Shaping the Future:

Education and Training for Nurses and Care Assistants

Council of Deans of Health

Response to the Shape of Caring Review’s Call for Evidence

September 2014
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Foreword

The Shape of Caring Review comes at an important moment for health higher education and for health and social care services. As we reflect on developments in health and social care and in health education, there is much to celebrate. Nursing in particular has proved itself to be an enduringly adaptable profession, embracing new roles and leadership challenges, often in the context of stretched resources and political pressure. We now have robust evidence that degree level education for registered nurses is associated with decreased mortality rates in hospitals: providing the evidence base for the confidence that many of us have long had as we see the commitment of students coming through our programmes. The vital work of support staff in teams alongside registered professionals is also now on the agenda in a way that would have been inconceivable five or ten years ago.

But we also know that there are many challenges: increased pressure on health and social care services, staff shortages, shifting demographics and pressures on the public purse that are unlikely to ease in the next five or even ten years. In this context, education and training plays an absolutely central role in supporting the health and care workforce to deliver for the future. The scope is vast: from initial pre-registration education to advanced practice and post-registration careers; from the early days of working as a care assistant to those who are educating the future workforce or carrying out research; from public health to palliative care and from hospitals to people’s homes.

Many of the themes of Shape of Caring take us into the territory of ‘wicked problems’ – issues that defy simple solutions, where stakeholders have different underpinning assumptions, where the resources that are needed to address an issue shift over time and where the ‘solution’ is heavily dependent on the problem definition. We have therefore structured our response to include a consideration of what we take to be some of the principal issues under each theme before giving examples of how they might be addressed.

We have also made two choices in seeking evidence from members that take our response slightly beyond the terms of reference for Shape of Caring. First, we have solicited evidence from across the UK, although the Review’s focus is on England. The value of exchanging learning across the home nations is in the DNA of the Council and we believe that there is particular value in England learning from the other home nations of the UK in many of the Review’s domains, not least from the CNO in Scotland’s review, Setting the Direction.

Our second choice has been to include examples from across a range of different professions and the support workforce. We fully understand that the remit of Shape of Caring has had to be tight, given its timing and political context. However, as a Council, it is our experience that the issues affecting nursing cannot be disaggregated from other
professions. We hold that to advance care that genuinely meets patients’ needs and to address the central issues facing education and training for nursing and care assistants, a whole workforce view must be taken.

I am very grateful to all the Council members who have supplied examples for us to use in this response and for the continuing dialogue across our membership and with our partners in health and social care services that will help us make education and training the best it can be.

[Signature]

Professor Dame Jessica Corner
Chair, Council of Deans of Health
The Shape of the Future Workforce

The changing needs and expectations of a growing population of people who are living longer with increasingly complex health needs are already driving change in the way in which health and social care are delivered. Patients with long term conditions currently make up 29 per cent of the population, and account for 70 per cent of the total health and social care spend in England. By 2025, the number of people in England living with at least one long term condition will have risen from three million to 18 million.1 In the context of continued economic constraint and the aspiration for a model of ‘whole person’ care, centred on patients’ needs, common themes in work looking at the future of care include proactive illness prevention, the impact of new technology, empowering patients to self-manage conditions within ‘communities of health’, integrated health and social care, and a greater role for primary and community care.

Some of these trends are already visible; it is important to note that the majority of the NMC’s register already works outside the NHS. However, although there is extensive political rhetoric on integrated care, centred on the needs of the ‘whole person’, in reality we are in many ways far from a system in England that makes it easy to organise services around the service user and their family. In practice, it is often health and social care professionals who act as integrators in a non-integrated system. Whatever the results of the next general election, there is no magic bullet for the challenges of fragmentation, shortages of staff and gaps in funding, particularly given the difficult public spending settlement that is expected to follow the next comprehensive spending review.

So what does this mean for nursing? Over the past decades, nurses have already demonstrated the profession’s adaptability: embracing developments in advanced practice and independent prescribing; working increasingly autonomously in people’s homes; and leading organisations and service redesign across the NHS and social care. Nurses are active in every health and care field, from public health and health promotion to palliative and intensive care; working in people’s homes, in research or education, in hospitals, in care homes and in schools.

This changing context does, however, have its challenges. Working autonomously in people’s homes, often supporting patients with multiple co-morbidities, requires a high level of educational preparation and on-going support. Leading the new services and service redesign that are necessary to meet an ageing population’s needs requires nurses able to lead and manage change, keeping services centred on high quality care informed by the best available evidence. Managing the provision of nursing care in a care home, with few other registrants and complex inter-sectoral relationships requires clinical

skill and management ability, both in delegating to others and in working across organisational boundaries.

Delivering the best patient-centred care and improvements in quality requires nurses able to use research to inform their own practice and a strong cadre who are active in research themselves, pushing the frontiers of knowledge and translating this back into patient care and education of the future workforce. Working with service users and carers, particularly those with long-term conditions, requires great skill to know how best to work with people as partners in their care and how to work for greater equity for those who miss out on access to health and social care services. Preparing the next generation of the workforce requires nurses equipped to educate and mentor, working in partnership between health and care and higher education.

This holds a number of broad implications for education and training:

1) The future workforce is, in large part, the current workforce – so making the most of the workforce means investing in education and training across the career span, thinking differently about how to make the most of the new nurses joining health and social care teams and developing those who will educate the future workforce.

2) Service users and carers are partners in care – so education and training needs to enshrine this at every stage, while raising awareness of inequalities in access to services and the social determinants of health.

3) We educate for a future we cannot see – so critical thinking and the ability to continue to learn, including understanding the implications of research, are vital for all those in the workforce.

4) Nurses work inter-professionally and inter-sectorally and will increasingly be leading redesigned services and deployed in advanced practice roles – so education and training should reflect these changing patterns, from pre-registration modules and clinical simulation through to CPD and post-registration education.

5) Research will keep pushing the frontiers of knowledge and improving care – so we need a strong cadre of nurses involved in and leading that research and capacity across the workforce to understand research and apply it to practice and education.
Increasing patient/carer voice and service user involvement

The 2010 NMC standards for pre-registration nursing education state that ‘programme providers must clearly show how users and carers contribute to programme design and delivery’. In this, the NMC has been further ahead in its engagement with service users and carers in education than the HCPC, which has only recently introduced a duty that ‘Service users and carers must be involved in the programme’. As reported Quality with Compassion there is high awareness among health education providers of the need to include service user voices and much evidence of growing public and patient involvement at all levels, from co-production of curricula and recruitment to practice learning and assessment.

Evidence from our members bears this out, demonstrating a strong commitment to finding new ways to integrate service user voices into the education process: service user engagement was one of the most populated categories for case studies within our Innovation in Teaching and Learning Project. However, work remains to be done to ensure that service user involvement is fully embedded across all programmes and to a depth that is transformative of education.

