further clarified and defined. There have often been problems of services within the NHS being available for those employed directly by the NHS, but not to others who have a legitimate interest through interaction with the NHS. Access issues also include technological access issues, and any provision within NHSNet or its successors will need to be addressed.

If one result of access is that NHS employees can ‘take on more skilled and demanding jobs’, who will then do the less skilled and demanding jobs that they may be over-qualified to do? We already see problems where basic care previously delivered by nurses is delegated to health care assistants and other staff, and we see reports of instances where such work may not be done or supervised appropriately. While we support enabling staff to progress in their careers, the dangers of basic care being neglected could be exacerbated as a direct result.

3.2 Relevance. ‘maintain a focus on healthcare improvement and on the benefits of NHSU for patients’ How will this benefit be measured? It has proved very difficult over the years to quantify the effects of individual variables, so how will the effect of NHSU be separated from effects, such as different levels of funding, number of staff etc?

We note that the sidebar and section 3.1 talk of ‘representatives of patients’ etc., rather than the patients themselves who are mentioned in other areas. Is this an example of confusion, or an issue that needs to be further addressed? Will NHSU use only the usual patient groups that NHS bodies have contact with (potentially ‘safe’ groups)?

3.3 Choice. ‘We will make learning available where, when and how learners want it, as far as is practicable.’ Wide choice is very nice in theory, but difficult to achieve and potentially expensive in practice. We also note that ‘as far as practicable’ is a potentially very broad escape clause.
The rhetoric of choice in learning styles, places, etc (‘learning just for you’) is all desirable, but very difficult to achieve in practice, especially with current work patterns, access to computers in the workplace and other issues.

There is also some possible mismatch in the language used here; section 3.3. talks about helping all NHSU staff to become more effective learners, but provide learning in forms, styles etc to meet the differing needs of NHSU learners (which could be more than NHS staff).

**Which principles do you believe will constitute the biggest challenges for NHSU?**

Quality, multi-professionalism, and equity are likely to be the three most problematic areas and provide the greatest challenges. We also have to ask what confidence we can have in NHSU achieving this when the NHS has missed almost every target it has set in terms of IT provision and access?

Maintaining relevance and contemporaneity of learning materials will be another issue as health care practices change.

In section 3.4 (Support for learners and for learning), there seems to be no mention of library provision. Access to these and other resources, both physical and electronic, will be needed to support learners and learning.

In section 3.5 (Equity and tackling digital divide), we very much support the aims, but wonder whether there is a potential degree of compulsion (in terms of use of the e-learning platform) here that may be incompatible with the wide choice in section 3.3.

In section 3.6 (Multi-professional and inter-disciplinary provision), while we agree in principle that multi-professional and interdisciplinary working seem to be a good thing to be encouraged, we are not convinced that there is evidence to say that this is the most effective form of educational provision. This may be one of the research areas to be addressed as a priority.

In section 3.7 (Partnership), while the ideas are excellent in theory, currently educational providers use many differing curricula which may limit the ability of learners to use this learning outside the higher education institution concerned. Much more work is needed on APL/APEL (Accreditation of Prior and Prior Experiential Learning) and credit transfer schemes.

In section 3.8 (Quality), there is likely to be a tension between university aspirations and ‘low level’ provision of learning (e.g. literacy and numeracy).

**How can NHSU best meet the challenges you have identified?**

Points identified by our members included:
• other obstacles to learning being successful and/or the learning attempted are the students’ own aspirations and their basic competencies when they enter into a course. While The Open University has demonstrated that many who lacked earlier opportunities can achieve high levels of educational success, it is also clear that any given model (e.g. distance education) is not for all students, and there is a certain drop-out rate;
• communication skills are also needed for general customer care reasons, not just when dealing with clients without English as a first language. Poor communication has been highlighted time and again as a major reason for complaints within the NHS;
• targeting inclusive programmes should also address those who do not have the personal competencies to get the most out of e-learning;
• why in section 3.6 does NHSU create partnerships only with a Post Graduate MEDICAL education training Board? Other professions’ representatives need to be included in such discussions.

**Section 4 of the plan.**
**In what ways can learning be better built into the everyday work of healthcare staff?**
This is a major issue, particularly in terms of protected time, and will require major cultural shift on the part of all staff, but in particular on the part of managers.

In practical terms, external access may be difficult if the current problems of access through NHS firewalls continue. There will be a need to ensure that there are enough staff to care for patients while others are learning during work time, and an aspect of the protected time will be to ensure that they can attend every time, not just when workload/staff allocation allows. This will have potentially serious implications for the review of shift patterns and working practices, even before lessons start.

What do you think of NHSU’s proposed establishment of a Learning Needs Observatory?

Respondents were divided on the need for the Learning Needs Observatory as proposed in the documents. Some felt it to be an excellent idea, although have concerns about major issues in terms of complexity and data quality, and that there would be major challenges for it to be comprehensive and kept up to date.

Concern was expressed as to whether the requirements of the organisation could be balanced against the ‘wants’ of individual staff.

