FROM CONCEPTION TO BIRTH

A POLICY ANALYSIS OF THE NHS UNIVERSITY

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FOREWORD BY

JOHN WYN OWEN

FOREWORD

In publishing this report, the Nuffield Trust reaffirms its commitment to promote independent analysis and informed debate about UK health care policy. In particular, the Trust has been keen to stimulate a rethinking of the tripartite mission of service, education and research that underpins the work of the NHS. As higher education has become increasingly important to the service in recent years, the need for clear perspectives on changing institutional arrangements has also increased.

In *From Conception to Birth: A policy analysis of the NHS University,* Celia Davies provides an insightful analysis of the genesis and development of an important new institution in the UK healthcare system. By locating its emergence within the changing web of relationships between government, the NHS, the health professions and higher education, she enables the NHS University to be seen in the wider context of the major changes that have taken place in each of these spheres over the last decade or more. The prospects for the NHSU are also viewed in terms of some of the wider forces that are shaping the way education is thought of and delivered, and in particular the emergence of the corporate university. It is argued that, as a public sector corporate university covering over a million people, the NHS University is uniquely placed to play an important role in the field of lifelong learning.

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Thanks for help with information for this paper are due to a number of people who have been involved in the debates about the setting up of the NHSU, and to The Open University colleagues. Mary Ann Elston and John Humphreys provided detailed comments for which I am particularly grateful. It should be stressed that while the paper includes a small number of remarks quoted with permission, the arguments are based on a study of material in the public domain, together with a certain amount of personal involvement. Nothing stated here should be construed as representing the views of the NHSU, The Open University or any other parties.

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INTRODUCTION

Policy has been changing at a bewildering rate since the announcement of a 'New NHS' by the Labour government, six months after it first took office (Department of Health 1997). The array of new agencies, the altered priorities, the detailed central directives and accompanying volume of documentation, create a relentless pace for staff, leaving them with little time for reflection. For those in the academic world, the challenges are also acute. University and college teachers are increasingly invited to come alongside the learner, to focus activities more firmly on creating specific competencies required for work at different levels. And yet educators are also invited to bring a broader perspective to the project of 'modernisation', to generate the capacity to analyse and engage constructively with the project of public sector renewal. The idea of creating a new kind of higher education institution, a corporate university for the NHS, is closely bound up with the Government's modernisation project. A new kind of service, it seems, requires a new kind of educational support.

Is there an evidence base that indicates the need for such a development? To talk of the evidence base is common in a world of managerial fads and fashions (Marmor 2001). Another current fashion, increasingly adopted in official policy documents, is future-oriented scenario-building. The first officially sanctioned account of the NHS University (NHSU) took this latter route. With 'Derek' and 'Linda', 'Christine' and 'Rakesh'- we were offered profiles of four people living a new kind of life of learning in the era of the NHSU (Department of Health 2001a). This paper resists both these directions, exploring instead the provenance of the NHSU - the background in which it has emerged (Davies 2000a). Specifically, it is guided by three broad propositions about the nature of a policy process and the shaping of the new institutions to which they give rise.

1. Policies always develop, they are never simply implemented

There is a longstanding strand of policy analysis that argues that the idea that implementation follows policy formation is overly simple (Simon 1958, Lindblom 1959). Neither the initial knowledge nor the levels of power and control that implementation implies are present. And if 'perfect implementation' is impossible (Hogwood and Gunn 1984), then policies are necessarily shaped by those charged to take them forward, and subject to an array of surrounding influences. Real world policy, in other words, develops through an active, iterative and often untidy process, where the new is not simply put in place, but actively created by participants (Kingdon 1984).

2. Policies attempt to fix a fault

It is not just a wish for improvement that drives a new policy. Its content and direction is shaped by an analysis of what is wrong, and who and what needs to change to put it right. Implicitly or explicitly, policies pin blame on something or someone - frequently a something or someone who is crucially important to the success of the new policy. In practice, however, it is rarely easy to lay the blame for a turn of events at the door of one single party. And to pinpoint blame, questioning the competence or motives of those who have worked with the old, can store up problems for the new.

3. Policies are shaped and reshaped by the context in which they emerge

Such a statement may seem trite. Taking it seriously, however, calls for close attention to the context, both immediate and longer term, in which policies are played out. There needs to be some understanding of the perspectives of the participants and their experience, and some understanding too of the vested interests that surround them. All this can be helpful in clarifying options and in tracing the way in which a policy unfolds.

Working with these orienting propositions, the paper will fall into three main parts. Part one describes the specific trajectory of events that have brought us to the position, at the turn of 2002, where the NHSU had issued a public 'prospectus' and was setting its priorities and putting in place the beginnings of its development team. Part two takes a longer view, sketching in some of the historical legacy of relations between educational institutions and the service and focusing on developments in the more recent past. Here policy developments have included, for example, the unification of educational funding streams and the formation of Workforce Development Confederations, as well as the creation of the NHSU itself. The third and final part of the paper will make reference to the rise of mega-universities, the reconfigured structures, the possibilities of on-line learning, and of course, the rise of corporate universities of which the NHSU can be seen as one.

1. THE NHSU - CAREER OF A CONCEPT

From personal vision to party political reality

The origins of the idea of a university for the NHS can be traced to what perhaps would seem an unlikely source, the British Association of Medical Managers (BAMM). The Association was constantly being confronted with a difficult reality for doctors who were trying to move into managerial roles. Their clinical education and work was no preparation for coming to grips with how the system functioned and how to work effectively across the complex occupational and organisational boundaries involved in health care. Their own backgrounds, attitudes and skills could work against them and the tensions and divisions between occupational cultures were all too apparent. Chief Executive Dr Jenny Simpson brought a further experience to bear. Mother of a small child needing frequent health service care, she was all too painfully aware of communication failures and system shortcomings of a service which fell down in its support of people at their most vulnerable. She tells a story of how car park staff at Disney in the USA, trained through the company's corporate university in first aid and customer care, came to her aid. It was an experience that prompted her to find out more about corporate universities and to develop the argument that empathy and other values were important as part of the core educational programme for everyone joining the NHS (personal communication, January 2002). If the NHS were to take on what the Labour government was calling the modernisation project of a truly patient-focused service, then alongside the redesign and joining up of services, there had to be a major shift in attitudes and behaviour of all staff. And the only way to do that was to inspire and motivate people through education and development.

