Council of Deans of Health: Response to Department for Business Innovation and Skills Consultation - Fulfilling Our Potential: Teaching Excellence, Social Mobility and Student Choice

January 2016

Council of Deans of Health

The Council of Deans of Health (CoDH) is the representative voice of UK university health faculties engaged in education and research for nursing, midwifery and the allied health professions (AHPs). Further information about us can be read at: http://www.councilofdeans.org.uk/.

Fulfilling Our Potential is a wide ranging consultation proposing fundamental reform to the regulation and funding of higher education. The consultation will attract detailed responses from individual institutions and other bodies representing higher education providers. These will pick up many of the general points that our members would wish to make. We have therefore limited our response to those questions that particularly affect our members' health education and research and their student bodies. We have indicated where these comments relate to a specific consultation question. We are also mindful that although these policy developments are focused on England, there may be UK-wide implications of some of these changes, including the Teaching Excellence Framework (TEF).

Teaching Excellence Framework (TEF)

[Question 7 relating to administrative burdens on institutions]

The quality assurance burden is already very substantial for institutions engaged in teaching nursing, midwifery and AHP students with inefficient parallel systems across health and higher education. For each health professional course, universities are accountable to at least three (often four) different bodies with overlapping requirements:

- Higher education regulators through the Quality Assurance Agency (QAA).
- Health professional regulators – the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC). These regulators approve and quality-assure programmes against their standards. The standards for pre-registration nursing education are 140 pages long and specify requirements for teaching, learning and assessment of nursing students. For example, approved education institutions must ensure that nurse and midwife teachers who make a major contribution to the

programme hold, or are working towards, a teaching qualification, and programme providers should ensure that teaching and learning methods address individual learning styles.

- Professional body requirements, which typically include a curricula framework and monitoring.
- The NHS via Health Education England's Local Education and Training Boards (LETBs). Contracts with universities currently stipulate a detailed QA framework that includes an annual cycle of monitoring and regular contract review meetings throughout the year. It is anticipated that this compliance regime will be largely removed through the changes to health education funding for new students for 17/18 announced in the 2015 Comprehensive Spending Review. However, the length of courses means that there will be a large number of students at university funded under these contracts and, therefore, compliance requirements until at least 2020.

Data requests for each of these bodies are frequently duplicative, with inconsistent definitions and requirements that create substantial unnecessary burdens for institutions.

Whilst we support efforts to ensure that all students receive excellent teaching at university, we are naturally sceptical that a further layer of quality assurance requirements will bring any benefit for the faculties we represent or their students**. There is a real risk that further bureaucratic requirements, especially after the first year of TEF, will instead divert focus from teaching and research**. This could give UK institutions an international disadvantage against less bureaucratic systems elsewhere. We welcome the Green Paper's commitment in paragraph 33 to minimising burdens on institutions by using the same metrics and indicators for QA and higher levels of TEF wherever possible. Existing requirements and metrics must be carefully mapped to TEF proposals to ensure there is no further duplication of datasets. We do agree however that these may need to be contextualised qualitatively by providers to take account of different student bodies **[Question 11]**.

Given the proposal to make TEF assessments at discipline level, we would strongly advise that, if this happens, a clear commitment is made to consider using existing stringent requirements, emanating from health professional regulations, professional bodies and the NHS, as the basis of TEF metrics for nursing, midwifery and AHP subjects. This would also be in line with the aspiration to more proportionate and risk-based regulation for these heavily monitored subjects, whilst safeguarding quality. We are concerned that multi-level TEF assessments could prove to be excessively bureaucratic and unnecessarily detailed. It might also prove difficult to define the different levels of assessment in a consistent manner across institutions.

The proposed timescales for introducing TEF will feel tight for faculties and institutions adjusting to major parallel changes in the higher education environment including changes to bursaries and regulatory standards from professional bodies.

We will respond more fully to the TEF technical consultation later in the year.

[Question 3: The applicability of TEF to all providers, disciplines and modes of delivery]

If TEF is to function at discipline level, consideration will need to be given to how this is defined and how this will work in practice without creating a disproportionate burden on providers. At present, data at discipline level for nursing, midwifery and AHP courses is notably poor: HESA codes do not map easily to courses regulated by the same health professional regulator and comparable courses use different Joint Academic Coding System (JACS) codes. Subjects that have been merged include: nursing, midwifery and operating department practice; physiotherapy with physiology and neuroscience; occupational therapy is grouped with occupational health, environmental health, and counselling and paramedic science.

For the faculties we represent, much of the teaching is delivered through learning in practice. It is a requirement under the Mutual Recognition of Professional Qualifications Directive (2013/55/EU) that pre-registration nursing students spend 2300 hours in 'clinical training'. Physiotherapists and occupational therapists spend 1000 hours of their course on practice placements. Universities are responsible for the quality of learning in practice but do not have responsibility for the practice areas themselves. The Green Paper does not address this in detail beyond stating that work-based teaching will be included in the TEF assessment. We would want to understand both how this element of student teaching would be assessed – including the mechanism for obtaining compliance from third parties with assessment processes - and what impact assessment of this teaching could have on overall TEF levels, assessments and university funding.