Other respondents questioned whether some of what the Observatory aims to do are really within the remit of NHSU (e.g. identifying demographic trends such as skills shortages). It was felt that NHSU should be taking this information from other bodies that might already be collecting and using and interpreting it, and there was serious danger of duplication.

In respect of prior learning – will it draw on existing best practice or reinvent the wheel? – will it just be prior learning or will it be full APEL taking account of learning from experience that might not previously have been measured or credited? – in areas such as nursing, a lot of rhetoric in this area to draw on, but how much good practice?

How do you think the Learning Needs Observatory can be made most effective?

Care should be taken in establishing the Learning Needs Observatory to adhere to all European Directives on privacy if any material is person-identifiable (like their own development plans).

Other issues from section 4

4.1 Relevance. We would question whether the ‘learning services and support offered by NHSU … geared to meeting the various needs identified by key national policy initiatives’ is really achievable in a climate where new policy initiatives emerge with apparent ever-increasing frequency. There will be problems for course design, validation and delivery which need a fairly stable climate and timescale, not least so that one can tell students what to expect from a course/module.

The aim of ‘balancing personal development opportunities with a curriculum to meet policy needs’ seems not to be fully congruent with a later statement about meeting personal needs.

4.3 Entitlement and responsibilities ‘…appraisal for doctors linked to re-validation.’

Why are doctors singled out here, when most, if not all, existing health professions have a need for and a system for some kind of re-validation or re-registration with professional bodies at intervals, as well as other emerging fields (e.g. health informatics, through the developing UKCHIP – United Kingdom Council for Health Informatics Professions).

4.4 Motivation ‘make learning at, for or through work ‘normal’ for all healthcare staff.’

While these are excellent ideals, they will require a major cultural shift, which will require support at all levels of the organisation, guaranteed time and positive recognition, and will probably take a generation to achieve.

4.5 Learning champions, link roles and leadership ‘NHSU will work to support local agreements about
'protected time’ to learn'
Protected time is probably the most difficult thing to achieve; if NHSU achieves this it will succeed, but there are many major obstacles.

4.2 Note that The British Computer Society is a Royal College and therefore should be considered alongside the clinical (medical) Royal Colleges given the proportion of NHS staff who are working in the informatics field or with informatics tools.

What are ‘health animators’???

Section 5 of the plan.
How can NHSU best support learners?

This may be achieved by using Open University and Learn Direct infrastructures which exist already, but will need to take account of tried and tested support models (such as The Open University’s)

Areas that will have to be addressed include:
• time to learn (protected time);
• payment of fees, i.e. free learning;
• easy access to face to face or email support, 24 hrs per day;
• escalator learning;
• credit rating, i.e. incentives to learn towards qualification.

What guidelines do you think should be established to clarify the entitlements and responsibilities of NHSU learners?

Limiting entitlement by grade, amount of money, time or resources per year, etc. is divisive and should not be done at this time until the scale of demand is established.

There will need to be a clear exposition (and costing) for ‘protected time’, and this may require ‘persuasion’ of managers to ensure that it is provided.

What role should patients have in the design and delivery of NHSU learning and in becoming NHSU learners?

Patients can be used as ‘intelligent vandals’ to test the resonance of learning material content with real life. However, if the delivery of a real ‘patient-centred’ NHS is to be achieved, it will be necessary to have patients fully and genuinely involved in all decision-making processes, including representation at the highest levels in NHSU.

Some of the pressure for development and delivery of particular courses is likely to come from existing NHS professionals, those aspiring to become such, and others who, perhaps through having carer responsibilities, have a personal desire to learn more. All courses should be commissioned with consideration of the full range of professional and lay participants, and their language and communication – and access – requirements and opportunities.

What challenges do you envisage with establishing NHSU’s support for learners?

Many organisations that are seen as potential partners have support mechanisms in place for learners. Substantiating the costs of establishing new and separate NHSU support may be difficult, if not impossible, given such pre-existing facilities. Attention will need to be paid to how such existing networks might be accessed or used.

There is likely to be either a shortage of appropriately qualified /prepared mentors, and/or a need to provide a mechanism for preparing mentors to provide the necessary support roles. This will relate particularly to providing online support, which is not an ‘easy option’ as some suggest.

Other issues from section 5
If NHSU is seeking to focus on where it can add ‘most value’ why is it suggesting duplicating resources, functionality etc of pre-existing bodies like OU, Learn Direct etc and roles like that of OU Associate Lecturer (NHSU learning facilitators)

There seems to be confusing use within the section of ‘learning credits’, ‘qualifications’ and ‘awards’ amongst other terms. Definitions are needed, or at least the consistent use of terms.

**Section 6 of the plan.**

**What learning and development do you think should be the priority for the NHS?**

Among areas identified by our members are:
- customer care
- informatics skills
- audit understanding and capability
- benefits appraisal skills.

**What is your view on NHSU establishing an NHSU Academic Strategy Board?**

Such a Board will be necessary however NHSU is to operate.

There are questions as to where / how will franchised courses be evaluated / accredited to ensure compatibility with existing courses. Will it be in the remit of this Board, or the Learning Advisory Group, or yet another body?

Where does this proposed body sit with, or how does it relate to, other bodies, such as the NHS Information Academy?