An initial paper outlining the idea of a University of the NHS began to be discussed with BAMM members and other parties early in 2000 (BAMM nd.a). A small set of energetic leaders of system redesign and culture change, the paper argued, was no longer enough. A broader and more inclusive approach was indicated - designed to include every individual at every level and to empower them to be more effective players in reshaping services to meet need. Corporate universities offered a model. As well as Disney and other well-known corporations with international reach, the leadership development programmes in the USA, for example of Savannah Memorial Hospital, Georgia and Beth Israel Hospital, Boston, seemed to point in the same direction (BAMM nd.a: parai2). Why not a university of the NHS?

At the heart of a University of the NHS, it was thus suggested, there should be a core programme of leadership and personal development - giving people a grasp of how the system really worked, developing skills for example, in negotiation and communication, in influencing and appraising colleagues. This core needed a compulsory induction programme emphasising the culture and values within the NHS and putting into words the expectations it had of its employees. It could also bring in life skills programmes for staff. It could sit alongside clinical education programmes run by Royal Colleges and professional bodies. It could provide a support environment for other programmes - well-known offerings from a range of schools of management in the public and private sectors were named as examples. The professions and key stakeholders such as the National Institute for Clinical Excellence and the Commission for Health Improvement would have an involvement in programme design. Key ideas were captured in the diagram shown in figure 1.

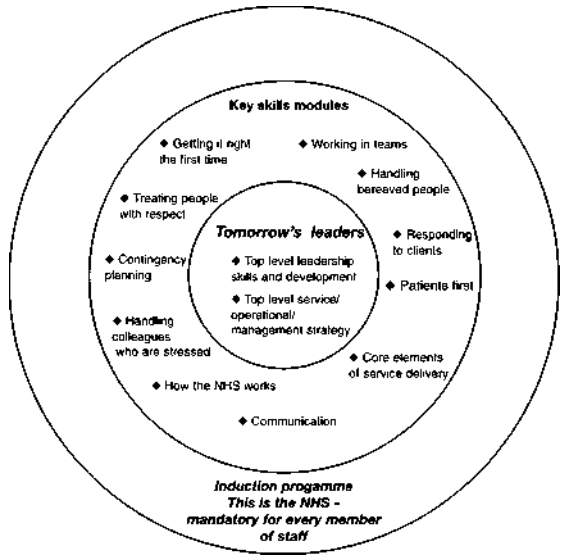
The growing technological capacity for learning online was a key feature of what at one point was called this NHS Online University'.

The taught programmes, in the form of presentation, discussion and case studies on CD-ROM would be reinforced by web-based facilitated networks, tutoring and mentoring, using technology already available in the form of virtual meetings, chat rooms and bulletin boards.

BAMM nd.a: para. 9

Evidence from the US, the paper argued, demonstrated that well-designed programmes could bring in people currently without IT skills, making learning accessible and fun.

Figure 1:



Source: BAMM (nd.a)

Throughout the first half of 2000, the idea continued to develop. In May, at the BAMM annual conference, Jenny Simpson laid particular emphasis on the importance of the induction programme. She went on to name a range of optional courses - decision-making strategies, IT, ethics, law, communication skills, managing money and time management - all taught mostly via CD-ROM and web-based learning groups and all attracting accreditation (Hospital Doctor, 22 June 2000). Networking helped to flesh out ideas. There were informal contacts with NTL and there were visits to The Open University. Meetings around the emerging National Electronic Library for Health stimulated a further paper in scenario-building vein. It imagined a continuing learning environment of the future in which 'Sally Rowe', clinical practitioner working in diabetes care,

logs in to the personalised continuing learning environment site, is prompted about progress in her studies, linked in to relevant peer networks, and advised how to progress (BAMM nd.b).

These ideas were not emerging in a vacuum. Informal discussions with some of the officials involved suggest that others were already thinking along similar lines, talking of the formation of a new college, academy or institute. Jenny Simpson, however, was well-placed to take the idea of a university into the heart of decision-making circles in the NHS and into government more generally. She was involved in one of the Modernisation Action Teams which preceded the publication of the far-reaching NHS Plan in the summer of 2000. She was one of what were to be 12 stakeholder signatories to the document when it was published (Department of Health 2000b). While hopes for an explicit commitment to the idea of a university for the NHS in the NHS Plan itself were dashed, Jenny Simpson's subsequent presence on the new Modernisation Board helped keep the idea alive. Work also now went on behind the scenes in Whitehall to advance the notion further, co-ordinate responses and build support. All this meant, however, that the idea would emerge onto an already crowded policy stage and would have to find its place alongside an array of other new institutions. The new Leadership Centre, for example, was already the focus of attention and activity following the publication of the NHS Plan.

The university idea gained official endorsement in spring 2001, in the context of the general election that was to give Labour a second term in office. The manifesto made a clear commitment.

We will set up a University of the NHS to guarantee to staff at all levels opportunities for career development. Healthcare assistants, porters, cooks and cleaners will be offered an individual learning account worth £300 a year to develop their careers. We will examine the potential for sabbaticals to help GPs, consultant nurses and consultants keep their skills up to date.

Labour Party (2001:22)

Reading the manifesto, it would seem that three related strands of political shaping had taken place around the idea. First, Labour was running for re-election on a programme that firmly tied together 'investment and reform'. Public services renewal, the argument went, had to mean more than just more of the same. To produce *'world-class public services' and 'fast, high quality treatment meeting rising expectations'* (ibid:i7), staff needed be much more responsive to change. Alongside more nurses, more doctors and others, major investments in leadership and in the skills of existing staff needed to be key components of the public services modernisation project. Second, the commitment to staff development was construed very widely. There had been questions, after the publication of the NHS Plan, as to who would be entitled to monies for learning - UNISON quickly taking up the issue on behalf of its members. The idea that the University of the NHS was to be for staff at all levels was now unambiguously underlined. We might perhaps see a Labour hope here of appeasing its old guard, of building a new relationship with its historic allies, the trade unions. Trade unions were themselves already beginning to sign up to the notion of 'learning representatives' alongside traditional shop stewards in the workplace, seeing for the first time the possibility of real pathways for both economic and social progress for their members.