Building the evidence base

As they implement service user and carer engagement in programmes, universities report positive feedback from students and service users alike – students experience increased confidence and welcome the chance to reflect on their own learning and skills as well as learn more about the lives of a variety of service users, and how quality of health care impacts upon them. However there is little evidence of the longitudinal effects of service user involvement on patient care and how involving service users at different points of the education cycle affects quality of care. This may act as a barrier to ensuring that the involvement of services users is fully integrated rather than ad-hoc or piecemeal, as there is no in-depth evidence base to build from. There is also work to be done to evaluate approaches to other issues relating to service user involvement, including suitably remunerating service users for their time and ensuring representation of both good and bad experiences of healthcare, particularly amongst ‘seldom heard’ groups.

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5 Innovation in Teaching and Learning in Health Higher Education is a joint project between the HEA and CoDH which has published more than 100 case studies of innovation in education. For further details see http://www.councilofdeans.org.uk/heacodh-innovation-teaching-and-learning-project/
6 Chambers, M., & Hickey, G. (2012). Service user involvement in the design and delivery of education and training programmes leading to registration with the Health Professions Council. Kingston University and St George’s, University of London
Involving service users with learning difficulties, their carers and families

There is strong evidence that people with learning difficulties have worse health and die younger on average than their peers due to a range of factors which include inequality of access to health services, caused by barriers such as diagnostic overshadowing, inexperienced or discriminatory staff, or failure to make reasonable adjustments. To address this, Healthcare for All recommended that:

‘Those with responsibility for the provision and regulation of undergraduate and postgraduate clinical training must ensure that curricula include mandatory training in learning disabilities. It should be competence-based and involve people with learning disabilities and their carers in providing training.’

The involvement of people with learning difficulties and their carers in healthcare education can help to break down barriers to equal access to healthcare by challenging attitudes, increasing understanding of communication issues, improving students’ confidence and deepening insight into the lived experience of people with learning disabilities. Whilst many education providers, particularly those that currently deliver Learning Disability pre-registration nursing programmes, engage service users with learning disabilities, there is still scope to fully integrate the involvement of people with learning difficulties, their families and carers in healthcare education across all fields of nursing and other health professions, something recognised in Strengthening the Commitment.

As the university no longer provides LD nursing pre-registration programmes, Oxford Brookes University works closely with My Life, My Choice, a self-advocacy group, to deliver workshops for other fields of nursing, following on from theoretical sessions addressing issues such as capacity and consent.

Northumbria University has implemented a full learning and teaching strategy based on implementation of the Michael Report’s recommendation 1(2009). This has three phases – starting with a workbook, followed by clinical simulation with people with learning disabilities and then a reflective practice session.

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Learning from existing good practice

As universities have expanded their work with service users and carers, there are now a number of different but complementary approaches that could be evaluated and disseminated more widely. These include: using service user and carer groups; adapting existing education processes to include service users; and creative uses of technology to embed service user experiences.

**Service user and carer groups**

Many institutions, including Staffordshire University, University of Southampton, Bournemouth University and Swansea University, coordinate service user and carers groups that meet throughout the year to develop new ways of working together. The Carer and Service User Partnership Group was set up at Bournemouth University in 2005, following a Skills for Care training programme ‘Getting Involved’. Those who attended the course became the first members of the group, which currently has 33 members who have used a range of services, including mental health, physical disability, drug and alcohol and learning disability. The group is facilitated by two coordinators who share a 1.2 FTE post and ensure that members of the group are supported to engage in a range of activities from interview to assessment and curriculum design. They also organise training for service users and carers as well as facilitate representation at internal and external meetings.

**Adapting processes to facilitate user involvement**

Reported barriers to service user involvement include lack of clinical expertise and medical jargon and health education providers are finding new ways to make involvement accessible.

King’s College London has developed an innovative method involving local schools to refine their selection process for children’s nursing candidates. Candidates were asked to plan a children’s ward party on the selection day. These were assessed according to the results of focus groups held with children aged 9-16, who were asked to identify both the ideal party plan and the key attributes of a children’s nurse. This data was analysed and has been used to refine the shortlisting criteria for personal statements and the scoring sheet used in the selection day task.

Adapted forms and questionnaires can be used to translate selection and assessment criteria so that service users can meaningfully participate. Northampton University has developed a voluntary feedback questionnaire for service users receiving treatment during final year clinical examinations for podiatry students. These are used by the examiners when constructing their comments on a student’s performance, and students have the option to receive the patient feedback sheets once their grades have been released.
Incorporating technology

As education delivery is being enhanced through technology, service user voices are increasingly being embedded into virtual learning environments and other learning aids. **Canterbury Christ Church** uses videos to capture service user stories, showing service users in their own environment, living with their condition. These are reported to humanise cases as well as increase students’ awareness of the importance of confidentiality and their ethical responsibilities.

**University of South Wales** has developed a freely available online educational resource, Telling Stories, Understanding Real Life Genetics. Launched in 2007, it sets stories from patients, carers, family members and professionals within an education framework that makes clear the links to professional practice and maps them to competency frameworks and/or learning outcomes for nurses, midwives, medical students and GPs.

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10 [http://www.tellingstories.nhs.uk](http://www.tellingstories.nhs.uk)
Valuing the role of the care assistant

Care assistants and health care support workers are undertaking a growing range and number of roles, supporting a wide variety of health professionals across the NHS, social care, independent and voluntary sectors. In healthcare, support workers make up 40 per cent of the NHS workforce and are responsible for an estimated 60 per cent of contact with patients.\(^{11}\) It is likely that this workforce will continue to experience growth, having doubled in size from 1997 to 2007 and that the breadth and complexity of the roles will continue to expand. Amongst other things, valuing the role of care assistants therefore requires an understanding of the diversity of roles undertaken by this workforce and a commitment to investing in education and continuing professional development opportunities.

Ensuring consistency in role design and qualifications

The breadth of roles undertaken by care assistants and support workers and the lack of a national strategic framework for developing support staff has led to a diverse range of award titles and education programmes, differing in almost every area of HE delivery. As a result, there is evidence that support workers access a disparate, non-transferable and inconsistent range of formal and informal learning programmes, ranging from statutory training to Qualifications Credit Framework accredited qualifications such as diplomas and, for Assistant/Associate Practitioners, foundation degrees.\(^{12}\)

Inadequate workforce intelligence and planning also contributes to misunderstandings about roles, inappropriate delegation of tasks, lack of opportunities for support workers to progress their careers and the under-utilisation of skills. Despite the future expectations of service provision, the Council’s 2013 joint research with Skills for Health found only a small number of higher education-led programmes (typically at foundation degree level) for support workers focused on primary, community or integrated care.\(^{13}\) Variability in award titles can also hamper the ability of support workers to move between different employers.\(^{14}\)

To overcome these barriers, the scope of practice of support worker roles needs to be more clearly defined. This requires identifying the core tasks and attributes that apply to all support workers at each level, while allowing local flexibility to identify patient/client specific requirements. For example, for Assistant/Associate Practitioner roles, Foundation Degrees or Diplomas of Higher Education should become the standard

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\(^{11}\) [http://eoe.hee.nhs.uk/our-work/1to4/](http://eoe.hee.nhs.uk/our-work/1to4/)


\(^{13}\) Ibid, p. 19

\(^{14}\) Skills for Health (2011) The role of Assistant Practitioners in the NHS: factors affecting evolution and development of the role p.39
qualification, given the complexity of the tasks performed by the roles and their degree of autonomy.