**What is your view on NHSU establishing an NHSU Learning Advisory Group?**

Such a group will be vital. As stated elsewhere, it will need to draw from a broad range of talents, backgrounds and experiences, and will need to include patients or their genuine representatives.

Where / how will franchised courses be evaluated / accredited to ensure compatibility with existing courses? – will it be remit of one of these groups?

**Other issues from section 6**

6.2 Focused ‘Our curriculum planning process will ensure that all of our proposals are rigorously tested for relevance and quality.’

This needs more explanation as to how this will be put in place and carried out.

Examples of the developing NHSU curriculum (page 42) There needs to be clarity about who develops and/or has ownership of these areas e.g. ECDL. Current plans by NHSIA say ECDL will be with them for at least next 3 years; does this mean that NHSU is going to ‘poach’ from other bodies?

‘…pilot programme of Foundation Degrees …’ Further work is needed on the level of Foundation Degrees and their likely perceived usefulness to learners. If they are seen to be ‘not a proper degree’, then the likelihood of them being attractive to the proposed target audience is small.

6.5 Practicality ‘A central aim of all NHSU learning programmes will be to help healthcare staff put their learning and achievements into improved practice.’

There are wide ranges of organisational and cultural barriers to be overcome for this, which NHSU alone cannot hope to achieve.

6.9 Developing NHSU curriculum ‘We have already indicated proposals to establish NHSU Junior Scholarships for secondary school pupils and leavers’

It is unclear exactly what purposes these will serve and what they are designed to achieve. They sound to be a form of apprenticeship or cadetship, but how they will operate, and the outcomes for students who decide, after undertaking one, that they do not want to work in the NHS are not discussed.
If an employee of the NHS changes jobs to one where it is more appropriate for them to study for a degree then it would seem that they are not allowed to do one if they have worked for the NHS for over 5 years. If this is so, it makes a mockery of the rhetoric of supporting lifelong learning.

6.9 Widening Access. The suggested figure of £150 for a Learning Account seems wholly inadequate when set against the current costs of courses and modules offered by partner organisations. In addition, lessons learned from the ILA debacle will need to be taken into account if similar problems are to be prevented.

The idea of materials around the ‘expert patient’ is worthwhile, and will be needed as patients increasingly take the lead in deciding on their care. However, such content must be developed with strong drivers from the patient perspective, and not from the usual, unsatisfactory, perspective of what health professionals think patients want or need.

Section 7 of the plan.
What are your views on the learning delivery and support systems being proposed?

In general, the mechanisms and systems seem suitable, but many are already operational elsewhere, so we have to question the apparent intention to ‘re-invent the wheel’. We have serious concerns about the apparent decision to invest large sums of money in developing yet another custom-built e-learning environment.

For any form of technology orientated or supported learning delivery, there have to be preparations to ensure that the staff are ready for it, or able to use it. Many who have recent experience of education and training are probably more used to face to face, therefore there is a great ‘learning to learn’ need and ‘learning to use technology’ need.

Support for learners in whatever mode they learn will be vital; more ‘human’ oriented approaches are good.

Access must be available for all staff 24 hrs per day.

What do you think of the idea of a ‘Learners’ Charter’?

Charters are always fraught with problems and risk being either full of platitudes or general, unenforceable aspirations, or being strait-jackets to constrain development. While the general idea of the Charter is to be welcomed, there are many potential problems raised. One such potential problem is that where there have to be signatories from the employer side, there could be inappropriate management influence as to which courses are undertaken by staff/learners. If self-learning objectives clash with management plans then there could be a constraint set, especially if funding is scarce or limited. The situation of, as is suggested in places, a citizen or a staff member as an individual wanting to do particular courses that may not fit with management objectives, but which they may be willing to pay for themselves and undertake in their own time, is unclear.

What do you think is the appropriate balance between computer-based learning and other forms of delivery e.g. face-to-face tutorials and correspondence courses?

This is, in many ways, a nonsensical question that betrays an underlying lack of understanding of the pedagogies of all forms of learning. There are many factors affecting such decisions and balances, and to suggest that the delivery mechanisms (online versus face to face, for example) should be the drivers to the education is an extremely serious error.

The overall balance depends on a whole range of factors including the content to be delivered (which may be deliverable in a number of parallel mechanisms to allow for students to access by means that are suitable to themselves), to the academic level of the materials, the students’ own learning styles, levels and means of access to different delivery mechanisms, and many other factors.

In respect of e-learning, the nature and balance will depend in part on the courseware used, on the
competencies of participants, and other factors. However, a major point that cannot be overemphasised, is that e-learning does require an extensive support infrastructure, and so is not a cheap or easy option, as some with lack of knowledge and experience of the field often suggest.

**How can the capacity to support and supervise learning in the NHS best be strengthened by NHSU?**

This could be achieved by empowering facilitators within the service, and by recognising (by financial, career progression, or other reward mechanisms) their NHSU role in parallel to their operational duties. Support and supervision are not things that can be simply be tagged on to a list of other duties within a given role; they require preparation, and ring-fenced protected time, to carry out the support role.

