



Department  
of Health



# Education Outcomes Framework

Report 2013/14

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# Education Outcomes Framework

Report 2013/14

**Prepared by Workforce Development Strategy and External Relations Analysis  
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# Part 1 – Overview of the Education Outcomes Framework

## 1 Purpose

This is the first report of the Education Outcomes Framework (EOF). The report is in two parts. Part 1 explains the context and background to the EOF policy and the developments taking place. Part 2 provides a high level analysis of the initial set of indicators which were identified for use in 2013/14.

## 2 Introduction

The Education Outcomes Framework (EOF)<sup>1</sup>, published in March 2013, sets the outcomes which the Secretary of State expects to be delivered from the reformed education and training system in supporting the improvement of patient care and health outcomes. The purpose of the EOF is to ensure that the education, training and development of the current and prospective healthcare workforce will contribute most effectively to improvements in the health and wellbeing of the population.

It is recognised that the metrics in this area are less well developed than those available for service outcomes and that attributing the cause and effect of the outcomes is complex. Research has been commissioned to help identify and strengthen the EOF indicators and improve the evidence base. Whilst recognising this is a difficult and complex area, it is nevertheless important that we try and use it as a platform to develop stronger metrics as the EOF matures over the next three or four years. All of the indicators will therefore be subject to further development in order to ensure that a range of measures are provided which best enable assessment of the system in delivering the identified education outcomes. As 2013/14 is the first year for the EOF some of the indicators were focused on establishing a baseline and therefore there are no specific comments or analysis which can be made on these indicators.

Additionally it must be noted that whilst the EOF is intended to have application across the social care system, as well as the NHS and public health systems, given its complexity, the initial baseline for the education outcomes has been with the development of the health workforce.

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<sup>1</sup> <https://www.gov.uk/government/publications/education-outcomes-framework-for-healthcare-workforce>

### 3 Background

The EOF was developed by the Department of Health (DH) in partnership with a wide range of stakeholders. It has been designed to help the integrated health and care workforce achieve the outcomes set out in the NHS, Public Health and Adult Social Care Outcomes Frameworks. It is central to the relationship between the DH and the whole health, public health and social care system.

Indicators in the EOF are grouped around five domains, which set out the high-level national outcomes that the system should be aiming to achieve. The domains are:

- i. Excellent education;
- ii. Competent and capable staff;
- iii. Flexible workforce receptive to research and innovation;
- iv. NHS values and behaviours; and
- v. Widening participation.

The EOF Indicators Technical Guidance 2013/14<sup>2</sup>, published in August 2013, identified some initial and 'proxy' measures to assess the benefits to patient care delivered by the system.

The introduction of this framework of outcomes and indicators, to track the impact of the investment in the education, training and development of the healthcare workforce, is an important new development which will continue to evolve as the new health and care system develops. The report highlights the first steps on this journey. The introduction of the EOF has also seen the launch of a programme of targeted research and development to improve the evidence base and to refine the indicators to be used to support the EOF (see 8).

The NHS is going through a period of significant change and transformation. The strategic drivers for service transformation are well documented and highlight the importance of a well trained workforce as a key enabler of sustainable change and a driver of continuous improvement. The fact that 90% of the existing workforce is expected to still be working in ten years highlights the size and scale of the task - of educating and training new staff, of up-skilling the existing workforce, and of changing the culture and behaviours driving current ways of working.

The DH looks to Health Education England (HEE), working in partnership with NHS England, Public Health England and other key national bodies, to ensure 'provider organisations' and health and social care professionals work in partnership to deliver system wide service transformation across the key elements of service provision in:

- Hospital care;
- Primary care (including GP practice, dentistry, pharmacy & optometry); and
- Integrated care (including community and social services).

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<sup>2</sup> <https://www.gov.uk/government/publications/education-outcomes-framework-for-healthcare-workforce>

In addition to the longer term workforce transformation agenda, there is a need to ensure that existing patient services are provided safely and to a high standard, and to ensure that organisations are equipping their staff accordingly to fulfil these needs. Some of the EOF indicators therefore are based on the experience and satisfaction of both patients and staff, including feedback from students and trainees.

#### 4 Aligning the Outcomes Frameworks

The DH publishes Outcomes Frameworks for the NHS, public health and adult social care. These provide a set of common goals for the health and care system as well as providing an overview of how the system is performing – for example, preventing people from dying prematurely; improving the health of the population; and ensuring that people have a positive experience of care and support.

The three Outcomes Frameworks reflect the different ways the NHS, public health and adult social care are delivered:

- The NHS Outcomes Framework is used to hold NHS England to account for improving health outcomes (See Annex A).<sup>3</sup>
- The Public Health Outcomes Framework sets out the broad range of opportunities to improve and protect the public's health across the course of people's lives and to reduce health inequalities (see Annex B).<sup>4</sup>
- The Adult Social Care Outcomes Framework supports transparency and local accountability, enabling benchmarking between local authorities, facilitating a programme of sector-led improvement and the sharing of best practice (see Annex C).<sup>5</sup>

These frameworks support local improvements in health and social care, increase accountability and transparency, and promote local leadership.

The Outcomes Frameworks share a common structure, which allows them to be closely aligned. Figure 1, below, sets out the specific contributions and areas of shared responsibility by outcomes framework 'domain'. Domains are the priority areas of each Outcomes Framework, the areas where energy and focus should be maintained. Each domain is supported by lower level indicators (for the NHS and Public Health Outcomes Frameworks) or measures (for the Adult Social Care Outcomes Frameworks).

The EOF supports the whole system and aims to measure improvements in education, training and workforce development, as well as the consequent impact on the quality and safety of services for patients and users.

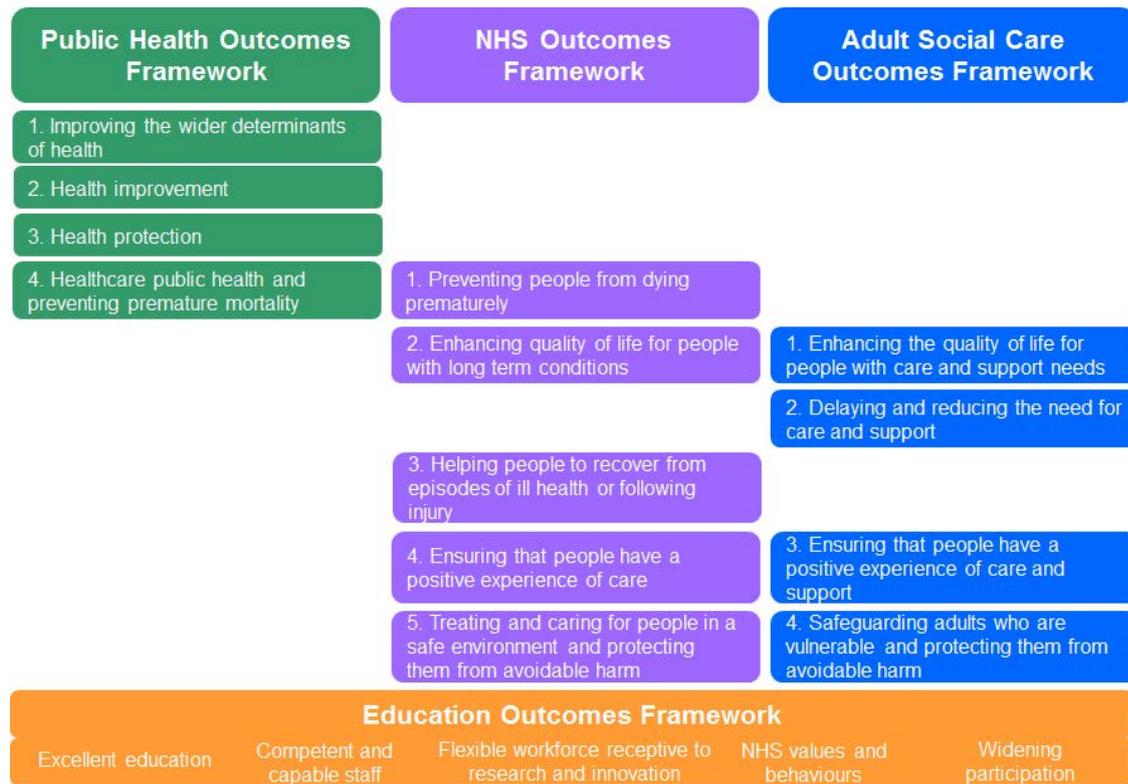
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<sup>3</sup> <https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015>

<sup>4</sup> <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

<sup>5</sup> [http://www.ecdp.org.uk/sites/default/files/ASCOF14-15\\_Document\\_-\\_FINAL.pdf](http://www.ecdp.org.uk/sites/default/files/ASCOF14-15_Document_-_FINAL.pdf)

Figure 1



Alignment between the Outcomes Frameworks has been agreed as a design principle for all future development of the frameworks. They will be clear and meaningful, whilst recognising the different governance and accountability arrangements for Public Health England, Local Authorities and the NHS. The DH remains committed to improving the alignment between the Outcomes Frameworks, where appropriate, in recognition of the joint contribution of health and social care to improving outcomes. The individual Outcomes Frameworks are refreshed annually and should be read alongside this report.