Thirdly, the new institution played on an even wider canvas - of Labour's historic commitment to promoting social justice and reducing inequality, doing it in New Labour fashion through education. As the manifesto put it, 'every extra trained, employed worker contributes to a fairer society, as well as to a more prosperous one' (ibid:8). The plans for enhancing basic skills through the Learning and Skills Councils, the vision of workers whose initial literacy and numeracy skills had improved, and who could then move into a University for Industry course, were clearly shading over into the idea of a University of the NHS. The commitment to a 50% cent participation target and to two-year foundation degrees as 'the option of a vocationally relevant, high quality qualification as a way into skilled work or further study' (ibid:2o) linked with this. In short, blue skies ideas, seen initially through the eyes of a small and unrepresentative corner of the medical world, were now beingtaken up in terms of a political agenda-of social inclusion and social justice as well as public service renewal.

The Times ran a front-page article. 'Nurses could become doctors and porters could rise to become managers', it began, envisioning as many as 100,000 people, a tenth of NHS staff, involved in courses which could range all the way up to degrees (The Times, 22 May 2001). The newspaper saw the new university as one of Labour's really big ideas in the campaign. And it linked all this with The Open University, an equally big Labour idea from an earlier era. It was a move that caused a flurry of surprise, but also, given its value base, a positive response from The Open University itself.

A second phase

After the election, the nascent University of the NHS became part of the work programme of the Department of Health Strategy Unit whose task it was to develop the idea further. With Professor Chris Ham seconded from his post as Director of the Health Services Management Centre at the University of Birmingham, the Government had someone in charge who combined current experience of the university sector with a deep familiarity with the contemporary development of the NHS. The topic, however, was just one among many priorities for a small unit working closely with politicians across the whole of the brief of the Secretary of State for Health. Could they learn from others - how much, indeed, could be learned from The Open University with its 30 plus years of open distance learning experience and a scale of delivery that dwarfed any campus university in the UK? How, for example, did it organise its UK-wide regional presence, what faculty resource was located there and how was student support accomplished? What kinds of on-line learning was it offering and in what forms? Politicians would want 'early wins' - which meant visible progress in time for the next general election. Any background work done at this stage might not be taken up, but it would give a fair wind to the development once a chief executive was in post. Exploratory visits to The Open University were arranged.

The first public signs that further thinking had been done came with the publication of an advertisement for the post of chief executive designate for the university. A glossy brochure, the 'prospectus', was prepared, key elements of which were

subsequently loaded onto a dedicated web-site (www.doh.gov.uk/nhsuniversity). The Times Higher Education Supplement (THES) reported considerable hostility in relevant groups in the university sector. There was alarm that a new institution, which had not followed the route to chartered status, had the temerity simply to call itself a 'university'. There was a feeling that establishing a separate university could be a costly diversion of resources and threatened to undo the developments in partnership working that had been achieved. There was doubt about whether the programme as outlined merited the description of a university prospectus. The THES, taking into account the sheer size and scale of the undertaking, signalled all this with a headline 'Birth of NHS Monster' on its front page (THES12 Oct 2001). Its leader writer commented that the idea, broadly a good one, had all the hallmarks of a 'hasty prescription' and interested parties deserved to have a say (ibid:i4).

The importance of a wide range of consultation and dialogue and the creation of models of partnership had actually been acknowledged in the prospectus. It emphasised:

We will keep talking to a range of organisations with a stake in the project, such as patients' organisations, Universities UK, The Open University, the Department for Education and Skills, the Higher Education Funding Council for England, the BBC, the trade unions, the Royal Colleges, the British Association of Medical Managers and the NHS Confederation.

Department of Health (2ooia:io)

Government also, having already had wind of hostility over the title issue, had moved to repair the damage by making it clear that the University of the NHS, while it worked towards university status, would henceforth be referred to as the NHSU (THES 5 Oct 2001:56). The Strategy Unit, however, moved swiftly to pour more oil on troubled waters. A follow-up article in the THES offered important reassurances (Ham 2001). The NHSU would not reinvent the wheel - it had no desire to duplicate good programmes that were already running. It would develop in dialogue with key stakeholders and in partnership with existing providers. Degree awarding power would be sought in due course through normal channels and - something that had been giving great concern - pre-registration programmes would not be among the early developments. Making a significant move to mollify the critics on this last point, work began on a Memorandum of Understanding between the Department of Health and Universities UK (the recently renamed Committee of Vice-chancellors and Principals). A brief document was released at the end of November. It emphasised the history of well-developed local and national partnerships between the NHS and the Universities. It noted innovative work already under way, giving assurances that the NHSU would build on good practice, including good practice in e-learning. It referred to possibilities for joint accreditation. And, most importantly of all, it gave a specific undertaking that the NHSU would not establish pre-registration education for health professionals. In circulating this document to member institutions, UUK took the opportunity to attach for its members the Department of Health press release on the matter which also announced the appointment of the chief executive designate, Professor Bob Fryer (UUK 2001). Bob Fryer came from a post as Assistant Vice-Chancellor at the University of Southampton. He had directed New College, an institution established with the specific purpose of widening participation in higher education. He was a member of the UK Learning and Skills Council, brought a background in adult education and a record of working with the trade union movement. He took up his appointment formally on 1 February 2002.

The concerns which had surfaced at this point were not simply matters of status and of duplication. The funding of pre-registration nursing over the last decade had become a substantial part of university income. Without it, as some of the early short term contracting had shown, university departments of nursing were not viable - indeed where those contracts were short term, they could present serious difficulties in recruiting and retaining academic staff and planning development - a point that will be taken further below.

All this took attention away from the shape that had been put on the content and activities of the NHSU during the time of its residence in the Strategy Unit. Much remained as before. It was to be a university for all in the NHS. 'Everyone' was the title of the document and the 'porters, cooks and cleaners' vision was in the forefront. The NHSU would work on a hub and spokes model, rather like the University for Industry, using both e-learning and local resource centres based in the new workforce development confederations. But it would have a base too - it

Figure 2: Development Areas for the NHSU

Induction - common programmes on core responsibilities, behaviours and values.

Patient care - programmes in partnership with public private and voluntary organisations to create a climate supportive of patients.