There is also scope to explore the use of so-called ‘Skills Passports’. Used as an integral part of formal education programmes, these can allow support workers to demonstrate their competence, which in turn, improves the confidence of registered staff to appropriately delegate tasks. Skills Passports also clarify the tasks support workers cannot perform, addressing ‘task drift’.

The Royal College of Midwives (RCM) and NHS Scotland have undertaken work on setting out the role and responsibilities of maternity support workers (MSW) and is an example of good practice in this field. Tasks have been identified and given traffic lights as follows: green - tasks all MSWs can perform, amber – MSWs can do with further training, and red – tasks MSWs can never perform.

Careful naming of healthcare support worker education programmes can help to promote a shared understanding of the roles and skills of healthcare support workers. Welsh Health Boards promote the Certificate in Higher Education in Health Care Nursing Support Worker Education to seek great consistency in award titles across Wales. This certificate is a nationally recognised qualification designed to develop the healthcare support worker within their existing role. Upon completion of the certificate, healthcare support workers may progress into the second year of a pre-registration nursing degree following successful application. Both the title and framework of this degree leaves the students, the educator and the employer in no doubt as to the intended outcomes of the programme.

Defining scopes of practice and aligning education and training frameworks would be an important underpinning for any future statutory regulation of support workers across health and social care, particularly if there is an aspiration to go beyond so-called ‘negative lists’ or barring systems. The potential to regulate higher level care assistants (particularly those working in roles such as Assistant Practitioners) should be considered as a priority.

Funding Continuing Professional Development (CPD)
The growing range and number of roles undertaken by health care support workers requires a workforce able to learn and adapt to new modes of patient care. There is sometimes a misconception that all support staff want to become registered health professionals; when asked about career progression in a recent HEE survey, 35 per cent

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15 Royal College of Midwives. (2012) The Role and Responsibilities of Maternity Support Workers. RCM, London
of support staff chose the option ‘remain in my current role and develop within it’. Development of current roles and responsibility must be underpinned by sustainably funded and accessible CPD, yet barriers to care assistants and other support workers accessing CPD opportunities mean that only half of the assistant practitioner workforce has benefitted from CPD opportunities. Alongside in-house programmes, the HE and FE sectors are well-placed to support the continuing professional development needs of healthcare support workers, with considerable experience of delivering CPD programmes. However this requires local and national commitment to the funding and commissioning of CPD for healthcare support workers.

Health Boards in Wales have demonstrated an active commitment to CPD; Abertawe Bro Morgannwg Health Board runs an across-board CPD meeting at least three times a year and runs monthly sessions in specific locations to support staff development and learning needs. In both Wales and Scotland, national funding is made available for the development of this workforce.

Supporting flexible models of delivery

As the demand for care assistants increases, the numbers of care assistants and health care support workers seeking places on university programmes for support workers, such as foundation degrees, is falling, partly due to employers looking for ways to minimise staff time away from clinical service. Some universities are developing e-learning courses for this workforce and many have expertise in this model of learning for healthcare and other students. Work-based learning allows healthcare support workers to incorporate work undertaken in the healthcare support worker’s current workplace with classroom study. In this way, one university can support a number of care assistant pathways.

Oxford Brookes University supports up to 50 different pathways through their Health and Social Care foundation degree. It is unique in that it can support care assistants from any practice area to undertake the Foundation degree, through four work-based learning modules taken over two years, where the competencies are designed purely with the practice area. This is combined with generic campus based modules which cover science for health and social care, social and welfare systems, legal and ethical aspects of care and research and evidence. The course serves both employers and employees well and reports low attrition rates; all students are seconded from their employer and return to assistant practitioner roles.

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Widening opportunities for care assistants’ career progression

Progression into pre-registration programmes

Many staff who are recruited into care assistant and other support worker roles do not wish to progress into pre-registration education. However, some do and universities play a particularly important role in supporting and developing pathways from care assistant to registered health professional, with many universities having a long track record in supporting health and social care staff to bridge between the two.19 Given the diversity of education, training and awards available to care assistants, this is a complex interface. A Department of Health document published in 2010 set out three educational models and one employment model that aims to support access to pre-registration nursing programmes and set out careers pathways for support workers20:

- Model A: Progression from foundation degrees to the relevant field programme of the pre-registration nursing degree course.
- Model B: Transition from the undergraduate pre-qualifying nursing programme to the foundation degree.
- Model C: National vocational qualifications (NVQ) level 3: transition into prequalifying nursing degree programmes.
- Model D: NHS clinical higher apprenticeships.

We remain broadly supportive of these models as a useful basis for discussions to address knowledge and skills gaps of healthcare support workers and allow staff to apply for entry to pre-registration programmes, including, where appropriate, to the second year. Our work on the pathway between support worker and pre-registration education also suggests two areas of work that would strengthen opportunities for support workers.

Equivalence of qualifications

With the plethora of qualifications open to support workers, their real equivalence for entry to pre-registration programmes is often difficult to determine, particularly in the case of numeracy and literacy, which is also usually now tested for at the early stage of the student application process. Work to consider qualification equivalence, particularly functional skills (qualifications in English and Maths), would be of particular value in helping smooth the pathway into higher education.

Commissioning bridging programmes

Aspiring pre-registration students in employment sometimes lack specific skills that are necessary to make a successful application to a pre-registration programme and then go on to complete it. In this context, bridging programmes can help clarify the pathway, connecting vocational education with higher education through progression agreements and plugging important gaps that will help aspiring students.

Skills for Health and the Council of Deans of Health are working together to set up a 15 credit (QCF level 3) bridging programme that would support learners with a relevant level 3 qualification and the required numeracy/literacy qualifications to access pre-registration programmes. The modules are focused specifically on areas that learners coming to pre-registration programmes from employment in the NHS or social care often find difficult, such as extended essay writing and researching a topic. Part of the condition of providing the bridging programme is a progression agreement with at least one university.

Middlesex University has introduced a new path to registration as a nurse. This enables those who do not meet university entry requirements for degree level study but are currently employed within the NHS as a clinical support worker to enrol on a one year certificate programme, which maps across to the first year of the pre-registration nursing programme. Students successfully completing the first year are eligible to enter year 2 of a Diploma programme at the end of which they will be eligible to undertake a further 18 months to complete the pre-registration nursing programme.