The concept of alignment has not been restricted to the DH sponsored Outcomes Frameworks. Indicators focused on the wider determinants of health offer an opportunity to align the frameworks with any that may emerge from other Government departments or indeed at local level across a range of related public services. Consideration is also being given to how the frameworks work together to improve outcomes in specific areas.

## 5 Accountability Framework

The EOF sets the outcomes which the Secretary of State expects to be delivered from the reformed education and training system in support of improving patient care and health outcomes. The DH leads the policy development of the EOF and, in partnership with the wide range of stakeholders across the whole healthcare and education system, will continue to develop and strengthen the indicators to help measure delivery against the high level outcomes set out in section 4.

The EOF considers the current workforce, not just the new and prospective professionals that are funded through HEE's £4.9 billion budget. Employers and the wider system have a significant contribution to make to improving the quality of care and to developing our workforce so that they deliver care consistent with the NHS constitution and its values. This in part is delivered through effective mandatory training, induction and continuing professional development of their workforce, some of which is self-funded by employees, but the significant proportion is funded by providers, both NHS and Independent, whose income is secured through service commissioning contracts. Delivering the outcomes for several of the EOF domains (especially important for Competent and Capable staff, NHS Values and Widening Participation) therefore needs a contribution from the education, training and workforce development system, and from the NHS itself. Neither can deliver without the other's support. It is also crucial that the workforce plans developed by providers reflect the commissioning plans of NHS England and local Clinical Commissioning Groups (CCGs). The EOF has been developed to reflect these desirable outcomes and it is essential that NHS England, Public Health England and other national bodies work together with HEE on this agenda.

HEE will provide leadership for the reformed education, training and workforce development system. The objectives set out by DH for HEE, in the Government's mandate to HEE, are shaped by the EOF. This mandate sets out the Government objectives for HEE and contributes to the delivery of the longer term educational outcomes described in the EOF. The EOF provides a focal point for the necessary partnership working within the system for the education, training and workforce development of the healthcare and social care workforces and those organisations with responsibility for the development of professional standards, the professional regulatory bodies, generic regulators in the health and social care system and their counterparts in the education sector.

The EOF provides a common purpose in a series of relationships including:

- i. DH and HEE, as the body leading the reformed education, training and workforce development system, and in turn HEE and the Local Education and Training Boards (LETBs) who deliver the reformed education, training and workforce development system at a local level;
- ii. HEE, LETBs, NHS England and the local service commissioners (CCGs), who have a responsibility to promote education and training;
- iii. HEE and Public Health England, who bring together public health specialists from more than 70 organisations into a single public health service;
- iv. HEE and other key bodies including:

- a. Skills for Care, the employer-led workforce development body for adult social care in England;
  - b. Local Government and Health and Wellbeing Boards, the forums where key local leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities;
  - c. NHS Trust Development Authority, who is responsible for providing leadership, support and performance management to the non-Foundation Trust sector of NHS providers;
  - d. Monitor, the sector regulator for Foundation Trusts in England;
  - e. the Care Quality Commission (CQC), the independent regulator for all health and social care services in England;
  - f. HealthWatch England, the national consumer champion in health and care;
  - g. National Institute for Health Research (NIHR), which provides the framework through which the Department of Health can position, maintain and manage the research, research staff and research infrastructure of the NHS in England as a national research facility; and
  - h. the National Institute for Health and Care Excellence (NICE), who provide independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.
- v. Commissioners of education and training and all organisations delivering education and training.

The publication of the EOF does not replace existing responsibilities, for example for those delivering education and training to meet their regulatory obligations to professional regulatory bodies. The EOF is relevant to all organisations delivering publicly funded care including non-NHS employers and individuals working in non-NHS settings.

## 6 Assessing progress

The education outcomes will be achieved, through a range of stakeholders across the whole health and education system working in partnership, with HEE and the LETBs playing leading roles. To date, the EOF has made the following impact:

- i. The EOF is acknowledged as an important framework facilitating and supporting the alignment of the three main Outcomes Frameworks (NHS, Public Health and Adult Social Care);
- ii. A number of developments have been initiated and a major three year research programme is scheduled to start, by April 2014, to develop the EOF indicators and strengthen the evidence base – see section 8;
- iii. In 2013/14 the HEE Mandate was based around the five EOF domains and provided the common thread for aligning and developing HEE’s business plan and reporting;
- iv. The domains of the EOF remain embedded in the 2014/15 refreshed HEE Mandate<sup>6</sup>;
- v. The EOF is also reflected in the refresh of the NHS Mandate, which acknowledges ‘NHS England ... has a statutory duty to promoting education and training ... and support HEE in ensuring that the health workforce has the right values, skills and training to enable excellent care’.<sup>7</sup>

The EOF is designed to help the current and prospective health and care workforce meet the outcomes set out in the NHS, Public Health and Adult Social Care Outcomes Frameworks. It is central to the relationship between the Department of Health and the whole health, public health and social care system. More needs to be done, however, to convey the message regarding the purpose of the EOF and to expand on the contribution of the EOF to ‘system delivery’. This includes:

- Delivery of healthcare and patient outcomes are workforce dependent – the biggest expenditure in the NHS is on staffing and therefore having an appropriately skilled workforce is key to achieving outcomes;
- Improvements in education, training and workforce development have a direct impact on the quality and safety of services for patients and users;
- Following the Francis Report<sup>8</sup> it is even more important that prospective and current employees embody the NHS values essential for a caring and patient centred service in addition to up to date specific skills, clinical or otherwise;
- Research has shown that access to training and development is a strong factor in staff recruitment and retention;
- Underpinning delivery of the core Outcome Frameworks – NHS, Public Health and Social Care;
- Assisting the delivery of integrated care;
- Informing both the HEE Mandate and the NHS Mandate and agreements with other national bodies; and

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<sup>6</sup> <https://www.gov.uk/government/publications/health-education-england-mandate-april-2014-to-march-2015>.

<sup>7</sup> Paragraph 4.7, page 18, [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/256497/13-15\\_mandate.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256497/13-15_mandate.pdf)

<sup>8</sup> <http://francisresponse.dh.gov.uk/>

- Measuring whether the system as a whole is operating effectively and facilitating joint agreement between key bodies.

## 7 Changes to the Education Outcomes Framework

The development of the EOF has been firmly based on principles developed and agreed through consultation with all stakeholders including patient representatives. These principles are to:

- Use a system-wide co-production approach;
- Minimise the need for new data requirements;
- Ensure relevance to the whole healthcare workforce delivering NHS funded care; irrespective of the type of organisation providing the care;
- Ensure relevance to the whole healthcare workforce prioritising development of the existing workforce equally with the education and training of individual professional groups; and
- Set the outcomes used in terms of impact for patients and carers.

These principles remain sound not least because there is limited resource currently available and utilising existing data sources is likely to be the only practical way forward. The continued development of the EOF will adhere to these principles.

The structure and content of the EOF has been well received by the health and social care system. At this early stage of development it is important that stability is ensured through a consistent, evidence based approach. The main challenge is to identify and develop indicators which best measure the outcomes identified. The planned research and development programme (section 8) will inform future changes to the framework.

One minor change is being made to the titles of two of the EOF domains, to provide greater clarity and focus, as follows:

- Highly competent and capable staff; and
- Staff embody the NHS values and behaviours.

During 2014/15 the EOF Reference Group will give consideration to and clarify the following issues:

- Terminology – whether to remove references to ‘the NHS’ as it is not applicable to some workforce e.g. those in social care and public health; and
- System wide approach – to determine whether the EOF is truly system-wide with application across social care or only applicable to the healthcare workforce to meet the NHS and the Public Health outcomes.

## 8 Research and Development Programme

### Figure 2: Three Year Policy Research Programme Project

A team led by Professor Jan Illing, Director of Research of the School of Medicine, Pharmacy and Health at Durham University, will be carrying out major research to inform the development of the Education Outcomes Framework. This research was commissioned through open tender, as part of the Department of Health's Policy Research Programme.

The researchers will draw on the current evidence base, as well as doing new research to add to our knowledge of how best to monitor 'what works' in health and care education, training and workforce development. Emerging findings will be shared as the research proceeds, to underpin and help improve the Education Outcomes Framework.

It is believed that quality healthcare education and training can directly and substantially benefit care – the EOF will provide a framework to make these benefits explicit and enable further research to directly link education and learning to improvements in patient care outcomes. However research is needed to help to address the relative lack of sound evidence in this area.