Providing such support will be a major challenge, and not one which will be solved in the short (or even medium) term. It is likely to have knock-on effects for those studying in other higher education institutions but gaining learning experiences in NHS, where there will be competition to use the same people as supervisors and support.

**What should the NHSU learning advice service offer?**

Among areas that it should offer are:

- advice on career pathways;
- cross-accreditation;
- transfer of APL/APEL; and
- comparability of courses / qualifications.

**Other issues from section 7**

7.1 Flexibility and student-centred learning. It is unclear how measurement takes place of, for example, 'how learners prefer to learn'. There is the additional danger that learning styles assessments and similar tools may result in staff identifying needs that cannot be matched or met.

7.5 A role for e-learning ‘We recognise that not all NHSU learners will have easy access to computers. We will ensure that those who do not will still be able to access NHSU learning and we will work actively with NHS organisations and other local partners to improve access to on-line services and information technology facilities for learning.’

These are major issues. There is no guarantee that the levels of access needed can be met by these means, especially as many other organisations are also increasingly competing to access the services and facilities outside the NHS that NHSU may be seeking to access. An over-optimistic expectation of, for example, access to broadband networks both in NHSnet (or its successor) and in people’s own homes, or access to IT generally, are likely to provide major stumbling blocks.

One idea might be to give all staff who register a laptop (and the training to use it) as The Open University does for some courses, and pay their phone bills while using e-learning.

The software and hardware needed to support our initial programmes will need to be available by summer 2003.

This is an extremely short timescale if NHSU wants good quality software and user-testing before rolling the systems out. The specifications for systems will need to be clearly defined, and must be educationally, not technologically-driven.

Access to ‘the literature’ also needs to be considered as a means of providing support to learning. Will NHSU be buying electronic journal subscriptions for students? How is integration with NeLH to be handled? Should this be included in the current NeLH OJEC procurement?

The rhetoric on ‘facilitating different learning styles’ is not matched by a fairly detailed description of an e-learning model and then little on other delivery models. This seems to suggest ‘one size fits all’ e-learning model will be the driving element, which again is a very dangerous approach to take in educational terms, not matter how much one might support the general aims and benefits of e-learning for some learners.
Section 8 of the plan.
What do you think will be the greatest challenges for the NHSU in seeking to work in partnership and collaboration with other learning providers?

One of the main challenges will be in removing the perception of threat from potential collaborators, who may see NHSU as ‘poaching’ their territory and their students. Another challenge will be in adding value to whatever is created, rather than creating a closed shop to which potential partners and collaborators have access problems, especially new partners who may not be in the first waves.

A key point from the view of existing higher and further education providers, especially in respect of their own funding models, will be ‘whose students are they’? This will be further complicated if courses are delivered in partnership or co-branded, or can count towards degrees and other awards from a number of institutions. This will be crucial to who receives funding, for meeting targets for student numbers, and may be a source of considerable friction between NHSU and other bodies.

The administration system required for working with so many partners across further and higher education, health authorities and Workforce Development Confederations is likely to be very complex and potential problems should not be under-estimated.

How can these challenges be met?
They will need very sensitive and transparent negotiations.

How do you think the partnerships between NHSU and the NHS Workforce Development Confederations should develop?
They should develop in parallel to other providers on a merit basis. Perhaps WDCs will need be treated and see to be treated as purchasers of the provision through NHSU, in the same way they are with higher education institutions, so as to give a "level playing field".

What other sorts of organisations and learning providers should NHSU seek to work with and how?
The approach may well be to not take on too many organisations to work with too soon. Rather than drawing up firm guidelines from the beginning, and locking NHSU into contracts with providers who may show themselves to be not appropriate, NHSU should set the policy after reviewing how the ‘pilots’ work. Unless there are overwhelming reasons not to, the current operational infrastructure / material / service model as envisaged in the consultation document should be treated as a pilot.

8.8 Forming Strategic alliances ‘…access to learning facilities, resources or provision that can help NHSU attain its objectives and targets’;
If these are to be run outside the NHS, e.g. with higher and further education organisations, the contractual arrangements need to be very clear.

Section 9 of the plan.
How can NHSU ensure that all workplace learning is recognised?
There will need to be cross-disciplinary accreditation of APEL, vocational learning, etc. This requires skilled evaluation and assessment to well-defined criteria, and is a not inconsequential task.

What do you think are the challenges for NHSU in delivering rigorous quality processes and standards?
Setting standards will require a mix and match strategy to confirm appropriateness to specific goals, not all of which will be known in advance. The requirement for skilled evaluators nationally who can look at local developments is very important, and the ability to generate enough of these people, skilled to the right level, to be able to cope with the initial peak demands will be logistically challenging.
It will be necessary to develop some process to be able to ‘cash-in’ points gained from study or experiential learning at any time against particular qualifications. This crosses sectoral boundaries and will need thoughtful preparation.

9.4. High-quality processes informed by evidence.
   The first point to note is that there is at present a lack of good evidence for some of the developments proposed in and by NHSU, so one wonders whether its really intends to support these processes. For example, the case for widespread application of some models of e-learning has a relative lack of research evidence. It is worth noting that the Business Case for the IM&T Awards was found to be too challenging to make. The complexity of (experiential and formal) learning and career development of existing NHS professionals will require substantial resources to accredit and comparatively place against proposed qualifications.