The Open University's model is predicated on offering a work-based pre-registration nursing education route. The programme is delivered in partnership with employers and is only open to those who are already working in healthcare roles, such as healthcare assistants, with employers sponsoring students through the programme. Students study part-time and typically take four years to complete the programme. The programme runs across most English regions, Scotland and Northern Ireland.

Glasgow Caledonian University, working in partnership with three FE colleges, has created a pathway to facilitate flexible articulation for students from the Higher National Certificate (HNC) to year 2 of the pre-registration nursing programme across all 4 fields of nursing. The transition is led by the student, who identifies the support the feel they need and additional support before entry is offered.

London South Bank University's ‘Wall and Step’ guide to developing bands 1-4 helps to make clear the route to pre-registration education for students, employers and educators.
Canterbury Christ Church University has a foundation degree which supports the development of the AP role and is delivered in partnership with both acute and community sector, with students learning together for a number of modules. Their local mental health trust have commissioned a Cert HE to support those who may wish to progress to nursing.

Working together, the University of Southampton and University Hospital Southampton NHS Foundation Trust have agreed a pathway from their Foundation Degree onto the second year of their BN (Hons) programme for those students who are interested in nursing as a career. GCSE Maths and English at C grade is an educational requirement for all candidates when applying for the BN programme except for the students from this particular Foundation Degree, because of a medicines management module taught by practitioners providing relevance for the drug administration aspect of nursing. The Faculty will guarantee a place for the prospective student to attend an interview.
Assuring flexibility in education and training

Nursing has a strong track record in its flexibility as a profession. Education and training makes a crucial contribution to this, not only in ensuring that nurses are able to remain up to date with the latest clinical practice, responding to the changing needs of the population and innovations in technology and research but also developing critical thinking skills that enable practitioners to continue learning across their career.

As the future workforce is prepared to lead services and organisations, as well as deliver the best possible direct care to individuals and families, we must continue to be ambitious about attracting highly capable, committed individuals into initial education and then retain them across their career span. There must in turn be flexibility and adaptability both in the development of course content, curricula and practice learning environments, but also in the mode of delivery to improve access to ongoing education, development and contribution to research.

Genericism versus specialism: the fields of nursing

We are aware of some concerns from employers that the split of nursing into four fields has perceived disadvantages for pre-registration nursing students developing the skills needed to work with a full range of patients (for example, an adult nurse working with mental health or learning disability patients in general care settings).

Data suggest there may be some basis for these concerns, particularly in the case of the relationship between physical illness and mental illness and in health outcomes for service users with learning disabilities in general healthcare settings. Numerous reports have found that for patients with learning disabilities, communication in general healthcare settings is a major barrier to people accessing timely and appropriate care, as well as a paucity of knowledge about issues surrounding capacity and consent and an ignorance of how to respond to the needs presented by people with different types of disability.21,22,23 Similarly, evidence suggests that service users with mental illness often have physical health needs overlooked and consequently have poor health outcomes across a range of morbidities.24,25

There are steps that can be taken to ensure that students have specific input within their pre-registration programmes to help overcome some of these barriers. For example, the NMC Standards are clear that all fields ensure that students can give appropriate care to people with learning disabilities. There are a number of universities that no longer provide pre-registration LD nursing education but that are embedding specific teaching strategies to build students’ knowledge and competence.

Beyond this, the implications of wanting a very broad base of understanding as well as the depth within a field are potentially significant for the length and scope of programmes and could push programmes into a fourth year. Without undermining the depth of knowledge required in each of the four fields it is already possible to offer dual qualifications that extend courses to a fourth year, something that some education commissioners have started to fund. If extended, however, this would increase the costs of commissioning and commissioners would need to be assured that there are roles in which a new registrant would use both parts of their dual qualification.

All pre-registration Nursing students at the University of Glasgow undertake two four week community practice placements in their first year of study. They are placed within a ‘hub’ – such as a health visiting team, school nursing, community older person’s team or homeless service. Within these four week placements, all students are encouraged to undertake ‘spoke’ placements specifically working with service users with mental illnesses and those with learning disabilities.

Learning/Intellectual Disability Nurse Academics Network has been working to develop good practice in teaching competencies in learning disability nursing within other fields of pre-registration education. Supported by the Council of Deans of Health, the group will publish a report in autumn 2014 setting out practical ways in which this can be achieved, as well as a draft competency framework.

Inter-professional learning

In our Innovation and Teaching Learning Project, 41 per cent of the case studies submitted were inter-professional in scope. Working effectively in teams with health and social care professionals, as well as with other staff, is already a vital part of good care delivery and is likely only to increase as expectations develop of health and social care integration and nurses take on increased responsibilities for leading and managing teams of professionals delivering services. It is therefore particularly important that education and training is inter-professional at all stages, including pre-registration, post-registration and CPD. This may include joint clinical simulation, placements or taught modules. The Shape of Caring Review is an important opportunity to signal the importance of inter-professional learning at all career stages.
**Birmingham City University** run a major simulation involving over 100 undergraduate students from a range of healthcare professions, providing an opportunity for students to work together as multi-professional care teams. The simulation is based around a car accident and is filmed by media students to produce a range of re-usable learning objects for future teaching.

Midwifery teachers and medical colleagues at **Queen’s University Belfast** have worked together to develop an innovative inter-professional teaching strategy between final year midwifery students and 4th year medical students. The planned workshops involve the midwifery students teaching the medical students on a variety of aspects of labour and birth. This has the role of preparing the medical students for labour ward placements undertaken in the fourth year, whilst building relationships between two sets of health professionals and encouraging understanding of each other’s roles.

**Bournemouth University** offers an inter-professional unit on evidence based practice which uses online case studies which immerse the learners in the ‘lifeworld’ of the people they encounter, through videos, media clips, poetry and associated evidence from journals and policy.

Inter-professional learning is embedded into the programme structure of pre-registration nursing and midwifery programmes at **Liverpool John Moores University**. In simulations nursing students practice alongside medical students; inter-professional course units are offered alongside inter-professional extracurricular activities such as seminars and lectures. This includes the seminar series ‘**Multi professional practice: real people, real lives**’ where health and social care service users and providers deliver seminars to students and staff from across the healthcare faculty.

**Balancing the freedom to innovate with clear standards**

In order to ensure course content is developed and delivered according to emerging patient needs, education providers need to be assured of a level of autonomy and flexibility in developing and delivering course content at all levels of education. A preoccupation with prescribing how universities should operate can create rigidity where flexibility and innovation is beneficial. Our recent study of Innovation in Learning and Teaching has revealed development of new modules and pathways to support emerging patient needs. A balance between academic freedom and health education policy has to be struck to ensure that universities are able to develop and deliver courses which react to the changing needs of the population, based on evidence, research and input from service users and providers.
Flexibility in education delivery

Universities are both well-equipped and experienced in delivering education and training across a range of platforms including flipped classroom technology, web based learning, virtual learning environments and social media. The ability to deliver education and training that fits around the lives of pre- and post-registered professionals is vital to ensuring access to ongoing learning, particularly if working patterns are to change, as suggested in *Framework 15*. Members have reported that the use of these methods of delivery can also have positive implications for widening participation.