Developing appropriate indicators and underpinning evidence will be challenging to obtain, given the complexity of health education contexts, processes and eventual outcomes. Measuring outcomes is not an exact science; however, to be effective in improving services, it is important that indicators which measure the benefits and effectiveness of educational provision are clearly, and preferably directly, linked to improved patient experience and healthcare delivery. As high level indicators we need them to evaluate progress of the whole system in meeting the education outcomes and help over time to identify comparable good practice and identify the value of education to improving outcomes for patients.

### Figure 3: Other Initiatives

The national evaluation of the 'Better Training Better Care' programme identifies and demonstrates evidence across the 16 NHS Pilots the value of integrating training within service delivery; enhancing both trainee experience and capabilities as well as quality improvements to patient care.'

'Through its national incubator projects and alongside transformational projects within the LETBs, HEE is now beginning to evidence the impact on the investment in education and training on patient care.'

In the initial stages of developing the EOF, a review was undertaken, by RAND Europe, of international practice in this area<sup>9</sup>. This identified that there is limited evidence linking education and training to the impact on patient and healthcare delivery and nothing which looked at this from a national 'whole system' perspective. It recommended that a further broad review be undertaken of local and regional initiatives in a variety of settings, to better understand the use of quality metrics applied to the delivery of education and training of healthcare workers. The EOF initiative is therefore at the forefront of a system-

### Figure 4: Buckinghamshire New University (Bucks) Project

'Student feedback' – will help develop evidence capturing and measuring student/trainee experience of a placement. It places an emphasis on obtaining real time, on-line, feedback.

<sup>9</sup> Use of outcome metrics to measure quality in education and training of healthcare professionals A scoping review of international experiences. RAND Europe, 2012. [http://www.rand.org/pubs/working\\_papers/WR883.html](http://www.rand.org/pubs/working_papers/WR883.html)

wide approach to monitoring education quality in delivering healthcare.

The following initiatives have been initiated and the findings will be reported on in next year's report:

- i. An EOF Reference Group established to provide expert advice and act as a point of reference to the DH to support the establishment of the EOF Development Programme;
- ii. A major three year research project funded through the Department of Health's Policy Research Programme commissioned. It is due to be launched early in 2014. It will help to improve indicators that are sensitive to inputs (investment in education, training and workforce development), and that capture where inputs improve process outcomes and ultimately outcomes for patients and improved health care – see Figure 2;
- iii. A scoping exercise identified a range of initiatives being undertaken by HEE and various professional organisations which will inform one or more of the EOF Indicators and contribute to improving specific EOF measures – see Figure 3;
- iv. In 2012/13 the DH funded an initial EOF development programme (£190k), through NHS Employers, and two schemes commissioned will be completed by the end of 2014:
  - a. Project 1 on 'Student feedback' – see Figure 4;
  - b. Project 2 on 'CPD learning in the workplace' – see Figure 5.

**Figure 5: Canterbury Christ Church University (CCCU) Project**

'CPD learning in the workplace' – will measure the impact of CPD learning in the workplace and develop and test impact indicators which can be captured at individual practitioner and team level.

## **9 Next steps in developing the Education Outcomes Framework and indicators for 2014/15**

The basic structure and approach of the EOF is considered to be sound and the immediate focus is to consider additional indicators for use in 2014/15 and evaluate feedback from the research and development programme as better evidence is identified. The next step will be to link EOF requirements, where appropriate, to the objectives of NHS England and Public Health England as well as HEE.

## Part 2 – Indicators 2013/14 and commentary

### 10 Introduction

Part 2 provides brief, high level analysis of the indicators identified for use in 2013/14. It looks at each of the five domains within the framework and briefly summarises the published data at the level of Local Education and Training Boards (LETBs)<sup>10</sup>. All data used within the report are published elsewhere and relevant links has been provided to data sources.

Each domain is briefly described and, for each indicator within the domain, graphical presentation and comment of data aggregated to LETB regional area is provided. Data underpinning charts, have been included in Annex D.

As discussed earlier in the report, it is important to note that all of the indicators are subject to further development and, in most cases, are focused on establishing a baseline rather than making specific comments or judgement of the LETB areas discussed.

The EOF is intended to have application across the social care system, as well as the NHS and public health systems and, whilst data have been presented at the level of LETB areas, figures reflect whole-system progress and are not necessarily indicative of HEE/LETBs progress but rather all healthcare organisations within the regional area.

For these reasons organisations and data are presented geographically (north to south) and importance has been placed on the direction of change (over time) within each LETB area, rather than absolute levels of progress or direct comparisons between LETBs.

The initial starting point for the education outcomes has been with the development of the health workforce. As part of its development the EOF will continue to expand and be more representative of different professions and settings. Figure 6 shows the current coverage of indicators across staff groups<sup>11</sup> and between future workforce and current workforce. More detail is provided in Annex E.

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<sup>10</sup> Where appropriate Higher Education Institutions and NHS providers have been mapped to LETB based on postcodes. The postcode mapping to reflect LETB geographies and the activity within them is under consideration by a focus group drawn from the England wide *National Provider Data Project*. The mapping is due to be finalised in July.

<sup>11</sup> Staff groups based on those defined in NHS Staff Survey (Annex E).

For some indicators it was not possible to present all data by the individual LETBs in London. Where this was not possible pan-London figures have been used. Full technical details of the indicators are published on the GOV.UK website.<sup>12</sup>

**Figure 6**

Data source	Indicator	Future (UG or PG) or current workforce	Staff groups covered
Dean's Reports	EE1a	PG	Medical/Dental
GMC Training Survey	EE2b	PG	Medical/Dental
National Student Survey	EE2a, EE3	UG	All
NHS Staff Survey	CC1a-b, VB1, FW1a-d	Current	All
NIHR	FW2	Current	Medical/Dental
Acute Inpatient Survey	VB2a-f	Current	Medical/Dental, Registered Nurses & Midwives, Nursing or Healthcare Assistants
HEE Integrated Performance Report	CC2a-d	Current	Specific priority groups

## 11 Summary conclusions

Overall, the indicators show a positive direction of travel with progress being made in each domain and in each regional area. The majority of indicators look at the change between 2010/11 and 2012/13 and all data sources show an improved national position. Whilst in some instances individual LETB areas did not appear to make progress against specific indicators, this is a limited occurrence and there is no evidence of consistent issues within any individual regional area. In the main, LETB areas showed progress against each indicator and this was consistent across the different domains.

<sup>12</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/225361/EOF\\_Indicators\\_-\\_Technical\\_Guidance\\_2013\\_14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225361/EOF_Indicators_-_Technical_Guidance_2013_14.pdf)

## 12 Excellent Education (EE)

### *Domain Description*

Education and training is commissioned and provided to the highest standards, ensuring learners have an excellent experience and that all elements of education and training are delivered in a safe environment for patients, staff and learners.

### **EE1a: Quality of clinical training**

This indicator is based on published GMC Dean's Report data<sup>13</sup> covering approved post-graduate medical training. The returns are subjectively completed by Deaneries/LETBs and submitted to the GMC reflecting local assessment of risks and action plans of education providers within the area - reporting is not standardised across LETBs. As this is a subjective return it is not possible to standardise outputs and make comparisons across different regions. Items submitted within returns may be grouped across specialties and providers, including LETB-wide, and these groupings will differ across LETBs. Neither does the number of reported items reflect the actual number of trainees and local challenges within programmes/specialities in each LETB.

The nature of the returns also makes it difficult to consistently track issues across years. For this reason, the data presented below shows the percentage of returned items/programmes flagged as 'red' in each year.