Communication - programmes relating to patients, teams, professions and organisations.

Mandatory programmes - e.g. lifting and handling, resuscitation, infection control.

Basic skills training - literacy, numeracy and IT.

New technologies - IT skills for learning and for managing patient care.

NSFimplementation - equipping clinical staff to meet best practice.

Service improvement programmes - skills of problem-solving and service redesign.

National programmes - a strategic approach e.g. to the Graduate Training Scheme.

NICE/CHI - ensuring advice reaches the right people.

Project management - enabling staff to manage practical projects.

Source: abridged from Department of Health 2001a:8-9

would be a matter of both 'bricks and clicks'. It would draw on national strategies for the NHS and develop training and support for National Service Frameworks and other advice and guidance (Department of Health 200ia:6).

Five main areas of activity were outlined - providing a core curriculum, acting as a signpost to existing training, providing a range of foundation, first-line and basic programmes, quality assuring and accrediting existing training, and developing evaluation tools to ensure education served to improve patient care (ibid:6). Eleven 'development areas' were briefly listed. These, it would seem, were drafted with a close eye on the array of central initiatives under way to improve the quality of services. (See Figure 2). Looked at from the perspective of a traditional university academic, the list must have seemed a puzzle. No way was it a university prospectus in any usual sense of the term. Had it not been for the emphasis on building up awards and credits, readers could be forgiven for seeing it more akin to a training college model than to a university one. But the prospectus made clear that a lot was still to play for. The document ended with a series of questions - inviting and encouraging readers to send in their views.

Into the NHS

More developments were in the wings. Little more than a month after the prospectus was first available, a half-day planning seminar was held. It was to coincide with the launch of the government's long awaited framework for lifelong learning for the NHS in England (Department of Health 2001b). Invitations went out from the NHS Learning and Personal Development Division to Chief Executives of the new Workforce Development Confederations, to the Royal Colleges, to the Council of Deans and Heads of Medical and Nursing Schools. Participants included individuals from something approaching a dozen universities, from trade unions, the UFI, the e-University and others. A question and answer brief made some things clear. The NHSU would both commission and provide education, it would identify gaps and expand over time. It would offer e-learning and distance learning, while recognising too the importance of personal and face to face contact. Other things were less clear - the relationship with the higher education sector and other bodies remained for discussion. The move to become an awarding and accrediting institution was to be in the future. The plan for a central hub now envisaged about 30 spokes, 'to provide local input and support alongside workforce development confederations' (Anon 2001:3). The eventual size and cost would be dependent on many factors 'not least of which is the extent of partnership with other institutions' (ibid:i).

The lifelong learning framework (Department of Health 2001b) gave a firmer NHS context to developments. Lifelong learning, it was explained, was one of four main planks of the current human resources policy. It sat alongside modernising pay and contracts, developing a streamlined regulatory framework and growing workforce numbers. A 'golden trust' was one that took advantage of all these developments in a coherent way, linking up education and training with personal development plans and appraisal, extending education to all, and showing itself to be a learning organisation, spotting and nurturing potential at all levels. There were four distinct areas of activity. First using a 'skills escalator' approach, learning opportunities needed to be opened up right across the NHS. Second, pre-registration education had to change, concentrating on skill-sharing across the clinical professions and opening up access as never before. Third came maintaining and extending the skills of existing staff, not just a matter of clinical update but of extending beyond clinical competence, for example into enhancing team capacity. Finally, there was leading and managing - where a more systematic approach and work at every level was needed.

Where exactly did the NHSU sit in all this? In the first place, it was now clearly envisaged as key to delivering the vision and the core values as expressed in the NHS Plan. References to it were to be found in each chapter - with the exception of the chapter on pre-registration education. There was a long list of activity around the skills escalator - basic skills work, use of Learning and Skills Councils, a promise of access to VQs at levels 2 and 3, NHS learning accounts, modern apprenticeships, foundation degrees and so on. A UFI NHS sector hub with 'Learndirect' centres was already centrally funded and in place in 16 trusts - over time there would be 'expansion through partnership with the NHSU' (ibid: para. 38). On the matter of continuing professional development, the NHSU, again in due course, would build on programmes already available, 'signposting and helping staff to make informed choices...'. The future scenario for 'Rebecca', the speech therapist, indicated the way in which the NHSU might act as a sophisticated information system. It could cut through the maze - indicating competencies for the next level in her career and pinpointing relevant learning opportunities, booking her onto a programme and linking her achievements with her personal record (ibid: para. 56). In the 'leading and managing' area, a corporate induction programme would be one of the first pieces of work of the NHSU. Within 3 or 4 years it would become 'a major partner with the Leadership Centre in delivering, co-ordinating and supporting leadership development, nationally and locally' (ibid: para. 63). The expectation of multidisciplinary and also multi-agency development across health and social care was underlined.

Publication of the framework for lifelong learning had thus put what was now a third gloss on the government idea of the NHSU. The manifesto had drawn the University into Labour's policies for social justice and for public services. The Strategy Unit had suggested content, brought aims closer to the current NHS policy and begun to outline some of the crucial links to the NHS. The Framework Document finally brought about a tighter integration with what had been a rapidly evolving HR strategy for the service. But the integration was more apparent than real. The NHSU idea had been brought late to the table. Could the interloper become the arch-co-ordinator? Could it succeed in aligning its activities with the Leadership Centre, the Modernisation Agency and the newly established Workforce Development Confederations, charged with planning and commissioning education for their localities? Induction was to be the linchpin, but was the NHSU to deliver a core curriculum as BAMM had envisaged or was it to have an altogether more amorphous co-ordinating role mapping and accrediting? The 'Rebecca' example suggested it would be getting into occupational standards and into rationalising the information systems needed to create a unified staff learning record -

muddy waters indeed - and all this with no clarity as yet on new monies and old.

Upbeat sentiments ended the Framework document. The position, it claimed, was one of' unparalleled support for all NHS organisations to develop and sustain a learning and knowledge sharing culture' (ibid: para. 67). At the year end, there was a similar message in-house for the NHS. With learning opportunities at every level, Workforce Development Confederations working together with education providers, the NHSU and the Leadership Centre, the scene was set for the NHS to become a real learning organisation, improving patient care through enhancing the skills and sustaining the morale of staff (Spencer 2001). And yet, the parallel policy processes, the crowded stage of players and the pressure from politicians, were all going to give major challenges. The next section will try to put more analytical interpretation on this set of events, stepping further back to start to explore why there had been such a lack of warmth from higher education providers about the vision that accompanied the idea of the NHSU.