Flexible learning technologies can be used to support inter-professional and integrated learning, as well as build links between research, learning and practice. There is room to further exploit flexible learning methods and technologies, particularly to engage more of the current workforce in flexible learning environments which enable active and reactive learning, allowing participants to engage with and contribute to education as a process.

Universities increasingly use new technology to support students’ learning. **Edinburgh Napier University** has introduced delivery of lecture content via webinars that can be delivered to students at different points including evenings. The use of webinars allows students to interact with lecturers and other professionals from around the globe.

A competence based module has been developed for senior health practitioners at **Swansea University**. This is a ‘compact’ one week module with an integrated assessment giving same day results, responding to the needs of both the employer and the student.

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Assuring high quality practice learning environments

All pre-registration education is at its heart a partnership between higher education and service providers. With nursing students spending 50 per cent of their time in practice, this is where culture is modelled and codes of behaviour learnt. An increasingly diverse range of employers and universities must therefore have a shared vision for education which values the students' learning experiences in practice. For this to work effectively, universities need to make sure that they are working closely with employers to understand their needs for both the existing and future workforce. Employers across health and social care also need to shoulder their responsibilities: mentoring and guiding students effectively as part of their investment in the quality of care. This in turn is heavily reliant on frontline leadership, on the quality of the mentors/practice educators that supervise students and on the staffing skill mix that allows registered staff time to teach.

As well as the constraints of the current legal framework that determines practice hours and the overall pressures on the quality of placement learning experiences, the evolving shape of care itself poses challenges, particularly in the provision of placements in a full range of integrated care, community and primary care settings. However, research as part of our joint Innovation in Teaching and Learning Project with the HEA has revealed a breadth of innovative approaches to supporting practice placements and providing high quality practice learning partnerships; using technology, drawing on partnerships and involving service users to ensure the focus remains on delivering patient-centred care.

Options for flexibility on placement hours

The legislative focus on the quantity of placement time rather than quality of placements remains a concern, notwithstanding the flexibilities to use clinical simulation as part of this time. The expectation that pre-registration nurses and midwives spend a set amount of time in clinical settings puts significant pressure on the administration of placements, access to supportive and meaningful mentorship and on students, particularly those with caring responsibilities or financial pressures. Although we understand that this aspect of the NMC's Standards is bound by EU law, we would welcome the opportunity, particularly in the run-up to the transposition of the revised Professional Qualifications Directive (2013/55/EU, amending 2005/36/EU) to explore with the NMC how other EU Member States, such as The Netherlands, manage the implementation of this provision.

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Delivering placements across a wide range of settings

Developing innovative and diverse placement settings is central to educating a flexible workforce, able to work across the range of settings required to meet future patient needs, both in care delivery and to promote a public health agenda.

Many pre-registration Occupational Therapy degrees across the UK involve a role emerging placement, which occurs at a site where there is not an established occupational therapist role. Students are supervised daily by an employee within the setting and by an off-site occupational therapist. This approach prepares students for work in a diverse range of settings, encouraging them to promote the public health agenda, whilst also delivering self-directed learning and an increased understanding of their professional role.

Robert Gordon University has developed placements in collaboration with two third sector organisations, Diabetes UK and Scottish Burned Children’s Club. Both of these placements allow students to understand how the third sector and the health sector complement each other, as well as enhance their understanding of living with a long term condition.

Dundee University has developed a four week inter-professional ‘Doctors and Nurses as Teachers’ programme, where student doctors and nurses are teamed up to develop and deliver health promotion education to classes of primary school children. This project provides an opportunity for trainee doctors and nurses to talk to children about healthcare promotion in a meaningful way. Placements such as this encourage a deeper awareness of the broader public health agenda, and creative ways in which this can be delivered.

Ensuring a high quality learning experience

Quality with compassion found that placement experiences were directly related to the quality of their mentorship, but that mentors often had insufficient time to spend with students. A lack of sustainable funding to ensure good mentorship was also highlighted, as well as a need for organisations to invest to ensure that mentors’ workloads allow sufficient time for mentoring and training. Shape of Caring is an opportunity to set a strong direction in calling for protected time for mentors, utilising the funding from the placement tariff as a lever (see p. 31).

The length of placement can also have an effect on building mentorship relationships, which has been addressed in some universities using the hub and spoke model. Other Universities provide additional support through social media and text messaging, whilst

some universities are embedding mentorship within nursing education through peer support programmes.

The peer mentoring system at the University of Nottingham lays the groundwork for taking on a mentoring role once qualified. All incoming students are matched to a more experienced student for informal support. This student has received training and can gains a value added credit NAA certificate in peer monitoring for their involvement in the scheme, as well as the experience of mentoring another student.

Robert Gordon University has tackled some of these issues through a hub and spoke model, which sees pre-registration mental health nurses undertake two placements for the duration of their degree. They have found that this increased the quality of placement and improved mentorship, whilst reducing time spent on allocating placements. Students are able to build a relationship with a consistent mentor, as well as follow service users through their patient journey, and are encouraged students to be more active shapers of their learning experiences.

A text messaging device, FLO, has been developed by Staffordshire University to provide students with a link to their university whilst on placement, offering additional support to students. This provides an extra layer of support beyond mentorship, and an alternative line of communication to students who may be experiencing difficulties on placement.

Glasgow Caledonian University has a similar model where the student spends the majority of their practice learning time in one team/service, spending at least 50% of this time with a mentor. Students are able to follow the patient journey to a different service or team (spoke) which may be in a clinical or non-clinical setting, before returning back to their original team (hub). This model has shown excellent outcomes for developing patient centred, integrated care, promoting working across teams and services to deliver streamlined care.

University of Salford have established a nursing Twitter account and blog curated by both students and academics. This has been used to both collect data and gather creative solutions to problems of practice based learning, particularly around the role of the mentor.

At Staffordshire University the relationship between education and practice is facilitated through involving clinical partners in the assessment and weighting of clinical practice within the pre-registration midwifery curriculum. Both practice and academic assessments of midwifery students are graded and moderated by mentors and the supervisor of midwives.
Facilitating feedback between education and placement providers

The public inquiry into Mid Staffordshire NHS Foundation Trust highlighted that medical students and trainees are 'invaluable eyes and ears in a hospital setting', a rationale that applies equally to other health professions. However, although student feedback on placements is a routine part of pre-registration programmes, there is still work to be done to ensure that students’ feedback is universally used effectively to stimulate change in both education and practice. Ensuring that feedback is shared and used within placement providers may be important in addressing both placement quality and also quality of patient care.