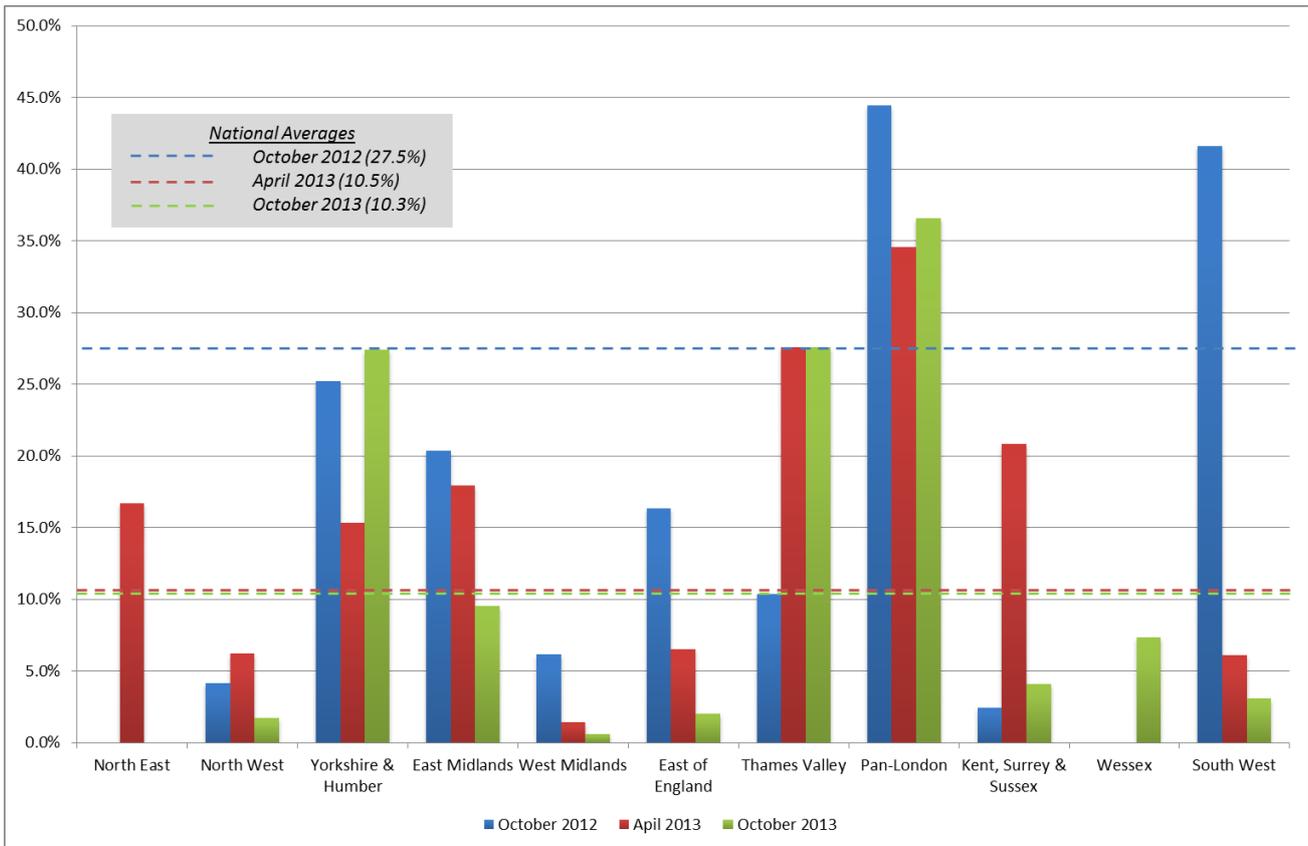
#### Key points:

- Of the reported items, the number flagged as 'red' in October 2013 (compared to October 2012) is down around 17% to just over 10%.
- Overall the results show a mixed picture across the country and this is likely a result of both the subjectivity and comparability of the individual reports as well as a continued refinement of the guidance produced by the GMC.

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<sup>13</sup> [http://www.gmc-uk.org/education/annual\\_deanery\\_reports.asp](http://www.gmc-uk.org/education/annual_deanery_reports.asp)

**Chart 1: Percentage of reported issues with red ratings October 2012 to October 2013, by LETB area**



### EE2a: Student experience of supervision on clinical placements

This indicator is based on National Student Survey data published by HEFCE<sup>14</sup>. Data presented covers responses from undergraduate students on health-related courses<sup>15</sup> including practice placements. It is based on the percentage of students who agreed that they had received appropriate supervision whilst on placement. The exact statement students responded to was:

*'I received appropriate supervision on my placement(s)'*

The information below looks at the change in percentage (between 2011 and 2013) of respondents who replied positively – i.e. agreed or strongly agreed, with the statement.

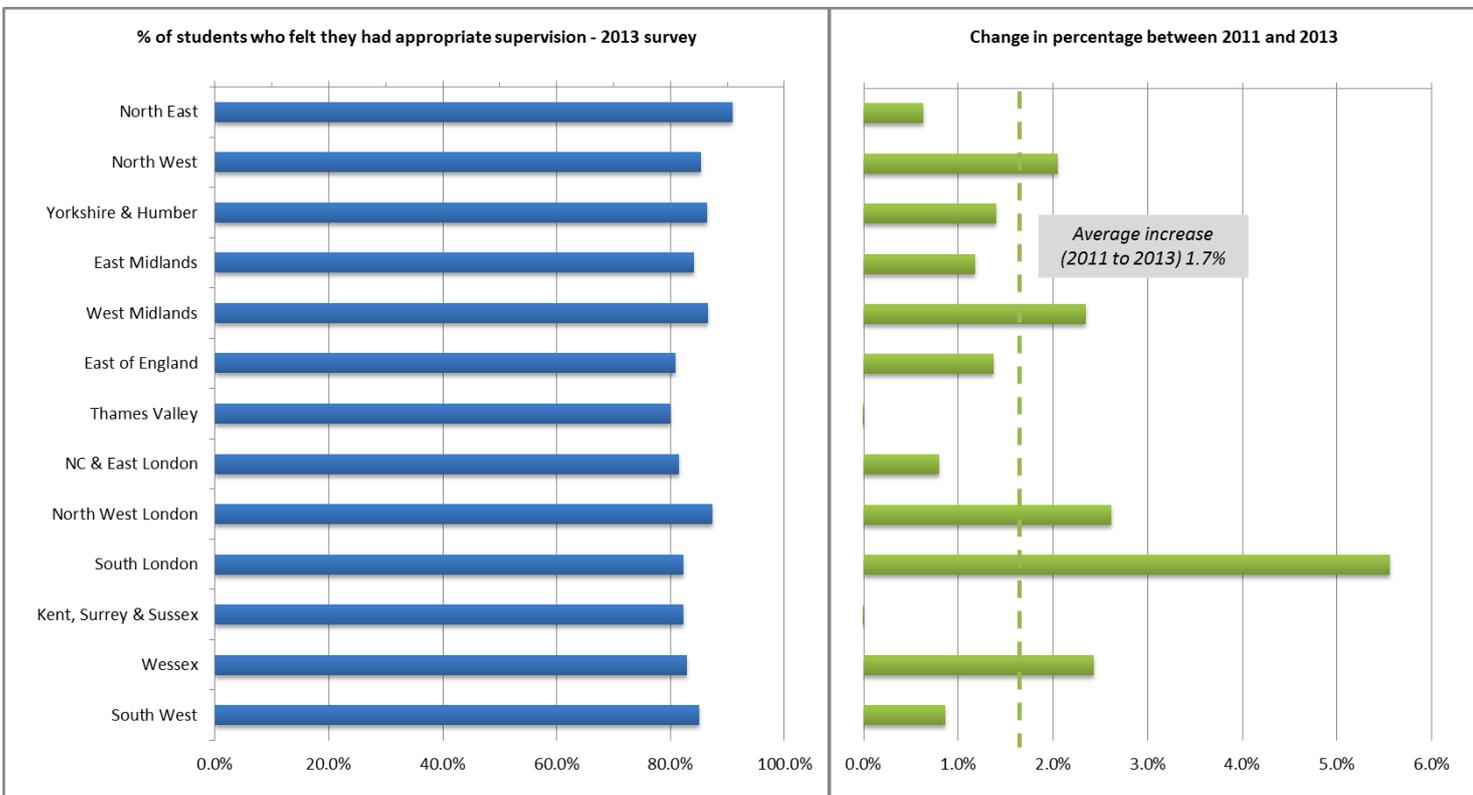
<sup>14</sup> <http://www.hefce.ac.uk/whatwedo/it/publicinfo/nationalstudentsurvey/nationalstudentsurveydata/>

<sup>15</sup> These have been defined as: (1) Medicine and Dental; (2) Courses allied to Medicine, and; (3) Biological Sciences.

Key points:

- Latest results show that overall there is some variation across the country (between 80% and 91%) with a national average of 84.5%.
- There has been an improvement in scores nationally of 1.7% between 2011 and 2013.
- Generally, LETB areas are clustered around this level. The exceptions are Thames Valley and Kent, Surrey & Sussex who show negligible increases and South London with a large increase of 5.5%. This latter result reflects the fact that South London were a slight outlier (around 77%) in 2011 but are now much closer to the national average at over 82%.

**Chart 2: Percentage of students who agreed with statement in 2013 survey and change from 2011 survey**



## EE2b: Trainees experience of clinical supervision during training

This indicator is based on GMC National Training Survey data<sup>16</sup> covering medical postgraduate trainees. It is composite score (based on the responses to 5 questions) provided by the GMC for the 'Clinical Supervision' component of the survey. The score is a measure of a doctor-in-training's perception of their clinical supervision so the higher the score, the more positive the result. A score of 90%, for example, indicates a high level of positive responses to the individual questions. It does not mean that 10% of trainees are unhappy with the clinical supervision received.