   In respect of the independence of research and academic practice, one has to ask whether, if the results of research do not match the objectives of NHSU or the wider NHS will they still be published and acted upon; ie, will NHSU adhere to the academic freedoms of publishing ‘unfavourable or unpopular’ research results that are seen in other educational institutions?

Other issues from section 9

9.7 University status ‘Both the Government and NHSU believe that it is in the clear interests of learners and staff that we aim to attain ‘full’ university status.’ There will be major challenges here, particularly in respect of the research capacity and quality areas, on current guidelines, although perhaps the recent Education White paper provides the necessary routes to achieving this.

9.8 It is very important that the value of a corporate university to maintain intra-organisational communication should be retained, even at the expense of the progression to ‘full university status’.

Section 10 of the plan.
How should NHSU get involved in high quality research and development? How important is this?

There is no doubt about the centrality of high-quality research and development to improving care. However, one question that will arise is whether such research will measure up in the Research Assessment Exercise, or its successors, if NHSU seeks to include any of its ‘research active’ staff.

Steps must be taken to maintain AT LEAST the status quo.

Some of the actions as suggested in the documents may curtail current research bids and progress. Much of the research mentioned in the document seems to be about health management, with little or no mention of clinical research and the attendant ethical issues.

How are impact factors to be measured? How do you measure the effect on patient care?

Which aspects of research and development should NHSU focus on?

NHSU should play to the strengths of the NHS and nurture Action Research methods to support the development of best practice.

How can we measure the impact of NHSU learning on improvements in the delivery of patient care?

Among the measures that might be used are:
• use as a proxy the amount of private health insurance being bought;
• study the number of direct learning registrations with competitor/collaborator bodies;
• do frequent user satisfaction studies with NHS professionals.
Other issues from section 10

10.2 Capacity and partnership ‘We also recognise that clear and equitable organisational arrangements will need to be made to separate NHSU’s own research activities from any responsibility it has for commissioning, managing and overseeing research.’

This is not as clear a situation as the statement suggests, and when one adds in a remit for research dissemination, the picture becomes increasingly cloudy. The NHS and NHSU could be acting as commissioner, researcher, enabler of access to patients and ethical safeguard – ‘judge, jury and executioner’ – which poses serious potential dilemmas and conflicts, so the roles and structures will need to be very carefully examined and transparently open to challenge.

If Sir John’s Pattison’s Directorate of RAI is going to ‘trade’ research to the NHSU, will the NHSU fund less research through external agencies than is presently outsourced by RAID, and will NHSU bid for research funding from others in competition with academic and commercial bodies?

10.7 Information and knowledge management ‘Making the application of research and development work more effective also depends upon improving understanding of information and knowledge management in the NHS.’

We would agree totally on the need for this; but it is not an area in which the NHS has a good track record.

10.8 This implies that NHSU will talk to international colleagues EVENTUALLY, creating an interim Research Blight, and a possibility of restricting participation from NHS in multi-national research

Section 11 of the plan.
What sort of relationship would you like your organisation to have with NHSU?

The BCS Health Informatics Committee would seek collaborative and consultative roles with NHSU. Among our members we have many experts in educational development and delivery, by a wide range of delivery mechanisms, including open and distance education, and e-learning. We also have a wide range of subject experts who could serve as developers, deliverers and reviewers of content and mechanisms.

Do you think NHSU has got the balance right between local and national functions?

Standards must be AT LEAST national.

How can NHSU best develop and maintain its engagement with stakeholders?

This can only be maintained through engagement with a wide range of stakeholders, within and outside the NHS, and through extensive consultation and communication. Perhaps there will be a need for Discussion Boards and FAQs also on a perpetual basis

Other issues from section 11

11. New Organisation. While we welcome the search for premises within 1.5 hrs travel of London as pragmatic move (especially in terms of office costs), does this mean Reading, Birmingham, Leicester, Bristol and other places are in the radius (on a good day)?

Suggesting devolving ‘main NHS curriculum areas’ seems to indicate that there is going to be a core manifesto of what will be ‘supported’ and ‘acceptable’; if this is the case (even on a phased basis) this should be declared up front to manage expectations, as its emergence later would result in bad feelings and dashed expectations.

Section 12 of the plan.
Who should pay for which elements, levels or types of learning undertaken through NHSU?
This question is perhaps fundamental to what the whole purpose is of NHSU. If it is to provide the education and training for NHS staff to support delivery of the NHS Plan, and nothing else, then it would be difficult to make a case other than that all costs should be borne by the NHS. This encompasses a major set of issues, which could be the ones on which the whole success or failure of NHSU will depend.

If it is to have a wider remit, then it should include an option for personal payment for self-development outwith management-supported pathways.

Who pays for what and how could be perceived as another potential mechanism for managing demand, constraining expectations etc. Should it not be possible, especially as Citizens are included in the domain for studying through the NHSU, for self-payment for courses, especially where an individual wants to move out of their current setting?