Birmingham University has developed a bespoke database which is used to both collect and disseminate student feedback on placements. This is reviewed with educators and clinical tutors to monitor placements, flag and issues and change practice on placement where appropriate.

University of Northampton is piloting a mini 360 degree review process for students on placements, with the mentor obtaining feedback from two patients selected by the mentor. This feedback is used within their feedback to the student in the assessment of their placement, which is then critically reflected on by the student as part of their practice portfolio.

Coordinating placement administration

The number of places a university can offer is dependent upon the availability of placement opportunities. Setting up and maintaining sufficient, high quality placements for the number of students across a range of health providers within increasingly complex logistical and legal requirements can be a challenge; members report perennial capacity issues which lead to lack of variety and the necessity for students to study over an extended academic year in order to fulfil the required practice hours. This can cause difficulties for students with additional caring responsibilities as well as financial concerns for those students who need to take on additional paid work during their holidays to support their study.

Leeds Metropolitan University together with Quantum IT have developed a regional placement system coordinating student placements across 5 University and 2000 placement provider organisations, increasing operational efficiency allowing staff to spend more time actively supporting students whilst on placement.

Access to on-going learning and development for registered nurses

The future workforce is, in large part, the current workforce. Making the most of the workforce and ensuring that it can meet future patient need therefore means investing in education and training across the career span, thinking differently about how to make the most of the new nurses joining health and social care teams and developing those who will educate the future workforce.

A number of areas, particularly urgent/emergency and primary care are also experiencing serious shortages of medical staff, with further pressures predicted: by 2021 there could be 16,000 fewer GPs than needed; more than 80 per cent of A&E units cannot provide coverage by an on duty consultant for the 16 hours a day needed to guarantee best possible care.\(^{30,31}\) There is therefore an urgent imperative to think creatively about how to provide the underpinning education that will allow the deployment of nurses and AHPs with advanced practice skills to provide services in new ways, particularly in meeting the needs of an ageing population and serving populations with high levels of chronic disease.

Supporting new registrants

New registrants need support as they make the transition to employment as a registered nurse, particularly as the settings that newly qualified nurses work in vary widely and as demands grow on the nursing workforce. We strongly support more detailed consideration of how new registrants can be supported in practice. In particular, we believe that Shape of Caring is an opportunity to set a clear direction on how new nursing registrants can be supported through schemes such as preceptorship and other measures to ensure a successful transition.

Working in partnership with local services, King’s College London has established two centres of clinical learning based in the local community to support pre- and post-qualification health visitors. Each centre has on practice teacher who has a lightened caseload for up to two years in order to focus on supporting students and developing on-site programmes of clinical education. The practice teacher is supported by lecturers from the HEI. Preceptorship and support for both newly qualified and student health visitors are thus delivered in partnership by the university and local services working together.

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\(^{30}\) Royal College of General Practitioners, 2013. NHS Funding black hold could lead to shortfall of 16,000 GPs

NHS Scotland’s Flying Start is a structured learning programme supporting all newly qualified NMAHPs within NHS Scotland in their first year of practice. The programme consists of 10 learning units designed to develop confident, capable practitioners through activities and mentor support. Practice Education Facilitators (PEFs) facilitate supported sessions to provide guidance. These allow for peer group discussions and enable nurses to raise concerns in a supportive environment. The programme provides a structure of support which identifies learning outcomes and opportunities for review and reflection. Setting the Direction\(^\text{32}\) notes that completion rates of the programme are highest when they are integrated into the workplace, with protected time and mentor support.

**Degree top-ups**

International research evidence demonstrates a clear association between increased numbers of degree-educated nurses and lower hospital mortality rates. In the results of the RN4CAST study, published in *The Lancet*, a ten per cent increase in nurses with degree-level preparation was linked to a seven per cent decrease in mortality rates.\(^\text{33}\) This research also showed that England had the lowest levels of degree prepared nurses in the countries studied, with only 28 per cent of nurses holding bachelor’s degrees in the hospitals studied (and a range of between 10 and 49 per cent).\(^\text{34}\) This compares to 50 per cent in Finland, 55 per cent in Belgium, 58 per cent in Ireland, and 100 per cent in Spain and Norway. Given this range and the registered to non-registered nursing care skill mix, it is likely that not more than one in ten of those giving nursing care at Mid Staffordshire had degree level education; the ranges shown in the RN4CAST project suggest this could have been as low as one in 20.\(^\text{35}\)

Although the all-degree education threshold will see graduate levels grow over the years, this will be relatively slow and incremental growth (c. 16000 per year across all fields on a total UK nursing register of 497,000).\(^\text{36}\) Increased investment in top-up courses to allow registered nurses to gain a degree level qualification may therefore be one way of reducing mortality levels and increasing the effectiveness of the existing workforce. The US Institute of Medicine Future of Nursing report has set a target of 80 per cent nursing

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\(^{34}\) ibid, p. 4.  
\(^{35}\) Calculated from 28% of the workforce (with 10% the lower end of the range); skill mix on wards with poor care was 40:60 registered to non-registered.  
\(^{36}\) The last statistics extract available on the NMC website is from 2007-2008; this number may therefore have changed.
students with baccalaureate (another terms for bachelor's) degrees by 2020.37

**Structured career pathways for nurses**

The majority of the nursing workforce that will be employed in 2020 or 2025 is already part of the workforce: adapting to evolving patient needs and service redesign will depend on making the most of their talents, recognising that most now work outside of the NHS. Although many employers support individuals to gain further education and training, there is a notable lack of structured career pathways, with nurses often progressing serendipitously, with the result left to the support of individual line managers or their own determination.

If health and social care are to make the most of its workforce, a clear but flexible career structure must be prioritised and consideration given to its resourcing. Nursing must find a model that is appropriate for its own roles but it is striking that medics are considered part of the ‘future workforce’ in budget terms (through what has traditionally been known as the Medical and Dental Education Levy, part of HEE’s budget) until they finish their specialist training.

*Setting the Direction* contains a commitment to map roles at all levels using the NES post-registration Career Framework (1.3) and to develop an effective model for centrally coordinated and funded post-registration and postgraduate education to support nursing and midwifery education/capacity (6.2).

This structured career pathway could then be used to give context to continued professional development, ensuring that resources are well-targeted at priority areas. As part of this, HEIs with existing expertise in relevant fields could be designated as centres of excellence.

**Making the most of Advanced Practice**

By 2022, the number of people with multiple morbidities is expected to rise from 5 million to 6.5 million.38 In order to deliver the complex care that many patients will need, particularly in the context of predicted shortages of medical staff in urgent/emergency and primary care, an increased number of nurses will need to practise at a higher level, supported by post-graduate education programmes. There are many examples of excellence in advanced practice, from neonatal nursing to palliative care to prescribing courses: NMC figures from 2010 show UK-wide over 19,000 supplementary and


independent nurse prescribers. However, strategic oversight of the areas of focus of advanced practice will be necessary for the wholesale change that is needed if future patient needs are to be met.