2. A FAULT, A FIX AND A FRAMEWORK

New institutions, as the previous section has emphasised, do not work in a vacuum - legacies of the past and tensions of the present are mirrored and reflected in what develops. This section dips somewhat deeper into the provenance of policies on the relation between education and service which are brought into the spotlight with the emergence of the NHSU. While as yet, there is little in the way of detailed primary research on which to draw, the overview presented here suggests that the NHSU has emerged in the context of historical relations between the NHS and higher education which are increasingly complex, fragmented, and tense. Three distinct periods will be outlined - each taking a new tack, each responding to the one before. The NHSU has emerged at a point where the tensions in relations between educators and service providers have become particularly acute.

Tradition, deference and hierarchical divisions

The NHS in its first 30 years was a time of strong faith in professions. Doctors, teachers and others in the social welfare field came to the fore. Governments provided the resources of money, plant and people to enable the professionals to use their expertise. The welfare state supported them by arranging for an environment in which they could exercise their skills, seeking to administer public funds in a way so as to ensure these skills were available equitably. As times have changed, so social policy analysts have begun to see more clearly the assumptions which underpinned the early welfare state. They have underlined the ways in which it elevated and trusted the expertise of the established professions, at the same time as mobilising and reinforcing traditional hierarchical and deferential relations of class gender and race (e.g. Butcher 1995, Clarke and Newman 1997:ch1).

Educational arrangements for health service professions were an expression of this. The medical profession dominated. Dentists perhaps escaped the yoke most, but all others, nurses and those grouped together and actually labelled professions 'supplementary to medicine', worked at the instigation of the doctor. The way they were educated and trained reflected and sustained this ordering. The medical schools remained associated with the oldest and most distinguished universities, looking more, however, to their long established Royal Colleges to be holders of standards and traditions. The long established and prestigious teaching hospitals with which they were linked, were granted a separate place in the governance of the NHS. When new medical schools came, the debates were much more about how many students rather than about what and how they were to be taught (Webster 1988). Sociologist Margaret Stacey, in her study of the General Medical Council of the 1970s and 1980s, observed the importance of the titled, and well-connected elite, the deans and professors, who conducted the business of professional policy informally over good food and wine. She emphasised the unthinkability of any external challenge and the distinctly 'light touch' of regulation (Stacey 1992). The join between a professionally dominated, private government of education and the delivery of care in the health service was accomplished through the long years of apprenticeship that followed medical school. Junior doctors were the real losers. The long hours on the wards, the cramming for exams, the humiliating process of attachment to the consultant, created heroes who, having survived, were ready to put the next generation through the same process. It was still possible to regard clinical knowledge as something for the few, gained at the outset of a career, with little needed in the way of overt competency checking or top-up later.

The contrast with nursing education could not have been more marked. Nursing schools had grown up closely associated with a myriad of local hospitals, with students providing the bulk of day to day labour as 'pairs of hand' on the wards. The General Nursing Council, as the statutory body responsible for registration, fought hard to increase the educational level of entry and improve and extend the curriculum. Its gains were limited. By the 1980s, despite waves of school mergers, education and service remained closely intertwined, and service was firmly in the lead. There were a few pioneering university programmes leadings to registration and a degree. For the most part, multiple intakes each year meant a relentless grind for tutors and a growing headache around placement and 'cover'. The demands of daily work on the ward continued to limit curriculum innovation. Around 2% of nursing students in England were studying for degrees; for the overwhelming majority, there was no agreed academic currency for their three-year training.

Efforts made over the years by nursing to escape this service capture and create a more sound educational base for all repeatedly foundered both on the rocks of the economics of a public service run on cheap student labour and on the rocks of status. In the main it appeared to policymakers that a mass occupation populated by young women with minimum educational qualifications was being unrealistic in its demands, and its leaders were getting above their station. Civil servant memoranda of the middle and late 1960s coming recently into the public domain suggest just such an attitude (Davies and Beach 2ooo:i8n8).

Members of the professions deemed 'supplementary' sometimes did better in this regard. They were fewer in number, in the main drawn from a narrower and higher band in the social class structure than nurses. For some, it proved possible to pursue an intermediate path, knocking on the doors of the universities, locating a two-year diploma or three-year degree perhaps in the medical school or perhaps, as these developed, in a social studies or health studies department of a polytechnic or new university. Developments, however, were largely unplanned, and the result of individual initiative (Burley 1998). By 1989, when new contracting arrangements were introduced, it was clear that there was considerable variation. Dietetics and speech therapy education, for example, were entirely in higher education, whereas occupational therapy, orthoptics, physio-therapy, radiology and chiropody were mostly in NHS schools

with some in higher education and still others in private schools (Department of Health 1989). In all, however, the picture was of fragmented, hierarchical and divisive relations, built as much on an established class structure as on a notion of skills and competencies needed to do the work. Neither the medical model nor the nursing one, nor those of the allied health professions balanced the needs of education and service in an entirely satisfactory way. And in all this, government attention focused elsewhere - much more on the organisation of the service than on the educational preparation of those who worked within it.

Hostility to professions and a contract culture

The conservative governments' quest for efficiency in the public sector through introducing ideas from business, imposing quasi-markets and new and more active management represented a sea change for the NHS. It brought a head-on challenge to professional autonomy and an attempt to control the conditions of professional practice (Pollitt 1993, Foster and Wilding 2000). Much less attention, however, has been paid to implications for the provision of education and, in particular, to the join between education and service. The three key clinical groups, doctors, nurses and those in allied health professions fared differently.

Aspects of medical education certainly started to change in the period between 1979 and 1997. The GMC became more active in considering both the content of the curriculum and the strategies for teaching and learning. A structured learning experience in the pre-registration year, the deanery system, the concept of specialist registrar, and in particular the new undergraduate curriculum in 1993, represented major shifts in thinking in this period (Allsop and Mulcahy 1996:76-7)- But the direct government challenge on the educational front and the imposition of relations of market competition came for non-medical rather than medical education. Here, after 1989, and under arrangements described in the document known as Working Paper 10 (Department of Health 1989), universities and colleges found themselves bidding to provide pre-registration training in nursing and the allied health professions and negotiating with local education consortia to win time-limited contracts.