12.6 If NHSU are looking to minimise cost to the NHS, they really should look at using existing infrastructures – such as WISDOM and Open University. However, the downside is that there appears to be NO MINIMUM SPECIFICATION for NHS terminals and networking, so it is difficult to ensure equity of access to e-learning. There are also a large number of health and social welfare professionals who do not have direct access at work to computers, let alone Internet-based capacity or competency (even against the NHS’s IMT Targets).

12.7 If the NHSU is to succeed or even validly bid for European Community monies it must recognise the principles of synergy and subsidiarity. These indicate that funding at EU level will not be forthcoming for any activity which could better be done at national or local level. To get around this, the NHSU will need to enter into international e-University, Virtual University, and other similar concepts.

Which other issues do you think NHSU needs to consider?

Any form of risk analysis of the whole concept, model, delivery mechanisms, etc. does not seem to be present, and will need to be undertaken, indeed should already have been undertaken.

Value for money of NHSU as against existing provision is not addressed.

There is no mention in the documents of risk transfer and contingency planning, elements which ought to figure in all Business Plans. How it is going to get any of its developments and procurements through the Government’s Gateway Procedures if the Business Case is not yet complete. The Business Case should address and meet all aspects of a ‘5-case model’ if it is to get through governmental Gateway Reviews, typically considering (1) strategic impact (2) economic value (3) financial affordability (4) commercial competitiveness (5) management feasibility. The document as drafted does not consider all 5 elements even in outline.

Other issues from section 12

• ‘Health and social care managers’ – please redefine as it is unclear whether the WHOLE document applies to a potential for social welfare professionals AND citizens. The document as currently written seems to sometimes have a wide or a narrow parochial focus inconsistently.
• There should be transparent processes for consideration of external solutions and services around ‘brokerage’.
• Expert sites – should be adequately recompensed and recognised – to avoid the overload and demotivation of previous Demonstrator and Beacon sites etc

Plan appendices

D1 and D2 - Developing NHSU’s e-learning platform and on-line services
‘…interoperability with other key NHS initiatives, such as the Electronic Staff Record, the new NHS email system and the replacement for NHSnet;’ ‘…’once-only’ registration for NHSU learners, incorporating secure validation procedures;’
All of these are vital, but there should also be exploration of authentication systems (e.g. Athens, LDAP etc) for those accessing learning materials outside NHSnet.
Consultation questions and other miscellaneous comments

The consultation questions seem generally fair and appropriate.

A few specific comments:

In the question on the staff leaflet asking ‘Which of the following would most encourage people working in the NHS to undertake learning and development?’, the list seems to exclude some of the more obvious motivators, such as financial or other rewards mechanisms.

We note many proofreading errors in the documents, particularly the downloadable PDF versions available early in the consultation exercise and that diagrams were usually missing from electronic versions of the documents. One could suggest that this does not inspire confidence in NHSU’s quality assurance mechanisms.

Appendix 1: The British Computer Society and its Health Informatics Committee

The British Computer Society (BCS) holds a Royal Charter (Information Science) and has over 40,000 members world-wide, with of the order of 5,000 of them involved with the health domain.

Currently the British Computer Society Health Informatics Committee (BCS HIC) is an umbrella body for all the health Specialist Groups (SGs). At present there are five established health SGs:
• BCS Health Informatics Specialist Group: London
• BCS Health Informatics Specialist Group: Northern
• BCS Health Informatics Specialist Group: Scotland
• BCS Health Informatics Specialist Group: Nursing
• BCS Health Informatics Specialist Group: Primary Care

Two more are awaiting formal confirmation:
• BCS Health Informatics Specialist Group: South West
• BCS Health Informatics Specialist Group: Allied Health Professions

There are two more in the process of being established:
• BCS Health Informatics Specialist Group: North East
• BCS Health Informatics Specialist Group: Acute Clinical

HIC acts as co-ordinator of the activities of these SGs and is responsible for developing and proposing new SGs when relevant. It provides funding for special activities of the SGs and funds for SG members to do pieces of work and to attend accredited international Conferences.

In addition to informatics professionals working within healthcare delivery and research, the HIC represents clinical professionals and health managers with a significant interest and involvement in informatics to support health. HIC works in conjunction with over 40 Liaison Groups who sit on the Committee as observers. These constitute all the major organisations concerned with UK healthcare IT.

The BCS Health Informatics Committee (HIC) has collective objectives addressing:
• the provision of a focus and point of contact for health informatics for and about the UK, both nationally and, increasingly, on an international basis. The coalition of relevant bodies for the purpose of exchanging ideas, promoting developments, maximising synergy and co-ordinating efforts
• the effective dissemination of the message of sound principles and good practice in health informatics
• the submission of informed comment on topical issues and major initiatives
• the facilitation of communication of UK activity in health informatics on a wider basis
• the management of an annual conference and exhibition (and contribution to similar focused specialist
group events) as a recognised national forum for these objectives (the annual HC event in March)

The HIC supports a website - http://www.health-informatics.org/hic - which contains descriptions of the general background of HIC, the constituent Specialist Groups, the Liaison Groups, the people involved, international associations, conferences, meetings of the groups, and journals. There are links within the site to further details of all of these.