Social mobility and widening participation

We strongly welcome the Government's commitment to double the proportion of people from disadvantaged backgrounds entering higher education by 2020 from 2009 levels **[Question 12]**. Nursing, midwifery and some of the AHPs have a particularly strong record in widening participation to higher education. A number of disciplines have more than double the average (10.9%) number of students from disadvantaged backgrounds. Secondary analysis of 2013 Higher Education Statistics Agency (HESA) data carried out by HEE's widening participation team shows that 22% of students on mental health pre-registration nursing courses came from low participation neighbourhoods, 21% on learning disability nursing courses and 19% on adult nursing courses. Of the AHPs, 14% of diagnostic radiotherapy students come from low participation neighbourhoods, 13% of speech and language therapy students and 13% of podiatry students. Given the overall size of the student populations in nursing, midwifery and AHPs, sustaining their record in widening participation will make an important contribution to the Government's targets.

Profession/field	% students from low participation neighbourhoods (POLAR3 Quintile 1)
Higher Education Average (Eng)	10.9%
Nursing (Adult)	19%
Nursing (Child)	15%
Nursing (LD)	21%
Nursing (MH)	22%
Midwifery	14.5%
Dietetics	13%
Occupational Therapy	12%
Physiotherapy	9%
Podiatry	13%
Speech and Language Therapy	13%
Diagnostic Radiography	14%
Therapeutic Radiography	12%
Orthoptics	8%
Paramedic Science	15%

Source: HEE (2014) *Widening Participation, it matters!* p.19 (Secondary analysis of HESA 2013/14 data)

It is essential that the commitments to social mobility and widening participation set out in *Fulfilling Our Potential* are translated into careful implementation of the Comprehensive Spending Review's changes to student funding from 2017/18. We cannot be certain what impact the move from grants to a loans-based system will have on applications to study at the faculties we represent. Evidence from previous reforms suggests the move from grants to loans might be expected to deter some mature students, particularly in the initial years of reform and there is a risk that the changes will impact on other groups. This is of particular concern to us as mature students constitute a very high proportion of our student intake – 51% of adult nursing students are aged 25 and over. We continue to argue for careful monitoring of the impact of the funding changes on all groups of students and the use of public funding to ensure sufficient applications from mature students and students from low participation neighbourhoods. This might include, for example, grants to cover the gap in placement travel costs and measures to encourage applicants into various undersubscribed health profession fields.

Our member institutions also have a particularly good record of allowing people to enter higher education through non-traditional routes like access courses. We would want to understand what role the entrance tariff will play in TEF to ensure that our members are not disadvantaged as a result.

Simplifying the higher education architecture

Although the ambition to simplify HE regulation is welcome, the proposed changes to the higher education architecture contain significant risks for the future of teaching funding and for the connection between education and research.

In particular, if teaching funding moves to BIS we are concerned that it will be unmediated and more vulnerable to political pressures and cuts, to the potential long-term detriment of the quality of higher education. The recognition in the CSR reforms of the science base and higher cost of nursing, midwifery and AHP courses is a significant step forward for the development of these disciplines. Any destabilisation of teaching funding in the new system would prove highly detrimental to the delivery of high quality education. Administration of teaching funding by OfS would elicit greater confidence from providers **[Question 18 d]**.

Dividing teaching and research funding is also potentially a significant problem. Excellent health education is built on research-led and research-informed teaching. The critical relationship between these activities should be reflected in the higher education architecture. We believe that the sector currently benefits from HEFCE's involvement in both teaching grants and a significant proportion of research funding. Basing financial support for both teaching and research within a single institution helps to give that organisation a clear overview of institutional financial stability. We note that the Nurse Review recommended that in any reformed system the linkage between high quality research and high quality advanced teaching, currently promoted by HEFCE's joint remit, will need to be maintained. Taking into account our reviews on both teaching and research funding, **we strongly recommend that the OfS assumes responsibility for the administration and allocation of both teaching and QR funding, and therefore for both TEF and REF [Question 21].**

We do not believe the OfS should be funded entirely by institutions as its proposed remit is much broader than regulation. **[Question 21b]**

Reducing complexity and bureaucracy in research funding

[Question 24]

The CoDH is proud of its members' important contributions to the UK's overall research excellence. Research by nurses, midwives and AHPs lies at the heart of responding to pressures on health services and the radical changes this requires. Sustaining and growing this vital research requires a robust funding architecture, commitment to investment and focus on supporting applied research through, for example, knowledge exchange with business. Any research reforms need to ensure that the work done by Innovate UK is preserved and strengthened.

We are broadly supportive of the recommendations made by the Nurse Review, particularly its commitment, shared by *Fulfilling our Potential,* to the dual funding system for research. We share widespread sector concerns that movement of QR funding away from HEFCE to a

single research funding body (Research UK) encompassing Research Council funding will make the dual support funding system more vulnerable to erosion. Should the two funding streams be brought under one overarching organisation we would certainly want to see a clear separation of the funding streams and related requirements, a considerable degree of hypothecation and total transparency of process, much of which could be captured by legislation **[Question 25a and b]**. It is also important to preserve the benefits of clearly independent research councils promoting very different fields of research. It is vital to avoid this system strength being undermined by an overly centralising Research UK.

Question 27

We would want to make greater use of existing datasets for REF and reduce the overall burden substantially but sole reliance on a metric-based approach would be misguided. All eligible staff should be submitted to the REF exercise and we would want to encourage more submissions on pedagogy research from nursing and AHP fields to showcase quality teaching and learning as evidenced by research impact. Any use of metrics should be calibrated within disciplines rather than between them.

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