An online Advanced Practice Toolkit has been developed by NHS Scotland which brings together resources, guidance and new information or research for employers, educators and advanced level practitioners. The toolkit contains a nationally agreed definition of Advanced Practice for Nurses, a competency map, a national job profile and template knowledge skills framework, activity analysis tools, portfolio mapping support, education programmes mapped to competencies and capabilities, assessment of competence, links to qualifications frameworks and regulatory guidance.

NHS Wales has implemented a Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales to ensure consistency in the development and evaluation of Assistant practitioner roles. These national guidelines provide clarity in defining the Advanced Practitioner level of practice, outline governance criteria and provide portfolio guidance. The introduction of advanced practice guidelines in Wales has enabled frameworks of local governance as well as developing a more robust understanding of advanced practitioners’ roles at a senior management level.

University of Southampton offers an MSc programme in Clinical Leadership in Cancer, Palliative and End of Life Care. This programme aims to enable emerging and established clinical leaders in these specialties to critically champion compassionate and informed care and create learning environments that promote excellence. The programme combines self-directed, work based learning and modules. The self-directed element has led to beneficial developments within practice, fostering an understanding of the relationship between research, clinical practice and care delivery.

Edinburgh University has developed an online telehealthcare module as part of the MSc in Advance Practice to understand and reflect on the use of healthcare technology. The module was developed to fill a gap in the knowledge and experience of healthcare professionals in delivering remote healthcare, a skill that is key to providing more care in the community.

39 Nurse Prescribing in the UK: RCN Fact Sheet 2012, RCN, London
Research, innovation and evidence based practice

Central to a flexible workforce able to adapt to changing patient needs, new technology and models of care is the translation of research into practice and the dissemination of knowledge, with a cadre of researchers, clinical academics/educators and broad research awareness across the nursing workforce an essential component of advancing patient care.

A new cadre: setting the vision

Health education relies on a three way exchange between research, education and practice. This is in a context of long-standing concerns that the integration between higher education and clinical practice could be increased, that the demographic profile of the nurse educator workforce is ageing and that education roles may be unattractive due to their terms and conditions.  

Although work can be done to strengthen mentorship and many other aspects of practice education (see below), the transformation of the partnership between health and higher education and students’ experiences in practice requires a bold commitment to growing and developing a new cadre of clinical academic educators, with an increased emphasis on posts that integrate research, education and practice. This will require significant capacity building and take time. However, the Shape of Caring Review is a significant opportunity to set out this vision for the connection between practice, education and research and to set out ways of supporting the development of a new generation of educators and researchers.

Birmingham University is developing an exchange scheme where academic nursing staff will be encouraged to spend 10 per cent of their time in clinical practice whilst nurses working in clinical settings spend 10 per cent of their time in the university.

Frontloading the numbers engaging in clinical academic careers

The numbers of nurses, midwives and AHPs engaging in CACs remains relatively low. The capacity to deliver research informed education and training to both pre- and post-registration nurses, midwives and AHPs is therefore dependent on expanding the number of health professionals engaging in clinical academic careers and post-graduate research who can provide leadership and support to the next generation. Serious investment is needed to support mechanisms for existing and aspiring NMAHP clinical

43 See for example findings from the StLAR HR Project, 2004/5
academics. The number of places offered for Masters in Clinical Research needs to be extended and promoted to NMAHPs at all stages of their career, with a clear route map as to how this may be used to develop a clinical academic career.

A Research Knowledge Transfer Strategy has been put in place at University of Nottingham following the development of a new health sciences school with three divisions: nursing, midwifery and physiotherapy. The school currently has six research groups developed from funded programmes, led by a senior academic supported by post-doctoral researchers, including the Centre for Evidence Based Care.

University of the West of England offers Clinical Academic Training Programme Internships, covered by a bursary which provides salary support and other costs, for those who wish to develop a clinical academic career. The intern is supported to develop a proposal and application for a PhD in any clinical area that is within the strategy plan of their Clinical Commissioning Group.

Glasgow Caledonian University has developed a strategy to promote clinical academic careers which includes the creation of clinical academic posts that have an impact on teaching and research activity. An example is a post funded jointly by the Department of Nursing and community health and the Greater Glasgow and Clyde Health Board which support the British Heart Foundation and Marie Curie Cancer centre to implement the Caring Together Project.

Developing the clinical academic career structure at national level

A number of universities have programmes and pathways which support the translation of research into practice and progression into CACs; research themes are often introduced during undergraduate and post-graduate study. However, the lack of clear and consistent career pathways particularly for mid-career or senior level NMAHPs is a serious barrier. It is currently estimated that 0.1 per cent of the nursing workforce in England are professors of nursing: an indication that there are simply inadequate numbers for the task of leading research and evidence-based practice.

Shape of Caring should also consider the merits of putting forward a stretching but realistic figure that would enable a step-change in the impact of nursing clinical academics on both research and education. The US Institute of Medicine’s Future of Nursing report, for example, recommended a doubling of the numbers of nurses with doctorates by 2020.44

44 The Future of Nursing: Leading Change, Advancing Health
Edinburgh University offers a Masters of Nursing in Clinical Research to its most promising nursing students, supported by Scottish Government funding, which allows students to undertake research within their original health board and return to this area upon graduating to pursue a research career. Students are attached to established research teams in Clinical Research and nurse led research, supported by specifically prepared research mentors. This course produces early career research nurses with the ability to work on research grant proposals and use research to influence their own clinical practice, as well as preparing students for undertaking a PhD.

Students as co-creators and innovators

Healthcare students are actively involved in shaping their education, both indirectly through standardised feedback mechanisms, course evaluations and student surveys; but also more directly as innovators, researchers and reflective participants. Whilst the importance of service user involvement in teaching and assessment is generally accepted within policy, the role of students as collaborators in the production of innovative approaches to teaching, research and delivery of healthcare is often overlooked. There is a risk that students are considered as passive recipients of education; people who are ‘done unto’ rather than critical, engaged and creative contributors, who enter education programmes with their own experiences of healthcare delivery.

Academics at Sheffield Hallam University worked with students to co-create interactive web-based workbooks to enable students to gain a greater understanding of possible therapeutic interventions, supporting decision making and reasoning skills. The role students played in developing this resource has led to a high level of engagement with it, both within teaching sessions but also whilst out in clinical practice. Students reported that co-creating the resource enabled them to better understand the level of knowledge required for their level of training.