Specific activities of HIC currently include:
• The publication of Ethics Guidance for Health Informaticians
• Workshops considering how the Department of Health (DoH) strategies can be achieved.
• Commenting on all major reports and proposals from Government.
• Liaison with senior members of the DoH and NHS
• Working with the NHS, the Medical Royal Colleges, NHS IT organisations and other bodies towards developing health informatics professionalism in the UK.

Appendix 2: BCS HIC response to PROPOSALS RE NHS UNIVERSITY, Nov. 2001

Submitted November 2001

Contact: Jean Roberts (jean@hcjean.demon.co.uk), HIC Task Group on Communications

SUMMARY

Overall, the British Computer Society Health Informatics Committee (BCS HIC) has significant grave reservations about the proposed NHS University. These concerns cover the core purpose of the NHS, educational issues, organisational logistics and the technological solutions required to deliver and sustain the concept over time. The BCS HIC is very willing to expand its comments and would wish to be involved in any further developmental considerations of the NHS University.

The BCS HIC respondents consider key challenges for the development of an NHS University to include:

• Balancing the declared aim of all NHS staff ‘reaching their full potential and achieving their ambitions’ with the agendas of effective, efficient and value for money service delivery, the goals of external educational providers and the limited resources available to bring this about
• Provision of support for staff doing education, development and training (EDT) whilst maintaining quality of service (this includes provision for locums and financial inducements)
• Allaying concerns that continuing professional development (CPD) may be used as an alternative way to monitor competence and a proxy for performance
• Breaking down inhibitors to professional development including the current management culture
• The development of a knowledgeable workforce by harnessing existing informatics & communications technologies and a range of learning styles and modes, rather than diverting funds from care priorities
• There is a strong view from the BCS HIC that the NHS should be looking to accredit qualifications from those focused on educational provision rather than creating a new vehicle.

BACKGROUND

• The BCS has over 30,000 members world-wide and of the order of 5,000 of them are involved with the health domain. The HIC is made up of 3 geographic groups, groups focussing on primary care and nursing informatics and a strong body of constituent liaison bodies including IHM (health managers), IHFRO (health records professionals), BMIS (medical informaticians) and other profession-specific societies. In addition to informatics professionals working within national healthcare delivery and research facilities, the HIC represents clinical professionals and health managers with a significant interest and involvement in informatics to support health.
• Many of the members have an involvement in commissioning and providing academic and vocational education, training and awareness at a local, national and international level; the latter through the International Medical Informatics Association, of which the BCS is the UK national representative society and its particular international Virtual University initiative.
• BCS HIC respondents would:
- Wish to input the international and professional experiences of its constituent members to further stages of consideration of the NHS University
- Welcome further exploration of a model that commissions the types of education the NHS wants and franchises their delivery to bodies focussed on their delivery
- Applaud the establishing of a positive partnership with focused educational providers and commercial bodies
- Be well-placed to nominate experienced professionals to be involved in many stages of the NHS University consideration, including the business case assessment, technical viability, academic accreditation, working in the e-environment and validation of educational content, user satisfaction and market communication

There is a strong feeling amongst the BCS HIC that if, as the documentation states, the predominantly successful UK Open University model is to be aspired to, there is mileage in exploring assimilation and refinement of that entity? Current documentation has not put up a cogent case for a parallel NHS-specific body.

The following represents views from members of all the HIC constituent bodies <<and has the acknowledgement of the BCS per se>>.

GENERAL CONCERNS

The domain of the NHS is considered to be in a state of considerable flux and disquiet at present with a necessary requirement to import clinical professionals and export patients. The position of the UK health service internationally (slipping substantially against WHO league positions) makes a diversion of resources into the accreditation of staff development (however cohesive) unpalatable. Strong views from operational NHS players who are active in health informatics emphasises the desire for the NHS to focus on its core purpose of delivering care and maintaining health.

Even within the UK, the constant upheaval of the health sector and the convergence of health and social welfare in the relatively near future, indicates that the focus on the NHS University as a domain may be outdated and impractical by as early as 2004. There have already been considerable changes, for example for nurse teachers who have recently undergone a change into the higher education sector. An NHS University is seen as further upheaval, for which a convincing case has not yet been made.

The BCS HIC represents members in all home countries and is concerned that the proposal for an NHS University does not have full backing across the whole domain, given the strategies for each country are at different points in their implementation and have different target dates for milestones.

The wide range of subjects suggested within the portfolio of the proposed NHS University is even wider than that of the UK Open University, and as such the traditional definition of a ‘university’ is inappropriate. Either considerable re-marketing or the coining of a different term will be necessary to generate an appropriate image for the proposed entity, should it go ahead.

The pressures of operational responsibilities are such that ring-fenced resources (technology, time and money) for EDT are unavailable. The achievement of an NHS University, even if its principles were found acceptable, is felt to be unlikely.

There is a recognition that the NHS University will need to avoid conflict with ‘vested interests’ such as the new Health Professions Council, GMC. UKCC and the Royal Colleges by making the distinction between pre- and post-registration training. As post-registration equates substantively to post-graduate, it is felt that general traditional and emerging university provision is best placed to address this.