The questions are:

- a. How would you rate the quality of clinical supervision in this post?*
- b. In this post did you always know who was providing your clinical supervision when you were working?*
- c. In this post how often, if ever, were you supervised by someone who you felt wasn't competent to do so?*
- d. In this post how often did you feel forced to cope with clinical problems beyond your competence or experience?*
- e. In this post how often have you been expected to obtain consent for procedures where you feel you do not understand the proposed interventions and its risks?*

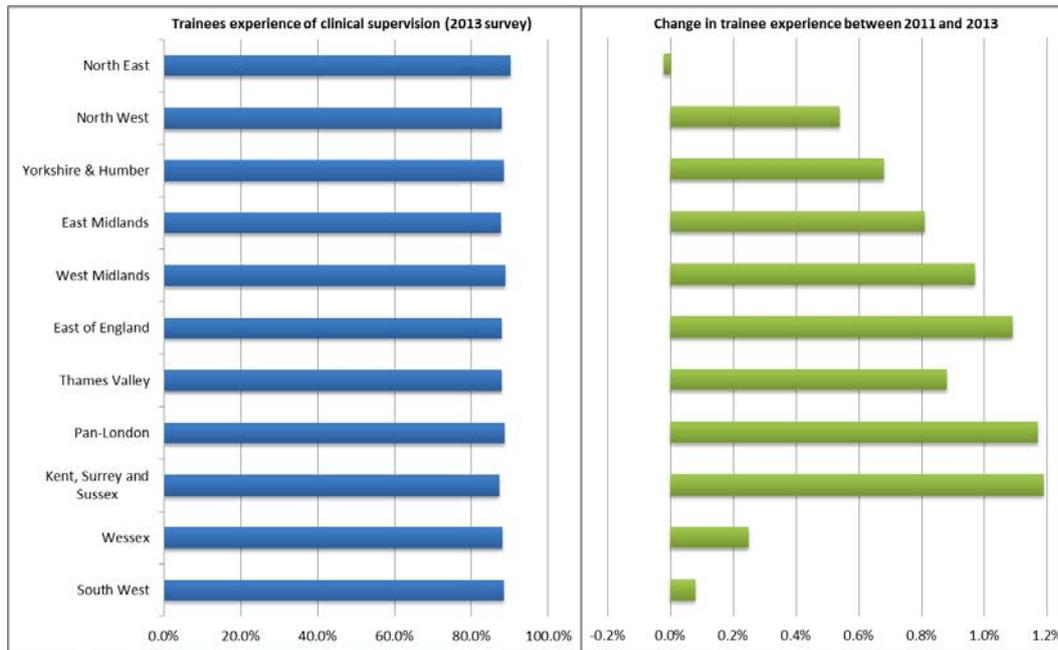
Key points:

- Latest results show very little variation across the country (between 87% and 90%) with a national average of around 88%.
- There has been a small improvement in scores nationally of 0.8% between 2011 and 2013, with only North East LETB area seeing a slight decrease.

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<sup>16</sup> <http://www.gmc-uk.org/education/surveys.asp>

**Chart 3: Medical trainees experience of clinical supervision, latest (2013) aggregate results and change from 2011 survey**



### EE3: Student satisfaction with training courses

This indicator is based on National Student Survey data published by HEFCE<sup>17</sup>. Data presented covers responses from undergraduate students on health-related courses.<sup>18</sup> It is based on the percentage of students who agreed with the statement:

*‘Overall, I am satisfied with the quality of the course’*

The information below looks at the change in percentage (between 2011 and 2013) of respondents who replied positively – i.e. agreed or strongly agreed, with the statement.

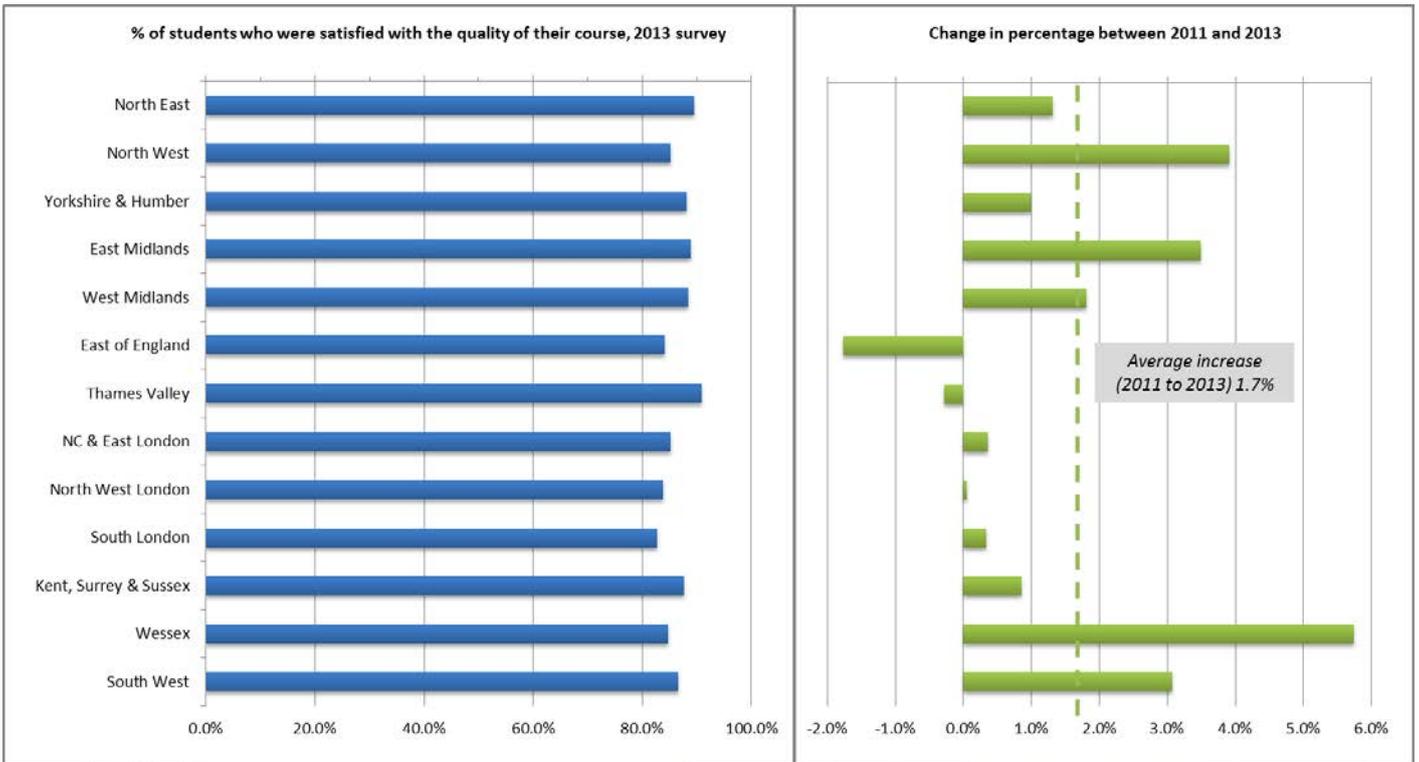
Key points:

- Latest results show very little variation across the country (between 83% and 91%) with a national average just under 87%.
- There has been an improvement in scores nationally of 1.7% between 2011 and 2013 though this differs widely across the country. LETB areas across London have seen relatively small improvements whilst East of England and Thames Valley have both reduced over the period though Thames Valley remains above the national average.

<sup>17</sup> <http://www.hefce.ac.uk/whatwedo/it/publicinfo/nationalstudentsurvey/nationalstudentsurveydata/>

<sup>18</sup> These have been defined as: (1) Medicine and Dental; (2) Courses allied to Medicine, and; (3) Biological Sciences.

**Chart 4: Percentage of students who agreed with statement in 2013 survey and change from 2011 survey**



## 13 Competent and Capable Staff (CC)

### *Description*

There are sufficient health staff educated and trained, aligned to service and changing care needs, to ensure that people are cared for by staff who are properly inducted, trained and qualified, who have the required knowledge and skills to do the jobs service needs, whilst working effectively in a team.

### CC1a-c: Training and education for staff

This indicator is based on published data from the NHS Staff Survey<sup>19</sup> between 2011 and 2013. The staff survey is open to all staff employed by the NHS. It is based on the percentage of staff who 'agreed' or 'strongly agreed' that training undertaken has helped them improve their effectiveness and patient experience. Specifically: *'Thinking about any training, learning or development that you have done in the last 12 months (paid for or provided by your trust), to what extent do you agree or disagree with the following statements?'*

- a. Do my job more effectively*
- b. Stay up-to-date with professional requirements*
- c. Deliver a better patient/service user experience*

The information below looks at the change in the percentage of respondents who replied positively – i.e. agreed or strongly agreed, with the statements. For (a) and (b) this is between 2011 and 2013 surveys. Statement (c) was not included in the survey prior to 2012 and so has been omitted from the chart though data is provided in Annex D.

Progress against this indicator reflects a range of factors influenced by organisations across the sector, most notably the employing organisation, and reflects the progress of the whole-system more-so than some of the other indicators.