The experience of nursing in this period is particularly significant. By the mid-1980s, the student labour system in nurse education was under severe strain. Regulatory body demands for curriculum coverage and practice experience had increased, but so too had the intensification of work in the hospitals. Logjams were the result (United Kingdom Central Council for Nursing Midwifery and Health Visiting i986:chi). There was strong pressure from within the profession for pre-registration educational reform. The result, Project 2000, was unquestionably a bid to escape the service capture of the earlier era. The aim was to create a situation where the programme was more firmly in educational hands, where trainees had real student status, where the experience created a more confident nurse - a thinker as well as a doer - and where the award had a recognised academic currency. The project was about status and respect, about nursing being recognised as valuable and having a place at the policy table (UKCC 1986). The idea of a move from hospital schools of nursing into higher education, however, was rejected by professional leaders at this point. Even if the join with service that meant the six cohorts a year grind ended, it was felt that nurse educators were not ready for university posts - few had first degrees. Ironically, the shift to a university-based education, goal of the arch-professionalisers in nursing, came about as a by product of an NHS reorganisation designed to make professions and the NHS face the rigours of the market. How couid some of the new self-governing NHS trusts, managing their own budgets, becoming entrepreneurial, competing for resource, remain entangled with the direct provision of nursing education? They could not. Their nursing schools had to go. But where could they go? Ultimately the answer was to universities. Facing the same business oriented culture, they were under pressure to diversify their sources of income and demonstrate relevance and value added to the economy. Humphreys (1996), charting the detail of this period, refers to nurse education's shift as a 'by product', an 'incidental consequence' and 'fallout' of these wider health policy imperatives. He made the important point that contracting on this huge scale was alien to the university world and that there was no good experience on which to build. And he observed that

there are no precedents in the field of mainstream pre-service higher education in terms of the direct and considerable powers that employers (collectively) now have over universities.

ibid:669

Undoubtedly there have been positive results of this move. But there are also negative ones. Service side impatience with book-based learning and with staff now inevitably more cut off from practice linked with public criticism of too many 'academic nurses'. By 1999, it had resulted in a 'back to the bedpans' backlash, no doubt prompting ministers to move towards the changes that will be described in the next section (Meerabeau 2001). But if universities were apparently being 'too academic', things looked very different from the other side of the fence. A survey of nurse lecturers carried out for the RCN in 2000 asked for a ranking of nine problems that earlier focus group work had uncovered. Workload emerged as the biggest single source of pressure, with lecturers reporting working weeks of 50-80 hours. The impossibility of managing multiple roles - as teacher, researcher, administrator and clinician - also featured in the top three issues, as did the lack of proper accounting for clinical time. The unifying link between those top three issues, the report concluded, was that the university, the NHS and the education consortia had 'unrealistic expectations of lecturers' (Evers 2001:25). One respondent was rather more blunt in a comment that 'hypocrisy pervades the whole system'.

I am convinced that the long period of service capture of nursing education, alongside thinking imbued with notions of gender, served nursing badly. It produced unconfident nurses and unsettled nurses, too ready to blame each other, to move between jobs and collect qualifications in a quest for a more satisfactory nursing experience. They found themselves doubted and challenged as they sought collective improvements, and seen as whingers and as 'hard to help' by those with whom they worked (Davies 1995). But the uncoupling of education and service was in some ways almost as disastrous as its initial coupling. It has left legacies of demoralisation,

tension, mutual recrimination and sometimes rank despair in the relation between the university nursing departments and the NHS. And nurses found relations with their new hosts, the universities, were particularly fraught as they tried to meet conflicting demands of supervising student placements, growing their own academic profiles and meeting targets in relation to research.

Allied health professions were affected by many of the same 'byproduct' processes as nurses (Burley 1998). Medicine, however, with a different starting point, did not experience the education/service relationship in the same way. The informal relationships of the earlier era have certainly come under noticeable pressure. One recent analysis, while at first suggesting a 'surrender' of autonomy to the state consequent on the 1990s reforms to medical education, nonetheless concludes that the jury is still out on how full and how complete that surrender will be (Moran 1999:108). There has also been a steady stream of task forces, reports and enquiries, recognising the need for closer joint working between medical education and service. The strategy in relation to a more confident and established profession has been to seek statements of principle and ways of clarifying what is distinctive and what is shared in the mission of each of the parties. Yet there has been what has been described as a 'reticence' (Smith 2001) on the part of all concerned to try to impose organisational change that echoes the deference to professional expertise of the earlier era. The idea of 'University Clinical Partnerships' is one proposed solution (ibid.).

This, then, is the context in which the most recent policy moves must be seen. A new government, anxious to deliver results in terms of a demonstrably improved NHS, has become altogether more impatient with the clinical professions, naming them as holding back change. And if the fault is with the professions, the fix is to change - quite fundamentally - the ways in which they are educated.

Another government - another strategy

Since 1997, there has been a rapid trajectory of new thinking inside the NHS. Labour's initial policy moves on health said little directly about education and training. Modernisation was more about a reorientation to primary care, standard-setting, inspecting and monitoring for quality through an array of new agencies. But the focus on quality and human resources development that was to come together in the four planks and the idea of a golden trust, noted in the previous section, was emerging too (see e.g. Department of Health 1998,1999a). Most important in terms of fixing where the fault should lie, however, were two documents. First there was 'Making a Difference', a new strategy specifically for nursing (Department of Health 1999b), and the forerunner for an array of further documents for allied health professions. Secondly, ostensibly about workforce planning and in practice also very much about the funding and control of all forms of clinical education, there was 'A Health Service of All the Talents' (Department of Health 2000a).