The unavailability of enough qualified competent staff to deliver sufficient higher and further education to meet the increased demand from a successful NHS University initiative is likely to create an unmet need, given the current demographic changes and profile of training of educational providers at present.
BCS HIC respondents feel it will be difficult to convince the general public about the goal of the NHS University and its position with reference to the crucial core objectives of the NHS to deliver care.

**NHS University – concept**

The range of professions and staff groups recognised as eligible for development is to be welcomed. However, the eclectic nature of the groups makes the likelihood of the achievement of a common cohesive infrastructure less likely. It must be recognised that BCS HIC group members may work outside the NHS (in other healthcare delivery and academic facilities or in industry, consultancy or commerce or in related sectors on secondment and career development assignments) whilst still working for or to the principles of the NHS. The current proposal for an NHS University is not therefore inclusive of all the potential participants in it. This is especially crucial because the mobility of staff both in and outside of the NHS must be harnessed if the NHS is ever to recruit and retain all the staff it requires to maintain a quality service.

**Continuing Professional Development**

Recognition of competency in whatever subject has to be possible in an experiential manner in order to retain and attract staff to the NHS. A particular challenge is in defining, recognising and accrediting the current level of existing staffs. Their backgrounds will be complex and varied and difficult to map to a guided career path or as contributory to particular awards. BCS HIC members can identify and provide expertise with a number of Training Needs Analysis tools.

For example, with informatics (IM&T Awards) within the NHS, the difficulties of inclusivity of award and qualification for existing staff from multi-professional backgrounds have not yet been fully addressed (despite the activities of groups like the NHS IA Ways of Working programme and the UK (Virtual) Institute of Health Informatics).

A concern has been voiced about whether a facility for CPD with an NHS imprimatur will covertly constrain its portfolio to only the core competencies the NHS itself needs to satisfy its short-term workforce and human resource requirements?

It should be recognised that across a workforce of nearly one million, there will be a plethora of learning styles to be accommodated, and that `one size fits all' will not be successful.

**E-LEARNING**

Overall, the BCS HIC view is that e-learning has a value but should be developed alongside continuing traditional EDT until and unless all target groups embrace the concepts and the infrastructure is in place for such learning delivery to be equitably available and effective across the board, regardless of pre-existing cultural, academic competency and technological issues.

Many BCS HIC members are designers, developers and deliverers of learning in this emerging mode. E-learning is an expensive environment to establish and is not the panacea for all learning challenges. Distance learning, flexible and open courses are useful, but require some release from operational duties and should not be considered as the `cheap option' or to be undertaken solely in personal time. It is naive and simplistic to assume that an e-environment will produce a solution without extensive preparatory work, which will need considerable investment up front.

Whilst there are a number of initiatives amongst different professional sections of the NHS addressing EDT delivery in this way currently, these initiatives are fragmented and inconsistent. The technology, the benefits realisation and adoption of this way of learning across the board are not yet proven in the NHS scenario. An umbrella body introduced in Autumn 2003, however virtual, may expend disproportional resources before the concepts are proven.

**TECHNOLOGY**
The technological infrastructure for operational support to healthcare delivery is not fully operational, and is not therefore available to support an NHS University. Whilst ubiquity is closer if home computing is included, it is still not feasible to consider available technology, however provided, as socially inclusive. BCS HIC members were indicating the potential of NHSnet as a cost-effective medium for continuing professional development back in 1997 (BJHC&IM, 14 (8) 30-32) but it was not suggested then, nor is it now, that it was scaleable to support a ‘university’ as envisaged now.

Developments such as the European Commission Information Society project MTM demonstrate e-learning through a personal device, but current bandwidth cost and availability precludes prototypical solutions being rolled out in practice to an organisation as wide as the NHS.

**ALIENATION**

In addition to the concern that the NHS University may compete with traditional educational locations for students and therefore funding, BCS HIC respondents highlighted as issues:

- The perceived need to create a distinct identity that presents an attractive synergistic image with existing education providers who may otherwise view the NHS University as a threat
- Finding sensitive mechanisms to remove historical ‘craft group’ elitist and protectionist barriers – in educational, research and operational contexts, in order to create a facility that is able to motivate and deliver to all – whether porter or professor
- The mandatory requirement that any NHS University established should operate as a business venture; looking to developmental pathways that are organisationally cost-effective, value rich for the individual and academically sound
- Looking to establish much more fruitful liaisons with industrial partners in the widest sense; encouraging a climate for investment partnerships, operational co-existence and satisfactory routes to transition research and researchers into practice and commercial viability
- The challenge of maintaining the parity of any NHS-specific University with similar courses delivered by other routes (particularly affected may be non-clinical qualifications and awards)

There is a strong view from the BCS HIC that the NHS should be looking to accredit qualifications from those focused on educational provision rather than creating a new vehicle. However, this would require a concerted effort over a short period of time in order to avoid a potential ‘restraint of trade’ caused by an elongated and selective validation process. A protracted process of accreditation could jeopardise the career development of NHS staff (potential and existing) who have qualified in routes not yet recognised within the NHS ‘portfolio’.