Canterbury Christ Church University offers a third year ‘Innovation and Creativity’ module to pre-registration occupational therapy students. The final outcome of the six week module is a fully developed business proposal for an innovative idea which promotes or supports the outcomes of occupational therapy. This gives students a chance to test out their solution to a self-identified gap in the market in a supportive environment, whilst exposing them to the challenges of realising an idea. A number of the services or products emerging from this module have been selected by the university for further development.
The Theory to Practice post-graduate programme offered at Edinburgh Napier University sees students undertake a project based in clinical practice in partnership with local trusts. The programmes uses quality improvement methods to evaluate important issues within different areas of practice, including auditing breast feeding practices among women in a post natal unit, a staff perspective of barriers to GP use by men with learning disabilities and an audit of an integrated care pathway for the dying patient. The results of these are fed back to the trusts, and many students go on to disseminate their work through publication.
Funding and commissioning levers

Sustainable future funding for pre-registration education

The funding structures for both pre-registration and post-graduate education are vital enablers for other recommendations within the review. Pre-registration education funding for nursing comprises a number of components, including payment of the student’s tuition fees (currently via the benchmark price), student support through the bursary system and a pro-rata contribution, or tariff, paid to service providers for the cost of placements.

The 2013/14 BMP for pre-registration nursing is £8315 (with London weighting applied where relevant). The price for the financial year 2014/15 has not yet been agreed. Aside from the inherent instability of protracted negotiation, there is essentially a divergence between the price that the education commissioner in England is willing to pay for pre-registration education and the cost of sustaining that education with the investment in facilities and staff needed to meet expectations of high quality education. Modelling carried out in 2014 shows that on the DH’s own formula there is now an 8-12 per cent gap between the BMP and the cost of providing education.45

Many universities are already close to a tipping point in the affordability of sustaining health professional courses: in a survey of universities with relevant programmes in August 2014, 70 per cent had BMP as a high risk on their overall university risk register.46 Substantial changes in higher education, such as the cap coming off for student numbers in England in 2015, may also make BMP-funded courses less attractive if funding is diminished and destabilised, with clear risks for the sustainability of future workforce supply.

The complexities of reforming the current system are not to be underestimated and the risks if workforce supply were to be disrupted are significant. However, there is now a clear imperative for a strategic review of pre-registration education funding for nursing, midwifery and AHPs, with a number of questions that need to be explored:

- Who pays? At present, the burden of funding pre-registration education for nursing, midwifery and AHPs falls on the taxpayer through the package of BMP, bursary and placement tariff. This is not the case or to this extent for many other health subjects, such as pharmacy or healthcare science.
- What is the right funding level? The last full costing review that underpins the BMP was undertaken in 2002, updated in 2007/8. With huge changes to the practise of education in the past eight years, a baseline of the real costs of this

45 Nursing, Midwifery and AHP Pre-registration Education in England: the Funding Gap, CoDH/UUK, March 2014
46 Unpublished UUK Member survey, August 2014
educational provision needs to be established, particularly if the funding model is to change (for example, if the case were to be made for a HEFCE funding supplement).

- Can a national model of funding for health professional education be sustained? Although far from perfect, the BMP has provided a measure of stability and competition on the basis of quality rather than price over the past ten years. However, a national system may not be possible to sustain in the context of short term affordability constraints.
- Are there efficiencies that could bring the cost of provision down at a system level? The compliance costs associated with NHS contracts for education place a significant cost burden on the HE and health sectors (e.g. duplicative quality monitoring systems, a separate bursary unit). Streamlining systems and reducing duplication should be considered as a matter of urgency.

Any review should also be placed in the context of an overall review of the MPET budget, which would impact on placement tariffs and student support.

**Supporting high quality practice education through the tariff**

The placement tariff for all 'non-medical' education is set at £3175 per year, adjusted pro-rata for the time spent in placement.\(^47\) The establishment of the placement tariff has been an important step forward. However, there are a number of issues:

- **Level:** when the tariff was established, its level was pragmatically based on affordability within the overall MPET budget (given the amounts moved across under the Service Increment for Teaching (SIFT) transition plan). The tariff therefore does not yet have a clear link to costs and also groups all 'non-medical' education together. The education reference costs work led by DH may provide some of the answers to how the tariff should develop; this important work should be explored within the context of the Shape of Caring Review and wide consultation conducted on any future implementation.
- **Accountability:** Commissioners must ensure that the opacity associated with SIFT (which functions at least in part as a service tariff supplement for tertiary/university hospital services, plugging deficiencies in the service budget rather than explicitly supporting spent on education) is not replicated in the 'non-medical' tariff. This requires clear expectations that the placement tariff is spent to support education and the establishment of an effective way to hold employers to account. It may also be possible to explore whether the tariff monies should be administered by universities (though there may be overhead costs associated with this).

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\(^47\) DH (2014), Education and Training Tariffs: tariff guidance for 2014-15
Post-registration funding

There is no substantial designated funding stream for post-graduate nursing, midwifery or AHP education, particularly not in comparison to that available to medicine and dentistry. Instead, relatively small amounts of post-registration education are commissioned using ‘workforce development’ funding.

In order to support the vision of post-registration career pathways and their underpinning education and training, an overall review of the MPET budget on a whole workforce basis is necessary, working with NHS England to explore service priorities and the relative responsibilities of the individual, the employer and HEE to support workforce development.

Adaptable and flexible workforce planning

Nursing pre-registration education is currently commissioned in England using a centralised workforce planning model, where projections from employers within LETBs are aggregated at national level, moderated and then numbers commissioned with universities to meet projected employer demand.

Data on ‘boom and bust’ workforce planning cycles suggest that centralised workforce planning is often driven by short term affordability concerns rather than long term developments and that these have tended to operate in professional silos. Although efforts have been made, particularly in the past year, to collect data from non-NHS employers, the model is also predominantly focused on the NHS in a fragmented system with a diverse range of providers.

A philosophy of centralised workforce planning is also increasingly divergent from the approach that underpins higher education in England, which is characterised by a more market-led philosophy, in which liberalisation of supply is moderated by factors such as employability rather than by central quotas. As recent discussions on the establishment of private medical schools highlight, there is little within the current higher education regulatory frameworks to restrict universities from recruiting self-funding students if they have programmes that meet the regulators’ standards and sufficient placement capacity. There are increasing numbers of domestic self-funding students within the allied health professions and signals of similar developments in nursing. Taken together with the inherent limitations of an aggregated model that tends to reflect short-term affordability more than need, centralised workforce planning models will need to be reviewed to be fit for the future. Such a review would need to take into account a number of issues, including mitigating risks of undersupply, maintaining appropriate budget controls and placement capacity.

The Council of Deans of Health is the representative voice of the 85 UK university health faculties providing education and research for nursing, midwifery and the allied health professions. We aim to influence health and higher education policies that impact on the development of an expert healthcare professional workforce across the UK and build partnerships that help demonstrate and support the contribution of our members to research.

www.councilofdeans.org.uk