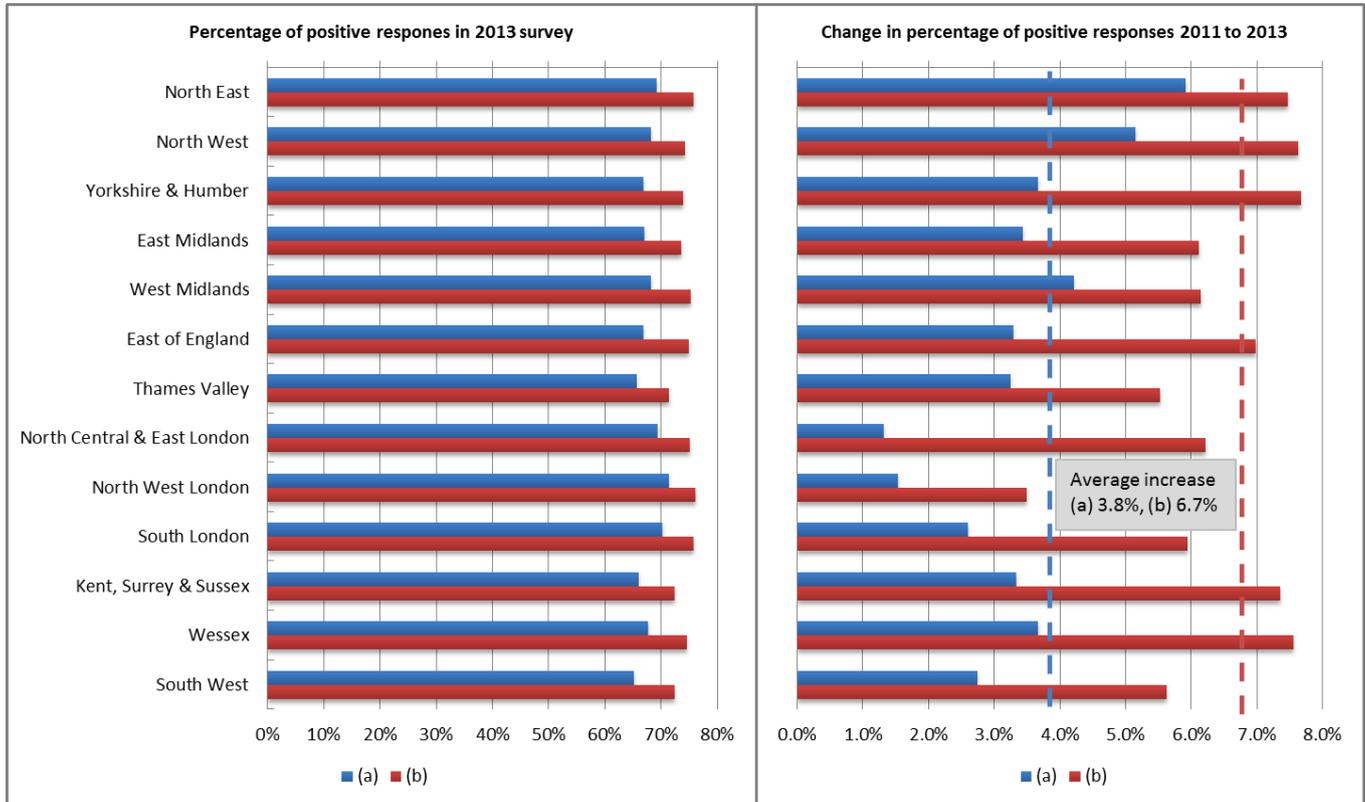
### Key points:

- Agreement to statements (a), about increased effectiveness due to training have seen average increases of around 1.5% to 6% respectively, with an average of 3.8% nationally.
- Agreement to statements (b), about keeping up-to-date professionally have seen increases of around 3.5% to almost 8% respectively, with an average of 6.7% nationally.
- The increases are broadly consistent across all LETB areas, with those across in London slightly lower than other areas overall though they perform well in absolute terms.

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<sup>19</sup> <http://www.nhssurveys.org/surveys/425>

**Chart 5: Changes in percentage of staff who responded positively to statements (a) and (b) between 2011 and 2013**



### CC2a-d: Delivery of nationally agreed commissioning requirements for priority staff groups areas

This indicator is based on the integrated performance report (IPR) published by HEE.<sup>20</sup> This indicator comprises a RAG rating of evidence that appropriate steps have been taken to secure workforce supply for the following priority areas for 2013/14 as set out in HEE’s Mandate:

- (a) shortages in the number of doctors working in emergency medicine;
- (b) the commissioning of sufficient numbers of health visiting training places to meet the objective of increasing the health visitor workforce by 4,200 FTEs by April 2015;
- (c) the commissioning of IAPT training places at sufficient levels and numbers to meet service demand and commissioning intentions across all aspects of the IAPT programme to 2015; and
- (d) reduction in the number of roles in the Shortage Occupation List.

<sup>20</sup> <http://hee.nhs.uk/wp-content/uploads/sites/321/2014/05/9a.-IPR-for-Board-2014-05-20.pdf>

A breakdown of the ratings by LETB has not been published, though the report does contain charts showing progress against (b) and (c) which have not been replicated here.

Key points:

- HEE is on target to meet its requirements for doctors working in emergency medicine, training of IAPT and health visitor places.
- With regards to Shortage Occupation List, 2014/15 commissions show either modest increases or roll over, and analysis indicates that training will enable growth to the workforce for the professions within the control of HEE.

**Table 1: Summarised position of current progress from HEE IPR**

Priority areas to address	Delivery Date	Measures	
Shortages in the number of doctors working in emergency medicine	Aug-13	Continued maintenance of the Emergency Medicine Workforce Implementation Group. Publication of recommendations in Summer 2013.	Green
The commissioning of sufficient numbers of health visiting training places to meet the objective of increasing the health visitor workforce by 4,200 FTEs by April 2015	Apr-15	LETB self-assessment RAG rating for the level of confidence that the target will be achieved based on recruitment to date. Additional metrics are being developed to supplement this data.	Green
The commissioning of IAPT training places at sufficient levels and numbers to meet service demand and commissioning intentions across all aspects of the IAPT programme to 2015	Sep-15	To ensure that places commissioned meet the planned target numbers for 13/14. Develop self-assessment processes to gain assurance for 2014/15 delivery. Work in partnership with NHS England to develop links between commissioners of services, workforce development and the LETB workforce plans.	Green
Reduction in the number of roles in the Shortage Occupation List	Mar-15	Forecast supply versus demand indicators for all roles on the shortage occupation list.	Amber

## 14 Flexible Workforce Responsive to Research and Innovation (FW)

### *Description*

The workforce is educated to be responsive to changing service models and responsive to innovation and new technologies with knowledge about best practice, research and innovation, that promotes adoption and dissemination of better quality service delivery to reduce variability and poor practice.

### **FW1a-d: Staff contribution to service improvement activities**

This indicator is based on published data from the NHS Staff Survey<sup>21</sup> between 2011 and 2013. The staff survey is open to all staff employed by the NHS. It is based on the percentage of staff who 'agreed' or 'strongly agreed' about their ability to contribute to service improvement activities in their work. Specifically:

- a. There are frequent opportunities for me to show initiative in my role*
- b. I am able to make suggestions to improve the work of my team/department*
- c. I am involved in deciding on changes introduced that affect my work area/team/department*
- d. I am able to make improvements happen in my area of work.*

Progress against this indicator reflects a range of factors influenced by organisations across the sector, most notably the employing organisation, and reflects the progress of the whole-system more-so than some of the other indicators.

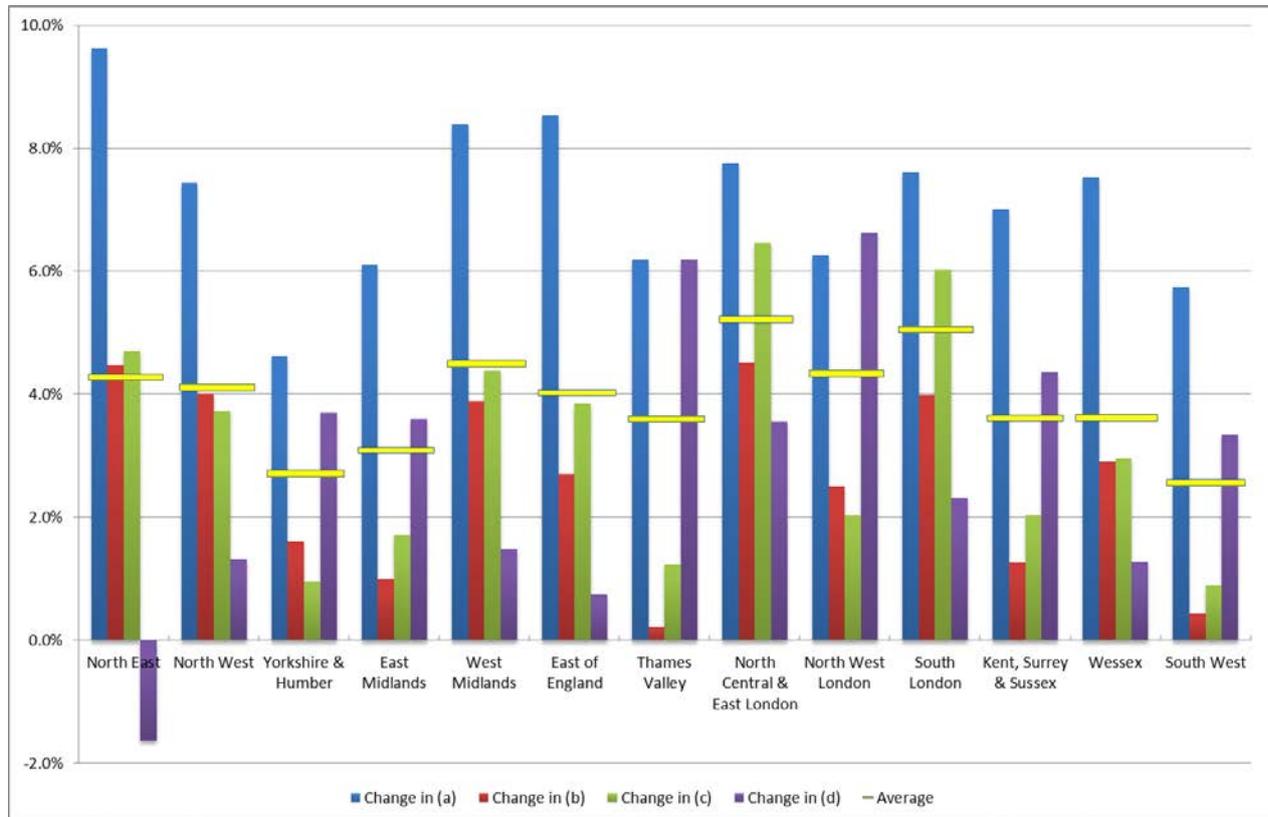
### Key points:

- There is an overall improvement in scores of 4% on average, with positive responses to each statement increasing from between 2.3% [d] and 7.3% [a]
- The only deterioration in score comes from North East (statement d) though, across the four statements, they show an above average increase.

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<sup>21</sup> <http://www.nhssurveys.org/surveys/425>

**Chart 6: Change in percentage of staff who 'agree' or 'strongly agree' with each statement between 2011 and 2013**



## FW2: Participants recruited to studies included on the NIHR CRN Portfolio

This indicator is based on published data from the National Institute for Health Research - Clinical Research Network<sup>22</sup> (NIHR CRN). It shows the number of patients recruited to studies included in the NIHR CRN portfolio. This is published by providers of NHS services but has been aggregated to LETB for this report. The absolute level of recruitment is strongly influenced by local population levels and accounts for much of the differences between areas.

Progress against this indicator reflects a range of factors influenced by organisations across the sector, most notably the employing organisation, and reflects the progress of the whole-system more-so than some of the other indicators.

Key points:

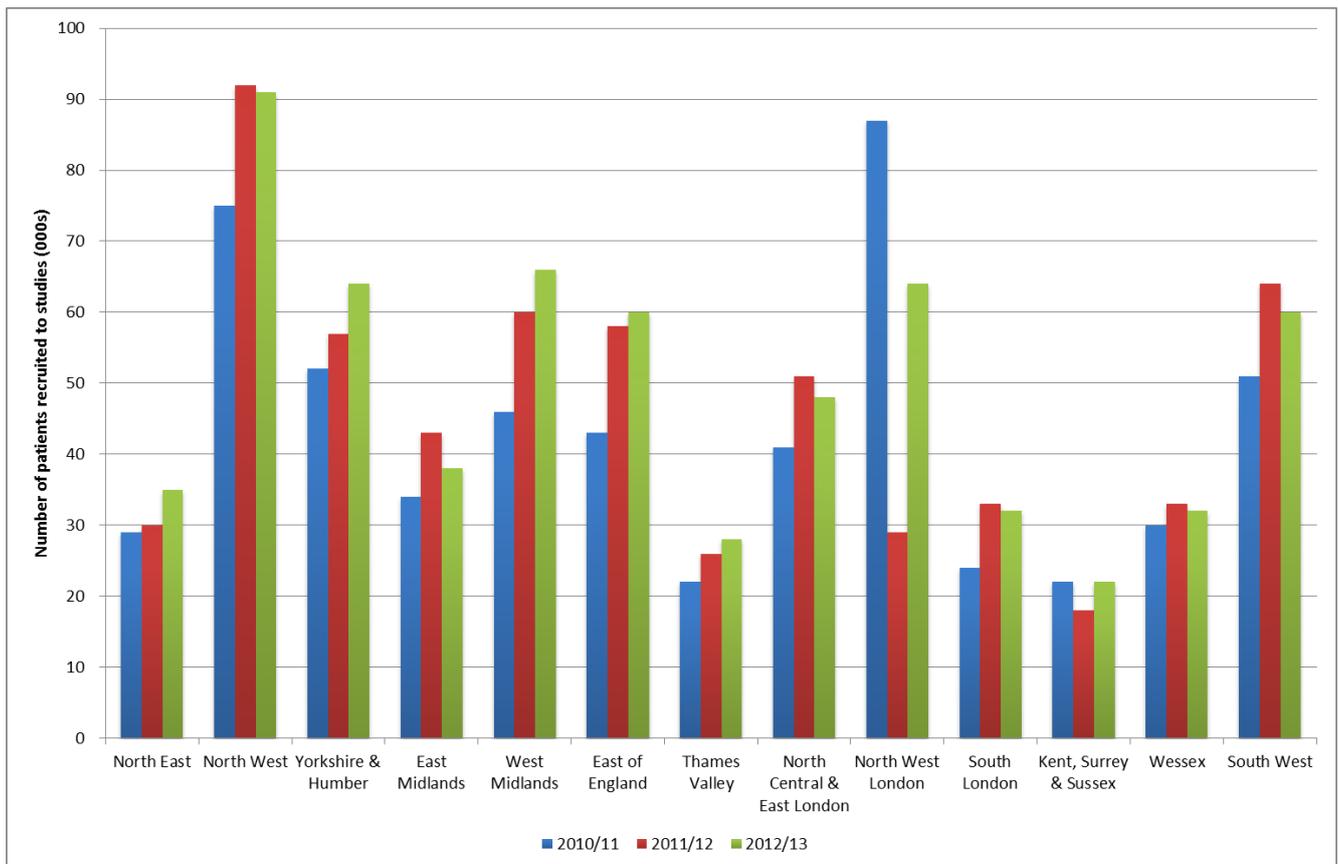
- Recruitment to studies has increased by an average of around 7.5% a year between 2010/11 and 2012/13 (a total increase in excess of 15%) and, with

<sup>22</sup> <http://www.theguardian.com/healthcare-network-nihr-clinical-research-zone/table/2012-trust-research-activity>

the exception of North West London, LETB areas have seen an increase on 2010/11 levels.

- The large reduction for North West London is due to large participation in a single, web-based study which recruited almost 105,000 people over the three years. The split of participants was significantly different in each year and this accounts for the changes seen. Recruitment was around 68,000 in 2010/11, less than 200 in 2011/12 and almost 37,000 in 2012/13.

**Chart 7: Published NIHR participation numbers for years 2010/11 to 2012/13, aggregated to LETB area level**



## 15 NHS Values and Behaviours (VB)

### *Description*

Healthcare staff have the necessary compassion, values and behaviours to provide person centred care and enhance the quality of the patient experience through education, training and regular Continuing Personal and Professional Development (CPPD), that instils respect for patients.

### **VB1: Staff opinion on the standard of care provided by their employing organisation**

This indicator is based on published data from the NHS Staff Survey<sup>23</sup> between 2011 and 2013. The staff survey is open to all staff employed by the NHS. It is based on the percentage of staff who 'agreed' or 'strongly agreed' with the statement:

*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*

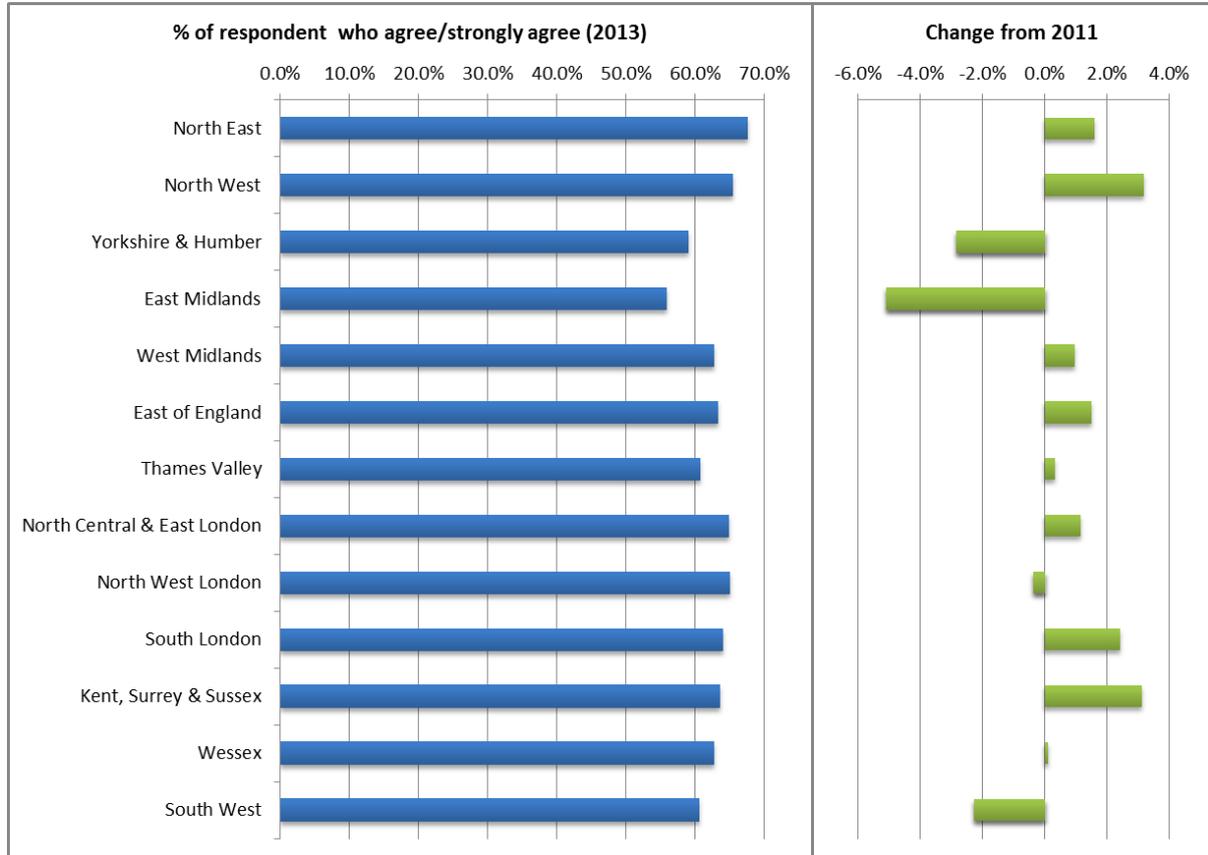
### Key points:

- All LETB areas are consistently around the national average of just under 63%, ranging from 56% (East Midlands) to just under 68% (North East).
- Compared to 2011, there has been a slight increase overall (0.6%) in those who agree with the statement, though the change varies quite widely at LETB area level, ranging from -5.1% (East Midlands) to +3.2% (North East).

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<sup>23</sup> <http://www.nhssurveys.org/surveys/425>

**Chart 8: Percentage (a) of staff in 2013 survey who ‘agree’ or ‘strongly agree’ and (b) change from 2011 survey, by LETB**



### VB2a-f: Patient experience of care and treatment

This indicator is based on published data from the Acute In-patient Survey run on behalf of the Care Quality Commission<sup>24</sup>. The questions cover patient experience of medical and nursing staff in hospitals.

It is based on the percentage of patients who replied negatively – i.e. “No” to the following questions related to their treatment and experience of care:

- a. *When you had important questions to ask a doctor, did you get answers that you could understand?*
- b. *When you had important questions to ask a nurse, did you get answers that you could understand?*
- c. *Were you involved as much as you wanted to be in decisions about your care and treatment?*
- d. *Do you feel you got enough emotional support from hospital staff during your stay?*

<sup>24</sup> <http://www.nhssurveys.org/surveys/425>

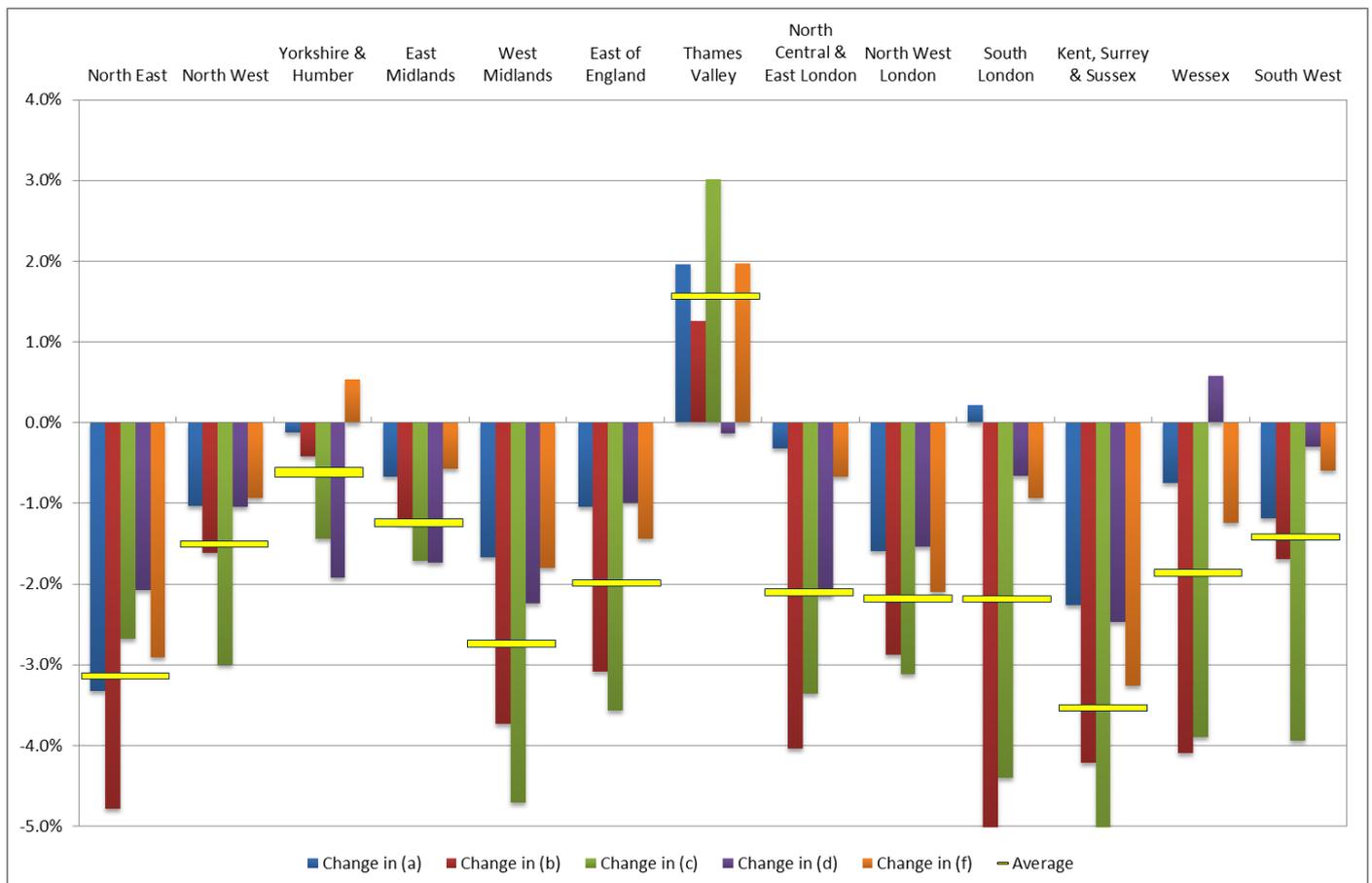
- e. *Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)*
- f. *Overall, did you feel you were treated with respect and dignity while you were in the hospital?*

With the exception of statement (e) the comparisons are between 2011 and 2013 surveys. Statement (e) was not included prior to 2012 and so has been omitted from the chart though data is provided in Annex D. Unlike other indicators this measures negative responses and readers should note that, for interpretation purposes, percentage reductions are a positive change.

Key points:

- Nationally there has been an improvement in scores for each statement and generally show improvements across all LETB areas. On average responses have improved by 2% with responses to questions (a), (d) and (f) showing moderate progress over 1% (1.1%, 1.4% and 1.2% respectively). Responses to questions (b) and (c) have improved by around 3% (2.7% and 3.3% respectively).
- The obvious outlier is Thames Valley which shows worst improvements/ biggest deterioration for the majority questions. This is an average deterioration of 1.6%.

**Chart 9: Change in percentage of 'No' responses to each of the questions (positive changes are a deterioration)**



## 16 Widening Participation (WP)

### *Description*

Talent and leadership flourishes free from discrimination with fair opportunities to progress and everyone can participate to fulfil their potential, recognising individual as well as group differences, treating people as individuals, and placing positive value on diversity in the workforce and there are opportunities to progress across the five leadership framework domains.

### **WP1: Education providers demonstrate their approach to equality & diversity**

As described in the 2013/14 technical guidance this indicator was expected to be available for reporting during 2013/14. Data has only recently been made available to HEE and further work is required to develop meaningful indicators. Given the early stages of development these indicators have been excluded from this report. HEE will continue to develop robust measures as part of its 2014/15 work programme.