'Making a Difference' contained two diametrically opposed messages. The first was positive and supportive. 'We value nurses' was the repeated mantra. Nurses know what is needed and they must be given more support, more power and more scope. Nurse prescribing and nurse consultant roles, for example, were strongly endorsed. This was clearly music to the ears of the profession. But the document was also a fierce critique of nurse education and of 'academic drift'. It ushered in pilot programmes for reorganisation and announced the setting up of a new Education and Training Unit inside the Department of Health itself. The timing is revealing. 'Making a Difference' pre-empted the report and recommendations of the Education Commission of the statutory body for nursing, due for publication only a matter of weeks later (United Kingdom Central Council for Nursing Midwifery and Health Visiting 1999). The message was clear - nurse education, in the government's view, had taken the wrong path in its brief time in higher education. A pre-emptive strike towards service recapture of nurse education had been made (Davies 2000b).

The message was taken a stage further in 'All the Talents' (Department of Health 2000a). This was not just a report about reorganising the business of workforce planning and forecasting as its subtitle suggested. It was a devastating critique of the way that education for all the health professions was being commissioned and delivered. Who was regarded as at fault? Certainly, the health professions were. Traditional demarcations between staff, the argument went, have held service development back. This report was 'about looking at the workforce in a different way, as teams of people rather than different professional tribes' (ibid:i3). The universities came out no better. They were judged as inward looking and unresponsive. A'disjunction between the needs of the NHS and the desires of education providers' introduced a catalogue of further weaknesses seen through the eyes of those delivering the service (ibid: para. 4.20). Others came in for criticism too. Consortia were judged as distinctly varied in their effectiveness in planning a workforce and commissioning education. Central planning was deemed weak and it was noted that education policy had never been tackled head-on or in an integrated way. Closer and more direct stewardship of public funds, an unprecedented recommendation for a single pot of funding - bringing medical education together with others, and the plan for a new structure of Workforce Development Confederations followed. A resolute move towards multi-professional training was a further key theme of the report.

Enquiries coming a little later by the Audit Commission (2001), by the National Audit Office (2001) and by the Auditor General for Wales (2001) were grist to the mill of the government's critique and of its direction of travel. Substantial variations in the pricing and costs of education commissions were revealed by the NAO, and calculations of attrition rates from pre-registration programmes came out significantly higher than figures from higher education had suggested. The Audit Commission argued that training needs were not being systematically identified, taking 'hidden talents' as the title of its report. The NAO, however, heard voices from higher education more than did government. It saw benefits from moving towards longer-term contracts, it gave some credit to the higher education sector in efforts to create more transparent accountability. And, highly significantly, it recommended that the Department of Health should consider funding for capital developments and for research in its contracts. If there were to

be developments on these two fronts, it would bring NHS funders into a debate not just about the training cost per student, but about supporting the idea of a university education and about the cost of providing a high quality student experience and an outcome including the elusive quality of 'graduateness'.

In examining the potential and the directions for the NHSU, the key government document is the Lifelong Learning Framework (Department of Health 2001b). But the significance of the diagnosis in the earlier 'All the Talents', is equally, if not more, important in understanding the climate surrounding the arrival of the NHSU. It analysed a fault, named a fix, and set a course of development. The NHS Plan, the detailed investment and resource plans six months later in a way simply echoed the analysis and added resource. The NHSU idea, as we have seen, did not have its provenance directly within this growing strand of health service policy. To those in higher education, however, it could be seen as coming from this stable - a judgement that the partnership working that had been built up, the give and take emerging around contracting, was in danger of being entirely discounted.

No great wonder, then, that the arrival of the NHSU idea was viewed with distinct wariness by those delivering educational programmes. The radical notion of a university 'for everyone', the lack of independence signalled by its tie with the NHS and the threat of loss of business for cash-strapped institutions would have been enough to make the sector wary. Coupled with the harsh judgement on the sector as a whole, this, for some, was enough to turn wariness into downright hostility. Where things go next will be influenced by how far and how well these tensions are acknowledged and handled. There is, however, at least one other important factor at work - change in the nature and role of universities coming from different directions, influenced by global trends and by technology. The final section offers some brief comments on this.

3. HIGHER EDUCATION - GLOBAL RECONSTRUCTION

In 1998, the journal Futures devoted a special issue to a consideration of the university world-wide. Drawing on the work of more than a dozen contributors, the introductory essay discussed several directions of possible development (Inayatullah 1998). A future based on globalism as a key driver would see the university ever more closely tied to the capitalist system with the removal of programmes that were not immediately self-funding and a major emphasis on fundraising and on the direct commercial possibilities of knowledge generation. A future based on multiculturalism as a major force would see universities addressing the universal pretensions of Western knowledge, creating more inclusive texts 'in the light of the ways of knowing of women and Pacific, African, Asian and other civilisations' (ibid:594). A third future based on virtualisation and the internet could result in the direction of mega-global universities on the one hand and localised, diversified universities on the other. The idea of localised community-based universities with a specific remit of helping a community to thrive (Milojevic 1998) is one that could have strong appeal now that Workforce Development Confederations are charged with bringing their several local universities into the planning cycle and working in closer partnership.

Within this broad context, however, a great deal of contemporary future-gazing centres around new technology, the explosion of access to information on the internet, the potential for learning on-line, and for electronically mediated communication. Students learning at work and at home, with electronic access to each other and to learning resources across the globe, mega-university conglomerates - pulling together excellence from any and every traditional university source - academics being replaced by network navigators, mentors and coaches, are among the predictions. While it may be true that this is 'the most referred to yet least analysed' of the new trends (Taylor, Paton and Chisholm 2001:12), it is now more than mere talk. There is the e-University, established by the Higher Education Funding Council as a trading company in 2001 and charged with developing and supporting e-learning projects in the university sector. There is the University for Industry, created in 1998 as a partnership between government and the public and private sectors. With a remit of promoting lifelong learning, it has already created Learndirect, with its local centres, the largest public funded online learning system in the UK. There is considerable institutional restructuring of the sector world-wide, including activity across a US/UK axis, in creating online universities, and forming consortia to deliver new forms of learning that transcend both national and local boundaries (Phillips 2001; Stallings 2000). Universities UK and the Association of Commonwealth Universities have very recently come together to create the Observatory on Borderless Higher Education to track e-learning and the new kinds of providers (for profit and not for profit) that are emerging (www.obhe.ac.uk).

Issues of online learning have become entangled with pressures for universities both to end their elitism regarding entry and to behave in more business-like ways. A history of change in the UK dates back to the Thatcher era with the ending, for example, of the binary divide, the pressures to diversify funding, the implementation of new forms of performance review and a growing number of enquiries into governance arrangements. Arnold (1999), in the context of the digital revolution, provides an important account of how the introduction of a highly overt financial imperative can direct attention way from a clear focus on teaching and learning, pushing towards commodification and technocentricism. His Australian case study, suggesting that in such a context academics become unable or unwilling to engage, deserves serious attention. It is perhaps no accident that we now hear a growing range of questioning voices about directions of development from the academic community. These restate long-held values, call for a renewal of discussion on the nature and purpose of universities, and defend the importance of a space for critical and transformative thought (see e.g. Barnett 1997,1999, Smith and Webster 1997, Coaldrake 2000, Delanty 2001).

The emergence of any corporate university (CU), and the NHSU can be no exception, is inevitably caught in this vortex and too easily seen as one more step on the road to the thoroughgoing corporatisation of the sector as a whole. Early papers from a three year study of the CU phenomenon, suggest that it may be less helpful to contrast the growing number of CUs with a classic vision of the university, and more useful to see them as part of a more complex institutional field. This, they suggest, covers a spectrum from collegia! universities through mass universities, to corporate universities and to company training schools (Paton and Taylor 2002; see also Taylor, Paton and Chisholm 2001). One implication to be drawn perhaps is that today's reconfigurations represent convergence towards the centre two (see also Smith and Webster 1997). Differences between US-style CUs and those on a European model, however, are also emerging (Taylor et al 2002), as are closer examinations of patterns of collaboration and stakeholder involvement (Blass 2001, 2002). An important issue here is the extent to which CUs choose to put stress not just on skills acquisition but on 'flexibility, charisma and skills beyond basic performance' (Brown and Scase 1997, cited in Taylor, Paton and Chisholm; see also Williamson 2001). Fraser and Greenhalgh (2001), in an influential article in the health field, directly echo this point. They point to new styles of work-based learning, and challenges to old academic practices as crucial for the NHSU. But in a world of complexity, they argue, the need is not only for competence but for capability - for 'individuals who can adapt to change, generate new knowledge and continue to improve their performance'. In my own experience, health service managers and senior clinicians are looking for exactly this - for people who are able to see the big picture, cope with uncertainty and think creatively and strategically. The development of the concept of the 'critical practitioner' as underpinning for The Open

University professional development course in health and social care, responds directly to this (Brechin 2000).

Whatever the level of support for or opposition to CUs and to online learning, considerable change in the higher education sector is thus already very apparent. At a policy level nationally, the push for widening participation, and for closer links with schools and businesses and for more work-based learning is gaining momentum. Research selectivity is again in the frame with the explosion of debate following the results of the Research Assessment Exercise of 2001. In a UK context, referring to the policy push for mass participation in higher education, the Secretary of State for Education and Skills recently accepted that this had occurred 'without anyone necessarily thinking strategically about what we want our universities to be achieving' (House of Commons, Hansard Debates 2001). Mergers of higher education institutions and reconfigurations across the higher/further education border are in the air (see e.g. THES Oct 12 2001, Jan 11, 2002). And at a more practical level, inter-university networks and consortia are beginning to emerge, explicitly positioning themselves in anticipation of attracting business, especially on-line courseware business from the NHSU. Universities, even five years on, may well be very different from how they are now.

The NHSU is inescapably going to be part of this transformation. How its governance arrangements are set up, how it manages the balance between public and private providers, what its contracts imply about its position on pedagogy, what scope it takes to encourage learning for capability as well as competence and to support research and reflection - these will be among the concerns of a higher education sector that has come through the history outlined in this paper. In short, the NHSU will have an important place in defining the new field of lifelong learning. In doing so, it will be contributing to the reconfiguration of higher education as a whole. With its market of a million and more staff, its involvement with the education and training of clinical and managerial professions, this newly born institution is a big player before it has grown up. Small wonder, then that those in the longer established institutions look at it with a mix of scepticism and trepidation.

CONCLUDING REMARKS

This paper has sought to tell the tale of the NHSU from conception to birth. Mixed parentage, uneven growth spurts in the womb, a lengthy labour and an ambivalent welcome into the families of health and higher education, are all elements in the story. I indicated at the outset that three propositions were particularly important in an analysis of the provenance of a policy. The uneven and untidy course of policy development rather than the more straightforward notion of policy implementation has been amply borne out by the events set out here. As responsibility shifted, so the vision of what the NHSU was subtly shifted also. The proposition that there is always some underlying notion of 'a fault and a fix' in a policy development process was given particular emphasis in the middle sections of the paper. It was argued that questions of blame need to be addressed in an open way if constructive development is to occur. And the notion that policy is constantly shaped and reshaped by context and by individuals striving to understand and respond to a context as they understand it, is apparent throughout.

What, then, is the potential of the NHSU, viewed some six months after the initial team of staff was assembled around a chief executive early in 2002? Three final points are worth making. Part one emphasised that the idea of a university came late to the scene. It emerged from outside, at a point of particularly rapid policy development. There have been successive moves to integrate it into the mainstream of that policy development, but it is one of a number of institutions whose relations and boundaries are yet to be settled. The first point then, is that the NHSU is emerging on a crowded stage, amongst a number of new players, all eager to demonstrate what they can achieve in terms of the NHS change agenda. Part two stepped further back to address the historic tensions between education and service. The pendulum, we might say, has swung between 'academic drift' and 'service capture' at different times and for different groups. This has left some bitter legacies and unanswered questions, particularly around forms of contracting and commissioning that respect the justifiable differences and needs of the parties concerned. And there is now a hitherto unprecedented determination on the part of government to control and shape an altogether more flexible kind of workforce. The second point about the potential of the NHSU is that it is starting out in a world of tense and complex relationships, where fault and blame are close to the surface and where government has taken more control of the agenda than ever before. Finally, there is an altogether wider set of questions, involving where universities are going in the 'wired world' and in the global age. The NHSU is a first in terms of being a Western, public sector, corporate university covering a million and more people. How will it see its mission and goals? The third point to be made about potential is that, difficult as the circumstances are, the NHSU has scope to invent itself. The stage is certainly crowded, relations are tense, but no one party at present holds the script.

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